M4A - Grizzly Files

1AC: Lack of Insurance

• Lack of Insurance kills 45,000 annually

Mona **CHALABI 17**. Data Editor; MA, International Security, SciencesPo, Paris. "Will losing health insurance mean more US deaths? Experts say yes." *The Guardian*. June 24. 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.\

• Comprehensive studies prove that insurance is the most important factor in accessing care.

Sommers et al, 17 – *PhD in Health Policy from Harvard and an MD from Harvard Medical School, associate professor of health policy and economics in the Department of Health Policy and Management, Harvard T. H. Chan School of Public Health, and an assistant professor of medicine at Brigham and Women's Hospital, both in Boston, Massachusetts, **M.D. from Harvard Medical School, M.P.H. from Harvard T.H. Chan School of Public Health, practices general and endocrine surgery at Brigham and Women's Hospital, professor in the Department of Health Policy and Management at the Harvard T.H. Chan School of Public Health and the Samuel O. Thier Professor of Surgery at Harvard Medical School, ***Boyden Gray Professor of Health Economics in the Department of Health Policy and Management at the Harvard T.H. Chan School of Public Health, Ph.D. in economics from Harvard (Benjamin D., Atul Gawande, Katherine Baicker, Health Insurance Coverage and Health — What the Recent Evidence Tells Us, The New England Journal of Medicine, 2017; 377:586-593)

Perhaps no research question better encapsulates this policy debate than, "Does coverage save lives?" Beginning with the Institute of Medicine's 2002 report Care without Coverage, some analyses have

suggested that **lack of insurance causes tens of thousands of deaths each year** in the United States.44 Subsequent observational studies had conflicting findings. One concluded that lacking coverage was a strong independent risk factor for death,28 whereas another found that coverage was only a proxy for risk factors such as socioeconomic status and health-related behaviors.27 More recently, several studies have been conducted with stronger research designs better suited to answering this question.

The Oregon study assessed mortality but was limited by the infrequency of deaths in the sample. The estimated 1-year mortality change was a nonsignificant 16% reduction, but with a confidence interval of –82% to +50%, meaning that the study could not rule out large reductions — or increases — in mortality. As the authors note, the study sample and duration were not well suited to evaluating mortality.

Several quasi-experimental studies using population-level data and longer follow-up offer more precise estimates of coverage's effect on mortality. One study compared three states implementing large Medicaid expansions in the early 2000s to neighboring states that didn't expand Medicaid, finding a **significant 6% decrease in mortality over 5 years** of follow-up.22 A subsequent analysis showed the largest decreases were for deaths from "health-care–amenable" conditions such as heart disease, infections, and cancer, which are more **plausibly affected by access to medical care**.29 Meanwhile, a study of Massachusetts' 2006 reform found significant reductions in all-cause mortality and health-care–amenable mortality as compared with mortality in demographically similar counties nationally, particularly those with lower pre-expansion rates of insurance coverage.9 Overall, the study identified a "number needed to treat" of 830 adults gaining coverage to prevent one death a year. The comparable estimate in a more recent analysis of Medicaid's mortality effects was one life saved for every 239 to 316 adults gaining coverage.29

How can one reconcile these mortality findings with the nonsignificant cardiovascular and diabetes findings in the Oregon study? Research design could account for the difference: the Oregon experiment was a randomized trial and the quasi-experimental studies were not, so the latter are susceptible to unmeasured confounding despite attempts to rule out alternative explanations, such as economic factors, demographic shifts, and secular trends in medical technology. But — as coauthors of several of these articles — we believe that other explanations better account for this pattern of results.

First, mortality is a composite outcome of many conditions and factors. Hypertension, dyslipidemia, and elevated glycated hemoglobin levels are important clinical measures but do not capture numerous other causes of increased risk of death. Second, the studies vary substantially in their timing and sample sizes. The Massachusetts and Medicaid mortality studies examined **hundreds of thousands of people gaining coverage over 4 to 5 years of follow-up**, as compared with roughly 10,000 Oregonians gaining coverage and being assessed after **less than 2 years**. **It may take years** for important effects of insurance coverage — such as increased use of primary and preventive care, or treatment for life-threatening conditions such as cancer, HIV–AIDS, or liver or kidney disease — to manifest in reduced mortality, given that mortality changes in the other studies increased over time.9,22

Third, the effects on self-reported health — so clearly seen in the Oregon study and other research — are themselves predictive of reduced mortality over a 5- to 10-year period.42,43 Studies suggest that a 25% reduction in self-reported poor health could plausibly **cut mortality rates in half** (or further) for the sickest members of society, who have disproportionately high rates of death. Finally, the links among mental health, financial stress, and physical health are numerous,45 suggesting additional pathways for coverage to produce long-term health effects.

DIFFERENT TYPES OF COVERAGE

In light of recent evidence on the benefits of health insurance coverage, some ACA critics have argued that private insurance is beneficial but Medicaid is ineffective or even harmful.46 Is there evidence for this view? There is a greater body of rigorous evidence on Medicaid's effects — from studies of pre-ACA expansions, from the Oregon study, and from analyses of the ACA itself — than there is on the effects of private coverage. The latter includes studies of the ACA's dependent-coverage provision, which expanded only private insurance, and of Massachusetts' reform, which featured a combination of Medicaid expansion, subsidies for private insurance through Medicaid managed care insurers, and some increase in employer coverage. But there is no large quasi-experimental or randomized trial demonstrating unique health benefits of private insurance. One head-to-head

quasi-experimental study of Medicaid versus private insurance, based on Arkansas's decision to use ACA dollars to buy private coverage for low-income adults, found minimal differences.11,19 Overall, the evidence indicates that having health insurance is quite beneficial, but from patients' perspectives it does not seem to matter much whether it is public or private.47 Further research is needed to assess the relative effects of various insurance providers and plan designs.

Finally, though it is outside the focus of our discussion, there is also quasi-experimental evidence that Medicare improves self-reported health48 and reduces in-hospital mortality among the elderly,49 though a study of older data from Medicare's 1965 implementation did not find a survival benefit.50 However, since universal coverage by Medicare for elderly Americans is well entrenched, both the policy debate and opportunities for future research on this front are much more limited.

IMPLICATIONS AND CONCLUSIONS

One question experts are commonly asked is how the ACA — or its repeal — will affect health and mortality. The body of evidence summarized here indicates that coverage expansions **significantly increase** patients' access to care and use of preventive care, primary care, chronic illness treatment, medications, and surgery. These increases appear to produce **significant, multifaceted, and nuanced benefits to health**. Some benefits may manifest in earlier detection of disease, some in better medication adherence and management of chronic conditions, and some in the psychological well-being born of knowing one can afford care when one gets sick. Such modest but **cumulative changes** — which one of us has called "the heroism of incremental care"51 — may not occur for everyone and may not happen quickly. But the evidence suggests that they do occur, and that some of these changes will ultimately help **tens of thousands of people live longer lives**. Conversely, the data suggest that policies that reduce coverage will produce **significant harms to health**, particularly among people with lower incomes and chronic conditions.

Do these findings apply to the ACA? Drawing on evidence from recent coverage expansions is, in our view, the most reasonable way to estimate future effects of policy, but this sort of extrapolation is not an exact science. The ACA shares many features with prior expansions, in particular the Massachusetts reform on which it was modeled. But it is a complex law implemented in a highly contentious and uncertain policy environment, and its effects may have been limited by policies in some states that reduced take-up,52 Congress's partial defunding of the provisions for stabilizing the ACA's insurance marketplaces,53 and plan offerings with high patient cost sharing. Furthermore, every state's Medicaid program has unique features, which makes direct comparisons difficult. Finally, coverage expansions and contractions will not necessarily produce mirror-image effects. For these reasons, no study can offer a precise prediction for the current policy debate. But our assessment, in short, is that these studies provide the **best evidence we have** for projecting the impact of the ACA or its repeal.

The many benefits of coverage, though, come at a real cost. Given the increases in most types of utilization, expanding coverage leads to an increase in societal resources devoted to health care.8 There are key policy questions about how to control costs, how much redistribution across socioeconomic groups is optimal, and how trade-offs among federal, state, local, and private spending should be managed. In none of these scenarios, however, is there evidence that covering more people in the United States will ultimately save society money.

Are the benefits of publicly subsidized coverage worth the cost? An analysis of mortality changes after Medicaid expansion suggests that expanding Medicaid saves lives at a societal cost of $327,000 to $867,000 per life saved.29 By comparison, other public policies that reduce mortality have been found to average $7.6 million per life saved, suggesting that expanding health insurance is a more cost-effective investment than many others we currently make in areas such as workplace safety and environmental protections.29,54 Factoring in enhanced well-being, mental health, and other outcomes would only further improve the cost–benefit ratio. But ultimately, policymakers and other stakeholders must decide how much they value these improvements in health, relative to other uses of public resources — from spending them on education and other social services to reducing taxes.

There remain many unanswered questions about U.S. health insurance policy, including how to best structure coverage to maximize health and value and how much public spending we want to devote to subsidizing coverage for people who cannot afford it. But whether enrollees benefit from that coverage is **not one of the unanswered questions**. Insurance coverage increases access to care and improves a **wide range of health outcomes**.

• Insurance makes a person 25 percent less likely to die

Sanders 13 – Katie Sanders on Friday, September 6th, 2013"Alan Grayson claims 45,000 people die a year because they lack health insurance" http://www.politifact.com/truth-o-meter/article/2013/sep/06/alan-grayson-claims-45000-people-die-year-because-/) RMT

The figure received a lot of media attention during the national debate over health care reform in 2009, as it was more than twice previous estimates. A team of six researchers from the Department of Medicine at Cambridge Health Alliance, which is affiliated with Harvard Medical School, used their findings to push for universal health care coverage. (Two of the researchers co-founded Physicians for a National Health Program, which advocates for a single-payer health system.)

The report builds upon a trail of research trying to answer the same question: What role does health insurance play in a person's death?

Researchers working with the National Academy of Sciences in 2002 found that uninsured residents often **delay or abstain from screenings** and treatment for cancer or chronic diseases, and they lack access to medications that treat conditions like hypertension or HIV. The researchers estimated 18,000 people between ages 25 and 64 died in 2000 because they did not have health insurance. (People age 65 and older are eligible for health insurance through Medicare.)

That team leaned on a 1993 study published in the Journal of the American Medical Association, which concluded that not having insurance makes a person **25 percent more likely to die** than someone who has it. The 1993 finding came after examining federal medical data throughout 1971-87.

• Health deaths outweigh – health disparities cause more annual US deaths than virtually any war

Sherman 6/29 (Erik, contributor to Forbes, War On Healthcare Could Kill More Americans Than Most U.S. Military Conflicts, Forbes, 6/29/17, https://www.forbes.com/sites/eriksherman/2017/06/29/war-on-healthcare-could-kill-more-americans-than-most-u-s-wars/#3d9d763e5005) PA

The other day I mentioned that the effective value in tax breaks from poor people dying from a lack of healthcare support was $3 million. Although it sounds inflammatory, it's the logical conclusion of the following factors:

The healthcare bills out of the House and, particularly, the Senate are primarily excuses for tax cuts. They don't find ways to get better care to people at more affordable prices as politicians have claimed.

Although they disagree in their final estimates, public health experts have largely agreed that a lack of access to healthcare results in anywhere from 25% to 40% higher mortality rates.

The biggest sources of financial savings in these bills comes from reducing subsidies and greatly cutting back on Medicaid, which makes it more difficult, if not impossible, for poor people to afford healthcare.

The Congressional Budget Office has estimated that the bills would have an additional 22 million to 23 million go without health insurance, which, in the U.S., pretty much means little effective healthcare. (And, no, emergency rooms do not provide a real solution for many reasons.)

An additional 18,000 to 45,000 people would probably die every year. When you divide the total of the $54.1 billion in expected average annual tax breaks by the low end, you have $3 million a dead person. (Use the 45,000 number and it's $1.2 million per person.)

That is a cold financial way of looking at the proposed healthcare strategies, which, given the results, might as well be called the War on Healthcare.

Again, the language is more accurate than inflammatory. A reader, who wished to remain anonymous, had emailed me and pointed out the following:

I had the thought while reading that this represents 6x to 15x the deaths associated with 911 and more American lives dying then all but a few of our larger wars.

I was struck by the observation and did some checking. In the 9/11 attacks, 2,977 people died, not counting first responders and others who would eventually die from complications of injuries or exposure to toxic materials, so the 6 to 15 multiplicative factor would be correct.

As for wars, here is a list of total service deaths in a number of wars along with annual figures based on U.S. participation from the Department of Veterans Affairs:

American Revolution (8 years) — 4,435, 554/year

War of 1812 (3 years) — 2,260, 753/year

Mexican War (2 years) — 13,283, 6,642/year

Civil War (4 years) — 498,332, 124,583/year

Spanish-American War (4 years) — 2,446, 612/year

World War I (1 year) — 116,516, 116,516/year

World War II (4 years) — 405,399, 101,350/year

Korean War (3 years) — 54,246, 18,082/year

Vietnam War (11 years) — 90,220, 8,202/year

Desert Shield/Desert Storm (1 year) — 1,948, 1,948/year

I've deliberated left out the 81 years of wars against Native Americans because the estimated 1,000 military deaths are dwarfed in size by the people whose ancestors had been here long before settlers, voluntary and involuntary.

Even at the lower 18,000 per year figure, a single year of additional deaths is larger than the combined deaths in many of these wars. If you take the 45,000 figure instead and factor that over the ten years of the Congressional Budget Office scoring, then only the Civil War would have resulted in more deaths total. On an annual basis, only the two World Wars and the Civil

War had much larger annual death tolls. The Korean War only came even on the low end of public health estimates of unnecessary deaths from lack of healthcare, which really means lack of affordable healthcare.

A couple of things to remember. First, people have been dying right and left in big numbers for a long, long time because they didn't have access to decent healthcare. We're just noticing this now because as a country we extended access and are now in a position where we're about to pull it away.

Second, given the argument is that the Affordable Care Act, otherwise known as Obamacare, had some significant flaws, why didn't both sides work together to fix things? Yes, Republicans kept on about repeal. But did Democrats make strong efforts to create a bipartisan approach to making necessary changes? It's not as if the shortcomings have only suddenly come to light.

War is always the result of a political decision. Clearly the War on Healthcare is no different, and even with the intensive efforts of GOP elected officials, there is also blame for the Democrats as well.

1AC: Bioterror Attacks

• Bioterror is the coming apocalypse

Farmer 17 (Ben, Telegraph Defense Correspondent, Citing Bill Gates, head of the Gates Foundation which researches outbreak detection and response, "Bioterrorism could kill more people than nuclear war, Bill Gates to warn world leaders", http://www.telegraph.co.uk/news/2017/02/17/biological-terrorism-could-kill-people-nuclear-attacks-bill/)

Bioterrorists could one day kill hundreds of millions of people in an attack more deadly than nuclear war, Bill Gates will warn world leaders. **Rapid advances in genetic engineering have opened the door for small terrorism groups to tailor and easily turn biological viruses into weapons**. **A resulting disease pandemic is currently one of the most deadly threats faced by the world, he believes, yet governments are complacent about the scale of the risk**. Speaking ahead of an address to the Munich Security Conference, the richest man in the world said that while governments are concerned with the proliferation of nuclear and chemical weapons, they are overlooking the threat of biological warfare. Mr Gates, whose charitable foundation is funding research into quickly spotting outbreaks and speeding up vaccine production, said the defence and security establishment "have not been following biology and I'm here to bring them a little bit of bad news". Mr Gates will today (Saturday) tell an audience of international leaders and senior officers that **the world's next deadly pandemic "could originate on the computer screen of a terrorist"**. He told the Telegraph: "**Natural epidemics can be extremely large. Intentionally caused epidemics, bioterrorism, would be the largest of all.** "**With nuclear weapons, you'd think you would probably stop after killing 100million. Smallpox won't stop. Because the population is naïve, and there are no real preparations. That, if it got out and spread, would be a larger number**." He said **developments in genetic engineering were proceeding at a "mind-blowing rate".** Biological warfare ambitions once limited to a handful of nation states are now open to small groups with limited resources and skills. He said: "**They make it much easier for a non-state person. It doesn't take much biology expertise nowadays to assemble a smallpox virus. Biology is making it way easier to create these things**." **The increasingly common use of gene editing technology would make it difficult to spot any potential terrorist conspiracy**. Technologies which have made it easy to read DNA sequences and tinker with them to rewrite or tweak genes have many legitimate uses. He said: "It's not like when someone says, 'Hey I'd like some Plutonium' and you start saying 'Hmmm.. I wonder why he wants Plutonium?'" Mr Gates said **the potential death toll from a disease outbreak could be higher than other threats** such as climate change or nuclear war. **He said: "This is like earthquakes, you should think in order of magnitudes. If you can kill 10 people that's a one, 100 people that's a two... Bioterrorism is the thing that can give you not just sixes, but sevens, eights and nines**. "**With nuclear war, once you have got a six, or a seven, or eight, you'd think it would probably stop. [With bioterrorism] it's just unbounded if you are not there to stop the spread of it**." By tailoring the genes of a virus, it would be possible to manipulate its ability to spread and its ability to harm people. Mr Gates said **one of the most potentially deadly outbreaks could involve the humble flu virus. It would be relatively easy to engineer a new flu strain combining qualities from varieties that spread like wildfire with varieties that were deadly**. **The last time that happened naturally was the 1918 Spanish Influenza pandemic, which went on to kill more than 50 million people** – or nearly three times the death toll from the First World War. By comparison, the recent Ebola outbreak in West Africa which killed just over 11,000 was "a Richter Scale three, it's a nothing," he said. But despite the potential, the founder of Microsoft said that world leaders and their militaries could not see beyond the more recognised risks. He said: "Should the world be serious about this? It is somewhat serious about normal classic warfare and nuclear warfare, but today it is not very serious about bio-defence or natural epidemics." He went on: "They do tend to say 'How easy is it to get fissile material and how accurate are the plans out on the internet for dirty bombs, plutonium bombs and hydrogen bombs?' "They have some people that do that. What I am suggesting is that the number of people that look at bio-defence is worth increasing." **Whether naturally occurring, or deliberately started**, **it is almost certain that a highly lethal global pandemic will occur within our lifetimes**, he believes.

• Bioterror attacks cause extinction

Myhrvold, 13 – PhD in theoretical and mathematical physics from Princeton, and founded Intellectual Ventures after retiring as chief strategist and chief technology officer of Microsoft Corporation (Nathan, Strategic Terrorism: A Call to Action, The Lawfare Research Paper Series

No.2,
http://www.lawfareblog.com/wp-content/uploads/2013/07/Strategic-Terrorism-Myhrvold-7-3-2013.pdf)

A virus genetically engineered to infect its host quickly, to generate symptoms slowly—say, only after weeks or months—and to spread easily through the air or by casual contact would be vastly more devastating than HIV. It could silently penetrate the population to unleash its deadly effects suddenly. This type of epidemic would be almost impossible to combat because most of the infections would occur before the epidemic became obvious. A technologically sophisticated **terrorist group could develop such a virus and kill** a large part of **humanity** with it. Indeed, terrorists may not have to develop it themselves: some scientist may do so first and publish the details.¶ Given the rate at which biologists are making discoveries about viruses and the immune system, at some point in the near future, someone may create artificial pathogens that could **drive the human race to extinction**. Indeed, a ¶ detailed species-elimination plan of this nature was openly ¶ proposed in a scientific journal. ¶ The ostensible purpose of that particular research was ¶ to suggest a way to extirpate the malaria mosquito, but ¶ similar techniques could be directed toward humans.16 ¶ When I've talked to molecular biologists about this method, they are quick to point out that it is slow and easily ¶ detectable and could be fought with biotech remedies. If ¶ you challenge them to come up with improvements to the ¶ suggested attack plan, however, they have plenty of ideas.¶ Modern biotechnology will soon be capable, if it is not already, of bringing about the demise of the human race—¶ or at least of killing a sufficient number of people to end ¶ high-tech civilization and set humanity back 1,000 years or ¶ more. That terrorist groups could achieve this level of technological sophistication may seem far-fetched, but keep in mind that it takes only a handful of individuals to accomplish these tasks. Never has lethal power of this potency been accessible to so few, so easily. Even more dramatically ¶ than nuclear proliferation, modern biological science has ¶ frighteningly undermined the correlation between the lethality of a weapon and its cost, a fundamentally stabilizing ¶ mechanism throughout history. Access to extremely lethal agents—lethal enough to **exterminate Homo sapiens**—will be available to anybody with a solid background in biology, terrorists included.¶ The 9/11 attacks involved at least four pilots, each of ¶ whom had sufficient education to enroll in flight schools ¶ and complete several years of training. Bin laden had a degree in civil engineering. Mohammed Atta attended a German university, where he earned a master's degree in urban ¶ planning—not a field he likely chose for its relevance to ¶ terrorism. A future set of terrorists could just as easily be students of molecular biology who enter their studies innocently enough but later put their skills to homicidal use. ¶ Hundreds of universities in Europe and Asia have curricula ¶ sufficient to train people in the skills necessary to make a ¶ sophisticated biological weapon, and hundreds more in the ¶ United States accept students from all over the world. ¶ Thus it seems likely that sometime in the near future a small band of terrorists, or even a single misanthropic individual, will overcome our best defenses and do something truly terrible, such as fashion a bioweapon that could kill ¶ millions or even billions of people. Indeed, **the creation of such weapons within the next 20 years seems to be a virtual certainty**.

• Universal coverage is the foundation for any effective response to disease or a bioterror attack – coverage gaps ensure piecemeal responses

Kahn 17 (Laura, researches public health, biodefense, and pandemics at Princeton University's Program on Science and Global Security, author of One Health and the Politics of Antimicrobial Resistance, previously FDA, "Why access to health care is a national security issue," Bulletin of Atomic Scientists, 6/5/2017, http://thebulletin.org/why-access-health-care-national-security-issue10819)//duncan

Early last month, US House Republicans rammed through the American Health Care Act, a remarkably regressive piece of legislation that, among other flaws, would be disastrous for pandemic planning and preparedness. The bill eliminates funding for the Prevention and Public Health Fund,

which was created under the 2010 Affordable Care Act to invest in vaccination programs, electronic laboratory reporting of infectious diseases, and infection-prevention programs. Vaccines are an **important preventive strategy** against **deadly pandemics**, while electronic lab reporting facilitates a rapid response to disease. In other words, these are precisely the funds that will be needed to prevent the next Ebola or Zika virus from turning into a **national catastrophe**.

In late May, the Congressional Budget Office delivered its projections on the House bill's costs and impacts, finding that it would leave an estimated 51 million people under the age of 65 uninsured by 2026—23 million more than the estimated 28 million who will be uninsured under the current law. A Senate version of the bill may not pass, which would end Congressional Republicans' umpteenth attempt to undermine or reverse the Affordable Care Act. But we can be sure their fight will continue, and that **has important national security implications even beyond slashing emergency-planning funds (which**, by the way, **Trump's** proposed federal **budget** also **does**).

Cutting the Prevention and Public Health Fund, which deals directly with planning for bioterror attacks and pandemics, was only the most obvious way in which the House bill attempted to undermine American security. Over the long term, there is also a movement afoot to put basic health care out of reach of many Americans. Simply **making healthcare unaffordable** may seem less dramatic than slashing an emergency-preparedness budget, but doing so also **undermines national security**.

As the Congressional Budget Office report suggests, the American Health Care Act would make healthcare essentially unaffordable for people with pre-existing conditions, because it would allow insurance companies to dramatically increase their premiums. Ten years ago, I wrote about the security impact of the uninsured during the George W. Bush presidency. In 2005, almost 47 million people (about 16 percent of the total US population) were uninsured. Thanks to the Affordable Care Act passed under the Obama administration, that number dropped to a low of 11 percent, according to a Gallup poll taken during the first quarter of 2016. The Affordable Care Act was a big step in the right direction, but it **didn't close the gap**, and the **national security** and public health **challenges** of having a large fraction of the population uninsured remain as **relevant today** as they were a decade ago.

Uninsured people delay seeking health care. Once they seek it, often in a busy emergency room, they are typically given less attention than people with insurance. This failure to get care becomes a danger not only for the individual but for the public at large when the problem is a **deadly infectious disease**. We saw this scenario play out in Dallas during the Ebola crisis of 2014 and 2015. A poor Liberian man, infected with the virus, presented himself to Texas Health Presbyterian Hospital with severe abdominal pain and a high fever. He was examined and sent home with a bottle of antibiotics. Amazingly, he did not set off an Ebola outbreak in his community, though the risk that he could have was significant and the wider public shouldn't count on being so lucky next time. Before dying, he infected two nurses who had received inadequate training and equipment to protect themselves.

During the anthrax crisis of 2001, in which spores of the deadly disease were sent through the US mail, many people infected were federal employees with health insurance. **If** these postal **workers hadn't had easy access to health care,** the **death toll might have been higher** than only five; 17 more were infected but survived thanks to timely medical attention. Anthrax spores do not spread from person to person, but it's no stretch to imagine a different scenario: Suppose a future attack involves smallpox, a highly communicable virus, and that the initial victims are uninsured childcare workers or food handlers. The initial signs of smallpox include fever, chills, and headache. Uninsured victims would likely delay trying to get care, hoping for the symptoms to pass. By waiting they would certainly expose others to the virus, **potentially setting of a pandemic**.

Countries like Canada, which has universal health coverage and a well-funded public health infrastructure, are much better prepared to handle deadly epidemics. In 2003, Canada confronted Severe Acute Respiratory Syndrome (SARS), which originated in China. A physician from Guangdong province inadvertently infected a number of tourists with the SARS virus, setting off a global pandemic after everyone returned to their home countries. Among the infected travelers was an elderly Canadian woman who returned to Toronto after a 10-day vacation in Hong Kong.

Over the course of about four months, the Canadian health system worked hard to contain the virus, treating 400 people who became ill and quarantining 25,000 Toronto residents who may have been exposed. Ultimately, 44 people died from the disease in Canada, but the result would have been much worse without a quick and well-organized response.

The Canadian government's response had its glitches—primarily in the form of poor political leadership. Mel Lastman, the mayor of Toronto and a former furniture salesman, became angry when the World Health Organization (WHO) issued a travel advisory against his city. He railed against the WHO's decision on television, revealing his complete lack of knowledge about either the organization or public health in general. As a result of Lastman's poor leadership, he was ultimately relegated to a secondary role as the deputy mayor took his place. Lastman's credibility and legitimacy never recovered from the SARS outbreak. Likewise, US leaders will be judged by how they handle a bioterrorist attack or pandemic.

Unlike Canada, America's **piecemeal** healthcare and public health systems are **inherently less able to handle such crises**. The Affordable Care Act helped fill in the gaps, but really, the only way to prepare for the eventuality of pandemics or bioterrorist attacks is with a single-payer government-run system that covers everyone. The United States might consider modeling its health care system after the one in Israel, a country that, given longstanding threats, takes every terrorist risk very seriously. In 1994, it established universal health coverage for all citizens. The country's Ministry of Health monitors and promotes public health, oversees the operations of the nation's hospitals, and sets healthcare priorities. As a result, Israel's public health, emergency response, and hospital systems are state-of-the-art, highly efficient, and coordinated—a necessity when responding to terrorist attacks.

The preamble to the US Constitution states the goals to "provide for the common defense" and "promote the general Welfare." The US government won't fulfill either of these duties if it fails to protect its citizens against pandemics and bioterrorism. **The mandate requires a robust public health infrastructure and a universal healthcare system that covers all Americans.** The Trump Administration and Congressional Republicans threaten to undermine this essential function of government, unnecessarily jeopardizing American lives.

• Access to care acts as an active deterrent to potential bioterror attacks

Kosal 14 – Margaret E. Kosal, PhD, Georgia Institute of Technology, Sam Nunn School of International Affairs ("A new role for public health in bioterrorism deterrence". December 10th, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4261597/pdf/fpubh-02-00278.pdf)

This commentary will explore the creation of new relationships between deterrence, infectious disease, and public health to reduce the threat of biological terrorism and increase international security. **Examining the global spread of re-emerging infectious disease**, such as the re-emergence of polio from northern Nigeria, **offers a novel case study for thinking about how to deter potential bioterrorists** who seek to use infectious disease. Polio outbreaks have more directly affected the developing world compared to the US or other nations with robust public health sectors. This example suggests that a bioterrorist attack would also be more devastating for developing countries in low-resource settings compared to the western world. Credibly, communicating this may offer a new approach to deterring bioterrorism by foreign actors. Although a robust public health sector has long been noted to reduce the vulnerability to a bioterrorism attack, **actively promoting the strength of US public health can also serve as a powerful deterrent** in its own right. **The issue of terrorist groups utilizing biological weapons against other states is a mounting concern, yet little deterrence research in the field of political**

science addresses methods of dealing with the threat of bioterrorism. Thus, creating new conversations among the life sciences, public health, and political science can lead to new perspectives on deterring bioterrorism. **The issue of bioterrorism deterrence,** if addressed, **has been often** added or **subsumed under the auspices of deterrence strategies associated with nuclear weapons.** In the second half of the twentieth century, nuclear deterrence dominated geopolitics and national security strategies. At its height, the threat of mutually assured destruction (MAD) existed in which both superpowers possessed arsenals with second-strike capabilities, i.e., the ability to respond to a first nuclear strike on land via use of nearly undetectable submarine-launched ballistic missiles with nuclear warheads. These **historical approaches**, however, **undermine and oversimplify the distinct challenges of deterring bioterrorism**. One such method attempted is focusing on pathogen security, or securing and denying access to the materials necessary to develop biological weapons (i.e., deterrence by denial). Based on the nuclear non-proliferation model, pathogen security strives to control the materials, equipment, and personnel involved with production and use of biological agents. **With nuclear weapons, controlling fissile materials proved successful because of key characteristics of the critical materials: fissile material is man-made and can be tracked. Those same characteristics** that make nuclear weapons easier to track are those that **make biological weapons material difficult to monitor**. **These characteristics include the presence of biological agents in nature, lower production costs, increased diversity of materials** that could be used in bioweapons attacks, **and multiple legitimate uses for biological materials**. These differing features have not always been fully considered by policy-makers (1). Rather than focusing solely on securing biological materials and laboratories from misuse, other recommendations and strategies that the US has pursued include prevention measures such as biosurveillance, global laboratory and research cooperation, research and development of diagnostics and countermeasures,international stockpiles of effective medical countermeasures, and increased response and mitigation capabilities (2–6). These approaches aim to reduce consequences of an attack, afford earlier detection, and reduce vulnerability; they do not address the challenge of deterring use and reducing motivation directly, however. To date, discussions about **public health and deterrence have focused on measures such as regular vaccinations**; **access to timely medical care** to treat infected, **isolate suspected infected, and mitigate the spread of disease**; confidence in the professional nature of health providers, etc. These are largely passive, **defensive deterrence measures**, in that they **demonstrate credible capacity by a state to respond and mitigate the consequences of an attack** (post-exposure) **or reduce vulnerability to an attack by making it ineffective** (preexposure) (7–9). Both approaches mentioned thus far, pathogen security and a defensive approach to terrorism, which ultimately aim to decrease vulnerability by fortifying civilian populations, are examples of deterrence by denial adapted from the realm of nuclear deterrence. In contrast to these passive approaches, active deterrence strategies have not been explored. **Active deterrence is actions and policies preventing a specific opponent from doing something they may wish to do.** Traditionally, robust active deterrence has involved the application of expressive force to change the policy or character of the target government or group (10). **Forces and policies are used to send a political message**. In contrast to passive strategies, active deterrence is more dynamic and may incorporate escalating threats in response to an adversary. What this would look like at the nexus of international security and public health is largely an unexplored area of study or policy. Therefore, there are limited models for thinking about deterrence that have been developed exclusively for bioterrorism. As

a consequence, the role of a robust public health system for twenty- first century active deterrence remains to be explored. **There has not been a substantive consideration of robust public health system as a strategic asset in a more active deterrence role.**

1AC: Inequality

• Replacing private insurance redistributes wealth towards minorities and the poor.

Caruso et al 15 – MD/MPH Candidate, *MD, *MD (Dominic, David Himmelstein, Steffie Woolhandler, Single-Payer Health Reform: A Step Toward Reducing Structural Racism in Health Care, July, Harvard Public Health Review Volume 6, http://harvardpublichealthreview.org/single-payer-health-reform-a-step-toward-reducing-structural-racism-in-health-care/)

Racial and income equality are too often absent from conversations about health care financing. Research continually exposes alarming health disparities in the United States, particularly impacting African Americans and Native Americans. These groups have lower life expectancies than non-Hispanic white Americans, and experience higher rates of most major causes of death including infant mortality, trauma, heart disease, and diabetes. Yet despite their greater need, access to care is worse for minority populations by most measures.8

Unequal medical care is often viewed as a consequence of broader social inequalities, but **the current health financing system also reinforces and institutionalizes inequality; unequal care may be viewed as a form of structural racism.**

While most Americans rely on private insurance, rates of private coverage are much lower for minorities and the poor.9

The Patient Protection and Affordable Care Act (ACA) offered subsidies to expand private coverage, making insurance more affordable for many families. However, many of these new private plans carry high deductibles and co-payments. Deductibles for the ACA's bronze and silver plans average over $5000 and $2900, respectively, for single coverage, and over $10,000 and $6,000, for family coverage.10

Deductibles have also soared in employer-sponsored plans; in 2014, more than 40% of such plans carried a deductible of more than $999, up from just 10% in 2006.11 Moreover, while Medicaid traditionally imposed virtually no cost-sharing, several conservative state governors have extracted waivers from the Centers for Medicare and Medicaid Services allowing the imposition of cost-sharing on recipients as a condition for implementing the ACA's Medicaid expansion.1213

High cost-sharing particularly impacts minority families, whose average incomes are far lower than those of non-Hispanic whites. Yet even figures on income disparities understate minorities' disadvantage when confronted with high out-of-pocket costs. With medical bills often reaching into the thousands for even routine care such as childbirth and appendectomy, many families must tap savings or other assets like housing equity, and racial/ethnic disparities in assets dwarf the differences in income. 14 African American and Hispanic median household income was 58 percent and 70 percent, respectively, that of non-Hispanic whites in 2011.15 In contrast, the median net worth of black and Hispanic householders was $6,314 and $7,683, respectively, vs. $110,500 for non-Hispanic whites, a 15-fold difference.16 Hence, the average family deductibles for bronze and silver plans would bring financial ruin to most African American and Hispanic households. Even the lower cost-sharing now increasingly common under Medicaid may be prohibitive for poor families, many of whom have zero or negative net worth.

The ACA's drafters erred in relying on private, for-profit insurers to fund health care. Health insurance's social purpose is to pay for care in order to promote access to health services and prevent financial hardship. For-profit insurers' purpose is to maximize shareholders' profits, a goal that provides strong incentives to maximize premiums and minimize the health care they pay for. Historically, this incentive led to such practices as denying coverage for pre-existing conditions and canceling policies for expensive enrollees. Although the ACA prohibits these tactics, recent evidence indicates that insurers are finding ways to subvert these regulations, e.g. through tiered pharmacy benefits that discriminate against enrollees with potentially expensive illnesses such as HIV, Parkinson's, seizures, psychosis and diabetes. 1718

The persistence of our corrupt and irrational insurance system may stem in part from the way Americans (and particularly health professional students) are taught to think about health care. In a recent conversation with a Canadian student at Harvard's school of public health, he expressed surprise that many of his U.S. classmates perceive health care interactions as business transactions, and reflected that Canadians, who have a publicly-funded universal coverage system, view health care as a fundamental right to be provided for all.

Should we in the U.S. continue to treat health care as a commodity distributed according to financial ability, or shift to a financing system that assures it as a right equally available to all without regard to income, health status, race or ethnicity? While market theorists might claim that a commodity-based approach to care breeds efficiency, facts on the ground argue otherwise. At present, we have the world's highest per-capita health care expenditures, yet tens of millions remain un- and under-insured, and our health outcomes trail most other wealthy nations.[9]192021

This isn't just an indication of failed policy, it's a national embarrassment. We have the resources to provide everyone in the U.S. with access to health care. And Canada provides a working model for how to put those resources to good use: a public, single-payer, national health insurance program, similar to an expanded and improved Medicare for all.

In our view a national single-payer health insurance program offers the best possibility for equitable financing of U.S. health care. It would eliminate the motive to deny needed care or discriminate against the expensively ill for the sake of profit. A national public insurance system would provide coverage based on residence in the U.S., not employment status, income level or ability to pay, as in the current regime. A program that abolished co-payments and deductibles would **level the playing field** for minorities and the poor who generally lack the assets to surmount these barriers.22

A single-payer system would also offer economic benefits. A federally-run financing system would have far lower administrative costs than private insurance, as the Medicare program consistently demonstrates. A universal public model would lift a significant financial burden from businesses that currently fund health insurance for their employees. Finally, a single-payer program would largely eliminate the financial burden of illness, a leading cause of bankruptcy and debts sent to collection.[19].23

Perhaps most importantly, a single-payer system would make a clear statement that health care is a human right. This framework recognizes health care as a universal necessity, not a commodity reserved for those lucky enough to have won the economic lottery, and most definitely not a scheme for denial and discrimination. While implementing a single-payer insurance program will not solve all of our nation's health, racial or social inequities, it is clearly a step in that direction.

• The squo is heavily unequal because of economic disparities---single payer solves by removing the financial incentive for disparate treatment

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The US healthcare system provides **unequal care**. Just as life expectancy is determined by **which neighborhood you live in**, for many Americans what **hospital or doctor you can see** is influenced by **neighborhood, insurance, race, and ethnicity**. And if you live in a high-mortality neighborhood, a trip to the local hospital might just be a matter of life and death. There are **three major reasons** why health care delivery in the United States is not equitable. The first is that health care is **treated as commodity, not a right**. The poor (with or without insurance) living in neighborhoods of concentrated disadvantage often have more **limited access to quality health care**.2 Those who are **uninsured and underinsured** experience **great difficulty accessing needed care**.3 Minorities and the poor are **less likely** to have private health insurance than white middleclass Americans.4 When minorities and the poor do have insurance, it is more likely to be one of the **publicly funded** insurance policies that not all hospitals and doctors accept. The second reason is that minorities sometimes get different treatment for the same illness from what whites get, regardless of insurance. Health care providers' **implicit racial bias** and **patients' mistrust** may be the causes of this differential treatment.5 The third reason why health care delivery is unequal is that the health care institutions that serve the poor in general **suffer from cash and capital shortages**. Neighborhoods of concentrated advantage where people with better insurance live have

better-resourced hospitals and clinics than poor neighborhoods do. This is **how structural violence works within the fabric of** the **health care** system. It is not as if great care **cannot** be delivered in underserved settings. **It is, every day**. But it is **inconsistent or constrained** by a lack of resources. Thus minorities and poor people **die disproportionally** a10 More than half were missed. Add to this injury the insult a black woman feels later when she goes to see a doctor with a bad cancer and is told that her genetics are at fault. Institutional racism as a structural cause of increased mortality can sometimes be as banal as a **poorly qualified doctor** missing a cancer in a poorly run mammography center. In a Chicago study of missed breast cancers, poor women, minority women, and publicly insured women were significantly more likely than well-insured white women to have their cancers missed (they were there on the mammogram on a lookback.)11 Socially disadvantaged women (poor, minority, and uninsured) are significantly more likely to have a cancer missed on mammography because they are more likely to receive care at substandard facilities, in segregated neighborhoods, than advantaged women are.12 Even if women of color **do everything right**—get screened, schedule follow-up appointments—they can still fare worse than white women simply by virtue of **where they live.** This is not just a product of poverty, though poverty itself is a big predictor of inequity. There are plenty of poor white women in Chicago, but there is not one poor white Chicago neighborhood.13 Poor white women can get their breast care in the same neighborhood hospitals as the more wealthy women in their neighborhoods. This is structural violence and institutionalized racism at work. We released a report.20 It confirmed that **access to quality of care** was responsible for the wide racial gaps in breast cancer mortality. , in too many areas and on too many levels we are still dealing with the **most basic inequities and prejudices. Bias**, even if **unconscious**, affects **individual physicians and their treatment decisions**. This is **unsettling but true**. While most doctors do not exhibit **explicit** racial bias, such as refusing to treat certain patients because of their race, on tests of **implicit bias** they, too, show **unconscious preferences** for whites over dark-skinned faces. The Implicit Association Test is a widely used test of social cognition. More than 70 percent of the millions of Americans who have taken it exhibit a subconscious preference for whites over blacks.30 Physicians score similarly. An ingenious 1999 experiment showed how unconscious bias **affects clinical decision making**. **Thousands** of doctors were asked to test their clinical acumen by **reviewing the medical history** given by a performer who acted out the symptoms of a potential cardiac syndrome on film.31 There were eight elderly patients. Four were men: two white and two black. Four were women: two white and two black. Physicians were asked to recommend a cardiac workup based on the clinical information the patients relayed. In addition, physicians were told whether the patient was insured or uninsured. The results were not surprising. Based on the gender, race, and insurance status of the patient, doctors recommended **entirely different medical workups**. What needs to be done to address implicit bias in medicine? **Awareness** is a start. Mandatory **bias testing** and **cultural intelligence training have been proposed**. But it requires **day-to-day interactions between people of different backgrounds** to break the implicit boundaries that prevent deeper understanding.35 And that's necessary, but fair. But bias is only a **piece of the story.** Having No Insurance Is Bad for Your Health Another major factor driving inequitable care is **lack of health insurance**. Uninsured adults are far more likely than those with insurance to **postpone or forgo health care altogether**. **Twenty-five percent** of adults without coverage say that they went without care in the past year because of its **cost**, compared to 4 percent of adults with

private insurance coverage. Moreover, 55 percent of uninsured adults do not have a regular place to go when they are sick or need medical advice.36 When uninsured patients get injured or develop a chronic disease that requires follow up, they are less likely than those with coverage to actually **obtain all the services that are recommended**.37 Blacks and Latinos are more likely to be uninsured than whites, which only increases the burdens of health care inequity borne in neighborhoods of concentrated poverty. Prior to the Affordable Care Act, an estimated 45,000 residents died each year due to a lack of insurance, or one person every twelve minutes. If being uninsured was a cause of death, it would be the tenth most common one in the United States.38 The next chapter will deal further with the issue of health insurance. Apartheid Hospitals Once people do get insurance, there is **no guarantee they will get good treatment**. As Nobel Prize winner Angus Deaton has noted, "Hospitals in the United States are run on something close to an apartheid basis with few white patients in the hospitals that treat mostly African Americans and vice versa."39 Hospitals in which the majority of patients served are minorities have higher mortality rates across the board, whether from trauma, cardiac surgery, or general surgery procedures. In fact, as the percentage of minority patients served increases at an institution, so do the mortality rates across many conditions. There seems to be a direct correlation between the proportion of minority patients served by a hospital and death rates.40 Take trauma care as an example. Trauma centers that serve mostly minority patients have higher mortality rates than those that serve mostly white patients. There is a gradation of trauma mortality based on the percentage of minority patients served by the trauma center. Those trauma hospitals with fewer than 25 percent minority patients have 60 percent better trauma survival rates than trauma hospitals with more than 50 percent minority patients. Hospitals with 25–50 percent minority patients have trauma mortalities in between the two.41 Why would this be? Trauma centers require specific levels of physician and other staff coverage, and they require periodic rigorous certification. Shouldn't this attention and regulation lead to better care, regardless of race and ethnicity? There are only two possibilities. One is that trauma severity or high-risk conditions are more prevalent among patients in institutions that serve mostly minorities. However, even when severity of illness is controlled for, minority trauma centers have 37 percent higher mortality rates than those serving mostly whites. The other possibility is that the care is actually unequal. I have shown how this is true for breast cancer care. It seems to be true for many conditions. What hospital you attend is literally a matter of life and death. In general, hospitals and clinics where many minority patients receive care are **lower quality than those that serve white populations**, whether for medical or surgical conditions.42 Further, hospitals treating a higher proportion of black patients have **higher mortality rates for many surgical procedures**. In addition, these hospitals have higher mortality rates **independent of race**: both black patients and white patients have higher mortality in hospitals with mostly black patients than their racial counterparts in other centers.43 The federal Center for Medicare and Medicaid Services recently created a national star ranking system for hospitals, to allow consumers a means to assess hospital quality. A hospital can be ranked from five stars to one star, with five stars denoting a very high quality hospital with lower mortality and one star being a low-quality hospital with high mortality.44 In practice, star rankings vary by the whiteness of the hospital's clentele. Five- and four-star hospitals in America serve patient populations that are predominantly white. One- and two-star hospitals in America serve predominantly minority paitients and very few whites. This is true for care at **clinics** as well as hospitals. The doctors who work at clinics that care for predominantly black and other minority populations are less likely to be board certified, have less access to specialty consultation, and work in more chaotic conditions. It is not a matter of the patients' race or ethnicity. Hospitals and clinics in poor neighborhoods, those that serve uninsured populations or those on Medicaid, often do not have enough resources to provide the very best care.45 What seems at first blush to be a racial disparity is actually a consequence of structural violence and institutionalized racism. Just follow the money. Let's compare the cash situations at two Chicago hospitals, both trauma centers. During my decade at Mount Sinai Hospital, located in a low-income black neighborhood, 20 percent of the patients had no insurance. Another 60 percent had Medicaid. The patient population served is virtually 100 percent black and Latino. If a white person happens to be hit by a car down the street from Sinai, then they might be brought there. Otherwise a white patient, or anyone who is well insured, would rarely set foot inside Sinai. Then there's Northwestern Memorial Hospital. One of the top hospitals in the United States, on the US News and World Report Honor Roll, it towers over Lake Michigan about five miles from Sinai, in Chicago's predominantly white Streeterville neighborhood. It has an A bond rating, and about 500 days of cash brimming in its accounts. This translates to $2 billion in bank reserves. Most of Northwestern's largely white patient population has private insurance. A small number are uninsured. During my time at Sinai, there were often only a few days of cash on hand. Sinai had no bond rating—meaning no bank would lend it money for capital investments. Just as Lawndale had been redlined seventy years prior, Sinai and other hospitals that serve poor communities are redlined by the banking industry today, limited in their ability to borrow. Sinai has been an anchor in the Lawndale neighborhood since 1919, and it takes care of everyone who comes to its doors, regardless of ability to pay. The price of this noble mission is a hospital's equivalent to a vow of poverty. From a banker's perspective Sinai is a bad investment. Compare Northwestern and Mount Sinai's spending on capital in 2012. Capital dollars reflect the amount of money that a hospital has to spend on patients, doctors, equipment, and upgrades. Northwestern spent $273 million on buildings and equipment. Sinai spent just $6 million.46 The failure of capital markets to support Sinai contributed to its chronic struggles to maintain service quality. If we really want to achieve equity in health care outcomes, then we have to invest more into the institutions serving those who need care the most, like Sinai. This means redistributing capital dollars based on need from Northwestern and its neighborhoods to invest in Sinai and its Lawndale neighborhood. This is just the opposite of how the American health care system works. In America we have arranged it so those who need it the most (often black people and other minorities) get less, while those with the most (white and affluent people) get the best care and facilities available in the world. It is no surprise that life expectancy in Northwestern's neighborhood is 85 years. In Sinai's neighborhood it is 72 years.47 Failure to Rescue When it comes to providing the highest quality of care, volume matters. The doctors and the nursing staff who are exposed to high volumes of particular kinds of cases have more time to hone their skills, and this leads to better outcomes. A surgeon who does liver transplants every week is better at them than one who does one per year. As for complex surgical conditions where high volumes of cases are crucial to achieve the best outcomes, nonwhite patients are more likely than whites to receive them at low-volume institutions. These patients are also less likely to be rescued if they deteriorate postoperatively. Procedural complication rates are exactly the same at high-mortality and lowmortality hospitals. So what is the reason for the death gap? The answer is culled failure to rescue. When a sick patient gets a complication, the doctors and nurses have to recognize and treat it—that is, rescue the patient from dying. Hospitals with well-developed systems to recognize complications and rescue patients have lower mortality.48 While all the components of rescue have not been identified, adequate nurse staffing and training is critical. The hospitals with the least capability to rescue—due to nursing shortages, lack of training opportunities for staff, or other factors—serve significantly more minority patients and suffer higher mortality rates.49 Truth or Consequences Cardiac surgery at Mount Sinai Hospital is an example of a low-volume and high-mortality program. Its struggles are instructive for understanding the day-to-day decisions in a poor hospital and how they lead to health inequities. When I worked there, the heart surgery program was small—about fifty cases each year. Programs this small have trouble maintaining quality because there is not enough repetition for all the staff who need to be in top form. In addition, because the capital investments required to maintain the service were so high, Sinai managers thought the limited capital we had should be invested elsewhere. So we closed the program and partnered with a nearby, higher-volume academic medical center (University of Illinois) to take our patients. It made sense. The neighborhood did not need a small, poorly functioning heart-surgery program. Then one day we had a patient in the cardiac-care unit with three blocked coronary arteries. He needed emergency bypass surgery. Our cardiologists inserted a special pump into his aorta to boost to his failing heart until lifesaving cardiac surgery could be performed. Time was critical. But the patient was uninsured, and the University of Illinois refused the patient. In desperation I phoned the chief of cardiology there. He recommended that the patient be discharged from Sinai and instructed to walk into the University of Illinois emergency room. Then, he said they would be required to treat him. I was shocked. Not only was this immoral, but it was medical malpractice. The patient was hooked to life support, teetering on the edge of death with an artificial heart pump attached to a blood vessel in his groin. Without surgery soon he would surely die. It took a call from our CEO to U of I's CEO to get this patient transferred. After this event, against their better judgment, our cardiologists urged our CEO to restart cardiac surgery at Mount Sinai. Despite the low volumes, inability to guarantee quality, and high capital costs, it became a necessary investment. These are the choices faced by safety- net hospitals in communities of concentrated disadvantage. Provide nothing and let patients die from neglect; or provide the best care you can, at risk of higher than desired mortality, and hope to pull most patients through. More broadly, a 2014 study evaluated cardiac-surgery mortality in patients insured by Medicare. Nonwhite patients succumbed at a 33 percent higher rate than whites (after risk factors were controlled for). Thirty-five percent of the death gap was due to deficiencies in hospital quality. The highest-mortality hospitals were those that served predominantly minority populations. Both white and black patients who received their heart surgery at predominantly minority hospitals had higher mortality rates, suggesting structural factors were responsible. When we speak of institutionalized racism as a structural cause of premature death, it is not the virulent type of racism that we associate with opposition to the civil rights movement of the 1960s. It's a more banal but deadly form of brutality woven into the tapestries of our institutions and thus harder to eradicate. I was not shocked by the study's findings.501 knew that race itself—as a social marker—was not the reason for the cardiac mortality gap at predominantly minority hospitals; it was our tolerance for inequality in quality across our health care system. This becomes even more obvious when we contrast these findings with the outcomes in the Veterans Administration system, where care is structured the same way nationwide. In the VA system there is no equivalent racial heart-disease death gap.51 Inequality in Quality and Unequal Treatment It is not only in majority minority hospitals that black health-care inequities exist. When black and brown patients receive medical care in any setting, they are **more likely than white patients to receive unequal care.** This was documented in the Institute of Medicine's shocking Unequal Treatment report, which synthesized hundreds of studies of age, sex, and racial differences in medical diagnoses, treatments, and health care outcomes. The report concluded that for almost every disease studied, black Americans received less effective care than white Americans. These disparities prevailed even among groups with identical socioeconomic or insurance status. Minority patients received fewer recommended treatments for diseases ranging from AIDS to cancer to heart disease.52 How much of the treatment gap is related to implicit bias, patient mistrust, physician practice style, or systematic organizational dysfunction is not known, but these gaps have persisted over the decade and more since the Institute of Medicine report.53 Each year since 2003, the Agency for Health Care Quality and Research has tracked progress on health care inequity across America, analyzing more than 250 quality measures across a broad array of settings and services. In the 2014 report, the agency reported no overall improvement in racial health disparities from prior years. Not one iota. The American Hospital Association Pledge In 2015, in response to years of intractable health care inequities, the American Hospital Association called upon CEOs of hospitals across America to sign a pledge to measure health inequities within their own institutions and to fix them. The Equity of Care Campaign to End Healthcare Disparities focus is on four areas. First, hospitals are to choose a quality measure that is important to their community. Next, they are to develop a plan to address a disparity, whether by race, ethnicity, or language preference. Third, hospitals are asked to provide cultural competency training for all staff or finalize a plan to do so. Finally, hospital operations teams are asked to initiate a dialogue with the board and leadership team about this disparity work.54 After over a century of documented health-care disparities, this step is important. But it is hardly enough. The nation's hospitals have been **organized for the most part to make money by attracting the best clientele with the best insurance policies**. For most hospitals this means **avoiding poor and minority neighborhoods.** Those frayed and capital-poor hospitals that have made it their mission to care for poor and uninsured often **struggle in poverty like their clients**. Just as the neighborhoods of **concentrated disadvantage** were created by **white and industrial flight** and the expansion of neighborhoods of concentrated advantage, a **similar phenomenon has occurred in health care**. The nation's wealthiest health care systems for the most part have avoided serving the residents of concentrated disadvantage by **placing offices and hospitals only in white communities of advantage**. So pledges are well and good, but without larger **structural changes that level the insurance** and capital decisions that underpin the health care system, health care equity will **continue to be elusive**. Only with **national health insurance reform that begins with the idea of health as a human right could these structural issues be resolved**. The Affordable Care Act, the most recent response to the need for health care reform, has tried to address these issues. However, as we will see, it has been an inadequate solution so far. HEALTH INSURANCE IN AMERICA You guys are evil. Canada's the best country in the world. We go to the doctor and we don't have to worry about paying him, but here your whole life you're broke because of medical bills.1 J U S T I N B I E B E R It will not do to note that under the Affordable Care

Act almost 90 percent of Americans currently have some form of health insurance, any more than it would do for a hotel to note that 90 percent of the time the roof over your bed does not leak when it rains.2 **Of all possible ways to remedy structural violence in America**, the creation of an **equitable universal health-care system based on the idea that health care is a right, not a commodity, ranks high**. While the health care law was a reform of the old system that saw fifty million Americans uninsured, the Affordable Care Act **perpetuates health care inequity** and **fragmentation** by its very design. Yet if Republican calls to repeal the law are heeded, we will be back to square one. And bad will revert to worse. I was not surprised that the solution for universal health care in the United States would be to prop up the existing costly, inequitable, and inefficient insurance system. In 2003 my wife and I cosponsored a fundraiser in Chicago for the then little-known Illinois state senator Barack Obama, who was running for the US Senate. In the living room of a modest single-family home in the neatly manicured South Shore neighborhood of Chicago, I asked the future president his position on national health-care reform. His words presaged what came to be known as "Obamacare." "I'm a proponent of a single-payer system," he responded. But he explained that the political power held by the health insurance companies was so formidable that opposing them would be political suicide. He noted that the insurance industry had over 250,000 employees across the country and a lobbying apparatus that had to be reckoned with in any drive for universal health care. "Single payer will never get passed in the United States," he concluded. He was correct. Single payer did not even get a hearing. The Affordable Care Act was a modest reform of the existing taxed healthinsurance system, which treats health care as a commodity, not a human right. The coverage provisions in the Affordable Care Act built on and attempted to fill in the gaps in a piecemeal system that had left many without affordable coverage. There have not been impressive gains since the passage of health reform.3 A net of twenty million more people gained health insurance coverage between 2013 and 2015. Medicaid has expanded in thirty-two states and the District of Columbia, providing new access to coverage to millions of previously uninsurable Americans.4 The Affordable Care Act has been successful in reducing the number of uninsured, but about 30 million Americans remain uninsured.5 Most important, the Affordable Care Act fails two critical parameters of health justice: it is neither universal nor equitable. Elegant, Equitable, and Not to Be **The most elegant, comprehensive, fairest, and lowest-cost solution to the health care crisis would have been to expand and improve** the **Medicare** insurance plan to cover **all Americans**.6 Medicare, enacted in 1965 as a single governmental payer system to provide health insurance for Americans 65 and older, has been well liked since its inception. Before Medicare, 48 percent of such Americans had no insurance; now only 2 percent are uninsured. In addition, before Medicare 56 percent of senior Americans paid out-of-pocket health care expenses, compared to 13 percent now.7 Satisfaction with coverage is **substantially higher** among Medicare recipients than for those who have private insurance. Only 8 percent of Medicare enrollees report their experience as fair or poor, compared to 20 percent of those with typical employer-based health insurance coverage and 33 percent of those who purchased private insurance directly.8 Moreover, the costs of **administering the program** are **substantially lower** than those of private insurance companies—only about 2 percent of the total cost for Medicare, compared to 12 percent for the least expensive insurance company's overhead charges.9 Most important, experts estimate that since its inception Medicare has added **five years to the life expectancy** of older Americans.10 **Polls** have shown that universal government-sponsored health coverage is **preferred by half of Americans**.11 And an improved Medicare would be an entitlement available to all Americans, with the exact same benefits for the wealthy and the poor. Medicare for all would **achieve the goal of universal access to health care**. As an entitlement for all US citizens (and extended to noncitizen residents), access to health care would be a right. This would contribute to the improvement of the life expectancy gap between rich and poor. Plus it would save an estimated $400 billion yearly by eliminating administrative waste.12 So if one wanted to solve the problem of the uninsured and **reduce the death gaps between rich and poor**, expansion of Medicare with other enhancements would have been the **most logical approach**. This is not a radical idea. Thirty advanced industrialized nations have forms of universal health care.13 Canada has a "Medicare for All" health insurance with easier access to care, lower costs, and better health outcomes (including life expectancy) than those of the United States. The evidence is compelling. While health inequity has not been eliminated in Canada, the differences between poor and rich are not as striking as they are in the United States.14 In Canada, men in the poorest urban neighborhoods experienced the biggest declines in mortality from heart disease from 1971 to 1996.15 Life expectancy gaps between income groups declined during that period as well. Poor Canadians with cancer had better survival than poor people from Detroit, an outcome The Poison Pill: Health Insurance in America " 135 136 " CHAPTER TEN attributed to the Canadian system.16 Of all the major Western economic powers, the United States is the only one without a universal health care system in which health care is considered a human right.17 Rather than treating access to health insurance as a universal right, the language of the Affordable Care Act endorsed the idea that health care is a mandate.18 The difference between health care as a right and health care as a mandate is critical, as these conceptions lead to very divergent solutions. If health care is a right, universal health care is an entitlement that should be the same for all citizens. If health care is a mandate, however, then there is no such entitlement, and health care is a commodity to be bought and sold. The Affordable Care Act established the mandate as a core component of health care coverage, perpetuating the complex system of multiple payers, limited access, variability in quality of care, high costs, and large rich-poor life expectancy gaps. Obamacare and Beyond The 2010 Affordable Care Act remains the most significant overhaul of the American health care system since the passage of Medicare in 1965, expanding insurance coverage to millions. The law survived multiple attempts by Congress and two Supreme Court challenges that aimed to gut its major provisions.19 As a reform of the current for-profit insurance marketplace, the Affordable Care Act addressed two major gaps in the existing system. First, it allowed young adults to stay on their parents' health insurance until the age of twenty-six—a popular provision that benefits almost eight million Americans.20 The second major reform prevented insurers from denying coverage to people with preexisting medical conditions. Medicaid was expanded to include millions of previously uninsurable individuals who had been excluded from the health care system. Uninsured rates among whites, blacks, and Hispanics dropped, narrowing though not eliminating racial and ethnic insurance coverage gaps.21 At the same time, **the Affordable Care Act incorporated the worst aspects of our fragmented for-profit health insurance system**. The tiered system of insurance—where the coverage options for the poor are markedly different from those for the rich—has further **hardwired inequity into the law.** In 2004 there were fifty million people without health insurance in the United States. That year the Institute of Medicine published a report, "Insuring America's Health," that outlined the principles against which any health reform legislation would have to be measured.22 The institute identified the ideal system as having "universal, continuous insurance coverage that is affordable and sustainable for individuals, families, and society, and should enhance well-being through care that is effective, efficient, safe, timely, patient-centered, and equitable." Eleven years later, none of these standards was being met. Even after the passage of the Affordable Care Act, there are around thirty million Americans without insurance and an equal number of underinsured who have health insurance policies but with deductibles and copayments that are high enough to deter care.23 How did the United States end up with a more fragmented, more costly, and more confusing health care system? Simply stated, collusion between members of Congress and entrenched corporate health insurance and Big Pharma interests precluded a more equitable and lower-cost solution. What Americans got with the Affordable Care Act was complicated insurance marketplaces in every state with a complex array of confusing private insurance products. The health reform process exposed, in the words of the British medical journal The Lancet, "how corporate influence renders the US Government incapable of making policy on the basis of evidence and the public interest."24 When the moment arrived to consider having a Medicare-like "public option" on the state exchanges to compete with private insurance companies, Senator Joseph Lieberman of Connecticut, the deciding Senate vote, deep-sixed the idea by threatening a filibuster.25 The capital of Connecticut is Hartford, the home of Aetna, one of the big five health insurance companies. Skin in the Game There are three major structural flaws in the Affordable Care Act, all of which could be solved by a single-payer system. The first flaw is The Poison Pill: Health Insurance in America " 137 138 " CHAPTER TEN that the insurance expansion is neither universal nor equitable. For example, because mandatory Medicaid expansion was blocked by the Supreme Court, nineteen states have left millions of poor people uninsured.26 These states account for over half of poor uninsured blacks, single mothers, and the country's uninsured working poor. For poor people in these states, it is as if Obamacare was never enacted. Note that for the most part these states that have refused to expand Medicaid are the former Confederate slaveholding states, accentuating the legacy of structural racism. Access to specialty care for those who receive Medicaid coverage is limited compared to access for patients with private insurance.27 More than one-third of US doctors refuse to take Medicaid—another structural barrier.28 The second flaw is that premiums, copays, and deductibles for private health insurance and products on the marketplaces are prohibitively high for many people, especially the working poor. In 2015 average annual premiums for employer-sponsored health insurance were $6,251 for single coverage and $17,545 for family coverage. Between 2014 and 2015, premiums increased by 4 percent, while during the same period workers' wages increased 1.9 percent. Premiums for family coverage increased 27 percent during the last five years, while cost sharing has skyrocketed.29 The average individual deductible across the marketplace plans in 2016 was $5,765 for bronze plans. After the deductible is paid, an individual with such a plan will face 40 percent copays for services.30 Insurance companies have reacted to their rising costs by creating narrow networks of providers and hospitals.31 This limits choice of patients by restricting the doctors and hospitals whose services they can use. At the heart of the Affordable Care Act are subsidies for the working poor to pay for health insurance premiums.32 The goal was to keep these premiums within reach of most Americans. It was a sweet deal for the insurance companies. The insurance companies are guaranteed to get their premiums; the federal government poured billions of dollars into their coffers. In exchange, an individual gets an insurance card. But with that card came unprecedented out-of-pocket expenses that kicked in before the insurance company paid one cent.33 The belief is that without "skin in the game," the newly insured will overuse the system. As a result, coinsurance and deductibles that many Americans now are forced to pay have skyrocketed across the insurance markets. Yet every study ever done on the impact of copays and deductibles (even for middle-class people) is that they cause individuals to delay medical care.34 Under a single-payer health care system there would be no copays or deductibles. Obamacare Bullshit The third flaw of the Affordable Care Act was that long-term doctorpatient relationships have been disrupted by insurance restrictions. President Obama said, "No matter how we reform health care, I intend to keep this promise: If you like your doctor, you'll be able to keep your doctor; if you like your health care plan, you'll be able to keep your health care plan."35 This turned out to be untrue. Windora Bradley, a year before her stroke, struggled to pay her health insurance premiums. Faced with the dilemma to buy food or go without medications, she chose to go without medications. At one of her office visits, she let loose. "I'm tired about this Obamacare bullshit," she shook her head, frowning as her jowls quivered. "I worked for thirty-five years. Those people on welfare who never worked are getting free health care. I am paying $700 each month and there is not enough left for medications and food. That's not right. That's why I call it Obamacare bullshit." Windora lived on a pension of about $1,000 per month. Most went for the premiums on her health insurance, which she still received through the Chicago Board of Education. She scrimped and saved to pay for her medications for her diabetes, hypertension, asthma, and vascular disease. Her situation is common among the working poor. Windora was ultimately able to get insurance on the marketplace that reduced her premium costs but not her out-of-pocket expenses. At first she purchased a Blue Cross insurance plan that she was told my hospital accepted, but this proved incorrect. She then had to purchase a more expensive plan to stay with me. Meanwhile her two sisters, who The Poison Pill: Health Insurance in America " 139 140 " CHAPTER TEN had also been my patients for over thirty years, had to switch doctors because my group did not accept the insurance they enrolled in. A number of my long-term patients found themselves in this dilemma. In 2015, after her stroke, Blue Cross dropped my hospital and many others from the plan Windora had just purchased. There was only one plan, from United Health Care, in all of Cook County that included my hospital and me in the network. The week after Windora signed up for it, United Health Care let it be known that it was considering withdrawing from all the exchanges in 2017.36 In three years of the Affordable Care Act, Windora had purchased three different insurance policies just to retain me as her physician. In the fall of 2016, United Health Care announced it would drop my hospital from its network, and Windora, now wheelchair bound and speechless, is forced to find another doctor (to say nothing of her many specialists) after thirty-six years. For someone like Windora with complex medical and social obstacles, keeping a team of providersa who are familiar with her medical travails is essential to getting good care. For me, her longtime doctor, it is a gut-wrenching experience. The fact is that Obamacare, despite its modest benefits, does not remedy American health care inequity. It will never achieve universal coverage. Eleven million noncitizen residents will never be eligible for its benefits. Thirty million people will remain uninsured. While insurance coverage has increased for all races, there is still a large racial and ethnic gap in insurance coverage, which will perpetuate health disparities. For those with health insurance, spiraling copays and deductibles have made access to care more difficult. Finally, by allowing a dizzying array of for-profit insurance carriers with high administrative overhead expenses, the Affordable Care Act as currently configured will not control costs. In 2016, the third year of Obamacare, insurance companies asked for double-digit increases in premium prices, as they claimed costs of delivery had outstripped the revenues. Meanwhile, health insurance stocks are trading at all-time highs, while patients like Windora Bradley face rocketing expenses and uncertainty about the future.37 The Poison Pill: Health Insurance in America " 141 A Call for Single Payer I speak for many of my health care colleagues across the nation when I say that **the Affordable Care Act is a disappointment**. In contrast, an improved and expanded Medicare for All would achieve **truly universal care, affordability, equity, and effective cost control**. It would put the interests of our **patients**—and our **nation's health**—**first**. By replacing multiple private insurers with a single nonprofit agency like Medicare that pays all medical bills, the United States would save approximately **$400 billion annually**. **Administrative bloat** in our current private-insurance-based system would be slashed. That waste would be redirected to **clinical care**. Copays, coinsurance, and deductibles would be eliminated. A single streamlined system would be able to **rein in costs** for medications and other supplies through the system's strong **bargaining**

clout—clout directed to benefit **health, not profits**. Finally, it would create an equitable system of care that would provide **equal access to rich, poor, black, and white.** As a result, **life expectancy gaps** between rich and poor would **narrow**. Hospitals that serve poor communities would have access to capital investment based on **need**. It has been done in other countries, and it can be done in the United States. Single-payer health care stands in **stark contrast to the ACA's incremental reform**. Yet it is important to remember that enactment of a single-payer system requires the defeat of **deeply vested, deep-pocketed ideological opponents, health insurance conglomerates, and a thick alliance of health care constituencies along with other interest groups**. The Affordable Care Act, passed by a Democratic majority and signed by a Democratic president, was a weak compromise that left the foundations of our flawed $2.9 trillion health care system intact. It will be some time before political conditions are again right to tackle an improved Medicare for All. So **why, given these hurdles, do** I (and **many** other health care providers) **persist?** I persist because I have watched too many patients suffer and die because they **lacked health insurance** or had the wrong insurance card. I persist because I have **witnessed** the **racial and ethnic death gaps** enabled by our current health insurance arrangements. I persist because **simple fairness** dictates that health care is a fundamental human right. I persist because of patients like Win142 * CHAPTER TEN dora and Sarai, who **deserve better.** For those who counter that single payer is too expensive or politically unfeasible, we persist because the American ideal of "life and liberty" cannot be achieved without an equitable and universal health care system. Winston Churchill reportedly said, "You can always count on the Americans to do the right thing... after they have tried everything else."38 We have tried everything else. I look forward to being part of a single-payer health care system that values the health of individuals, families, and communities as a common good—where health care is valued as a human right. Someday.

• Health costs drive income inequality. Wasteful spending only benefits the wealthy.

Warshawsky and Biggs, **14** – visiting scholar at the Mercatus Center at George Mason University, *resident scholar at the American Entreprise Institute (Mark J., Andrew G., Income Inequality and Rising Health-Care Costs, Wall Street Journal, October 6th, https://www.wsj.com/articles/mark-warshawsky-and-andrew-biggs-income-inequality-and-rising-health-care-costs-1412568847)

A new Kaiser Family Foundation survey reports that health-insurance premiums rose by a "modest" 3% in 2013. Even more modest, however, was the 2.3% growth of workers' earnings last year. These figures merely illustrate a long-term trend of rising health costs eating away at wages. The real story is even more dramatic: **Government data show that health costs are the biggest driver of income inequality in America today**.

Most employers pay workers a combination of wages and benefits, the most important of which is health coverage. Economic theory says that when employers' costs for benefits like health coverage rise, they will hold back on salary increases to keep total compensation costs in check. That's exactly what seems to have happened: Bureau of Labor Statistics data show that from June 2004 to June 2014 compensation increased by 28% while employer health-insurance costs rose by 51%. Consequently, average wages grew by just 24%.

But here's what the news headlines miss: Rising health costs don't affect every employee the same. An average family health policy today costs employers nearly $12,000 per year, up from only $4,200 in 1999. Had employer premiums not risen, average salaries today would be around $7,800 higher. For a lower-income worker who today makes $30,000, that could have meant a 26% salary increase. By contrast, a "one percenter" making $250,000 today would have seen his earnings rise only by 3.1%.

Health costs are a bigger share of total compensation for lower-wage workers, and so rising health costs hit their salaries the most. The result is higher income inequality.

Data from the BLS National Compensation Survey show this is what happened. For low-income workers, total pay and benefits rose by 41% from 1999 through 2006. But these workers' wages increased only by 28%, barely outpacing inflation. The reason: Employer costs for these workers' health costs nearly doubled, from 6.5% to 12.2% of compensation, and ate up money that could have gone toward salaries.

Now consider a worker who earns $250,000 or more a year. BLS data show that total compensation for these workers rose by 36% from 1999 through 2006. That's actually less than for low-income workers. But the one-percenters' health costs rose from just 4% of compensation in 1999 to only 4.3% in 2006.
It's not that their health costs didn't rise in dollars terms, it's simply that health benefits are a much smaller part of their total pay and benefits. As a result, salaries for the one-percenters grew by 35%, a faster rate than for low-wage workers. The inequality of total compensation barely changed from 1999-2006, but rising health-care costs held back the growth of lower- and middle-class earnings.
Ordinarily, what workers care about is their total pay and benefits, not merely salaries. For instance, an employer might make up for a lower salary by paying more generous retirement benefits. But a lot of health spending today is wasted through overuse or excessive costs. This truly does hurt the poor more than the rich.¶ We can't settle the health-reform debate here. But federal tax policy regarding health coverage almost certainly increases income inequality. Employer-provided health care is exempt from income taxes. As MIT Prof. Jonathan Gruber puts it, this subsidy makes health insurance "artificially cheap relative to other goods bought with taxed dollars, leading to over-insurance for most Americans." And the more we spend on health care the more unequal Americans' incomes become.
Reducing the tax preference for health care over other forms of compensation could lower health costs directly, as well as providing incentives to shift from "first-dollar coverage" of all health outlays to true insurance against large and unforeseen health costs. The classic Rand Health Experiment that ran from 1971 to 1982 showed that high-deductible health plans reduced spending by 30% compared with a plan with no co-payments, while producing very comparable health outcomes. Cost-sharing has broadened in the private sector, which some analysts believe has contributed to the recent slowdown in health-cost growth. We should apply these principles to Medicare and Medicaid as well.
Health costs are by no means the only factor affecting income inequality. But it is shocking that health costs are seldom mentioned with regard to income inequality when the BLS data show that rising health costs can fully account for the increasing inequality of workers' salaries from 1999 through 2006.
These data give us a different perspective on the inequality debate. Most people think of income inequality as money "redistributed" from the poor to the rich. In reality, much of what we're seeing is more of low-income workers' compensation going toward their health benefits and less ending up in their pockets. That's a different problem and points toward different

• Employer-based insurance drives of income inequality – it forces wage stagnation and expansive medical debt.

Marmor et al 14 – Theodore R. Marmor, Yale University Professor Emeritus in the Schools of Management and Law and the Department of Political Science, Adjunct Professor in Public Policy at Harvard's Kennedy School of Government, Ph.D., Harvard University, Jerry L. Mashaw, Sterling Professor Emeritus of Law and Professorial Lecturer in Law at Yale Law School, Ph.D. (European Governmental Studies), University of Edinburgh, LL.B., Tulane University Law School, John Pakutka, Managing Director, The Crescent Group, an advisory services firm with expertise in healthcare management, policy and litigation, MPPM, Yale University (*Social Insurance: America's Neglected Heritage and Contested Future*, CQ Press, Public Affairs and Policy Administration Series, 2014, Location 274.7-283.1 on kindle)

Whatever the resolution of these debates, **employment-based health insurance is in trouble**. The average costs of employer coverage have doubled over the past decade, to $5,400 for an individual and $15,000 for a family (see Figure 7.5). **Worker incomes in real terms have stagnated as health insurance inflation has consumed most of the gains from increased productivity**.14 **Workers at the low end of the wage spectrum have been especially hard-hit as a growing global economy has allowed employers to move jobs overseas or to low-cost areas of the United States**, where they often can hire workers without offering any health insurance benefits at all. The percentage of American workers covered by employers' health benefits fell

from 63% in 2000 to 56% in 2012.15 In addition, health care coverage for retirees is fast disappearing, with only 25% of large firms offering such benefits, down from 66% in 1988.16

An employee with family coverage through work faces directly only a fraction of the typical plan's overall $15,000+ annual premium cost. In 2009, this amounted to a cost per worker of $3,926 in large firms and $5,134 in small firms.17 Workers often pay this $300–$400 a month through direct deduction from their paychecks. Individual employees who do not add family members to their coverage typically pay closer to $100 per month.

As required by the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985, **workers who leave or are fired from jobs may continue to receive the same health coverage they had before for eighteen months, provided they are willing to pay the full premium costs**. This is known as COBRA coverage—perhaps appropriately, since it carries a bite. Many, like Robina Castaut, are shocked to get a bill for three times the monthly premium they were paying, or more. This "bite" is $1,300–$1,500 per month per family.

High and rising premiums are bad enough, but **employment-related health insurance itself has changed for the worse, becoming less protective of family income**. **Employers**, as mentioned, **are increasingly shifting a portion of costs onto employees in the forms of higher deductibles and medical visit co-payments**. In 2006, only 10% of firm plans for individuals required deductible payments of $1,000 or more before insurance payment began. By 2011, 34% of all and 49% of small firm plans did.18 Just under half of these plans have deductibles of $2,000 or more.

It doesn't end there. A relatively recent "innovation," the high-deductible health plan, carries with it a deductible of at least $5,000 per family. The good news is that those who choose such plans may set up corresponding health savings accounts (HSAs), in which they can deposit funds to be devoted to health expenses and deduct those funds from gross income. This allows families, in effect, to pay for their out-of-pocket health expenses with pretax dollars. It is one health care– targeted tax break atop another—at least for those workers who can afford to make HSA contributions from their current income.

This **increased cost sharing**, however, **causes a number of problems**. **One in ten insured patients claim to have used most or all of their savings paying their medical bills**. Others report that they are unable to pay for other basic necessities because of high medical bills. When patients cannot or will not pay, physicians and hospitals provide increasing levels of charity care or bear more bad debt expense. **Increased bad debt leads some physicians and hospitals to call in collection agencies, which in turn hassle those insured patients** who are unable or unwilling to pay their share of the cost of care (see Figure 7.6). **It also leads medical professionals to increase the price of services for those who can pay**, **thus raising insurance and out-of-pocket costs for everyone who is insured**. Of course, the problems of America's 50 million chronically uninsured are even worse. One in five uninsured adults report collection agency contact and depleted savings accounts in a given year.

These symptoms of financial trouble often lead to bigger problems. In a 2007 study funded by the Robert Wood Johnson Foundation, **29% of those filing for bankruptcy cited medical bills as the cause**. The researchers classified another 28% of respondents as having "medical bill problems."19 While other researchers have persuasively contested the magnitude of the

problem, none have argued that medical costs are an insignificant factor in the incidence of personal bankruptcies.20

In the two years prior to their declaration of bankruptcy, more than one-third of those sampled in the 2007 study **cited** above reported **health insurance coverage lapses**. These periods were likely associated with job loss and exposed many to potentially ruinous health care expenses. Indeed, lapses in coverage are common for those who do have employment-based health insurance. A Kaiser Family Foundation analysis shows that for adults covered in January 2006, 6.7% lost coverage over the next year. By the end of two years, 9% had lost coverage (see Figure 7.7). **The numbers were somewhat worse for those covered by "nongroup" or individual health insurance plans** (7.3% and 11.5%) **and much worse for those covered by the means-tested Medicaid program** (20% and 23.7%).

• Growing economic inequality drives diversionary nationalism and sparks international conflict due to greater military intervention

Solt 11 – Frederick Solt, Ph.D. in Political Science from University of North Carolina at Chapel Hill, currently Associate Professor of Political Science at the University of Iowa, Assistant Professor, Departments of Political Science and Sociology, Southern Illinois at the time of publication ("Diversionary Nationalism: Economic Inequality and the Formation of National Pride," *The Journal of Politics*, Vol. 73, No. 3, pgs. 821-830, July 2011, Available to Subscribing Institutions)

One of the oldest theories of nationalism is that **states instill the nationalist myth in their citizens to divert their attention from great economic inequality and** so **forestall pervasive unrest**. **Because the very concept of nationalism obscures the extent of inequality** and is a potent tool for delegitimizing calls for redistribution, **it is a perfect diversion**, **and states should be expected to engage in more nationalist mythmaking when inequality increases**. **The evidence presented by this study supports this theory**: across the countries and over time, **where economic inequality is greater, nationalist sentiments are substantially more widespread**.

This result adds considerably to our understanding of nationalism. To date, many scholars have focused on the international environment as the principal source of threats that prompt states to generate nationalism; the importance of the domestic threat posed by economic inequality has been largely overlooked. However, at least in recent years, **domestic inequality is a far more important stimulus for the generation of nationalist sentiments than the international context**. **Given that nuclear weapons**—either their own or their allies'—**rather than the mass army now serve as the primary defense of many countries against being overrun by their enemies, perhaps this is not surprising**: nationalism-inspired mass mobilization is simply no longer as necessary for protection as it once was (see Mearsheimer 1990, 21; Posen 1993, 122–24).

Another important implication of the analyses presented above is that growing economic inequality may increase ethnic conflict. **States may foment national pride to stem discontent with increasing inequality, but this pride can also lead to more hostility towards immigrants and minorities**. Though pride in the nation is distinct from chauvinism and outgroup hostility, it is nevertheless closely related to these phenomena, and recent experimental research has shown that members of majority groups who express high levels of national pride can be nudged into

intolerant and xenophobic responses quite easily (Li and Brewer 2004). This finding suggests that, **by leading to the creation of more national pride, higher levels of inequality produce environments favorable to those who would inflame ethnic animosities**.

Another and perhaps even more worrisome **implication regards the likelihood of war**. **Nationalism is frequently suggested as a cause of war**, **and more national pride has been found to result in a much greater demand for national security even at the expense of civil liberties** (Davis and Silver 2004, 36–37) **as well as preferences for "a more militaristic foreign affairs posture and a more interventionist role in world politics**" (Conover and Feldman 1987, 3). To the extent that these preferences influence policymaking, the **growth in economic inequality** over the last quarter century **should be expected to lead to more aggressive foreign policies and more international conflict**. If economic inequality prompts states to generate diversionary nationalism as the results presented above suggest, then **rising inequality could make for a more dangerous world**.

The results of this work also contribute to our still limited knowledge of the relationship between economic inequality and democratic politics. In particular, it helps explain the fact that, contrary to median-voter models of redistribution (e.g., Meltzer and Richard 1981), **democracies with higher levels of inequality do not consistently respond with more redistribution** (e.g., Bénabou 1996). **Rather than allowing redistribution to be decided through the democratic process suggested by such models**, this work suggests that **states often respond to higher levels of inequality with more nationalism**. Nationalism then works to divert attention from inequality, so many citizens neither realize the extent of inequality nor demand redistributive policies. By prompting states to promote nationalism, greater economic inequality removes the issue of redistribution from debate and therefore narrows the scope of democratic politics.

• Inequality hurts the economy

Sherman 14 – Erik, Freelance Journalist, Contributor to WSJ and Forbes ("Income Inequality Hurts Economic Growth" https://www.forbes.com/sites/eriksherman/2014/12/09/income-inequality-hurts-economic-growth/#7fda3605591a) RMT

The new OECD analysis found a "negative and statistically significant" correlation between income inequality and economic growth. Specifically, the 3 Gini point rise in inequality that was the average for OECD states over the last 20 years meant 0.35 percent less economic growth per year for the same time, or a total 8.5 percent GDP loss in that period. Here's a graph that shows the hit various national economies have taken as a result, along with an explanation of the impact. [Graph Omitted] Inequality-impact-on-national-economies Rising inequality is estimated to have knocked more than 10 percentage points off growth in Mexico and New Zealand, nearly 9 points in the United Kingdom, Finland and Norway and between 6 and 7 points in the United States, Italy and Sweden. On the other hand, greater equality prior to the crisis helped increase GDP per capita in Spain, France and Ireland. **Even at 6 points, that would be a 0.3 percent hit to U.S. GDP every year for the last 20**. The inequality problem is not one of the poorest of the poor in a country. It's the bottom 40 percent by income, according to the OECD study, which makes sense if you consider the rationale behind why

inequality can hurt an economy. Growth happens when lots of people spend money. In the U.S., for example, the small number of people at the top of the economic ladder can't consume and spend at the rate that the broader population can. And the distribution of income means that there are many more in the bottom 40 percent by income than there are in the top 40 percent by income. Unless a policy addresses lower incomes, and not just official poverty, it won't succeed in helping the economy. The OECD said that certain types of income redistribution -- specifically, high-value services like good education and healthcare -- increase, and not decrease, economic growth if effectively targeted without inefficiency and waste.

1AC: Primary Care

• Primary Care important

Phillips 2005 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1309658/

Most **countries that have built their healthcare systems on primary care enjoy better population health outcomes, lower health disparities, more equitable access to care, and lower costs** There are trade-offs of course, but what should $2 trillion purchase? **If primary care cannot make the considerable investment** required to transform its business and clinical model, and cannot attract new doctors, **the result will be worsened health outcomes and disparities.** The same outcome may result if primary care abandons its core functions and instead survives by providing expensive technology and ancillary services. **Continuing to stoke the healthcare economic engine for purposes other than producing health is also unlikely to be sustainable.** Things could get much worse for primary care and people in the US before they get better.

• US lacks primary care, M4A solves by moving physician workforce towards primary care

Geyman 16 – John Geyman, M.D., professor emeritus of family medicine at the University of Washington School of Medicine ("Single-Payer FAQ," SITE LAST UPDATED IN 2016, Physicians for a National Health Program, http://www.pnhp.org/facts/single-payer-faq#bankrupt)

Countries with strong health care systems have at least half of their physicians in **generalist primare care practice** 50 percent in Canada, 70 percent in the United Kingdom (Starfield, B, Is primary care essential? Lancet 344: 1129, 1994)

In 2008, less than 8 percent of U. S. seniors chose family medicine, a 50 percent decline since 1997; only 199 U. S, seniors matched into primary care internal medicine, 248 into IM/Peds, and 53 into primary Peds. The percentage of international medical graduates (IMG's) in our 3 primary care specialties is now **73 percent** for IM, 68 percent for Peds, and 55 percent for Fam. Med. (Pugno, P , et al Fam Med 40 (8): 563, 2008) I don't believe that we have more than about 30 percent of our physicians in primary care. Only 20 percent of internal medicine graduates become general internists, and most pediatric graduates go into sub-specialties. (Bodenheimer, T. Primary care—Will it survive? N Engl J Med 355 (9):861, 2006).

Primary care has been declining in this country for many years, as a result of multiple factors, including more attractive lifestyles and reimbursement on the non-primary care fields;student perceptions of the demands, rewards, and prestige of generalist practice; and uncertainty of the health care environment. The American College of Physicians in 2007 declared that: "Our primary care infrastructure is at grave risk of collapse".

Single-payer national health insurance will provide an **opportunity to restructure the U.S. physician workforce, strenghten and rebuild primary care**. We should have at least 50 percent of our physicians in primary care fields.

1AC: Socialism

• The ACA prioritizes profits over people which makes coverage and access to care out of reach for millions.

Isaac **CHRISTIANSEN 17**, Assistant Professor of Sociology at Midwestern State University ["Commodification of Healthcare and its Consequences," *World Review of Political Economy*, Vol. 8, No. 1, Spring 2017, p. 82-103, Accessed Online through Emory Libraries]

When a healthcare system is privatized, the goal becomes not only the provision of healthcare and the advancement of science and technology to better that end, but also the maximization of profit for shareholders. In the United States, healthcare is generally treated as a commodity with a large portion of healthcare expenditure managed by private insurance companies that have an economic incentive to deny coverage or care for those well positioned enough to have coverage. The system of insurance gradually replaced earlier systems of direct customer payment for care in the early twentieth century as a way of being able to better handle large and sudden costs. From here we have seen pre-paid plans and managed care models (such as Health Maintenance Organizations [HMOs]) develop in the United States to (ideally) address the issue of rising healthcare costs and protect quality, cutting out presumably unnecessary, ineffective or wasteful procedures. Nevertheless, managed care models and healthcare in the United States are treated more and more as commodities; "the managed care movement has become increasingly for-profit. As a result, the balance between offering access to care runs counter to the bottom line of corporate profits for the organization" (Matcha 2000, 375-76).

The US healthcare system is **highly commodified**. According to the WHO (World Health Organization) Global Observatory (2016), private insurance accounted for 40.7% of all health expenditures while direct out of pocket expenditures accounted for an additional 11.5%. By 2013, the indicators were roughly identical, with all private expenditure on health (insurance + out of pocket) totaling 52.9% of all US health expenditure.

In spite of neoliberal claims that the private sector exhibits greater efficiency, the cost of insurance companies' excess administration, profit, and additional costs resulting from uninsured and underinsured people postponing or forgoing care have led to the United States having **inferior health outcomes** in key indicators in spite of spending more on healthcare than other wealthy nations. In 2011, according to World Bank data, the United States ranked number one in the world in terms of GDP (gross domestic product), at roughly 15 trillion dollars. However, contrasted with other wealthy nations, the United States "spends more than twice as much per capita on healthcare, yet nearly 50 million people are uninsured, and tens of millions more are grossly uninsured" (Gottschalk 2009, 103).5 Far from improving under the Affordable Care Act (ACA), the proportion of GDP represented by health expenditure is projected to "increase cumulative health spending by roughly $621 billion" (Centers for Medicare and Medicaid Services n.d.).

Lamentably, the threat of high medical bills, particularly for the poor and working classes, serves as a **barrier** to obtaining care, often leading to the postponement of care and the exacerbation of medical conditions that could either be prevented or less expensively treated if caught earlier. In a recent comparative study of healthcare systems of 11 developed countries funded by The Commonwealth Fund, Davis et al. (2014) found that 39 [percent] % of people surveyed in the United States did not go to the doctor in spite of a medical problem because of cost, compared with 7% in Norway and Canada, 5% in Sweden and just 1% in the UK. Hence, while the United States ranked fifth in terms of quality and

timeliness of care, it nevertheless was ranked with the worst health system overall due largely to significant problems with **accessibility and outcomes**.

In addition, the privatized nature of healthcare provision in the United States encourages **excessive** medication, testing and procedures for those adequately insured, as these "sales" help the bottom line of pharmaceutical industries and other interested parties, while serving as a barrier to care to those underinsured (Applbaum 2009; Gottschalk 2009; Leys 2009; Farmer 2005). A further complication of the commodified healthcare model has been the growing power of the pharmaceutical industry and its control and influence over the research process (Leys 2009; Applbaum 2009; Suarez-Villa 2012). These phenomena raise further ethical concerns regarding a **conflict of interest** between private profit and societal well-being.

The Obama administration has attempted to balance the needs of private insurers with the goal of universal insurance coverage through the ACA. The law ostensibly aims at increasing access to care for poorer and less healthy segments of the US population through the expansion of Medicaid eligibility and not allowing insurers to deny coverage to individuals based on pre-existing conditions. The law also imposes a tax penalty on individuals who do not have coverage through Medicare, Medicaid or private insurance. With the intention of avoiding a "death spiral" increase in insurance premiums due to the "adverse selection" phenomenon (where those who are sick select more "generous" insurance policies to gain access to needed care while healthier individuals seek out cheaper less "generous" policies) and to prevent insurance companies from creating disincentives for sicker populations to obtain insurance, the US Department of Health and Human Services (HHS) created a three-prong system of pooling risk.

The first prong is risk adjustment, where lower risk insurance plans contribute to higher risk plans and is a permanent feature of the ACA. The second prong is "reinsurance," a pooled-risk system for insurers administered by HHS where all insurance companies contribute funds and those whose costs exceed a threshold up to a certain amount receive payments. The third prong is the creation of risk corridors where plans with claims at 3% below the 80% medical loss ratio make payments to those insurance companies that paid a higher percentage of their premium revenue to medical claims (Cox et al. 2016). The latter two features are temporary and are due to only last for three years.

Unfortunately, the ACA has not weakened the distortion of US healthcare provision caused by the **profit motive**. To the contrary, while the ACA once implemented is expected to reduce the number of uninsured to around 27 million, it has **exacerbated "underinsurance"** and increased **administrative costs**. The ACA has increased financial barriers to care for the poor in the form of undermining public hospitals and safety nets, high deductibles, premiums, and coverage limitations that vary according to the actuarial value of the specific tiered plan (Waitzkin and Hellander 2016; Andrews 2015).

Early reports indicated that insurance companies, in spite of their voiced opposition to the law, might have benefited. Andrews (2015) presented data indicating that United Health Group, Aetna, Anthem, Cigna and Humana reported large stock price gains from July 2013 to July 2014. However, more recent reports indicate that several large insurance companies (Aetna, United Health Group, and Humana) have reported large losses on ACA plans and are contemplating opting out of the ACA all together (Wall Street Journal 2016). The potential exodus of insurers from the ACA ultimately emanating from the modest requirement of requiring insurance companies to cover those with preexisting conditions reflects the inherent difficulty in attempting to erect a policy that seeks to extend access to care **within a framework of privatized healthcare financing**.

• That commodification of care arbitrarily executes thousands every year. We must transform healthcare into a social institution to address mass inequality and confront neoliberalism.

Gavin **MOONEY 12**, Honorary Professor of Public Health at the School of Public Health, University of Sydney ["Neoliberalism is Bad for Our Health," *International Journal of Health Services*, Vol. 42, No. 3, 2012, p. 383-401, Accessed Online through Emory Libraries]

As the commodification of health care continues, it is too often seen as being solely about individual care. There has been a neglect of health care as an institution, especially as a **social institution**. In this sense, the framework of the market has been retained and there has been little or no recognition of wider considerations and value systems that might accommodate the idea of health care as a social institution—where not only outcomes, but also processes, are valued. There is all too little research on the political economy of health care. Mackintosh and Koivusalo (44), however, in their political economy of health services, argue that "health services must aim for universality of access according to need, and solidarity in provision and financing, and . . . health systems should be judged against these objectives. Solidarity here is about robust redistribution and cross-subsidy to sustain access on the basis of need." They add: "This implies that health system performance should not be exclusively defined in terms of health outcomes." Such thinking is rare but much needed.

I have argued (1) that there is a need to view health care more as a social institution than a commodity and to move toward community values in society more generally, in essence promoting the ideas of communitarianism. On both fronts, this means an **explicit abandonment** of neoliberalism.

Before that, however, there needs to be clear recognition and acceptance of the fact that **neoliberalism is the problem**. That is the starting point and, given the current global power structure, achieving that recognition will be no small step.

There are, however, countries such as Cuba and Venezuela and the Indian state of Kerala that have been able to find a route to health, even though none of these three economies is wealthy. So the message is not just an attack on neoliberalism, but a more hopeful one that another economic system and ideology **do exist** and can create a healthy environment. The relationships between neoliberalism and economic growth and between wealth and health are complex, but there is little reason to believe neoliberalism has brought faster economic growth. Even if that were the case, it is not clear whether wealth beyond a relatively low level brings greater health to a society.

The Venezuelan model is based on primary care, funded by the public and with public participation in decision making, as described by Muntaner and colleagues (45): "This integrated model of care emphasises a holistic approach to health and illness through the coordination of [the primary health care organization with others] addressing education, food security, public sanitation and employment, among other key social determinants of health." They explain that "people lacking potable water who suffer from recurring intestinal infections are not only prescribed the appropriate antibiotics but also encouraged to organise to demand adequate access to clean water" (45). The organizational structure is such that "health teams and patients are supported by Health Committees comprised of [community] residents." In this way, local community residents "exercise their participation in primary health care clinics."

I have argued (11) for a communitarian approach, in essence because of neoliberalism's deleterious effects on health, primarily through the individualism that this form of political economy promotes. Such individualism is highlighted by Wilkinson (46):

> We are used to feeling indignation at the human rights abuses in countries where people are imprisoned without trial, are tortured, or simply disappear, but health inequalities exact a much greater toll. What would we think of a ruthless government that arbitrarily imprisoned all less well-off people for a number of

> years equal to the average shortening of life suffered by the less privileged in our own societies? Given that higher death rates are more like arbitrary execution than imprisonment, perhaps we should liken the injustice of health inequalities to that of a government that **executed a significant proportion of its population** each year **without cause**. And as Navarro (6) emphasises: "It is not inequalities that kill people. It is the people who produce and reproduce inequalities through their public and private interventions that kill people."

Within the specific context of health care systems, where markets fail and the question of what to do about the failing of consumer sovereignty fails, Joan Robinson (47) argued in a more general context that

> [N]o-one who has lived in the capitalist world is deceived by the pretence that the market system ensures consumers' sovereignty. The true moral to be drawn from capitalist experience is that production will never be responsive to consumer needs as long as the initiative lies with the producer. Even within capitalism consumers are beginning to organise to defend themselves. In a planned economy the best hope seems to be to develop a class of functionaries, playing the role of wholesale dealers, whose career and self-respect depend upon satisfying the consumer. They could keep in touch with demand through the shops; market research which in the capitalist world is directed to finding out how to bamboozle the housewife could be directed to discovering what she really needs; design and quality could be imposed upon manufacturing enterprises and the product mix settled by placing orders in such a way as to hold a balance between economies of scale and variety of tastes.

Also relevant here is Hegel's emphasis on the role of institutions "so that self-conscious individuals could become more aware of the meaning of the institutions in which they participated—a step towards feeling at home in these institutions" (48).

I have previously taken up this issue (1):

> Social institutions matter. It is important that we as citizens of our own countries but also citizens of the world "feel at home" in our institutions and that participation in social institutions, as integral parts of the state, is encouraged. There is further a need to defend our social institutions and, most fundamentally, to recognise the importance of, and in turn celebrate, the institution of community autonomy. A sense of belonging counts.
>
> The social institutions that are health care, public health and health policy need more often to be recognised as **valuable in their own right**. Societies do value them for the health and other outcomes they produce, as conventional health economics implies; but these institutions per se can also be valued as contributing to a better, more decent society. They also need to be valued in more direct Hegelian terms as providing pillars (along with other social institutions) to protect the state, not least from being overrun by the forces of the neoliberal market place.

Neoliberalism kills. We need to find a better way. The idea of a communitarian economics in which—locally, nationally, and globally—people have a real say in what kind of social institutions they have and how these are run is one way to address the planet's health problems. There are others. The crucial issue, however, is to accept as Navarro (6) has argued that public health must be **political** and that fundamental to any genuine progress in addressing poverty, inequality, and ill health at a global level is to recognize that, first, neoliberalism is at the **root** of these problems and, second, **some alternative** must be found. That is the debate on which public health must embark. Whatever the solution, what is needed is a new political economy of public health.

CONCLUSION

There is something badly wrong that the world today, while having more abundant resources than ever in its history, is not having more success in improving the health of the global population. I have tried to show that a major contributor to this lack of success is the increasing pervasiveness of neoliberalism and the fact that this "creed," not democratic values, drives our global institutions. These institutions could do so much to reduce poverty and inequality and, in turn, improve global health. It is difficult to understand why they do not do more, until we recognize that they are trapped

in the ideology of neoliberalism and a seemingly unshakable belief that the market has the answer to most things and hence must have the answers to global health problems.

The power of the marketplace now pervades so much of the thinking surrounding health care. The influence wielded by large corporations on governments is such that society too seldom looks for other value sets or, perhaps increasingly, fails to look at all. The "growth fetishism" of neoliberalism forces out other value sets; even the threat of other values can bring extraordinary responses such as the attack on Obama as a Socialist. Neoliberalism brings increasing inequalities and class divisions that can only impact negatively on the health of the poor and, more likely, the health of populations in general.

Governments are more and more wont to serve corporations rather than act democratically. Corporations, especially transnational corporations, act either hand-in-hand with governments or above governments.

Health care and health are increasingly commodified and the idea of health care systems as social institutions is being **lost**. To address this, the answer would seem to lie in accepting that the major actor missing from the stage of health and health care policy is the critically informed citizen. Adopting community or communitarian values in societies, returning health care systems to "the people," and resurrecting the idea of such systems as **social institutions** can allow the goals of health maximization to be realized. While there are many examples of how things have gone wrong with respect to such goals, where countries or regions have followed these values, even relatively poor parts of the world have achieved remarkably good health for their populations.

• The fight for single-payer is a critical step in the anti-capitalist struggle for universal social programs

Day and Brown 17 – Meagan Day, freelance writer who focuses on politics, social movements, labor, law and history, former ben bagdikian editorial fellow at mother jones, and is an at-large editor at full stop, Keith Brower Brown, graduate student in geography at UC Berkeley ("How Socialists Can Fight for Single Payer," *Jacobin*, August 2nd, https://www.jacobinmag.com/2017/08/socialist-left-single-payer-medicare-for-all-dsa-nurses-union)

Over the last half-century, the relationship between socialists and the labor movement has **grown tenuous**, as both groups have been diminished and devitalized by state repression and capitalist advancement. As socialists, we know that **acting in concert with organized labor is fundamental**, and that it's necessary to rebuild our role, both as socialist organizers and workers ourselves, in the labor movement. By uniting with nurses against CEOs, we're committing to working-class solidarity in practice, not just in theory.

Socialists must continue to build our own independent organizations steered by the democratic power of our members, but the nurses are a strategic ally to learn from and fight alongside in this moment.

Finally, **single payer would win power for the working class like no other reform** popularly on the table in the US today. When socialists consider fighting for a reform, we should ask if it **builds working-class power towards future struggles**. Some left organizers and scholars call this "building the crisis": by winning reforms that strengthen the material conditions and class consciousness of working people, we **advance the fight for more radical victories**.

Many union workers, who have seen spiraling private health insurance costs undermine their position for wage and benefit increases, have rallied behind single payer as a **bulwark for future battles with management**. For non-union workers, too, single payer would strengthen both their actual health and their bargaining position for raises and other benefits. A push for single payer, in this political moment, is **uniquely able to draw clear lines of class conflict**: it's capitalists versus all of us who work.

Single payer is already a concession on the part of socialists. We want fully socialized medicine, which would function on the same principles but extend to hospitals and doctors themselves, and which already exists in many nations. We envision single payer as a **first step in a long struggle to implement full universal social programs**. We see it as a **non-reformist reform**: that is, a structural modification of power relations that **elevates the ability of working-class people** to fight against capital while radically shifting the window of political possibility.

We're interested in using SB562 as a political education opportunity for our membership and neighbors, and publicly advancing the idea that universal social programs are better than means-tested ones. According to the **neoliberal logic of means-testing**, some people need public assistance to attain things like health insurance, but only those in the direst of straits. Socialists, on the other hand, believe in the decommodification of essential goods and services for all, for both moral and politically strategic reasons.

Universal programs are essential to eliminating wealth inequality. They decrease disparities in the here and now, creating a stronger working class that is less fearful and insecure, and therefore less easily exploited by capital. They also build powerful new constituencies dedicated to defending public goods against privatization.

In this way, universal programs can function as "**engines of solidarity**." To make health insurance universally guaranteed and public is to both assert that coverage is a right, and to build a stronger body politic that can mobilize to protect that right.

In our discussions at peoples' doors, we hear our neighbors' indignation that the wealthy are able to receive medical care when necessary without fear of ruinous financial consequences, while everybody else is faced with hard choices about whether to go into massive amounts of debt to seek necessary treatment. In those conversations, we hear the raw material for a mass oppositional class politics.

1AC: Drug Prices

• Prescription drug prices are skyrocketing. Millions of lives are in jeopardy.

Anderson 14 – BBC News (Richard, Pharmaceutical industry gets high on fat profits, November 6, http://www.bbc.com/news/business-28212223)

Imagine an industry that generates higher profit margins than any other and is no stranger to multi-billion dollar fines for malpractice.

Throw in widespread accusations of collusion and over-charging, and banking no doubt springs to mind.

In fact, the industry described above is responsible for the development of medicines to save lives and alleviate suffering, not the generation of profit for its own sake.

Pharmaceutical companies have developed the vast majority of medicines known to humankind, but they have profited handsomely from doing so, and not always by legitimate means.

Pharmaceutical profits

Last year, US giant Pfizer, the world's largest drug company by pharmaceutical revenue, made an eye-watering 42% profit margin. As one industry veteran understandably says: "I wouldn't be able to justify [those kinds of margins]."

Stripping out the one-off $10bn (£6.2bn) the company made from spinning off its animal health business leaves a margin of 24%, still pretty spectacular by any standard. In the UK, for example, there was widespread anger when the industry regulator predicted energy companies' profit margins would grow from 4% to 8% this year.

Last year, five pharmaceutical companies made a profit margin of 20% or more - Pfizer, Hoffmann-La Roche, AbbVie, GlaxoSmithKline (GSK) and Eli Lilly.

'Profiteering'

With some drugs costing upwards of $100,000 for a full course, and with the cost of manufacturing just a tiny fraction of this, it's not hard to see why.

Last year, 100 leading oncologists from around the world wrote an open letter in the journal Blood calling for a reduction in the price of cancer drugs.

Dr Brian Druker, director of the Knight Cancer Institute and one of the signatories, has asked: "If you are making $3bn a year on [cancer drug] Gleevec, could you get by with $2bn? When do you cross the line from essential profits to profiteering?"

And it's not just cancer drugs - between April and June this year, drug company Gilead clocked sales of $3.5bn for its latest blockbuster hepatitis C drug Sovaldi.

Drug companies justify the high prices they charge by arguing that their research and development (R&D) costs are huge. On average, only three in 10 drugs launched are profitable, with one of those going on to be a blockbuster with $1bn-plus revenues a year. Many more do not even make it to market.

But as the table below shows, drug companies spend far more on marketing drugs - in some cases twice as much - than on developing them. And besides, profit margins take into account R&D costs.

The industry also argues that the wider value of the drug needs to be considered.

"Drugs do save money over the longer term," says Stephen Whitehead, chief executive of the Association of the British Pharmaceuticals Industry (ABPI).

"Take hepatitis C, a shocking virus that kills people and used to require a liver transplant. At £35,000 [to £70,000] for a 12-week course, 90% of people are now cured, will never need surgery or looking after, and can continue to support their families.

"The amount of money saved is huge."

True, but just because you can charge a high price for something does not necessarily mean you should, especially when it comes to health, critics such as Dr Druker might say. Shareholders, who big pharma companies ultimately have to answer to, would have little time for such an argument.

No loyalty

Big pharma companies also say they only have a limited time in which to make profits. Patents are generally awarded for 20 years, but 10-12 of those are typically spent developing the drug at a cost of about $1.5bn-$2.5bn.

This leaves eight to 10 years to make money before the formula can be taken up by generic drug companies, which sell the medicines for a fraction of the price.

PillsImage copyrightTHINKSTOCK

Once this happens, sales fall by 90%-plus. As Joshua Owide, director of healthcare industry dynamics at research company GlobalData, explains, "Unlike other sectors, brand loyalty goes out the window when patents expire."

This is why pharma companies go to such extraordinary lengths to extend their patents - a process known as evergreening - employing "floors full of lawyers" for this express purpose, one industry insider says.

For a drug raking in $3bn a quarter, even a one-month extension can be worth huge sums of money.

New formulations, combining two existing drugs to give a wider use, and enantiomers - a mirror image of the same compound - are some of the legal ways to eke out patents. But some drug companies, including the UK's GSK, have been accused of more underhand tactics, such as paying generics to delay the release of their cheaper alternatives.

As the loss of sales at the big pharma companies far outweighs the revenue made by the generics, this can be an attractive arrangement for both parties.

Courting doctors

But drug companies have been accused of, and admitted to, far worse.

Until recently, paying bribes to doctors to prescribe their drugs was commonplace at big pharmas, although the practice is now generally frowned upon and illegal in many places. GSK was fined $490m in China in September for bribery and has been accused of similar practices in Poland and the Middle East.

The rules on gifts, educational grants and sponsoring lectures, for example, are less clear cut, and these practices remain commonplace in the US.

Indeed a recent study found that doctors in the US receiving payments from pharma companies were twice as likely to prescribe their drugs. This may well exacerbate the problem of overspending on drugs by governments. A recent study by Prescribing Analytics suggested that the UK's National Health Service could save up to £1bn a year by doctors switching from branded to equally effective generic versions of the drugs. Big pharmaceutical fines $3bn Glaxo SmithKline, 2012, over promoting Paxil for depression to under-18s $2.3bn Pfizer, 2009, over misbranding painkiller Bextra $2.2bn Johnson & Johnson, 2013, for promoting drugs not approved as safe $1.5bn Abbott, 2012, over illegal promotion of antipsychotic drug Depakote $1.42bn Eli Lilley, 2009, for wrongly promoting antipsychotic drug Zyprexa $950m Merck, 2011, for illegally promoting painkiller Vioxx Source: ProPublica Getty This all may change when new rules in the US and UK will force doctors to disclose all gifts and payments made by the industry.

Drug companies have also been accused of colluding with chemists to overcharge for their medicines and of publishing trial data that highlight the positive at the expense of the negative. They have also been found guilty of mis-branding and wrongly promoting various drugs, and have been fined billions as a result.

The rewards are so great, it would seem, that pharma companies have continually been prepared to push the boundaries of legality.

'Undue influence'

No wonder, then, that the World Health Organisation (WHO) has talked of the "inherent conflict" between the legitimate business goals of the drug companies and the medical and social needs of the wider public.

Indeed the Council of Europe is launching an investigation into "protecting patients and public health against the undue influence of the pharmaceutical industry".

It will look at "particular practices such as sponsoring health professionals by the industry... or recourse by public health institutions to the knowledge of highly specialised researchers on the pay-rolls of industry".

No matter what the outcome of such investigations, however, the pharmaceutical industry is facing fundamental change, as the traditional model of developing drugs breaks down due to rising costs and scientific advances.

The cosy world of big pharmaceuticals is under threat like never before.

• Re-pricing drugs enables effective R&D for antibiotic resistant drugs. It alters the pharma market incentives

McKenna 11 – award winning journalist and expert on antibiotic resistance (Maryn, Maryn McKenna answers questions about antibiotic resistance, April 11th, https://blogs.scientificamerican.com/observations/maryn-mckenna-answers-questions-about-antibiotic-resistance/)

"Brendan Maher: Is the French approach to testing and isolating patients with drug resistant strains effective? If so, why is it not used more widely?

McKenna: That's a great question. They have only been screening for gram-negative resistance for a few months, so there isn't a lot of data. But we do know, for instance, that when the Dutch started screening for MRSA at the doors of their hospitals, their MRSA rate stayed very, very

low—much lower than it did in the U.S. But what France and the Netherlands have in common is that they are both single-payer health systems—and when you own the hospitals and employ the doctors, you have access to carrots and sticks that aren't available to us here in retail-based U.S. medicine. There is one health system in the U.S. that is very like a European one in structure: the Veteran's Administration. The VA started screening for MRSA in all its hospitals more than a year ago, and its infection rate and its costs went way down in response. So perhaps we should consider their example.

Andy Comanda: Do you think that maybe like in the movie "The Constant Gardener" that the drug companies may be responsible for this?

McKenna: Well, not deliberately! But the market behavior of pharmaceutical companies is part of this story, just as much as the behavior of medicine in overusing antibiotics. Here's why: Many drug companies no longer find it profitable to make antibiotics, because there really isn't much return in them. So **they have been slower to bring out new antibiotics than, for instance, new lifestyle drugs.** Therefore, when resistance takes a drug out, we don't have a new one to use instead."

• Now is key. R&D is faltering, and international crisis is inevitable.

Scandlen-Finken and Wertheimer, **15** – PharmD Candidate, *PhD/Professor at the Temple University School of Pharmacy, author of over 40 books and 430 journal articles, has received many awards and recognitions including fellowships from the American Association of Pharmaceutical Scientists and the International Pharmacy Federation (FIP). He is Scheele Laureate and an honorary member of several professional societies (Leah and Albert, Incentivizing Antibiotic Research and Development, 2015, Vol. 6, No. 1, Article 191 INNOVATIONS in pharmacy)

Introduction We are on the dawn of an international crisis. Infections are getting harder to treat, treatments are becoming more frequent, more expensive, and more people are dying.1,2 Multi-drug resistant organisms (MDRO) are being found all over the world.3 Many fear that infection treatment may return to a pre-antibiotic era, or a "post-antibiotic era," a time when tuberculosis, for example, was a death sentence. When the only prescription available was fresh air.4,5,6 According to a BBC report, infections due to MDRO are estimated to rise more than tenfold, kill more than cancer currently does by 2050, and cost more than $100 trillion. Reporters believe these figures are an underestimate.7 To make matters worse, **there are not enough antibiotics being developed to satisfy the current and future needs**.8 The reasons for the lack of antibiotic drug development include difficulty developing novel drug classes, high costs of drug research and development, a challenging clinical trial drug approval process, and low to negative returns on investment.5,9,10

Methods A preliminary literature search was done using PubMed. Articles that dealt with "antibiotic resistance," "antibiotic research and development," and "international policy and antibiotics" were included. President Barack Obama's Executive Order to Combat Antibiotic Resistance was analyzed, as well as the recommendations made by the President's expert advisors regarding antibiotic resistance. Follow-up questions were posed to experts in the field of antibiotic development, and their suggestions were investigated Misuse of antibiotics is also common.12 In many countries antibiotics are readily accessible without a prescription.13 Compound this with the fact that many patients seek antibiotics for non-bacterial infections, unaware antibiotics will not treat a viral infection such as a cold or flu.14 Inappropriate antibiotic use extends beyond humans. Antibiotics are used, among other reasons, to promote growth in livestock in the United States and abroad.15 Such use has been banned in the European Union.16 However, even when used under the supervision of a veterinarian, there may be unintended residual consequences, and subsequent transmission of antibiotics to the consumer.17 Furthermore, there are not enough antibiotics to keep up with the growing bacterial resistance. Antibiotic Research and Development (R&D) is challenging.10,18 Despite this, new classes of antibiotics are needed, and the current antibiotic pipeline is "thin."18,19 Over the past eight decades, since the inception of antibiotics, there has not been sufficient antibiotic advancement to support our

cavalier attitude toward infectious disease (table 1). Perhaps in response to the current antibiotic need, the field of antibiotic research, development, regulations, and policy-making is an exciting, interdisciplinary, charming, solution-focused, and widely innovative space.19,20 Recently there has been collaboration to find solutions to the combined lack of innovation and increasing threats due to antimicrobial resistance. Due to the work of many skilled and passionate leaders in the antimicrobial resistance specialty, there has been substantial progress made through international dialogue. Bacterial diagnostics have seen recent attention, and are the focus of the 2014 Longitudinal Prize.21 Antimicrobial Stewardship is flourishing, and has seen an encouraging push from the Executive Branch with President Obama's recent Executive Order to Combat Antibiotic-Resistance on September 18, 2014. In this report, President Obama requires antimicrobial stewardship initiatives across various health care settings, including long-term care facilities.22 President Obama based the executive order on a report, Combating Antibiotic Resistance, developed by an expert panel with the President's Council of Advisors on Science and Technology (PCAST).23

• M4A solves: expands government bargaining power for lower prices and reins in runaway manufacturers.

Seidman 15 – Chaplin Tyler Professor of Economics at the University of Delaware. He received his BA from Harvard University and PhD in economics from the University of California, Berkeley. He is the author of several articles on health insurance public policy including "Medicare for All: An Economist's Case" (Challenge, January–February 2013); "Responsible Health Insurance Revisited" (Inquiry, summer 2005); and "Prefunding Medicare without Individual Accounts" (Health Affairs, September–October 2000). His books include The Earned Income Tax Credit (with coauthor Saul Hoffman; 1990); The USA Tax: A Progressive Consumption Tax (1997); Funding Social Security (1999); and Public Finance (a textbook with a chapter on health insurance; 2009) (Laurence, The Affordable Care Act versus Medicare for All, Journal of Health Politics, Policy and Law 2015 Volume 40, Number 4: 911-921)

Single-Payer Bargaining Power

For several decades the United States has been an extreme outlier among high-income countries with respect to medical cost as a percentage of GDP. Virtually all high-income countries have used government single-payer bargaining power to limit the rise in prices of medical goods and services. Payer bargaining power has been used to limit prices set by hospitals and drug companies and fees set by doctors and to set budgets — total spending caps — for hospitals, drugs, and doctors.

Why is government needed to negotiate prices for medical care but not for most other goods and services? For most goods and services, consumers pay the price, can judge quality, and are able to shop around, so if one firm sets its price higher than a rival firm but its quality is no higher, consumers will switch to competitors. But for most medical care, most patients (consumers) don't pay the price (except for a small co-payment), can't judge quality, and are in no condition to shop around. So consumers are incapable of limiting prices for medical care.

Of course, private insurers who pay most medical bills often refuse to pay the full price that medical providers charge. But when there are many private insurers, each insurer has weak bargaining power to restrain price increases because a provider can refuse to take a patient covered by an insurer who won't pay a high enough share of the price. Each insurer fears that patients will tell their employer to get another insurer who will pay a high enough share of the price so that medical providers will treat them. With many private insurers, no single insurer has sufficient bargaining power to significantly hold down prices. Merging private insurers into one is the wrong solution because that single private insurer would use its enormous monopoly power to charge very high premiums to employers and individuals. The best solution is for the government to become the single payer of medical providers.

High price, not high quantity, is the main reason that US medical expenditure — which equals price times quantity — is so high. That is the conclusion of an empirical study of OECD countries (Anderson et al. 2003), titled "It's the Prices, Stupid: Why the United States Is So Different from Other Countries." The study's authors analyze the split between price and quantity in 2000, presenting comparisons of different quantity measures including the number of doctors, nurses, hospital beds, hospital admissions, and hospital days. In most of these, the quantity per capita in the United States was at or below the OECD median. They conclude that prices, not quantities, are the drivers of cross-national differences in health spending and that a major cause of the difference in prices is the difference in the bargaining power of the payers of medical providers. They emphasize the difference between the United States and other OECD countries in the degree of bargaining power on the buyers' side of markets for medical care, writing: Although the huge federal Medicare program and the federal-state Medicaid programs do possess some monopsonistic purchasing power, and large private insurers may enjoy some degree of monopsony power as well in some localities, the highly fragmented buy side of the

U.S. health system is relatively weak by international standards. It is one factor, among others, that could explain the relatively high prices paid for health care and for health professionals in the United States.
In comparison, the government-controlled health systems of Canada, Europe, and Japan allocate considerably more market power to the buy side. (Anderson et al. 2003: 102)
But will government single-payer bargaining power under Medicare for All lead to waiting lists and low quality? It depends on whether bargaining power is applied severely or moderately. The aim of the government single-payer should be to negotiate prices that are high enough to make it worthwhile for medical providers to provide high-quality medical care to all patients, but no higher. If the single-payer forces prices down too far, providers won't find it worthwhile, and there will be waiting lists and low quality. The single-payer should let prices rise enough to eliminate waiting lists and achieve high quality, but no higher. Without government single-payer intervention and negotiation, medical prices will be much higher than needed to prevent waiting lists and achieve high quality. In countries where payer bargaining power has sometimes been applied severely (Britain and Canada), waiting lists have sometimes been generated and quality has sometimes been inadequate. But in countries where payer bargaining power has been applied moderately (France and Germany), waiting lists have generally been avoided and quality has generally been high.

• Single payer solves – creates economies of scale, increases consumer spending and reduces cost inflation – helps reduce pharma monopolies

Anamaria **Lopez**, Research assistant to Joseph Stiglitz, **7-8**-2017, "The Economic Case for Single Payer Health Care in the US," Institute for New Economic Thinking, https://www.ineteconomics.org/perspectives/blog/the-economic-case-for-single-payer-health-care-in-the-us

Since the Republican Party's alternative to Obamacare passed the House of Representatives in May, the debate over health care in the United States has erupted anew. While his party tries to overcome warring factions to push its "repeal and replace" legislation, President Donald Trump himself called the House bill "mean," while official estimates say 22 million people would lose health coverage under the Senate version. Protests over these proposals have broken out across the country, from Capitol Hill to members of Congress' town halls in home districts. Economists, too, are divided on what model of health care will ultimately be best for the American economy. But most agree that the status quo cannot continue indefinitely. A significant contingent, including Nobel laureate and INET grantee Joseph Stiglitz, view a single-payer system—in which the government (the "single payer") covers the cost of health care for every citizen—as the only viable model in the long run. An inefficient system Much of the economic argument in favor of single payer centers on the question of efficiency. The need for hospitals to sift through mountains of insurer-related paperwork keeps administrative costs extremely high, and these costs are passed on to consumers. This inefficiency is compounded by a problem of asymmetric information built into the structure of the American health care system. The average consumer of health care has limited information on the quality of a given insurance plan, and shopping between plans—and accurately assessing the difference in quality between each—is difficult. The result of these problems, say some economists, is a fundamental failure in the market for health care, which is distributed unevenly and uneconomically among consumers. Anders Fremstad, Professor of Economics at the University of Colorado, observes that consumers consistently overpay for health care because of inefficiency, and that many are discouraged from seeking it at all due to the complexity of the system. Economist Dean Baker, Co-director and Founder for the Center for Economic and Policy Research in Washington, D.C., agrees, citing the inefficiency linked to the current multi-payer system as the most compelling factor driving the need for single payer. Drawing a comparison with the United Kingdom, in which health care is paid for and distributed by the government, Baker notes that "part of the greater efficiency of the U.K. system is the fact that their hospitals and doctors don't have to shuffle endless papers back and forth to collect from competing insurers, along with the various copays and deductibles that must be paid by the patient." Baker argues that this blizzard of paperwork imposes administrative costs not only upon the health care system as a whole, but also upon the patient. He or she must expend time and energy puzzling through how much they owe for each

visit, as opposed to paying a straightforward proportion of their income annually to the government, as is the case in a single-payer system. Baker also cites the role of protectionism in the pharmaceutical and health care industries, which keeps costs in the U.S. artificially high compared to other countries. In his view, the government practice of granting monopolies to pharmaceutical companies has resulted in unreasonable price gouging of lifesaving medicine. Protectionist regulations governing who can practice health care practice keep doctors' salaries high, he says, because there is little competition from foreign-trained competitors. Like Baker, Julie Nelson, Professor of Economics at University of Massachusetts Boston, notes the logistical hurdles the private insurance-based system engenders. Simply keeping track of whether a person is covered, what they are covered for, where they can receive care, and who gets billed for what consumes endless hours of time on the part of those in need of care, and bloats the offices of providers, insurers, employers, and program agencies. Julie Nelson Nelson posits that a move away from an employer- or private insurer-based system will have a net positive effect on efficiency because workers will no longer need to consider the availability of insurance when deciding whether to take or leave a job. As a result, they will be more likely to take up employment that they enjoy and that fits their skill set, without being restricted in terms of hours or location. As a self-described feminist economist, Nelson also notes a further single-payer benefit: Employers would not be able to limit access to contraception or any other procedures on the basis of religious freedom arguments. What the numbers say Other economists emphasize that empirical evidence appears to favor single-payer. Robert Pollin, Professor of Economics at the University of Massachusetts Amherst and Co-Director of the Political Economy Research Institute, notes that in the U.K., Germany, Japan, and other major developed nations, costs for health care make up only between 9 and 12 percent of GDP, while in the US spends closer to 17 percent of GDP. Yet, as he stresses, all of these countries perform better than the U.S. according to standard public-health measures such as average life expectancy. Pollin was one of four authors of a recent report assessing the potential economic effects of California's single-payer health care bill, which recently passed through the state's Senate. We found that the proposed Healthy California measure will generate [substantial] financial benefits for both families and businesses at all levels of the California economy. Robert Pollin To these financial arguments, he adds moral reasoning in his case for single-payer, which for him is "the organizing principle through which decent health care can be delivered to everyone in the U.S. as a basic human right." Why the government should be the payer L. Randall Wray, Professor of Economics at Bard College in New York, criticizes the framing of single-payer health care as "universal health insurance." Wray argues that a single-payer health care system would in reality need to operate very differently than a universal health insurance program—largely because the concept of covering health care through an insurance system in the same way that we cover our homes or cars is fundamentally flawed. He explains that going to the doctor is not like going to the auto repair shop: Humans require consistent, preventative health care, and for-profit insurance isn't designed to provide it. Wray notes that home or auto insurance is designed to be a "bad deal" for consumers, who pay premiums throughout their lives to protect themselves in the rare event that their house catches on fire or they get into a high-impact car crash. Health care is different because coverage isn't just about catastrophe: Most costs go toward routine or preventative care, like annual checkups. As Wray puts it, routine health care is "not analogous to an 'act of God' that destroys your house: It is predictable, welcome, and life-enhancing." Economist Gerald Friedman, also of University of Massachusetts Amherst, has similar concerns about applying insurance companies' profit-based business model to health care coverage. Such an arrangement leads to "adverse selection," he says. Friedman explains that because of the concentration of health care spending on a few sick and injured individuals, private insurers will seek to save costs by identifying and avoiding such people— a practice called "lemon dropping"—while attracting the healthy—or "cherry picking." Even with Obamacare protections around preexisting conditions, insurers are able to drop out of the Obamacare market altogether. While these strategies are profitable for insurers, they raise costs for consumers, putting those who can least afford to pay at risk. Like Baker, Friedman is also concerned with the soaring price of pharmaceuticals and hospital services in the U.S., and argues that only a single-payer system

can reverse the trend: A system with multiple insurers leaves none with the market power to stand up to elite providers, including drug companies and hospitals. Gerald Friedman Over time, Friedman argues, a single-payer system will not only cut costs, but also significantly improve the quality of health care and lead to more innovation and deeper research. For example, there are currently no data on outcomes and health care utilization across the country other than those collected by the VA and Medicare. The mass of data a single-payer system would accumulate—across the population and over time—would open doors to more conclusive research and "allow for quality analysis of treatment and provider behavior," says Friedman. In the long run, he says, such data—and the system that produces it—could revolutionize the way health care is practiced in the US.

1AC: Cost Crisis

• ACA death spiral is inevitable – growing national liabilities for health insurance companies guarantees a crisis that collapses the entire economy

Howrigon 16 – Ron Howrigon, President and CEO of Fulcrum Strategies, Masters in Economics from North Carolina State University, has held Senior Management level positions with three of the largest Managed Care Companies in the country, including Kaiser Permanente, CIGNA HealthCare and BlueCross BlueShield, former Director of Community Medical Services with Kaiser Permanente (*Flatlining: How Healthcare Could Kill the US Economy*, Greenbranch Publishing, pages 53-54, December 30th, kindle)

So **the nationals have started leaving** this market like rats jumping from a sinking ship. **By the end of 2017** it's likely that if the national carriers participate at all in the exchanges it will be **sparse at best**. The more likely scenario is that the national carriers will be out completely by the end of 2017. That leaves only the BCBS plans and a few local insurance options to provide insurance for 12 million people.

The reason for this mass exodus is the simple fact that the cost of the people enrolling in the ACA exchanges is beyond anything that could have been predicted. **The cost of that care is producing staggering losses**. Some of the statistics are truly shocking. The national carriers all report significant losses with the limited experience they have had with the exchanges. Remember they cherry-picked the markets they entered and still they got stung. **United HealthCare reports losses of over $1 billion in just two years**. Aetna and Cigna report losses of close to $500 million each over two years.

Think about this for a moment. Three large insurance companies who make a living by estimating risk and pricing their products to that risk tiptoed into a new market, hand- picked the cities and states they believed would produce the best results, and in two years **lost a combined $ 2 billion dollars**. The BCBS experience has been no different. Every BCBS plan reports significant losses from the ACA. If you combine the financials for the nonprofit BCBS plans around the country, they posted a net loss in 2015. That hasn't happened in over 30 years. BCBS of North Carolina reports that the members they attracted in the exchange were 40% more costly than their average member before the ACA.

These losses and this experience have produced the **beginning of the death spiral**. The death spiral begins when a health insurance company starts losing money. **The reaction is to raise premiums**. However when you raise premiums, the young healthy people can no longer afford it and they drop out—Which leaves you with an **even sicker mix of people**. That results in increased costs and more losses, which drives up premiums . . . **thus the death spiral**.

As we've already discussed, the fact of the matter is health insurance only works if you have enough young healthy people to make up for the small percentage of very sick people who use most of the services. We now know that **the ACA exchanges have attracted some very expensive and sick people**, and that the individual mandate and federal subsidies are not enough to attract, or force, enough young healthy people into the market to offset these costs. The result is **the national companies have fled the scene** and have left the various BCBS plans holding the proverbial bag. This development could have a **significant negative impact**

on the delivery and financing of healthcare in this country beyond what anyone thought of when the law was passed. That will be explored later in this book.

Big Pharma

The only major winners in all of this seem to be the big pharmaceutical companies. The combination of Medicare Part D prescription benefits and the ACA adding 12 million covered lives—all with pharmacy benefits—has provided a serious boost to the profits of the pharmaceutical industry. In 2014, the biotech and pharmacy sectors worldwide produced revenues of over $1 trillion for the first time in history. To put that into perspective, if this industry were a country, it would be the 16th largest economy in the world just behind Mexico.

But massive revenues tell only part of the story. In 2014, the top 10 most profitable publicly traded healthcare companies were all in either the biotech or pharmaceutical industries. That's right, no insurance company stocks cracked the top 10. Seven of the 10 were biotech and the other three were pharma companies. Even more staggering are the profit margins these companies produce. Remember that the ACA, through the medical loss ratio requirement, effectively limited insurance companies to a profit margin of 3% to 4% on commercial insurance products. With that in mind, it's staggering that the top 10 most profitable biotech and pharmaceutical companies produced profit margins in 2014 ranging from 40% to 109%. Can you imagine being the CEO of a company that produces a 40% profit margin and being told by your board that you failed because nine of your peers did better?

While these are the 10 most profitable companies, the sector as a whole produced a profit margin of over 20%. So, if the ACA put the same kind of profit controls on pharmacy and biotech as it did on insurance, it would have reduced drug company profits— and therefore healthcare costs—by $160 billion in 2014 alone. I'm not suggesting the key to controlling costs is to enforce government profit controls in a free-market economy. Whenever that happens you have to look at the negative side effects. Just like raising the minimum wage leads to increases in unemployment, limiting corporate profits often results in a reduction in investment and innovation. The point of these statistics is to shed some light on the Winners and losers in the healthcare environment today rather than prescribe solutions. The solutions will come a bit later.

As we look at the healthcare landscape today, we see a market that is **inflating faster than overall economic growth can accommodate**. We find a market that is **massive** and consuming an ever-increasing portion of the U.S. economy. We see a market that is negatively affecting not only governmental spending, but also the private sector. We see a market where there are few winners other than the big biotech and pharmaceutical companies and **several significant losers**. We see a market where the problem of the uninsured still hasn't been solved. Lastly our most recent solution, the Affordable Care Act, has not only failed to solve the problem of runaway inflation, but by all accounts, made it worse.

Simply put, we see a market that is poised for **correction if we are lucky and collapse if we aren't**. We see the economic version of the perfect storm. Hold on to your hats ladies and gentlemen it's going to get a little windy.

• Even absent a death spiral, increases in health care costs ensure an epic collapse that ripples through the entire economy, forcing debt and unemployment to skyrocket to unsustainable levels

Howrigon 16 – Ron Howrigon, President and CEO of Fulcrum Strategies, Masters in Economics from North Carolina State University, has held Senior Management level positions with three of the largest Managed Care Companies in the country, including Kaiser Permanente, CIGNA HealthCare and BlueCross BlueShield, former Director of Community Medical Services with Kaiser Permanente (*Flatlining: How Healthcare Could Kill the US Economy*, Greenbranch Publishing, pages 8-11, December 30th, kindle)

In 2010, the United States GDP was $15 trillion. The total healthcare expenditures in the United States for 2010 were **$2.6 trillion**. At $2.6 trillion, the U.S. healthcare market has moved up from 15th and now ranks as the 5th largest world economy, just behind Germany and just ahead of both France and the United Kingdom. That means that while healthcare was only 5% of GDP in 1960, it has risen to **over 17% of GDP** in only 50 years.

Over that same time, the Defense Department has gone from 10% of GDP to less than 5% of GDP. This means that in terms of its portion of the US. economy, defense spending has been reduced by half while healthcare spending has more than tripled.

If healthcare continues to trend at the same pace it has for the last 50 years, it will **consume more than 50% of the US. economy** by the year 2060. Every economist worth their salt will tell you that healthcare will never reach 50% of the economy. It's simply not possible because of all the other things it would have to crowd out to reach that point. So, if we know healthcare can't grow to 50% of our economy, **where is the breaking point?** At what point does healthcare consume so much of the economy that it **breaks the bank**, so to speak?

This is the big question when it comes to healthcare. If something doesn't happen to reverse the 50-year trend we've been riding, when will the healthcare bubble burst? How bad will it be and how exactly will it happen? While no one knows the exact answers to those questions, economists and healthcare experts agree that something needs to happen, because **we simply can't continue on this trend forever**.

Another way to look at healthcare is to study its impact on the federal budget and the national debt. In 1998, federal healthcare spending accounted for 19% of the revenue taken in by the government. Just eight years later, in 2006, healthcare spending had increased to 24% of federal revenue. In 2010, the Affordable Healthcare Act passed and significantly increased federal spending for healthcare—so much so that in 2016, healthcare spending accounted for almost **one-third of all revenue** received by the government and surpassed Social Security as the largest single budget category. What makes this trend even more alarming is the fact that revenue to the federal government doubled from 1998 to 2016. That means healthcare spending by the federal government has almost quadrupled in terms of actual dollars in that same time period. If this trend continues for the next 20 years, healthcare spending will account for over half the revenue received by the government by the year 2035. Again, that simply can't happen without causing **significant issues for the financial wellbeing of our country**.

In recent history, the U.S. economy has experienced the near catastrophic failure of two major market segments. The first was the auto industry and the second was the housing industry. While each of these reached their breaking point for different reasons, they both required a significant government bailout to keep them from completely melting down. What is also true about both of those market failures is that, looking back, it's easy to see the warning signs. What happens if healthcare is the next industry to suffer a **major failure and collapse?**

It's safe to say that a healthcare meltdown would make both the automotive and housing industries' experiences **seem minor** in comparison. While that may be hard to believe, it becomes clear if you look at the numbers. The auto industry contributes around 3.5% of this country's GDP and employs 1.7 million people. This industry was deemed "too big to fail" which is the rationale the U.S. government used to finance its bail out. From 2009 through 2014, the federal government invested around $80 billion in the U.S. auto industry to keep it from collapsing. **Healthcare is five times larger than the auto industry** in terms of its percentage of GDP, and is ten times larger than the auto industry in terms of the number of people it employs.

The construction industry (which includes all construction, not just housing) contributes about 6% of our country's GDP and employs 6.1 million people. Again, the healthcare market dwarfs

this industry. It's three times larger in terms of GDP production and, with 18 million people employed in the healthcare sector, it's three times larger than construction in this area, too.

These comparisons give you an idea of just how significant a portion healthcare comprises of the U.S. economy. It also begins to help us understand the impact it would have on the economy if **healthcare melted down** like the auto and housing industries did. So, let's continue the comparison and use our experience with the auto and housing industries to suggest to what order of magnitude the impact a failure in the healthcare market would cause our economy.

The bailout in the auto industry cost the federal government $80 billion over five years. Imagine a similar failure in healthcare that prompted the federal government to propose a similar bailout program. Let's imagine the government felt the need to inject cash into hospital systems and doctors' offices to keep them afloat like they did with General Motors. Since healthcare is five times the size of the auto industry, a similar bailout could easily cost in excess of $400 billion. That's about the same amount of money the federal government spends on welfare programs. To pay for a bailout of the healthcare industry, **we'd have to eliminate all welfare programs in this country**. Can you imagine the impact it would have on the economy if there were suddenly none of the assistance programs so many have come to rely upon?

When the housing market crashed, it caused the loss of about 3 million jobs from its peak employment level of 7.4 million in 1996. Again, if we transfer that experience to the healthcare market, we come up with a truly frightening scenario. If healthcare lost 40% of its jobs like housing did, it would mean **7.2 million jobs lost**. That's more than four times the number of people who are employed by the entire auto industry—an industry that was considered too big to be allowed to fail.

The loss of 7.2 million jobs would increase the **unemployment rate by 5%**. That means we could easily top the all-time high unemployment rate for our country. In November of 1982, the U.S. unemployment rate was 10.8%. A failure in the healthcare sector could push unemployment to those levels or higher. The only time in our country's history when unemployment was higher was during the Great Depression. It should also be noted that in 1982, home mortgage interest rates were close to 20%! The U.S. Federal Funds Rate, or the interest rate the government pays on our national debt, was also close to 20% in 1982.

Economists fear that a large increase in unemployment could cause interest rates to escalate to levels approaching those of the early 1980s. If that were to happen today, with a $19 trillion national debt, it would mean that our annual debt service would be $3.8 trillion. Keep in mind that the federal government only takes in $3.4 trillion in total revenue. That's right, in our nightmare scenario where healthcare fails and eliminates 7.2 million jobs, which pushes unemployment above 10% and causes interest rates to climb to almost 20%, we would be in a situation where the interest **payments on our current debt would be more than our entire federal tax revenue**. Basically, we would be Greece, but on a much larger scale.

Ok, now it's time to take a deep breath. I'm not convinced that healthcare is fated to unavoidable failure and economic catastrophe. That's a worst-case scenario. The problem is that **at even a fraction** the severity of the auto or housing industry crises we've already faced, **a healthcare collapse would still be devastating**. Healthcare can't be allowed to continue its

current inflationary trending. I believe we are on the verge of some major changes in healthcare, and that how they're implemented will determine their impact on the **overall economic picture** in this country and around the world. Continued failure to recognize the truth about healthcare will only cause the resulting market corrections to be worse than they need to be.

I don't want to diminish the pain and anguish that many people caught up in the housing crash experienced. I think an argument can be made, though, that if the healthcare market crashes and millions of people end up with no healthcare, the resulting fallout could be much worse than even the housing crisis.

• Single-payer solves the cost crisis by lowering administrative cost burdens and reshaping payment incentives

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

With the U.S. spending more on health care than any other developed nation and yet achieving lower levels of health (ranking 28th, in terms of life expectancy at birth, among the 35 OECD countries, for instance), it is evident that **our health care system is ailing**. David Collander's thought-provoking article ''Reforming the Affordable Care Act'' (ACA) rightfully diagnoses what ails U.S. health care, underscoring the central problems related to cost and accessibility. The issue that David points to is that accessibility and health care costs are **strongly intertwined** – the high cost of medical care **raises insurance premiums** making it difficult for many to afford coverage and obtain access to quality care. While I agree with this assessment, David overlooks the reverse feedback (from the uninsured or under-insured to higher costs) and downplays the importance of the ''insurance problem.'' Certainly, as health care costs rise, more people – many younger, and for the moment in good health – **opt to live without insurance**, which raises rates for everyone else. However, there is evidence that **uninsured individuals end up costing the health care system more**, not just from the standpoint of administrative expenses or because of their lower bargaining ability as David notes, but because they lack a routine source of care. For instance, those who were previously uninsured received fewer basic clinical services when uninsured and, upon gaining Medicare coverage, cost the program an additional $1,000 annually per person when compared to those who were consistently covered.1 These increased costs were mainly due to delayed care and preventable hospitalizations. **Lack of insurance**, which leads to such fragmented care, is thus at least partly responsible for the inefficient care; when we look at life expectancy at age 65, the age at which Medicare provides virtually universal care in the U.S., health disparities between the U.S. and other developed nations substantially narrow.

The primary aim of the ACA has been to improve accessibility, and it does so by reforming the non-group insurance market. To the extent that almost 20 million individuals have newly gained coverage as a result of it, this would lead to a more efficient allocation of resources between preventive and curative care and reduce costs over time. Nevertheless, almost 30 million individuals still lack coverage. And, for political reasons **the ACA was not able to fully take on**

cost control, instead including a variety of promising proposals which may or may not be successful in bending the cost curve. I agree with David that holding down health care costs is key to addressing the accessibility problem as well, but **the $3 trillion question** is how.

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

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

David concludes with the essential point that the reforms he outlines (and those brought about by the ACA) are not sufficient. Cost control in the health care system ultimately has to address **how we deliver care and the embedded payment incentives**, which currently are mostly based on quantity and volume rather than quality and performance. I am not sure however that a multi-payer system would be most amenable to new models of organizing and reimbursing medical providers. On the contrary, such reforms are intrinsically **more likely under a single-payer system**. As Jon Gruber notes, cutting health care costs in the U.S. would mean cutting incomes for the medical sector, which is never politically easy and would be even more difficult under a multi-payer system.

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

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

Howrigon 16 – Ron Howrigon, President and CEO of Fulcrum Strategies, Masters in Economics from North Carolina State University, has held Senior Management level positions with three of the largest Managed Care Companies in the country, including Kaiser Permanente, CIGNA HealthCare and BlueCross BlueShield, former Director of Community Medical Services with Kaiser Permanente (*Flatlining: How Healthcare Could Kill the US Economy*, Greenbranch Publishing, pages 17-20, December 30th, kindle)

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

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

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

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

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

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

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

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

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

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

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

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

1AC: Military

• Healthcare spending is a huge draw on the military budget

Mackenzie **Eaglen and Morrison, 13.** 10-17-13. (Eaglen: resident fellow in the Marilyn Ware Center for Security Studies at the American Enterprise Institute. "Preserving the Military Health Care Benefit: Needed Steps for Reform." *American Enterprise Institute*. Accessed 8-1-17. http://www.aei.org/publication/preserving-the-military-health-care-benefit-needed-steps-for-reform/ JSD.)

Despite the threat of almost $1.5 trillion in cuts to the US military, top-line reductions are only one component of the multitude of challenges facing the Pentagon. **The rising cost of personnel within the Department of Defense is squeezing the budget from within as military health care costs, the largest personnel cost driver, grow exponentially. Although the cost of military pay, allowances, and health care has risen 90 percent since fiscal year (FY) 2001, the active-duty personnel count has risen by less than 3 percent.[1]** These pay and benefits increases were created with the best of intentions in the midst of two brutal wars, but they have reached the point where they are simply unsustainable. **This spending is set to rise further, threatening to crowd out crucial modernization spending and leave the United States behind the cutting edge**. In the words of former defense secretary Robert Gates**, "Health-care costs are eating the Defense Department alive."[2] In FY 2013, DoD requested a total of $48.7 billion for military health care—approaching 10 percent of its base budget. Increasingly, this money is going to individuals no longer in the military, while active-duty service members are seeing a decreasing share of DoD health benefits.** According to TRICARE's 2012 annual report to Congress**, active-duty members make up only 15 percent of all military health care beneficiaries, while retirees of all ages and their family members make up 53 percent**.[3] In less than a decade, **defense health care spending increased by over $25 billion, from $17.4 billion in FY 2000 to $42.5 billion in FY 2008, a 144 percent increase**.[4] **At this rate, health care spending is growing faster than the Defense Department's discretionary spending.** Given demographic trends and spiraling health care costs across the wider US economy, this trend will only grow more pronounced in future years. The Congressional Budget Office (**CBO) projects that military health care costs will increase to $65 billion by 2017 and $95 billion by 2030—nearly a 100 percent increase from today**.[5]

• Military healthcare doesn't meet field needs

Justin **Johnson, 16**. 2-17-16 (Johnson: Senior analyst for defense budgeting policy in the Heritage Foundation's Center for National Defense. "It's Time to Improve Military Health Care." *War on the Rocks*. Accessed 8-1-17. https://warontherocks.com/2016/02/its-time-to-improve-military-health-care/ JSD.)

At the same time**, the current military health system is not optimized to provide medical support to an active, global military. TRICARE and the military treatment facilities produce doctors who overwhelmingly focus on providing care to military families rather than the types of injuries and health problems seen in combat.** While military medical professionals have done amazing work saving lives in Iraq, Afghanistan, and elsewhere, some of this expertise might be fading, in part because

the **military medical practitioners at home are not focused on trauma. The top two inpatient procedures in military hospitals, both by volume and by cost, are pregnancy/childbirth and newborn care.** In fact, in 2014 there were twice as many pregnancy and newborn care procedures in military hospitals as the rest of the top 20 procedures combined. **An IDA study of military medical staff concluded that the military "understaffs operationally required specialties" and "overstaffs beneficiary care specialties."** For example, the Army had only 126 general medicine doctors in uniform but needs to be able to deploy 378. At the same time, the Army has 232 pediatricians in uniform, but only needs to be able to deploy one. **Caring for military families is vitally important, but pediatricians are not in high demand in combat medicine.**

• Healthcare spending trades off with defense

Mackenzie **Eaglen and Morrison, 13.** 10-17-13. (Eaglen: resident fellow in the Marilyn Ware Center for Security Studies at the American Enterprise Institute. "Preserving the Military Health Care Benefit: Needed Steps for Reform." *American Enterprise Institute*. Accessed 8-1-17. http://www.aei.org/publication/preserving-the-military-health-care-benefit-needed-steps-for-reform/ JSD.)

For one, as CBO notes, the "**growth rates of per-person costs in the military health system over the past six years have been significantly higher than the corresponding national averages**."[6] Much of this cost growth was due to generous TRICARE benefits and relatively low cost sharing. This led many enrollees in TRICARE Prime, for instance, to consume health care at a much higher rate than civilians enrolled in traditional plans. **A related issue is how the military health system provides private-sector care for its beneficiaries, especially retirees**. From FY 2001 to FY 2006, **costs for purchased care increased by 19.6 percent per year, while direct care costs grew by only 6.2 percent** annually.[7] These cost increases are not going unnoticed. **A consensus has begun to emerge that the rising cost of military health care is unsustainable and poses a challenge as spiraling costs undermine the military's ability to train, equip, and supply America's men and women in uniform**. As retired Marine Corps General Arnold Punaro has said, "I am very concerned that as current trends continue**, this country will not have the strong military it needs 20 years from now, because all of the money is going to go to pay people that are no longer serving**."[8] Punaro is not alone in this concern. In fact, in 2011, the Joint Chiefs of Staff penned a 24-star letter—signed by the chairman, vice chairman, and four service chiefs, in support of modest increases in TRICARE cost-sharing requirements as a first step to getting rising spending under control.[9] The letter insisted that fee increases would not break faith with those in uniform but, rather, were necessary given increasing budgetary pressure—which has only since increased.

• Healthcare spending detracts from military readiness

John **Kokulis 13.** 10-17-13. (Kokulis: Board of Directors for Gold coast Veterans Foundation. "Preserving the Military Health Care Benefit: Needed Steps for Reform." *American Enterprise Institute*. Accessed 8-1-17. http://www.aei.org/publication/preserving-the-military-health-care-benefit-needed-steps-for-reform/ JSD.)

Introduction **The rise in military health care spending has been a primary driver of the large growth in military personnel compensation** over the past decade. Left unchecked**, these costs will impact the ability of the DoD's Military Health System (MHS) to support its three critical missions: Readiness for deployment:** Maintaining an agile, fully deployable medical force and a health care

delivery system so they are capable of providing state-of-the-art health services anytime, anywhere; **Readiness of the fighting force**: Helping commanders create and sustain the most healthy and medically prepared fighting forces anywhere; **and The benefits mission**: Providing long-term health coaching and health care for 9.7 million DoD beneficiaries.[11] At the center of these three missions are the DoD's Military Treatment Facilities (MTFs) and the medical professionals that work and train at them.

• Reform of healthcare key to the military crisis

John **Kokulis 13.** 10-17-13. (Kokulis: Board of Directors for Gold coast Veterans Foundation. "Preserving the Military Health Care Benefit: Needed Steps for Reform." *American Enterprise Institute*. Accessed 8-1-17. http://www.aei.org/publication/preserving-the-military-health-care-benefit-needed-steps-for-reform/ JSD.)

Rapid Cost Escalation **DoD's total medical costs have more than doubled, from $19 billion in fiscal year 2001 to $48.7 billion for fiscal year 2013.**13 Growing faster than DoD's overall budget, **these costs now make up close to 10 percent of DoD's total budget, whereas they represented only 5.9 percent of the total back in FY 2001.** (See figure 1.) Left unchecked, **the problem is forecasted to get worse**. In a 2012 report, the Congressional Budget Office **(CBO) estimated the military health care budget will jump to $65 billion by 2017 and to $95 billion by 2030**.14 CBO is not alone in its concern. Since 2007, the Government Accountability Office (**GAO) has identified concerns regarding the sustainability of military health care benefits and recommended that Congress consider restructuring** military compensation.[15] **The consensus surrounding military health care reform runs even deeper. Numerous independent panels, commissions, and organizations,** including the Quadrennial Review of Military Compensation, the Defense Business Board, the Quadrennial Defense Review Independent Panel, the Center for American Progress, the RAND Corporation, the Heritage Foundation, and the Center for Strategic and International Studies, **have all agreed that serious reform is im**perative. Although these groups and organizations are often bitterly divided on many issues, one thing they have in common is the belief that the status quo is unsustainable.

• Readiness remains crucial to global stability

Richard **Dunn, 13** 7-18-13 (Dunn: Senior Research Fellow. Consultant on international security affairs. He is a retired army colonel. "The Impact of a Declining Defense Budget on Combat Readiness." *The Heritage Foundation*. Accessed 8-1-17. http://www.heritage.org/defense/report/the-impact-declining-defense-budget-combat-readiness JSD)

Regrettably, world events and potential threats to U.S. strategic national interests are not driven by the same forces that drive the political and budgetary gridlock in Washington. **North Korea's increasingly bellicose rhetoric and actions endanger regional stability in the economically vital Western Pacific. The maelstrom of conflict in Syria threatens to engulf its neighbors as Iran continues to pursue a destabilizing nuclear capability** in the Middle East. **The one-word descriptor for our strategic situation is "uncertain."** Under these conditions**, allowing the readiness of our armed forces to decline is extremely unwise**. Despite major political and legislative challenges**, maintaining balance**

among the different dimensions of readiness should be a major goal of our defense policy, and defense resources should be apportioned accordingly. **Even as defense budgets decline, we need to recognize that imbalances among the personnel, equipment, and training dimensions can weaken readiness** as much as or more than the reduction in overall defense spending can. To fulfill its obligations for national defense, Congress needs to maintain full awareness of the different dimensions of readiness, present and projected, and the relationships among them as the Defense Department navigates through the budget crisis. This will require a deeper look into readiness than is currently provided by the formal military readiness reporting system. It necessitates a more holistic understanding of how apparently unrelated changes in one dimension may have a longer-term and more far-reaching impact in others.

• Readiness key to response time to war

Richard **Dunn, 13** 7-18-13 (Dunn: Senior Research Fellow. Consultant on international security affairs. He is a retired army colonel. "The Impact of a Declining Defense Budget on Combat Readiness." *The Heritage Foundation*. Accessed 8-1-17. http://www.heritage.org/defense/report/the-impact-declining-defense-budget-combat-readiness JSD)

Although we know that the future may hold significant dangers, they remain ill defined, creating a challenging analytical problem for national security policymakers. **History can provide useful insights into how to approach strategic uncertainty**. We know we cannot "get it entirely right." Therefore, we should strive not to get it so far wrong that we suffer unacceptable consequences when hit by unexpected threats. **Under conditions of uncertainty, a hedging strategy that provides a range of options makes the most sense. Historically, maintaining effective balance among the different dimensions of readiness and having some ready capability to deal with a wide range of potential threats have been an effective way to hedge strategic bets**. **In times of defense budgetary retrenchment, combat readiness of the armed forces often becomes one of the first casualties** of fiscal tightening. This was particularly true of the years between World War I and World War II, when the Great Depression and isolationism made military preparedness a very low national priority. **Despite the threatening war clouds rapidly expanding in Asia and Europe, the U.S. was woefully unprepared for global conflict. The shock of Pearl Harbor mobilized both the industrial capability and the moral determination** to overcome the early, disastrous reversals in the Pacific and tactical defeats in North Africa**. Once focused on military production, the U.S. economy rapidly produced overwhelming quantities of ships, aircraft, tanks, ammunition, and other matériel** needed for America to become the "Arsenal of Democracy." **However, U.S. forces quickly learned that training for combat, p**articularly in developing military leaders, **was just as complex and demanding**.

1AC: Undocumented Access

• Food insecurity causes WW3 – largest threat.

Heneghan 15. (Carolyn Heneghan for Food Dive, an industry and sustainability organization for the global food. Where food crises and global conflict could collide. January 22, 2015.www.fooddive.com/news/where–food–crises–and–global–conflict–could–collide/350837/)

World War III is unimaginable for many, but some experts believe that not only is this degree of **global conflict imminent**, but it may be instigated **not by military tensions, oil and gas, or nuclear threats, but** instead by, of all things, **food.** As it stands, countries across the globe are enduring food crises, and the U.N.'s Food & Agriculture Organization (FAO) estimates that about 840 million people in the world are undernourished, including the one in four children under the age of 5 who is stunted because of malnutrition. Assistant director–general of U.N. FAO Asia–Pacific Hiroyuki Konuma told Reuters that **social and political unrest, civil wars, and terrorism could all be possible results of food crises, and "world security as a whole might be affected."** Such consequences could happen unless the world increases its output of food production 60% by mid–century. This includes maintaining a stable growth rate at about 1% to have an even theoretical opportunity to circumvent severe shortages. These needs are due to the growing global population, which is expected to reach 9 billion by 2050 while demand for food will rise rapidly. Where the problems lie Exacerbating this issue is the fact that the world is spending less on agricultural research, to the dismay of scientists who believe global food production may not sustain the increased demand. According to American Boondoggle, "The pace of investment growth has slowed from 3.63 percent per year (after inflation) during 1950–69, to 1.79 percent during 1970–89, to 0.94 percent during 1990– 2009." Decreased growth in agricultural research and development spending has slowed across the world as a whole, but it is even slower in high–income countries. Water scarcity is another problem, including in major food–producing nations like China, as well as climate change. Extreme weather events are having a severe effect on crops, which have been devastated in countries like Australia, Canada, China, Russia, and the U.S., namely due to floods and droughts. An Intergovernmental Panel on Climate change recently warned that climate change may result in "a 2% drop each decade of this century," according to RT. Rising food costs also contribute to poor food security across the world as prices remain high and volatile. Higher food costs inhibit lower socioeconomic people's access to food, which contributes to the FAO's disturbing figure of global malnutrition. In addition to an inability for people to feed themselves, poverty can also reduce food production, such as some African farmers being unable to afford irrigation and fertilizers to provide their regions with food. Still another issue for decreased food production is the fact that many farmers are turning crops like soy, corn, and sugar into sources for biofuel rather than edible consumption, which means these foods are taken away from people to eat. Could these shortages lead to a major global conflict? Studies suggest that the food crisis could begin as early as 2030, just a short 15 years from now**,** particularly in areas such as East Asia and Sub–Saharan Africa. Both regions have significant problems with domestic food production. Some experts believe that, **to secure enough food resources for their populations, countries may go to war over the increasingly scarce food supply.** This could be due in part to warring parties blocking aid and commercial food deliveries to areas supporting their enemies, despite the fact that such a practice breaks international humanitarian law. Conflict also leads to lack of food supply for populations as people become displaced and forced from their homes, jobs, and income and thus cannot buy food to feed themselves. Displaced farmers are also unable to produce their normal crops, contributing still more to food shortages in certain countries. **Food insecurity is a major threat to world peace and could** potentially **incite violent conflict between countries across the world**. Thus, the U.N. and other governmental bodies are desperately trying to find ways to solve the problem before it becomes something they cannot control.

• US agriculture is key – shortages guarantee global conflict.

CCGA 4/30/17. (The Chicago Council on Global Affairs is an independent, nonpartisan organization. The Council takes no institutional positions on policy issues. STABILITY IN THE 21ST CENTURY: GLOBAL FOOD SECURITY FOR PEACE AND PROSPERITY. March 30, 2017. https://www.thechicagocouncil.org/publication/stability–21st–century–global–food–security–peace–and–prosperity)

America is facing enormous global challenges at the beginning of 2017, including **the threat of rapidly increasing global instability, conflict, and migration** as a result of **inadequate global**

food supplies and water scarcity. Today's global population of 7.4 billion people is expected to grow to 8 billion by 2024 and 10 billion by 2056.1 In addition, rising incomes in many low– and middle–income countries are further increasing the demand for food to satisfy the desire for higher quality, more nutritious, and diverse diets. Yet we have never been as well equipped as we are today to respond to these challenges. Bipartisan leadership from the United States and action by the global community over the past 25 years has led to impressive results in the fight against the destabilizing forces of food insecurity. **The US government**, in close cooperation with the private sector and university system, is **well positioned to expand its legacy of commitment to food security and not only bolster the livelihoods of millions of smallholder farmers and entrepreneurs around the world, but also open up new business opportunities and partnerships in emerging economies. Global food and nutrition security is in America's national security and economic interests** Food security promotes national security. Particularly in urban areas of low– and middle–income countries, **high food prices and reduced access to food can trigger protests and rioting, including armed conflict, that lead to political and economic instability with global consequences**.2 The global food crisis of 2007–08 demonstrated how spikes in food prices can plunge millions into hunger and deeper poverty, sparking riots that can undermine progress for years. **The food price crisis hit hardest in countries with systems that were least able to respond effectively to global price volatility.** For example, food price–related protests toppled governments in Haiti and Madagascar in 2007 and 2008. In 2010 and 2011 food prices and grievances related to food policy were one of the major drivers of the Arab Spring.3 Food insecurity can also be a powerful driver for migration. Despite ongoing conflicts, much of today's global migration crisis is driven by economic factors, as millions of people flee hunger and poverty in their countries. On the other hand, countries that have achieved sustained development progress and greater food security are less susceptible to volatility and violence. Food security promotes stability and economic opportunity. Greater prosperity and economic growth in low–income countries create new and expanding markets, presenting growth opportunities for American farmers, ranchers, and businesses. For instance, in Africa alone the value of the agriculture and food sector is expected to reach $1 trillion by 2030.4 Rising incomes and changing diets are increasing demand for more diverse and nutritious foods. As economies grow, so does the demand for agricultural products, benefiting farmers locally and globally. Growing economic opportunities in the agriculture sector reach well beyond food production into sales of machinery and inputs, growth in demand for consumer packaged goods, and digital technologies for agriculture, where American companies are global leaders. Agricultural development leads to greater food and nutrition security, economic growth, and well–being If the history of development has taught us anything, it is that a strong agricultural sector is a cornerstone of inclusive and sustainable growth, broad–based development progress, and long–term stability. Simply put, **sustainable growth, job creation, and stability in low– and middle–income countries is not possible without a robust and productive agricultural sector**. Agricultural development programs are cost–effective. Investments in agricultural development have been proven to be more than twice as effective at reducing poverty as investments in other sectors.5 And gains to farmer productivity and income have proven enormously important both for the individuals involved and for societal progress more broadly. Agricultural production has, on average, almost doubled in low– and middle–income countries since 1995.6 Private investment in small and large farms and in agricultural value chains has been central to this growth, alongside public investments in infrastructure, R&D, and improvements in agricultural policies. There has been notable progress across almost all regions. These gains in agriculture are central to generating inclusive and sustainable growth, reducing hunger and poverty, improving nutrition, and achieving long–term stability. The combination of greater food availability and higher incomes over the past two decades has led to substantial reductions in hunger and improved nutrition. There are 200 million fewer chronically undernourished people in the world today compared with 1990, despite significant increases in population.7 The proportion of chronically undernourished people in low– and middle–income countries has fallen from 23 percent to 13 percent.8 At the same time, the number of people suffering from physical and cognitive stunting as a result of malnutrition has fallen from 250 million to 150 million.9 Current challenges must be met As important as the gains in fighting hunger and malnutrition over the past several decades have been, **they are not nearly enough. Major obstacles for food and nutrition security loom large. Population growth and rapid urbanization are increasing demand.** The global population will reach 8 billion by 2024 and 10 billion by 2056.10 Ninety–nine percent of the projected growth in the next century will occur in low– and middle–income countries.11 The challenges posed by this growth are daunting, especially in Africa, where more than half of the total population growth between now and 2050 will take place, adding another 1.3 billion people to the region. Most striking of all, in Nigeria, already the seventh–largest country in the world, the population is projected to grow from 180 million to nearly 400 million, surpassing the population of the United States by 2050. At the same time, many more people will live in cities than ever have before.12 The United Nations (UN) projects that the share

of people living in urban areas worldwide will increase from about 50 percent today to two–thirds by 2050. Virtually all of the expected growth in world population between now and 2050 is expected to be concentrated in the urban areas of low– and middle–income countries. Youth populations are exploding. In much of Africa and South Asia, a large and increasing share of growing populations will be adolescents and young adults – known as a "youth bulge." Africa has the youngest population in the world. There are currently 200 million people in the region between the ages of 15 and 24, and this number is expected to double within the next 30 years.13 As young populations boom, their creativity and productivity can help boost their countries' gross domestic product (GDP) – creating a pool from which the best and brightest can emerge to help solve problems around the world. Barred from participation in employment and opportunity, however, large populations of young people can be a destabilizing force in economies on the rise. A thriving food and agriculture sector, while by no means a silver bullet, is important to addressing the youth bulge by not only ensuring food and nutrition security, but also offering a source of employment throughout agricultural supply chains.

• Expanding undocumented access to health care prevents agticulture collapse from ACA restrictions.

Escalante and Luo 17. (Cesar L. Escalante is Professor, Department of Agricultural and Applied Economics, University of Georgia. Tianyuan Luo is a PhD candidate, Department of Agricultural and Applied Economics, University of Georgia. Sustaining a Healthy Farm Labor Force: Issues for Policy Consideration. 2017. www.choicesmagazine.org/choices–magazine/theme–articles/farm–labor–issues–in–the–face–of–us–immigration–and–health–care–reform/sustaining–a–healthy–farm–labor–force–issues–for–policy–consideration)

The success and viability of farm businesses depend to a certain extent **on the quality and quantity of the labor force**. Promoting a healthy workforce is a **priority for U.S. agriculture** because hired labor is an essential production input, accounting for the third largest production expense (Kandel, 2008). Recruiting and retaining farm workers, however, has usually presented a difficult challenge for farm businesses given high physical demands, heavy workloads, and relatively lower wages in the agricultural sector (Luo and Escalante, 2017a). These employment challenges are further aggravated by health risks: farm employees work under volatile weather conditions and risk contamination from chemicals in the production and processing environments (Grzywacz, Quandt, and Arcury, 2008). **Maintaining a healthy farm labor force is** further **complicated by the reality that a majority of workers on U.S. farms are immigrants**, some of whom may not even have legal authorization to work or be in the United States (Kandel, 2008; Martin and Jackson–Smith, 2013). Martin (2016), for instance, claims that between 2007 and 2009 only 30% of U.S. crop workers were born in the United States, while the remaining 70% were foreign–born. Within this category, about 55% were unlawfully residing in the United States and did not have legal employment authorization. Notably, jobs in the agricultural sector are 3.5% more likely to be performed by an undocumented worker than by a local, documented worker (Bump, 2015). Recent stricter implementation of immigrant control policies has resulted in the deportation of some undocumented immigrants (Escalante, Yu, and Li, 2016). At the same time, employment verification systems and monitored hiring procedures have been established and enforced, as have harsher sanctions (involving higher civil fines and criminal penalties) for employers who violate the law (Smith and Sugimori, 2015). However, **even with the intensified immigration control enforcement efforts**, the share of undocumented workers dropped in only a few industries, such as construction (Passel, 2015). Given the legal/illegal status profile of the farm sector labor force, understanding the patterns of workers' health care decisions could illuminate critical health care needs for farm workers. **Nurturing a productive farm labor force requires immigrant farm workers' health care needs and access to be given attention and consideration to a similar extent afforded farm workers who are U.S. citizens** (Mohanty, 2006; Mohanty et al., 2005; Laroche, 2000). What health care decisions do farm workers make? Do these decisions vary by legal status? Having this information can provide accurate and specific suggestions for farm operators in their efforts to maintain acceptable health standards among their workers. As the country's new leaders contemplate introducing significant changes to the previous administration's health care policies, the social imperative requires policy–makers to optimally allocate medical resources and promote the health welfare of all agricultural workers. To answer these questions, we first compare the health care utilization patterns of green card and undocumented farm workers with those of citizen farm workers who may be less constrained in accessing health services and benefits. The increasing immigrant population in the United States has created strong public sentiment due to the adverse effect on the adequacy and cost of social welfare programs (Borjas 1999). Given the implementation of public health reforms (e.g., the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and stringent immigration enforcement (e.g., E–verify mandates), do immigrants enjoy access to health care services and rates comparable to those enjoyed by U.S. citizens? We answer this question by investigating farm workers' choices among health care provider alternatives and the payment methods they use to settle health care bills. Based on legal status and demographic characteristics, farm workers may have diverse preferences for health care providers and methods of payment. Existing Farm Worker Health Care The availability of adequate and reliable health insurance coverage enhances a farm worker's access to health care services and provides relief in the settlement of health care bills. In addition to existing public health programs – such as Medicaid, Medicare, and military health care plans – a farm worker's options may also include employer–provided health insurance (EPHI) or directly purchased health insurance (DPHI). EPHI is a major means of providing employee health insurance coverage in the United States and covers over 54% of the U.S. population (Smith and Medalia, 2014). Among working–age adults (ages 18–64), the overall EPHI coverage rate for U.S. citizens is 67%, compared to 46% among legal permanent residents and 31% among undocumented immigrants (Capps, Rosenblum, and Fix, 2009). Immigrant workers are less likely to be covered by EPHI because 40% of them work in construction or agricultural industries, which generally have lower EPHI coverage rates (Ku and Jewers, 2013). The Affordable Care Act (ACA) passed in 2010 mandated that employers with at least 50 employees must provide health insurance coverage to full–time employees and their dependents. But the ACA excluded companies in the farm and service industries that either hired fewer than 50 employees or depended on seasonal workers. The 2012 annual average number of hired workers per farm business ranged from 18.5 to 85.8 in the sixteen farm labor regions (excluding state–level estimates provided separately for California and Hawaii) defined under the NASS farm labor survey system. Only three regions (Pacific, Lake, and Southern Plain) reported an average of more than 50 workers per firm (USDA–NASS, 2012). Directly purchased health insurance (DPHI) is a costly but important alternative for individuals in the United States who not eligible for both EPHI and public health insurance programs. According to Smith and Medalia (2014), 11% of the U.S. population choose DPHI and paid the premium out–of–pocket in 2010. U.S immigrant health care policies are inextricably linked to the effectiveness of the public health insurance program, which the Trump administration has explicitly targeted for a significant overhaul. A major immigration policy reform in 1996, the PRWORA1996, requires a five–year waiting period for all lawful permanent residents to be eligible for Medicaid and Children's Health Insurance program (CHIP), regardless of financial situation. Undocumented immigrants remain ineligible for all public insurance programs (Ku, 2006). As a result, immigrant workers, especially those who are undocumented, have lower rates of health insurance coverage than citizens (Derose, Escarce, and Lurie, 2007). Are Farm Workers Healthy? The demographic and health–related profiles of about 28,000 farm workers were compiled from National Agricultural Workers Survey (NAWS) annual datasets from 2007 to 2012. Workers fall into three legal status classes: citizens, green card holders, and undocumented workers. Based on average demographic attributes, undocumented workers are usually younger, with an average age of 30 years, relative to other workers, who are at least 10 years older on average. The age profile of undocumented workers is supported by the supposition that younger people are healthier and thus more likely to migrate to where there is work (McDonald and Kennedy, 2004). This would also explain the small incidence of chronic diseases (e.g., asthma, diabetes, and hypertension) among the younger undocumented cohorts compared to the other groups of workers as compiled from the NAWS (Figure 1). Better health status of undocumented farm workers may result in lower utilization rate of health care services than that of the average U.S. citizen of the same age. The NAWS dataset also provides information on health insurance coverage for farm workers and their spouses. The indicator of health insurance availability considers a farm worker's acquisition of single or multiple coverage of public (e.g., Medicaid and Medicare) and private (e.g., EPHI and DPHI) health insurance. In the United States, EPHI coverage can also be extended to spouses and children, which creates a reliable health insurance bond between farm workers and their families. Moreover, in regard to public health insurance such as Medicaid, if one person in the household is eligible, there is a higher chance that the spouse may also be able to benefit from a public health insurance plan. Even if only one person is eligible, it would increase the chance that additional coverage would be purchased to cover other family members. The trends in Figure 2 confirm a large discrepancy in health insurance availability among the different legal classes of workers. Citizens usually enjoy more access to health insurance coverage opportunities, while undocumented workers experience more hurdles and constraints in obtaining health insurance, whether these were obtained by the workers themselves or through their spouses. The health care utilization rate for undocumented workers is significantly lower compared to that of other workers. This is validated by the trends in the workers' rate of access to health care services during the two–year period prior to the start of the 2007 survey. Figure 2 shows that citizens registered the highest frequency rate of health care use (75.3%), while undocumented workers had the lowest frequency rate (36.3%). Health Care Provider Selections If certain farm workers experience more constrained access to health care services than others, which service providers do they rely more on for their urgent health concerns? Figure 3 presents separate plots of the annual health care provider choices among citizen, green card, and undocumented farm workers (calculated as the proportion of visits made to each service provider alternative to total visits) from 2007 to 2012. Citizen and green card workers had almost identical patterns of health provider selection, notably the consistently higher patronage of private hospitals, during the six–year period. The only deviation in these workers' choices can be observed during the last four years of the time period, when green card holders started increasing their patronage of community health centers. Such modified choices could have been induced by tighter household budgets and income constraints due to the effects of the recession and its aftermath. With their lower socioeconomic status and constrained mobility, undocumented workers find themselves in a more disadvantageous position in accessing social resources, especially during recessionary periods (Massey, Gross, and Shibuya, 1994). Figure 3 indicates that these workers are initially inclined to use the relatively more costly private clinic services for most health care needs. Interestingly, this choice could have been influenced by their need for less visibility to immigration enforcement authorities, as legal identities are not essential requirements for receiving services at these clinics. During the recession (from 2009 onwards), however, these workers have relied more on community health centers, which were apparently the more affordable option during those times. These workers also used migrant health centers at higher rates than the other two worker groups, but these rates did not exceed their utilization rates for private clinics and community health centers. These trends can be partly attributed either to the inadequacy of extensive or comprehensive medical services at these centers or the need to elude immigration authorities, who may have closely monitored activities because of the possible presence of deportable undocumented persons in such places. Health Bill Payment Arrangements Given workers' varied preferences for certain health service providers, their usual payment arrangements for settling their health care services bills can also provide important indications of motivations and choices, thus leading to financial and welfare implications. As can be seen in Figure 4, farm workers in general have a high probability of paying for health care services using their own funds, with undocumented farm workers registering the highest probability at 48%. For those with legal immigration status, this could be caused primarily by lack of health insurance. Workplace hazards and risks raise health insurance premiums significantly, such that farm workers could have been discouraged from purchasing any individual health plan (Sundaram–Stukel and Deller, 2009). Only 32.6% of farm workers actually enjoyed EPHI benefits in 2010. This rate is considered low compared to management and professional jobs, where 89.4% of workers are provided health services benefits (U.S. Census Bureau, 2010). Without any health insurance plans, even farm workers with legal immigration status may need to absorb all

medical costs themselves. In Figure 3, EPHI is the second most frequently used payment method by citizens and green card holders in most years, although this option's probability is less than half of that of out–of–pocket payments. Green card holders also use more Medicaid/Medicare assistance than the other two worker groups. Given their lower average reported incomes in the NAWS datasets compared to citizens, they may have resorted to avail themselves of such payment relief services after they have completed the five–year residence requirement for availing of certain public health benefits. Undocumented workers are least accommodated by EPHI benefits at the discretion of some employers because U.S. labor laws only guarantee these workers basic rights, which exclude such benefits (Contreras, 2015; Bray, 2016). Their conditions are compounded by their illegal immigration status, which inhibits them from accessing any public benefit programs such as Medicare. As a result, undocumented workers are most likely to pay for health care costs out–of–pocket. As Figure 4 indicates, their personal funds account for a much larger proportion of their health bill payments compared to other workers. The average proportion of this payment option for these workers is almost 60%, while citizens and green card holders pay average out–of–pocket rates of only 34% and 44%, respectively. Implications **The goal of sustaining a healthy farm workforce is an important policy consideration given the sector's dependence on labor inputs.** This priority is a challenge that must consider several issues. **First**, replacing foreign workers could be complicated due to difficulties in sourcing and hiring domestic workers to replace displaced undocumented workers. Citizens and green card holders have usually been unwilling to endure demanding, strenuous farm work in favor of better pay, more employee benefits, and more favorable working conditions in other industries (Wozniacka 2013; Wells 2012). **When documented domestic workers are hired, some farmers have had to contend with levels of farm labor productivity that are significantly lower than those achieved by former undocumented workers.** In less mechanized operations, **large quantities of crops remained un–harvested and resulted in huge crop losses** (Preston, 2007; McKissick and Kane, 2011). **Second**, **employing foreign labor** (except those sourced under the H2A guest farm worker visa program) **translates to substantial farm cost savings**. **Wages for documented workers** in fruit, nut, and vegetable farms **are 18% higher than wages for undocumented workers** (Ruark and Moinuddin, 2011). **Third**, retaining farm workers is a pressing concern in the farm sector, especially in the more labor–intensive fruit, vegetable, and horticulture industries. In their analysis of farm labor turnover trends by analyzing workers' employment time allocation between farm and non–farm work, Luo and Escalante (2017a) found that citizen and green card farm workers tend to have significantly lower workweek allocations to farm work than undocumented workers. During periods of economic downturn, citizens and green card holders further reduce their workweek allocation to agricultural employment as they explore more financially rewarding job opportunities in the non–agriculture sector. In contrast, **undocumented farm workers are usually much less responsive to economic shocks as they tend to stick to their status quo labor allocation pattern** (favoring farm employment) **during such difficult times**. Finally, **even during the Obama administration, legislative policies** (such as the PRWORA96) **were already being enforced to restrict immigrants' access to public benefits**. These policies were intended to quell growing concern that the increasing presence of immigrants in the country could deprive many domestic residents, especially citizens, of necessary health care and public services (Borjas, 1999). Given the Trump administration's stronger immigration stance, **more restrictive policies could further diminish foreign workers' access to** welfare resources, including **health care** services. **Such policies**, if indeed implemented, could **have serious negative repercussions on the agricultural sector**, which relies heavily on immigrant workers, especially for seasonal farm work (Martin and Jackson–Smith, 2013). In addition, the reality is that a disconnect exists between the sector's actual provision of health insurance benefits to its workers and farm workers' more physically demanding, riskier, and more taxing workloads (Grzywacz, Quandt, and Arcury, 2008; Luo and Escalante, 2017b). **Even if foreign workers in the farm sector were replaced entirely** by domestic workers, the persistent reality is that these replacement workers and their dependents are not adequately covered with insurance through their EPHI benefits and thus would resort to making health care decisions based on their own financial resources. **In the absence of more reliable health insurance**, health care, and public service programs, **the agricultural sector confronts the issue of maintaining a healthy workforce as its deterioration could have a negative impact on labor productivity, the sector's viability, and the nation's domestic food supply**.

• In status quo, undocumented immigrants are barred from insurace

Jimenez and Simas 16. (Daniel Jimenez graduated from California State University, Bakersfield with a bachelor's degree in communications, with an emphasis in digital media. In college, Daniel was active in organizations promoting the rights of undocumented immigrants, and others supporting environmental and animal rights. He currently works at a nonprofit organization dedicated to helping students in Kern County access higher education and leadership opportunities. He has worked as a journalist and photographer for South Kern Sol, a youth media outlet, and as a freelancer for El Popular News, a Spanish–language weekly serving the Bakersfield area. As a fellow, Daniel is excited to begin reporting on issues that affect his community, such as the health impact of pesticides used in agriculture. Jacob Simas is the project manager and editor of the Rise Up: Be Heard journalism fellowship at Fusion. Meet the uninsured immigrants propping up our $800 billion food industry. March 21, 2016. https://splinternews.com/meet–the–uninsured–immigrants–propping–up–our–800–bill–1793856334)

BAKERSFIELD, CA – After 26 years of waking up at 4 a.m. to stoop, grasp, and shuffle her way through the fields and vineyards of California's Central Valley, Maria Elena's body hurts. Her bones ache. Her skin burns. She's one of the lucky ones. Maria, 51, is among the estimated **2.5 million farmworkers in the United States**, a workforce that is the **backbone of an agriculture industry** generating $835 billion per year. Like many farmworkers, Maria is **undocumented and does not have** medical **insurance**, **despite** the **serious health risks associated with her job**. "Working in the fields is a tough task," she said. "The heat can be unbearable, waking up every day at 4 a.m. is exhausting and the pesticides are bad for our health." Calling field work "tough" is probably an understatement. The U.S. **D**epartment **o**f **L**abor **ranks agriculture among the most dangerous industries**. In 2011 (the most recent year cited on the DOL website), agriculture workers were 7 times more likely to be killed on the job than other private industry workers. Between 2003 and 2011, at least 5,816 agricultural workers in the U.S. died from work–related injuries like heat exhaustion and farm vehicle accidents. Every day, on average, 243 agricultural workers suffer a "serious" injury that leads to lost work time, and 5% of those injuries leave workers permanently impaired. Not all injuries are of the one–time–accident variety. Farm jobs require awkward and repetitive body movements that can lead to muskuloskeletal disorders, resulting in chronic pain such as Maria's aching bones. Long–term exposure to pesticides poses another risk. Maria attributes her burning, painful rashes to decades of near constant exposure to chemicals used in the fields. When she took a break from doing crop work for a few years, she said, the rashes went away. Now that she's back in the fields, so are the rashes. When Maria once asked her work supervisor to take her to a hospital, she said he refused. "I had no recourse," Maria said. "I couldn't go to the doctor because I couldn't afford treatment, and I couldn't miss work because I had bills to pay. The only thing I could do is go to a local pharmacy to try to buy something that would help my condition." Just over one–third of farmworkers in the U.S. have health insurance. And when they do see a doctor, they're likely to pay out of pocket like Maria. Only 14% of workers used an employer–paid insurance plan for their last doctor's visit, in the latest National Agricultural Workers Survey. Roughly **half of all farmworkers are undocumented**, according to Department of Labor surveys, although **the actual number is thought to be much higher than that**. **Undocumented immigrants are ineligible for most government health programs and barred from purchasing private insurance through the exchange established by the A**ffordable **C**are **A**ct.

• M4A solves, will make undocumented immigrants eligible for healthcare

Debenedetti 2016 https://www.politico.com/story/2016/01/bernie-sanders-health-plan-undocumented-immigrants-217931

Millions of undocumented immigrants would gain health care coverage under Bernie Sanders' plan for a single-payer health care system, a detail he didn't include explicitly in his just-released proposal but one confirmed by an aide shortly after Sunday's Democratic presidential debate. **"It would cover everyone, including aspiring Americans," said Warren Gunnels, senior policy adviser to the**

Vermont senator's campaign, when asked whether the plan would cover immigrants in the country illegally. That proposal separates Sanders' plan even further from Obamacare, whose framers carefully excluded undocumented immigrants from any form of assistance or access to coverage offered through the law. The acknowledgment ensures that Sanders' already politically treacherous push for "Medicare for All" will end up entangled with messy immigration politics that have roiled the 2016 election cycle. It also could add fuel to Hillary Clinton's argument that her rival's proposal is unrealistic in today's partisan climate, which she lodged during Sunday's debate. During the primetime showdown, she noted that a push for a scaled-down single payer health care system — the so-called public option — was scuttled during the 2009-2010 fight over Obamacare, when Democrats controlled both chambers of Congress.

2AC - A/T Crowd-Out

• No insurance crowd-out – empirics prove

Timothy **JOST 8**. Emeritus Professor at the Washington and Lee University School of Law. "The Role of a Public Health Insurance Plan in a Competitive Market Lessons from International Experience." Last cited date: 2008. http://law2.wlu.edu/deptimages/Faculty/Jost%20Role%20of%20a%20Public%20Health%20Insurance%20Plan%20in%20a%20Competitive%20Market.pdf.

Within its private health insurance system, Australia offers perhaps the most relevant example for American health reform. The largest "private" insurer in Australia is Medibank Private Ltd., the only private insurer that is found in all Australian states and territories. Medibank Private is a government corporation. Thus Australia offers an example of a publicly owned insurer that competes head to head with private insurers (some of which are for profit and others of which are nonprofit) without public subsidies, the model that is proposed for the United States. Medibank exists for historical reasons–it is what survives of an attempt to create a universal public system in the 1974 after that system was abandoned with the election of a new more conservative in favor of a predominantly private system two years later.8 When the public Medicare system was introduced in 1984, the private system, and with it Medibank Private, was preserved as an alternative for funding hospital service¶ Although Medibank is currently the largest private insurer in Australia, it controls only about 29% of the market. Its market share has varied from year to year. Its prices are competitive with those of other insurers, but it is considered by some to be a market leader in holding down premiums. It also has consistently had administrative costs slightly below the average of other insurers. It has, according to some commentators, served as a social conscience for the private insurance industry, supporting a complementary role for private insurance and community rating. It is also believed that its existence has discouraged collusion among private insurers. Attempts to privatize it in recent years have been successfully resisted by those who believe that there are advantages to having a public plan in the private market. The Australian experience demonstrates that it is possible to have a public plan that runs efficiently, pays providers competitive rates, and competes successfully with private insurers **without** driving them out of the market.¶ What lessons can we learn from the experience of other countries with public/private health insurance competition? **First**, we learn what we already know from our own experience, particularly with Medicare Advantage plans: private insurance **inherently costs more** than public insurance. This is logically inescapable. Private insurers must usually (depending on the nature of the regulatory regime) spend money on marketing, underwriting, and reserve costs, as well as make a profit if they are for-profit, all costs that can be avoided by a private plan. **Second**, private insurers generally prefer to compete based on **risk selection** rather than by holding down their costs. It is a well known fact that the costs of health care are heavily skewed—in any given year 1% of the population accounts for over a quarter of health care costs, 5% for over half. An insurer can gain much more by simply capturing a low risk applicant or avoiding a high risk applicant than by controlling costs. Risk selection is better controlled in some countries than in others, but it is very difficult to eliminate it entirely from private markets. Public insurers have less reason to risk select, and thus are more likely to end up with higher risks. They have to control costs in other ways, such as holding down administrative costs or payments to providers. **Third**, when private insurers and public insurers compete, private insurers compete primarily through claiming to offer more rapid access to care, more attentive care, and care from providers with better reputations. They are less likely to compete on the basis of price. Public plans can offer a lower price product to those who are more focused on the cost of care. **Fourth**, coverage under private insurance plans tends to be less transparent than under public insurance. **Finally**, and perhaps most

important in terms of the current debate, competition among private and public providers neither drives private plans nor private providers out of the market. Public-private competition is consistent with a **thriving** private insurance market and with the **provision of high quality care** in both public and private markets.

• No insurance crowd-out -- Germany proves

Timothy **JOST 8**. Emeritus Professor at the Washington and Lee University School of Law. "The Role of a Public Health Insurance Plan in a Competitive Market Lessons from International Experience." Last cited date: 2008. http://law2.wlu.edu/deptimages/Faculty/Jost%20Role%20of%20a%20Public%20Health%20Insurance%20Plan%20in%20a%20Competitive%20Market.pdf.

German private insurers pay higher prices for health care and have higher administrative costs than the social insurers.6 They compete with public insurers primarily on the basis of risk selection and by claiming to offer higher quality care and quicker access to care. This system has existed for decades, however, and private insurers have **continued to prosper**, while health care providers have continued to offer high quality care **without significant rationing** to both publicly and privately insured Germans.

• Markets reach equilibrium --- best models show

Andrei **BARBOS AND** Yi **DENG 15**. *Associate Professor of Economics, University of South Florida. **Associate Professor of Economics, University of South Florida. "The Impact of a Public Option in the U.S. Health insurance Market." *Economic Inquiry* 53(1): 520. Emory Libraries.

This paper develops a stochastic game-theoretical model to analyze the consumers' behavior in choosing between a private medical insurance plan and a public insurance plan, with the former a profit-maximizer and the latter a social-welfare maximizer who faces different profit constraints. The model is calibrated based on the data on medical expenditure from the U.S. Medical Expenditure Panel Survey and estimation of a Bayesian hierarchical model using a Markov Chain Monte Carlo (MCMC) method. The Nash equilibrium is solved using a numerical algorithm.¶ Calibration results reveal that neither insurer will be completely driven out of the market, and instead each of them will capture a significant segment of the population. At equilibrium, the public insurer will choose to cover the less healthy group of consumers, leaving the healthier, more profitable section of the market to the private insurer. Consequently, the private insurance plan generates a **substantially positive profit**, while the public plan runs at a **balanced budget**. When the risk-aversion coefficient is set to higher levels, the public plan's market share rises, the public and private insurance premiums decline, and the private profit falls. We also find that when the nonnegative profit constraint imposed on the public plan is relaxed, both the public and private insurers substantially lower their premiums, and the social welfare improves. A more cost-effective public insurer and an upper limit on private insurer's profit margin both lead to a decline in private insurer's profit and to an improvement of social welfare.¶ Our study constructs a framework to analyze competition between profit-maximizing private insurers and a social-welfare-maximizing public insurer, and suggests that an **equilibrium exists** in the U.S. health insurance market where both insurers **stay in** the market even when the public option is subjected to the severe adverse selection (as in the study by Rothschild and Stiglitz 1976) that is induced by the distinct objectives of the two insurers. Empirical results of the current study provide a first-order approximation of the potential

crowd-out effect of a public option in the U.S. health insurance market. Developing this framework further to incorporate additional institutional details, and thus, to refine the precision of the quantitative results obtained in this paper is an interesting avenue for future research. In a different direction, this framework could be employed to analyze competition between private and public insurers and its potential outcomes in other health insurance markets. One prominent example would be the insurance market for individuals aged 65 and above, where in recent years policy makers have proposed introducing a private component to compete with traditional Medicare for the coverage of individuals whose premiums would be subsidized directly rather than through Medicare as in the case of the current Medicare Advantage private plans.

• Structural dynamics protect private insurers

Maria **POLYAKOVA 16**. Assistant Professor, Department of Health Research and Policy, Stanford. "Risk selection and heterogeneous preferences in health insurance markets with a public option." *Journal of Health Economics* 49: 153-68. Emory Libraries.

5 Conclusion¶ Conventional wisdom suggests that private health insurers operating in parallel to a public option may endanger the latter's financial stability by cream-skimming good risks. Despite this concern, co-existing private-public arrangements are becoming ever more common in health and other social insurance systems, raising the question of which policies and incentive structures may be able to **mute** the cream-skimming dynamics.

In this paper I **empirically** explore this issue in the institutional environment of Germany; several unique institutional features make the German market a **fruitful lab**oratory for studying the interaction of private and public health insurance. Germany has a well-developed private non-group individual health insurance market in parallel to a statutory system. The statutory system has many elements of a traditionally public option - public insurers are not allowed to reject enrollment or to underwrite risks. Insurers in the private system, on the other hand, can do both within annuity-like long-term insurance contracts.

I find **no convincing evidence** of extensive cream-skimming of better risks by private insurers. To explore this puzzle, I first test whether demand for private insurance is affected by preferences that are plausibly unrelated to health risk and could be muting the extent of selection. I find empirical support for the presence of such **"heterogeneous preferences."** Private insurers in the German system offer more convenience and "luxury" in healthcare utilization, including slightly broader provider networks, shorter waiting times, and access to "star" physicians. Accordingly, I find that individuals that appear to exhibit preferences for **convenience** and higher value of time, conditional on income, are more likely to enroll in the private system.

These results suggests that if individual demand for, e.g., broader networks or shorter wait times is related to the value of **time rather than health risk** directly, such preferences may **significantly mute** the scope for risk selection in the system. These findings are in general consistent with the idea that **consumer choice** in insurance may be **efficient**: there is scope for **horizontal** rather than purely vertical or risk-protective differentiation of health insurance contracts that is **valuable for individuals**.

In addition, I speculate that the long-term structure of private health insurance contracts in this empirical setting may have an additional **dampening effect** on the degree of selection. Instead of offering annual community-rated prices, private insurers offer an annuity-style contract to each individual. Individual risk profiles are measured at the time of enrollment and reclassification of risks is prohibited by the regulator. This type of insurance contracting creates an incentive to enroll in insurance as early as possible or "behind the veil of ignorance," when little information about risk has been revealed and which hence leads to little scope for meaningful risk-sorting.

2AC - A/T Cyber Attacks

• Turn: hacks are inevitable but centralization makes data easier to defend

Joseph **Conn 16**, Modern Healthcare, 12-2-2016, "Cyber and ransomware attacks to rise in 2017 a security analyst forecasts,"
http://www.modernhealthcare.com/article/20161202/NEWS/161209980

The healthcare industry will be a **target for cyber attackers in 2017** while the nefarious practice of holding patient records for ransom will be an industry scourge, according to predictions by credit reporting firm Experian. “Personal medical information remains one of the most valuable types of data for attackers to steal,” according to the 10-page report, the company's fourth annual data breach forecast. Patient data is useful in both identity theft and in a more insidious variant, medical identity theft. The latter is when a person uses another's identity to obtain medical treatment, creating a double whammy by defrauding the victim's insurance company and muddling up the victim's medical records. Hospital networks continue to be “a **ripe target for attackers**,” the report said, since data is **spread over different networks, making it harder to defend than more centralized organizations.** Electronic health records systems within these organizations are likely to be cyber attackers' prime targets, since access to EHRs has become more “mobilized” with tablets and smartphones. “As more healthcare institutions deploy new mobile applications, it's possible that they will introduce **new vulnerabilities that will also be attractive targets for attackers**,” the report authors said.

• AND it makes employee education easier

James **Litton 16**, CEO, Identity Automation, 5-17-2016, "Why Isn’t Healthcare Doing More To Protect Against Cyber-Attacks,"
https://www.healthitoutcomes.com/doc/why-isn-t-healthcare-doing-more-to-protect-against-cyber-attacks-0001

Centralize Security Healthcare organizations often consist of a hospital, a clinic, and a lab all working with the same patient information but with **different medical and patient record systems using varying degrees of security**. This type of infrastructure — with **multiple, unconnected security systems** – actually **increases an organization’s risk.** Each patient record has **multiple points of entry** through the disparate security systems an attacker could target for intrusion. In instances like this, healthcare providers must have **one central security team,** managed by a CISO to manage and oversee all security projects. Access can still be decentralized by department or group, but the systems must be **connected**. **Limited entry points mean limited points of attack.** The CISO and security team should also implement a **security awareness program across the whole organization** so employees can understand the risks they could encounter and are trained on how to react when they do. A central team is **more likely to be successful in rolling out comprehensive training programs and communicating to the employee base than an uncoordinated, loosely affiliated group of multiple security teams.** Healthcare organizations must get proactive in dealing with their security instead of waiting for something to happen to make changes. Cyberattacks have become too damaging and too costly to sit back idly and wait. **Systemic change is needed at healthcare organizations**, from systems admins

all the way up to the CEO and board. The right people, technologies and protocols need to be implemented that can prevent attacks and minimize damage in the event of an attack.

• That's key---the majority of healthcare breaches are internal failures

ICIT 16, Institute for Critical Infrastructure Technology, Jan 2016, "Hacking Healthcare IT in 2016: Lessons the Healthcare Industry can Learn from the OMP Breach," http://icitech.org/wp-content/uploads/2016/01/ICIT-Brief-Hacking-Healthcare-IT-in-2016.pdf

The human element of cybersecurity continues to be the **weakest element**. Ongoing training must be paramount in any responsible healthcare organization. Adversarial initiatives 84 typically **start** with **targeting staff** via spear phishing and watering hole attacks. The act of an illprepared executive clicking on a malicious link can trigger a **hurricane of immediate and long term negative impact on the organization** and innocent individuals whose records were exfiltrated or manipulated by bad actors. **Staff education**, pre-market dissection of technology and patching of vulnerabilities that stimulate innovation and protect the public, and legislation that protects patient privacy and enforces device cybersecurity at the manufacturer level are only the first steps in creating better national cybersecurity hygiene. A cybersecurity-centric culture must demand safer devices from manufacturers, **privacy adherence by the healthcare sector as a whole** and legislation that expedites the path to a more **secure and technologically scalable future by policy makers**.

• N/U Large cyberattacks on medical data have already happened

Li 15

Shirley Li (former editorial fellow with The Atlantic). "The Next Cybersecurity Target: Medical Data." The Atlantic. March 19th, 2015. https://www.theatlantic.com/technology/archive/2015/03/the-next-cybersecurity-target-medical-data/388180/

Hackers often carry out massive cyberattacks to gain access to financial data through banks and retail companies, but this week's cybercrime hit a seemingly new target: **medical data**, taken from the health insurance company Premera Blue Cross. The attack affected 11 million patients, **making it the largest cyberattack involving medical information to date**. The healthcare industry has been catching hackers' attention lately. In February, the health insurance company Anthem reported a breach in which hackers accessed to about 80 million records, and in 2014, the Tennessee-based hospital operator Community Health Systems saw 4.5 million records accessed, though both companies said no medical data was exposed. Even so, as Pat Calhoun, the senior vice president of network security at Intel Security, puts it, the healthcare industry is just beginning to find itself **in cyber-criminals' crosshairs**, making it slow to shield people's records. "The healthcare industry is not immune to attacks," he told me. "It's really a wake up call for manufacturers and healthcare providers to understand how to minimize the impact on security challenges."

2AC - A/T Doctor Drain

• Turn --- single payer increases retention by reducing administrative hassles

Cathleen **London 17**, physician based in Maine who developed a cost-effective alternative to the standard EpiPen in response to skyrocketing prices, 5-6-2017, "Why are fiscal conservatives opposed to single-payer healthcare?," The Hill, http://thehill.com/blogs/pundits-blog/healthcare/332226-why-are-fiscal-conservative-opposed-to-single-payer-healthcare

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

• Turn --- single payer will trim unneeded specialty positions and adequately compensate primary care. Primary care solves better and more cheaply.

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

The problem with Medicare, of course, is the fee schedule itself. It vastly undervalues the work that doctors like me do. At the same time, it overvalues the work of my **sub-specialty colleagues**. The fee schedule favors technology over touch, performing procedures over spending time with patients. Of course, Medicare didn't pick numbers out of the air; the fee schedule has been unduly influenced by the **richer** and thus more powerful **doctor groups** that sit on the American Medical Association's resource update committee. This secretive and specialist-stacked assemblage advises Medicare on setting procedural fees. Ninety percent of such advice finds its way into the schedule, which is why an otolaryngologist makes more money to clean wax out of an ear than a geriatrician gets for evaluating an 85-year-old woman who comes into the office after having had a "little spell." I believe that a vibrant system of primary care is **essential for patient wellbeing**. Every one of us needs and deserves enough space for an unrushed visit and a thorough physical examination by someone who knows us and our unique circumstance and is available across time and sites of care to minister and to advocate. Patients who are under the watchful eye of a primary care physician receive **less expensive medical care** without **sacrificing the quality** of that care. Medicare may track every test I order, every consultant to whom I make a referral, every hospital admission I initiate. But Medicare has never known how many patients I saved from inappropriate testing and consultations, ED referrals, hospital stays, and LTC placements. And aside from the dollars saved, my patients have been spared many needless procedures and the associated morbidity these entail. Single-Payer Solution There is one simple way to accomplish this. A **single-payer plan** can **tinker with the fee schedule and fi nally make it financially remunerative for young doctors to once again pursue primary care**. Increase the routine doctor visit reimbursement codes signifi cantly — enough to allow primary care physicians to actually spend **face-to-face time** with patients. The 7-minute visit is unsatisfactory to patients and demoralizing to doctors. Undoubtedly, **this is contributing to the greater than 50% burnout rate for primary physicians.** Changing

to a single-payer system will not require an infusion of more dollars into the system. It will require a **rebalancing** of what a sane single-payer system pays for the thousands of over-compensated procedure codes that currently exist. Yes, my **specialty colleagues** will be unhappy with such a proposal. But unless they want to take over the 24/7 responsibility of caring for the soon-tobe 75 million seniors with their complex medical histories, polypharmacy, and fraught social needs, my specialist friends should **yield to the reality** that our current system of crumbling **primary care** cannot accomplish this task without major change.

• Single payer has no effect on physician income

Woolhandler 16 – Steffie Woolhandler, distinguished professor of public health and health policy in the CUNY School of Public Health at Hunter College, adjunct clinical professor at Albert Einstein College of Medicine, and lecturer in medicine at Harvard Medical School, M.D. from Louisiana State University, MPH from University of California ("Single-Payer FAQ," SITE LAST UPDATED IN 2016, *Physicians for a National Health Program*, http://www.pnhp.org/facts/single-payer-faq#bankrupt)

Under single payer, **won't physician incomes go down.** Not necessarily. Canadian physicians have done well under their single payer system - as documented in a recent, careful study. In addition, streamlined billing under single payer would save US doctors vast amounts in overhead, and free up additional physician time to see a few more patients. Hence, even if doctors' gross incomes declined slightly (a questionable assumption if they're freed up from insurance paperwork and able to devote more time to patient care) physicians' average take home incomes wouldn't change under single payer. Of course, some doctors' incomes would go down - e.g. those who currently enjoy a particularly rich payer mix. On the other hand, some would see an increase - e.g. those currently caring for many Medicaid or uninsured patients.

2AC - A/T: Economy

• No evidence for economic downturn from single payer

Master, 8/01 – founder and CEO of MCS Industries Inc., Palmer Township, and executive producer of two documentaries,"Fix It: Healthcare at the Tipping Point" and "Big Pharma: Market Failure." (Richard, A businessman makes the case for a single-payer health care system,
http://www.pnhp.org/news/2017/august/a-businessman-makes-the-case-for-a-single-payer-health-care-system,
http://www.pnhp.org/news/2017/august/a-businessman-makes-the-case-for-a-single-payer-health-care-system)
With all due respect to President Trump, he is wrong about the single-payer model of health insurance. Single payer — centralized public financing of a continued privately operated health system — will not "bankrupt the United States." In fact, the opposite is true.
Single payer is the only internationally proven strategy to transition the U.S. out of its current crisis of runaway health care costs to economic sustainability, where overall system cost growth is consistent with overall economic growth and inflation.
At one-sixth of our economy and over 25 percent of the federal budget, health care will continue to be a focus in Congress until real progress is made and the angst of the American people about the system is resolved. It is clear to most Americans that runaway health care costs translate into flat wages and also a deterioration of real disposable income that drags down our 70 percent consumer-driven economy.
But recent efforts in Congress to confront the crisis have been misguided. Congress has focused on cost shifting — moving the burden of our health system away from the federal government to the states and also to employers and to working families across the country, who will pay higher private insurance premiums to cover the expected cost of increased uncompensated care as the system absorbs the loss of Medicaid funds.
Going forward, the focus of the administration and its allies in Congress should be on controlling the real drivers of cost of care, such as prices of pharmaceuticals, which are rising at double digits a year, and addressing wasteful administrative costs associated with our complex, multipayer-financing model, which costs U.S. private doctors $83,000 a year to interact with multiple health plans vs. $22,000 for doctors in Canada, according to a 2011 Commonwealth Fund study. And it costs hospitals nearly double in administrative costs vs. other countries, according to a 2014 Commonwealth Fund study.
We do not need to reinvent the wheel. Single payer is the recognized best practice. Warren Buffet points out that, in the 1970s, Canada and the U.S. had roughly equivalent health system expense — 7 percent of gross domestic product. Canada went the single-payer route; the U.S. did not. Canada covers all of its citizens, has better health outcomes and today spends 11.4 percent of GDP. Our cost went to 18 percent of GDP. France, the highest ranked health system in the world, spends 11.8 percent of GDP, and Japan, 8.5 percent
We need to investigate and follow the examples of successful health systems operating throughout the world where all citizens are covered, public health outcomes are measurably superior and the overall cost to society is less.
We need to also review closely the many in-depth studies by prominent American economists reporting overall system savings from a transition to centralized financing. Consider in

particular the May study, "Economic analysis of the healthy California single-payer health care proposal (SB-562)." That study, from four economists at the University of Massachusetts, demonstrated how single payer would **reduce California's overall health care expense by 10 percent,** even with universal care for all residents and assuming comprehensive benefits. (The bill has been referred to a legislative committee.)
The study found substantial savings in administration and pharmaceutical pricing and on mitigating the current high variance in fees for service providers. Today 7.5 percent of Californians have no health coverage and an additional 30 percent of those insured are considered underinsured and are particularly vulnerable to the economic consequence of serious illness. The status quo in California and throughout the country is unacceptable. The solution is single payer.

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

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

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

However, our results also suggest that a **single-payer** public health-care system is likely to be the **most beneficial for economic growth** in that the government can maximize health insurance coverage and **use its monopsony power** as the only major buyer of health services to control costs. Single-payer systems have the benefit of covering the entire population (and therefore the entire working age population) and allow governments to set the rate for procedures, prescriptions, and other health-care expenditures. This suggests that regardless of

how the ACA specifically affects the economy, if the goal of health insurance regulators and reformers is to **increase economic growth**, they should reconsider a universal coverage public system. However, even as the ACA stands now, where many states have significantly expanded Medicaid to previously uncovered working age populations, our results do suggest that this should be beneficial to those states' economies.

• Single-payer reduces total costs for 95% of Americans and only imposes new taxes on the richest 5%

Geyman 16 – John Geyman, M.D., professor emeritus of family medicine at the University of Washington School of Medicine ("Single-Payer NHI: The Only Way the U. S Can Ever Get Affordable Health Care," *Physicians for a National Health Program*, February 16th, http://pnhp.org/blog/2016/02/16/single-payer-nhi-the-only-way-the-u-s-can-ever-get-affordable-health-care/)

You can't believe most of the claims that are being made about the costs of single-payer NHI. Hillary is saying that the middle class will be hit with a big tax increase without mentioning what **patients and families will save and get** with NHI. She says that Bernie's numbers for savings for typical American families under NHI "don't add up." (3) Some economists are also jumping on the bandwagon to discredit NHI. Paul Krugman, still thinks it is "not politically feasible" because of the political and economic power of the medical-industrial complex, and worries about "disruption for patients" with the ACA, but doesn't acknowledge the huge gains that NHI would bring with **far more efficiency** than our current multi-payer system. (4) Economist Kenneth Thorpe, an Emory University professor who served in the Clinton administration, claims that NHI would break the bank, and cost $1 trillion more a year than estimated as he grossly underestimated savings on overhead, drug costs, and other government expenses while assuming a grossly exaggerated increase in utilization by patients. (5)

Despite demagoguery on the issue, **we have solid information on the costs—and savings**—of NHI. The landmark 2013 study by Gerald Friedman, professor of economics at the University of Massachusetts, estimated that implementation of single-payer NHI will save $592 billion annually by cutting administrative waste of private insurers ($476 billion) and reducing pharmaceutical prices to European levels ($116 billion). Those savings would be enough to cover all the uninsured and provide comprehensive coverage for all other Americans, even including dental and long-term care. **Co-payments and deductibles will be eliminated**, savings will fund retraining of displaced workers and phasing out investor-owned for-profit delivery systems over a 15-year period. (6)

How will this be paid for? Table 1 proposes **a progressive financing plan** under which 95 percent of Americans will pay less than they do now for insurance premiums, deductibles, co-payments, and out-of-pocket payments for health care. Only 5 percent of high-income Americans will pay more. The payroll tax will become the main health care tax for people with annual incomes below $225,000—$1,500 for those with incomes of $50,000, $6,000 for those earning $100,000, and $12,000 for those with incomes of $200,000.

With NHI, all Americans will have full choice of doctors and hospitals, **quality of care** for the whole population **will improve**, bureaucracy will be sharply reduced, and we will finally have a

more accountable and sustainable system. (7) Employers will be relieved of their burden of providing health insurance for their employees and may be able to convert some of their previous contributions to employer-sponsored insurance to **employees' forgone wage increases** as they gain a healthier workforce and become more competitive in global markets. Physicians and other health professionals will have a simplified billing system and more time for direct patient care.

We already pay much more in taxes each year for health care than we realize. In their just-published article in the American Journal of Public Health, Drs. Woolhandler and Himmelstein report that the U. S. government, at taxpayer expense, is now paying 65 percent of the total annual tab for health care—$2.1 trillion last year, $6,560 per person, more per capita than people pay in taxes in any other advanced country with universal health insurance. As they report, much of this taxation is invisible to us, such as government spending to buy private health coverage for public employees and tax subsidies for private employer-sponsored insurance and other privately paid care. (8)

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

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

What is the effect of **replacing premiums with taxes?** Taxes vary with ability to pay, while premiums do not (Seidman 2009). **It would be better for the economy** and fairer to use a set of earmarked taxes that have moderate rates (Seidman 2013b). The set of taxes earmarked for Medicare for All might consist of the following: the Medicare payroll tax, a VAT, and a Medicare for All income tax surcharge on the 1040 income tax return. The Medicare payroll tax is currently 1.45 percent on the employer and 1.45 percent on the employee— a combined rate of 2.90 percent on all wage income. The VAT is used successfully by virtually every economically advanced country except the United States. Many US economists have recommended a US VAT (Seidman 2004, 2013b; Hines 2007). Several analysts have recommended that a VAT be enacted and earmarked for universal health (Morone 2002; Burman 2009). The VAT burden on low-income households would be offset by giving these households a refundable tax credit on their 1040 income tax return to compensate roughly for most of the burden they bear from the VAT (Seidman 2013b). Today US medical costs are 18 percent of gross domestic product (GDP), while no other country exceeds 12 percent. Suppose Medicare for All aims to cut the huge 6 percentage point gap in half to 3 percent so that US medical costs are 15 percent of GDP. If Medicare for All succeeds in using its single-payer bargaining power (as explained below) to achieve its medical cost target of 15 percent of GDP, then **Medicare for All taxes would need to be 15 percent of GDP**. Government (federal and state) spending on Medicare, Medicaid, and other government health programs is currently about 7 percent of GDP (CBO 2012: 49, 55-57), so new earmarked taxes would need to be **roughly 8 percent of GDP**. To put this 8 percent of GDP number in perspective, in 2007 (before the Great Recession caused a plunge in tax revenue) US taxes (federal, state, and local) were about 30 percent of GDP. Thus taxes would rise from 30 percent of GDP to **38 percent** (federal taxes would rise by 9.5 percent

of GDP, while state taxes would fall by 1.5 percent of GDP due to the reduction in state Medicaid expenses), which would still leave US taxes as a percentage of GDP **slightly lower than the average of the** economically advanced member countries of the Organisation for Economic Cooperation and Development (**OECD**) (roughly 40 percent) and far below the Scandinavian countries (roughly 50 percent).

• Single-payer doesn't create a net-increase in public spending – the net sum of taxes is $6 trillion less than total out-of-pocket and private premium spending

Friedman 16 – Gerald Friedman, Professor of Economics at UMass-Amherst, Ph.D. in Economics from Harvard University ("What would Sanders do? Estimating the economic impact of Sanders programs," January 28th, http://dollarsandsense.org/What-would-Sanders-do-013016.pdf)

Footnote 10: The **Medicare-for-All** program is analytically different from other spending programs because it **supplants a greater amount of private spending**, through the inefficient private health insurance system, rather than simply providing additional public spending, as do the infrastructure and other programs. For the ARRA, see Alan S Blinder and Mark Zandi, "How the Great Recession Was Brought to an End" (Moody's Analytics, July 27, 2010), https://www.economy.com/mark-zandi/documents/End-of-Great-Recession.pdf. The Medicare-for-All program will require new public spending that is $6 trillion less over 10 years than the out-of-pocket spending and private health care premiums (**a form of private taxation**) that it replaces. For the stimulative effect of the ARRA, see Alan J. Auerbach, William G. Gale, and Benjamin H. Harris, "Activist Fiscal Policy," The Journal of Economic Perspectives 24, no. 4 (October 1, 2010): 141–63; Barry Eichengreen, Hall of Mirrors: The Great Depression, The Great Recession, and the Uses-and Misuses-of History, 1 edition (New York, NY: Oxford University Press, 2015); Paul Krugman, "The Not-So-Bad Economy," The New York Times, December 7, 2015, http://www.nytimes.com/2015/12/07/opinion/the-not-so-bad-economy.html. The comparison to the ARRA's annual stimulus is, of course, apart from the Medicare-for-All program.

• Single-payer won't bankrupt the country—simple arithmetic proves.

Margalit **GUR-ARIE 17**, founder, BizMed, a company devoted to supporting practicing physicians through software and services that simplify the business of medicine, formerly served in executive and consulting roles at various Health IT companies ["A single-payer system is the American way," *Kevin MD*, August 7, 2017, http://www.kevinmd.com/blog/2017/08/single-payer-system-american-way.html]

We have $3 trillion in our health care pot right now. We have 325 million Americans, men women and children of all ages. First-grade arithmetic says we have almost $10,000 per year to spend on each American, the vast majority of whom is either young or healthy or both. For comparison, Medicare spends on average around $12,000 per year for the oldest and sickest population. Last year a platinum plan for a 21 year old cost less than $5,000 per year and this includes the **built in**

waste of private health insurance. So please, tell me again how we can't afford to pay for everybody's health care needs at a Medicare actuarial level, which is slightly less than commercial platinum.

And no, we need not increase taxes either. You keep paying what you're paying. Your employer keeps paying what it is paying. The government keeps paying what it's paying. But instead of dispersing all that cash to all sorts of corporate entities standing in line with their golden little soup bowls ready to catch the last drop, we put it all together in one big beautiful barrel, and pay for care directly to those who provide care – one pool, one budget, and one accounting system for all. This is a national endeavor. It is irrelevant that Vermont failed and California bungled the whole thing. Do you think California and Vermont could afford to provide for their own armies, air force, and navies? I didn't think so.

• Pandemics turn -- collapses the economy.

Peter C. **DOHERTY 13**. Albert Lasker Award for Basic Medical Research, Nobel Prize in Physiology/Medicine, PhD in veterinary science from the University of Edinburgh. Pandemics: What Everyone Needs to Know. Oxford University Press. 152-5.

The SARS experience taught us that a mysterious, rapidly spreading, and potentially fatal respiratory infection can **trigger a short, sharp, severe economic shock** that has **longer term consequences**. Though less than 900 people died from SARS and Toronto was the only city hit outside the Asia Pacific . region, the losses to airlines, the hospitality sector, and all those associated with the travel industry were estimated at around $50 billion. Two years later, the big hotels in Singapore and Toronto were still recovering. Contrast that with the situation for seasonal influenza: the calculated mortality based on "excess deaths" in the United States alone ranges from 20,000 to 40,000 (250,000-500,000 worldwide) for any given flu year. But influenza is familiar, many of us will have been vaccinated, and the fact that one of the standard strains is circulating does not cause business travelers and tourists to stop flying or induce most people outside Asia to wear face masks in the streets and in airports.¶ Even so, the CDC economists estimate that the total US economic burden, including loss of productivity, hospitalization, and so forth, is in excess of $80 billion for a "normal" influenza year. It may be too soon to cost the "mild" 2009 SW [END PAGE 152] HINl pandemic, though a 2006 economic modeling exercise put the global expense of an influenza pandemic in the $330 billion to $**4.4 trillion range**, depending on the severity of the disease. Of course, as the global financial crisis of 2007 taught us, the economic damage that can be done by New York bankers and financial speculators operating in a poorly conceived and administered regulatory framework can be much greater, but the cost of a global infectious disease pandemic is still very substantial, in addition to the enormous social dislocation.

• Insurance companies have a profit incentive to raise costs.

Robert **SIEGEL 17**. Senior Host, All Things Considered, NPR. "As Cost Of U.S. Health Care Skyrockets, So Does Pay Of Health Care CEOs." *NPR*. July 26. http://www.npr.org/sections/health-shots/2017/07/26/539518682/as-cost-of-u-s-health-care-skyrockets-so-does-pay-of-health-care-ceos.

In the seven years since the Affordable Care Act was passed, CEOs of U.S. health care companies have made a lot of money.¶ Their compensation far outstrips the wage growth of nearly all Americans, according to reporter Bob Herman, who published an analysis this week of "the sky-high pay of health care CEOs" for the online news site, Axios.¶ Based on corporate financial filings with the Securities and Exchange Commission, Herman did research on 113 heads of 70 of the largest U.S. health care companies in the last seven years.

Cumulatively, he says, these CEOs have earned $9.8 billion since the ACA was first enacted. Only four of the 113 CEOs were women, he notes, and only two are right now in charge of major health care companies.¶ The top earner was John Martin, the former CEO of the pharmaceutical company Gilead Sciences, who took home nearly $900 million, Herman says. Gilead makes, among other things, medicines to treat HIV and AIDS, as well as two leading drugs to treat hepatitis C.¶ Several other executives topped $250 million.¶ Robert Siegel, host of NPR's All Things Considered, spoke with Herman about his analysis. Excerpts of the interview follow, edited for length and clarity.¶ Interview Highlights¶ Who are these CEOs and why are they earning so much money — on average, $20 million per year, you say?¶ We looked at a wide array of different companies. They include pharmaceutical companies, health insurers, hospitals, pharmacies — it really spans the gamut. And we found that since the Affordable Care Act went into effect in 2010, their pay has really gone up. So the ACA hasn't really hurt their earnings, per se. And a lot of the money that they're earning is coming in the form of vested stocks.¶ Of course, an underlying issue behind all the talk about Obamacare is not just how we pay for health care and who gets insurance (and in what form) to pay for health care, but how much we pay for health care. What do these CEOs' earnings say about health care costs in the United States?¶ For the longest time, health care inflation has really blown away the rate at which the rest of the economy is growing. And a big reason why is because health care executives are **not paid to slow spending**. Because so much of their pay comes in the form of stock, their **incentive** is to do whatever it takes to make that stock go up. So that means selling more drugs; **raising prices above inflation**; performing more procedures; getting more people into the hospital. And those are the exact **opposite** things that health policy experts believe would benefit the broader system: lower prices; eliminating unnecessary care and drugs; coordinating better care.

2AC - A/T: Innovation

• Innovation arguments are industry propaganda – pharma industry is sustainable and drugs are overpriced

Kesselheim et al, 16 – Program On Regulation, Therapeutics, And Law (PORTAL), Division of Pharmacoepidemiology and Pharmacoeconomics, Department of Medicine, Brigham and Women's Hospital and Harvard Medical School, Boston, Massachusetts(Aaron S., Jerry Avom, Ameet Sarpatwari, The High Cost of Prescription Drugs in the United States, August 23rd, JAMA. 2016;316(8):858-871)

Justifications for High Drug Prices

The pharmaceutical industry has maintained that high drug prices reflect the research and development costs a company incurred to develop the drug, are necessary to pay for future research costs to develop new drugs, or both. It is true that industry often makes expensive investments in drug development and commercialization, particularly through late-stage clinical trials, which can be costly.84 These assertions have been used to justify high prices on the grounds that if drug prices are constrained, the pipeline of new medications will be adversely affected. Some economic analyses favored by the pharmaceutical industry contend that it costs $2.6 billion to develop a new drug that makes it to market.85 However, the rigor of this widely cited number has been disputed.86,87 **A number of factors weigh against these rationales for high drug prices**. First, important innovation that leads to new drug products is often performed in academic institutions and supported by investment from public sources such as the National Institutes of Health. A recent analysis of the most transformative drugs of the last 25 years found that more than half of the 26 products or product classes identified had their origins in publicly funded research in such nonprofit centers.88 Other analyses have highlighted the importance of small companies, many funded by venture capital.89,90 These biotech startups frequently take early-stage drug development research that may have its origins in academic laboratories and continue it until the product and the company can be acquired by a large manufacturer, as occurred with sofosbuvir. Arguments in defense of maintaining high drug prices to protect the strength of the drug industry **misstate its vulnerability**. The biotechnology and pharmaceutical sectors have for years been among the very **best-performing sectors in the US economy**. The proportion of revenue of large pharmaceutical companies that is invested in research and development is just 10% to 20% (Table 4); if only innovative product development is considered, that proportion is considerably lower.91 The contention that high prescription drug spending in the United States is required to spur domestic innovation has not been borne out in several analyses.92 A more relevant policy opportunity would be to address the stringency of congressional funding for the National Institutes of Health, such that its budget has barely kept up with inflation for most of the last decade. Given the evidence of the central role played by publicly funded research in generating discoveries that lead to new therapeutic approaches, this is one obvious area of potential intervention to address concerns about threats to innovation in drug discovery.

Thus, there is little evidence of an association between research and development costs and drug prices93; rather, **prescription drugs are priced in the United States primarily on the basis of what the market will bear.** This explanation also helps to account for several high-profile case studies, including high-priced new branded products94 and exorbitantly priced generic drugs described above.95 In preparation for recent hearings on this topic, the

US House Committee on Oversight and Government Reform subpoenaed internal correspondence from Turing and Valeant Pharmaceuticals, which had sharply increased the prices of older drugs the companies had acquired. The investigation revealed, for example, that Turing received “no pushback from payors” when it increased “Chenodal price 5x... [Thiola] price 21x... [and Daraprim] price 43x.”96 Similarly, Gilead spent $11 billion to purchase sofosbuvir from Pharmasset, a small biotechnology firm that developed the drug, based in part on federally funded research led by an investigator at Emory University.97 Gilead recouped almost all of this cost in the first year that sofosbuvir was on the market, recording sales of $10.3 billion in 2014.98 In December 2015, the US Senate Committee on Finance released a detailed report based on its access to internal company documents on Gilead’s strategies to maximize the prices it could charge for both that drug and its planned successor, which the company also owned.99 In the current system for drug payment in the United States, few options exist to counter this approach.
Companies should of course be rewarded fairly for the research innovations they make that help generate new drug products and for their costly trial work that facilitates the assessment and availability of new medications. But providing them with large incentives to do the opposite is counterproductive.

• Innovation profit arguments are false

Kantajian and Ho 16 – Hagop Kantarjian is chairman of the Leukemia Department at the University of Texas MD Anderson Cancer Center and a Baker Institute scholar for health policies at Rice University. Vivian Ho , Ph.D., is the James A Baker III Institute Chair in health economics, director of the Center for Health and Biosciences, a professor in the department of economics at Rice University and a professor in the department of medicine at Baylor College of Medicine. (“The Harm of High Drug Prices”, https://www.usnews.com/opinion/policy-dose/articles/2016-12-12/the-harm-of-high-drug-prices-to-americans-a-continuing-saga) RMT

Despite protests, prices continue to escalate. In 2015, the average price of a new cancer drug was $145,000/year. The price per year of life gained increased from $54,000 in 1995 to $207,000 in 2013, while real median American household income rose by seven percent. Unlike in Europe and elsewhere, the prices of older drugs in the U.S. continue to increase by an average of 8-12 percent annually, allowing new cancer drugs to be launched at higher prices every year, in lockstep with the rising prices of older drugs.

Under criticism, the drug industry repeats the same arguments: 1) high cost of research and development; 2) benefit justifies price; 3) market forces; and 4) regulating prices stifles innovation. But all four arguments lack validity. The cost of research and development is only **10 percent of the $1-2.6 billion figure** that is claimed in industry-supported studies. More than 50 percent of important discoveries are made in **independent academic centers**, funded by taxpayers, and **85 percent of basic research** is conducted in academic centers. The drug industry spends **1.3 percent of its budget on basic research**, but 20-40 percent on advertisements and related activities. Some studies show no relationship between drug benefits and price. Drug companies enjoy monopoly-like conditions that discourage

competition based on price. Finally, innovation is driven by **independent investigators** who will continue to conduct research even if drug prices fall.

We Can Make Medicine AffordableCommonsense fixes to Medicare and FDA drug approval can lower the cost of lifesaving drugs.High drug prices are harmful. Medical costs and out-of-pocket expenses result in high rates of bankruptcies, and 10-25 percent of patients either delay, abandon or compromise treatments because of financial constraints. Survival is also compromised. For example, in chronic myeloid leukemia, the 8-10 year survival rate is 80 percent in Europe (where treatment is universally affordable); in the U.S., where finances may limit access to drugs, the 5-year survival is 60 percent. In surveys, 78 percent of Americans worry most about costs of drugs.

Sadly, three years after the issue was raised, there has been little progress. The problem is compounded by 2 additional factors. First is the increasing shift in the cost of care and drugs to patients. Insurers justify this "skin-in-the-game" strategy as effective in reducing costs, but the high out-of-pocket expenses have turned this into "deterrence-in-the-game," discouraging patients from seeking care or purchasing drugs. In a recent survey, one-third of insured Texans delayed or did not pursue care because of high out-of-pocket expenses. Second is the spill-over of high drug prices to generics. Complex regulatory issues and shortages allow companies to increase prices of generics to levels as high as patented drugs. The latest scandals – Turing, Valiant and Mylan – are only the most extreme examples of a common strategy in pricing drugs. Generic Imatinib to treat chronic myeloid leukemia is priced at $5,000-8,000/year in Canada, $400/year in India, but $140,000/year in the U.S. For generic drugs to be priced low, four to five generics have to be available. The average cost of filing for FDA approval of a drug is $5 million in 2016, and the average time to approval is 4 years. There are currently more than 3,800 generic drug applications awaiting FDA action. The FDA should overhaul its procedures to reduce the cost of filing to less than $1 million per drug, reduce the timeline to approval to 6-12 months and monitor for the availability of multiple generics at all times. Lawmakers want affordable health care, but none seem willing to ban pharma-backed advertising. While expressing a desire to "be part of the solution," **the drug industry has done little**. ‘gInstead, it funded a $100+ million public relations campaign in 2016 to support the sustenance of high prices. Of interest, some drug industry CEOs favor lowering drug prices, arguing that affordable drugs will have deeper market penetration, keeping more patients alive who continue to purchase and use these drugs, thus generating more long-term profits.Several solutions can be implemented to reduce drug prices: 1) Allow Medicare to negotiate drug prices (this can save $400-800 billion over a decade). 2) Establish a post-FDA mechanism to review the benefits of drugs and define fair prices. 3) Encourage medical organizations to incorporate price into definitions of "treatment value." 4) Prevent strategies that delay the availability of generics (this saved the U.S. health care system $227 billion in 2015 and $1.46 trillion over a decade. 5) Accelerate the process of generics approval and reduce costs of filing. 6) Request that drug companies report transparently the costs of research and development to justify prices. Unfortunately, these measures are opposed in Congress because of the influence of the drug industry lobby. Elected officials seem to represent industry interests rather than interests of American citizens who elected them. Future actions and legislation will show whether the U.S. is still a democracy, or whether it has transformed into a "pharmaceutocracy."

• Clinical trials are a key alt cause

Weisfeld et al 13 *Rapporteurs of workshop attended by relevant experts (Victoria, Rebecca A. English, and Anne B. Claiborne, Institute of Medicine of the National Academies, "Public Engagement and Clinical Trials: New Models and Disruptive Technologies Workshop Summary," Institute of Medicine of the National Academies, 2012, pp. 1, THE NATIONAL ACADEMIES PRESS, http://www.nap.edu/catalog.php?record_id=13237)//duncan

What the concepts of "evidence-based medicine" and "learning health care system" have in common is their reliance on the accumulation of medical knowledge based on science, not hope, and, further, that **clinicians would take that knowledge out of the medical textbooks and laboratory notebooks and apply it in the care of individual patients and patient populations.**

Clinical trials are the linking step that enables basic research findings to emerge at the patient's bedside and in physicians' examining rooms. The questions clinical trials seek to answer change over time, depending on advances in basic research and the population health problems they are intended to address. **Potential new treatments must be tested in humans in order to find out whether they "work" and whether they cause harm** (see Appendix B for an overview of the clinical trials process set forth in the workshop summary from an earlier Institute of Medicine [IOM] workshop in this workshop series). Clinical trials can comprise a series of rather elaborate steps, and the rationale for these trials may not be well understood by the public. **An adequate infrastructure to support the efficient and effective conduct of the nation's clinical trials enterprise can help ensure that the system does not become too narrow a bottleneck, impeding the flow of discovery from science to practice.**

Meanwhile, **biomedical research is advancing rapidly, and certain significant problems in clinical trials have hindered their ability to keep pace with demands to translate discoveries** into improved patient care. In short, as discussed at a 2009 workshop of the IOM's Forum in Drug Discovery, Development, and Translation, there is concern that "the current clinical trials enterprise in the United States is unable to produce the high-quality, timely, and actionable evidence needed to support a learning health care system" (IOM, 2010a). Among the broad categories of problems identified at that workshop were:

• We solve long term innovation – that outweighs

J. **COHN 7**. Reporter. "Does universal health care suppress innovation?" *The New Republic*. November 12. http://www.pnhp.org/news/2007/november/does_universal_healt.php.
But **it's one thing to say** that **universal coverage could lead to less innovation** or reduce the availability of high-tech care. **It is quite another to say that it will** do those things, which is the claim that opponents frequently make. **That argument requires several leaps of logic**, **many of them highly suspect**. **The forces that produce innovation in medicine turn out to be a great deal more complicated than critics of universal coverage seem to grasp**. Ultimately, whether innovation would continue to thrive under universal health care depends entirely on what kind of system we create and how well we run it. In fact, **it's quite possible that universal coverage could lead to better innovation.** The **single biggest source of medical research funding**, not just in the United States but **in the entire world, is the National Institutes of Health (NIH):** Last year, it spent more than $28 billion on research, accounting for about one-third of the total dollars spent on medical research and development in this country (and half the money spent at universities). The majority of that money pays for the kind of basic research that might someday unlock cures for killer diseases like Alzheimer's, aids, and cancer. **No other country has an institution that matches the NIH in scale**. And **that is probably the primary explanation for why so many of the**

intellectual breakthroughs in medical science happen here. There's no reason why this has to change under universal health insurance. **NIH has its own independent funding stream.** And, during the late 1990s, thanks to bipartisan agreement between President Clinton and the **Republican Congress**, its funding actually increased substantially—giving a tremendous boost to research. With or without universal coverage, subsequent presidents and Congress could ramp up funding again—although, if they did so, they would be breaking with the present course. It so happens that, starting in 2003, President Bush and his congressional allies **let NIH funding stagnate**, even though the cost of medical research (like the cost of medicine overall) was increasing faster than inflation. The reason? They needed room in the budget for other priorities, like tax cuts for the wealthy. **In this sense, the greatest threat to future medical breakthroughs may not be universal health care but the people who are trying so hard to fight it**. The ideal would be to come up with some way of achieving the best of both worlds—paying for innovation when it yields actual benefits, but without neglecting less glitzy, potentially more beneficial forms of health care. And that is precisely what the leading proposals for universal health care seek to do. All of them would establish independent advisory boards, staffed by leading medical experts, to help decide whether proposed new treatments actually provide clinical value. Of course, the idea of **involving the government** in these decisions **is anathema to many conservatives**—since, **they argue, the private sector is bound to make better decisions** than a bunch of bureaucrats in Washington. But, **while that's frequently true in economics, health care may be an exception**. **One feature of the U.S. insurance system is its relentless focus on short-term good**. **Private insurers have little incentive to pay for interventions that don't yield immediate benefits, because they are gaining and losing members all the time**. As a result, **money invested on patient health may very well help a competitor's bottom line. What's more, the for-profit insurance industry**—like the pharmaceutical and device industries—**responds to Wall Street, which cares more about quarterly filings than long-term financial health. So there's relatively little incentive to spend money on the kinds of innovations that yield long-term, diffuse benefits. The government, by contrast, has plenty of incentive to prioritize these sorts of investments**. And, **in more centralized systems, it can do just that**. Several European countries are way ahead of us when it comes to establishing electronic medical records. **Another virtue of** more **centralized health care is its ability to generate savings by reducing administrative waste**. **A universal coverage system that significantly streamlined billing** (either by creating one common form or simply replacing basic insurance with one, Medicare-like program) **and cut down on the need for so many insurance middle-men would leave more resources for actual medical care—and real medical innovation. … the truth about universal health insurance: You don't have to choose between universal access and innovation.** It's possible to have both— as long as you do it right.

• Firms prioritize innovation of lucrative drugs over drugs necessary for public health

Sachs and Frakt, **16** – Washington University School of Law, JD, MPH, *Veteran Affairs Boston Healthcare System, PhD (Rachel, Austin, Innovation–Innovation Tradeoffs in Drug Pricing, December 20th, Annals of Internal Medicine, Ideas and Opinions, http://annals.org/aim/article/2566330/innovation-innovation-tradeoffs-drug-pricing)

The uproar about the price of the EpiPen is the latest episode in the controversy over drug pricing that extends back decades. However, the more recent, sustained public outrage and media attention have occurred during a presidential election cycle, which places greater focus on policy prescriptions. A common concern with proposed regulation of drug markets is the extent to which it would reduce the rate of drug innovation and decrease the number of new drugs in the marketplace. But another important consideration is less frequently voiced: How would (or could) policy affect the composition of innovation—the types of drugs that are brought to the marketplace?

To encourage greater affordability and access, policymakers, academics, and other stakeholders have offered proposals that would reduce payment to pharmaceutical companies for their products. Some proposals are familiar, such as the idea that Medicare should be allowed to negotiate with drug companies and decline to cover a drug if the manufacturer is recalcitrant (1). Others are novel, such as Secretary Clinton's proposal to curtail price increases on generic drugs through the use of an expert administrative body (2).

The response from the pharmaceutical industry has been the same: Even if these proposals improve access to medicines today, they will have a negative effect on innovation in the future (3). If the government limits manufacturers' ability to recoup the costs of

risky research and development, including investments that fail to lead to marketable drugs, they will simply reduce their investment in developing new drugs. This could harm all of us. The drugs we may need in the future may not be available. Pointing out that there could be an innovation–access tradeoff is often too simplistic, however. Some policy proposals on drug pricing that would broaden access might also stifle innovation, but others would change incentives for the type of innovation the pharmaceutical industry invests in—an innovation–innovation tradeoff. The aim of these approaches is not necessarily to change the rate of innovation but to change its composition, which would reduce some types of innovation we have now and encourage other types that would yield greater social value.

This is best illustrated with examples. Our current system of drug reimbursement provides additional incentives for pharmaceutical companies to pursue maintenance therapies for common chronic conditions (for example, a new proprotein convertase subtilisin/kexin type 9 inhibitor for treating high cholesterol). Pharmaceutical companies often earn higher profits from drugs that many patients will take every day for their entire lives than they do from cures or preventive interventions. But patients prefer products for cures and prevention to maintenance treatments. If drug prices were commensurate with cost-effectiveness, they would be higher for cures and prevention and companies would invest more in developing these products, all else equal (4).

A related approach would be to adopt a system of reference pricing similar to that used by many European countries in which 1 price is established for each class of drugs with similar therapeutic effect. Patients who want more expensive drugs from the class pay the difference out of pocket. This encourages the development of more cost-effective innovation (5).

Another example is the distortions that arise from the different prices pharmaceutical companies receive from various insurers. In the United States, policymakers have essentially created a tiered pricing system in which drugs prescribed to privately insured patients or Medicare recipients cost more than the same drugs prescribed to Medicaid recipients. From an access perspective, this system is salutary and enables us to provide care to more low-income persons. But it also fosters bias in which companies invest in drugs disproportionately prescribed for the wealthy, such as Viagra (Pfizer). If policymakers equalized payments across Medicare, Medicaid, and private insurers, pharmaceutical companies might instead invest more **in drug treatments for diseases that affect the most patients**, regardless of income (6).

These are just a few of the many examples of welfare-improving innovation–innovation tradeoffs that could result from changes to drug pricing policy or practice. However, consideration of these ideas, and others, is often stifled by a reflexive focus on innovation–access tradeoffs. Instead, we advocate focusing on how these proposals would affect the composition of innovation. This would encourage more types of innovation we want and reduce the types we dislike.

Our current system of paying for pharmaceuticals—a tangle of various privately initiated and public price controls—is flawed and has produced an untenable situation for many patients. With the rise of high-deductible and higher cost-sharing plans, patients are no longer as insulated from high drug prices as they once were (7). The clamor for change grows louder despite current political challenges. Rather than being blinded by innovation–access tradeoffs, policymakers should redirect their energy toward innovation–innovation tradeoffs for the benefit of patients and society.

• High prices aren’t key --- marketing costs outweigh and government research solves.

Annie **WALDMAN 17**. Reporter covering education. Dual masters with Honors, Columbia’s School of International and Public Affairs and the School of Journalism. “Big Pharma Quietly Enlists Leading Professors to Justify $1,000-Per-Day Drugs.” *ProPublica*. February 23. https://www.propublica.org/article/big-pharma-quietly-enlists-leading-professors-to-justify-1000-per-day-drugs.

Over the last three years, pharmaceutical companies have mounted a public relations blitz to tout new cures for the hepatitis C virus and persuade insurers, including government programs such as Medicare and Medicaid, to cover the costs. That isn’t an easy sell, because the price of the treatments ranges from $40,000 to $94,000 — or, because the treatments take three months, as much as $1,000 per day.¶ To persuade payers and the public, the industry has deployed

a potent new ally, a company whose marquee figures are leading economists and health care experts at the nation's top universities. The company, Precision Health Economics, consults for three leading makers of new hepatitis C treatments: Gilead, Bristol-Myers Squibb, and AbbVie. When AbbVie funded a special issue of the American Journal of Managed Care on hepatitis C research, current or former associates of Precision Health Economics wrote half of the issue. A Stanford professor who had previously consulted for the firm served as guest editor-in-chief.¶ At a congressional briefing last May on hepatitis C, three of the four panelists were current or former Precision Health Economics consultants. One was the firm's co-founder, Darius **Lakdawalla**, a University of Southern California professor.¶ "The returns to society actually exist even at the high prices," Lakdawalla assured the audience of congressional staffers and health policymakers. "Some people who are just looking at the problem as a pure cost-effectiveness problem said some of these prices in some ways are too low."¶ Even as drug prices have come under fierce attack by everyone from consumer advocates to President Donald Trump, insurers and public health programs have kept right on shelling out billions for the new hepatitis C treatments, just as Precision Health Economics' experts have urged them. With a battle looming between the industry and Trump, who has accused manufacturers of "getting away with murder" and vowed to "bring down" prices, the prestige and credibility of the distinguished academics who moonlight for Precision Health Economics could play a crucial role in the industry's multipronged push to sway public and congressional opinion.¶ While collaboration between higher education and industry is hardly unusual, the professors at Precision Health Economics have **taken it to the next level**, sharpening the conflicts between their scholarly and commercial roles, which they **don't always disclose**. Their activities illustrate the growing influence of **academics-for-hire** in shaping the national debate on issues from climate change to antitrust policy, which ultimately affect the quality of life and the household budgets of ordinary Americans — including what they pay for critical medications.¶ The pharmaceutical industry is digging in, with one of its trade groups raising an additional $**100 million for its "war chest."** For years, it has spent millions of dollars lobbying politicians, hoping to enlist their support on a wide range of legislation. It has similarly wooed doctors, seeking to influence what they research, teach and prescribe. Now, it's courting health economists.¶ "This is just an extension of the way that the drug industry has been involved in every phase of medical education and medical research," said Harvard Medical School professor Eric G. Campbell, who studies medical conflicts of interest. "They are using this group of economists it appears to provide data in high-profile journals to have a positive impact on policy."¶ The firm participates in many aspects of a drug's launch, both advising on "pricing strategies" and then demonstrating the value of a drug once it comes on the market, according to its brochure. "Led by professors at elite research universities," the group boasts of a range of valuable services it has delivered to clients, including generating "academic publications in the world's leading research journals" and helping to lead "formal public debates in prestigious, closely watched forums."¶ Precision Health Economics may be well-positioned to influence the Trump administration. Tomas Philipson, an economist at the University of Chicago and the third co-founder of Precision Health Economics, reportedly served briefly as a senior health care adviser for the Trump transition team. He did not respond to requests for comment. Dr. Scott Gottlieb, reported to be a candidate for commissioner of the Food and Drug Administration, is a clinical assistant professor at New York University School of Medicine and a former "academic affiliate" of Precision Health Economics, according to its website.¶ Although it's hard to gauge the firm's precise impact, associates of Precision Health Economics have often waded into the political fray. Last fall, big pharma spent more than $100 million successfully defeating a California referendum that would have controlled the prices of both generic and name-brand drugs. Testifying in September at a state Senate hearing on a generic drug, co-founder Dana Goldman steered the discussion to name-brand drugs, such as the hepatitis C treatments, arguing that their prices should not be regulated.¶ "We have to ensure access to future innovation, and that's going to require some recognition that if someone develops an innovative drug, they're going to charge a lot for it," Goldman said.¶ Prescription drugs on average cost more than twice as much in the U.S. as in other developed nations. That's mostly due to name-brand drugs. They represent 10 percent of all prescriptions but account for almost three-quarters of the total amount spent on drugs in the U.S. Their prices have doubled in the past five years.¶ The U.S. grants drugmakers several years of market exclusivity for their products and remains one of the only industrialized countries that allows them to set their own prices. These protections have allowed the pharmaceutical industry to become one of the economy's most profitable sectors, with margins double those of the auto and petroleum industries.¶ To justify the value of expensive drugs, the professors affiliated with Precision Health Economics rely on complicated economic models that **purport** to quantify the net social benefits that the drugs will create.¶ For one industry-funded hepatitis C study, Lakdawalla and nine co-authors, including three pharmaceutical company researchers, subtracted the costs of the treatment from the estimated dollar value of testing all patients and saving all livers and lives. By testing and treating all patients now, they concluded, society would gain $824 billion over 20 years.¶ Critics have at times **questioned the assumptions** underlying the consultants' economic models, such as the choice of patient populations, and suggested that some of **their findings tilt toward their industry clients**. For example, some have **tried and failed to reproduce** their results justifying the value of cancer treatments.¶ Precision Health Economics allows drugmakers to review articles by its academics prior to publication in academic journals, said a former business development manager of the consulting group. Such prior review is controversial in higher education because it can be seen as impinging on academic freedom.¶ "Like other standard consulting projects, you can't publish unless you get permission from the company," the former employee said. Carolyn Harley, senior vice president and general manager of the firm, said that pre-publication review was not company policy, but "in some cases, client contracts provide them the opportunity for review and comment before submission."¶ "I have never published anything that I am not comfortable with or prepared to defend, nor have I ever been asked to," said Lakdawalla about his firm's research.¶ Goldman says the firm's research is independent, and its clients don't influence its findings. "From my perspective it's very clear: I say things that piss off my sponsors, I say things that piss off the detractors," he told ProPublica. "People are coming to us because they have an interest in sponsoring the research that's generated. These are our ideas. This is how you get your ideas recognized."¶ He said his consulting work does not involve setting prices of specific drugs, and his academic research focuses only on categories of drugs, rather than on particular brands.¶ The professors' disclosure of their ties to the firm and to the pharmaceutical industry in scholarly articles is **inconsistent**: sometimes extensive, sometimes scanty. Members of Precision Health tend to reveal less about their paid work in blogs, public forums like conferences, and legislative testimony. At the Capitol Hill briefing last May on hepatitis C drugs, Lakdawalla didn't mention his affiliation with Precision Health Economics, though it was listed in the journal issue, which was provided to attendees.¶ "Conflicts are always a concern, which is why it is important to be transparent about study methods — that way they can be scrutinized and debated in the academic literature," said Lakdawalla, adding that he has disclosed his ties to the firm in at least 33 publications over the past three years.¶ Goldman said he and other academics at Precision Health Economics disclose their ties whenever appropriate, but typically journal editors and conference sponsors decide how to make that information available. "I wear two hats," Goldman said in an interview. "And I try to reveal what that might mean in terms of perceived conflict of interest."¶ The issues at stake aren't just academic. Goldman says that pharmaceutical companies need to reap financial rewards from the enormous time and expense they invest in developing better medical treatments. Yet the high prices of some drugs have left government health programs strapped, or forced them to limit coverage. For example, one promising hepatitis C treatment is so expensive that some state Medicaid programs have chosen to cover its cost for only the sickest patients.¶ "Triage, triage, triage," said Emily Scott, a Tennessee factory worker with hepatitis C who was denied coverage for the new treatment. "They set their price so high that we poor folks can't afford it."¶ Despite such cases, four researchers from Precision Health Economics warned in an article last month that any government controls on drug prices could actually shorten the average American's life by two years by discouraging development of new drugs.¶ "As the pace of innovation slows, future generations of older Americans will have lower life expectancy relative to the status quo," they wrote. The article, funded by the pharmaceutical trade group PhRMA, was published in Forum for Health Economics & Policy, of which Goldman is the editor-in-chief and co-founder. More than half of the editors listed on its masthead are current or former consultants at the firm.¶ Just after Precision Health Economics co-founder Dana Goldman completed his Ph.D. in economics at Stanford, in 1994, he was diagnosed with type 1 diabetes. He was 29 years old. With a pump he wears every day, he takes insulin to treat the disease.¶ "I would pay hundreds of thousands of dollars if I could take one pill that would make me better," Goldman said.¶ His desire for a cure led to a new scholarly interest: the economics of medical innovation. Because there were few government funders for research in the field, he turned to industry. In 2005, Goldman established the firm with Lakdawalla and Philipson.¶ The headquarters of Precision Health Economics sits in a West Los Angeles office building flanked by palm trees, about 10 miles from Goldman's academic center at USC. Goldman's assistant at USC is also an executive assistant at the consulting firm. Daniel Shapiro, director of research compliance at USC, said that both Goldman and Lakdawalla were in compliance with the university's standards on consulting.¶ Precision Health Economics has counted at least 25 pharmaceutical and biotech companies and trade groups as clients. The roster includes Abbott Nutrition, AbbVie, Amgen, Biogen, Bristol-Myers Squibb, Celgene, Gilead, Intuitive Surgical, Janssen, Merck, the National Pharmaceutical Council, Novartis, Otsuka, Pfizer, PhRMA, rEVO Biologics, Shire and Takeda. The firm has 85 staff members in nine locations.¶ Over the years, the founders recruited an impressive cadre of high-profile academics to consult for these clients. Early in 2016, the firm boasted more than two dozen academic advisers and consultants from top universities on its website. (The site later stopped identifying professors by their university affiliations.) The list of associates has also included some policy heavyweights who recently left the government, including a top official from the Congressional Budget Office, a senior economist from the White House's Council of Economic Advisors, and an FDA commissioner. About 75 percent of publications by the firm's employees in the past three years have either been funded by the pharmaceutical industry or have been done in collaboration with drug companies, a ProPublica review found.¶ Some academics worry that a tight relationship with industry might suggest bias. "I personally find, when your enterprise relies so substantially on a particular source of funds, you will tend to favor that source," said Princeton economist Uwe Reinhardt.¶ Goldman says his industry connection has helped him ask better questions.¶ "The right way to do these things is not to push away the private sector,

but to engage them," he told ProPublica. "If we end up with a world where everyone who has a voice in a debate must be free of perceived bias, we lose the importance of the diversity of ideas." In a later interview, he added, "You have to separate the appearance of the bias with actual bias."¶ These ideas were recently echoed in an op-ed that he wrote with Lakdawalla in the online publication The Conversation.¶ "To be sure, collaboration with industry supplements our income through consulting fees. But no matter who funds our research — foundations, government, or companies — we apply the same template to our work," wrote Goldman and Lakdawalla. "The ivory tower is not always the best place to understand the social benefits of treatments, the incentives for medical innovation, and how aligning prices with value can aid consumers."¶ Engaging the private sector has indeed boosted Goldman's income. According to federal conflict of interest forms filed last year, when he served on an advisory panel to the Congressional Budget Office, Goldman earned consulting income from the firm in the range of $25,000 to $200,000, on top of his income as a USC professor. He also has more than $500,000 in equity in the firm. Precision's Harley says Goldman and Lakdawalla each have equity stakes of less than 1 percent, indicating that the firm is worth at least $50 million. Lakdawalla and Philipson have not publicly disclosed their consulting incomes.¶ In April 2015, Precision Health Economics was acquired by a privately held biotech company, Precision for Value. Terms weren't disclosed.¶ Precision Health Economics raised its profile in 2013 when the president's annual economic report cited a cancer study by several of the firm's principals and consultants. To some critics, though, the study showed how industry funding can taint academic research.¶ Originally published in Health Affairs, where Goldman also serves on the editorial board, the study found that Americans paid more for cancer care than Europeans but had better survival gains.¶ As the study acknowledged, it was funded by Bristol-Myers Squibb, a company that at the time was developing a much-anticipated cancer treatment. It was priced at more than $150,000 per year when it eventually came on the market. All three founders of Precision Health Economics were listed as authors of the Health Affairs article, alongside one of their employees, yet none of the founders disclosed their ties to their consulting firm in the published study. In an interview, Goldman said this might have been an "oversight."¶ Goldman later emailed ProPublica to clarify that the journal was aware that the study was a Precision Health Economics publication and that Goldman and his co-founders were affiliated with the firm. Goldman has published more than 25 articles and letters to the editor in Health Affairs since co-founding Precision Health Economics, and only five have listed the connection.¶ "This affiliation is clearly not a secret and I include it where relevant," Goldman wrote in the email. "The bottom line is that disclosure policies vary across journals, journal editors, and over time. Definitions of what is 'relevant' are also subject to their own judgments."¶ Donald Metz, executive editor of Health Affairs, said the journal followed its policy of leaving disclosure to the "authors' discretion." Its editorial staff did not exclude any information on conflicts or affiliations that the authors provided alongside their draft, he said.¶ As the cancer study gained national recognition, its methodology and findings came under fire. Researchers from Dartmouth College tried and failed to reproduce the results. Cancer care in the U.S., their research found, may actually provide less value than cancer care in Europe, considering cost.¶ "We know that [the U.S. health care system] is more disorganized and disorganization is more expensive, so it's surprising to believe that the U.S. would perform better in a cost-effectiveness sense," said Samir Soneji, one of the authors of the counter-study and an assistant professor of health policy at Dartmouth. The science in the original study, Soneji says, was **"questionable."**¶ Soneji was not alone in his criticism. Aaron Carroll, a pediatrics professor at the Indiana University School of Medicine, reviewed the methodology and concluded that the Precision Health Economics researchers had used a measure that can **frequently be misinterpreted**. Instead of relying on mortality rates, which factor in a patient's age of death, the study employed survival rates, looking at how long people live after diagnosis. Cancer screening, which can increase survival rates, is more frequent for some cancers in the U.S. than in other countries, Carroll says.¶ "When they wrote that paper using survival rates, **they were clearly cherry picking**," Carroll told ProPublica. "If the arguments are flawed and people keep using them, I would be concerned that **they have some other motive**."¶ The founders of Precision Health Economics defended their use of survival rates in a published response to the Dartmouth study, writing that they "welcome robust scientific debate that moves forward our understanding of the world" but that the research by their critics had "moved the debate backward."¶ Precision Health Economics has become a prominent booster of a new way of setting drug prices — based on their overall value to society. Value is determined by comparing the drugs' cost with their effectiveness in saving lives and preventing future health expenses.¶ Pharmaceutical companies have traditionally justified their prices by citing the cost of research and development, but recent research on drug pricing has challenged this argument. Many of the largest drug companies **spend more on sales and marketing** than on developing their drugs. And notably, one researcher has found that about **75 percent** of new molecular entities, which are considered the most innovative drugs, trace their initial research funding **back to the government**.¶ "There is substantial evidence that the sources of transformative drug innovation arise from publicly funded research in government and academic labs," said Dr. Aaron Kesselheim, an associate professor at Harvard Medical School whose research looks at the cost of pharmaceuticals. Pharmaceutical pricing, he says, is primarily **based on what the market can bear**.

• High prices aren't key to R&D, and public research solves

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Aaron S. Kesselheim, MD, JD, MPH; Jerry Avorn, MD; Ameet Sarpatwari, JD, PhD. "The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform." JAMA Special Communication. August 2016. http://jamanetwork.com/journals/jama/fullarticle/2545691

Justifications for High Drug Prices The pharmaceutical industry has maintained that high drug prices reflect the research and development costs a company incurred to develop the drug, are necessary to pay for future research costs to develop new drugs, or both. It is true that industry often makes expensive investments in drug development and commercialization, particularly through late-stage clinical trials, which can be costly.84 These assertions have been used to justify high prices on the grounds that if drug prices are constrained, the pipeline of new medications will be adversely affected. Some economic analyses favored by the pharmaceutical industry contend that it costs $2.6 billion to develop a new drug that makes it to market.85 However, the rigor of this widely cited number has been disputed.86,87 A number of factors weigh against these rationales for high drug prices. First, important innovation that leads to new drug products is often performed in academic

institutions and supported by investment from **public sources** such as the National Institutes of Health. A recent analysis of the most transformative drugs of the last 25 years found that more than half of the 26 products or product classes identified had their origins in publicly funded research in such nonprofit centers.88Other analyses have highlighted the importance of small companies, many funded by venture capital.89,90 These biotech startups frequently take early-stage drug development research that may have its origins in **academic laboratories** and continue it until the product and the company can be acquired by a large manufacturer, as occurred with sofosbuvir. Arguments in defense of maintaining high drug prices to protect the strength of the drug industry **misstate its vulnerability**. The biotechnology and pharmaceutical sectors have for years been among the very best-performing sectors in the US economy. The proportion of revenue of large pharmaceutical companies that is invested in research and development is just 10% to 20% (Table 4); if only innovative product development is considered, that proportion is considerably lower.91The contention that high prescription drug spending in the United States is required to spur domestic innovation has not been borne out in several analyses.92 A more relevant policy opportunity would be to address the stringency of congressional funding for the National Institutes of Health, such that its budget has barely kept up with inflation for most of the last decade. Given the evidence of the central role played by publicly funded research in generating discoveries that lead to new therapeutic approaches, this is one obvious area of potential intervention to address concerns about threats to innovation in drug discovery. Thus, there is **little evidence** of an association between research and development costs and drug prices93; rather, prescription drugs are priced in the United States primarily on the basis of **what the market will bear**. This explanation also helps to account for several high-profile case studies, including high-priced new branded products94 and **exorbitantly priced generic drugs** described above.95 In preparation for recent hearings on this topic, the US House Committee on Oversight and Government Reform subpoenaed internal correspondence from Turing and Valeant Pharmaceuticals, which had sharply increased the prices of older drugs the companies had acquired. The investigation revealed, for example, that Turing received "no pushback from payors" when it increased "Chenodal price 5x... [Thiola] price 21x... [and Daraprim] price 43x."96 Similarly, Gilead spent $11 billion to purchase sofosbuvir from Pharmasset, a small biotechnology firm that developed the drug, based in part on federally funded research led by an investigator at Emory University.97 Gilead recouped almost all of this cost in the first year that sofosbuvir was on the market, recording sales of $10.3 billion in 2014.98 In December 2015, the US Senate Committee on Finance released a detailed report based on its access to internal company documents on Gilead's strategies to maximize the prices it could charge for both that drug and its planned successor, which the company also owned.99 In the current system for drug payment in the United States, few options exist to counter this approach. Companies should of course be rewarded fairly for the research innovations they make that help generate new drug products and for their costly trial work that facilitates the assessment and availability of new medications. But providing them with large incentives to do the opposite is counterproductive.

• Innovation is stagnating and profits aren't key

Richard **FRANK AND** Paul B. **GINSBURG 17**. **Margaret T. Morris Professor of Health Economics, Harvard Medical School. **Senior Fellow, Economic Studies; Leonard D. Schaeffer Chair, Health Policy Studies; Director, Center for Health Policy. "Pharmaceutical industry profits and research and development." *Brookings*. November 17. https://www.brookings.edu/blog/up-front/2017/11/17/pharmaceutical-industry-profits-and-research-and-development/.

Reviews of the literature on the impact of market size differences on innovation suggest two broad conclusions. First, increases in market size and potential profits have a strong positive impact on innovative activity, whether it is measured by clinical trial activity, R&D spending, or number of new drugs launched. The second conclusion is less unanimous but represents the weight of the evidence: innovation increases less than proportionately with market size.

Together, these conclusions are consistent with a couple of interpretations. One is that the science required to produce new drugs in 2017 is harder than it was a decade or two previously and so the **"low hanging fruit" has been picked**. A second interpretation, mentioned earlier, is that **differentiated competition** drives

excessive entry and **duplication** of R&D effort, resulting in **overinvestment** in certain clinical areas. Both forces can be at work.

A third conclusion has recently emerged but it reflects only one research effort. Using changes in market size stemming from insurance expansion, Dranove and colleagues examined both the number of new drugs brought to market and the degree to which new drugs are "truly innovative," as measured by being aimed at an under treated illness or being rated by the U.S. Food and Drug Administration (FDA) as high priority. Like prior researchers, they found that as markets grow the number of new products increases; the vast majority of increases occur in markets where there are already five or more products being sold. Dranove and colleagues found no meaningful increases in the number of drugs rated by the FDA as high priority as market size grew. These latter two results are consistent with a conception of the pharmaceutical market that exhibits differentiated competition and a tendency to overinvest in a limited number of clinical areas. It is important to note that the evidence on this point remains limited and more work is needed. Nevertheless the mix of research findings, alongside the institutional changes in the prescription drug markets, **raises fresh questions** about the trade-off between high prices and profits on the one hand and innovation on the other. LOOKING FORWARD Reactions on the part of the pharmaceutical industry to proposals that would lead to lower drug prices, either through market forces (e.g. faster generic approvals) or regulation (e.g. price controls), have emphasized reductions in future innovation. The relationship between prices and innovations is real, but that is only part of the needed analysis. Innovation, like everything else, is constrained by the law of **diminishing returns**.

Indeed, it is possible that the current magnitude of innovation in pharmaceuticals is **already too high** in the sense that resources going into it might be better used for infrastructure, education, housing and other priorities. For those concerned about the growing role of government in the economy, since a large portion of higher drug prices are paid either directly (Medicare, Medicaid) or indirectly (tax subsidies for insurance) by government, higher drug prices inevitably lead to either higher taxes or cuts in spending for other priorities.

• US not key to innovation -- other countries solve

Salomeh **KEYHANI ET AL. 10**. *MD, MPH, corresponding author. **Steven Wang, MD, Paul Hebert, PhD, Daniel Carpenter, PhD, and Gerard Anderson, PhD. "US Pharmaceutical Innovation in an International Context." *Am J Public Health* 100(6): 1075-80. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2866602/.

Pharmaceutical innovation is an **international enterprise**. Although the United States is an important contributor to pharmaceutical innovation, we found that **more than 20 countries** contributed to the development of the 288 NMEs with patents at the time of approval. More than 171 companies were involved in the development of these NMEs, and the vast majority of companies were **multinationals** with facilities located in more than 2 countries. We also found that the United Kingdom, Switzerland, Belgium, and a few other countries innovated proportionally more than their contribution to the global GDP or prescription drug spending, whereas Japan, Spain, Australia, and Italy innovated less. In contrast with the United States, all other countries investigated had instituted at least 1 form of **drug pricing regulation**.[1] Critics of drug price regulation argue that free market pricing strategies and higher prices in the United States are instrumental to innovation.[20,21] One might therefore expect the United States to be the most innovative given that it is the only country with a predominantly unregulated pharmaceutical market. However, US pharmaceutical innovation appeared roughly to be **proportional** to its national wealth and

prescription drug spending. Our data suggest that the United States is important but **not disproportionate** in its contribution to pharmaceutical innovation. Interestingly, some countries with direct price control, profit control, or reference drug pricing appeared to **innovate proportionally** more than their contribution to the global GDP or prescription drug spending.

There are 3 general types of price regulation strategies that are implemented in OECD countries: (1) direct control of prices, (2) reference pricing and generic substitution, and (3) profit control (an indirect form of price control in which a country limits the profits generated by a company within its territory).20,22 The United Kingdom, Spain, and South Korea1 use profit control to lower drug costs.23 Canada uses a mixture of measures to control drug prices in different provinces.24 Denmark, Germany, the Netherlands, Italy, Norway, Spain have all implemented a form of reference drug pricing.1 Belgium, Switzerland, Sweden, Italy, Austria, and Finland set the manufacturer price, the reimbursement price, or both.1 Although many researchers20,21,25 have speculated that reference drug pricing in the United States would have dire consequences for innovation, our data suggest that the pharmaceutical innovation of countries with reference drug pricing is more or less what one would expect given their prescription drug spending or even the general size of their economies. Many countries with significant price regulation were **important innovators** of pharmaceuticals; therefore, our data suggest that country-specific pricing policies probably **do not affect** country-specific innovation. For example, although prices in the United Kingdom are much less than are prices in the United States, the industry continues to be very **profitable and innovative**.11 In Canada, income from domestic sales of brand name companies is, on average, about 10 times greater than is research and development costs, even in the face of prices that are approximately 40% lower than in the United States.11 In addition, companies in the United Kingdom invest proportionately more revenue from domestic sales into research and development activity than do their US counterparts.11 Despite the above average profitability of US-based companies,26 the higher prices paid by US consumers are **not rewarded** by more than expected domestic innovation. US consumers pay disproportionately higher prices for brand name drugs,6 but the United States is **not disproportionately innovative**.

• Turn: M4A Centralizes data---that's key to innovation

Andrew **Torrance 3-24**, Staff Writer, 3-24-2017, "Life, Liberty, and Minor Complaints: Single-payer health care," Knight Errant, http://bsmknighterrant.org/2017/03/24/life-liberty-and-minor-complaints-single-payer-health-care/

Furthermore, a single-payer health care system would create a **cooperative, comprehensive medical database** for **all patient and medical records**. In the current system, **H**ealth **M**aintenance **O**rganization**s** and **insurance companies privately** possess their **own patient records**, and these are accessible **solely to people within the company**; this **hinders medical research** on what causes certain diseases. If doctors and researchers could examine the entirety of a population affected by a certain medical condition and the procedures that aid in the treatment of said condition, **remarkable steps could be taken towards curing a multitude of diseases**

2AC - A/T: Stock Crash

• Econ crash imminent and crises are cyclical – non unique

Egan and Weiner-Bronner 18 (2/18, "Sunny days for the economy can't last forever", http://money.cnn.com/2018/02/18/investing/stocks-week-ahead-economy-recession/index.html)

Sunny days for the economy can't last forever 1. **It's getting late**: **The recovery** from the Great Recession **is already one of the longest** economic expansions in American history. And **recently the economic cycle has gone from humming along to booming**. Unemployment is down to a 17-year low, small business sentiment is roaring, and economic growth hit the 3% mark twice last year. **But economic expansions don't last forever**. **A recession comes along eventually and ruins the party**. Wall Street is already pondering the demise of this recovery, which in May would become the second-longest in history. **Most economists and investors believe the U.S. economy is** either in or **approaching "late cycle," meaning the final chapter of the business cycle**. **At that stage, employers struggle to find workers, pushing wages and inflation higher**. The good news is that 91% of investors polled by Bank of America Merrill Lynch this month believe a recession is "unlikely" at this point. But the same poll showed 70% of investors think the global economy is in "late cycle." That's the highest since January 2008 and up from around 20% in 2015. Late cycle doesn't mean game over. Just like in baseball, the later innings of the economic cycle can still be successful, for Main Street and Wall Street. Stocks tend to boom and wages rise more meaningfully. This thinking helps explain why investors have recently become fixated on wage and inflation readings. The fear is that inflation will get too hot, forcing the Federal Reserve to step in with dramatic interest rate hikes that rock the economy and financial markets. Sixty-three percent of investors polled by Bank of America believe the biggest risks right now are an inflation-induced bond crash or a policy mistake by central banks. S&P Global Ratings said in a recent report that the current expansion has a "good chance" to stay alive until the summer of 2019 and become the longest ever. "Barring a shock, this expansion has staying power," the firm wrote. Some think the economy may struggle to keep going after that, though. **Guggenheim Partners predicted** last month that **the next recession "will occur by the end of 2019 or 2020."** "**Seeing an overheating labor market and rising inflation, the Fed will raise rates into restrictive territory, leading to an eventual recession**," Guggenheim wrote. **It's also possible that the spending spree by the Trump administration** on $1.5 trillion in tax cuts and a potential $200 billion infrastructure program **will overheat the economy more quickly.** That's what Goldman Sachs (GS) CEO Lloyd Blankfein told CNN he's concerned about. "What could possibly go wrong?" Blankfein joked. "I haven't felt this good since 2006." 2. Inside Janet Yellen's final meeting: On Wednesday, the Federal Reserve will release minutes from its January meeting. It was the last before former Fed Chair Janet Yellen turned the seat over to Jerome Powell. As expected, the Fed left interest rates unchanged. The market has penciled in three rate hikes for this year. But **the Fed may feel a need to move faster**. **Wage growth is expanding more quickly than it has in years, and inflation rose faster than expected in January**. The central bank said immediately after the meeting that it would "carefully monitor" inflation. **The wage hikes** — and the prospect of faster interest rate hikes — **sent investors into frenzy of selling earlier this month**, **including the worst point decline ever for the Dow**. The Fed minutes will offer insight into whether policy makers were already discussing data concerning inflation and future hikes, and offer some insight into why they signaled that a rate increase is coming in March.

• Insurance stocks wouldn't crash

Berman 17 (Michael Berman, Consulting Actuary, B.A in Actuarial Science at Georgia State University, August 12, 2017. "If single payer health care passed in the US, would health care stocks crash?" https://www.quora.com/If-single-payer-health-care-passed-in-the-US-would-health-care-stocks-crash)

Not necessarily. Even in a single payer environment there could be a **role for the private sector**. Medicare Advantage is a good example of a possible role for private insurers. CMS is the single payer for Medicare yet millions of people receive fully insured Medicare Advantage plans from commercial insurers. Thus if the entire country went to a single payer system there could be a similar role for private insurers. Some of these companies have **other lines of business** that **would not be displaced** by single payer medical. For example, Cigna has a group insurance division that sells group life and disability. I don't think this country is anywhere close to single payer and if it did happen, its **easy to imagine** some important roles for commercial **insurance** companies.

• Stocks market declines can't cause recessions

Weissmann, 16 — Jordan Weissmann, Senior Business and Economics Correspondent, "Could Our Cruddy Stock Market Cause a Recession?" Slate, http://www.slate.com/blogs/moneybox/2016/02/11/could_the_stock_market_cause_a_recession.html

What this leaves unanswered is **how the stock market could crash the economy.** Previously, **Farmer has blamed "animal spirits"—which is just the term of art economists have adopted to describe what the rest of us call human emotion. The stock market plunges**, ~~businessmen~~ **[business people] get pessimistic**, and they stop hiring or start laying off workers. During a recent appearance on Bloomberg's What'd You Miss, however, he suggested "wealth effects" might be at play. That's another fairly common-sense—but up-until-recently controversial—notion that when people feel richer they spend more, even if their wealth might only exist on paper. Likewise, when they feel poorer, they spend less. Here's how Farmer put it: If you're, say, a 65-year-old couple, and your 401(k) drops by 10 percent and goes up again the next day, you're not going to do very much. **If your 401(k) drops by 10 percent** and stays down for three or four months, **you might decide not to take that cruise** you were going to take, you might decide you're not going to put as much money into your grandchild's college fund. And **you're going to cut back on spending.** And that I think is the channel. **So, confidence, in my view, drives the real economy. Here's where this story sort of falls apart for me. The most recent research suggests Americans' spending habits just aren't that sensitive to stock prices. When Nobel Prize winner** Robert **Shiller and** his **collaborators** Karl Case and John Quigley last **looked into the subject, they found "at best weak evidence of a link between stock market wealth and consumption."** Insofar as the link was real at all, it wasn't very large. **This makes sense when you consider that stock ownership is concentrated among relatively well-off households who can** often **keep spending** like normal **when the economy turns** rocky. **Middle-class Americans care a lot about home values, since that's where their money is tied up, not the S&P 500.**

• No stock or bond impact – the government acquires the industry

Messman, 17 – BSEE, MBA, Health Care for All Colorado Foundation, The Center for the Study of a Public National Health Insurance (PNHI) (Robert, Funding the Consolidation to a National Health Insurance Enterprise, April 16th, http://www.hcacfoundation.org/funding_the_consolidation_to_a_national_health_insurance_enterprise)

A recent white paper by the HCAC Foundation proposes a surprisingly practical financing strategy for converting U.S. health care to a single insurer system. The plan, detailing eye-popping savings for Americans, would maintain the integrity of stock and bond markets by using an acquisition process under which the Federal government would buy out the health care insurance business of private insurance providers at an adjusted enterprise value in order to consolidate the industry under the proven low cost model of Medicare. This, of course, fairly compensates those invested in the stocks and bonds of the private health care insurers while allowing Medicare to roll up the industry at a reasonable price. The goal is to provide national health insurance at an affordable price by eliminating the bloated costs of private insurers and installing an insurer better aligned with both the best

interests of the public's health as well as fair pricing for services and medicines. The paper's calculations show that for an approximate price of $714 billion, the consolidation of the pre-retirement insurance market would generate a potential annual savings of $405 billion per year for the economy. But since the **savings would be spread throughout the economy, with significantly lower medical costs, insurance premiums and regulations** for citizens, businesses and local governments, we need to determine how Medicare would responsibly fund the substantial acquisition price (without frightening deficit hawks) so that it could, over time, pay off its investment from its share of the savings. If this can be done, then the spectacular two year payback to our society should make this a high priority project among all of the Federal government's funding priorities, especially from a capital budgeting standpoint. In other words if this can be financed soundly, this would be the kind of project that a government, which struggles to balance its budget and stimulate the economy, should undertake immediately.

Fortunately for this project, we happen to be living in a time of extraordinarily low interest rates. With rates hovering today below 2.5%, the government could, for example, complete the acquisitions with $714 billion in 10-year Treasury bonds and expect the annual amortization payments to be around $81.6 billion per year. The question, addressed below, is whether the direct benefits to the government would cover this debt service for the duration?

Among the direct financial benefits to the Federal government of the consolidation would the additional tax revenues resulting from the drop in tax-deductible health care expenses of businesses and individuals. Obviously, if businesses and citizens spend less on health care including insurance, their medical deductions go down and net taxable incomes—and tax collections-- go up.

Noting that the Federal Government subsidizes private health insurance coverage with tax exclusions, deductions, and credits, the Congressional Budget Office estimates the cost for these subsidies at $300 billion in fiscal year 2016. A single insurer system would cut health insurance premiums, deductibles and co-pays significantly due to a combination of the low (3-5%) overhead of Medicare and its ability to negotiate lower rates with providers. If the single insurer is also empowered to negotiate drug prices down to the level now paid by the VA—35-55% lower than current prices, Americans' drug costs and related tax deductions would drop further. It is therefore reasonably safe to estimate that the Federal Government could save AT LEAST a third of the current tax subsidies or around $100 billion per year—more than enough to cover the annual estimated amortization costs of $81.6 billion. Also note that once the financing bonds are paid off in fact or theory, Medicare would become more solvent by the same annual $100 billion. There is no denying that the Federal government will be acquiring a significant amount of health care costs from a consolidation. However, if it institutes an actuarially-based premium policy for the pre-retirement population (with appropriate subsidies for lower income enrollees) and negotiates the sensible but fair provider rates it has done for its senior customers, the system should not burden the Federal budget. However, there are huge opportunities to improve the Federal budget while still achieving some of Congress's big objectives if we properly address the economics of health insurance consolidation on key parties. Specifically, since a single insurer would relieve states of Medicaid costs (Colorado FY 2-16-17 budget allots $3.6 billion for Medicaid after Federal reimbursements) and greatly reduce costs for state and local government employee healthcare, why not then let the states fund much of their own infrastructure needs with a portion of these health care savings by reducing Federal assistance for these projects. It makes a lot more sense to let states manage local infrastructure projects than to have 50 state bureaucracies managing aspects of health care with difficult national portability and reduced negotiating power with providers. So Republicans would get a chance to shrink the Federal Transportation bureaucracy and budget in exchange for picking up a very efficient, consolidated-for-economies-of-scale national health insurance system.

• Stocks aren't key to the economy

Showley 15 (Roger Showley covers growth and development for the San Diego Union Tribune – interviewing leaders in business. "Does stock market decline signal a recession?". August 28, 2015.

http://www.sandiegouniontribune.com/business/economy/sdut-stock-market-decline-recession-2015aug28-story.html)

Gina Champion-Cain, American National Investments Answer: NO The **stock market** and U.S. **economy** have **never been as negatively correlated as they are today**. The same can be said for **individual stock prices** compared to **recognized metrics**. The revolving nightly market media recap explanations have become so nonsensical that they are of no value. Our economy is plodding along a positive trajectory. **The stock market is not the economy**. No recession in sight. Alan Gin, University of San Diego Answer: NO But it does suggest turbulent times ahead. The drop in the U.S. stock market was in response to big drops in the Chinese stock market. The concern is that a slowing Chinese economy would hurt economies around the world as China imports fewer products. The recent devaluation of the renminbi also makes U.S. products more expensive and less competitive. This will hurt export industries and slow growth, but I think the U.S. economy is resilient enough to avoid a recession. James Hamilton, University of California San Diego Answer: NO At least not in the U.S. I believe that U.S. fundamentals continue to have a lot of positive momentum. However, I have big concerns about China. Nobody knows for sure what is going to happen there, but a recession in China this year cannot be ruled out. If that happened, it would certainly put a big drag on the world economy, but it is not enough in my mind to bring the U.S. into recession. Jamie Moraga, intelliSolutions Answer: YES It definitely signals a market correction. Whether that leads to a recession remains to be seen. In the meantime, we are on Mr. Toad's Wild Ride. Between China's economic slowdown and currency devaluation, to fears of interest rates rising, and declining oil prices - the market is spooked. On Monday we saw the Dow Jones dive 1,089 points yet rebound down 588.47 points by closing. In our global economy we will have the squeamish and those that take this wild ride for opportunity. It has been several years since we had a sizeable market correction – we were due for a pullback. Gary London, The London Group Realty Advisors Answer: **NO** The stock market predicted 14 of the last eight recessions, so it is a **dubious track record!** It is **far more important** to look at **GDP**, **employment** **growth**, and other **key metrics** that show the **real progress** of the economy. None are showing any signs of recession. I know we all look at the Dow because, after all, there is a lot of retirement money stuffed into those stocks. There is a relationship between stock values and a company's performance, but it is mainly rooted in the mind of the beholder. Gail Naughton, Histogen Answer: **NO** Few economists envision a recession in the U.S. and rather believe that developments such as lower oil prices and rising home values will actually help U.S. businesses and consumers. The U.S. economy could be restrained in the coming months since the higher value of the dollar will hurt exportation, but factors such as low unemployment rates and steady, albeit unremarkable economic growth over the past six years, do not support a near-term recession. Norm Miller, University of San Diego Answer: NO The U.S. economy is doing fine. Housing starts are nearly normal although multifamily may be too aggressive in some metros. Employment growth stats and general productivity looks solid. Only the government has been downsizing, affecting the unemployment increases observed recently. Inflation is really modest and with oil prices down, consumer spending will thrive. **Stock market** declines do affect housing demand and discretionary spending among the **wealthiest households** but have **little impact on most households**.

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

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

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

particular seem to suggest that a rising stock market goes hand in hand with increased wages: Former president Barack Obama was a bit more discerning when he compared the stock market to wages. However, he still used the stock market as a yardstick to measure the strength of the economy. A few years after the financial crisis, when the stock market began to pick up, Obama said in his 2011 State of the Union Address: “Two years after the worst recession most of us have ever known, the stock market has come roaring back. Corporate profits are up. The economy is growing again.” Our political leaders seem to suggest a soaring stock market means great things for our country. But, **what does the stock market do** for average Americans? More specifically, what does it do for their wages? The figure above compares the average real wages of nonsupervisory workers and the real level of the S&P 500 from the early twentieth century to today. Both series are adjusted for inflation using the CPI (pre-1978) and CPI-U-RS (post-1978). To begin, let’s look at real wages measured in 2016 dollars. From 1920 to the early 1970s, real wages rise quickly and consistently. But in the mid-1970s **real wages begin to decline**. Then in the mid-1990s wages begin to slowly rise. The S&P, on the other hand, behaves quite differently. From the 1920s to the early 1970s it also moves upward, but slowly. Then the S&P rapidly shoots up just as wages begin to decline. Let us study the figure in more detail. Before 1980, real wages grow at an average rate of two and one half cents ($0.025) per month. Then, after 1980 wages grow by only an average rate of 0.7 cents ($0.007) per month — a 71 percent drop in the average rate of growth. The S&P 500 follows a different pattern. Before 1980, the S&P grew at an average pace of 0.53 points per month. But, after 1980 the S&P begins to soar. The index increases by 4 points per month — a 660 percent rise in its growth rate. Looking at this more abstractly, how does the real wage respond when the S&P increases by one point? Before 1980, when the S&P rises by one point, on average the real wage increases by three cents ($0.027). After 1980, when the S&P rises by one point, the real wage increases by only **one tenth of one cent** ($0.001). This leads us to ask: are these two variables even correlated? When the S&P increases, does the real wage also increase? Correspondingly, when the S&P decreases, does the real wage decrease? From 1950 to 1975, they were largely positively correlated. But after 1975, the correlation **tended to be more negative than positive**. Meaning, when the S&P increases the **real wage tends to decrease**, and when the S&P decreases the real wage tends to increase. After 1975, on average, while one was moving up the other was moving down. Political leaders seem to believe that what’s good for the stock market is good for the larger economy. But the data show that since the 1980s, **when the stock market rises, wages barely move**. Today, hourly wage earners — who constitute nearly 60 percent of the workforce — are only making slightly more on average than they did forty years ago. In fact, if the federal minimum wage kept pace with the average hourly wage and average productivity since the late 1960s, it would be over $18 per hour today. Yet, political and business leaders still proceed as if the stock market is key to measuring the success of the economy. Perhaps the stock market tells us about the prospects of capital owners. But it certainly **doesn’t tell us much** about the average worker.

• Shocks to stocks in one industry don’t spill over

Oyedele, 10/12 – Senior Markets Reporter at Business Insider (Akin Oyedele, 10/12/17, “More and more stocks are doing the market's heavy lifting,” http://www.businessinsider.com/stock-market-earnings-growth-less-concentrated-2017-10)

But the biggest companies' contribution to earnings and sales growth — the most important drivers of the bull market — has been falling since 2010, Morgan Stanley found. Instead, earnings growth is becoming spread out among more stocks. The implication of lower concentrations for earnings and earnings growth is positive for investors: **one big** company's **miss is less likely to send a shockwave through the rest of the market. "Fewer stocks are doing the heavy lifting as more stocks have meaningful contributions** to these metrics," wrote Brian Hayes, the head of equity quantitative research, in a note Thursday. "This is positive from a risk perspective; the market is becoming less dependent on a small group of stocks to drive earnings and revenue growth numbers." Large tech and bank stocks have made the largest percent contribution to positive earnings over the last five years. Hayes forecasts that Micron Technology, Apple, and Chevron would add the most this year. Hayes expects Apple to be the biggest contributor to S&P 500 earnings growth in 2018, adding 7.6%. But that would be down from 9.1% in 2015.

2AC - A/T: Wait Times

• No wait-lists – doctors will adjust to increased demand

Himmelstein and Woolhandler 5-10-17 - *professors of health policy and management at the City University of New York School of Public Health and lecturers in medicine at Harvard Medical School, Co-founders, Physicians for a National Health Program David; Steffie. The Urban Institute's Attack On Single Payer: Ridiculous Assumptions Yield Ridiculous Estimates, The Huffington Post, http://www.huffingtonpost.com/david-himmelstein/the-urban-institutes-attack-on-single-payer-ridiculous-assumptions-yield-ridiculous-estimates_b_9876640.html

Utilization of care: Holahan projects a massive increase in acute care utilization, but does not provide detailed breakdowns of how big an increase they foresee for specific services like doctor visits or hospital care. However, it is clear that the medical care system does not have the capacity to provide the huge surge in care that he posits.¶ For instance Holahan's figures for the increase in acute care suggest that Sanders' plan would result in more than 100 million additional doctor visits and several million more hospitalizations each year. But there just aren't enough doctors and hospital beds to deliver that much care. Doctors are already working 53 hours per week, and experience from past reforms tells us that they won't increase their hours, nor will they see many more patients per hour.¶ Instead of a huge surge in utilization, more realistic projections would assume that doctors and hospitals would reduce the amount of unnecessary care they're now delivering in order to deliver needed care to those who are currently not getting what they need. **That's what happened in Canada**. Doctors and hospitals can adjust care to meet increasing demand, as happens every year during flu season.¶ Moreover, no surge materialized when Medicare was implemented and millions of previously uninsured seniors got coverage. Between 1964 (before Medicare) and 1966 (the year when Medicare was fully functioning) there was absolutely no increase in the total number of doctor visit in the U.S.; Americans averaged 4.3 visits per person in 1964 and 4.3 visits per person in 1966. Instead, the number of visits by poor seniors went up, while the number of visits by healthy and wealthy patients went down slightly. The same thing happened in hospitals. **There were no waiting lists**, just a reduction in the utilization of unneeded elective care by wealthier patients, and the delivery of more care to sick people who needed it.¶ Bizarrely, despite projecting a roughly $1.6 trillion increase in total payments to doctors over 10 years, Holahan says in his discussion that "Physician incomes would be squeezed by the new payment rates."

• No wait times – studies prove

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iii. Wait Times **Much has been made of the problem of wait times in the Canadian** healthcare **system**—corroborated by 2014 Commonwealth Fund survey data, finding that wait times for specialists, elective surgery, and emergency room treatment are worse in Canada than in any of the other eleven developed nations under study. The surveys found the United States to be comparatively average.50 Similarly, a 2010 study ranked Canada last among eleven countries in terms of wait times, finding that 33% of Canadian patients reported waiting six or more days for an appointment with a doctor or nurse, 41% reported waiting two months or more to see a specialist, and 25% reported waiting four months or more for elective

surgery.51 It is not clear, however, that long wait times are endemic to single-payer financing. Certainly, jurisdictions with single-payer finance such as England have largely eliminated wait times. Within Canada, there has been some success in tackling wait times in priority areas of care: For example, a recent study found that all provinces were able to provide radiation therapy to at least nine out of ten patients within a benchmark timeframe of twenty-eight days.52 The province of Quebec, facing pressure from the courts, established maximum wait times for certain services, whereupon the province will pay for patients to obtain care in private clinics or abroad if necessary.53 Wait times in the United States are comparable to those in Canada for patients looking to get same- or next-day appointments, as well as those requiring specialized tests (e.g., CT, MRI).54 The cost of medical treatment also hinders timeliness of care in the United States, where more people chose not to seek recommended medical care or not to fill prescriptions than in any other country.55 In short, while Canada could do a better job managing wait lists—most provinces having no system for prioritizing patients outside of emergency and urgent-care settings—the American approach reduces wait times in part through gaps in coverage.56