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

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1 Topic Analysis by Inko Bovenzi

Inko Bovenzi debated for Hunter High School in New York City. He qualified to the Tournament of Champions twice and reached outrounds in his junior year. He has reached late elimination rounds in several varsity tournaments, including finals at Yale, quarterfinals at UK and semifinals at Scarsdale. In addition, he was 8th speaker at Harvard, 3rd speaker at UK, and 7th speaker at Scarsdale. He was invited to compete at the Harvard Round Robin twice, and during his senior year, he was ranked first in the country. He was an instructor at the Victory Briefs Institute this summer.

1.1 Introduction

Unlike past Public Forum topics which gave debaters significant ground to debate exactly how the resolution at hand would be implemented (ex. How much would a universal basic income be?), this resolution specifies an exact bill for the federal government to pass. This means two things: first, a lot of sources talking about drawbacks or posi-tives about “Medicare for All” might not specifically apply to the Medicare-For-All Act of 2019 since what exactly is meant by “Medicare for All” is quite vague and secondly, I would highly, highly recommend reading the full text of the bill. The house version can be found here, the Senate version here.

A lot of teams will be reading arguments (particularly on neg) that are specifically addressed by the bills to avoid any potential pitfalls to Medicare for All. Here are some examples:

A lot of neg teams are reading an argument about how Medicare for All will likely use Medicare’s low reimbursement rates for hospital care, undermining rural hospitals. However, the house bill states:

> (1) PAYMENT IN FULL.—Such payment shall be considered as payment in full for all operating expenses for items and services furnished under this

> Act, whether inpatient or outpatient, by such provider for such quarter, including outpatient or any other care provided by the institutional provider or provided by any health care provider who provided items and services pursuant to an agreement paid through the global budget as described in paragraph (3).

Hospitals will be paid in full for all services they provide, which should prevent any closures. Moreover, if rural hospitals need to expand or are understaffed, the bill also solves for these issues:

> ”(7) SPECIAL PROJECTS BUDGET.—The special projects budget shall be used for the construction of new facilities, major equipment purchases, and staffing in rural or medically underserved areas (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))), including areas designated as health professional shortage areas (as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a))).”

Some teams are also reading an argument about how all of the workers currently employed by the healthcare insurance industry will lose their jobs, hurting the economy. But the bill has a plan for that:

> (A) IN GENERAL.—For up to 5 years following the date on which benefits first become available as described in section 106(a), at least 1 percent of the budget shall be allocated to programs providing assistance to workers who perform functions in the administration of the health insurance system, or related functions within health care institutions or organizations who may be affected by the implementation of this Act and who may experience eco-nomic dislocation as a result of the implementation of this Act.
>
> (B) CLARIFICATION.—Assistance described in subparagraph (A) shall include wage replacement, retirement benefits, job training, and education benefits.

As a final example, the implementation of single-payer systems in Europe may have caused significant deaths as a result of delays in the release of drugs, because it takes time for the government to negotiate with the private sector for lower prices on drugs/treatments. Once again, that shouldn’t be an issue for this bill:

> FINALIZATION OF NEGOTIATED PRICE.—The negotiated price of each covered drug for a negotiated price period shall be finalized not later than

30 days before the first fiscal year in such negotiated price period.

1.2 General Thoughts for Both Aff and Neg

In Public Forum, I would always strongly recommend that teams only read weighable arguments on the topic. The reason for this is pretty clear—if your opponents' arguments always outweigh yours, then the only clear way for you to win rounds is by delinking their cases. However, usually teams win their own cases since they spend hours and hours researching them, as opposed to maybe 30 minutes on blocks for a spe-cific argument. In most rounds between two equally-matched teams, both teams will at least win some offense off their cases. The winner is then determined by the weighing debate.

So, what are the most easily weighed impact on this topic? In my eyes, there are three: issues pertaining to the health of the global economy, issues pertaining to the health of people worldwide, and issues pertaining to structural violence with appropriate fram-ing. I have not seen any clear, well warranted arguments on this topic with large impacts that don't link into one of these three issues (i.e. there's no common war arguments, for example).

1.2.1 The Global Economy

One of the most common ways to link into the health of the global economy I've seen in PF rounds is to impact to American growth, and then to argue that American growth spills over due to remittances, trade, tourism, or any other globalization-related rea-son. While intuitively this link feels fairly strong, the extent to which a small increase in the size of the American economy benefits the globe is very limited. The growth of the United States and any other country on the globe is usually weakly correlated, par-ticularly the growth of developing countries. While very few countries escaped from the 2008 recession unscathed, the degree to which smaller recessions impact countries varies greatly. Moreover, whether the US grows at a rate of 2% or 3% doesn't alter trade patterns enough in the short term to meaningfully affect foreign economies.[1]

[1] In the long term, it does matter because the difference between 2% growth and 3% growth is huge over long periods of time. For example, 100 years of 2% growth will yield a net increase of 724%, whereas 100 years of 3% growth will yield a net increase of 1921%, nearly a three-fold difference.

One reason for this phenomenon is that economies that have not yet completed the transition from agrarian-based economies to industrialized economies tend to produce goods that have low elasticity of demand, such as produce or oil. The price (and hence profitability) of such goods tends to be influenced by supply-side issues much more than demand, because the demand rarely meaningfully changes. The way in which American recessions hurt developing countries tends to center more around reversing flows of capital, i.e. investors pull their investments from these countries. This seems unlikely to happen to any significant extend from passing Medicare for All, even if trade does rise/fall a little.
The best links into the health of the global economy will be argument that highlight a specific group of economies, such as emerging markets, and explain precisely how Medicare for All will positively or negatively affect them. The best example for this type of argument is the neg debt arguments, discussed in a later section.

1.2.2 Health

There are two ways to link into people's health on this topic: access and innovation. With greater access to drugs, people can better make use of existing innovation and life expectancy rises. Similarly, innovation creates cures/treatments for more conditions, saving lives. Both of these two issues are prerequisites to each other to some extent. Without any access, innovation is useless, and without innovation, access isn't so use-ful either. They also both impact each other: greater access begets greater innovation by raising the profitability of producing drugs, while innovation reduces the cost of treatments and creates competition in the market, increasing accessibility. Ideally, there should be a good balance between the two.
The debate between access and innovation has been at the heart (get it) of US healthcare for decades. While many Americans believe that prices for drugs should be lowered so that consumers can afford the drugs, they need without risking bankruptcy, others (mostly in the pharmaceutical industry) argue that high profits are needed to allow for greater innovation. The general academic consensus with regard to the issue is as fol-lows:
U.S. consumers generate more pharmaceutical revenue per person than Europeans do. This has led some U.S. policymakers to call for limits on U.S. pharmaceutical spending and prices. Using a microsimulation approach, we analyze the welfare impacts of low-ering U.S. prices toward European levels, and how these impacts vary with key model-

ing assumptions. Under the assumptions most favorable to them, price controls gener-ate modest benefits (a few thousand dollars per person). However, for the remainder of plausible assumptions, price controls generate costs that are an order of magnitude higher. In contrast, publicly financing reductions in consumer prices, without affecting manufacturer prices, delivers benefits in virtually all plausible cases.[2]

The Medicare for All Act combines the concept of price controls with that of publicly financing reductions in prices. While almost all care in the United States would be free if the bill were enacted, the government would have the capability to negotiate down the prices of drugs to decrease its own spending.

Weighable arguments about health will impact to global health i.e. impacts outside of the United States. That means that arguments about accessibility should link into the global pricing/availability of drugs, and arguments about innovation should impact to drugs that can save lives around the world.

1.2.3 Structural Violence

While this is an area of argumentation that I do not have much experience with, as PF expands to include a greater variety of argumentation and more voices, structural vio-lence framing is increasing in prevalence. There isn't a strict definition of what exactly is and isn't structural violence: for example, some would argue that poverty is a form of structural violence, while others would differ. Here is a explanation by Dr. Paul Farmer:

"Structural violence is one way of describing social arrangements that put individuals and populations in harm's way… The arrangements are structural because they are em-bedded in the political and economic organization of our social world; they are violent because they cause injury to people … neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency. Structural violence is visited upon all those whose social status denies them access to the fruits of scientific and social progress."[3]

Because impacts to structural violence are challenging to weigh in terms of typical utilitarianism-centric weighing metrics (for example nuclear war impacts more people than any form of structural violence), good debaters reading cases impacting to struc-tural violence will read framing explaining why these impacts should come first. This framing may include arguments saying that because the voices of those most oppressed

[2] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.1.w138

[3] http://www.structuralviolence.org/structural-violence/

under structures of violence are ignored in policy making, their issues should come first, arguments explaining how “slow violence” magnifies over time without many individuals in society seeing it, or other similar argumentation.

While in theory both sides on any topic can link into structural violence, the framing is most persuasive when one side can solve for a structure in its totality, not just mitigate its effects. On this topic, the aff is the side that most easily links into such a framework, though there are link-ins that the neg can read, discussed later.

1.3 Common Aff Arguments and Their Strengths and Weaknesses

1.3.1 Accessibility and Its Benefits

By far the most common type of aff argument on this topic are the ones concerning access to healthcare and its benefits. Because Medicare for All would make nearly all medical care essentially free for Americans, there would be two benefits. First, more individuals who have been barred from seeking care due to cost reasons would be able to access it, and second all individuals would be able to save a greater share of their income for purposes other than healthcare.

The advantage of these access arguments is that they are completely true. While there are certainly plenty of disadvantage that the neg can throw at these arguments, such as Medicare for All increasing wait times, on balance it is pretty clear that access will rise in an aff world. As long as you have thoroughly researched this argument before reading it, it should be winnable in every round.

However, as usually is the case with very high strength-of-link arguments, the impacts are tough to weigh. Because an impact to just healthcare in the United States isn’t going to outweigh any significant global impact, these arguments probably need to link into one of the three categories lifted above: global economy, global health, and structural violence.

The most common link into one of these impacts through access-related arguments is that increasing free income in the United States by making healthcare free will increase imports, benefiting developing countries. While this argument is true to some extent, as discussed before, it is tough to fully establish the link from a small increase in trade to

meaningful improvements in foreign countries, though the argument is better than noth-ing. For example, Obamacare significantly increased healthcare access in the United States but did not affect the global economy.

Alternatively, many teams read that greater accessibility in the United States will break structures of violence currently inherent in the American healthcare system. Our cur-rent system is full of discrimination, from the costs that insurance companies charge their consumers to the medical care that is covered (and left out) by these plans. Most marginalized communities in the United States are only further harmed by these sys-tems of violence.

1.3.2 Businesses

Under the Affordable Care Act, most businesses are required to provide healthcare for their employees. This comes at a great cost to them, as healthcare in the United States is incredibly expensive. Affirming would shift the cost to the government, giving these businesses more capital to spend on higher wages, expansion, or other positive endeav-ors. Moreover, Medicare for All would reduce some of the job lock that exists in the United States: many people are afraid to start their own businesses or join infant ones because switching jobs would cost them their healthcare. That's no longer an issue with Medicare for All.

These arguments have similar strengths and weaknesses to the accessibility arguments. They are very true in the real world, but are tough to weigh without creative thinking.

1.3.3 Data Sharing

Medicare for All mandates that data currently controlled by competing insurance providers be shared in a national database open to the government and innovative companies. By putting together currently fractured data, a number of benefits could arise. First, the government might be better able to respond to the spread of pandemics, like COVID-19, with better data. This argument need not be only limited to pandemics, however, because less deadly seasonal "pandemics" like the flu kill tens of thousands per year. This impact, while large, is tough to fully contextualize (how many lives will this save?) and also somewhat challenging to weigh against global impacts.

Secondly, better data improves the ability of innovative companies and the government to innovate new drugs, bolstering new drug creation by decreasing the number of failed

drugs, as currently half of drugs fail well into the costly innovative process. This impact is more easily weighed than the previous one, as drug innovated in the United States can save lives globally: a very weighable impact.

1.3.4 Value-Based Pricing

Because Medicare for All gives the power to the government (specifically, the health sec-retary) to negotiate down the prices of drugs, it is up to the United States what the price of different drugs should be. The bill recommends that the pricing of drugs be based on their utility, the cost to innovate that drug, and competitor pricing, among other fac-tors. When drugs are priced based on their utility to society, that is called "value-based pricing."

Value-based pricing has a number of benefits. First, it ensures that the government does not overpay for drugs that barely affect patient well-being, or offer limited clinical value over preexisting, cheaper drugs, both huge problems in the status-quo. Second, and more importantly, it makes sure that pharmaceutical companies have a profit incentive to develop the drugs most important for society, not the ones they can sell to wealthy people at the highest prices. This is especially important considering that 80-90% of the current drugs in the market are me-too drugs offering little to no clinical benefits over already existing drugs.

This argument has huge potential: value-based pricing could remake and vastly im-prove innovation in the United States, perhaps even without decreasing the profitability of pharmaceutical companies. This argument is super weighable, as US drugs have the potential to save lives around the world. Its only drawback is that it's unclear how ex-actly value-based pricing could be implemented, as it is almost entirely up to the discre-tion of the health secretary, and implementations have had some hiccups in European nations with single-payer systems.

1.4 Common Neg Arguments and Their Strengths and Weaknesses

1.4.1 Care Quality and Downstream Effects

Rural Hospitals Close/Doctor Pay Declines/Wait Times/Insurance Company Workers Fired

While these arguments may seem different at first glance, I grouped them together be-cause they all have the same weaknesses. First, as mentioned in the introduction, the Medicare-for-All Act of 2019 specifically accounts for all these problems. Second, even if it didn't, none of them are easily weighable against a huge increase in access in the United States (the impact of rural hospitals closing is a few dozen hospitals, the impact of doctor decline is 4% of US doctors). And third, even if these arguments were true and had weighable impacts, they all are temporary problems in their nature that would decline over time as market forces corrected for them, as they have in Europe. For ex-ample, a shortage of doctors would increase the salaries of doctors, increasing demand for medical school and in the long term creating more doctors.

1.4.2 Innovation

Because Medicare for All would allow the government to negotiate down the prices of drugs, it is likely that pharmaceutical companies would lose a significant quantity of revenue due to depressed prices. Considering their intense lobbying against the bill, it is unlikely that this would not be the case. Importantly, even if Medicare for All did not hurt pharmaceutical profits, the perception that it would is enough to change the decision making calculus of these corporations and their investors.

When pharmaceutical companies' drugs lose their profitability, both the incentive to innovate and the capital with which to do so decline. It is well documented empirically that lower prices decrease innovation:

More important, there is a statistically significant response of the entry of nongeneric drugs, which more closely correspond to new products and "innovation": a 1 percent increase in potential market size leads to approximately a 4 percent increase in the entry of new nongeneric drugs. We also look at the relationship between market size and entry of new molecular entities. These drugs, which contain active ingredients that have not been previously marketed in the United States, provide a measure of more radical

innovations (there are 442 new molecular entities compared with 2203 new nongenerics during our sample period). We find that a 1 percent increase in potential market size is associated with a 4–6 percent increase in the entry of new molecular entities. These results together show an important effect of potential market size on pharmaceutical innovation.[4]

This argument has the advantage of being easily weighable: as explained before, innovation is a global impact, saving countless lives. While this argument has no clear weaknesses as it is pretty true in the real world, it relies on the link that Medicare for All will decrease corporate profits. This link can be contested because a) Medicare for All will increase access to drugs, and thus demand for them and b) the pharma lobby is probably powerful enough to keep the prices of drugs high. Moreover, if your opponent wins that Medicare for All will lead to the effective implementation of value-based pricing, you will probably lose the innovation debate, considering that 80% of current "innovative" drugs are almost useless me-toos.

1.4.3 Debt

Medicare for All will likely cost the United States government a mammoth sum, with estimates ranging from $30 trillion to $60 trillion over the next decade. These quantities are so great that the government lacks the ability to finance such high expenditures through just modest tax hikes or spending cuts. Thus, it is likely that affirming will increase the size of the debt.

There are countless reasons for why a high debt might be harmful to the United States or the global economy, but the two most common ones are the "crowding-out effect" and increasing emerging market interest rates.

1.4.4 The Crowding-Out Effect

When investors buy US bonds (the US government maintains its debt by issuing bonds), that inherently trades off with other investments they may make in either the US econ-omy or the global economy. For example, if I have $10 I want to invest and I buy $10 worth of bonds, I'm not investing my money in a business. That means that a high debt trades off with investment to businesses, both in the United States and abroad.

[4] Here, market size is synonymous with revenue.

While this argument is probably weighable with its implications for foreign economies, it is unclear that major spending ever harmed the US economy, because government spending pumps money into the economy that people can then use to invest in the private sector. Generally speaking, greater government deficit spending increases, not decreases the GDP.

1.4.5 Emerging Market Interest Rates

When the US government issues more bonds, in order to incentivise investors to buy up these bonds, the rate of return on those bonds, or interest rates, must rise. When the interest rates on US bonds rise, the interest rates on the bonds of emerging markets must rise too, otherwise investors will forsake those bonds in exchange for comparatively more attractive American bonds (because they now have higher interest rates). Higher interest rates harm emerging market economies because they increase the amount that these governments have to pay to the owners of their bonds. These greater payments trade off with public investment, like education spending. Such rises in interest rates have caused significant crises in the developing world, pushing tens of millions into poverty.

This argument is probably the one on this topic with the biggest impact in terms of utilitarianism, making it a good choice for neg cases. However, while all of the links in its link chain are true to some extent, in the real world the rising American debt has never caused the crises that the argument predicts, largely because the US is currently able to borrow at historically low interest rates. Subce 1980, as the debt has generally risen, interest rates have fallen.

2 Topic Analysis by Ilana Cuello-Wolffe

Ilana Cuello-Wolffe debated for The Dalton School for three years. She qualified to the Tournament of Champions her junior and senior year, and the NSDA National Tournament her senior year. She reached elimination rounds at many national cir-cuit tournaments, including the New York Invitational, Princeton, Harvard, Ridge, and many others. She received many speaker awards including third speaker at Princeton, Ridge, Villiger, and top speaker at the Byram Hills Invitational and the Westridge Round Robin. She was an instructor at VBI this summer.

Hello, and welcome to the Septober topic! It's definitely a weird year for debate, but one upside of the online format is that it's easier than ever to travel to tournaments all across the country from the comfort of your own home. The flip side of this is that because it's so easy to jump into competitions, it's easy to feel the pull to dive into arguments and have as many rounds as possible. Make sure to take breaks and to think carefully about the topic. You're a person first and a debater second, so it's alright to want to ease up to take care of your mental health and not go for every tournament signup.

With that said let's talk dive into the topic!

2.1 Introduction

The resolution is Resolved: The United States federal government should enact the Medicare-For-All Act of 2019. There are two Medicare-For-All Acts, one for the Sen-ate (Sander's bill) and one for the House (Jayapal's bill). There are a couple of things to know that most arguments will be centered on.

The first largest difference between Medicare-For-All and all other public options that have been proposed is that it is a universal program, which means that it applies to all residents of the United States. This is a pretty large change from any public healthcare option in the United States thus far. For example, there are nearly 3 million people who qualify for Medicaid but who do not receive it. A lot of this has to do with the barriers

to applications (only being able to apply in certain places, forms only being in English, etc.) but the automatic enrollment guarantees that these barriers to access would be eradicated[1]. After the four year implementation period, every resident of the United States is automatically enrolled in the Medicare-For-All program. Medicare-For-All also gets rid of Medicaid, Medicare, and Obamacare as separate programs, enveloping their funding and all those who were previously covered by it.

The second large change that the bill would implement is to nearly completely eradicate private insurance.

> SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE.
>
> (a) In General. —Beginning on the effective date described in section 106(a), it shall be unlawful for—
>
> (1) a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act
>
> This means that private insurance can't cover anything that the public insur-ance will cover – which would mostly eradicate the need for private insur-ance (although not completely, as it might offer more elective services like plastic surgery).

Medicare-For-All bill would cover most commonly used services – physicians, dental care, reproductive care, and so many more. A really critical aspect of this is that the government is given an immense expansion of power as it relates to what services are offered which has the potential to give future administrations the ability to expand or restrict services that have been widely politicized (e.g. abortion, treatment for addiction, etc.).

Another large change with Medicare for all is that it eliminates all upfront costs.

> SEC. 202. NO COST-SHARING.
>
> (a) In General. —The Secretary shall ensure that no cost-sharing, including de-ductibles, coinsurance, copayments, or similar charges, be imposed on an individual for any benefits provided under this Act, except as described in subsection (b).

This plays into a lot of arguments about saving individuals money, which will be out-lined later.

[1] https://www.commonwealthfund.org/publications/issue-briefs/2016/aug/ who-are-remaining-uninsured-and-why-havent-they-signed-coverage

The third large change is in the way that hospitals are funded.

SEC. 611. PAYMENTS TO INSTITUTIONAL PROVIDERS BASED ON GLOBAL BUD-GETS.

This plan, only in Bernie's bill, outlines that funding for all hospitals would be calculated by divvying up the profits of all hospitals according to hospital's needs (taking into account their historic inflows and funding gaps).

The final large change is creating a centralized data resource.

Since all healthcare is going to go through the government, Medicare-For-All grants the government a massive amount of data. The plan establishes a centralized place to collect this and gives the government the ability to use this data to create data surveys and inform medical treatments.

> (A) IN GENERAL.—The Secretary shall establish uniform State reporting re-quirements and national standards to ensure an adequate national database containing information pertaining to health services practitioners, approved providers, the costs of facilities and practitioners providing items and ser-vices, the quality of such items and services, the outcomes of such items and services, and the equity of health among population groups. Such database shall include, to the maximum extent feasible without compromising patient privacy, health outcome measures used under this Act, and to the maximum extent feasible without excessively burdening providers, a description of the standards and qualifications, levels of finding, and methods described in subparagraphs (D) through (F) of subsection (a)(1).
>
> (B) REQUIRED DATA DISCLOSURES. —In establishing reporting require-ments and standards under subparagraph (A), the Secretary shall require a provider with an agreement in effect under section 301 to disclose to the Secretary, in a time and manner specified by the Secretary, the following (as applicable to the type of provider):
>
> Another crucial part of the bill is that it has built in a 2 – 4 year transition period (depending on which bill is implemented). This transition period includes full pay and retraining programs for all workers who are laid off in the transition. The fact that there is some delay until full implementation is something that interacts with a lot of arguments. Especially if you're going to be running something that's about a current issue (the election, COVID),

> it's worth keeping in mind that the implementation may not necessarily hit in time to affect these things.
>
> A lot of things in the bill are quite vague, especially the specifics about which services will be offered and the financing numbers. The bill grants the power to make these decisions to the health Secretary, a position to be appointed by the administration.

I really recommend that you read the full text of the bill - a lot of different arguments have already been accounted for, and you might miss some really good evidence, or accidentally run something that isn't topical if you don't read closely!

Let's get into the arguments!

2.2 Aff

2.2.1 Accessibility

The most stock and straightforward arguments on the Aff are about increasing access to health insurance.

Scott for Vox in 2019[2] writes,

> "In 2018, the number of people in the United States without health insurance rose to 27.5 million, up from 25.6 million in 2017. The uninsured rate jumped from 7.9 percent in 2017 to 8.5 percent in 2018. It was the first year-to-year increase in uninsured rates since 2008 and 2009.
>
> …
>
> It's hard to determine the exact cause for the decline in insurance coverage. President Trump and congressional Republicans repealed the ACA's indi-vidual mandate, which ended the requirement that people purchase cover-age or pay a penalty. That could have led some people to voluntarily drop their insurance. The administration has also sought to make skimpier "short-term insurance" plans more available and it has cut enrollment outreach for Obamacare enrollment.

[2] https://www.vox.com/policy-and-politics/2019/9/10/20858938/health-insurance-census-bureau-data-trump

…

> The Census report found persistently high uninsured rates among impoverished in states that have refused to expand Medicaid under the ACA. In those states, which have declined a generous federal match to cover their poorest citizens through the health care law, more than one-third of people in poverty lack health insurance."

This only was exacerbated during COVID-19, as Stolberg in 2020 for the NYT[3] writes "The coronavirus pandemic stripped an estimated 5.4 million American workers of their health insurance between February and May, a stretch in which more adults became uninsured because of job losses than have ever lost coverage in a single year, according to a new analysis."

There are two impacts to this. The first is improving health outcomes. If you're unable to afford going to the doctor pre-emptively or at the onset of any symptoms you're likely to have preventable illnesses boil over. Tan for the NIH[4] in 2009 outlines the effects of this, "More than 26,260 Americans aged 25 to 64 died in 2006 because they lacked health insurance—more than twice as many as were murdered, Families USA said. In the seven years from 2000 to 2006 an estimated 162,700 Americans died because of lack of health insurance."

The second impact is reducing debt.

Leonhardt for CNBC[5] in 2019 writes,

> "Almost a third of working Americans currently have some kind of medical debt and about 28% of those who have an outstanding balance owe $10,000 or more on their bills.
>
> When asked if they've ever defaulted on those bills, about 54% of people with medical debt said they had, according to a new survey fielded by Salary Finance of over 2,700 U.S. adults working at companies with over 500 em-ployees."

Konish for CNBC in 2019[6] furthers "about 137.1 million Americans have faced financial

[3] https://www.nytimes.com/2020/07/13/us/politics/coronavirus-health-insurance-trump.html

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2323087/

[5] https://www.cnbc.com/2020/02/13/one-third-of-american-workers-have-medical-debt-and-most-default. html

[6] https://www.cnbc.com/2019/11/10/americans-are-drowning-in-medical-debt-what-to-know-if-you-need-help. html

hardship this year because of medical costs… high health-care bills are the No. 1 reason people would consider taking money out of their retirement accounts or filing for bankruptcy."

In fact, medical costs are the leading cause of bankruptcy.

Konish furthers, "66.5 percent of all bankruptcies were tied to medical issues —either because of high costs for care or time out of work. An estimated 530,000 families turn to bankruptcy each year because of medical issues and bills, the research found."

2.2.2 Rural Hospitals

Archer for The Hill in 2020[7] writes,

> "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

[7] https://thehill.com/blogs/congress-blog/healthcare/487026-453-rural-hospitals-are-failing-medicare-for-all-would-save

> 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 Med-icaid 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."

The argument here is that because rural hospitals specifically serve such a large uninsured portion of patients – services they often don't receive payment for - the increase in coverage, even if the governments rates are lower than those of private insurance for the same services, it's an increase in revenue on net.

Another reason why rural hospital would thrive under Medicare for all is global budgeting (referenced in the Introduction). Under this system, the profits of all hospitals would be allocated according to the need and profitability of hospitals – providing extra support for rural hospitals in order to ensure that they're able to stay afloat.

2.2.3 Innovation

The bill grants the government the ability to regulate the prices and kinds of drugs which enter the market, outlining this process in the following way:

> (1) IN GENERAL. —The Secretary shall establish a prescription drug formulary system, which shall encourage best-practices in prescribing and dis-courage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.

The language of this paragraph seems to suggest that it would be a value-based pricing model. A value-based pricing model is one wherein price is decided taking into account the amount of value that drugs provide to consumers – how much they improve health outcomes compared to the options that previously existed.

Empirically, a value-based system of price controls has increased the quality of innova-tion of drugs:

HBS Working knowledge for Forbes[8] writes in 2020 that after Germany adopted VBP,

[8] https://www.forbes.com/sites/hbsworkingknowledge/2019/12/23/why-germanys-approach-to-drug-pricing-offers-lessons-to-us

”Stern and her co-authors studied 171 new drugs that Germany’s IQWiG reviewed between 2012 and 2016. They found that manufacturers were 10 times more likely to withdraw products that lacked any evidence of added benefit than ones that performed better. Equally important, 98% of drugs with added benefits remained on the market, including all treatments for heart and respiratory diseases.

“The drugs that left the market were ‘me too’ drugs—only one of these drugs was shown to have added benefit over comparable therapies, but that decision was actually re-versed in a later evaluation. That means that none of the drugs that left the market were, ultimately, ones that had additional patient benefit,” Stern says. “Innovative, high-value drugs that were found to lead to better patient outcomes all remained on the market.”

2.2.4 Pandemics

The argument here is that having a centralized data source would be critical when creat-ing a response for the next pandemics, giving the government up-to-date knowledge on health numbers. On top of this, having guaranteed healthcare for all residents would al-low the spread to be contained quickly, as people wouldn’t postpone care for fear of the cost of services. Even if Medicare for all wouldn’t be implemented in time to respond to COVID, as Dunne[9] writes in 2020, climate change is going to make more pandemics more likely in the next couple of years.

Watson of The New Republic[10] in 2020 outlines how Medicare for all would have improved the United States’ response to COVID-10.

> ”Nevertheless, it is hard to argue that ensuring universal coverage, something that Biden’s plan explicitly does not ensure, would not improve our ability to respond to this crisis, if for no other reason than the fact that it would provide the means by which a gravely sick person could go to a doctor or a hospital emergency room to get treatment without going into bankruptcy. The same could be said of a health care system that would have broadly assured that people could receive comprehensive treatment for any of the number of pre-existing medical conditions that exacerbate Covid-19 without encountering roadblocks, like the high deductibles that

[9] https://www.carbonbrief.org/q-and-a-could-climate-change-and-biodiversity-loss-raise-the-risk-of-pandemics

[10] https://newrepublic.com/article/157287/case-for-single-payer-coronavirus

perversely incentivize consumers to not seek medical advice. It would have improved our response to the pandemic, as well as society more broadly, if these barriers—which are for all intents and purposes additional taxes on the working and middle classes—did not exist.

Germany, a country with a multi-payer system but where only 11 percent of the populace has private insurance, has one of the lowest fatality rates. Italy has a health system where most are covered by government insurance, but the crisis has been particularly dire as hospitals in its wealthier northern regions have been absolutely crippled by the virus. South Korea, meanwhile, has a single-payer system and swiftly implemented some of the most aggressive and successful testing measures anywhere in the world, limiting the virus' spread and yielding low fatality rates. Overall, Western Europe is a couple weeks ahead of the U.S. in its outbreak, but we appear to be faring worse than they were at this stage."

2.3 Neg

Blumberg 2019 for the Urban Institute[11] writes "that a broad single-payer reform (referred to as Reform 8: Enhanced Single Payer in the report) would increase federal gov-ernment spending by $34 trillion over the 2020–29 period, $34 trillion beyond what the federal government already spends on health care."

There is no explicit funding plan within the bill, but most plans of this size have primarily been funded through deficit funding, as hiking taxes enough to fully cover wouldn't be politically popular on either side of the isle.

There are many possible impacts off of this about how this would affect the US and global economies. When running economic impacts like this, the primary thing to keep in mind is to articulate exactly how much this decline in growth would affect the current depression.

[11] https://www.urban.org/urban-wire/dont-confuse-changes-federal-health-spending-national-health-spending

2.3.1 Hospital Shortages

Abelson 19 for the New York Times[12] writes “If Medicare for all abolished private insurance and reduced rates to Medicare levels — at least 40 percent lower, by one estimate — there would most likely be significant changes throughout the health care industry, which makes up 18 percent of the nation’s economy and is one of the nation’s largest employers.”

Because of this, FTI in 2019[13] estimates that “Medicare for All’s reimbursement cuts would result in 90% of hospitals across the country running consistent deficits, increas-ing the risk of hospital closures nationwide and negatively impacting the health care workforce.”

The impact of hospital closures would be widespread. Nicholl of Sheffield University in 2019[14] outlines that finds that for every additional kilometer that someone has to travel to a hospital there is a 2% increase in mortality.

2.3.2 Doctor Shortages

While there is currently a doctor shortage in the United States, as Medicare-For-All would increase the demand for services, but not increase the number of doctors, this shortage would likely grow. There are two ways that this can be run.

The first is within the United States.

FTI in 2019 writes, “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.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.”

The second is outside of the United States.

[12] https://www.nytimes.com/2019/04/21/health/medicare-for-all-hospitals.html#:~:text=If%20Medicare%20for%20all%20abo

[13] https://americashealthcarefuture.org/wp-content/uploads/2020/01/FTI-Medicare-for-All-and-the-Future-of-Americas-Workforce.pdf

[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464671/

To fill the gap for doctors, the United States would likely increase the number of foreign doctors. This has happened empirically, as in order to fil similar gaps in the United Kingdom[15] "Around 170,000 out of 1.28 million staff report a non-British nationality. This is 13.8% of all staff for whom a nationality is known, or just almost 1 in 7. Between them, these staff hold 200 different non-British nationalities. Over 67,000 are nationals of other EU countries – 5.5% of NHS staff in England."
The United States already does this to a lesser degree right now, as the American Immigration Council[16] writes "There are more than 247,000 doctors with medical degrees from foreign countries practicing in the United States, making up slightly more than one-quarter of all doctors."

2.4 Conclusion

Good luck and have good debates!

[15] https://commonslibrary.parliament.uk/research-briefings/cbp-7783/

[16] https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf

3 Topic Analysis by Siva Sambasivam

Siva Sambasivam debated in Public Forum for Saratoga High School in California, and is currently a freshman at Indiana University studying Business and Political Science. During his two years on the circuit, he amassed 4 gold bids and 7 speaker awards, along with 2 autoquals to the TOC, placing 5th at the NCFL Grand Na-tional Tournament his junior year, and in the top-14 at NSDA nationals his senior season. Most notably, Siva semi-finaled at MiniApple, Santa Clara University, and the Presentation Round Robin; finaled at Golden Desert; placed second at the Cali-fornia Round Robin; and championed the Robert Garcia Invitational, reaching the top-5 of the national rankings his senior year. Individually, Siva was the top speaker at Stanford, third speaker at Apple Valley, and fifth speaker at Milpitas. Outside of Public Forum, Siva semifinaled Arizona State University twice in Congress, quali-fied to Nationals in Congress, and placed 6th in NSDA Nationals Extemporaneous Debate.

3.1 Background

3.1.1 Introduction

Hi y'all!

Welcome to my topic analysis for the September-October topic: "Resolved: The United States Federal Government should enact the Medicare-For-All Act of 2019." Coming from a family with a ton of doctors, I've always been fascinated with healthcare, and I'm really excited to see what kind of debate this resolution brings. After seeing Andrew Yang's primary policy action be debated last February, we now transition to another popular Democratic politician, Bernie Sanders, and his flagship proposal.

Generally speaking, September and October are huge months for debaters, and this topic is probably one of the most important of the regular season. From the UK Season

Opener to Yale to Bronx, these months are packed with large bid tournaments that will enable you to get a head start on qualifying to the TOC. With the rise of online tourna-ments, expect to see more teams at each tournament along with a broader diversity of teams with regards to location and style. But perhaps most importantly, expect to see ter-rific judging pools at these tournaments, as coaches and first-year-outs will be available to judge more, as travel is no longer a restriction. Add in the fact that most debaters will have attended camp and will have extensive prep, and this year's September-October topic is setting up to have some amazing rounds.

3.1.2 The Current US Healthcare System

Usually, the most important part of the topic to understand is the uniqueness picture. This topic is no different. The current US healthcare system is extremely comprehensive and complex, with numerous undeniable flaws, so I'll try to do my best to break it down:

The most recent overhaul of the healthcare system was in 2010, when President Obama passed The Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA) or Obamacare. This was the most significant expansion of insurance coverage in America since the passage of Medicare and Medicaid in 1965, increasing access to around 16 million Americans. Some of the notable changes that were made to the system in addition to the expansion of Medicaid eligibility were: insurers were made to accept all applicants without charging them based on pre-existing medical con-ditions or demographic status, mandating that individuals buy insurance, and ensuring that insurers cover a list of essential health benefits. While the individual mandate was later repealed, Obamacare still represented a transformative shift in US healthcare pol-icy improving health access and outcomes across the board. [1]

However there still exists problems with our healthcare system. According to the most recent Census, nearly 27.5 million people are uninsured[2], and nearly 30 percent of Amer-icans are underinsured, meaning that their out of pocket healthcare costs exceed 10 per-cent of their income.[3] For these individuals, accessing any form of healthcare is a taxing burden, often pushing them into severe debt, or at the least, depleting a lot of their income.

[1] https://www.healthline.com/health/consumer-healthcare-guide/pros-and-cons-obamacare
[2] https://www.census.gov/library/publications/2019/demo/p60-267.html#:~:text=In%202018%2C%208.5%20percent%20of,7
[3] https://www.commonwealthfund.org/press-release/2019/underinsured-rate-rose-2014-2018-greatest-growth-among-people-employer-health

There is also a ton of mismanagement and waste within our healthcare system. Because of the sheer number of private insurance companies, paperwork is often a huge bur-den for doctors, and at times leads to errors in patient records that are the difference between life and death. In fact, a recent Johns Hopkins University study found that nearly 250,000 people die in the United States every single year.[4] But the overall mis-management goes further. In fact, the US spends more on health care as a share of the economy than nearly every other country on the planet, and nearly twice as much as the average developed nation, yet still has the lowest life expectancy and highest suicide rates among the 11 OECD nations.[5]

In addition, the US has the highest chronic disease burden and an obesity rate that's twice the average OECD nation, and our citizens also averaged fewer physician visits than most other countries. Lots of these likely stem from the fact that there is a low supply of physicians in the United States, but the causes for this shortage are debatable (we'll get into this later). However, there are some positives in our system. America is the most developed of industrialized nations in terms of technology in healthcare, using MRI's and specialized procedures more often than most countries while also out-performing OECD nations in terms of preventative measures. We have extremely high rates of breast cancer screening and flu vaccinations. But overall, our system is still bro-ken - compared to peer nations, we have the highest number of hospitalizations from preventable causes and the highest rate of avoidable deaths.

The biggest strength of the AFF, and the biggest weakness of the NEG, in my opinion, is this uniqueness picture. If you understand this well, and all the intricacies of our complex healthcare system, you will be well on your way to winning rounds cleanly. Especially for lay and flay rounds that are narrative based, explaining this to your judge to frame the round helps parents and other non-coaches have an easy time filling out their ballot.

3.1.3 What is Medicare for All

Medicare for All is a healthcare policy proposal that attempts to fix this system and im-prove overall health outcomes in the United States. The basic idea is simple - right now US citizens and American companies are shouldering a heavy burden for healthcare

[4] https://www.cnbc.com/2018/02/22/medical-errors-third-leading-cause-of-death-in-america.html#:~:text=According%20to%20a%20recent%20study,after%20heart%20disease%20and%20cancer.

[5] https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019#:~:text=The%20U.S.%20spends%20more%20on%20health%20care%20as%20a%20share,higher%20than%20

costs, without necessarily getting better quality healthcare. Medicare for All, or M4A, attempts to solve both these problems. It provides government-based healthcare to ev-ery single American for basic health insurance and any life-saving medical procedures. It also no longer requires employers to provide insurance for their employees, saving businesses millions of dollars, hopefully allowing them to re-allocate these expenses to wages for their workers. The bill removes nearly all co-pays, deductibles and other out of pocket expenses with the hope of removing one of the primary cost/debt burdens for Americans. It also adds government negotiations for drugs, reducing the costs of medication for Americans.

While this seems like a panacea scenario, there are always harms to such a major policy shift, and this one is no different. In fact, this is probably one of the most balanced topics in recent memory. While the AFF argument may be easier to win, the NEG arguments have far better impact scenarios and weighing attached to them. Probably the biggest internal link on the NEG is healthcare for the developing world. These arguments are pretty simple - when US healthcare improves, it comes with an equal decline to health-care quality in the developing world, and the developing world is comparatively more important because they are already worse off in terms of poverty and mortality rates. Some of these arguments include the fact that if the US were to increase it's insured population, it would need to get doctors to meet this demand. Because of the sudden increase, US medical schools would not be able to pump out doctors quick enough, ne-cessitating us to increase visas and take doctors from other, poorer countries, worsening health outcomes there. Another argument is that the loss in revenue for pharmaceutical companies through price negotiations would force them to hike prices in the developing world to make back lost revenue.

Quite simply, this resolution can be broken down into the question: "Is government consolidation of healthcare a good idea?"

Every argument on both sides likely stems from this idea. If you ever hit a confusing ar-gument, you can likely make sense of it by looking at it through this lens. For the stock arguments, the interaction is clear - If the government takes control, they would obvi-ously have to cut costs to make the program affordable, while also either passing taxes, debt, or spending cuts, to handle the financing. This gives the neg plenty of ground, but at the same time, most AFF arguments stem from the idea that government intervention in instances like healthcare is a necessity, because our capitalist private insurance sys-tem has failed the most vulnerable.

3.2 Aff Arguments

3.2.1 Access

The access argument is the most intuitive and obvious aff argument and, quite frankly, the most true. In short the argument centers around the idea that in the current state, tens of millions of Americans are uninsured and can't access medical care. And worse, it's on a downward trend. Tolbert of the KFF[6] writes that:

> For the second year in a row, the number of uninsured increased. In 2018, 27.9 million nonelderly individuals were uninsured, an increase of nearly 500,000 from 2017. Since 2016 when the number of uninsured reached his-toric lows, the number of people who lack health insurance coverage has grown by 1.2 million.

However, by extending coverage to every American resident, aff teams argue that the Medicare for All Act will allow presently uninsured and underinsured Americans to access care and thus live healthier lives. But it goes further- it also increases access to numerous services that most healthcare plans do not include right now. The New York Times writes[7]:

> Yes. When you think about Medicare for all, it is more helpful to focus on the "all" part than the "Medicare" part. Mr. Sanders's proposal would set up a brand-new government health insurance system, with many more benefits than Medicare. Everyone in the United States would get health insurance from this new, generous government system. Existing private health insur-ance plans would be eliminated. So would insurance premiums, deductibles and copayments. Medicare for all insurance would cover many services that most health plans omit now, including dental care, eyeglasses, hearing aids and home-based long-term care for people with disabilities. It would also make major changes to how healthcare is financed in the United States. Now, we pay for health care through federal taxes and state taxes, as well as pre-miums and cash when we go to the doctor or the pharmacy counter. Under Medicare for all, federal taxes would pay for the entire system.

[6] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=In%202018%2C%2027.9%20million%20nonelderly,has%20grown%20by%201.2%20million

[7] https://www.nytimes.com/2020/02/25/upshot/medicare-for-all-basics-bernie-sanders.html#:~:text=Everyone%20in%20the%20United%20States,this%20new%2C%20generous%20government%20system

Ultimately, all access arguments impact saving many lives domestically, with figures ranging from the tens of thousands to the millions. There are many different nuances that teams will read to the access argument, such as ending the opioid epidemic or im-proving access to preventative care, or even preventing pandemics from arising in the future, but each of them has the same link of Medicare for All universalizing access to healthcare. Finally, you might hit an impact scenario about how consolidating access would make our overall healthcare system more efficient, allowing us to care for more patients and improve quality of healthcare, while also saving billions of dollars. Galvani of The Lancet[8] writes:

> 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 expan-sion 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.

3.2.2 Consumer Spending

The affirmative on this topic basically breaks down into two arguments - access, and the economy. The primary link into the economy from the aff is consumer spending. This argument hinges on the idea that in the status quo, medical out of pocket costs are rapidly increasing, taking money out of Americans' pockets. Leonhardt of CNBC[9] writes:

> 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

[8] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)33019-3/fulltext

[9] https://www.cnbc.com/2019/10/09/americans-spend-twice-as-much-on-health-care-today-as-in-the-1980s.html

> 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.

However, by socializing medicine and thus making all "medically necessary" care free, the Medicare for All Act would wipe out these costs. Teams argue that eliminating out of pocket expenses will free up more money for average Americans to spend, thus boosting growth at a period when consumer spending and economic growth are at historic lows.

The other link into consumer spending that aff teams read is boosting wage growth. Currently, employers foot the bill for all their workers' insurance. Aff teams argue that this burden on employers is passed on to workers through decreased wages, something Medicare for All would reverse by shifting the burden of insurance from employers to the government. Thus, employers would have greater fiscal space to increase wages which would subsequently boost consumer spending and economic growth. Bivens of the Economic Policy Institute[10] writes:

> Medicare for All could increase wages and salaries for U.S. workers by reducing employers' costs for health insurance—freeing up fiscal space to invest in wages instead. The share of total annual compensation paid to Ameri-can employees in the form of health insurance premiums rather than wages and salaries rose from 1.1% in 1960 to 4.2% in 1979 to 8.4% in 2018.5 If this post-1960 increase had been only half as large—and employers had spent the health cost savings on wages and salaries—the take-home wages of American workers would have been almost $400 billion higher in 2018.6 Given that the share of total compensation spoken for by health insurance premiums is starting from a high base today, any reform that managed to slow the excess growth of health spending going forward would go a long way in making space for faster growth of cash compensation.

10 https://www.epi.org/publication/medicare-for-all-would-help-the-labor-market/

3.3 Neg Arguments

3.3.1 Financing

The primary neg arguments are about the financing conundrum that Medicare for All would bring. What is widely expected to be the most expensive single government proposal, Medicare for All is estimated to cost around $34 trillion in its entirety, and around $2 trillion dollars per year. There are numerous options for financing this plan, with nearly every proposal adopting some combination of higher taxes and increased deficit spending. Indeed, the Committee for a Responsible Federal Budget writes[11]:

> 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 pub-lic 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.

There are very easy ways to argue why either taxes or debt would be bad for the economy. With higher corporate taxes, especially during a recessionary period like we are in now, corporations will be forced to lay off more workers pushing us further into the downturn. With higher income taxes, consumer spending into the economy will be sti-fled. There are also unique types of taxes that some of Sanders' proposals highlight that people might read. For example, an increase in the capital gains tax is something that has been floated around. The CGT was a former PF topic a few years ago, meaning there is quite a large literature base about whether it is good or bad for our economy.

With debt on the other hand, teams will likely argue that an increase in the deficit would force us to increase the number of bonds available on the market, while perhaps even increasing the interest rate on these bonds to make them more attractive investments. Teams might argue that this causes a shift in capital from both developing economies in the global south, as well as from the private sector in the United States, which have large macroeconomic consequences. Indeed, the CRFB continues:

11 http://www.crfb.org/papers/choices-financing-medicare-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 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 per-cent, respectively – the equivalent of 17 million, 14 million, and 10 million jobs. Most financing options would be more progressive than new spend-ing but have different distributional implications within and between in-come 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 ad-ditional spending. Significant increases in tax rates from these options could lift the top rate to near or above the revenue-maximizing level, leaving lit-tle 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.

As alluded to in the last line of this card, the debate arguments will likely not correspond to the real world arguments in this instance - NEG teams will likely choose to read these arguments as a binary, either solely taxes OR debt, in order to gain full access to impact scenarios, as it would be hard to isolate the likely impacts of a combined proposal. The best response to make to any taxes/debt argument that you hit is that, logically speaking, any policy proposal would likely have this combination. This also means that if you chose to read either of these scenarios, you'll likely need scalar impacts about how bad each would be, independent of your general impacts.

3.3.2 Tiered Pricing

Another common neg argument will be about tiered pricing. In essence, the idea of this argument is that currently companies are able to sell drugs at significantly lower costs in the developing world than in America because they have such high profit margins based off the US market. When companies' revenue is cut due to price negotiations in the United States, they would need to make up that lost revenue and hike prices to the developing world as a result. Brittan of the European Commission writes[12]:

> The low prices in France, Belgium or Greece are, it is alleged, nothing to do

12 https://ec.europa.eu/commission/presscorner/detail/en/SPEECH_92_113

> with efficiency or comparative advantage, but government interference. A pharmaceutical company may only be willing to sell in a low price country because it can recoup any losses that it makes there from sales in higher priced countries.

This philanthropy by companies has increased developing world access to drugs signif-icantly. Danzon of the University of Pennsylvania[13] writes:

> For example, Dumoulin (2001) simulates worldwide pharmaceutical prices, revenues and number of consumers served under the extremes of price dis-crimination between each national market (i.e. one price per country) and a single global price. He concludes that price discrimination increases access by a factor of roughly 4–7 times. Access in this model can only be further increased by governments or other agencies financing the purchase of phar-maceuticals in low income countries.

The most common response to this argument is the idea that it would not be in companies' profit incentive to hike prices in the developing world simply because it would make the drugs unaffordable to so many people there. However, in most of the countries where tiered pricing is adopted there are high levels of income inequality. The capping of profits would likely force companies to recoup the losses, and maximize rev-enue for their investors, forcing them to capitalize on this income inequality by jacking up prices. This would increase prices in areas that are the most vulnerable, likely costing the lives of millions every year.

3.4 Concluding Thoughts

As intense as this topic will likely be with the large tournament pools and the many online tournaments offered every month, always remember to take a step back and enjoy it. Especially with the online platforms, it will be much easier to get burnt out, so don't stack tournaments early and always give yourself some time to recover. That said, good luck with all your tournament endeavors!

As always, feel free to reach out to me on Facebook with any questions!

13 https://faculty.wharton.upenn.edu/wp-content/uploads/2014/10/differential-pricing_3.pdf

4 Topic Analysis by Lawrence Zhou

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4.1 Introduction

M4A is a fantastic topic – it's just deep enough that no one will run out of arguments to read on either side and not too broad to make this topic prep load unmanageable. It's also incredible timely given our current situation and because healthcare policy is one of the most important issues facing people now. I imagine many of these debates will be enjoyable, exciting, and reflective of many of the core controversies surrounding one of the most important issues that faces thousands of Americans today.

4.1.1 What is M4A?

So, what is Medicare for All?

Well, at its most basic, you can think of it as a giant GoFundMe. If you've seen those really heartwarming (dystopian[1]) news stories of people who pooled their money together to help a teacher pay for a surgery or something like that, you've probably seen a GoFundMe in action. Medicare for All is basically just that, as this College Humor video describes it: "I'm not even saying we do anything as extreme as single payer health care. I'm just saying, what if we had something along the lines of like one giant GoFundMe every single year that would just pay for all the people that got sick or hurt that year."[2] Well, that's basically Medicare For All. But let's get into some of the details here. What is Medicare? And what makes it "For All"?

In the US, there are two entirely separate, government-run health programs designed to increase coverage for certain populations: Medicare and Medicaid. A lot of people still confuse these two programs, so let's get it straight: Medicare provides health coverage for those either over the age of 65 or under 65 with a disability; Medicaid is both a state and federal program that provides health coverage to low income individuals. In other words, care for the old, aid the poor.[3] The reason why this topic is about "Medicare For All" is because M4A is a single-payer insurance program based on the existing Medicare program.[4] There are a few phrases that deserve unpacking:

Single-payer: "Single-payer is an umbrella term for multiple approaches. In essence, single-payer means your taxes would cover health expenses for the whole population."[5] This distinguishes it from what the United States currently has, which is multiple groups paying for healthcare where private health insurance companies, employers, and the government all are paying.

National health insurance: "National health insurance means the guarantee of health insurance for all the nation's residents—what is commonly referred to as"universal cov-erage."[6]

[1] https://www.youtube.com/watch?v=fYOA8gXpios
[2] https://www.youtube.com/watch?v=tIsXEkR5OVs
[3] https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html
[4] https://www.webmd.com/health-insurance/news/20191120/medicare-for-all-faq
[5] https://www.healthline.com/health/what-medicare-for-all-would-look-like-in-america#6
[6] https://accessmedicine.mhmedical.com/content.aspx?bookid=1790&sectionid=121192308

4.1.2 What Makes Single Payer Different?

Healthcare policy is quite complex so it's not just enough to understand what M4A is, but also the ways in which it differs from other healthcare policies.[7] There are three other systems that are worth contrasting M4A with so that we can get a better picture of what M4A's advantages and disadvantages are.

Let's start with the current system which is basically Employment Based Health Insurance or EBHI. That's basically just the idea that you get health insurance through your job. Most people tend to like their EBHI plans but they are incredibly expensive. There's also an obvious problem with trying to cover everyone using EBHI – not everyone has a job!

So, back in 2010, then President Obama pushed through the Affordable Care Act, also know as Obamacare. This was a pretty radical overhaul to the existing healthcare sys-tem although oddly enough, it was basically just a Republican healthcare plan despite Republican opposition to it.[8] It did a lot of things, including allowing children to stay on their parents' healthcare plans until the age of 26 and stopped insurers from denying coverage due to preexisting conditions. But most notably, it set up individual insurance market exchanges and widely expanded Medicaid.

Finally, you have the public option, which became known as "Medicare for all who want it" after Mayor Pete Buttigieg termed it that.[9] Basically, this is the government entering the marketplace with its own insurance plan and it's usually pitched as an addition to ACA exchanges. Theoretically, this would be an affordable option for many because the government has lots of leverage which would allow it to negotiate rates and reduce costs.

So single payer is none of these. It's not based on your employment, it's far more radical than the ACA, and instead of being one of many competitors in the insurance market, it would be basically the only one (apart from a few private insurers covering niche markets like elective surgeries).

[7] https://www.cnn.com/2019/07/30/politics/health-care-explainer/index.html

[8] https://www.cnbc.com/2015/10/23/mitt-romney-admits-romneycare-had-to-precede-obamacare.html

[9] https://www.vox.com/2019/9/19/20872881/pete-buttigieg-2020-medicare-for-all

4.1.3 What is the Specific Act?

Well, we're discussing the Medicare For All Act of 2019, referring to the bill proposed by Pramila Jayapal that builds on the legislation famously introduced by Senator Bernie Sanders back in 2017, and a lot of the other topic analysis essays have done a pretty good job going in-depth over different provisions and sections of the Act so I'll leave the nitty-gritty details up to them.[10] Instead, I want to cover, broadly, what M4A would mean in very simple terms.[11]

First, M4A would be a huge change. I want to emphasize how huge it would be. It would be Medicare but even bigger. Everyone would get health insurance from this newly created, incredibly generous government system.[12] Existing EBHI or private health insurance programs would be gone. So would premiums (the payment you make to your health insurance company that keeps your coverage active), deductibles (a set amount you have to pay every year toward your medical bills before your insurance company starts paying), and copayments (the flat fee you pay every time you go to the doctor or fill a prescription).[13] It would cover services usually not covered in existing health care plans: dental, eyeglass prescriptions, hearing aids, etc. And it would be entirely federally financed.

Second, this bill is very aggressive. It establishes the program in just like two years. Wild.

Third, this would consolidate a lot of existing benefits programs. Medicare, Medicaid, CHIP (the Children's Health Insurance Program), etc. It would also replace the ACA's marketplaces and eliminate its pay for performance and valued-based programs.

Fourth, this particular bill doesn't really cover funding. I imagine that will lead to some interesting debates.

Other than that, there are a lot of interesting details and nuances of the proposal so I would recommend taking a day or two and just reading up about what this bill entails to be ready for those debates.

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[10] https://khn.org/news/theres-a-new-medicare-for-all-bill-in-the-house-why-does-it-matter/

[11] https://www.ajmc.com/view/5-things-to-know-about-medicare-for-all

[12] https://www.nytimes.com/2020/02/25/upshot/medicare-for-all-basics-bernie-sanders.html

[13] https://www.medmutual.com/For-Individuals-and-Families/Health-Insurance-Education/Health-Insurance-Basics/Understanding-Costs.aspx#:~:text=Your%20premium%20is%20the%20payment,include%20deductibles%2

4.1.4 Dispatching the Bad Takes

There are legitimate conversations to be had about Medicare for All. Does it result in reduced quality of care? Can we afford it? Are there better plans out there? These are deep and robust debates worth having.

Unfortunately, many bad takes exist, and I think they aren't even worth making in most debates because they're lazy and don't deserve anyone's attention. Here are just a few of the ones that shouldn't ever see the light of day.

"But but but… free healthcare makes doctors slaves!" Well, no more than free police protection enslaves the police, or how a right to an attorney enslaves public defenders, or literally any position that is paid for by tax dollars. Doctors can quit, they can seek employment elsewhere, they are not slaves. Most European doctors don't seem to think of themselves as slaves despite working under single payer regimes. If you're employed, compensated, and free to leave, you're not a slave. While there are perhaps some real (but not very persuasive) libertarian objections to universal health care, this is not one of them.

"But I don't wanna pay for other people's health care!" Sorry to break it to you, but that's literally what insurance is… All insurance companies pool money together and distribute that when people make a claim. Literally, the whole point of insurance is to distribute risk – if you're healthy, then you're paying for other people's medical bills, if you're sick, other people are paying for your medical bills. Literally the whole point of insurance is to pay for other people's health care! It's also a fairly bad general argument

– you pay for many things you don't use: national parks you never visit, schools you don't attend, scientific research you may not know about, roads you never drive on, etc.

There are some other bad takes out there but these two, in particular, irk me to no end. There are actual arguments to be had about the desirability and costs of Medicare For All – let's not derail it with the level of argument one expects of someone who read Atlas Shrugged for the first time, not a high school debater that actually does real research.

4.2 Pro Arguments

4.2.1 Coverage

The most basic arguments also come with one upside: they're basically true. The one solution to the problem of thousands of deaths each year from lack of insurance is to just give everyone insurance. You know it will work. The only question is at what cost? But such a framing betrays a status quo bias that fails to give weight to just how dire the current circumstances are. The question the Pro should be asking isn't whether we can afford to have Medicare for All; it's whether we can afford to not have Medicare for All.
This is all the more important during the current pandemic.

> The coronavirus pandemic is putting the failings of the U.S. health-care sys-tem into sharp relief.
>
> U.S. citizens already ration medicine, avoid care due to financial stress, and use internet fundraisers to cover health costs. The virus could expose more Americans to that ugly reality. Millions of uninsured and under-insured patients could be vulnerable to big bills if they seek treatment. Hospitals don't have enough spare capacity and could become overwhelmed. There's also no single entity in charge of coordinating and paying for the virus response, which has contributed to confusion and testing delays.
>
> The outbreak and the weaknesses it lays bare make a strong case for signifi-cant health-care reform, which has been a primary focus of the fight for the Democratic presidential nomination and an issue of key importance to vot-ers. Any of the plans proposed over the course of the campaign — from modest public options to a full-on transition to free government run health care under Bernie Sanders's "Medicare for All" — would be an improvement on the status quo. The presumptive nominee, Joe Biden, has a plan on the milder side of that spectrum. As the coronavirus crisis unfolds, it may help build a case for stronger medicine.[14]

I'm going to gloss over the facts and evidence surrounding this argument – it shouldn't

[14] Max Nisen (Bloomberg Opinion columnist covering biotech, pharma and health care), "Coronavirus Crisis Makes a Case for Medicare for All," Bloomberg, March 13, 2020, https://www.bloomberg.com/opinion/articles/2020-03-13/coronavirus-crisis-makes-a-case-for-medicare-for-all

be hard to win this point. The real question is how to win that this increased coverage warrants a Pro ballot.

Many of you are probably considering avoiding reading a coverage contention because you're afraid that the Con will either have blocked it out extensively (not a good reason to shy away from core topic debate) or, perhaps more legitimately, that you won't be able to win that this impact outweighs. Here, I want to offer three suggestions on how to impact this out.

The first is in terms of human rights. While Public Forum still doesn't have explicit frameworks (and it should continue to be that way), it doesn't mean that debaters can't introduce weighing arguments beyond the typical cost-benefit analysis assumed in most rounds. One thing that debaters can do is argue for the priority of a right to health that is owed to citizens either by virtue of their humanity or because of their status as a citizen. This could be either justified in terms of the beneficial consequences of adopting such a human right or along more deontological grounds. There is no shortage of evidence suggesting that healthcare ought to be considered a human right and this might be one way to outweigh the Con's arguments.

The second is in terms of systemic impacts. We don't always have to prioritize huge flashpoint impacts. Doing so tends to ignore the systemic impacts that are right in front of us that are basically invisible. Arguing that systemic impacts outweigh is a tried and true tradition in Lincoln-Douglas debate and it's something that could be tried in PF as well.

Finally, and perhaps most persuasively, you could argue that it outweighs on the grounds of equality as several organizations wrote in a letter to Congress:

> Dear Honorable Members of the United States Congress:
>
> As organizations that represent people of color, we respectfully urge you to co-sponsor the "Medicare for All Act of 2019" (H.R. 1384/S. 1129). Medicare for All, the only truly single-payer, universal health care system, guarantees that health care is a right and enables every person living in the United States to receive the health care they need to survive and thrive.
>
> 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 hav-

ing 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 Afford-able 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. De-spite 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 partic-ular, 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 fac-tor.

Medicaid – a lifeline for many people of color and low-income patients – is not accepted at many hospitals and doctors' offices. Black and low-income

> women are more likely than others to be treated at under-resourced hospitals, increasing the chances they may experience complications during and after childbirth. Hospital quality can account for nearly 50%t[8] of the racial disparity in maternal illness. With Medicare for All, there are no “out of network” provider limits. Patients can get the care they seek, when it is ap-propriate and convenient for them.
>
> Communities of color need a health care system that rectifies these long-standing structural biases and challenges. Medicare for All is that system. Medicare for All universal health care would support the health and economic security of patients of color, including finally providing full health coverage for all reproductive health services, alongside controlling the costs of prescription drugs – both glaring affordability and access issues for low and moderate-income patients of color.[15]

No matter how you go about it, you should really consider defending the coverage contention, even if just a short one. It’s true and that truth makes it difficult to refute.

4.2.2 Economic Considerations

There are lots of economic arguments in favor of M4A, which is surprising to many be-cause the typical citizen largely thinks of M4A as this unaffordable monstrosity that will destroy the American economy as we know it (never mind that it already is destroyed by recognition). Many argue it will have disastrous economic consequences but that may not be true. So, is M4A really unaffordable? Gaffney, a prominent advocate for M4A argues not.

> More than 24 million people require hospitalization annually in the United States, and many more see their doctors or other providers, or have tests and procedures, in these institutions. Yet as the health care reform debate heats up, some have painted a grim picture of how hospitals would fare un-der Medicare for All — predicting slashed budgets, shuttered wards, service cuts, and mass layoffs. Especially for those who rely on hospital care, such claims may sound an alarm.

[15] A. Philip Randolph Institute, Action Center on Race and the Economy (ACRE) Black Women’s Health Imperative, Center for Popular Democracy, Color of Change, League of United Latin American Citizens (LULAC) NAACP, People’s Action, Policy Link, United We Dream, ”Medicare for All is a Racial Jus-tice Issue,” July 10, 2019, https://populardemocracy.org/news-and-publications/medicare-all-racial-justice-issue, accessed 8-18-2020]

> A recent commentary in the Journal of the American Medical Association predicted that Medicare for All would put hospitals deep in the red, forcing them to shed up to 1.5 million jobs. An article in the New York Times last month gave voice to similar concerns that hospitals, especially vulnerable ones, would close “virtually overnight” under Medicare for All, or would abandon “lower-paying services like mental health” altogether.
>
> An editorial from the Washington Post warned that single payer could “shut-ter smaller or regional facilities whose margins are already low.” Even some progressives have given credence to such claims, predicting — or even call-ing for — deep reductions in “prices,” i.e., insurance payments to hospitals, under Medicare for All, or under other reforms.
>
> These claims have a common, flawed underpinning. For one thing, they fail to appreciate a key cost baked into the “prices” paid by insurers today: the billing-related cost forced on hospitals by our dysfunctional multi-payer sys-tem, and so they discount the potential savings for hospitals under Medicare for All.
>
> More fundamentally, however, the focus on hospital “prices” fails to recognize that a properly structured single-payer reform would not merely change what hospitals are paid, but how they are paid. Indeed, it could move us away from a system where hospitals have prices at all.[16]

In fact, M4A may ultimately be a boon to the economy. One consideration is the labor case for M4A.

> But a report released Thursday by the Economic Policy Institute, a progres-sive think tank that surveyed the available data, laid out a case for why Medicare-for-all could actually be beneficial to the American job market.
>
> By decoupling employment from health care, economist Josh Bivens argues, workers would be able to find jobs that better match their skills and have more freedom to start their own businesses. The job losses in health care administration, while very real, are less of a concern in the context of normal amount of job creation and destruction in any given year, he says.
>
> Academics who believe Medicare-for-all would reduce total health care spending point to the bloated U.S. industry as a big opportunity for savings.

[16] Adam Gaffney, ”The Hospital Under Medicare for All,” Jacobin, May 10, 2019, https://www.jacobinmag.com/2019/05/medicare-for-all-hospital-financing-costs

> We spend a lot more on health care than other countries do, largely because billions of dollars a year are being spent on the salaries of private insurance company workers and enriching their executives and shareholders.
> Cutting out those middlemen, as Medicare-for-all would, saves money, in part, by eliminating those jobs — about 1.8 million of them, according to a recent estimate. That sounds like a lot, but it's less than one-tenth the typical number of layoffs in a single year, which added up to 21.8 million in 2018.[17]

The econ debate will certainly be in-depth. The Pro will likely also want to throw out arguments about reducing administrative costs[18] and how high health care costs are also strangling the economy.[19] The Con will be able to toss a bunch of arguments right back in the Pro's face. There's reason to think M4A won't affect admin costs enough to matter, that downstream effects might outweigh, or that the sheer upfront cost might be unbearable.[20] I lack the ability to fully interrogate each one of these arguments but it's certainly a fruitful strand of literature to explore.

4.3 Con Arguments

Despite the fact that the aff has the advantage of getting one big argument that they are almost certain to solve (cause if there are a lot of uninsured people, giving them insurance would indeed solve that), the neg has access to a broad array of well-researched arguments that have a great deal of plausibility to them. Let's start with the big one.

4.3.1 Cost Objections

There's no way around it. We could probably afford M4A in the sense that we could drum up the money for it. But could we afford the huge hit it would bring to our economy? There's simply no doubt that M4A would be pricey. How pricey? Well…

[17] Christopher Ingraham, "Medicare-for-all would be a boon to the U.S. job market, study finds," The Washington Post, March 5, 2020, https://www.washingtonpost.com/business/2020/03/05/medicare-for-all-jobs-labor/

[18] Zachary Hendrickson, "A new study reveals the US could save $600 billion in administrative costs by switching to a single-payer, Medicare For All system," Business Insider, January 8, 2020, https://www.businessinsider.com/single-payer-system-could-save-us-massive-administrative-costs-2020-1

[19] https://money.cnn.com/2018/01/30/news/economy/health-care-costs-eating-the-economy/index.html

[20] https://www.cato-unbound.org/2020/04/21/jay-bhattacharya/economic-case-against-medicare-all

> Senator Elizabeth Warren's refusal to answer repeated questions at last night's debate about how she would fund Medicare for All underscores the challenge she faces finding a politically acceptable means to meet the idea's huge price tag—a challenge that only intensified today with the release of an eye-popping new study.
>
> The Urban Institute, a center-left think tank highly respected among Democrats, is projecting that a plan similar to what Warren and Senator Bernie Sanders are pushing would require $34 trillion in additional federal spending over its first decade in operation. That's more than the federal government's total cost over the coming decade for Social Security, Medi-care, and Medicaid combined, according to the most recent Congressional Budget Office projections.
>
> In recent history, only during the height of World War II has the federal gov-ernment tried to increase taxes, as a share of the economy, as fast as would be required to offset the cost of a single-payer plan, federal figures show. There are "no analogous peacetime tax increases," says Leonard Burman, a public-administration professor at Syracuse University and a former top tax official in both the Bill Clinton administration and at the CBO. Raising that much more tax revenue "is plausible in the sense that it is theoretically pos-sible," Burman told me. "But the revolution that would come along with it would get in the way."[21]

Now does it cost more than the entire US federal budget, as some have claimed? No.[22] But does it cost a lot? Oh yeah. That being said, it's kind of obvious that M4A is ex-pensive. The negative winning the link alone isn't relevant – it's being able to defend against the large variety of Pro responses.

Question 1: Does M4A save more than the current system? This is a relevant question – M4A could be really expensive, but it has to be more expensive than the current system for it to count for the Con. And the Pro has some really solid evidence that it would actually save money. This is a contentious claim to say the least and the Con needs to be able to defend against this charge.

[21] Ronald Brownstein (a senior editor at The Atlantic), "The Eye-Popping Cost of Medicare for All," At-lantic, October 16, 2019, https://www.theatlantic.com/politics/archive/2019/10/high-cost-warren-and-sanderss-single-payer-plan/600166/

[22] Shefali Luthra, "Would 'Medicare For All' Cost More Than U.S. Budget? Biden Says So. Math Says No.," Kaiser Health News and Politifact, February 2, 2020, https://khn.org/news/does-medicare-for-all-cost-more-than-the-entire-budget-biden-says-so-but-numbers-say-no/ xs

> If Medicare for All's fans are banking on a Congress dominated by Democrats to bring the industry to heel, their hopes are misplaced. Democrats voted for "doc fixes" repeatedly and stood shoulder to shoulder with Republicans when the SGR was repealed. The parties may differ on some things but judging by their actions they both believe that the government cannot possibly spend too much money on health care. Only a person who is incredibly naïve or who ignores history entirely can believe that Medicare for All will be financed on the backs of doctors, hospitals, and drug companies.
>
> Medicare for All is also certain to drive up spending by generating an enormous surge in demand for medical care. The bills pending in Congress promise soup-to-nuts coverage for free. Premiums, deductibles and copays are supposed to vanish. If that happens, prodigious consumption of medical services will be inevitable.
>
> The fundamental problem is that Medicare for All's supporters have cause and effect reversed. They think Americans need universal comprehensive coverage because health care is expensive. In reality, we spend too much on health care because we rely so heavily on third parties—Medicare, Med-icaid, and private insurers—to pay our bills. In 1960, when patients paid about $1.73 out of pocket for every $1 paid by an insurer, health care spend-ing per capita was $165. In 2010, when patients paid out 16 cents for every insurance dollar, spending per capita was $8,400. And in 2017, when the ratio was 14 cents out of pocket for every insurance dollar, spending per capita was $10,740. The more we rely on third party payers, the more we spend. Because the full-on, government-run, single-payer plans introduced by Senators Bernie Sanders and Elizabeth Warren will reduce out of pocket costs to zero, they will drive spending to new heights.[23]

Question 2: What is the impact to spending? Just saying that it costs a lot is probably a decent argument in the real world but in debate, we're expected to provide concrete impacts to what the harms of spending are. Does excessive spending harm growth? Does it stagnate the economy? Does it tradeoff with other spending priorities? Does it cause unemployment? Does it cause debt? Are most of these concerns even relevant in

[23]Charles Silver (a law professor at the University of Texas at Austin) and David A. Hyman (a law pro-fessor at Georgetown), "No, Medicare for All Won't Save Money," Cato Institute, November 25, 2019, https://www.cato.org/publications/commentary/no-medicare-all-wont-save-money

the age of COVID? I cannot say which of the spending impacts are the best – that's for you to come up with! But if you plan on arguing that the cost of M4A is to great, you'll need to be able to concretely explain why.

Question 3: Does that impact to spending outweigh? The Pro is likely going to be mak-ing strong argument about how "we cannot afford what we have now."[24] The Pro is going to be able to argue that we need M4A in an age of millions of un- and under-insured. That's going to be a fairly concrete impact. Maybe spending does hurt the economy in some way. Does that outweigh what the Pro says? You'll need to invest some time in thinking about how the cost argument should be more important than whatever the Pro says.

4.3.2 Quality Concerns

There a variety of quality concerns regarding M4A. The Cato Institute lists a bunch of them in one article which I'll let do the explaining.

> After repealing your health care rights, Medicare for All would replace them with dangerously low-quality health care. Part of the problem is rationing by waiting, a problem that plagues health systems in United Kingdom, Canada, and elsewhere. The Congressional Budget Office projects that the Sanders bill would create "a shortage of providers, longer wait times, and changes in the quality of care." But there's a larger problem inherent in any single-payer system, whether it exhibits waiting lists or not.
>
> Health care is so complex that every method of paying health care providers creates perverse incentives. Promoting all dimensions of quality requires open competition among multiple payers with different payment and deliv-ery systems. A single-payer system, no matter what form it takes, cements in place one set of perverse incentives and eliminates the competitive pres-sures that would otherwise rescue patients from the low-quality care that results.
>
> Take Medicare, which is the largest purchaser of health care services in the United States and likely the world. Medicare has spent five decades reward-ing low-quality care and punishing high-quality care. Former Medicare ad-ministrator Tom Scully complained, "Everyone with an M.D. or D.O. degree

[24] https://pnhp.org/2019/09/16/fact-check-on-claims-by-opponents-of-medicare-for-all/

gets the same rate [from Medicare], whether they are the best or worst doc in town. Every hospital gets the same payment for a hip replacement, regard-less of quality."

It's worse than that. MedPAC warns that Medicare traditionally has not rewarded doctors and hospitals who reduce medical errors, hospital acquired infections, medication errors, or unnecessary re-admissions, and often it punishes them instead: "Medicare often pays more when a serious illness or injury occurs or recurs while patients are under the system's care." Medicare thus has a "neutral or negative" impact on the quality of care. And we wonder why preventable medical errors are the third-leading cause of death in the United States.

Primary care is relatively simple, right? In 2018, MedPAC wrote, "The Com-mission has also become concerned [Medicare's physician] fee schedule— with its orientation toward discrete services that have a definite beginning and end—is not well designed to support primary care, which requires ongo-ing care coordination for a panel of patients." Note the recency of "become." Medicare for All would turn the entire health system over to central plan-ners who took 50 years to notice they were rewarding low-quality care, and who still haven't fixed that glitch.

Pilot programs to improve quality or reduce spending usually flop, and those that succeed don't scale. Decades after markets developed health sys-tems that maximize incentives to reduce hospital acquired infections, Medi-care is still only taking baby steps in that direction. In one Medicare quality-improvement program, one fifth of the hospitals that received bonuses had below-median quality scores. When the ACA combined cuts to Medicare-participating private insurers with bonuses for those that provided high-quality coverage, Medicare rescinded the cuts and sabotaged the quality in-centives by offering the bonuses meant for high-quality plans to mediocre plans, too. On and on it goes.

Some argue Medicare for All would better prepare the United States to fight pandemics like the current coronavirus (SARS-CoV-2/COVID-19) outbreak. Yet many British doctors argue the NHS is unprepared, and cite tens of thousands of unfilled clinician positions. Medicare has spent 55 years discouraging efforts to contain infections by shifting the financial cost of preventable infections from health care providers to taxpayers. Medicare pays ambu-

> latory surgical centers regardless of whether they give their clinicians flu vaccines; as of next year, it won't even measure whether they do. Health systems like Kaiser Permanente internalize those costs and thus tend to do a better job of vaccinating both their enrollees and clinicians. Medicare for All would eliminate that superior model, subsidize the model that discourages efforts to fight contagion, and—at least under the Sanders bill—it would re-sult in less health care capacity, including fewer hospital beds.[25]

It makes sense to separate each of the concerns, e.g. rationing, wait times, etc. into separate arguments so that you can take individual warrants into the later speeches and to force the Pro to be specific in answering these. If the Pro just reads one card that says "No reduction in care quality" that doesn't actually respond to individual things that your arguments say, you should punish them by exploiting specificity.

Some may think these concerns aren't serious and can be hand waved away. Either they're false (debatable) or without impact (less debatable). I leave it up to you to re-search more in-depth the specific reasons why wait times, shortages, rationing, etc. may or may not be true. However, I want to emphasize that these arguments have a real im-pact if won.

If the Con is correct that any of these quality of care concerns come to light, then it broadly turns most of the Pro's best arguments. The Pro just cannot win that they do much for the economy, saving lives, preventing pandemics, etc. if the Con wins that the care will be either sub-par quality or simply not given out to those who need it.

That being said, this argument works much better if the Con pairs it with a counterplan – it's going to be a bit hard to win that our current healthcare system is really worse than what single-payer might bring about. Something like a public option or some other reform to the existing healthcare system would help here.

4.4 Concluding Thoughts

4.4.1 Counterplans? Wait, Aren't Those Against the Rules?

Chris Theis and Devon Weis gave an elective at VBI Philadelphia this summer where they argued that counterplans should be allowed in Public Forum debate. Despite the

[25] Michael F. Cannon (Cato Institute's director of health policy studies), "Why Not Have Medicare for All?," Cato Unbound, April 6, 2020, https://www.cato-unbound.org/print-issue/2614

fact that I strongly despise the fact that Public Forum debate is morphing into what is basically policy debate lite, I don't have any strong opposition to including counterplans in Public Forum. In the real world and in everyday debates, alternative proposals are always offered up to solve a given problem. When debating about where to go eat out (when that becomes a safe thing to do again), it's very rare that someone just negates a suggestion without offering an alternative suggestion of where to go eat.

In the policy realm of healthcare debates, you're not going to find anyone who opposes M4A that doesn't have some alternative suggestion. Almost no one likes the status quo we have now. Libertarians advocate rolling back most of the government programs currently in the market. Some propose public options. Others think that tweaks around the edges are good. We don't need to get into the details of any proposal, but we should be able to debate about different strategies to tackle the healthcare problem in the United States. "Medicare for all" versus "Medicare for all who want it." Excluding these sorts of arguments seem silly at best, wholly illogical at worst.

Does it violate the NSDA rules? No more than defending the resolution does! The NSDA bans comprehensive formalized proposals for implementation. A counterplan is not that – it is merely an alternative suggestion or an opportunity cost for doing something (learn more about that here[26]). And if a counterplan is that, then this resolution in particular – a very specific bill – would certainly violate the rule.

I urge debaters to consider defending a counterplan on this topic – without it, the Pro is going to be in a nice position to get some easy wins.

4.4.2 Stick With Core Arguments

I feel like I conclude each one of these PF topic analyses with some warning that debaters should not stray away from the core controversies on the topic. While I think this topic will be better than average in terms of the core topic debate, I imagine many debaters are still trying to figure out what fringe-of-the-topic arguments they can come away with. What about random pharma impacts? Or what about how this affects the US' global standing? Maybe there's something interesting to discuss about how M4A affects the criminal justice system? I'm really not sure what you all PFers will find to extrapolate from this topic but I want to stress, once again, that you should not be trying to find those impacts. If you're looking for big, hard to answer impacts, this topic has got them in spades: the economy, pandemics, bioterrorism, etc. Both sides have access to fantastic

[26] https://www.youtube.com/watch?v=D4fK6-BqCzY

arguments with deep literature and lots of impacts. There's absolutely no need to run to the margins of things.

I remember watching finals of NSDA PF this year and thinking that (A) Charter schools are just like definitely bad and (B) The Pro went for such a tenuous link chain about how charter schools were like key to the entire standardized testing regime that they lost to a well-prepared Con team that defended that one excellent CATO study. Not only was the Con's impact probably bigger, but it also just more true. Why run to arguments that aren't true? Why run to arguments that are met with a skeptical audience upon introduction? Sure, you'll beat some unprepared teams on these arguments. You'll also probably catch a decent team by surprise once or twice. But it's just not a consistent formula for winning against top teams. The best teams will be able to beat you on arguments that are core to the topic because they will have researched the arguments and will be prepared to defend them.

Some of you may feel that novelty wins out. That's true to some degree. But novelty doesn't just exist in the broad strokes of which arguments you read – it also exists in how you deploy and defend such an argument. I'd much rather watch a team get real practiced with winning the coverage debate and defending it against a slew of attacks in a fun way that watch someone go for an interesting argument poorly.

Some of you may feel that it's too easy to get prepped out. Not only did policy debate use this topic for an entire year and survive case hits the whole time, it's also just not true that many debaters actually have that scary of a prep out to generic arguments on the topic.

No matter your fears, I would encourage debaters to stick to the simple and true arguments on the topic. You'll learn a lot about the topic that way and secure yourself a consistent recipe for success!

4.4.3 Recommended Reading

There are three fundamental papers in the literature I recommend for debaters wanting to understand the nature of healthcare and various proposals meant to reform it ---

Uncertainty and the Welfare Economics of Medical Care, Kenneth Arrow, 1963. Outlines some of the economic mis-incentives inherent to the healthcare industry. https://web. stanford.edu/~jay/health_class/Readings/Lecture01/arrow.pdf

The History and Principles of Managed Competition, Alain C. Enthoven, 1993. Outlines a vision for “managed competition” that served as a pre-cursor to the ACA. https:// www.healthaffairs.org/doi/full/10.1377/hlthaff.12.Suppl_1.24

Reforming the health care system: the universal dilemma, Uwe Reinhardt, 1993. Outlines a vision for “global budgets” in American healthcare that resembles calls for Medicare-for-All. https://pubmed.ncbi.nlm.nih.gov/8368201/

5 Background

Overview of provisions in the Medicare-for-All Act of 2019.

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On February 27, 2019, Rep. Pramila Jayapal (D-WA)—with 106 cosponsors—introduced the Medicare for All Act of 2019, a bill that would transition the health care system to a single-payer system. The highly anticipated bill follows similar legislation from Sen. Bernie Sanders (I-VT)—with 16 cosponsors—that was introduced in September 2017. Tim Jost and I wrote about that bill here. In addition to the Sanders bill, Rep. Jaya-pal’s bill builds upon previous House single-payer legislation long led by Rep. John Conyers (D-MI).

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

Once the bill went into effect, most benefits would no longer be available under the traditional Medicare program, the Medicaid program, the Children’s Health Insurance Program (CHIP), the Federal Employees Health Benefits Program, or the TRICARE program. The bill would prohibit the sale of private health insurance, employer-sponsored insurance, and retiree coverage if that coverage duplicates payment for any item or service covered under M4A. (Insurers and employers could still offer coverage of addi-

tional benefits that are not covered under M4A.) The Department of Veterans Affairs and the Indian Health Service would remain intact.

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

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

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

This post summarizes the M4A program along with the transitional coverage options outlined in the bill. Major differences between the Jayapal bill and the Sanders bill are highlighted throughout the post.

What's In The M4A Program?

Eligibility And Enrollment

Under M4A, every resident of the United States would be entitled to health care benefits. This would presumably include immigrants and potentially undocumented individuals. Residency eligibility requirements would be defined by the Secretary of HHS through regulations. The bill allows HHS to more broadly define eligibility requirements to in-clude others in the country so long as rules inhibit travel to the U.S. for the sole purpose of obtaining health care services.

The bill includes few details about the M4A enrollment mechanism and largely defers the development of this process to HHS. HHS would be required, however, to provide for automatic enrollment of individuals at birth in the U.S. or upon the establishment of residency in the U.S. Upon enrollment, each individual would be issued a universal Medicare card, which would not include a Social Security number, to facilitate identification and claims processing.

Ban On Cost-Sharing

The bill would prohibit all cost-sharing for consumers, stating that no deductibles, coinsurance, copays, or similar charges can be imposed for benefits covered under M4A. This part of the bill goes further than the Sanders bill, which would have allowed limited cost-sharing for a new Medicaid long-term care program and a cost-sharing maximum of $200 for drugs and biologics (with an exception for a brand-name drug if a generic version is available). The bill would prohibit balance billing by barring providers from imposing an additional charge to beneficiaries for benefits provided under M4A.

Covered Benefits and Services

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

hospital services (including inpatient and outpatient hospital care, emergency services, and inpatient prescription drugs);

ambulatory patient services;

primary and preventive services (including chronic disease management);

prescription drugs, medical devices, and biologics;

mental health and substance abuse treatment services (including inpatient care);

laboratory and diagnostic services;

comprehensive reproductive, maternity, and newborn care;

pediatrics;

oral health, audiology, and vision services;

rehabilitative and habilitative services and devices;

emergency services and transportation;

early and periodic screening, diagnostic, and treatment services covered under Medicaid;

transportation to receive health care services for persons with disabilities or low-income people (as determined by the Secretary); and

long-term care services and support.

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

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

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

Providers that participate in M4A could not bill or contract with those who are eligible for M4A to provide covered M4A benefits. However, if they followed certain require-ments, participating providers could bill or contract with 1) eligible individuals to pro-vide non-covered benefits; or 2) ineligible individuals for any item or service. Providers not participating in M4A at all could bill or contract with 1) eligible individuals for cov-ered benefits; or 2) any individual for non-covered benefits.

However, contracts between providers and consumers would have to have been made in writing prior to when the service was delivered and could not be entered into during

an emergency. Both parties would have to agree not to submit a claim under M4A, and the providers would have to file an affidavit with HHS within 10 days of entering into the contract. The affidavit would have to attest that the provider will not file a claim for any non-covered item or service provided to any M4A beneficiary.

If the provider were to nonetheless knowingly and willfully submit a claim or receive reimbursement from M4A, no payment or reimbursement would be made for any item or service furnished by that provider for one year. This period is extended to two years for a non-participating provider that knowingly and falsely submits a claim.

As noted above, most benefits would no longer be available under the traditional Medi-care program, the Medicaid program, or the CHIP program once M4A went into ef-fect. The only exceptions are for patients in the middle of inpatient hospital services or extended care services and for school-related health programs, initiatives, and other services currently offered under Medicaid and CHIP. These school-related programs would continue and be covered by M4A.

Long-Term Care

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

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

These principles include providing coverage of a broad spectrum of services and sup-ports and coverage that maximizes autonomy and civic, social, and economic participa-tion. The bill also directs the Secretary to prioritize home and community-based services over institutionalization regardless of disability, service need, or age. In developing reg-ulations, the Secretary would have to consult with an advisory commission that includes

people with disabilities, those who represent people with disabilities, providers of long-term care (including family caregivers and unions), disability rights organizations, and academic researchers.

Provider Participation

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

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

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

The bill includes a broad nondiscrimination provision that mimics the protections out-

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

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

Financing And National Health Budget

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

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

The M4A bill includes more detail (and limitations) on what expenses would be in-cluded under the operating budget, capital expenditures budget, special projects bud-get, and health professional education expenditures. These payments could not, for in-stance, be used for marketing, profit or net revenue, or incentive payments or bonuses.

Providers could not divert operating expenditures for capital expenditures or profit, and the Secretary would have to prioritize funding for capital expenditures to improve service in medically underserved areas or address health disparities. In a curious provi-sion, the Secretary is explicitly prohibited from using quality metrics or standards when developing payment methodologies, programs, or other adjustments for provider pay-ments.

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

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

Payments For Institutional Providers: Global Budgets

In a significant difference from the Sanders bill (but with similarities to the Conyers bill), the M4A bill would pay institutional providers based on a negotiated global bud-get. Institutional providers include hospitals, skilled nursing facilities, federally qual-ified health centers, home health agencies, and independent dialysis facilities. These providers would receive a lump sum payment for all operating expenses for covered services, both inpatient and outpatient, pursuant to a global budget set by the Secretary and disbursed to each regional office.

Operating expenses would include wages and salaries for doctors, nurses, and ancillary staff; prescription drugs administered at the institution; the purchase of medical devices, supplies, and other technologies; all incidental services; patient care, education, and prevention programs; and administrative costs. Group practices and other health care providers could agree to receive a salary from an institutional provider under the global budget (rather than under the M4A fee schedule), but these salaries would have to be equivalent to other negotiated rates.

Global payment amounts would be determined in advance through negotiations be-tween each provider and the regional director. Negotiations would have to include a consideration of factors such as historic volume of services, actual expenditures, wages, provider capacity, and any other factor deemed appropriate by the Secretary. The Sec-

retary is directed to also look to the appropriate Medicare prospective payment system as a point of comparison; in the first year, the Secretary would use this fee schedule to help determine what the institutional provider would have been paid for covered items and services in the preceding year.

Negotiation could not account for capital expenditures, exceed a provider's capacity to provide care, or be used to compensate an executive, board member, or administrator. Regional directors would have to review, on a quarterly basis, whether institutional providers are complying with and performing under their participation agreement and whether an adjustment to their budget is warranted.

Payments For Individual Providers: Fee Schedule

Other providers—whether individuals or those in group practices—would be paid based on a fee schedule within one year of enactment of M4A. In developing the fee schedule, the Secretary is directed to consider the current Medicare fee schedule and the expertise and value of health care items and services furnished by these providers.

The M4A bill, unlike the Sanders bill, would establish a uniform national system for electronic billing for provider payments and a physician practice review board. These review boards would focus on quality, cost-effectiveness, and fair reimbursements for physician-delivered care. The boards could not include quality-adjusted life years (QALYs), disability-adjusted life years (DALYs), or other measurements that discriminate against people with disabilities in value or cost-effectiveness assessments.

The bill would require more frequent reviews of the value of physicians' services, direct the Secretary to consult with the Medicare Payment Advisory Commission, and require the development of a public, standardized process for reviewing the relative values of physicians' services. This new process would include, at a minimum, the development of methods and criteria to identify and prioritize services for review, review stakeholder recommendations, and identify additional resources to consider during the review pro-cess.

The bill would also require HHS to present Congress with 1) a written plan for using funds to collect and use information on physicians' services in the determination of relative values; and 2) a proposed plan to track HHS's review of the relative values of physicians' services, including a timeline for tracking data such as when, how, and by whom services are identified for review, when relative values are adjusted, and when new services are reviewed or added.

Payments For Prescription Drugs, Devices, And Equipment

HHS would annually negotiate the prices to be paid for covered pharmaceuticals, med-ical supplies, and medically necessary equipment. Relative to the Sanders bill, the M4A bill includes quite a bit more detail on how these negotiations would work. In negoti-ating for prescription drugs, the Secretary would be required to account for factors that include comparative clinical effectiveness and cost-effectiveness, the budget impact of covering the drug, the number of similarly effective drugs or alternative treatment regi-mens for each approved use of drug, and the manufacturer's total revenue from global sales. Negotiated drug prices would have to be finalized at least 30 days before the first fiscal year of the price period.

If the Secretary could not successfully negotiate an appropriate price for a drug, she could authorize a "competitive license" that allows the drug to be sold under M4A. An entity that used a competitive license would have to provide "reasonable compensation" to the original manufacturer as determined by factors laid out in the statute. The Secre-tary could procure drugs directly under a competitive license, and a drug manufacturer could not sue the federal government to recover additional funds. There is no similar type of provision for a competitive license in the Sanders bill.

Finally, the bill would prohibit drug manufacturers from engaging in anti-competitive behavior with other manufacturers that could interfere with a competitive license or "run contrary to public policy." The Secretary would also be empowered to require drug manufacturers to submit data she deems necessary for administering M4A.

State Flexibility

The M4A bill allows states to set additional standards with respect to eligibility, benefits, and provider standards so long as these standards do not restrict eligibility or reduce access to benefits or services.

Uniform Reporting Standards

The M4A bill would require the Secretary to establish uniform reporting requirements and standards to develop a national database with information on providers, the cost of facilities, the quality of services, health care outcomes, and health equity. In a difference with the Sanders bill, the M4A bill includes a more detailed list of the types of data that providers would have to submit to HHS on a regular basis, such as annual financial data, the number of registered nurses per staffed bed, and spending on health IT.

HHS would be required to regularly analyze this information and define rules and pro-cedures to allow researchers, scholars, providers, and others to access and analyze the data for quality and outcomes research. This data would be used to develop statistical

studies, create and test delivery system reforms, and inform evidence-based policymak-ing. The information would be regularly audited and included in an annual report to Congress on the status of implementation, including information on enrollment, ben-efits, expenditures and financing, cost-containment measures, quality assurance, and opportunities for improvements. These requirements, but for a few elements, are con-sistent with the Sanders bill.

Regional Offices And Beneficiary Ombudsman

The M4A bill directs HHS to establish and maintain regional offices to promote access to tertiary care facilities, equipment, and services. Under the legislation, regional offices would have to include a director appointed by the Secretary and one deputy director to represent the Indian and Alaska Native tribes in the region. The M4A bill does not reflect a Sanders bill requirement that also would have mandated one deputy director for each state in the region. Regional offices would be responsible for providing an an-nual state health care needs assessment report, recommending changes in provider re-imbursement or delivery system reform, and establishing a quality assurance program. Existing Centers for Medicaid & Medicaid Services (CMS) regional offices should be incorporated wherever possible, the legislation says.

HHS is also directed to appoint a beneficiary ombudsman to receive complaints, grievances, and requests for information with respect to any part of M4A and assist consumers in seeking appeals or redeterminations. The ombudsman would be required to submit annual reports to Congress and HHS on the office's activities along with recommendations for improving the law.

Office Of Primary Health Care

The bill would establish an Office of Primary Health Care within the Agency for Health-care Research and Quality. The Office would be tasked with functions that include coor-dinating health professional education policies, developing a system to track physician specialties and practices, consulting with the Secretary on the allocation of the special projects budget, and promoting policies that expand the number of primary care prac-titioners, registered nurses, midlevel practitioners, and dentists. The Office would also be required to develop national goals to increase access to high-quality primary health care, particularly in underserved areas and for underserved populations, no later than one year after the bill's enactment.

In a difference with the Sanders bill, the M4A bill notes that the section of the bill on the

Office does not preempt state scope-of-practice laws and cannot be construed to impose

additional educational standards or guidelines for health care professionals.

Quality Standards

Under the M4A legislation, the Center for Clinical Standards and Quality within CMS would take the lead in developing new quality standards and addressing health disparities. The Center would evaluate existing practice guidelines, quality standards, performance measures, and medical review criteria and adopt methodologies for profiling health care practice patterns and identifying outliers. In a difference with the Sanders bill, M4A explicitly prohibits the use of QALYs, DALYs, or other measurements that discriminate against people with disabilities. The Center would also develop minimum criteria for external quality review entities, for example, by adopting conflict of inter-est standards to prohibit financial incentives that would favor one pattern of practice over another. The Center would annually report its findings on outcomes research and practice guideline development to inform the Secretary's decisionmaking.

The Center would also be required to evaluate approaches for ongoing, accurate, and timely collection of data on health disparities and health system performance on the ba-sis of race, ethnicity, gender, geography, and socioeconomic status. The Center would be required to identify these approaches in a report to Congress and HHS within 18 months after benefits become available. HHS would then be required to implement those approaches no later than 2 years after benefits become available. The Center would submit similar reports to Congress and HHS with recommendations for improv-ing the identification of health disparities on an ongoing basis thereafter.

Transitional Coverage Options

Transitional Medicare Buy-In Option

Because M4A would not go into effect for adults until two years after enactment, the bill includes a transitional Medicare buy-in option for certain eligible individuals beginning one year after enactment. The buy-in option would be available to U.S. residents under the age of 19 or 55 or older, or who are currently enrolled in Medicare. Individuals enrolled in the buy-in option would be entitled to the same M4A benefits outlined above. HHS would define other program requirements, such as enrollment periods, and the buy-in option would be considered minimum essential coverage so enrollees would comply with the individual mandate (which was zeroed out beginning in 2019).

There are key differences between the M4A bill and the Sanders bill in areas such as eligibility, benefits, premiums, and administration. For instance, the Sanders bill would establish a phased-in buy-in option that would be treated as a silver marketplace plan

with premiums that could be reduced by premium tax credits. The Sanders bill would allow seniors to enroll in the buy-in option (based on phased-in age requirements) but does not extend this to children. Benefits under the Sanders bill would be the same as current benefits under Medicare Parts A, B, and D or Medicare Advantage with qualified prescription drug coverage. The M4A bill does not include similar provisions directing the buy-in option to be sold through the marketplace nor does it include information about how and whether premiums would be calculated or imposed.

Transitional Public Option

As an additional transitional coverage option, the bill requires CMS to establish and offer a public option—a Medicare Transition buy-in—through the ACA marketplaces beginning with the first plan year after enactment of the bill and ending once M4A goes into effect. The Medicare Transition buy-in would comply with the ACA's consumer protections, such as the ban on preexisting condition exclusions, coverage of essential health benefits, and the coverage of preventive services without cost-sharing, as well as requirements that apply to qualified health plans. However, the plan would be available to any U.S. resident and would provide consumers with generous cost-sharing protec-tions by requiring an actuarial value of 90 percent, equivalent to a platinum plan. All current participating Medicare providers would be considered Medicare Transition plan participating providers, and HHS would establish a process to allow for additional par-ticipating providers.

Premiums for the Medicare Transition buy-in would vary based on family size, age, and tobacco use. This is largely consistent with the ACA's rating rules except that rates for this plan would not vary based on geography, as is currently allowed under the ACA. Enrollees would be eligible for premium tax credits and cost-sharing reductions.

However, the bill alters eligibility requirements for these subsidies in several ways. First, premium tax credits for the Medicare Transition buy-in would be available to all eligi-ble individuals, including those with incomes over 400 percent of the federal poverty line (FPL) in all states. Second, in states that have not expanded their Medicaid pro-gram, premium tax credits for the Medicare Transition buy-in would be available to those with incomes under 100 percent FPL. Third, the bill would adjust premium af-fordability thresholds for Medicare Transition buy-in enrollees from those found in the ACA, establishing a 2 percent threshold for those with incomes up to 100 percent FPL and a 4.08 percent threshold for those with incomes of 150 percent FPL and higher.

The M4A transitional public option is relatively similar to the one outlined in the

Sanders bill but there are some differences. First, the M4A bill would set rates for individual providers based on the fee schedule that needs to be developed for the full M4A program; the Sanders bill would reimburse providers at Medicare fee-for-service program rates for services provided under Medicare Parts A and B and set reasonable rates for services not provided under Parts A and B. Second, while both bills direct HHS to negotiate for prescription drugs, the M4A bill does not have a "fallback" option included in the Sanders bill if HHS and a drug manufacturer are unable to reach a negotiated agreement. Third, unlike the Sanders bill, the M4A bill does not specify that cost-sharing reductions can be adjusted for certain Medicare Transition buy-in enrollees. Fourth, the bill does not explicitly require HHS to ensure that there is no effect on benefits for current Medicare beneficiaries and no negative impact on the Medicare Trust Fund.

Continuity Of Care

The M4A bill requires individuals enrolling in a health plan during the transi-tion period—including people with disabilities, complex health needs, or chronic conditions—to have continuity of care, including continued treatment by current health care provider teams. The bill also prohibits insurers and employers from ending coverage or excluding coverage based on disability, medical needs, or chronic conditions during the transition period until all ages are eligible to enroll in M4A. The bill directs the Secretary to consult with disability and patient advocacy organizations to ensure that the transition buy-in accounts for the needs of those with disabilities, medical need, or chronic conditions.

Waiting Period For People With Disabilities

The bill would also eliminate the two-year Medicare waiting period for individuals with disabilities within one year of enactment. The M4A bill does not reflect many of the tran-sitional Medicare reforms included in the Sanders bill, such as an annual out-of-pocket cost-sharing maximum of $1,500 for individuals entitled to or enrolled in Medicare Parts A and B; a Part D annual out-of-pocket threshold of $305, with potential exceptions for brand-name drugs; and elimination of cost-sharing for covered prescription drugs. This could be because the M4A bill has a transition period of only two years, half of the four-year transition period in the Sanders bill.

6 Pro Evidence

6.1 Coverage

6.1.1 Inequality

America's healthcare system is an engine of inequality. It costs the most and produces the worst outcomes. We can afford a world-class system.

Case and Deaton 20

Anne Case and Angus Deaton (Alexander Stewart 1886 Professor of Economics and Public Affairs, Emeritus at Princeton University, and Senior Scholar and the Dwight D. Eisenhower Professor of Economics and International Affairs Emeri-tus at the Princeton School of Public and International Affairs and the Economics Department at Princeton University, respectively). "America Can Afford a World-Class Health System. Why Don't We Have One?" New York Times, April 14, 2020. https://www.nytimes.com/2020/04/14/opinion/sunday/covid-inequality-health-care.html

In March, Congress passed a coronavirus bill including $3.1 billion to develop and pro-duce drugs and vaccines. The bipartisan consensus was unusual. Less unusual was the successful lobbying by pharmaceutical companies to weaken or kill provisions that addressed affordability — measures that could be used to control prices or invalidate patents for any new drugs.

The notion of price control is anathema to health care companies. It threatens their basic business model, in which the government grants them approvals and patents, pays whatever they ask, and works hand in hand with them as they deliver the worst health outcomes at the highest costs in the rich world.

The American health care industry is not good at promoting health, but it excels at taking money from all of us for its benefit. It is an engine of inequality.

Now is a difficult time to talk about the costs of health care. Doctors and nurses are risking their lives to fight the virus. We need more doctors and nurses. We need more beds, more ventilators and more protective equipment, and we need vaccines and drugs. High prices are not the best nor the only way to get drugs or vaccines that will win the war against the virus, but they can help.

Yet we cannot go on as we have been. America is a rich country that can afford a world-class health care system. We should be spending a lot of money on care and on new drugs. But we need to spend to save lives and reduce sickness, not on expensive, income-generating procedures that do little to improve health. Or worst of all, on enriching pharma companies that feed the opioid epidemic.

The crisis will, inevitably, change health care in countless ways. The industry might emerge as a superhero of the war against Covid-19, like the Royal Air Force in the Battle of Britain during World War II. If so, it might become even more untouchable than before. Or it may be seen as a financial predator that leaves many thousands with unpayable bills for coronavirus care.

But the virus also provides an opportunity for systemic change. The United States spends more than any other nation on health care, and yet we have the lowest life expectancy among rich countries. And although perhaps no system can prepare for such an event, we were no better prepared for the pandemic than countries that spend far less.

6.1.2 Saves Lives

Lack of health insurance causes tens of thousands of preventable deaths each year.

Chalabi 17

Mona Chalabi (Data Editor at Guardian US). “Will losing health insurance mean more US deaths? Experts say yes.” *The Guardian*, June 24, 2017. https://www.theguardian.com/us-news/2017/jun/24/us-healthcare-republican-bill-no-coverage-death

Various studies have looked at whether uninsured people have a higher risk of death. The most cited was published by the American Journal of Public Health in 2009 and found that nearly 45,000 Americans die each year as a direct result of being uninsured.

Dr Andrew Wilper and a team at Harvard Medical School used two main datasets: they took a nationwide US survey of more than 30,000 people conducted by the Centers for Disease Control and Prevention (CDC) and checked it against the National Death Index, another national database collected by the CDC.

The two sets of numbers allowed the researchers to examine something called hazard ratios, which are a way to measure risk. For example, if a clinical trial finds that drug users are three times more likely experience a certain side effect, that drug has a hazard ratio of three.

In America, deep inequality can affect the usefulness of data like this. Lots of things can increase an American’s chances of being sick – being a person of color or being poor to name just two – and if those factors overlap with a lack of health insurance, it can be difficult to determine what exactly is affecting an individual’s risk of death.

In the Harvard study, the researchers had 9,000 people in their dataset – enough that they were able to ensure they were really measuring the impact of a lack of health insurance.

The researchers found that a lack of health insurance had a mortality hazard ratio of 1.40. In other words, they concluded that Americans without health insurance were 40% more likely to die than those with it, even after taking into account the individual’s “gender, age, race/ethnicity, poverty income ratio, education, unemployment, smoking, regular alcohol use, self-rated health, physician-rated health and body mass index”.

The researchers calculated that in 2005, lack of health insurance resulted in 44,789 deaths of Americans age 18 to 64.

6.1.3 Universal Coverage Good

Nearly 100 million Americans are uninsured or underinsured. M4A solves by making coverage universal and affordable.

Bivens 20

Josh Bivens (Economic Policy Institute, Director of Research). “Fundamental health reform like ‘Medicare for All’ would help the labor market.” Economic Policy Insti-tute, March 5, 2020. https://www.epi.org/publication/medicare-for-all-would-help-the-labor-market/

Background: The need for fundamental health reform

Currently, despite the significant gains in health care coverage spurred by the passage of the Affordable Care Act (ACA) in 2010, roughly 23 million Americans between the ages of 19 and 64 are uninsured, and another 64 million are underinsured (Collins, Bhupal, and Doty 2019).1 In addition to problems with access, the American health care system also suffers from excess costs.2 While excess health care cost growth has slowed notably in the last decade, it would be prudent for policymakers to try to keep this cost growth in check with significant policy reforms rather than simply hoping for the best going forward. Some highly important health-related prices have begun rising rapidly in the very recent past. Insurance premiums, for example, rose 20% in 2019.3 Overall spending on prescription drugs rose more than 9% between the fourth quarter of 2018 and the fourth quarter of 2019—the largest year-over-year change since 2015.4

Bivens 2018b provides data demonstrating that health spending in the U.S. is higher than in advanced peer countries and has risen faster over time—and yet continues to buy worse health outcomes. The higher and faster-growing spending of the United States is driven by faster growth of prices, not by growth in the volume of health care goods and services consumed. Further, international evidence shows that a key com-ponent of controlling cost growth is a strong public role in setting and negotiating the prices of health care goods and services.

A fundamental reform like Medicare for All (M4A) would make coverage universal. Further, by providing a counterweight to (or outright eliminating) the substantial mar-ket power that keeps prices high and that is currently wielded by many key players in the health care sector (e.g., insurance companies, drug companies, specialty physicians, and device makers), such a reform could also have great success in containing health

care cost growth. This could in turn provide relief from many of the ways that rising health costs squeeze family incomes.

6.1.4 AT: Death Prevention Data Poor

Even if the data is not entirely clear, the overall consensus is that lack of health insurance risks thousands of lives.

Chalabi 17

Mona Chalabi (Data Editor at Guardian US). “Will losing health insurance mean more US deaths? Experts say yes.” *The Guardian*, June 24, 2017. https://www.theguardian.com/us-news/2017/jun/24/us-healthcare-republican-bill-no-coverage-death

Those who have sought to repeal the ACA have rejected this connection between health insurance and health. However many of them, such as Republican Raul Labrador when he spoke at a town hall event last month, have seemed unable to cite evidence in support of their position.

There is scant evidence directly against the connection between mortality and health insurance. But that does not mean that studies such as the one published in 2012 are without flaws.

For one thing, the numbers do not necessarily match up. A 2002 study published by the Institute of Medicine found that 18,000 people died each year due to lack of health insurance. A study published by the Urban Institute put the figure at 22,000 deaths in 2006.

But while estimates disagree, the researchers who produce them often do not. In a 2013 Politifact interview, the author of the Urban Institute study, Stan Dorn, said: “It makes sense that as time goes by … health insurance coverage has greater impact on health outcomes.”

The specific numbers might be hard to agree upon, and even harder to forecast if the Republican bill is passed. But the link is clear: a lack of health insurance could increase the risk of death for millions of Americans.

6.1.5 AT: Not Feasible

Despite challenges, the current system is unsustainable and only Medicare for all would solve

Woodson 19

Dr. Jonathan Woodson (a professor of the practice of health law, policy & management, is director of the Institute for Health System Innovation & Policy), ”Medicare for All—Is It Feasible?,” BU Institute for Health System and Innovation and Policy, April 29, 2019 https://www.bu.edu/ihsip/2019/04/29/medicare-for-all-is-it-feasible/

The 2020 presidential race has ignited a new focus on healthcare reform. On the left, 10 proposals have been put forth to expand Medicare or create a “Medicare for all” universal health insurance program. On the right, there are renewed calls for repeal of the Affordable Care Act without articulation of what would replace this plan and create options for the 26 million Americans currently uninsured. Furthermore, no rem-edy has been established to address rising premiums and those individuals with high deductibles, coinsurance, and copays, all of which render their insurance unusable be-cause of the high out-of-pocket costs. In a recent speech, Seema Verma, administrator of Medicare and Medicaid, criticized “Medicare for All” plans and called a single-payer system the biggest threat to the future of the American healthcare system.

The US currently has the most extensive tax-financed healthcare system of any econom-ically developed country without the benefits of universal coverage of its citizens. Ev-eryone understands the costs of direct government tax-supported insurance programs like Medicare ($480 billion), Medicaid ($450 billion), and Tricare, but as Woodhandler has noted, every municipal, state, and federal worker has tax-supported health insur-ance with a premium paid in administrative costs to private insurance companies to act as middle managers of the health benefit. These costs can be as high as 24 percent of total costs as opposed to the 2 percent to 4 percent administrative costs of Medicare. In addition, the US tax payer supports the Veterans Health System ($200 billion) and the Military Health System ($50 billion).

Employer-based insurance has been a major source of financing health care since the 1930s. It evolved at a time when healthcare costs were low and was institutionalized during WWII when wages were frozen and healthcare benefits were used to attract workers. Following WWII labor unions fought for health insurance benefits as part of labor contracts leading to expansion of the private, for-profit health insurance mar-

ket that used “experience ratings” to set premiums. Today, with the enormous costs of health care, the employer-based insurance system creates a competitive disadvantage for companies operating in global markets and financial risk for the individual.

The simple idea behind “Medicare for all” is the transfer of all the money we now spend for private insurance into a tax-based system with standard health benefits for all US citi-zens. Since we currently have a well-established system for collecting taxes, no new sys-tem for collecting premiums would need to be created, and administrative costs could theoretically be reduced. In an efficiently run system, a large tax increase (in excess of what we pay currently for insurance premiums) may not be necessary, and insuring the entire population would allow costs to be based upon community rating, since all (healthy and unhealthy) would pay into the system. However, there would be a require-ment for change by all stakeholders.

The insurance industry would be radically changed if not eliminated under some “Medi-care for all” proposals. The insurance industry employs tens of thousands of individuals and is part of stock market portfolios that fund retirement plans. Destabilization of the private healthcare insurance industry could have significant second- and third-order ef-fects on others segments of the US economy. Some proposals would preserve a private insurance market under stricter regulation or provide co-insurance, creating a tiered system of care.

Patient/customers would also have to change. Seventy-five percent of Americans with health insurance receive coverage through employer-based plans. Although there has been a trend to shift more costs to the employees, and despite statistics that show the average time an employees stays with the same plan is two and a half years (because employers offer different products based upon negotiated rates and business analysis), most are satisfied with their employer-based insurance.

Healthcare providers will also need to change, as the collective buying power of a sin-gle payer will blunt the rise of reimbursements to providers, although they may benefit from a reduction in the varied requirements for quality measures and billing documen-tation now seen as problematic as a result of the myriad of differing insurance company rules plaguing the market. The pharmaceutical industry will experience increased pres-sure from a single payers to moderate prices, and hospitals will need to adjust to reduced reimbursements rates.

Government will need to change as well. A universal health system cannot be subjected to the constant changing influences of party politics. For a universal health insurance

system to work, an independent commission would need to be established with business rules that allow for efficient vetting of new therapies based upon scientific evidence of effectiveness. Such a system could address some social determinants of health and health outcome disparities.

So the question still remains, “Is Medicare for all feasible?” The current political and economic environment makes the likelihood of passage of such reforms slim, in large part because of stakeholder reaction to needed changes. However, it seems improbable that we can sustain the current illogical system with its high costs and poor outcomes. Furthermore, the current system does not comport well with American values and seems immoral that all Americans in need of care do not have access to appropri-ate care when required because of the inability to pay out of pocket costs. The private for profit insurance system has no incentive to insure those individuals with chronic disease or preexisting conditions unless heavily regulated.

Perhaps the best course of action at this time is for politicians to define the process that will get us to where we need to be—universal health care—a process which can evaluate the negative impact of the shift to universal health care and develop plans to mitigate the consequences for certain stakeholders. The US cannot continue to be a world leader without a healthy society. We would all do well to reflect on the words of the ancient Greek physician Herophilus’ (325-255 BC), who aptly defined the importance of meeting the challenge of creating a healthy society when he wrote:

“When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied.”

6.2 AT: Public Option

6.2.1 AT: Choice Good

Even if choice is good in the abstract, M4A is superior because it makes accessing healthcare simple and non-stressful.

Studebaker and Robinson 19

Benjamin Studebaker & Nathan J. Robinson (PhD student in Politics and International Studies at the University of Cambridge, and columnist for The Guardian US, and Editor-in-Chief of Current Affairs magazine with a J.D. from Yale Law School, respectively). “Why A”Public Option” Isn’t Enough.” *Current Affairs*, July 14, 2019. https://www.currentaffairs.org/2019/07/why-a-public-option-isnt-enough

But how do proponents of (actual) Medicare For All respond to the basic arguments made by those proposing “Medicare For All Who Want It”? What Pete Buttigieg and other moderates say is this: Why force people into a government program? Most people are satisfied with their healthcare (though note the huge difference between the 70 per-cent of Medicare enrollees who say they are satisfied with the cost, and the 51 percent of people with private insurance who are satisfied with cost). Why abolish private insur-ance? Why not just have insurance companies compete against a government plan in an open marketplace where people can choose? That way, everyone who wants Medicare gets it, while people who are satisfied with their current insurance can keep it. Every-one wins. The implication here is that anyone who supports a full single-payer plan, in which everyone would just be insured under a government program, must be rigidly ideological, wanting to shutter the private insurance industry for no good reason. Why would we do that instead of just providing a new option?

To understand why full “single payer” health insurance is the left’s goal, rather than just “another insurance plan on the marketplace,” it helps first to understand the left’s vision for how healthcare should work. In an ideal world, your healthcare would not be something you have to think about very much. If you got sick, you would choose a doctor’s office and make an appointment. You would go to that appointment and see the doctor. Then you would leave. You would not have to apply for insurance, not have to pay bills. And this would be the case no matter who you were or how much money you made. In Britain, this is what you do already. As U.K. Current Affairs contributor Aisling McCrea has explained, the NHS makes healthcare easy. “Insurance” isn’t a part

of it at all: Your relationship is between you and your doctor, not you and your doctor and your doctor's hospital's billing department and your insurance company. Leftists dream of making healthcare as easy as possible to receive and universally accessible to all regardless of how much money they have.

6.2.2 Coverage

Public option can't achieve universal coverage – affordability issues, and preservation of EBHI creates instability.

- EBHI – employer based health insurance

Studebaker and Robinson 19

Benjamin Studebaker & Nathan J. Robinson (PhD student in Politics and International Studies at the University of Cambridge, and columnist for The Guardian US, and Editor-in-Chief of Current Affairs magazine with a J.D. from Yale Law School, respectively). "Why A"Public Option" Isn't Enough." *Current Affairs*, July 14, 2019. https://www.currentaffairs.org/2019/07/why-a-public-option-isnt-enough

Private health insurance is an unnecessary part of the healthcare system. Insurance companies are middlemen, and insurance just exists to make sure that providers get paid. It was our government's own choice to encourage the proliferation of private insurance, through laws like the Health Maintenance Organization Act of 1973. It was the federal government that subsidized private insurance companies and encouraged employers to use them. Other countries didn't build this kind of healthcare system, for two reasons:

1. It doesn't cover everyone.
2. It creates a bloated, inefficient insurance bureaucracy.

Our government has always been playing catch-up trying to get more people covered. It's created employer subsidies, Medicaid, CHIP, and the Obamacare exchanges in a desperate bid to get this system to do its job, and despite decades of piecemeal healthcare reforms 13.7 percent of Americans remain without health insurance and millions more have inadequate coverage. Offering to let Americans "buy-in" to Medicare keeps Americans paying premiums, and as long as Americans must personally pay premiums to receive healthcare there are going to be some people who can't or won't pay those premiums and go without. It turns Medicare-For-All into a publicly run HMO. Main-taining an employer-sponsored health insurance system means remaining in a situation where large numbers of people go through a period of being uninsured each year, be-cause when you lose your job you lose your insurance. (Currently 1 in 4 Americans go through an uninsured period each year.) Single payer advocates ask the question: "Why have a nightmarish tangle of public and private options, varying by state, with

people moving on and off all the time? Why not just pay for healthcare with taxes, cover everyone, and make it free at the point of use?”

6.2.3 Cost

Public option fails to reduce healthcare costs --- maintains duplicative bureaucracies and profit incentives

Studebaker and Robinson 19

Benjamin Studebaker & Nathan J. Robinson (PhD student in Politics and International Studies at the University of Cambridge, and columnist for The Guardian US, and Editor-in-Chief of Current Affairs magazine with a J.D. from Yale Law School, respectively). “Why A”Public Option” Isn’t Enough.” *Current Affairs*, July 14, 2019. https://www.currentaffairs.org/2019/07/why-a-public-option-isnt-enough

Not only will a public option fail to cover everyone, it will do nothing to restrain the growth of healthcare costs. Single payer systems control costs by giving the health ser-vice a monopoly on access to patients, preventing providers from exploiting desperate patients for profit. If instead there are a large number of insurance companies, providers can play those insurance companies off each other. Right now, we have a two-tier sys-tem, in which the best doctors and hospitals refuse to provide coverage unless your insurer offers them exorbitantly high rents. To support that cost while still making a profit, your insurer has to subject you to higher premiums, higher co-pays, and higher deductibles. Poor Americans with poor-quality insurance are stuck with providers who don’t provide high enough quality care to make these demands. The best providers keep charging ever higher rents, and the gap between the care they offer and the care the poor receive just keeps growing. Poor Americans are now seeing a decline in life expectancy, in part because they cannot afford to buy insurance that would give them access to the best doctors and hospitals. Costs balloon for rich Americans while the quality of care stagnates for the poor.

The bloat doesn’t just come from providers. Because insurance works on a profit incentive, the insurance companies must extract rents as well. So the patient is paying to ensure not only that their doctor or hospital is highly-compensated, but that the insur-ance company generates profit too. Each insurance company has its own managers—its own CEO, its own human resources department, and so on. We have to pay all of these people, and because there are so many private insurance companies, there are so many middle managers to pay. (Barack Obama once bizarrely critiqued single payer by say-ing it would eliminate millions of jobs in the insurance bureaucracy, implying that we should keep admittedly pointless jobs and gouge patients as a make-work program.)

These duplicate bureaucracies are expensive to maintain and do nothing to improve the quality of care. The providers make them compete to offer higher compensation, and you pay for it. Getting rid of these middle men makes the system far more efficient. We now spend 17 percent of GDP on healthcare. Britain spends 10 percent, and British people can expect to live two years longer. (Though in order to achieve a full cost-effective British system, we'd have to socialize medicine rather than just socializing insurance.) People do not associate government with efficiency, but when it comes to moving money from one place to another—which, after all, is all an insurance company does—it can be quite good, and it makes far more sense to have government handle healthcare payments than to leave it to companies with a direct financial incentive to deny treatment.

Private insurance is inconvenient, inefficient, and continues to leave large numbers of Americans with inadequate insurance or no insurance at all. The Affordable Care Act shored up this system by funnelling more public money into subsidies for private insurance. Now these Democratic candidates are proposing to make a new insurance company, call it "Medicare," and charge you premiums to use it. That doesn't get rid of the problem of wasteful duplicative bureaucracies, and will guarantee that some people remain uninsured. It was the federal government's decision to build this bizarre, bur-densome system. Nothing about private health care is natural or inevitable. It doesn't have to be like this.

6.3 Covid-19

6.3.1 EBHI Fails

That Covid-19 created massive loss of health insurance during a deadly pandemic demonstrates that alternatives to EBHI are badly needed.

- EBHI = employer based health insurance

Interlandi 20

Jeneen Interlandi (member of the Times editorial board since 2018, and a contributor to The New York Times Magazine since 2006). “Employer-Based Health Care, Meet Massive Unemployment.” *New York Times*, June 29, 2020. https://www.nytimes.com/2020/06/29/opinion/sunday/coronavirus-medicare-for-all.html

In the early months of 2020, Americans were engaged in the perennial election-year debate over how best to reform the nation’s health care system. As usual, the electorate was torn and confused. Polling indicated that a small majority of likely voters favored a new universal system that would cover everyone. But that support evaporated when it was made clear that any such overhaul would involve abolishing the private insurance market. At the time, nearly 160 million Americans received their health benefits through an employer, and the vast majority of them liked that coverage just fine — maybe not enough to sing about it, but enough to be wary of a potential replacement.

Then came the pandemic of the century. And the highest level of unemployment since the Great Recession. And the most concentrated wave of job loss in the nation’s history — more than 40 million Americans filed new unemployment claims between mid-March and late May. It will take time to ascertain the full impact of those losses on the nation’s health insurance rate, but an early survey from the Commonwealth Fund is not encour-aging: 41 percent of those who lost a job (or whose spouse lost a job) because of the pandemic relied on that job for health insurance; 20 percent of those people have not managed to secure alternative coverage.

Nothing illuminates the problems with an employer-based health care system quite like massive unemployment in the middle of a highly contagious and potentially deadly dis-ease outbreak. For one thing, uninsured people are less likely to seek medical care, mak-ing this coronavirus that much more difficult to contain. Also, people with chronic or immune-compromising medical conditions are particularly susceptible to this new con-

tagion — which means the people most in need of employer-sponsored health benefits are the same ones who can least afford to return to work at the moment.

“The pandemic has amplified all the vulnerabilities in our health care system,” says Drew Altman, president of the nonpartisan Kaiser Family Foundation, including “the uninsured, racial disparities, the crisis of unmanaged chronic conditions and the general lack of national planning.”

As dire as the crisis is, though, it’s also an opportunity to look at health care reform with fresh eyes — and to maybe, finally, rebuild the nation’s health care system in a way that works for all Americans, not just the wealthy and the well employed.

6.3.2 Worsens Uninsured Rate

Up to 35 million people will lose insurance due to Covid-19. That makes moving past EBHI an imperative.

Klein 20

Ezra Klein (Founder and editor-at-large, Vox). "It's time to move past employer-based health insurance." *Vox*, April 9, 2020. https://www.vox.com/2020/4/9/21210353/coronavirus-health-insurance-biden-sanders-medicare-for-all

According to a new analysis by the consulting firm Health Management Associates (HMA), the Covid-19 crisis could lead to between 12 million and 35 million people losing employer-sponsored health coverage due to job losses.

Not all of them will tumble into the ranks of the uninsured. Some will be caught by Medicaid, by Obamacare, or by other safety net programs. Some will find new jobs, with new insurance. But millions will fall through the cracks, particularly in states that have refused to expand Medicaid. In a scenario where unemployment hits 25 percent — calamitous, but plausible — HMA forecasts that as many as 11 million people could find themselves uninsured. That wipes out about half of Obamacare's coverage gains, practically overnight.

Here, as elsewhere, Covid-19 is worsening a policy problem that long predates the virus. Tying health insurance to employment is now, and always has been, a disaster. It gives bosses too much power over workers, reduces entrepreneurship, saddles businesses with health costs they can't control and insurance problems they don't understand, makes the tax structure more regressive, reduces wages, bloats administrative spend-ing, and drives up costs throughout the system.

It has also, as Paul Starr writes in Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform, created a "policy trap" that has stymied health reformers over and over again: About 160 million Americans get insurance through their employers, and for all the system's flaws, they are mostly pretty happy with that insurance, which makes them resistant to disruptive change.

But disruptive change is here, whether anyone wants it or not. It won't just be felt in the rising ranks of the uninsured, in the millions of people who lose the insurance provided by their workplace and have to scramble, desperately, for an alternative. It will also be felt by those who keep their job-based insurance, only to see it degrade as their employer rushes to cut costs.

According to the Kaiser Family Foundation, average premiums for employer-based insurance have risen 54 percent over the past decade — far outpacing wages or inflation. Cost-sharing has increased, too: Average annual deductibles have doubled in the past decade. Employers have been shunting health costs onto employees in both good times and bad, and these are the worst times. Many of those who keep their employer-based insurance will see their premiums and deductibles rise, their networks narrow.

This is a crisis. But it is also, perhaps, an opportunity to solve the policy trap and finally move beyond employer-based insurance.

6.4 Costs

6.4.1 Net Saves

Medicare for All net saves money --- the studies are decisive

Archer 20

Diane Archer (a senior adviser at Social Security Works), ”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

The evidence abounds: A ”Medicare for All” single-payer system would guarantee com-prehensive coverage to everyone in America and save money.

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

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

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

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

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

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 de-tect and correct. A uniform claims data system helps reduce health care spending for fraudulent services. In 2018, total U.S. health care costs were $3.6 trillion, representing 17.7 percent of GDP.

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

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

Other wealthy countries dictate virtually every element of the health insurance people receive, including what's covered, what's paid, and people's out-of-pocket costs — all identical for everyone. The insurers operate like claims processors or bill payers. They follow the coverage and payment rules set by the government, nothing like the private health insurers in the U.S. which revel in product diversity (read: complexity and con-fusion).

And, if you're thinking that having the federal government guarantee coverage to all Americans is a big deal, it's actually not. The government already pays for about two-thirds of health care costs. Among other things, it pays for Medicare, Medicaid, VA, TriCare and a wide range of state and local health care programs, along with private insurance for government employees and tax subsidies for private insurance.

Whether you call it single-payer or Medicare for All, it isn't some socialist pipe dream. It's a sensible, efficient, and effective way to guarantee excellent health insurance to everyone.

6.4.2 Administrative Costs

Private insurance goes towards subsidizing overhead instead of actual care.

M4A reduces costs by eliminating this inefficiency.

Day and Sunkara 18

Meagan Day and Bhaskar Sunkara (staff writer and editor at Jacobin, respectively). "Why America Needs Medicare for All." *New York Times*, August 10th, 2018. https://www.nytimes.com/2018/08/10/opinion/medicare-for-all-health-costs.html

A growing majority of Americans agree: Health care shouldn't be a business. They're finally coming around to the idea that it can and should be a public good instead — something we can all turn to when the need arises.

The favorite right-wing argument against Medicare for All — the most popular approach to universal, publicly financed heath care — is that it's too expensive. More on those costs in a moment. But first, we should note that our current health care system is actually the most expensive in the world by a long shot, even though we have millions of uninsured and underinsured people and lackluster health outcomes.

This is partly because a lot of that money doesn't go directly toward keeping people healthy. Instead it goes to the overhead costs required to keep businesses running. These include exorbitant executive salaries, marketing to beat out the competition, the labor-intensive work of assessing and denying claims and so on. None of these would be a factor in a single-payer, Medicare for All system. Taiwan and Canada both have single-payer systems, and both spend less than 2 percent of total expenditures on administrative costs — and so does the United States's current Medicare program. By contrast, private insurers in the United States spend as much as 25 percent on overheads.

6.4.3 Cost-Effectiveness

American healthcare is inefficient. It is costliest but much less effective.

Interlandi 20

Jeneen Interlandi (member of the Times editorial board since 2018, and a contributor to The New York Times Magazine since 2006). “Employer-Based Health Care, Meet Massive Unemployment.” *New York Times*, June 29, 2020. https://www.nytimes.com/2020/06/29/opinion/sunday/coronavirus-medicare-for-all.html

The first step will be acknowledging the problems of our current system. If American health care were its own country, it would be the fourth largest in the world by gross do-mestic product. The nation spends an average of $3.5 trillion per year on health care — more than Japan, Germany, France, China, the United Kingdom, Italy, Canada, Brazil, Spain and Australia combined — and still loses more people to preventable and treat-able medical conditions than any of those countries do.

In other words, America has created the most expensive, least effective health care sys-tem in the modern world, and the most vulnerable Americans have been paying for that failure with their lives since long before the coronavirus came to town.

In many ways, of course, that system is no system at all. It’s a patchwork in which access to care depends on a roster of factors, including age, employment status and state of residence. It’s a free-for-all in which the prices of life-or-death essentials like insulin and heart surgery are set at whatever the market will bear, and efforts to check those prices are routinely bludgeoned by interest groups that hold enormous sway over lawmakers. It’s a labyrinth in which consultants, billing clerks and administrators vastly outnumber medical professionals. And it’s a voracious beast that feeds American households with well-paying jobs, then devours them with insurmountable medical bills — often at their weakest moments.

6.4.4 Payment Rates

M4A saves trillions by reducing payment rates.

Berwick 19

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

Nearly certain to save trillions

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

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

M4A saves money by dramatically reducing payment rates.

Day and Sunkara 18

Meagan Day and Bhaskar Sunkara (staff writer and editor at Jacobin, respectively). “Why America Needs Medicare for All.” *New York Times*, August 10th, 2018. https://www.nytimes.com/2018/08/10/opinion/medicare-for-all-health-costs.html

But the most important way Medicare for All would save money isn’t by slashing admin-istrative costs. It’s by using the power and size of the government, like other countries

around the world currently do, to negotiate favorable terms with drug companies and service providers. There's a reason a CT scan costs $896 in the United States, but only $97 in Canada.

6.4.5 AT: Can't Afford

Government financing sounds expensive because it consolidates all healthcare expenditure into one source, but it is cheaper for ordinary Americans. Public financing could be obtained through progressive income and corporate taxes.

Day and Sunkara 18

Meagan Day and Bhaskar Sunkara (staff writer and editor at Jacobin, respectively). "Why America Needs Medicare for All." *New York Times*, August 10th, 2018. https://www.nytimes.com/2018/08/10/opinion/medicare-for-all-health-costs.html

And what about the sticker shock factor — the dramatic rise in government spending to accommodate such a program? Medicare for All would transfer all payment responsibility to one public agency (as opposed to a bunch of private companies), and that act of combination produces the big price tag that conservatives use as a cudgel. But while this would be more expensive for the government, it wouldn't be for ordinary Ameri-cans. The money would be raised through progressive income and corporate taxes and end up costing most people less than their current health care. And coverage would be comprehensive and universal, meaning nobody would ever be unable to afford the care they need.

Pursuing Medicare for All would come with its own set of dilemmas: Eliminating an entire industry won't be easy, and we'll face plenty of political resistance and calls for half-measures. But if we want actual universal coverage, and we want it to be affordable and high-quality, Medicare for All is the only way forward.

Turn – rising healthcare costs create an unsustainable government financial burden.

That makes reform necessary

Case and Deaton 20

Anne Case and Angus Deaton (Alexander Stewart 1886 Professor of Economics and Public Affairs, Emeritus at Princeton University, and Senior Scholar and the Dwight D. Eisenhower Professor of Economics and International Affairs Emeri-tus at the Princeton School of Public and International Affairs and the Economics Department at Princeton University, respectively). "America Can Afford a World-Class Health System. Why Don't We Have One?" New York Times, April 14, 2020.

https://www.nytimes.com/2020/04/14/opinion/sunday/covid-inequality-health-care.html

Rising costs are an untenable burden on our government, too. States' payments for Medicaid have risen from 20.5 percent of their spending in 2008 to 28.9 percent in 2019. To meet those rising costs, states have cut their financing for roads, bridges and state universities. Without those crucial investments, the path to success for many Americans is cut off. We face a looming trillion-dollar federal deficit caused almost entirely by the rising costs of Medicaid and Medicare, even without the recent coronavirus relief bill.

Every year, the United States spends $1 trillion more than is needed for high quality care. Of course, that waste is also someone's income; executives at hospitals, medical device makers and pharmaceutical companies, and some physicians, are very well paid.

American doctors control access to their profession through a system that limits medical school admissions and the entry of doctors trained abroad — an imbalance that was clear even before the pandemic. That keeps their numbers down and their salaries up. As of 2012, doctors were the largest single occupation in the top 1 percent. The business model under which most doctors practice isn't working; without the revenue from high-paid elective care, some hospitals are now resorting to furloughs and layoffs of doctors and nurses.

Hospitals, many of them classified as nonprofits, have consolidated, with monopolies over health care in many cities, and they have used that monopoly power to raise prices. Many Americans, even those with insurance, face bills that they cannot pay, or are hit with "surprise" medical bills charged by providers working at in-network hospitals who have opted not to accept insurance. Ambulance services and emergency departments that don't accept insurance have become favorites of private equity investors because of their high profits. Medical device manufacturers have also consolidated, in some cases using a "catch and kill" strategy to swallow up nimbler start-ups and keep the prices of their products high.

These are all strategies that lawmakers and regulators could put a stop to, if they choose.

They choose not to. And so we Americans have too few doctors, too few beds and too few ventilators — but lots of income for providers. While millions suffer, our health care system has turned into an inequality machine, taking from the poor and working class to generate wealth for the already wealthy.

The health care industry has armored itself, employing five lobbyists for each elected member of Congress. But public anger has been building — over drug prices, co-

payments, surprise medical bills — and now, over the fragility of our health care system, which has been laid bare by the pandemic. This anger could breach the protective cordon in Washington.

6.4.6 AT: Middle-Class Taxes

M4A saves the middle-class money compared to what they would spend in the squo.

Berwick 19

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

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

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

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

6.4.7 AT: Costs More Than Current Budget

It would be expensive but substantially less than the federal budget

Luthra 20

Shefali Luthra, "Would 'Medicare For All' cost more than U.S. budget? Biden says so. Math says no.," MedCity News, February 24, 2020, https://medcitynews.com/2020/02/would-medicare-for-all-cost-more-than-u-s-budget-biden-says-so-math-says-no/

During the Feb. 7 Democratic presidential debate, former Vice President Joe Biden once again questioned the price tag of "Medicare for All," the single-payer health care pro-posal championed by one of his key rivals, Sen. Bernie Sanders of Vermont.

Biden argued that the plan was fiscally irresponsible and would require raising middle-class taxes. Specifically, he claimed, the plan "would cost more than the entire federal budget that we spend now."

Medicare for All's price — and whether it's worth it — is a subject of fierce discussion among Democratic presidential candidates. But we had never heard this figure before. It caught our attention, so we decided to dig in.

Biden's campaign directed us to the 2018 federal budget, which totaled $4.1 trillion. It compared that amount with the estimated cost of Sanders' single-payer proposal: between $30 trillion and $40 trillion over a decade. The math, they said, shows Medicare for All would cost more than the national budget.

But it turns out, based on the numbers and interviews with independent experts, Biden's comparison of Medicare for All's price to total federal spending misses the mark because the calculation is flawed.

The Numbers

Sanders has said publicly that economists estimate Medicare for All would cost somewhere between $30 trillion and $40 trillion over 10 years. Research by the nonpartisan Urban Institute, a Washington, D.C., think tank, puts the figure in the $32 trillion to $34 trillion range.

We pointed out to Biden's campaign that comparing 10-year spending estimates to one-year budgets is like comparing apples to oranges. The campaign suggested that if you take 10 times the current federal budget, you get a figure smaller than the estimated cost of Medicare for All over that 10-year window.

That calculation would lead you to multiply $4.1 trillion by 10 to get $41.1 trillion. That result is close to the high mark Sanders set for his program's cost but well above the $34 trillion that Urban researchers projected.

Still, that's not the correct way to formulate a comparison, experts say. "That's not good math," said Marc Goldwein, the senior vice president and senior policy director at the Committee for a Responsible Federal Budget. "That's taking a 2018 number and multiplying it by 10, whereas the $34 trillion is a 10-year number that assumes a lot of growth."

What you would need to do is add up the Congressional Budget Office's projected bud-get outlays from 2020 to 2029, and compare the sum to the Medicare for All spending figure.

So we spoke to Linda Blumberg, an institute fellow at Urban's Health Policy Center, who arrived at the $34 trillion estimate. She ran the CBO's numbers: The next 10 years of on-budget outlay, the government office projects, add up to $44.8 trillion.

To be clear, $34 trillion (34 followed by 12 zeros) is no small sum. It accounts for about 75% of that nearly $45 trillion budget estimate and would represent a bigger single in-crease to the federal budget than we've ever experienced, Blumberg said.

That raises one point on which Biden may have some ground. Goldwein argued that you would indeed need significant tax increases to finance the Sanders proposal.

But its price tag still would be less than the projected budget.

"If he said [Medicare for All] was as big as the current federal budget, that would be incorrect," Blumberg said.

Goldwein looked at the numbers another way: Including interest, he found, the federal budget would consume about $55 trillion between now and 2030. Again, that's more than what Medicare for All would cost during the same period.

Big picture: No matter how you slice Biden's math, his numbers are off.

"If what he said was Medicare for All will cost as much as the entire rest of the budget, that would be fair," Goldwein said. But that's not the same thing.

Our Ruling

Biden argued that Medicare for All "would cost more than the entire federal budget that we spend now."

This relies on faulty math. Medicare for All would certainly represent a substantial increase to the federal budget. But it would neither match nor dwarf current federal spending overall. We rate this claim False.

6.5 Economy

6.5.1 EBHI

EBHI hurts the economy by creating downward pressure on wages and locking workers into their current jobs. Alternatives like M4A solve.

Interlandi 20

Jeneen Interlandi (member of the Times editorial board since 2018, and a contributor to The New York Times Magazine since 2006). “Employer-Based Health Care, Meet Massive Unemployment.” *New York Times*, June 29, 2020. https://www.nytimes.com/2020/06/29/opinion/sunday/coronavirus-medicare-for-all.html

By 1960, roughly two-thirds of all Americans were insured by their employers, by 1970 health insurance had become big business, and by the 1980s health care costs were soar-ing. Some of that increase can be attributed to advances in technology that made care more expensive. But a great deal of the spike resulted from what economists refer to as “price insensitivity” and what the rest of us might call obliviousness. “If the insurer is paying, nobody looks at the bill,” says Zack Cooper, a health economist at the Yale School of Medicine. “So you can raise prices as much as you want, and you can create a much more luxurious system overall, to justify it.”

Unencumbered by the demands of a cost-conscious clientele, hospitals ramped up equipment purchases, expanded hospital wings and workforces, created specialty clinics — and then increased their reimbursement rates to pay for it all. Rather than scrutinize those price hikes, which were passed from hospitals to insurers to customers, employers simply accepted them. And why wouldn’t they? The more generous the insurance package and the nicer the hospitals and clinics, the bigger the tax break for the companies paying the tab. “For employers, it’s essentially the house’s money,” Mr. Cooper says. “But then, for anyone not on that raft of good coverage, it’s enormous costs or nothing.”

That calculus is especially brutal for un- or underemployed Americans, but it’s a bad deal for all workers. Economists tend to agree that health benefits sap wages — meaning that employers recoup at least some of the cost of insuring their employees by paying them less money than they otherwise might. At least some unions say that they spend so much of their bargaining power securing these benefits for their members that they have little left for other crucial fights, like retirement. Lower-skilled workers have long been

squeezed out of better paying jobs because, as the economists Anne Case and Angus Deaton note, a labor market skewed by pricey health benefits tends to favor those whose talents can more easily justify the expense.

Perhaps worst of all, employees of every ilk frequently find themselves trapped: chang-ing jobs, foregoing employment or taking professional risks (like starting a business) all involve changes in health insurance and, in the worst case scenario, a loss of cover-age. The end result is a medical underclass whose horizons are contracted by the sheer logistics of hanging on to health care.

To change this system, Americans will have to change their thinking. There is a tendency among workers with good health insurance to see those benefits as something that's purely earned, through work. But employer-based insurance is heavily subsidized by the federal government. Those subsidies are not much different than the ones granted to low-income Americans through Medicaid and the Affordable Care Act, but through the lens of American politics the latter are frequently derided as an outrageous form of welfare, while the former are accepted as par for the course.

That thinking may already be evolving. According to a 2019 poll, nearly 60 percent of Americans agree that health care is a human right and that the government should be responsible for ensuring that as many people as possible can access it when they need to. But to truly realize this ideal, the country will have to stop making employers the sole source of health care for so many people. America must create either a new health care system or offer significantly more options within the current one.

There's no shortage of ideas for how to accomplish this goal. A single-payer system in which one entity (usually the federal government) covers every citizen regardless of age or employment status, could work. So could a new "public option" that makes federally guaranteed health insurance available to many more people. Any such choice will involve trade-offs and will need to be accompanied by other aggressive reforms, including price controls and checks on the influence of special interests over legislation.

Any of these reforms will be politically difficult. Even in the midst of a global pandemic, Republicans are still trying to gut the Affordable Care Act, and Democrats are still di-vided over how best to respond to that threat. But if there were ever a time to take bold steps — or to finally undo the mistakes of the past — it's now.

Healthcare spending is unsustainable – the US spends 18% of GDP on it. EBHI and high prices crowd out wages for workers.

Case and Deaton 20

Anne Case and Angus Deaton (Alexander Stewart 1886 Professor of Economics and Public Affairs, Emeritus at Princeton University, and Senior Scholar and the Dwight D. Eisenhower Professor of Economics and International Affairs Emeri-tus at the Princeton School of Public and International Affairs and the Economics Department at Princeton University, respectively). “America Can Afford a World-Class Health System. Why Don’t We Have One?” New York Times, April 14, 2020. https://www.nytimes.com/2020/04/14/opinion/sunday/covid-inequality-health-care.html

The first step to reform is to change the way we think about the health care system. Many Americans think their health insurance is a gift from their employers — a “benefit” bestowed on lucky workers by benevolent corporations. It would be more accurate to think of employer-provided health insurance as a tax.

One way or another, everyone pays for health care. It accounts for about 18 percent of G.D.P. — nearly $11,000 per person. Individuals directly pay about a quarter, the federal and state governments pay nearly half, and most of the rest is paid by employers.

In 2019, employer-based insurance plans cost an average of $21,000 for a family policy or $7,200 for a single person. This system requires companies to calculate whether a worker’s value to the company can cover both wages and benefits, a difficult test for less-skilled workers. Wages fall or employers shed or outsource these positions to companies with few benefits and fewer prospects for career advancement.

Rising health care costs account for much of the half-century decline in the earnings of men without a college degree, and contribute to the decline in the number of less-skilled jobs. Employer-based health insurance is a wrecking ball, destroying the labor market for less-educated workers and contributing to the rise in “deaths of despair.”

6.5.2 AT: Labor Market (Laundry List)

M4A helps the overall labor market. Here's a laundry list.

Bivens 20

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

An underappreciated benefit of such a reform is that it would also lead to a much bet-ter functioning labor market in many areas. Job quality would increase, job switching would become less stressful, better "matches" between workers and employers would boost productivity, and small businesses would be much easier to launch.

Despite the fact that M4A could deliver these large benefits to efficient labor market functioning, the policy often comes under fire from critics making highly exaggerated claims about the potential job loss that could occur under such a reform. The grain of truth in some of the claims is that, like any productivity improvement, the adoption of a reform like M4A would require the redeployment of workers from one sector (the health insurance and medical billing complex) to other sectors (mostly the delivery of health care). But there is little in the M4A-induced redeployment of workers that would greatly stress the American labor market over and above the uncertainty and churn that characterizes this labor market every year. Smart policy could make this redeployment eminently manageable for those workers who would be required to make the transition.

This brief highlights some labor market implications of M4A and critically examines claims that large job losses in the health insurance and billing administration sectors would make M4A an undesirable policy.

Health reform as labor market policy: Key effects for workers

Fundamental reforms like M4A could greatly aid labor market outcomes for U.S. work-ers. The most obvious benefits would be higher wages and salaries, increased avail-ability of good jobs, reduced stress during spells of job loss, better "matches" between workers and employers, and greater opportunity to start small businesses.

Higher cash wages and salaries

Medicare for All could increase wages and salaries for U.S. workers by reducing employ-ers' costs for health insurance—freeing up fiscal space to invest in wages instead. The

share of total annual compensation paid to American employees in the form of health insurance premiums rather than wages and salaries rose from 1.1% in 1960 to 4.2% in 1979 to 8.4% in 2018.5 If this post-1960 increase had been only half as large—and em-ployers had spent the health cost savings on wages and salaries—the take-home wages of American workers would have been almost $400 billion higher in 2018.6 Given that the share of total compensation spoken for by health insurance premiums is starting from a high base today, any reform that managed to slow the excess growth of health spending going forward would go a long way in making space for faster growth of cash compensation.7

Increased availability of 'good jobs'

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 ma-jority 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

Less damaging spells of joblessness

Medicare for All could make job losses and transitions less stressful by delinking employment and access to health insurance, emulating the universal access to health care offered by our rich country peers. The U.S. is unique among the rich countries of the world in how much it ties crucial social benefits—like health insurance and retirement income—to specific jobs. Hacker (2002) has referred to this arrangement as the "divided welfare state," with some Americans having relatively full access to health and retire-ment security while others have access to virtually none, all based on the specific jobs they have. This makes some jobs in the U.S. economy especially valuable, and hence especially damaging to lose. Manufacturing workers without a college degree, for ex-ample, likely incur enormous income and social benefits losses in the event of job loss stemming from either automation or trade. The ability of universal, public social ben-efits to make individual job losses less damaging has been long recognized by social scientists (see, for example, Estevez-Abe, Iversen, and Soskice 2001).

Smooth job transitions contribute to economic dynamism by helping ensure that vacancies are filled quickly by appropriate workers and that unemployed workers can quickly find new jobs that make good use of their skills. Smooth job transitions will also be an important components of meeting crucial policy goals such as mitigating greenhouse gas emissions with wholesale changes in how energy is created. Policies that make job transitions easier and inspire less resistance from workers should be encouraged. Fundamental health reform that, like M4A, guarantees access to insurance regardless of one's current job status is a key part of making such transitions easier.

Better labor market matches between workers and employers

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 busi-ness 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 peo-ple 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 employ-ment "matches" that are less productive and that decrease overall worker welfare rela-tive to job choices that are not constrained by the availability of health insurance.

More small-business formation

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

Employment effects of fundamental health reform: gains in health care, losses in insurance and billing—with likely economywide net job gains from rising economic demand

Like all positive productivity gains, Medicare for All would be more likely to increase the total number of jobs in the U.S. economy, even as health reform leads to the redeployment of workers from some sectors and into others.

Despite the many labor market benefits of fundamental health reform like M4A, many

critics have claimed that such reform would lead to a loss of jobs. This claim is mislead-ing. One small grain of truth to it is that the universal provision of health insurance would allow people who would strongly prefer not to work (or not to work full time), but who have remained in their current jobs in order to retain health insurance, to be free to quit. This type of voluntary reduction in labor supply following a health reform would be strongly welfare-improving. For example, the ACA was clearly associated with a large increase in parents with young children transitioning to part-time work (see Jørgensen and Baker 2014). To the degree this occurred because these parents no longer needed to work full time to obtain ESI, and they preferred spending more time with their children for reasons of work–life balance, it should be seen as a clear win for the policy.

Generally, people expressing concern about job loss stemming from a policy are con-cerned about involuntary job loss that leads to a higher level of unemployment in the economy. Unemployment is almost entirely a function of the level of aggregate de-mand: spending by households, businesses, and governments.12 The effect of funda-mental health reform on the level of aggregate demand depends in turn on the balance of increased public spending and the means of financing this spending. All else equal, more public spending will boost aggregate demand and create jobs, while higher taxes will reduce aggregate demand and restrain job growth. Further, the progressivity of taxes used to finance fundamental health reform will also condition its effect on aggre-gate demand. The more progressive the taxes that finance health reform, the less they will drag on job growth. Increased public spending combined with progressive tax in-creases would almost certainly boost the level of aggregate demand and lead to lower unemployment, all else equal.

While the overall number of jobs and the level of unemployment in the economy is largely a macroeconomic issue determined by aggregate demand, claims that funda-mental health reform like M4A will lead to job loss sometimes sound plausible because it is easy to envision the specific jobs that might be displaced: jobs in the health insurance and billing administration sectors. But these job displacements would be balanced by likely job gains in other sectors—most particularly in health care delivery. The health insurance coverage expansions of M4A will boost demand for health care goods and services, and workers will need to be hired to meet this demand.

Job losses in the health insurance and billing administration sectors

A recent analysis of the economic effects of M4A (Pollin et al. 2018) includes the projec-tion that up to 1.8 million jobs in the health insurance and billing administration sector

(the divisions of hospitals and doctors' offices dedicated to administrative processing of bills and payments) could be made redundant. These potential 1.8 million lost jobs are frequently presented as if they constitute the net employment effect of M4A.13 This is a deeply flawed misrepresentation of Pollin and his colleagues' work. In fact, their estimates are a gross (not net) measure of job displacement or "churn"—the regular pro-cess of workers starting and leaving jobs during the course of their work lives. Relative to the scale of other gross measures of job churn, the churn associated with M4A is not large.

It is true that one source of cost savings from the introduction of M4A is the reduced demand for insurance and billing administration. In turn, this reduced demand would shift employment out of these sectors. This could certainly cause challenges and eco-nomic distress for the workers within these sectors who are directly affected. But for some perspective, it is worth noting that 21.5 million workers were laid off in 2018 (BLS 2020b). If the 1.8 million workers that Pollin et al. (2018) identify as potentially being displaced by M4A were forced to transition over the four-year phase-in commonly iden-tified with M4A plans, this would increase the national rate of layoffs by about 2%. It is also worth noting that even within just the finance and insurance sectors, there have been 1.7 million layoffs in the past four years (BLS 2020b). And yet it's safe to say that very few people even in the business press have made any note of this. This is not a shock: Our economy generates a huge amount of job churn every year. This churn is the hallmark of growth in productivity—getting more economic output with fewer in-puts. While productivity growth can indeed put downward pressure on jobs in the sec-tor experiencing it directly, Autor and Salomons (2018) demonstrate that productivity gains within a given sector strongly boost job growth in other sectors, as the savings to households and businesses stemming from enhanced productivity increase purchasing power that supports demand for these other sectors' outputs.

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

Substantial likely job gains in the health care sector

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 neces-sarily 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 doc-tors 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.

6.5.3 AT: Labor Market (Short)

The effect of M4A on the labor market would be nearly uniformly positive. It spurs creation of healthcare jobs and increases worker pay. That outweighs the labor effects of eliminating insurance market inefficiencies.

Bivens 20

Josh Bivens (Economic Policy Institute, Director of Research). “Fundamental health reform like ‘Medicare for All’ would help the labor market.” Economic Policy Insti-tute, March 5, 2020. https://www.epi.org/publication/medicare-for-all-would-help-the-labor-market/

The upshot: M4A creates a small amount of manageable churn but increases the overall demand for labor and boosts job quality

The job challenge relating to a fundamental health reform is managing a relatively small increase in job churn during an initial phase-in period. Most Medicare for All plans explicitly recognize and account for the costs of providing these workers the elements of a just transition. As noted previously, this sort of just transition is far easier when health care is universally provided.

Besides this challenge, the effect of fundamental reform like M4A on the labor market would be nearly uniformly positive. The effect of a fundamental reform like M4A on aggregate demand is almost certainly positive and will therefore boost the demand for labor. The number of jobs spurred by increased demand for new health care spending (including long-term care) will certainly be larger than the number displaced by realizing efficiencies in the health insurance and billing administration sectors.

Finally, the introduction of fundamental health reform like M4A—particularly reform that substantially delinks health care provision from specific jobs—would greatly aid how the labor market functions for typical working Americans. Take-home cash pay would increase, job quality would improve, labor market transitions could be eased for employers and made less damaging to workers, and a greater range of job opportunities could be considered by workers. The increased flexibility to leave jobs should lead to more productive “matches” between workers and employers, and small businesses and self-employment could increase.

Fundamental health reform would benefit typical American families in all sorts of ways. Importantly, contrary to claims that such reform might be bad for jobs, this reform could substantially improve how labor markets function for these families.

6.6 AT: Private Insurance Popular

6.6.1 AT: Freedom of Choice

The public is supportive of M4A and doctor choice would be expanded.

Burgis 20

Ben Burgis (Ph.D. in Philosophy from the University of Miami and is a profes-sor of philosophy at Georgia State University Perimeter College). “The Many Bad Arguments Against Medicare For All.” *Current Affairs*, January 23, 2020. https://www.currentaffairs.org/2020/01/the-many-bad-arguments-against-medicare-for-all

4. Most people like their private health insurance. Forcing everyone onto Medicare for All violates freedom of choice.

Like most Medicare for All advocates, I have trouble taking the premise that anyone anywhere “likes” their health insurance company seriously. Liking your doctor is one thing—and, by the way, one of the glories of Medicare for All is that you’ll never be told that the doctor you used to go to is “out of plan” ever again. (The only way to go “out of plan” with national health insurance is to leave the nation.) But are there really human beings who are personally emotionally attached to the rent-seeking financial entity that gets between them and their doctor?

Medicare for All critics insist that the answer is “yes.” In fact, they say, there is statistical evidence for this. Lots of surveys show that a majority of people with private health insurance are “satisfied” with their current insurance. Therefore most people wouldn’t want you to replace that insurance with Medicare for All.

One problem with interpreting “satisfied” as “wants to continue to be privately insured rather than publicly insured” is that there are also plenty of surveys showing majority support for Medicare for All. Not all polling shows this, of course, and a lot depends on how the question is asked. (If lots of people weren’t unsure about how they felt about Medicare for All, I wouldn’t have bothered to write this article!) No matter how you slice these results, though, the numbers only add up if there aren’t lots of people who are both open to nationalizing health insurance and “satisfied” with their private plans. That’s a pretty compelling reason to think what should be obvious on reflection in any case—that most survey respondents take “I’m satisfied with what I have” to mean “I

don't want to switch to a different private insurance company or lose the amount of coverage I currently have." That's what's important: What people really care about is not losing coverage, not "keeping a particular corporation in charge of their healthcare." Survey questions that imply Medicare for All means "losing your insurance" are actu-ally misleading and tell us little. "Losing" implies that people will have less insurance after the transition to Medicare for All, which is what they're worried about. Medicare for All is not "taking away" people's insurance, in the sense that they will have less cov-erage; it's changing the payment structure of their insurance, routing money through a public entity rather than a private one.

Even so, you may argue, Medicare for All could violate freedom of choice even if a ma-jority of the public doesn't want to keep their private insurance. Standard Medicare for All proposals would give Medicare a monopoly on at least basic health insurance. This is how Canadian Medicare works. While many Canadians have supplemental private insurance, it's illegal to charge insurance customers for "duplicate" coverage of what's already covered by the public plan. As I've argued elsewhere, such a public monopoly on at least basic insurance is a positive good both in terms of cost control and avoiding an unjust two-tier system. But doesn't it violate freedom of choice?

In a limited sense, perhaps, in that people do not have a particular choice that they used to have. Any time you make it illegal to sell something, you've limited consumers' choices in so far as they no longer have the option of buying that kind of thing. All sorts of health and safety regulations (quite legitimately) limit our choices in this way. So would Medicare for All. It doesn't follow, however, that instituting Medicare for All would represent a net reduction rather than net increase in most people's personal autonomy and freedom of choice. Think about people who don't quit jobs they hate because they don't want to lose their employer-based insurance. Or for that matter spouses who don't leave bad or even abusive marriages because they don't want to lose the insurance they have through their spouses. Those situations strike me as more important restrictions on people's ability-in-practice to live their lives in whatever way they choose than taking away their ability to choose between Aetna and Blue Cross Blue Shield—especially when we pause to consider that, for most of us, those decisions are actually made by our employers.

"But don't employees choose their employers?" Sort of, but sometimes your insurance plans change after you've been hired or you desperately need a job and will settle for one with inadequate health insurance. If you're actually committed to meaningfully expanding freedom in American society, then it's crucial that you support decoupling

healthcare from employment so that every person in the country gets the care they need, independent of their employment, marriage, and any other irrelevant factor. It's hard to say that something violates "freedom of choice" when it ends up giving you more choice over your life: more choice of doctors, more choice of employers, and more choice over how to use the money you save in healthcare costs.

6.6.2 AT: Gov't Takeover

M4A is not government healthcare takeover. It is government paying for healthcare, not providing it.

Berwick 19

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

And no one should buy the myth that Medicare for All represents a "government takeover of health care." It does not. Medicare for All is about paying for care, not providing it. Not one proposal suggests that health care delivery should become a government function (beyond existing forms like the Veterans Health Administration). It offers Americans, at last, a simple way to assure that they have the coverage they need to see the doctors they want and use the hospitals they choose. Almost all doctors and hospitals would be in Medicare's network, and no patients would have to check their insurance card to find out whom they can see and at what cost out of pocket.

6.7 AT: Quality of Care

6.7.1 AT: Innovation

Innovation concerns don't justify scrapping M4A and government R&D investment solves anyways.

Burgis 20

Ben Burgis (Ph.D. in Philosophy from the University of Miami and is a profes-sor of philosophy at Georgia State University Perimeter College). "The Many Bad Arguments Against Medicare For All." *Current Affairs*, January 23, 2020. https://www.currentaffairs.org/2020/01/the-many-bad-arguments-against-medicare-for-all

2. Medical innovation will suffer without market incentives.

The picture critics paint on this point sounds intuitive enough on first glance. Pharma-ceutical companies make more money selling drugs in the United States than they do in countries whose government-run systems set lower rates of reimbursement. If they started making less money in America, they'd have less of an incentive to innovate. Hence, innovation would suffer.

Dig a little deeper, though, and we can ask at least two follow-up questions. First, is it true that our current system is good for medical innovation? Second, even if it were, would this be enough to make that system morally acceptable?

We've already established that Medicare for All and similar systems do a better job of preventing medically preventable deaths in the here and now than America's system of mostly private health insurance. Let's assume for the sake of argument that (a) keeping the insurance industry mostly private will considerably speed up the rate of medical innovation (when compared to the pace of medical innovation in a world where Amer-ica adopted Medicare for All), and that (b) this sped-up pace of innovation will, over the long term, more than make up for the deaths that will result from keeping our in-surance system in mostly private hands. Unless we're willing to make hardcore utili-tarian assumptions about morality, it doesn't follow from (a) and (b) that maintaining our current insurance system is morally defensible. For one thing, socialized healthcare improves health outcomes now and it's at best speculative that innovation will maybe, down the line, save more lives. Innovation is to a significant extent a matter of luck. Does it really make sense to hold off on providing everyone with the medical care they

deserve because it might harm innovation, which might sometime in the future save more lives?

Even if we could be sure that this gamble would work, it doesn't follow that it would be morally defensible. Think about one of the statistics references above—the much higher rate of infant mortality in the U.S. as compared to Canada and the U.K. If you're an unin-sured or underinsured American parent, anyone making the Medical Innovation Argu-ment is essentially saying, "Sure, if we gave you national health insurance, your baby would have a greater chance of surviving right now, but by letting your baby die—by in effect sacrificing it to the hungry gods of the free market—we're creating financial in-centives that will lead to the development of new treatments that will save other babies in the future. So you really have no legitimate complaint!"

Medicare for All advocates believe that people (of all ages) have a right to healthcare. If you accept that premise, the Medical Innovation Argument isn't persuasive, even if it were true that American-style market healthcare is good for medical innovation. As a matter of fact, the opposite is true.

In their excellent book People's Republic of Walmart, Leigh Phillips and Michal Roz-worski point out that more than three-quarters of really new drugs—NMEs for New Molecular Entities—are already developed in government labs. The most profitable (and hence most common) procedure is for drug companies to give slight tweaks to already-existing drugs that they can then patent. And when it comes to one of the most important kinds of medical research—the development of new antibiotics—the picture painted by Phillips and Rozworski is extremely disturbing.

Amid a growing global crisis of anti-microbial resistance, in which microbial evolution is defeating antibiotic after antibiotic and patients are routinely dying from routine in-fections, pharmaceutical companies have all but given up research into new families of the life-saving drugs, simply because they are not profitable enough. That amputation or surgery to scrape out infected areas might return as common medical responses is not a pleasant thought. But this alternative was the only one left to the doctors of 19-year-old Antonio Ricci of Seattle when they surgically removed part of his leg, following repeated infections from drug-resistant bacteria—acquired in a train accident in India— that could not be treated, even with highly toxic last-resort antibiotics. Each time the infection returned, more and more of the leg had to be cut off. Although Ricci has since recovered, he has lived in perpetual fear of the reappearance of bugs that cannot be fought. As a 2008 "call to arms" from the Infectious Diseases Society of America (IDSA) put it, "[Antibiotics] are less desirable than other drugs to drug companies and venture

capitalists because they are more effective than other drugs."

That last point may sound counterintuitive. Wouldn't principles of supply and demand dictate that the most effective drugs were the most profitable to manufacture? As it turns out, they wouldn't. No matter how much they gouge patients and their insurance companies for a few weeks' supply of antibiotics that will, if effective, never need to be used again, the drug companies will make less money off these sales than they will off drugs that patients have to continue to use over long periods of time.

If you're concerned about the state of medical research, the best option isn't to preserve a free market in health insurance. It's to go a step beyond single payer insurance and nationalize the pharmaceutical industry so future research can be directed toward our most urgent needs. We do not have an argument against Medicare For All here. What we have is in fact an argument that we need colossal new public investment in the development of new treatments. We shouldn't accept the false tradeoff between innovation and the right to health care: the only morally acceptable system is one that can do both.

6.7.2 AT: Doctor Shortages/Wait Times

No empirical evidence of doctor shortages. Longer wait times are simply an effect of more patients, which is a feature of M4A, not a bug.

Burgis 20

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7. Doctors won’t work for Medicare rates. If we adopted Medicare for All, we’d end up with doctor shortages and long wait-times like they have in Canada and the U.K.

While the point is often exaggerated, it is true that wait times are somewhat longer in Canada and the U.K. than they are in this country. In the age of three-second Google searches, however, no one has any excuse for believing that this is because socialized health systems suffer from “doctor shortages.” Canada and the U.S. have exactly the same rate of physicians per capita (2.6). The British rate is a bit higher (2.8). And the highest rate in the world (8.2!) can be found in Cuba.

The reason wait times are higher in countries with socialized health systems isn’t that there aren’t as many doctors. It’s that there are more patients.

Of course, those waiting times could still be reduced by increasing the supply of doc-tors. If you want to do that, you should support two other left-wing policies typically endorsed by Medicare for All advocates—Free College for All so people can become doctors without burying themselves in student debt, and a more lenient immigration system so it would be easier for foreign doctors to move to the United States.

Let’s assume for the sake of argument that for whatever reason we couldn’t combine Medicare for All with these other policies. We can implement it a la carte or not at all. How much weight should we assign to the Argument from Longer Waiting Times?

If the issue were that Canadians were dying in droves while they waited for specialist appointments, that would be a serious objection to Medicare for All, but we’ve already established that Canada has a much lower rate of “mortality amenable to healthcare” than the United States. Anyone who knows this but still objects to Medicare for All on the basis of wait times is in essence expressing the concern that the lines will be

longer than the ones they're used to because more people will be allowed to stand in them. Worse yet, from their perspective, everyone will be standing in the same line. (If America gets Medicare for All, upper-income Canadians can't even go to the U.S. to buy their way to the head of the line!) A different way of putting all of this would be that basic fairness will have been achieved. Let's do that.

Opponents of Medicare For All throw whatever talking points they can think of at it. The more Americans hear about single-payer healthcare, the more the insurance indus-try will viciously fight back with half-baked arguments designed to scare people into thinking that Medicare for All will mean worse, more expensive coverage rather than better, cheaper coverage. We have to be prepared. We need to understand the argu-ments against Medicare for All and be able to show why they don't hold up. The case for the policy is straightforward and powerful, but people are also easily frightened by industry talking points. They need not be, though. Medicare for All is a good idea that will improve our lives and make us healthier and happier.

6.7.3 AT: Rationing

The status quo is already cost rationing. M4A simply shifts it to a more equitable system.

Burgis 20

Ben Burgis (Ph.D. in Philosophy from the University of Miami and is a profes-sor of philosophy at Georgia State University Perimeter College). “The Many Bad Arguments Against Medicare For All.” *Current Affairs*, January 23, 2020. https://www.currentaffairs.org/2020/01/the-many-bad-arguments-against-medicare-for-all

3. Socialization means that healthcare will be rationed by a cold and heartless bureau-cracy.

There’s an important equivocation here. If “rationing” just means that the resources of a system aren’t unlimited, so not every patient is guaranteed to get every treatment that might possibly help them, then every health system involves rationing. Under the current American system if your insurance provider won’t cover something and you can’t afford to pay for it out of pocket, you don’t get it. (Opponents of socialized healthcare don’t seem to care about this type of rationing. With socialized healthcare, everyone receives a minimum standard of care, whereas now, only those who can afford it do.) But if “rationing” means what it sounds like it means—if, in other words, it carries a connotation of miserly “rationing out” of extremely scarce resources—then well-funded national health insurance systems needn’t involve “rationing.”

To see the difference between the two senses of “rationing,” think about military spending. The American military has a finite amount of weapons and ammunition. It wouldn’t be possible for it to simultaneously make war on every other country in the world at the same time. But no one would normally describe America’s lavishly well-funded military as having to “ration out” guns and bullets.

If we stick to the first sense of “rationing,” we can see how strange the “rationing” com-plaint is by thinking about other kinds of potentially life-saving services. Fire depart-ments don’t have unlimited resources either. If too many fires start at the same time, they might not be able to put them all out. Now, imagine that we had a system in which most people weren’t eligible for government-sponsored fire protection. When there weren’t enough fire trucks to put out all the fires in a given city, the people who can afford to pay top dollar for really good fire insurance plans would have the best chance

of having a truck come put out the fire at their houses. We can argue about whether this is accurately described as a form of "rationing," but I hope we can all agree that it's just about the least fair and least reasonable possible way of determining where to send a limited number of fire trucks.

Some people might be tempted to say that the issue isn't rationing per se but rationing by bureaucrats. The idea here is that even if there's some sense in which any system for allocating scarce resources is "rationing," letting the chips fall where they may in a free market isn't as bad as empowering individual gate-keepers to make these decisions.

The reasonable core of this concern is that everyone rightly resents having imperious bureaucrats second-guess the decisions of doctors and patients. But here's the thing: If you have private insurance, abstract "market forces" aren't denying your claim. That's being done by individual gate-keepers who work for your insurance company. "Yes," a critic might reply, "but I can change my private insurance company if I dislike my individual gate-keepers, whereas with the government I'm stuck." But the wonderful thing about living in a democracy—which our fictitious critic forgets—is that we can choose our individual gate-keepers. If you're unhappy with the way the healthcare system is being run, you have the right to vote out the people who are overseeing it. And, in fact, a Medicare for All system affords more people more choice, because there are millions of people right now without healthcare who are denied the choice entirely.

You can say that the power of these private bureaucrats is more limited than that of public bureaucrats because even after they deny coverage you can pay for the treatment out of pocket. But if you don't have the money in your pockets, that "right" is very unhelpful. It's as if you live on an island and the authorities have closed down the only bridge going to the mainland, but the police officer who turns you away from the bridge helpfully reminds you that if you can afford a private plane, you have a right to buy one and use that to leave the island.

If your goal is to minimize the number of bureaucrats in the system, then you should support Medicare for All. The insurance companies have market incentives to deny coverage wherever this is possible. While socialized systems sometimes have to make hard decisions when they hit the limits of their resources, coverage rules tend to be far simpler, more standardized, and more transparent. Fewer bureaucrats are required.

In fact, another common argument against Medicare for All is that most "administra-tors" at insurance companies would become redundant. (When we're supposed to sym-pathize with such people, they're "administrators." When we're supposed to hate them,

they’re “bureaucrats.”) In any case, as Matt Bruenig explains here, they’ll be fine under Medicare for All. Meanwhile, the rest of us will be far less likely to ever have to talk about our healthcare with anyone who isn’t a doctor or a nurse.

6.7.4 AT: Chown

They don’t vote neg --- quality of care wouldn’t necessarily decline.

Waikar 19

Sachin Waikar citing Jillian Chown (Assistant Professor of Management & Organizations), David Dranove (Walter J. McNerney Professor of Health Industry Management; Faculty Director of PhD Program; Professor of Strategy), Craig Garthwaite (Associate Professor of Strategy; Herman Smith Research Professor in Hospital and Health Services Management; Director of Healthcare at Kellogg). ”Would ”Medicare for All” Really Reduce Healthcare Costs in the U.S.?,” Kellogg Insight, October 4, 2019, https://insight.kellogg.northwestern.edu/article/medicare-for-all-reduce-healthcare-costs-prescription-drugs

However, the exact outcomes would depend on how, exactly, the U.S. implemented its “Medicare for All” program. Chown does not think it’s inevitable that such a policy would reduce the quality of care, for example, pointing out that many countries with more affordable public healthcare consistently outperform the privatized U.S. system (although the authors acknowledge that some of those disparities may result from factors beyond the healthcare system, such as diet, physical activity, and socioeconomic inequality).

“If you compare the U.S. health outcomes to other countries with single-payer systems,” says Chown, “it’s not clear that the U.S. is better off.”

7 Con Evidence

7.1 General

7.1.1 Economics

M4A is terrible economics --- MGH proves Medicare inflates prices

Johnson 19

David W. Johnson (CEO of 4sight Health, a thought leadership and advisory company working at the intersection of strategy, economics, innovation and capital formation), ”Let’s Get Real: Medicare for All Can’t Work, but Affordable Health Insurance for All Can,” 4sight Health, April 24, 2019, https://www.4sighthealth.com/lets-get-real-medicare-for-all-cant-work-but-affordable-health-insurance-for-all-can/

Sen. Sanders is an astute politician with a populist bent. He is reaching out to President Trump’s working-class voters with the promise of great healthcare for those who cannot afford or access it. Many are receptive. M4A is good politics, but it’s terrible economics because the legislation creating Medicare contained two fundamental flaws:

Cost-plus reimbursement (now called fee-for-service or FFS) pays for treatment activity, not treatment outcomes.

A prohibition against governmental participation in medical decision making.

Together, these provisions require the government (and commercial health insurers by extension) to pay for all “reasonable” treatments whether or not they deliver appropri-ate care outcomes. This is how healthcare providers and suppliers manufacture artificial demand for their products and services. Basic economics confirms the obvious: when buyers pay for more services, producers provide more services.

This is American healthcare in a nutshell. The best predictor for cardiology procedures in any given market is not demographics, environmental factors or lifestyle behaviors.

It is the number of cardiologists practicing in that market. Supply doesn't create its own demand in well-functioning markets; supply adjusts to intrinsic levels of demand at various price points.

In 2012, The New England Journal of Medicine published an article that examined 200 years of mortality and cost data from Massachusetts General Hospital (MGH). MGH, among the nation's oldest and most respected hospitals, celebrated its 200th anniversary in 2011.

The data are fascinating. Hospital mortality varied wildly in the 1800s and steadily declined through the 1900s, plateauing at just above 2% in the late 1980s. MGH's discharge costs go in the opposite direction.

On an inflation-adjusted basis, MGH's cost per discharge hovered between $1,000 and $2,000 until 1965 and then spiked upward, reaching $30,000 in 2010. What happened in 1965 to trigger this change? Medicare and Medicaid became law.

Supply-driven demand is the reason both the number of procedures and the costs per procedure at MGH and other hospitals have spiraled upward since Medicare's creation. Fifty-plus years later, America has a bloated acute care delivery system that treats illness and injury at excessive cost but fails to promote health, prevent disease and manage chronic health conditions.

Consequently, job one for policymakers is to normalize healthcare's supply-demand relationships. Given the right incentives and regulatory environment, health companies will deliver the right care (no over- or undertreatment) at the right time (consumer convenience is essential) in the right facilities (more distributed, less centralized) at the right prices (best outcomes at the lowest costs).

The good news is that healthcare policymakers at HHS understand the challenge and are tackling it with vigor.

7.1.2 Generally Fails

Single-payer fails – watered down, rent-seeking, private path-dependency

Pollack 15

Harold Pollack (PhD in Public Policy @ Harvard, Helen Ross Professor at the School of Social Service Administration @ UChicago, Codirector of the University of Chicago Crime Lab and a committee member of the Center for Health Administration Stud-ies), "Medicare for All — If It Were Politically Possible — Would Necessarily Replicate the Defects of Our Current System," *Journal of Health Politics, Policy, and Law*, 2015, http://jhppl.dukejournals.org/content/early/2015/06/09/03616878-3150172.abstract

Many of the most sensitive challenges that now bedevil the ACA would be sensitive challenges to a Medicare for All system, as indeed they long have been within Medicare and Medicaid. Within any financing system, we would require new care models for complex patients. We would face the economic, organizational, and human challenges of end-of-life care. We would make difficult decisions about network adequacy and pa-tient cost sharing and face difficult questions in designing essential health benefit pro-visions for autism, substance use disorders, and cancer. We would face difficult ques-tions regarding safety net reimbursement rates. We would face our society's tenuous commitment to the well-being of our most disadvantaged citizens. Federalizing care for dual-eligible Medicare-Medicaid recipients might be done in a way that resembles states with the most expansive Medicaid programs. Just as plausibly, national policies could resemble the policies of far less generous states.

In all of these matters, Medicare for All cannot offer itself as the replacement of our depressing health politics. It would have to arise as another product of that very same process, passing through the very same legislative choke points, constrained by the very same path dependencies that bedevil the ACA. Any politically feasible single-payer plan would include a dense thicket of provisions for the myriad of protected publics ranging from veterans to public employees to retirees to affluent professors whose health coverage is more generous than a national plan can uniformly provide.

Such realities would render Medicare for All an inferior, more convoluted product to what Seidman (and I) would wish to see. Imagine the national policy debate over abortion, contraception, HIV prevention, immigration policy, and other matters in a national Medicare plan. Imagine liberal discomfort with a single-payer plan with Presi-dent Mitt Romney's hand on the tiller, acting in partnership with Speaker of the House

John Boehner and Senate Majority Leader Mitch McConnell. The same congressional committee chairs will remain in place to bedevil Democratic and Republican administrations with self-interested micromanagement of Medicare procurement and other rent-seeking behavior. The same justices would sit on the Supreme Court.

7.2 Public Option Solves

7.2.1 Poverty

The Biden public option plan would have the same anti-poverty effects as M4A.

Buffie 8/9/2020

Nick Buffie (Masters in Public Policy from the Harvard Kennedy School, worked at two D.C. think tanks). “If you supported Bernie Sanders’ Medicare for All plan, you should get on board with Biden’s healthcare plan too.” Business Insider, 9 August 2020. https://www.businessinsider.com/bernie-sanders-medicare-for-all-supoort-public-option-healthcare-biden-2020-7

But if you’re a supporter of single-payer, rest easy: Biden’s plan holds many of the upsides of a traditional single-payer scheme. The difference is that his public option has a better chance of being enacted.

A boost to low and middle-income workers

The first great benefit of a single-player system as Bernie conceives it actually has nothing to do with healthcare. It is about poverty. A shift from employer-sponsored to government-sponsored health insurance would raise the pay of low- and middle-income workers.

To understand why, think about how health insurance looks from an employer’s perspective. A profit-seeking company will always look to cut costs, so it will compensate its workers as little as possible.

But while employers wish to lower the costs of employing a worker, they don’t care how those costs are distributed. For example, $30,000 in wages and $20,000 in health insurance benefits cost an employer just as much as $50,000 in wages. Unsurprisingly, a series of academic studies have found that employers fund their workers’ health in-surance by docking their pay.

According to estimates from the Social Security Administration, this hurts low-wage workers the most. Due to the costs of employer-sponsored health insurance, pay is cut by 10% for workers in the bottom half of the wage distribution. For the richest 1 in 20 workers, pay falls by just 4%.

Single-payer systems, by contrast, boost the incomes of working-class people. Unlike employer-sponsored insurance, government-sponsored insurance can be funded

through higher taxes on the incomes, estates, and spending of the rich.

And while the Biden plan is not a single-payer system, the public option carries many of those same benefits. Under the current federal income tax, dividends and long-term capital gains are taxed at special extra-low rates. Dividends are regular payouts that corporations make to their shareholders; capital gains are profits made from the sale of an asset above its purchase price. In 2014 (the most recent year for which we have data), the 400 highest-income Americans drew three-quarters of their income from these two sources. As a result, they paid just 23% of their income in taxes.

Biden would repeal this specialized rate for all taxpayers with incomes above $1 million, generating more than $440 billion over the next decade, according to the nonpartisan Tax Policy Center. This new revenue would fund generous healthcare subsidies for low-income Americans. So while Biden hasn't endorsed the rhetoric of "redistribution," his public option, like single-payer, would raise the incomes of the poor while lowering the incomes of the rich. To the extent that Biden's plan differs from a single-payer scheme, it is only a matter of degree.

7.2.2 Coverage

The public option covers over 97% of the population.

Buffie 8/9/2020

Nick Buffie (Masters in Public Policy from the Harvard Kennedy School, worked at two D.C. think tanks). “If you supported Bernie Sanders’ Medicare for All plan, you should get on board with Biden’s healthcare plan too.” Business Insider, 9 August 2020. https://www.businessinsider.com/bernie-sanders-medicare-for-all-supoort-public-option-healthcare-biden-2020-7

Getting more Americans health insurance

The second great benefit of single-payer healthcare is that it covers everybody. Admittedly, Biden’s plan is imperfect on this front. It would leave just under 3% of the population uninsured, and that’s 3% higher than what single-payer advocates want.

Yet here too, Biden’s plan is a significant departure from the status quo. Even before the COVID-19 outbreak, 8.5% of Americans were uninsured. By covering over 97% of the population, Biden would get our country most of the way towards universal coverage. This is similar to the gains after the enactments of Medicare, Medicaid, and Obamacare, all three of which are rightly viewed as monumental steps toward a more compassionate healthcare system. Biden’s public option deserves to be viewed in the same light.

7.2.3 Political Support

M4A causes Democratic election losses. A public option, on the contrary, is supported by three-quarters of the public.

Buffie 8/9/2020

Nick Buffie (Masters in Public Policy from the Harvard Kennedy School, worked at two D.C. think tanks). “If you supported Bernie Sanders’ Medicare for All plan, you should get on board with Biden’s healthcare plan too.” Business Insider, 9 August 2020. https://www.businessinsider.com/bernie-sanders-medicare-for-all-supoort-public-option-healthcare-biden-2020-7

However, there is one striking difference between Biden’s proposal and Bernie’s: it won’t cost Democrats the election. A January 2019 poll from the Kaiser Family Founda-tion found that 74% of Americans believe that people should be given the option to buy insurance from the government. By contrast, 56% support Medicare For All (MFA), and support falls to just 37% when poll participants learn that MFA would eliminate private insurance. Since virtually every opinion poll suggests that healthcare reform is Amer-icans’ top priority, the difference between a popular public option and a single-payer plan that turns off a much larger chunk of the electorate will likely decide the election.

Biden’s plan would not maintain the status quo. Far from it. His plan would raise the incomes of poor and working-class people while making significant strides towards universal coverage.

Attacks on Biden’s plan make the perfect the enemy of the good. And we aren’t just talking about the difference between the perfect healthcare plan and the good healthcare plan. If endorsing an unpopular proposal like Medicare For All keeps Donald Trump in the White House, Democrats will have sacrificed the perfect healthcare plan for the good healthcare plan, the good climate plan, the good education plan, and so much more. If you are a supporter of single-payer, make sure to vote for Joe Biden’s public option in November.

7.3 Global Budgets

7.3.1 Inefficiency

Global budgets increase waste and inefficiency.

Matthews 19

Merrill Matthews (Ph.D., resident scholar with the Institute for Policy Innova-tion, a research-based, public policy "think tank."). "What Medicare-for-All Supporters Won't Tell You." Institute for Policy Innovation, March 27, 2019. https://www.ipi.org/ipi_issues/detail/what-medicare-for-all-supporters-wont-tell-you

How Single-Payer Systems Control Health Care Spending

M4A proponents point out that single-payer countries spend less on health care—often much less—than the U.S. But that's not because those systems are more efficient.1

Rather, in those countries politicians set the health care budget. The country is only allowed to spend a predetermined amount on health care.

Suppose a family spends $400 a month on food. But a job layoff or unexpected expenses force it to cut back to, say, only $200 a month.

No one would consider a 50 percent, top-down cut in the food budget efficient or a model for anything. And while the family may survive on the reduced amount, it likely won't be able to have what it enjoyed at $400 a month.

That's essentially what happens in most countries with government-run health systems.

A government-set "global budget" for health spending is not the same as cutting waste or operating more efficiently. Indeed, when bureaucrats arbitrarily impose budget and price controls, they often increase waste and inefficiency.

7.3.2 AT: Arrow

Arrow doesn't say markets can't work, just that they need properly established incentives. That's why a squo balance of regulation and private markets is best.

Garthwaite and Illing 17

Craig Garthwaite and Sean Illing (Herman R. Smith Research Professor in Hospital and Health Services, an Associate Professor of Strategy, and the Director of the Program on Healthcare at Kellogg (Northwestern School of Business), and Interviews Writer for Vox, respectively). "I think health care is a right. I asked an expert to tell me why I'm wrong." *Vox*, Jun 30, 2017. https://www.vox.com/policy-and-politics/2017/6/30/15879702/health-care-capitalism-free-market-socialism-single-payer

Craig Garthwaite

I think we don't have enough competition. I think we've allowed too much consolidation in various parts of the market.

Sean Illing

If that's the case, I'd like to toss Kenneth Arrow's influential 1963 paper at you. You know this better than I do, but I'll briefly summarize for readers. Arrow, a Nobel Prize-winning economist, argued that health care is distinct from other products like chocolate bars or dress shirts and can't be marketed as such.

For one, there's enormous uncertainty — you don't know when you'll have a heart attack or need major surgery. Thus, there really is no consumer choice because patients can't decide whether or when they need triple bypass surgery — doctors have to make those calls. Nor can they easily swap physicians or hospitals if they don't like the care or cost. So all of this means we need protection in the form of insurance. But for-profit insurance companies are in the business of making money, not protecting health. What did Arrow get wrong?

Craig Garthwaite

He's not saying that markets can't work. It's that markets need appropriate support in this area. So I'm not saying we need free and unfettered markets. What I think we need is true competition among providers. You don't need patients to necessarily move across providers, right? Insurers can establish that. Insurers have a lot of price compe-tition driving their actions.

But we have to find a way to have competition, and it's not about necessarily having consumers be forced to choose across providers at the time of service. We could have that conversation happening at the insurer/hospital/negotiator level, which is fundamentally what we see. But that being the case, we need large numbers of insurers and large numbers of hospitals, and that's what we're seeing less of over time.

Sean Illing

And you're convinced that an appropriately supported insurance market would create an incentive structure that favors what's best for patients? Because right now there's a misalignment of incentives between the insurers and the patients. Insurance companies are looking to make money and reduce costs, and that doesn't seem to be working out well for consumers.

Craig Garthwaite

But that's why we need a competitive insurance market. If an insurance company provides worse service in the face of higher costs, then a consumer can just go to another insurer. The competition is not just about getting the price right; it's about getting the quality right as well.

7.4 Payment Rates

7.4.1 AT: Administrative Savings

New costs created by M4A far exceed administrative savings --- CBO projections.

Blahous 19

Charles Blahous (J. Fish and Lillian F. Smith Chair and Senior Research Strategist at the Mercatus Center at George Mason University). “The Winners and Losers of ‘Medicare for All’.” Mercatus Center, May 24, 2019. https://www.mercatus.org/bridge/commentary/winners-and-losers-medicare-all

The projected additional costs of M4A’s coverage expansion would exceed the potential savings from eliminating private health insurance administration.

Many proponents of M4A hope that a single-payer system would allow health care to be provided more efficiently, by eliminating private health insurance administrative overhead and profit. However, my projections as well as others have found that the additional costs of providing expanded and more generous health insurance would far exceed the savings from reducing insurance administrative costs. CBO’s analysis is con-sistent with this calculation, and its text reinforces the point: “[E]xisting evidence indi-cates that people use more care when their cost is lower, so little or no cost sharing in a single-payer system would tend to increase the use of services and lead to additional (national) health care spending, as well as more government spending.”

Importantly, this additional spending wouldn’t just be a matter of previously uninsured people finally receiving the care they need. Instead, previously-insured individuals would also demand more services, irrespective of those services’ quality, necessity or efficacy. The net effect would be an introduction of new inefficiencies and added costs to our health care system, exceeding the savings that might be gained by eliminating private insurance administration.

Administrative costs would be comparatively higher---their studies are alchemy, not actuality

Galles 17

Gary M. Galles (Professor of economics at Pepperdine University and a research fellow at the non-profit Independent Institute). “Single-payer healthcare is far

more expensive than advocates claim." 6/15/2017. http://thehill.com/blogs/pundits-blog/healthcare/337826-single-payer-healthcare-is-far-more-expensive-than-advocates.

In the roughly quarter-century since then-First Lady Hillary Clinton's health care plan hit the headlines, advocates of expanded government control have asserted that single-payer systems such as Medicare have far lower administrative costs than private in-surance. So moving toward "Medicare for all," they said, would generate vast sums to increase access to health care. Paul Krugman, for example, argued that ObamaCare administrative cost savings would pay for its expanded coverage.

But the cost claim is alchemy, not actuality.

Early in the ObamaCare fight, one literature review found private insurance administrative costs estimated at 11-14 percent of premiums, while direct Medicare administrative outlays were estimated at 3 percent of total costs. Considering how large the health care sector is, cutting private administrative costs to Medicare's presumed level would indeed provide a huge chunk of money to finance expanded promises. Unfortunately, those estimates involve multiple misrepresentations, leaving them unable to support the conclusions typically drawn.

The usual measurement of efficiency–administrative costs as a percentage of total costs–is highly misleading. Medicare patients are far older and less healthy than the rest of the population, making health care costs far higher per person. But nonmedical administrative costs largely depend on the number of persons insured, not on medical expenditures. So the usual measure grossly exaggerates Medicare's administrative efficiency and distorts the comparison with private insurance. Before ObamaCare, medical expenditures per Medicare recipient were more than double that per younger insured person, making Medicare look less than half as expensive as it would look if costs were computed per person. In fact, Medicare's reported administrative cost per beneficiary has been consistently higher than for private health insurance.

Another bias, as several studies have found, is that many of Medicare's administrative costs do not show up in its budget. For example, the IRS collects the taxes; Social Se-curity helps collect Medicare premiums: and Health and Human Services helps with accounting and related concerns, as well as paying for building and marketing costs. Including those costs roughly doubles Medicare's administrative costs.

Simply computing costs in per-person terms and including administrative costs that appear in other agencies' budgets, Medicare's reported four-to-one administrative cost

advantage over private insurers disappears, taking the promise of a treasure trove of single-payer “found money” with it.

But these are not the only biases.

Typically, private insurance administrative costs have been defined as premiums paid in minus claims paid out, implying that everything but claims paid is administrative. However, many states impose a premium tax (averaging about 2 percent) on health insurers (but not on Medicare), and those tax payments are counted–erroneously–as administrative costs. Also, many insurers offer disease-management and on-call nurse consultation services, which do not result in claims, so the costs of those services are counted as administrative. Ironically, by limiting private insurers’ administrative costs, ObamaCare requires more precision in defining nonmedical costs, markedly improving the estimates.

Other private administrative costs are misrepresented as waste or inefficiency. Consider fraud, a major issue for Medicare. If Medicare spends less to combat fraud, it looks more efficient since its administrative costs will be lower and its other costs will be counted as medical expenses rather than waste. But $1 of fraud prevention has been estimated to reduce fraud costs by $15. So when insurance companies invest more in fraud prevention, they benefit their customers, but their administrative cost percentage appears worse than Medicare’s.

In addition, the taxpayer-funded parts of Medicare (which are the vast majority since premiums cover only a small proportion) impose another substantial but unrecorded cost, which economists call “excess burden.” Taxes impose wedges between what buy-ers pay and what sellers receive, destroying opportunities for gains from trade as money is diverted to the government. One study found that even the “lowest plausible assump-tion about the excess burden engendered by the tax system raises the true costs of deliv-ering Medicare benefits to about 20-25 percent of its Medicare outlays,” far higher than private insurance administrative costs.

Thus what everyone “knows” about the lower administrative costs of single-payer sys-tems is false.

7.4.2 AT: Maintain Current Rates

If M4A maintains current payment rates, expanding coverage drives up healthcare costs

Chen and Liao 20

Frederick M. Chen (MD, MPH) and Joshua M. Liao (MD, MSc). “Can Medicare for All Control Health Care Costs?” *Society of Teachers of Family Medicine*, 2020. https://journals.stfm.org/familymedicine/2020/january/prescol-jan20/

Debates about the role of universal coverage in American health care have made this a remarkable time in health policy. Overall, we are encouraged by the ongoing discourse about challenges that face our current health insurance marketplace, and coverage so-lutions such as Medicare for all.

To date, much of the discussion has centered on issues related to definitions (“What is Medicare for all?”),1 implementation (“How could Medicare for all be operational-ized?”), and financing (“How would we pay for a Medicare-for-all system?”). Unfortu-nately, these issues obscure the most important question: How much would Medicare for all pay clinicians and hospitals?

Some proposals suggest that payment continue at the current rates,2 while others would peg reimbursement at a given percentage of current Medicare rates,3 and yet others seek to give the Secretary of Health and Human Services broad authority to set payment amounts4 via strategies such as global budgets and fee schedules.5 We believe this is a key distinction that carries implications for how a Medicare for all system would fun-damentally impact providers and patients nationwide.

Consider a Medicare-for-all policy that maintains current payment rates. This approach could achieve the goals of universal coverage and streamline the current health insur-ance system while also mostly preserving the status quo, without major disruptions to other segments of the health care industry. Clinicians and health systems could con-tinue delivering care largely as they have been. This approach would mirror what we saw with the Affordable Care Act (ACA)—expanded coverage, more insured individu-als, less uncompensated care, and a bigger pie of payment.

However, this approach would fail to restrain health care spending—perhaps the single-most important driver of reform in health care over the last decade. Without major payment rate changes, provider organizations may not be compelled to implement ma-jor delivery system changes to improve health care. This reality—increased health care

coverage at the expense of greater costs—is in fact one of the legacies of the ACA, and Romney Care in Massachusetts before it.

7.4.3 AT: Negotiate Prices

Negotiating prices exacerbates pre-existing healthcare disparities.

Chen and Liao 20

Frederick M. Chen (MD, MPH) and Joshua M. Liao (MD, MSc). “Can Medicare for All Control Health Care Costs?” *Society of Teachers of Family Medicine*, 2020. https://journals.stfm.org/familymedicine/2020/january/prescol-jan20/

The alternative would be a Medicare-for-all system in which the proverbial payment pie doesn’t get bigger, and universal coverage was implemented alongside counterbal-ancing rate cuts to reign in health care spending. The potential financial benefits of this approach are straightforward: providers would have to stamp out administrative and clinical inefficiencies, address labor costs, and explore other solutions such as price ne-gotiation, supply chain changes, waste reduction, and care standardization.6

However, the potential negative consequences of implementing universal coverage with rate reductions could be far-reaching. This is particularly true for provider organizations, many of whom have expressed concern about the adverse impact on financial viability and ability to care for patients as they currently do.7

One particular concern related to payment reductions is the unintentional consequence of worsened selection—a phenomenon in which providers seek out (“cherry pick”) low-risk or low-cost individuals and avoid (“lemon drop”) high-risk or costly ones. Cur-rently, selection already occurs at the health plan level, with providers seeking to avoid insurance plans with too many high-cost individuals.

Universal coverage and lower payments could stoke selection at the individual patient level. Without different payers to select, providers could only cherry pick by patient or geographic community—a concerning possibility given the widespread health care disparities that already exist. Such selection could manifest through providers choosing not to serve communities perceived to be high risk (eg, not building clinics or hospitals in certain areas), or operating in those areas but avoiding high-cost individuals.

Ultimately, health care spending will not decrease on its own, and policies that increase coverage only heighten attention on efforts and strategies for curbing costs. It is up to decision makers to determine if cost control should be incorporated into universal coverage policies or addressed separately. If the former, other nations’ health insurance systems caution that while a single payer can be a powerful tool, it must be empowered

properly in order to achieve coverage without undoing progress to control health care spending. If the latter, both political will and practical solutions will be needed outside of Medicare for all to meaningfully address national health care spending. Medicare for all would give our patients universal access and coverage, but it's the provider payment that will dictate the future of family medicine and US health care.

7.5 Federal Spending

7.5.1 Costs

M4a costs up to 60 trillion for the first ten years. It's unknown if the federal government could pay for it.

Blahous 19

Charles Blahous (J. Fish and Lillian F. Smith Chair and Senior Research Strategist at the Mercatus Center at George Mason University). "The Winners and Losers of 'Medicare for All'." Mercatus Center, May 24, 2019. https://www.mercatus.org/bridge/commentary/winners-and-losers-medicare-all

New federal costs under M4A would be unprecedentedly large.

I estimated in my testimony that new federal budget costs would be somewhere between $32.6 trillion and $38.8 trillion over the first 10 years of M4A. These large numbers represent just the additional federal costs above and beyond currently projected federal spending. Total federal costs of M4A over the first ten years would be much higher, somewhere between $54.6 trillion and $60.7 trillion. This increase in federal spending would be of such a magnitude that even doubling currently projected individual and corporate income taxes would be insufficient to finance it.

We do not know how or whether the federal government could successfully finance its additional spending under M4A.

Multiple experts who testified at the hearing agreed that most of these new federal costs would arise from the federal government's taking on spending currently done by the private sector—e.g., through private health insurance and individual payments out of pocket. Under M4A the federal government would also assume health spending obli-gations currently financed by state and local governments. The fact that most of this spending is already being done by someone else does not, however, imply that the fed-eral government could successfully finance it without causing significant damage to the U.S. economy. Indeed, most of the taxes under discussion for financing M4A would leave Americans poorer on average, after the deadweight loss from such taxation is taken into account.

Single-payer is woefully inefficient – doesn't reduce costs

McClure et al. 17

Walter McClure – PhD @ Florida State, Senior Fellow and Chairman of the Cen-ter for Policy Design, former director of the Center for Policy Design. Alain Enthoven. Time McDonald. "Universal Health Coverage? Why?" 25 July 2017, http://healthaffairs.org/blog/2017/07/25/universal-health-insurance-why/

The left's faith in "single-payer" has proven ill-founded; we have had a public single-payer program for 50 years, Medicare, that absolutely controls the over-65 market. Yet despite the best efforts of the agency its costs still balloon out of control. The right's faith in the private health care and insurance markets has proven equally ill-founded because both are severely unsound and, as Adam Smith taught us, unsound markets do not self-correct. As a consequence, in the same five decades the private market has done no better than Medicare on cost control. Five decades of efforts by both approaches using bureaucratic controls, micromanagement, and token bonuses to make providers efficient have failed to contain run-away cost.

And here is the fallacy of both: You cannot ask providers to be efficient—i.e., produce steadily better health outcomes while earning less on each patient—unless they can win more patients from costlier providers by doing so. Neither single-payer nor private in-surance presently give patients valid comparative information to know which providers are better for less, nor incentives to choose them if they did.

M4A collapses growth – empirics

Stark 17

Dr. Roger Stark (health care policy analyst at Washington Policy Center). "Is a Single-Payer Health Care System Right for America?" May 22, 2017, http://www.washington policy.org/library/doclib/Stark-Single-Payer-Health-Care-System-5.22.2017.pdf

The non-partisan Committee for a Responsible Federal Budget (CRFB) analyzed Senator Sanders' proposal from a financial standpoint.11 He calls for six new or expanded taxes. Everyone would pay 6.2 percent more in payroll tax and 2.2 percent more in income tax. This combined 8.4 percent tax increase would have the greatest impact on low-income workers, according to the analysis. Rather than receiving "free" Medicaid, these workers would have 8.4 percent less in take-home pay.

High-income workers would experience four additional taxes. Income taxes would increase, capital gains would be taxed as ordinary income, certain current deductions would be eliminated, and estate taxes would increase. Marginal tax rates for people earning between $18,550 and $75,300 would go from 30.3 percent to 38.9 percent. For higher-income workers (those with incomes greater than $250,000) income plus payroll taxes would go up to 77 percent and capital gains taxes would reach 64 percent.

Even with these expanded taxes, the CRFB reports that multiple analysts, including the non-partisan Congressional Budget Office, find Senator Sanders' calculations to be short of funding needed by up to $14 trillion over 10 years. Although the tax increase would be staggering, the overall impact on the U.S. economy and economic growth would be devastating. There are now multiple examples of countries that enacted socialist programs and ultimately became mired in stagnant economies.

7.5.2 Taxes

Tax hikes slash growth

Pipes 16

Sally C. Pipes (President and CEO of the Pacific Research Institute, former Assistant Director of Canada's Fraser Institute), "THE UGLY REALITY OF SINGLE-PAYER," 21 January 2016, https://www.pacificresearch.org/article/the-ugly-reality-of-single-payer/

This is complete nonsense. Every other single-payer system around the world delivers subpar care at astronomical cost. Worse still, the multitrillion-dollar tax hikes – that's "trillion," with a "t" – that Sanders has proposed to finance his single-payer monstrosity would decimate the American economy.

Voters in need of a definitive reason to dismiss Vermont's "democratic socialist" as a legitimate candidate now have one.

Sanders's "Medicare-for-All" proposal would require $14 trillion in new public spend-ing over the next decade and would expand the size of the federal government by over 50 percent. He plans to cover those costs by ratcheting up taxes on virtually everyone. He wants to hike income tax rates by 2.2 percentage points and levy a new 6.2 percent payroll tax on employers. He'd also dramatically crank up income tax rates for families making over $250,000 year. And he'd set the estate tax at 65 percent.

These new taxes would slow our economy to a halt. They'd rob businesses of capital to invest in expansion and job creation. The returns on entrepreneurship would dwindle. Corporations would direct investments to friendlier environs abroad.

7.5.3 AT: High Costs Hurt the Economy

High prices don't hurt the economy.

Graham 16

John R. Graham (Public-policy analyst, Director of the Health Technology Forum, and a Senior Fellow at the National Center for Policy Analysis). "The U.S. Health System Is Not An Economic Burden." *Forbes*. April 20, 2016. https://www.forbes.com/sites/theapothecary/2016/04/20/the-u-s-health-system-is-not-an-economic-burden/#177a6f862832

Health spending consumes a higher share of output in the United States than in other countries. In 2013, it accounted for 17% of Gross Domestic Product. The next highest country was France, where health spending accounted for 12% of GDP. Critics of U.S. healthcare claim this shows the system is too expensive and a burden on our econ-omy, demanding even more government intervention. This conclusion is misleading and leads to poor policy recommendations, according to new research published by the National Center for Policy Analysis (U.S. Health Spending is Not A Burden on the Economy, NCPA Policy Report No. 383, April 2016).

Discussing health spending in dollars, rather than proportion of GDP, the report notes Americans spent $9,086 per capita on healthcare in 2013, versus only $6,325 in Switzer-land, the runner-up. (These dollar figures are adjusted for purchasing power parity, which adjusts the exchange rates of currencies for differences in cost of living). This big difference certainly invites us to question whether we are getting our money's worth. However, it is not clear that this spending is a burden on Americans, given our very high national income.

After subtracting health spending from U.S. GDP, we still had $44,049 per capita to spend on all other goods and services we value. Only two countries, Norway and Switzerland, beat the United States on this measure. But compared to larger developed countries, Americans have higher income per capita after subtracting healthcare spend-ing. For example, in the United Kingdom, GDP per capita after health spending was only $34,863 in 2013. So, even though Americans spent significantly more on healthcare than the British, the average American enjoyed $9,185 more GDP after health spending than his British peer; and just under $6,000 more than his Canadian neighbor.

Britain socialized its health system shortly after World War II, completing the work by 1948. Canada's healthcare was more gradually socialized by provincial and federal gov-ernments during the period 1947 through 1966. Many assert these so-called single-payer

systems relieved the burden of private payment from citizens and made the economy more productive.

On the contrary: Since 1960, the U.S. economy has outperformed all comparable developed countries except Norway and Switzerland with respect to economic growth, after subtracting health spending. From 1960 through 2013, the share of U.S. GDP allocated to healthcare more than tripled. However, this had no impact on the ability of the U.S. economy to deliver high GDP per capita, outside healthcare. Adjusted for purchasing power parity, U.S. health spending increased $8,937, while GDP per capita increased $50,269, from 1950 through 2013. Thus, GDP per capita available for other goods and services, after spending on health care, increased $41,332, or $780 per year.

Over these 53 years, only Norway and Switzerland increased their non-health GDP per capita more than the United States. Norway, which had become a petro-state due to revenue gushing from the North Sea oilfields, increased this amount by $57,981, which is $16,649 more than the United States, or $314 more in non-health spending per year per person.

The report concludes the theory that health spending influences economic growth for better or worse is too simple. In fact, wages, prices and resources allocated to healthcare are a consequence of economic activity in other parts of the economy, as well as health policy.

Further, whether the system is defined as “universal” or “single payer” may be less important than other characteristics in determining how the system performs. The report ranks 13 developed countries by the share of health spending that is controlled directly by patients out-of-pocket versus the share controlled by third-party bureaucracies, ei-ther private or public. With only 12% of health spending controlled by patients directly, the U.S. ranks ninth by this measure. Swiss patients directly control over one-quarter of their health spending. Even Canadians, who live under a tightly closed, government monopoly, so-called “single-payer” system, control a somewhat higher share of their own health spending than Americans do.

Because most other countries allow patients to control a higher share of health spending than the United States does, the report concludes this is likely another factor keeping health spending lower than in the United States.

7.5.4 AT: Mercatus Center (Blahous) Study

Blahous votes for us. If every assumption held by M4A proponents holds true, costs slightly decrease – but that won't happen. Large cost increases are more likely

Graboyes 18

Robert Graboyes (senior research fellow at the Mercatus Center at George Mason Uni-versity). "No, Medicare for All Won't Lower Health-Care Costs." *Real Clear Policy*, Au-gust 6, 2018. https://www.realclearpolicy.com/articles/2018/08/06/medicare_for_all_unlikely_to_lower_health_care_costs_110748.html

Some years back, I concluded that single-payer health insurance would profoundly alter America's financial structure, but change the country's health care relatively little. This thesis is reinforced by the strident, bipartisan emotionalism aroused by a new study by my colleague, Charles Blahous. While the paper's findings are striking, they should be utterly unsurprising to anyone who has thought through the full implications of single-payer.

The cacophony is a reminder of why improving Americans' health — particularly for the least-advantaged — depends mostly on things outside the monotonous 75-year dis-putation over health insurance.

Blahous's findings have found traction for different reasons with very different audi-ences. So what does his paper ("The Costs of a National Single-Payer Healthcare Sys-tem") actually say?

It's a cautious, narrowly focused numerical what-if analysis. Senator Bernie Sanders (I-VT) introduced a bill in 2017 to establish a single-payer health insurance system called "Medicare for All" (M4A, for short). The federal government would become the sole health insurer for all Americans. Most would be covered by M4A, which would differ radically from today's Medicare for seniors. Everyone — including current Medicare beneficiaries — would see their current coverage replaced by Sanders's vision.

M4A would extend coverage to the tens of millions who are currently uninsured and confer sweeping new benefits on everyone else — wiping away deductibles and co-pays and adding dental, vision, and hearing care. Supporters argue — against substantial evidence — that M4A would substantially reduce health-care spending.

Blahous asked a simple question: If M4A yielded every benefit and saving Sanders foresees, how would federal government finances change?

Sanders's assumptions, if true, imply lower national health expenditures (NHE is total health-care spending by everyone, including governments, corporations, and individuals) by around $2 trillion over 2022–2031 — largely via forced pay cuts of roughly 40 percent for doctors, nurses, and other providers. At the same time, under this scenario, the federal government's 10-year total expenditures would rise by $32.6 trillion (com-pared with current projections).

Blahous notes that this would change the financial relationship between American tax-payers and their federal government profoundly. To cover the $32.6 trillion, Congress would have to more than double corporate and federal income taxes.

Contrary to claims by Senator Sanders and others, Blahous certainly didn't predict that M4A would reduce health-care spending. He merely said that under the best-case sce-nario touted by M4A supporters, the bill would effectively transform the federal gov-ernment into history's largest insurance company — with much smaller subsidiaries engaged in foreign relations, defense, law enforcement, agriculture, transportation, and so forth.

As the study makes clear, M4A's expenditure-cutting promises are dubious. Sanders assumes we can slam doctors, nurses, hospitals, drug companies, and others with enor-mous pay cuts, and yet expect them to happily provide even more services and products than they do now. He also assumes federal bureaucrats — contrary to a wealth of past experience — will be paragons of efficient management.

The study suggests these rosy outcomes are extremely unlikely. If Sanders's dubious assumptions don't come to fruition, total health-care spending (NHE) would rise, not fall, and federal spending would grow well beyond the already earth-shattering $32.6 trillion forecast. If the roughly 40 percent provider reimbursements don't stick, for ex-ample, NHE would rise, and federal health expenditures would hit $38 trillion.

While a theoretical $2 trillion spending decrease sounds large in raw numbers, it is small in percentage terms — between 2 and 4 percent of health-care spending in any given year. Less-than-perfect performance by M4A would easily flip these purported savings into increases.

7.5.5 Consensus

Bipartisan consensus of experts agrees M4A spikes federal spending.

Graboyes 18

Robert Graboyes (senior research fellow at the Mercatus Center at George Mason University). “No, Medicare for All Won’t Lower Health-Care Costs.” *Real Clear Policy*, August 6, 2018. https://www.realclearpolicy.com/articles/2018/08/06/medicare_for_all_unlikely_to_lower_health_care_costs_110748.html

None of this is surprising. In 2016 the left-of-center Urban Institute estimated that an earlier version of M4A would increase federal expenditures by $32 trillion from 2017 through 2026 — a figure remarkably close to Blahous’s number.

Blahous’s numbers are also consistent with recent state-level forecasts. In 2011, Vermont passed a statewide single-payer plan but abruptly canceled it in 2014 when the magnitude of costs became evident. In 2017, the California Senate approved a single-payer plan, but that died in the Assembly (lower house) when budget estimates showed that — similar to Blahous’s findings — state taxes would have to more than double.

The risk of economic disruption proved too great even in states where the single-payer idea was enormously popular. Several other states have also moved enthusiastically toward single-payer and then tiptoed away.

7.5.6 AT: Saves Money

The economics and empirics are decisively neg on this question --- M4A will spike costs, not save

Silver and Hyman 19

Charles Silver (a law professor at the University of Texas at Austin) and David A. Hyman (a law professor at Georgetown), ”No, Medicare for All Won’t Save Money,” Cato Institute, November 25, 2019, https://www.cato.org/publications/commentary/no-medicare-all-wont-save-money

When the massive new health program known as Medicare was created in 1965, Presi-dent Lyndon Johnson got health care providers on board by buying their support: He promised that the government would let them decide how much to charge and which services to deliver. In many countries with single-payer health systems, governments decide how much they will pay; when adopting Medicare, the U.S. let providers make that decision. It gave doctors and hospitals the keys to the U.S. Treasury and guaranteed their profits.

Spending went through the roof as “unrestricted cost reimbursement became the modus operandi for financing American medical care.” The costs wildly exceeded the govern-ment’s expectations at the time: A 1967 estimate by the House Ways and Means Com-mittee predicted that, in 1990, Medicare’s total cost would be $12 billion. The actual cost was $98 billion—eight times as much.

Half a century later, we are still living with the consequences of the decision to put providers in charge of the payment system. A recent study by scholars at Johns Hopkins University estimated that in 2018, fully “48 percent of the entire U.S. federal budget” was spent on health care. That isn’t a typo, and it’s not an accident either: Industry groups lobby the government around the clock to maximize the number of taxpayers’ dollars they receive.

Medicare for All’s supporters promise that this time will be different. Once a single-payer program is implemented, they argue, the government will save billions of dollars by slashing payments to drug-makers, doctors, and hospitals.

Although cuts of that magnitude would severely affect patient care, there’s no need to worry. If past is prologue, they will never occur. Time after time, providers have blunted initiatives designed to economize at their expense. There’s no reason to think

this Congress will succeed when virtually every past Congress has failed to reduce the flow of Medicare dollars.

Consider how, in recent years, a few attempts to save money fared:

In 1997, Congress tried to rein in spending increases by tying Medicare spending on physicians' services to something called the Sustainable Growth Rate (SGR) formula. Whenever payments to doctors grew faster than GDP, the SGR was supposed to reduce them automatically. The formula triggered payment cuts in 2003 and every subsequent year—but the cuts never happened. Under pressure from physicians, Congress adopted a series of "doc fixes" that delayed them and often gave doctors a raise. Finally, in 2015, when the SGR formula required payment cuts of roughly 25 percent, Congress repealed it entirely, plowed the whole cost of doing so into the budget deficit, and guaranteed raises for doctors through (at least) 2019.

In 2019, the industry used lawsuits to put the kibosh on three money-saving initiatives. First, the Trump administration's attempt to require drug-makers to include list prices in consumer-directed advertisements went down in flames when a federal judge de-cided that the Department of Health and Human Services lacked the power to impose it. Then, the administration's attempt to save $3 billion to $4 billion over nine years by changing the way payments to "disproportionate share" hospitals are calculated met the same fate. Finally, a lawsuit brought by the Association of American Medical Col-leges, the American Hospital Association, and nearly 40 hospitals killed any hope of saving about $800 million a year by eliminating "site-of-service differentials" that pay doctors employed by hospitals more than physicians with independent practices—even when the physicians are delivering the same services in the same offices.

2019 was also the fifth year in which the Centers for Medicare & Medicaid Services (CMS) failed to implement legislation enacted in 2014 which sought to save a paltry $200 million over 10 years by discouraging physicians from needlessly ordering expensive CT scans and MRIs. Regulations were supposed to take effect in 2018, but more than two dozen medical societies complained, so the Trump administration delayed them until January 2020.

Big Pharma is currently working overtime to kill the Prescription Drug Pricing Reduc-tion Act, which would penalize drug companies for raising prices faster than the rate of inflation. Although the bill has bipartisan support, knowledgeable observers say it has no chance of achieving the 60 votes needed to pass the Senate. Indeed, the bill may not make it out of the Senate Finance Committee, since 13 of the 15 Republican senators on

the Committee oppose it.

The health care industry has also turned back efforts to audit its charges. Medicare Ad-vantage plans, which are paid based on how sick their enrollees are, don't want Medi-care to know whether they are exaggerating enrollees' illnesses, so they have fought off or watered down efforts to audit their reports. CMS is already unenthusiastic about au-diting the health care system: for the past four years, it has canceled Medicaid eligibility audits, and "has never taken meaningful actions to minimize improper payments from the [Medicaid] expansion.

If Medicare for All's fans are banking on a Congress dominated by Democrats to bring the industry to heel, their hopes are misplaced. Democrats voted for "doc fixes" repeat-edly and stood shoulder to shoulder with Republicans when the SGR was repealed. The parties may differ on some things but judging by their actions they both believe that the government cannot possibly spend too much money on health care. Only a person who is incredibly naïve or who ignores history entirely can believe that Medicare for All will be financed on the backs of doctors, hospitals, and drug companies.

Medicare for All is also certain to drive up spending by generating an enormous surge in demand for medical care. The bills pending in Congress promise soup-to-nuts coverage for free. Premiums, deductibles and copays are supposed to vanish. If that happens, prodigious consumption of medical services will be inevitable.

The fundamental problem is that Medicare for All's supporters have cause and effect re-versed. They think Americans need universal comprehensive coverage because health care is expensive. In reality, we spend too much on health care because we rely so heav-ily on third parties—Medicare, Medicaid, and private insurers—to pay our bills. In 1960, when patients paid about $1.73 out of pocket for every $1 paid by an insurer, health care spending per capita was $165. In 2010, when patients paid out 16 cents for every insur-ance dollar, spending per capita was $8,400. And in 2017, when the ratio was 14 cents out of pocket for every insurance dollar, spending per capita was $10,740. The more we rely on third party payers, the more we spend. Because the full-on, government-run, single-payer plans introduced by Senators Bernie Sanders and Elizabeth Warren will reduce out of pocket costs to zero, they will drive spending to new heights.

7.5.7 AT: Lancet Study

Multiple problems with this study --- faulty assumptions and violates basic principles of economics.

Pipes 20

Sally C. Pipes (President, CEO, and Thomas W. Smith Fellow in Health Care Policy at the Pacific Research Institute), ”No, Bernie, ’Medicare-for-all’ won’t save money,” Pacific Research Institute, March 2, 2020, https://www.pacificresearch.org/no-bernie-medicare-for-all-wont-save-money/

On Feb. 24, Sen. Bernie Sanders, I-Vt., released a document outlining how he plans to pay for his agenda, including “Medicare-for-all.” He claims his signature health plan will save the country billions of dollars each year.

That estimate rests on faulty math and flawed assumptions. Medicare-for-all would cost far more than Sanders admits and force Americans to pay dearly for subpar care.

The Democratic presidential frontrunner has gone to great lengths to avoid saying exactly how much the many new government programs he’s proposing would cost. “Nobody knows,” he said in an interview with CBS. But on Feb. 23, the senator let slip that his Medicare-for-all plan would cost around $30 trillion over a decade.

Most economists peg the cost a bit higher. The Mercatus Center forecasts around $32 trillion over 10 years; the left-leaning Urban Institute, about $34 trillion.

But neither estimate includes the cost of a new federal long-term care entitlement, which Sanders has tacked onto his Medicare-for-all plan since the two think tanks did their analysis. Add that in, and the 10-year cost of Medicare-for-all swells to a $46 trillion, per a recent American Action Forum analysis.

Sanders imagines funding Medicare-for-all with taxes that would strain the economy and American families. He’s floated a new 4 percent income tax on all households earn-ing over $29,000 a year, a new 7.5 percent payroll tax, and a new corporate income tax rate of 35 percent. That would make U.S. corporate income taxes the highest in the world and result in lower wages for workers. He’s also proposed higher taxes on the wealthy and on capital gains.

Those high taxes would make Medicare-for-all a bad deal for many Americans. Emory University professor Kenneth E. Thorpe estimates that 70 percent of working, privately

insured households would pay more for health insurance under Medicare-for-all than they currently do.

All these new taxes would not come close to covering the cost of Medicare-for-all. Together, they'd generate about $17.5 trillion — just over half of what Sanders estimates Medicare-for-all would cost and about one-third of the American Action Forum's more realistic estimate.

Sanders has taken to touting the supposed savings Medicare-for-all would deliver in order to distract from concerns about its cost. His latest piece of "evidence" is a study published by a Yale epidemiologist and unpaid advisor to his campaign in the medical journal The Lancet claiming that Medicare-for-all would save the United States $450 billion every year and save 68,000 lives.

There are several problems with this study. For starters, $100 billion of these savings would come from reimbursing doctors and hospitals at Medicare's existing rates, which are much lower than those currently paid by private insurers. The study acknowledges as much but argues that healthcare providers would happily accept pay cuts in exchange for reduced administrative costs.

Healthcare providers have successfully staved off just about every pay cut Congress has threatened over the past two decades. Further, Democrats in Congress have stopped well short of foisting Medicare-style price controls on surprise medical bills, as Avik Roy of the Foundation for Research on Equal Opportunity has pointed out. If they can't muster the political courage to cap something as universally reviled as surprise medical bills, they're unlikely to do so across the entire healthcare system.

Second, the study assumes $219 billion in administrative savings, if Medicare-for-all matches the current Medicare program's level of overhead. But many of the administrative costs currently borne by the private sector wouldn't disappear under Medicare-for-all. They'd shift to other parts of the federal government.

The IRS would have to spend more money collecting taxes. The Department of Health and Human Services would have to build a huge new infrastructure to process claims and investigate fraud. On that front, the government's track record isn't great, given that about 10 percent of Medicare's existing payments are fraudulent.

Perhaps most important, the Yale study Sanders cites assumes that millions of people who already have health insurance will not consume any more care after Medicare-for-all makes it "free." That runs counter to the basics of supply and demand. Make care

cheaper, and people will demand more of it. If taxpayer-funded care induces additional demand, much of Sanders' savings will vanish.

Sanders' plan to pay for Medicare-for-all amounts to little more than wishing for savings that will never materialize.

7.5.8 AT: Canada

Huge differences between Canada and the US mean that it wouldn't reduce costs.

Waikar 19

Sachin Waikar citing Jillian Chown (Assistant Professor of Management & Organizations), David Dranove (Walter J. McNerney Professor of Health Industry Management; Faculty Director of PhD Program; Professor of Strategy), Craig Garthwaite (Associate Professor of Strategy; Herman Smith Research Professor in Hospital and Health Services Management; Director of Healthcare at Kellogg). "Would "Medicare for All" Really Reduce Healthcare Costs in the U.S.?," Kellogg Insight, October 4, 2019, https://insight.kellogg.northwestern.edu/article/medicare-for-all-reduce-healthcare-costs-prescription-drugs

In particular, proponents often argue that a single-payer system could help bring down healthcare costs, which have ballooned in recent years to a whopping $3.5 trillion (18 percent of GDP) in the U.S., compared with just $253 billion (11 percent of GDP) in Canada.

Why? Since governments in single-payer countries are the primary purchaser of health-care services—the Canadian government is responsible for 69 percent of health spend-ing in Canada, for instance—those countries should have a great deal of "buyer power." That means they should theoretically be able to effectively set prices to keep healthcare costs in check—and that the U.S. could do the same with a single-payer system. "There's this belief that it's going to lead to big savings when the government uses its large buyer power," Garthwaite explains.

But is that really the case?

"It may be easy to say, 'single payer can bring all these savings by reducing wages or pharma costs,' " says Jillian Chown, assistant professor of management and organiza-tions at Kellogg. "But we have to know if that's actually true."

So Chown, Garthwaite, Kellogg strategy professor David Dranove, and Kellogg research assistant Jordan Keener designed a study to shed more light on the issue. They used an economic model to analyze why current costs of labor and drugs—two of the largest categories of healthcare expenditure—are lower in Canada than in the U.S. They then considered whether the U.S. could expect similar savings under a hypothetical "Medicare for All" system.

The authors found that when it came to pharmaceuticals, the Canadian government was indeed exploiting its status as sole buyer to keep prices down. Canada's cheaper healthcare labor, on the other hand, was largely the result of normal price differences between countries.

The study shows that a single-payer system in the U.S. could potentially lower costs of both personnel and pharmaceuticals. But because of important differences between the two countries—the average salary for skilled workers, as well as the size of their health-care markets—these savings may ultimately compromise quality of care for Americans in ways they don't in Canada. That is, lowering healthcare workers' wages could cre-ate incentives for workers to avoid those fields, while suppressing U.S. pharmaceutical prices would dangerously curtail the industry's motivation to innovate.

"If you think we're going to spend less and get the same care," Garthwaite says, "the evidence doesn't support that."

In particular, lower compensation in Canada explains cost more than buying power.

Waikar 19

Sachin Waikar citing Jillian Chown (Assistant Professor of Management & Organizations), David Dranove (Walter J. McNerney Professor of Health Industry Management; Faculty Director of PhD Program; Professor of Strategy), Craig Garthwaite (Associate Professor of Strategy; Herman Smith Research Professor in Hospital and Health Services Management; Director of Healthcare at Kellogg). "Would "Medicare for All" Really Reduce Healthcare Costs in the U.S.?," Kellogg Insight, October 4, 2019, https://insight.kellogg.northwestern.edu/article/medicare-for-all-reduce-healthcare-costs-prescription-drugs

Does "Medicare for All" Really Reduce Healthcare Costs?

Overall, the researchers found that Canadian healthcare workers made 26 percent less, on average, than their U.S. counterparts.

But the model showed the discrepancy can be largely explained by the generally lower compensation across all highly skilled career fields in Canada, rather than Canada's single-payer system and accompanying buyer power per se. "Canadians simply don't make as much as Americans," Dranove says.

"On average, Canadian doctors make less than U.S. doctors to the same degree that Canadian lawyers make less than U.S. lawyers," Garthwaite explains. "That suggests

the lower healthcare wages are not a strategic decision from the Canadian government but instead the result of broader economic factors."

The authors expect that a single-payer system in the U.S. would face similar limitations. "If you lower U.S. healthcare wages to Canadian levels, people might find higher-paying careers like banking and law more attractive than becoming a surgeon," says Chown.

When it came to drugs, the researchers' prediction was again correct: Canada pays much less for pharmaceuticals than the U.S. does—56 percent less, compared to only about 4 percent less for non-pharmaceutical products such as groceries—suggesting that the government was intentionally pushing prices downward. "Canada can afford to exer-cise buyer power for drugs because it has much less negative impact than for healthcare wages," Garthwaite explains.

So could the U.S. expect similar savings on pharmaceuticals if it adopted "Medicare for All"? Yes, the authors say—but at a different kind of cost.

"Canada's not afraid to lower drug prices because it doesn't have an effect on drug sup-ply," Dranove says. "They're too small a market." However, that's likely not the case for the U.S., where such a move could put a major dent in pharma profits, preventing many drugs from ever coming to market, as manufacturers would have less incentive to invest in innovation and development.

"If Canada lowers prices, it doesn't affect the global market size for drugs," says Chown. "If the U.S. does, it's much more disruptive."

7.6 Supply Shortages

7.6.1 Hospitals

M4A forces hospital closures, particularly in rural areas. This exacerbates shortages created by pandemics

Pipes 20

Sally C. Pipes (President, CEO, and Thomas W. Smith Fellow in Health Care Pol-icy at the Pacific Research Institute). “Coronavirus fight – Would ‘Medicare-for-all’ have improved US response to COVID-19?” *Pacific Research Institute*, April 27, 2020. https://www.pacificresearch.org/coronavirus-fight-would-medicare-for-all-have-improved-us-response-to-covid-19/

“Medicare-for-all” would also hasten hospitals’ descent into insolvency. The plan en-visions reimbursing health care providers at levels similar to Medicare’s existing rates, which are about 40 percent less than what private insurance pays.

One-quarter of rural hospitals are already at risk of closure due to poor finances. A massive pay cut could force them to shut – and leave millions of Americans without ready access to care.

That’s a position many patients in countries with socialized medicine have found them-selves in. Their health care systems don’t have sufficient capacity to handle a health crisis like COVID-19. Italy has just over 12 intensive-care unit beds per 100,000 people. The United Kingdom has fewer than seven per 100,000.

The United States, by contrast, has 35 ICU beds for every 100,000 people – the highest per-capita rate worldwide.

Perhaps more important, the United States has more open acute care beds than most developed countries, as Doug Badger and Norbert Michel point out in a new analysis for the Heritage Foundation. Over one-third of acute care beds are open in the United States, compared with just 15 percent in the United Kingdom and under 10 percent in Canada.

7.6.2 Rationing

M4A causes rationing

Mordo 17

Dave Mordo (is legislative council chair of the National Association of Health Underwriters), “Single-payer would be a nightmare for Americans,” Washington Post, July 25, 2017 http://www.washingtonexaminer.com/single-payer-would-be-a-nightmare-for-americans/article/2629120

Supporters of single-payer claim that it would eliminate wasteful spending and im-prove the quality of care. The reality is quite different. Single-payer systems ration healthcare, slow the development of life-saving drugs and medical devices, and ham-string economic growth. Single-payer systems control costs primarily by limiting access to healthcare. In the United Kingdom’s National Health Service, 5 million patients will languish on waiting lists for non-emergency surgeries, such as hip replacements, by 2019. The president of the country’s emergency room doctors association warned ear-lier this year that wait times are causing ”untold patient misery” and that the NHS is ”broken.” In Canada, patients wait more than nine weeks between referral from a gen-eral practitioner and consultation with a specialist. By comparison, American patients wait less than four weeks, on average. Fewer than 4 percent of Americans who need non-emergency surgeries must wait longer than four months, compared to 18 percent of Canadians. In many cases, single-payer systems force patients to wait indefinitely for lifesaving medicines — again, to keep costs down. For instance, Britain’s NHS only permits 10,000 people per year to receive highly advanced drugs that cure hepatitis C, a deadly infectious disease that afflicts 215,000 Britons. As of late 2015, the NHS covered just 38 percent of cancer medicines approved for sale in 2014 and 2015. Canada’s na-tional health system offered access to 24 percent of those drugs; Spain’s, only 5 percent. Those medicines that are available are subject to government price controls. Patients may feel like they’re getting a good deal, but such controls discourage investment in medical research, slowing the pace of medical innovation. In the 1970s, four European countries developed more than half of the world’s medicines. But since they imposed price controls on drugs, those countries now invent only one-third of medicines. The United States, by contrast, developed nearly 60 percent of the world’s new drugs be-tween 2001 and 2010. Single-payer systems don’t just cap spending on drugs. They also insist upon artificially low reimbursement rates for hospitals and doctors. In many cases, these payments don’t even cover the cost of providing certain treatments and pro-

cedures. The result? Fewer hospitals and doctors. Canada has about 10 percent fewer hospital beds per person than the United States — and 35 percent fewer surgeons per capita. Despite these rigid limits on spending, single-payer systems still end up being enormously expensive. Lawmakers in New York and California are considering bills that would abolish private insurance and enroll all state residents in a single-payer sys-tem. Those systems would cost $226 billion and $400 billion, respectively. That's more than the state's budget in both cases. To fund such systems, governments would need to impose crippling taxes. And the tax hikes needed to pay for a nationwide "Medi-care for All" system would eliminate more than 11 million jobs, according to a recent study. In 2014, Vermont dropped its plans for a statewide single-payer system after calculating that it would have required a new state payroll tax of 11.5 percent. And in 2016, voters in Colorado overwhelmingly voted against Amendment 69, a single-payer referendum that would have required a more modest 10 percent state payroll tax. Dis-enchanted with the ACA marketplaces, tens of millions of Americans now dream of government-funded single-payer healthcare. If politicians actually grant their wish, pa-tients and taxpayers would experience nightmares of rationed care, reduced innovation, and economic devastation.

7.6.3 Payment Rates

Payment rate cuts cause healthcare supply shortage and disrupt timely access to care. The long-term impact is provider shortages, longer wait times, and decreases in quality of care.

Blahous 19

Charles Blahous (J. Fish and Lillian F. Smith Chair and Senior Research Strategist at the Mercatus Center at George Mason University). “The Winners and Losers of ‘Medicare for All’.” Mercatus Center, May 24, 2019. https://www.mercatus.org/bridge/commentary/winners-and-losers-medicare-all

Current M4A proposals would sharply cut payments to health providers while increasing health service demand, most likely causing supply shortages, and disrupting Amer-icans’ timely access to health care.

Neither my study nor my subsequent writings or testimony offer judgments of what health providers should be paid. The study simply notes that we do not know what will happen to the timeliness or quality of health services if we cut provider payments from current, higher private insurance payment rates down to Medicare payment rates, as current M4A proposals stipulate.

The CBO report is more explicit that doing so would likely limit Americans’ timely access to health care services (emphasis in bold added):

”Setting payment rates equal to Medicare FFS rates under a single-payer system would reduce the average payment rates most providers receive—often substantially. Such a reduction in provider payment rates would probably reduce the amount of care sup-plied and could also reduce the quality of care. Studies have found that increases in provider payment rates lead to a greater supply of medical care, whereas decreases in payment rates lead to a lower supply. . . .

In addition to the short-term effects discussed above, changes in provider payment rates under the single-payer system could have longer-term effects on the supply of providers. If the average provider payment rate under a single-payer system was significantly lower than it currently is, fewer people might decide to enter the medical profession in the future. The number of hospitals and other health care facilities might also decline as a result of closures, and there might be less investment in new and existing facilities. That decline could lead to a shortage of providers, longer wait times, and changes in the

quality of care, especially if patient demand increased substantially because many pre-viously uninsured people received coverage and if previously insured people received more generous benefits. How providers would respond to such changes in demand for their services is uncertain."

The costs of M4A would be borne most directly by health providers and those most in need of health services.

An irony of the Rules Committee hearing was that it featured positive comments about M4A from the perspectives of physicians and those facing severe and expensive health conditions. While there would be winners and losers under single-payer health care, some of the groups represented at the hearing would be among those paying the largest and most direct costs. Under current M4A proposals, health providers would pay the greatest price up front, for they would bear the brunt of payment cuts that have been pro-posed to contain the additional costs of M4A's expanded and more generous insurance coverage. The other group to feel M4A's costs most severely, at least under the M4A legislation as written, would be those in most dire need of health care services. This is because, as CBO notes, the supply of health services would be reduced relative to de-mand, making the services less available in the aggregate and putting upward pressure on prices.

This would be particularly problematic for those with income limitations and urgent health needs, because M4A would not target federal resources on those of modest in-come, nor on those facing severe health challenges. Instead it would provide first-dollar coverage of all Americans' health care services, from the most routine to the most urgent, from the least expensive to the most, and for the wealthiest patients as well as the poor-est. By so doing, it would create much more competition for access to urgently needed health services.

It would be an elementary analytical mistake to compare the imperfect reality of our current health system to an idealized fantasy of perfectly functioning M4A, in which everyone gets more care for less money. That is not how things would work. Instead of cost-saving improvements for everyone, there would be winners and losers. The winners would include state governments as well as those who currently pay for routine health expenses out of pocket under their plans' deductibles. The biggest losers under the introduced M4A bills would be federal taxpayers, hospitals, doctors and nurses, and patients urgently needing swift access to care.

7.6.4 Politicization

M4A leads to politicized rationing --- ensures that funding is never enough and the most vulnerable get hit hardest

Matthews 19

Merrill Matthews (Ph.D., resident scholar with the Institute for Policy Innova-tion, a research-based, public policy “think tank.”). “What Medicare-for-All Supporters Won’t Tell You.” Institute for Policy Innovation, March 27, 2019. https://www.ipi.org/ipi_issues/detail/what-medicare-for-all-supporters-wont-tell-you

Care Will Be Rationed

All government-run health care programs ration care. Some rationing is subtle, some is blatant. But they all do it.

When the government pays for health care, it must compete against other claims on government funding, such as welfare, defense and education. As a result, there is never enough money to go around. NEVER!

So politicians look for subtle ways to limit health care spending that affect smaller pop-ulations to free up money for other claims on government funds.

That means cutting at the margins, at least initially: the very old, the very young, and the very sick—i.e., people who typically don’t vote.

Thus a 65-year old might be able to receive a pacemaker but perhaps not at 75 or 85. An otherwise healthy teenager hurt in a car accident might receive significant resources, while a premature infant with only a small chance to survive might not.

It may sound cruel but it makes sense. Given a zero-sum game, where a dollar spent on one patient is a dollar that can’t be spent on another, maximizing the benefit is likely the best way to decide who receives how much.

Another way to ration is through waiting. For years the Vancouver-based Fraser Insti-tute has published an annual list of waiting times in Canada.

Ironically, among single-payer systems waiting lines can be a feature, not a bug. When famed Canadian pediatric orthopedic surgeon Dr. Walter Bobechko invented a spinal clamp for children with scoliosis—known as the Bobechko clamp—that would help them leave the hospital in a few days rather than several weeks, he claimed hospital

management criticized him.5 Those quicker departures opened up beds sooner, creat-ing additional costs for the hospital's limited budget. Dr. Bobechko eventually left Canada to practice medicine in Texas.

The U.S., by contrast, generally has an open-ended health care spending system, even for the two largest government-run programs, Medicare and Medicaid.

However, because both programs impose price controls, patients may be denied certain therapeutic options—e.g., more expensive medical devices or pharmaceuticals—and doctors' offices may limit their Medicare and Medicaid patient loads, creating longer waits to see a doctor.

While there is already rationing for both Medicare and Medicaid patients, it is often limited and subtle. Under M4A rationing will be open and explicit—and widespread.

7.6.5 Turns Everything

Wait times link turn everything – broadly undercuts care, access, and health-outcomes

Pipes 16

Sally Pipes (Thomas W. Smith Fellow in Health Care Policy at the Pacific Research Institute, President and CEO of the same organization), “My view: Dear America: Don’t buy the single-payer snake oil,” 4 August 2016, http://www.deseretnews.com/article/865659365/Dear-America-Dont-buy-the-single-payer-snake-oil.html

This support is troubling. Single-payer systems are little more than snake oil. Both in the United States and abroad, single-payer has never delivered on its grand promises.

The central feature of single-payer is brutally long wait times. Consider Canada, where I grew up. A patient must wait an average of four-and-a-half months to see a specialist after getting a referral from his general practitioner. In Britain’s National Health Service, one in five cancer patients has to wait at least two months before getting treated. Delays even plague the NHS’s ambulance and ER services.

Single-payer here at home has performed similarly. Multiple investigations have found that patients in the government-run Veterans Health Administration must withstand chronic delays in order to receive treatment. More than half a million veterans have waited more than 30 days for an appointment this year, according to the VA’s own data. More than 30,000 have been waiting for over four months.

And the delays keep getting worse. In 2014, Congress gave the VA $10 billion to create Veterans Choice — a program that would allow veterans to see non-VA doctors if they lived more than 40 miles from a VA hospital or had to wait more than a month for care. But as of May, 70,000 more vets have waited more than 30 days to see a doctor, relative to the same time last year.

These delays aren’t just inconvenient. They can be deadly. One recent report found that as many as 307,000 veterans may have died waiting for the VA to process their requests for care.

Those that did receive treatment from the VA may not have fared much better. Accord-ing to a new Senate report, the VA inspector general — the agency’s alleged watchdog — hid evidence that showed caretakers prescribing dangerous and sometimes lethal drug dosages to patients.

Unfortunately, the inefficiencies — and consequent deaths — caused by single-payer aren't unique to the VA. The five-year survival rates for diseases like breast, colon, and prostate cancers are worse in single-payer countries than in the United States, according to a worldwide study authorized by the Centers for Disease Control and Prevention.

7.7 Innovation

7.7.1 General

The government will slash funding for drug research on day-one

Stark 17

Dr. Roger Stark, health care policy analyst at Washington Policy Center. “Is a Single-Payer Health Care System Right for America?” May 22, 2017, http://www.washingtonpolicy.org/library/doclib/Stark-Single-Payer-Health-Care-System-5.22.2017.pdf

A single-payer system discourages innovation. There is virtually no money in the system to encourage investment in new life-saving medicines and medical devices. Lack of innovation guarantees that no new treatments will be discovered, with no improvement in quality of life or life expectancy.

Under a single-payer system, health care spending must compete with all other govern-ment activity for funding. This makes health care very political and subject to change with every new budget. It also forces each health care sector, for example hospitals and doctors, to compete with each other for limited money.

Fundamentally, a single-payer system centralizes all health care with the government. Bureaucrats, not patients and their providers, get to make life and death decisions about the kind and amount of health care people receive.

Medicare for all tanks innovation --- multiple warrants

Rich 19

J.J. Rich (a policy analyst at Reason Foundation and a Young Voices contributor), ”Medicare for All Means Innovation for None,” Real Clear Policy, April 8, 2019, https://www.realclearpolicy.com/articles/2019/04/08/medicare_for_all_means_innovation_for_none_111151.html

Leading Democratic presidential primary contenders have now almost unanimously endorsed some sort of Medicare for All proposal. Public support to expand the universal health services currently granted to older Americans via Medicare to the entire country is now in the majority, and the move would replicate publicly-funded universal healthcare in other developed nations.

Many progressive and moderate Democrats alike have supported Medicare for All, tout-ing superior access and lower healthcare costs of single-payer, socialized systems. But healthcare coverage alone does not mean better health outcomes, and a brief review of Medicare's real-world results reveals a chief problem of socialized healthcare — its destruction of innovation.

When President Lyndon B. Johnson first introduced Medicare and Medicaid in 1965, health coverage was much less common. Fifty percent of American seniors did not have health insurance, and those who did faced rates three times those of younger people. Johnson's Medicare initiative sought to end this inequality, giving all American seniors the coverage reflective of a "Great Society." And consequently, nothing in American senior care resembles what existed before Johnson's initiative.

Nothing except life expectancy.

In 1965, American life expectancy was 70 years — it is now just 78 years, a modest im-provement at best. The fact that the last 54 years of unprecedented American innovation has been accompanied by only eight years of increased life expectancy is quite concern-ing. During that period, rotary phones transformed into pocket-sized supercomputers, but most Americans still live fewer years than many of the Founding Fathers. Pub-lic health enthusiasts often challenge this correlation, noting that medical care has also greatly improved. They are partially correct.

This innovation has been unequally distributed. Ailments mostly reserved to the elderly in many cases persist, even as those that plague the young are cured en masse. Diseases like Alzheimer's, Parkinson's, and dementia are all just as prevalent among seniors and untreatable today as they were in 1965. The lack of innovation is staggering, but is enabled by an equal lack of competition among healthcare providers for seniors, most of whom are on Medicare rather than private plans.

Payroll taxes allow Medicare to survive regardless of outcomes and make superior alter-natives unaffordable for seniors. Heart disease and cancer treatment have seen improve-ments, 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 sur-vival 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 therapeu-tic 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 healthcare has little incentive to introduce new technologies and prolong life. Rich countries like the United Kingdom and Canada provide universal healthcare, 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.

If socialist healthcare is as great as Democrats claim, why do Saudi Kings and half a million other medical tourists fly far away from their socialized systems to America to receive adequate treatment?

Even the few socialized healthcare systems with higher life expectancy, due primarily to healthier lifestyles, count on American innovation to improve their health systems. But American socialists emboldened by good intentions seek to sabotage the vestiges of our free market system. America should resist the regressive movement to end inequality by giving everyone equally terrible healthcare.

7.7.2 Cost

M4A stifles innovation over cost concerns

Matthews 19

Merrill Matthews (Ph.D., resident scholar with the Institute for Policy Innova-tion, a research-based, public policy “think tank.”). “What Medicare-for-All Supporters Won’t Tell You.” Institute for Policy Innovation, March 27, 2019. https://www.ipi.org/ipi_issues/detail/what-medicare-for-all-supporters-wont-tell-you

The Government Decides Which Treatments You Can Have

Government-run health care systems decide how to allocate funds in two primary ways: cost vs. benefits or political power. If bureaucrats believe a new drug or medical device is too expensive compared to the benefits, they likely won’t cover it—even if that is the best option for some patients.

Or the government may force patients to try the least-expensive options first, known as “step therapy” or “fail first,” before trying a more expensive therapy. Indeed, that approach is already being proposed by Medicare as a way to save money.

Finally, diseases the media and prominent politicians care about most are likely to receive more funding than those less fashionable.

7.7.3 Incentives

M4A eliminates market incentives towards better and more innovative treatments. Shifting to it would be harmful because the US is the world leader in healthcare innovation.

Garthwaite and Illing 17

Craig Garthwaite and Sean Illing (Herman R. Smith Research Professor in Hospital and Health Services, an Associate Professor of Strategy, and the Director of the Program on Healthcare at Kellogg (Northwestern School of Business), and Interviews Writer for Vox, respectively). “I think health care is a right. I asked an expert to tell me why I’m wrong.” *Vox*, Jun 30, 2017. https://www.vox.com/policy-and-politics/2017/6/30/15879702/health-care-capitalism-free-market-socialism-single-payer

Sean Illing

But I guess that’s my point: I don’t think people should be buying and selling health care in this way, because, again, I don’t think health care should be treated as a product in the conventional sense. Maybe you can respond to that by telling me why you think the free market is the answer here.

Craig Garthwaite

Fundamentally, you have to understand that getting access to healthcare services, get-ting people to be willing to provide high-quality services and innovative treatments, is the result of a market decision for those providers as well, and so if you don’t treat it like a marketplace to some degree, you’ll get less innovation and fewer new treatments than you will if you do. If you’re happy with the degree of innovation and treatments and quality we have now, then that’s fine, but I think we all would like more cures for more diseases than we currently have.

Sean Illing

Surely you allow for some role of the government, right? The problem isn’t that our sys-tem doesn’t produce innovation and high-quality treatment; it’s that not enough people have access to it.

Craig Garthwaite

I think where people who don’t have access to the ability to pay for these things, there’s a role for the government to write social insurance for those people. We do that through

Medicaid and a little bit through Medicare and other programs, but I fundamentally believe that we get better and more innovative treatments when we allow marketplace incentives to work.

Sean Illing

As you know, most of the industrialized world doesn't treat health care like this. Most countries have some form of universal care. So what is it we've figured out that the rest of the world is confused about?

Craig Garthwaite

Well, the rest of the world drafts off of the innovation generated by the profits of the United States. If I'm running the health care system in another country, and if I have the United States here to generate huge profits to provide incentives to develop new drugs, I can choose to provide lower prices that take innovation less into account. I mean, the world of the Western European systems might be a little bit different if they had to think more carefully about that point.

Sean Illing

That's an interesting point. Do you think these other countries are producing better overall health outcomes for their citizens?

Craig Garthwaite

I think it becomes a question of what that means, right? If the choice is between access to the best parts of the American health care system versus the best parts of any other system, I'd rather be in the United States. Now if we take a more Rawlsian view and you ask me which system I'd prefer if I didn't know where I'd end up in society or how much income I'd earn, I'd probably want to be in another country.

Sean Illing

You see, that's the core of the problem here. This whole debate reduces ultimately to a question of values, not facts. A system that tilts so heavily toward the rich is unjust in my mind. People should be not be denied health care because they don't make enough money, and I'm willing to sacrifice that dynamism at the top if it means less human suffering.

Craig Garthwaite

That's where social insurance comes into play. That's why we have Medicaid. That's why we have things like an expanded ACA, to provide a subsidy to help people to get

to that level.

Sean Illing

Right, but those are half-measures, and in any case they're not working — or not work-ing for enough people. And if you're one of those people shut out of this system for financial reasons, you don't give a damn about all that innovation and high-quality treatment that others are enjoying.

Craig Garthwaite

Listen, I'd certainly rather have the Western European world contributing their fair share of innovation. I'm happy to talk about a willingness to accept less innovation for more access, but you've got to be willing to accept that there's a trade-off here and then to account for that in our analysis. It might be that the innovation we're getting isn't worth the human costs, and that's a conversation we can have, but there's absolutely a trade-off, and I'm not sure everyone understands that.

Sean Illing

I think you're right about that, to be honest.

7.7.4 Innovation Impact

Innovation controls the root cause to improved care and cost reduction.

M4A's redistributive nature runs counter to that goal.

Graboyes 18

Robert Graboyes (senior research fellow at the Mercatus Center at George Mason Uni-versity). "No, Medicare for All Won't Lower Health-Care Costs." *Real Clear Policy*, Au-gust 6, 2018. https://www.realclearpolicy.com/articles/2018/08/06/medicare_for_all_unlikely_to_lower_health_care_costs_110748.html

The M4A bill is almost entirely redistributive. It doesn't generate new doctors or drugs or hospital beds or medical devices. Nor does it alter how providers use those resources. In fact, massive reimbursement cuts and centralized direction would likely do the oppo-site: reduce the available resources and lock current modes of care in place. Increased care for one person would be offset by decreased care for others.

I've argued that single-payer would fulfill neither the Left's dreams nor the Right's nightmares ("Single Payer Health Care — Dream, Nightmare or Status Quo?"). Better care for more people at lower cost won't come from scrambling the insurance system, as M4A would do, as Obamacare did, and as various Republican alternatives would do. Actual improvement will come from bold changes in the technologies and structures of care — from allowing health care to innovate as fervently as information technology has over the past quarter-century.

That will happen when health-care providers are allowed to innovate and learn from the bright pockets of transformation that already exist. Why, for example, can the pri-vate, for-profit Narayana hospitals in India perform cardiac bypasses for around $1,000 — versus $100,000 here — yet experience outcomes that are as good as or better than America's or Europe's? Why does Rwanda, not America, have a nationwide system of unmanned drones rapidly delivering drugs and blood products to clinics? Why can the Surgery Center of Oklahoma post to-the-penny costs of every surgical procedure on their website while most hospitals assault patients with unreadable bills stretched out over many months?

Innovation, not insurance, is where our bright future lies. In the meantime, someone has to run the numbers on insurance proposals. I'll happily leave that task to Chuck Blahous.

7.8 AT: Covid-19

7.8.1 Current Programs Solve

Current state and federal programs insure adequate healthcare access during pandemics. M4A undermines this by creating physician shortages during normal and pandemic times

Axelsen 20

Kirsten Axelsen (visiting fellow at the American Enterprise Institute). “We need health insurance in this coronavirus time, not ‘Medicare for All’.” Morning Consult, May 26, 2020. https://www.aei.org/articles/we-need-health-insurance-in-this-coronavirus-time-not-medicare-for-all/

Since the enactment of the 2010 Affordable Care Act, more Americans are using pre-ventive care and fewer are failing to fill prescriptions or see physicians. The biggest expansion in health insurance coverage since 1965, the ACA today covers 20 million in-dividuals despite the Trump administration’s best effort to undermine enrollment. Pre-ventive care, including vaccines are covered, and people with pre-existing conditions cannot be denied coverage. While the ACA is still flawed, with insurance coverage options lacking in some areas and some insurers discriminating against people with se-rious illnesses, it should not be replaced by a worse system which assumes that only the federal government has the answers when states and health providers have worked to improve the ACA.

Some states, for example, have taken creative approaches and have been successful in managing high-cost patients in the individual insurance marketplaces. Minnesota adopted a reinsurance plan in 2018, which resulted in a 13 percent decrease in premiums in just the first year, while expecting another reduction of 8-9 percent for 2019. Mary-land also adopted a plan in 2018 and reported a 13.2 percent decrease in premiums for the first year. While Wisconsin and Maine do not have official numbers from the first year, estimates place the rate decreases at 3.2 percent and 9 percent, respectively.

While there is no federal requirement to do so, many states have opened special en-rollment periods during the pandemic to cover people left unemployed and uninsured. However, many states have reopened enrollment for the newly uninsured and the fed-eral government should require a special enrollment period for all states.

While physicians opinions are mixed about the ACA, the majority want to change but

not repeal the law. Many favor expanding Medicaid eligibility and employing either the Temporary Assistance for Needy Families or Supplemental Nutrition Assistance Program benefits to facilitate the enrollment process. Physicians are concerned with the administration's attempts to undermine the ACA, believing instead that fixing the ACA's imperfections should focus primarily on extending coverage of the uninsured — not dismantling the existing coverage enjoyed by many Americans today. In addition, more than 150 million Americans have health insurance through their employers. A single-payer option such as Medicare for All would destabilize, if not eliminate insurance coverage for this group. This would have a devastating impact on the supply of physicians, particularly in lower income and rural areas. Many other repercussions would arise. For decades, American unions have fought for a combination of wages and health care benefits when negotiating on behalf of their members. "Medicare for All" effectively undermines these agreements, creating a need for restitution.

Physicians advocate for their patients with a unified voice on issues that truly matter. These issues include removing obstacles to patient care, leading the charge to confront public health crises and creating the future of medicine through improved technology, physician training and public education. In the absence of a non-partisan federal perspective on health care, it is increasingly important for physicians to provide the necessary expertise and leadership. Hospitals, states, mayors and local providers have shown extraordinary resilience and great responses in this crisis. We need to lean on and empower them to provide solutions to expand access to preventive care and treat-ment for serious illnesses. The Affordable Care Act is a framework to do just that. Not only does it increase insurance coverage, it charges individuals for premiums and out-of-pocket expenses on a sliding scale. "Medicare for All" is just an ill-defined catchy phrase, obscuring a federal grab for control, which would have a devastating impact on the medical community and the people served by it.

7.8.2 Deregulation Better

M4A nations haven't fared better with Covid-19 – and it was deregulation that prevented US hospitals from being overwhelmed

Norquist 20

Grover Norquist (President of Americans for Tax Reform). "Coronavirus Is not an Argument for Medicare-for-All." *Real Clear Health,* May 27. 2020. https://www.realclearhealth.com/articles/2020/05/27/coronavirus_is_not_an_argument_for_medicare-for-all__111050.html

We could start by looking at how those nations that have socialized health care have fared in the wake of COVID-19.

The pandemic has created a surge in health care demand that has tested every nation's ability to meet the needs of their patients.

Even before the virus, other developed nations with government-run health care systems had understaffed hospitals and long waiting lines for even basic treatment.

In 2019, The United Kingdom had a shortage of 10,000 doctors and 43,000 nurses, with 9 in 10 managers in the National Health Service saying that too few doctors and nurses presented a danger to patients. At any one time, 4.5 million patients were waiting for hospitalization.

Closer to home, in Canada, the typical patient had to wait a record 21.2 weeks – or five months – to receive treatment from a specialist after being referred by their general practitioner in 2017.

Before the pandemic, the U.S. had 35 intensive care unit beds per 100,000 people – nearly three times the 12 beds Italy and five times the 7 ICU beds in the UK.

How did the USA avoid the virus overwhelming our ability to provide ventilators, hospital beds and care? Did we centralize control? Move towards Medicare-for-All?

No, the Trump Administration moved in the opposite direction by removing bureaucratic roadblocks and ending government monopolies.

The federal, state and local governments together abolished or suspended over 500 rules and regulations since the pandemic began. Less government red tape allowed hospitals, medical research centers, pharmaceutical companies and doctors and nurses to respond to the ever-changing challenge of the virus.

This deregulation has spurred medical innovation, allowing America to lead the way on the development and production of a Coronavirus vaccine.

Regulatory relief has also protected and expanded access to health care for American patients. Doctors were allowed to more easily move across state lines. Telemedicine was allowed to speed up health care while lowering costs.

If we had socialized health care, we would look more like Britain, Canada and Italy.

7.8.3 Undermines Response

M4A restricts physician supply and access to innovative treatments --- that undermines pandemic response

Axelsen 20

Kirsten Axelsen (visiting fellow at the American Enterprise Institute). “We need health insurance in this coronavirus time, not ‘Medicare for All’.” Morning Consult, May 26, 2020. https://www.aei.org/articles/we-need-health-insurance-in-this-coronavirus-time-not-medicare-for-all/

The coronavirus crisis has underscored the need for comprehensive health insurance coverage in the United States. Every individual needs affordable and consistent access to a medical provider, hospital, diagnostic tools, vaccines and medicines, both for that person’s health and for all of society. Poor health has many repercussions, not just sus-ceptibility to infectious diseases. Children, spouses, employers, friends, institutions and businesses lose when people are not active, productive and well.

Once America moves beyond the pandemic crisis, politicians and others will have to shore up our existing health care infrastructure and insurance coverage. Because the country will have taken an economic hit, and likely be in a recession with a huge deficit and growing unemployment, proposals to cover the uninsured, like “Medicare for All” (supported by Bernie Sanders and Elizabeth Warren), will be popular. Beware. “Medicare for All” is both ill-defined and poorly thought out. Most interpretations include government price setting and less involvement by the private market. Govern-ment price setting will likely exacerbate physician shortages and reduce access to new medicines and treatments. Already, investment in infectious disease research is lacking and primary care physicians are in short supply.

7.8.4 AT: Recession

Covid-19 induced recession means M4A tax increases would be disastrous for the middle class

Norquist 20

Grover Norquist (President of Americans for Tax Reform). “Coronavirus Is not an Argument for Medicare-for-All.” *Real Clear Health,* May 27. 2020. https://www.realclearhealth.com/articles/2020/05/27/coronavirus_is_not_an_argument_for_medicare-for-all__111050.html

Adding insult to injury, Medicare-for-All would lead to significant middle-class tax increases at a time that the U.S. economy and American families and businesses across the country are struggling.

The Committee for A Responsible Federal Budget finds that “impossibly high taxes on high earners” would raise just one third of the total cost. The rest—some $20 Trillion would come from us.

Even Bernie Sanders admits that the middle class will take it on the chin to pay for Medicare-for-All. His plan includes a new, $3.9 trillion, 4 percent payroll tax on workers, as well as trillions of dollars in taxes on employer benefits and businesses. And it still falls trillions of dollars short of paying for the full cost of the program.

There is reason to suspect that Democrats are under-stating the taxes they plan to im-pose on middle income Americans. In 2007, candidate Obama promised that he would NEVER raise any taxes on any American earning less than $250,000.

What happened?

Obamacare imposed at least 7 taxes on the middle class. Getting anywhere close to the $30 trillion in new spending will require trillions of dollars in new taxes on middle class families and small businesses. That will cost most Americans more than the virus ever did. Every year.

To protect us against the next virus we need to say “no” to the single payer system that has failed in Europe.

7.8.5 AT: EBHI Bad

Congressional bridge funding can maintain EBHI without unemployment disruption

- EBHI = Employer based health insurance

Norquist 20

Grover Norquist (President of Americans for Tax Reform). “Coronavirus Is not an Argument for Medicare-for-All.” *Real Clear Health,* May 27. 2020. https://www.realclearhealth.com/articles/2020/05/27/coronavirus_is_not_an_argument_for_medicare-for-all__111050.html

In the short term, lawmakers must protect against efforts to incrementally move the U.S. health care system toward more government control. This means opposing proposals that impose price controls on medicines including efforts to adopt foreign price con-trols. It also means rejecting plans to impose price fixing on the health care system as a “solution” to surprise medical billing.

Lawmakers must also prevent COVID-19 from forcing an expansion of government health care. Almost 40 million Americans have recently lost their jobs, and with it their employer provided health care. Congress should step in and offer a bridge for these workers to retain their employer health care so they are not forced onto Obamacare or Medicaid, an outcome that would strengthen the effort of socialists to expand the federal government’s role in health care.

The Coronavirus pandemic has not changed the fact that socialized health care is a bad idea. It would harm medical care and lead to trillions in higher taxes for American families.

The lesson from the pandemic should be that the costs and failures of government con-trol of health care—higher taxes, more spending, wage and price controls and innova-tion killing regulations—are clearer to all Americans.

Such lessons are most expensive if we fail to learn from them.

ACA and short-term plans ensure that insurance rates won’t skyrocket during Covid-19.

Pipes 20

Sally C. Pipes (President, CEO, and Thomas W. Smith Fellow in Health Care Pol-icy at the Pacific Research Institute). “Coronavirus fight – Would ‘Medicare-for-all’ have improved US response to COVID-19?” *Pacific Research Institute*, April 27, 2020. https://www.pacificresearch.org/coronavirus-fight-would-medicare-for-all-have-improved-us-response-to-covid-19/

But “Medicare-for-all” would not have improved our nation’s response to the outbreak. Other countries with socialized medicine have struggled mightily to combat COVID-19. In fact, the United States would have been even less prepared for the pandemic under “Medicare-for-all.”

Sanders claims that COVID-19 lays bare the “absurdity and cruelty” of our health care system. He takes issue with the fact that millions of Americans who have recently lost their jobs have also lost their employer-sponsored health insurance. The Vermont sen-ator worries about hospitals going bankrupt and health care workers getting laid off, even as the pandemic rages around us.

Sanders believes “Medicare-for-all” is necessary to fix all those problems. He’s sorely mistaken.

Take the coverage issue. Anyone who has lost their employer-sponsored insurance has the ability to purchase insurance through ObamaCare’s exchanges. Thanks to an ex-ecutive order promulgated by the Trump administration, many can also purchase an affordable short-term, limited-duration health plan that can last for up to a year. Insur-ers can renew the plans for up to three years. Some of these short-term plans offer more generous coverage at lower cost than is available on the exchanges.

Sadly, short-term plans are unavailable in 11 states, whether due to outright bans or regulations that have resulted in insurers declining to sell coverage. More than half of states restrict the availability of short-term plans beyond what the Trump executive order envisions.

Sanders envisions “helping” those who lost their employer-sponsored coverage by just banning private insurance altogether and dumping everyone into a one-size-fits-all gov-ernment plan. That would be tremendously disruptive.

According to the most recent U.S. Census figures, some 178 million people had pri-vate insurance coverage through their employers; another 34 million purchased private insurance directly. Most working privately insured households would pay more for health coverage under “Medicare-for-all.”

7.8.6 Proves Failure

That the federal government completely mishandled the pandemic proves that it cannot be trusted to manage the entire health care system.

Pipes 20

Sally C. Pipes (President, CEO, and Thomas W. Smith Fellow in Health Care Pol-icy at the Pacific Research Institute). “Coronavirus fight – Would ‘Medicare-for-all’ have improved US response to COVID-19?” *Pacific Research Institute*, April 27, 2020. https://www.pacificresearch.org/coronavirus-fight-would-medicare-for-all-have-improved-us-response-to-covid-19/

Finally, the U.S. government’s own mishandling of the COVID-19 pandemic is proof enough that it’s incapable of running the entire health care system. “Sloppy” practices at the Centers for Disease Control and Prevention left the agency’s first batch of COVID-19 tests contaminated and set the country’s pandemic response back nearly a month.

Federal officials assured us everything was fine – and went so far as to initially prohibit private labs from producing COVID-19 tests of their own. Those labs later struggled to get approval to create and conduct tests.

“Medicare-for-all” wouldn’t serve the country any better post-pandemic. Americans are understandably shocked at the prospect of hospitals choosing which COVID-19 patients get ventilators. But such rationing occurs on a daily basis in countries with single-payer.

Under “Medicare-for-all,” rationing and long waits for care would become the norm in the United States, too – not just during once-a-generation outbreaks but each and every year.

7.9 AT: Healthcare is a Right

7.9.1 Private Good

Healthcare is a private good. And even if it wasn't, it can best be delivered through private market incentives coupled with some government involvement.

Garthwaite and Illing 17

Craig Garthwaite and Sean Illing (Herman R. Smith Research Professor in Hospital and Health Services, an Associate Professor of Strategy, and the Director of the Program on Healthcare at Kellogg (Northwestern School of Business), and Interviews Writer for Vox, respectively). "I think health care is a right. I asked an expert to tell me why I'm wrong." *Vox*, Jun 30, 2017. https://www.vox.com/policy-and-politics/2017/6/30/15879702/health-care-capitalism-free-market-socialism-single-payer

Sean Illing

I believe that health care should be regarded as a public good, not a marketplace com-modity. Tell me why I'm wrong.

Craig Garthwaite

Well, first of all, it's not a public good. It's both rival and excludable, so it doesn't have the characteristics of a public good, right?

Sean Illing

Explain what you mean there.

Craig Garthwaite

If I consume health care services, someone else can't. So it's not a public good in the sense of, like, a park or something like that. Or clean air. Those are things that we think of as public goods.

Sean Illing

I guess what I mean is that's a social good or resource. Health is vital to our social capital, our human capital.

Craig Garthwaite

We don’t need to abandon the market to get to that, though. We have a market system now in which people get access to health insurance. There are clearly private benefits from that, so it’s not clear the government should be funding all of that. If the gov-ernment does become the sole purchaser of health care, they’re monopsonist, meaning we have a market with one buyer and many sellers, and the prices therefore become inefficiently low.