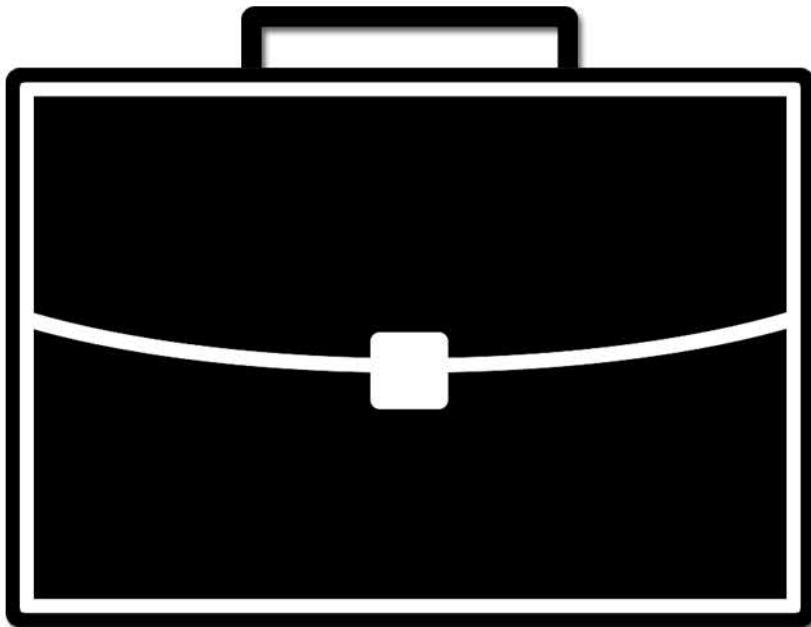


# **Champion Briefs**

## **Sept/Oct 2020**

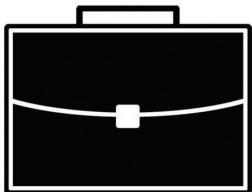
### **Public Forum Brief**



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

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Resources for Speech & Debate



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These seven statements, while simple, represent the complex notion of what it means to advance students' understanding of the world around them, as is the purpose of educators.

**Letter from the Editor**

Welcome back for another exciting year of Public Forum debate! This year will obviously be unlike anything we've ever experienced, with COVID-19 significantly impacting debaters' ability to attend tournaments, though I hope that despite everything you are excited and ready for what should still be a great year of debating (albeit, virtual). The first resolution we will be addressing in the 2020-2021 season is "Resolved: The United States federal government should enact the Medicare-For-All Act of 2019." In an election year that has been dominated by a global pandemic, a discussion on healthcare is both timely and exciting – personally I'm thrilled to see this topic chosen as I believe it's one of the most relevant questions in American politics, and I believe it has ample ground for debaters on both sides of the resolution.

Medicare-For-All has been a common topic of political discussion for the past few years, in large part due to efforts by politicians like Bernie Sanders who have championed the proposal. The American healthcare system, for years now, has fallen behind other wealthy nations with regards to cost and quality of care. Yet, Americans still spend an extremely large amount of money on healthcare due to various inefficiencies, regulations, and cost disparities. Americans are justified in questioning the current state of affairs, as the American healthcare system should largely be considered a disappointment given America's wealth and status.

One of my favorite elements of this resolution is the breadth of the topic. Debates about healthcare spillover into discussions of economics, justice, and even foreign policy. As a result, you and your team should be able to find a number of different strategies and impacts to research and develop when writing your cases and blocks. Furthermore, I appreciate that the debate is limited to a specific policy, because it means that con teams have room to advocate for alternatives. This gives con teams a lot more room to work with given that they can win by proving Medicare-for-All precludes a better policy that would be cheaper or provide better care.

I'm excited to jump right back into the debate season – best of luck, and happy researching!

Michael Norton  
Editor-in-Chief

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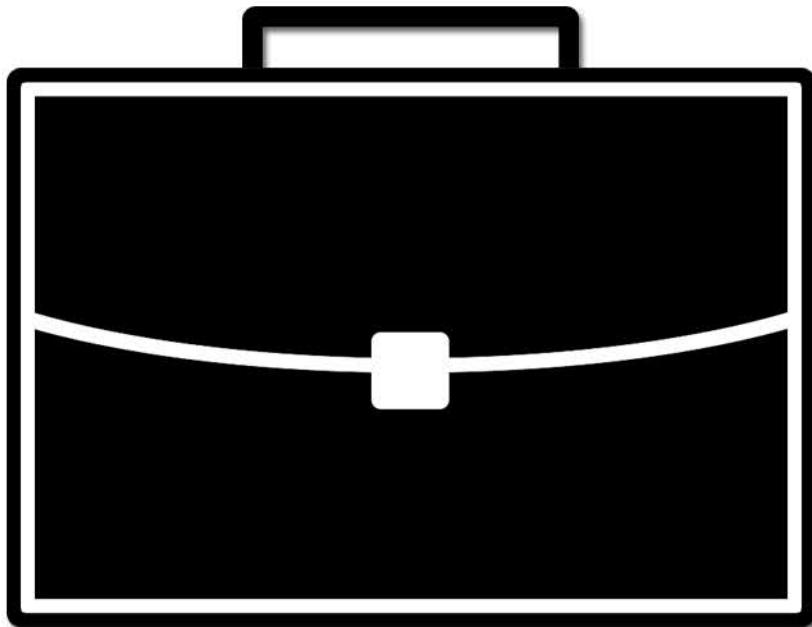
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# Champion Briefs

## Sept/Oct 2020

### Public Forum Brief



## Topic Analyses

**Topic Analysis by Sara Catherine Cook**

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

**Introduction**

Welcome to a new debate season! I'm very excited to break down this topic with you!

Before we get started, I want to lay out what I intend to do in this Topic Analysis. I am first going to talk about the problems with the healthcare system right now to attempt to explain why this topic was chosen and why it is relevant to our current world. I will then be discussing what Medicare-For-All does and some of the facets of the bill itself. As I then get into some potential Aff and Neg arguments, please recognize that the list will not be exhaustive. As this topic lasts longer than others and overlaps with many summer debate institutes, it will be impossible for me to cover every single argument. Rather, I will be looking into the main areas and considerations of the topic that most of these arguments stem from to give you a foundational understanding. With that being said, let's dive in.

**What are the issues with healthcare right now?**

Let's begin by understanding health insurance. There are four main populations in the United States with regards to health insurance: Medicare, Medicaid/CHIP, private insurance, and people who lack health insurance. Medicare covers the elderly, while Medicaid and CHIP cover mainly low-income people as well as people otherwise eligible for welfare benefits. Private insurance coverage mainly comes often through employment benefits but is paid for

out-of-pocket rather than by the government. There is a large amount of the population that is uninsured or underinsured, meaning that they lack access to health insurance or their health insurance is not sufficient to meet their needs. You might be asking: why does insurance matter? Healthcare is incredibly expensive about eight to eleven million people go into poverty every single year due to medical debt. Insurance is meant to stop that from happening because it establishes another party that will pay for part of all of the cost of your care. Let me explain further. If I have insurance, I pay a monthly rate to my insurance company so that if anything happens to me, my insurance company will pay for it. The insurance company makes money by calculating risk. Since I will (hopefully) not need medical care the majority of the time, the insurance company makes money even if they have to pay for my surgery or cover part of my medication. If I do not have insurance, I have to foot the entire bill for my care. My options for care are also limited if I don't have insurance. If I cannot afford care, my only option is to go to the Emergency Room. Not only does this make our healthcare system inefficient by increasing wait times in the ER, but also means that I am unlikely to go to the doctor for something less serious, which ends up making me sicker in the long run. This also imposes a large burden on hospitals themselves. They regularly have to treat patients who are not able to pay and also in hard times are overburdened as more people find that the hospital is their only option for care.

This problem with insurance is also only getting worse for a couple of reasons. First of all, healthcare costs are rising due to things like rising drug prices and new technology. This means that to retain the same level of profit, insurance companies have to raise the rates of private insurance. At the same time, millions of people have become unemployed because of the pandemic, losing their insurance benefits. Even more so, there are a couple of problems

with the Medicaid and Medicare systems as well. The Medicaid system is part of the government's welfare system, which means that in times of recession it expands rapidly to accommodate more and more people falling below the poverty line. Because Medicaid has a specific cutoff, sometimes by taking a new job or promotion, families will lose all of their benefits. This is no indicator of "laziness", but rather shows that the system often forces families to choose between keeping their healthcare coverage or losing all benefits to raise their level of income (which often is not enough income to pay for insurance or cover medical costs). The Medicare system faces issues related to how many people it has to cover. Because we have an aging population, more and more people are taking out benefits from Medicare per person paying into the system. For this reason, some estimate that Medicare and Social Security will eat up almost all of the money in our current national budget in the next ten to twenty years.

Let's talk about the issues in our healthcare system on a much smaller scale: doctors, hospitals, and medicine. First, many doctors' offices will limit or refuse Medicare or Medicaid patients. This is because Medicaid and Medicare pay less than private insurance does. This means that the system benefits those who can afford private insurance over those who cannot. This not only is bad on a human level, as people who are on Medicare and Medicaid are more likely to have health challenges, but also bad because when people are unable to prevent more serious illnesses, that increases the burdens on the health system as a whole. Let's take the pandemic as an example. With a proper response, we would have been able to flatten the curve, preserving enough hospital beds to treat anyone in need. As it is clear that did not happen, our healthcare system is now unable to handle the rising amounts of people getting

sick. Preventative care works similarly. If our health system can do a better job of preventing disease before it happens, we lower the burden on our health system as a whole. The second issue we face with regards to doctors compounds the first: a shortage. There are projections that we will be facing a shortage of doctors in the next ten to twenty years. While there are multiple reasons why this could be happening, including the amount of time doctors spend doing administrative work and the rising cost of education, a shortage of doctors is not only bad for patients but also increases the amount of work that each doctor must do, likely multiplying the shortage in the future.

Similar issues face hospitals, especially rural ones. Hospitals get funding on a fee-per-service basis, meaning that if they lack patients or lack patients who can pay, they will lose revenue and be forced to lay off workers, cut certain services, or ultimately close. This is part of the problems that rural hospitals face right now. Additionally, Medicare and Medicaid rates in the status quo pay below cost for most procedures, meaning that the only source of profit comes from patients with private insurance. Since rural areas tend to have overall poorer and smaller populations, hospitals in rural areas have been closing at disproportionate rates. Even more so, hospital costs continue to increase which brings us into the problems with the pharmaceutical industry.

Drug prices have been rising pretty rapidly for the past few years, increasing costs for both consumers and hospitals. Let's talk about why. When a pharmaceutical company makes a new drug, they often do so by either funding or acquiring a small biotech company. The costs of innovation are expensive and risky because not only do investors and companies have to cover the cost of producing that drug, but also have to pay for the other ten attempts at making the

drug that failed. Once the drug is made, a company will apply for a patent to sell it exclusively on the market, meaning no other companies can make a generic of the drug. This is the time where a company can set whatever price they see fit, and they will often make small incremental changes to the drug to extend the patent for more than 20 years. This is often called "me too" innovation because companies will patent a drug after changing something as simple as the pill-coating. After the patent expires, generics enter the market and price their drugs lower than the name-brand, forcing the original company to lower the price of their drug. Because of this system, it's often more advantageous for companies to invest more in marketing rather than research and development. Because "me-too" innovation has such low risk and such high profits, companies have an incentive to continue doing that over making groundbreaking discoveries that are riskier and more expensive. For this reason, there are disagreements on whether or not the U.S. does the best pharmaceutical innovation. While we spend the most and overall make more new drugs, there are questions as to whether the European industry is more productive. Ultimately, our drugs are also pretty unaffordable, as our drug prices are anywhere from thirty to eighty percent more expensive than drugs in other countries. This means that medical non-adherence is a huge problem in our country, where people may not fill their prescriptions or may do things like cut their pills in half.

It's also incredibly important to note that like other systems in this country, our healthcare system discriminates. Black and Hispanic folks are the most likely to be uninsured and also likely to have higher health risks due to issues like environmental racism as well as just poverty in general. Healthcare is specifically discriminatory towards black women, as their pain and concern are regularly written off by doctors. Healthcare also affects people along with sex

and gender lines as well, as people needing reproductive care or gender-affirming care often cannot afford it - both services that the government does not cover or allocate funding to in the status quo. Native and indigenous people also suffer from having unequal access to healthcare. There are many ways in which our healthcare system continues to benefit those who have always been advantaged in society, and continues systematic discrimination against many groups.

### **What does Medicare-For-All do?**

While bills like the Affordable Care Act worked with our current system to expand access, the Medicare-For-All Act completely replaces our current system. The bill is implemented over four years expanding Medicare out to all age groups and expanding Medicare to cover more services, specifically all services that are "medically necessary" which includes primary and preventative care, mental health care, reproductive care, vision, and dental care, and prescription drugs. The bill also eliminates cost-sharing, which means that there would be no more out-of-pocket costs for healthcare. With this, it eliminates private insurance for all care covered by the bill - meaning that everyone is enrolled in government insurance at birth and has no options to opt-out. The financing options are not outlined specifically in the bill. Bernie Sanders' White Paper outlines some of the financing, specifically highlighting how the bill would save money in comparison to our current system. Many still estimate that the bill will require a large increase in taxes or a large increase in the federal deficit, potentially both. While it would eliminate private insurance, one thing to note is that Medicare-For-All does not eliminate private care. There has been a rise in the past few years of

doctors leaving the insurance industry and instead of creating a "self-pay" market, offering their services for out-of-pocket pay rather than insurance. This option would exist under Medicare-For-All, but no doctor would be allowed to practice under both the Medicare-For-All and the self-pay market.

## Aff Argumentation

Before talking about specific arguments, it's important to understand that your success in running Aff arguments lies in your understanding of the problems in the healthcare system right now and why they happen. While the Neg on most topics can use the status quo to their advantage, there is a much more limited ability to do so on this topic. Put simply, since our healthcare system is failing in many ways, the Aff will always have an advantage because they have at least the risk of solving those issues, while the Neg has to defend a bleak status quo. At the same time, unlike most topics, there are offensive arguments on both the Aff and the Neg of each issue. What this means is that both the Aff and the Neg have reasons why the Medicare-for-all system would make an issue better or worse, as opposed to just a reason why the one side does not access their impact or why their argument does not happen. The way you will win these debates on the Aff is through your understanding of why issues happen right now and why you solve them.

With that being said, I like to classify Aff arguments into five different topic areas: general access, doctors, hospitals, drugs, and the economy. The first is the most simple. Many people do not have access to care right now and Medicare-For-All would give them that access. This argument can be run generally, discussing the cost barriers to care in the status quo, or can

be run related to specific groups who are uniquely impacted by a lack of access in the status quo. As I mentioned before, healthcare discriminates along racial and gender lines, as well as leaving out homeless folks, undocumented immigrants, and people who need mental health care, reproductive care, or gender-affirming care. Medicare-For-All would likely cover all of these services, functioning as an equalizer and giving access to insurance and care for those who do not currently have it. One thing to note is that depending on whether you view access to abortion and other more controversial medical care as a good thing will determine the side you read the argument on. I think that this would be an Aff argument as even if you don't personally agree with things like abortion, there are multiple ways in which providing this care links into an individual's human rights. More broadly, it is probably more strategic debate-wise to consider access to abortion as a good thing as the impacting is much clearer and more convincing. The good thing about these arguments is that the link is inherent to the bill - no one can argue that Medicare-For-All does not provide basic insurance and healthcare for those who do not have it. Providing access also solves poverty, as around eight million people fall into poverty every year specifically because of medical debt. Because the government takes on those costs, families no longer have to take on medical debt. Similarly, the bill eliminates the cutoff under the Medicaid system. This means that people can make career and personal decisions without risking losing access to healthcare when taking or switching jobs.

The second main area of the Aff regards how the bill would impact doctors. There is a doctor shortage projected to happen in the status quo likely because doctors have to spend long hours coordinating with multiple insurance companies to do billing, overburdening doctors, and increasing their costs. Medicare-For-All would centralize the healthcare system,

meaning that doctors would have more time to spend with patients and less administrative costs. Additionally, by increasing access to preventative care, Medicare-For-All could specifically help primary care physicians because they would be able to treat more patients. As mentioned earlier, part of the problem right now is that patients either forgo care until their problems become serious or have to go to the emergency room for non-serious conditions. Shifting care over to primary care doctors not only helps patients but also helps the sector that will experience the greatest doctor shortage.

Next, let's talk about hospitals. The Aff argument is that rural hospitals are closing in the status quo specifically because they lack patients in general and lack of patients who can pay for their care. As Medicare-For-All compensates all care, hospitals will make more money and more people will go to the hospital because the cost-barrier is eliminated. Expanding access has helped rural hospitals in the past, as Medicaid expansion decreased the likelihood of hospital closure in states that accepted it. Secondly, the administrative costs argument also applies here. Hospitals spend an extreme amount of money coordinating billing with private insurance companies, and thus affirming the resolution would centralize the system and decrease the cost of care. Lastly, there is an Aff argument that Medicare-For-All would switch from a fee-per-service process to a format called global budgeting that would allocate lump-sums of money to hospitals based on need. This would solve both of the issues in the status quo and would likely even expand rural hospital capabilities rather than just keeping them afloat.

The section of the topic discussing pharmaceuticals is incredibly similar to the price controls topic from two years ago. One thing to note is that drug prices and accessibility are not connected to this topic because no one has to pay out of pocket for drugs. Under Medicare-For-

All, prescription drugs become free for consumers so there is no point in conceding that drug prices decrease unless making arguments about emerging markets and innovation that I will outline now. This is because Medicare-For-All includes a clause that allows the government to negotiate drug prices with companies. Since the government is the single-payer, they have leverage in this negotiation as drug companies who say no to the government-proposed price would likely lose their business. Even more so, any company that says no to negotiations allows the government to make a generic of their drug, even worse for business. Thus, the government has power over negotiations and what's most likely is that they will enforce some form of price controls on pharmaceuticals, especially because both sides are in favor. I am unsure how much of a component of the topic pharmaceutical companies will be as Trump recently passed four executive orders lowering drug prices, but it might be in the best interest of each side to look past that as both sides can garner offense from arguments related to government price negotiations. The Aff side of this argument deals with what the price controls set up and how companies react to them. One argument regards the incentives behind pharmaceutical innovation. Medicare-For-All potentially establishes a value-based pricing system, where companies would no longer be able to make high profits from "me-too" innovation and would thus redirect their efforts into more productive innovation. Another argument here is that pharmaceutical companies would have an incentive to expand into emerging markets to make up for their losses at home. Because manufacturing costs are so low for drugs and profit margins are so high right now, companies would likely be able to ramp up manufacturing and increase their sales both domestically and in lower-income countries. This has happened in the past when pharmaceutical companies have lost profits.

Finally, there are a slew of economic arguments to make on both sides, most of them dealing with the financing mechanism of the bill. Three main taxes have been proposed: income taxes, payroll taxes, and commercial taxes. For brevity's sake, I will briefly touch on the economic arguments on both sides. Most of the arguments on either side answer similar questions: Will Medicare-For-All cost the government more or less? Will Medicare-For-All cost businesses more or less? Will Medicare-For-All cost consumers more or less? This means that the arguments are virtually the same on either side of the debate and just depend on weighing the economic costs and savings of the bill to determine which side is better. Most of the arguments regarding savings to consumers and businesses end up flowing Aff because of the extreme costs of private insurance in the status quo, while most of the debt arguments end up flowing Neg as the government has to bear all of the costs of the healthcare system that are currently spread out between the private and public sector in the status quo. One popular argument thus far outlines that increasing the national debt would cause debt defaults in lower-income countries by both shifting investors away from their debt and forcing them to increase interest rates to compete with safer bonds from the U.S.

## **Neg Argumentation**

While the key to winning Aff arguments is using uniqueness (the status quo) to your advantage, the key to every Neg argument is financing. The reason why single-payer healthcare systems create issues in Europe and Canada is not inherently because they are single-payer, but because they are poorly financed. Thus, the way to control the round on the Neg side is to link into poor or insufficient financing for Medicare-For-All.

I will be breaking down the Neg side of the topic in the same five topic areas. With regards to access, while the general link that everyone gets access to health insurance is true, there are a few ways the Neg can spin this argument with regards to advocating for specific groups who do not have a care in the status quo. First, the bill specifies it will cover anything "medically necessary" but gives the Secretary of Health the power to change that. That means that in a world with a more conservative Secretary of Health, things like gender-affirming care, reproductive care, etc. could be eliminated from coverage. This would likely be conservative lawmakers' first priority. Even more so, ambiguous terms always end up going to court, which means it could be up to the majority conservative Supreme Court to set precedent for Medicare-For-All. Even absent this, it is possible for Congress to set funding for abortion or gender-affirming care extremely low to limit it. The issue with these arguments from a debate-context is that if the Medicare-For-All system does not provide coverage, we would likely be right back to the status quo where there is a cost barrier. This means that the arguments do not generate much of an impact because if they happen as other opportunities for this care would still exist outside of a Medicare-For-All system, albeit with a high price tag. Secondly, everyone getting access could overwhelm the health system. If we don't increase the capacity of our health system, we cannot actually handle the rising demand. This leads to an argument about wait times increasing when the healthcare system becomes overburdened. It's worth noting that this is not a strategic argument to read in the case because it concedes that more people go to the doctor under a Medicare-For-All system, limiting the ability for the Neg to respond to Aff arguments about access.

The arguments about doctors and hospitals on the Neg is controlled by funding.

Medicare rates are much lower than private insurance rates in the status quo. The argument on the Neg is that this would mean that doctors make less under a Medicare-For-All system causing more doctors to leave the profession entirely or for the self-pay market or not enter the profession at all due to the high cost of education. The argument about hospitals is similar but carries one additional detail: that Medicare and Medicaid pay specifically below cost. This means that even if Medicare and Medicaid pay for people who currently cannot, hospitals still run a consistent deficit. While I think the Neg has better ground on this topic, there is almost no solvency that they access because rural hospitals are closing in the status quo. If the Neg cannot prove any status quo solvency to this, they at best access marginally faster or more closures for rural hospitals. This means that the argument functions well as a response to an Aff case about hospitals but probably is not the best case argument.

The prescription drugs aspect of the Neg is probably where most of the best arguments lie. The link into this is the same as many of the Aff arguments I discussed earlier: that Medicare-For-All lowers prescription drug prices. Here are a few ways that could be negative. First, is innovation. Decreasing drug prices would likely lead to a decrease in revenue for pharmaceutical companies. While it's debatable whether this would tank larger pharmaceutical companies, it would likely majorly affect the ability for small biotech companies to innovate because they are incredibly reliant on upfront investment to create new drugs. The Neg argument is thus that by decreasing revenue to pharmaceutical companies, they would be forced to cut back on innovation because of how expensive it is. Secondly, there are a couple of arguments related to emerging markets. About half of pharmaceutical companies will sell drugs

for low-prices in lower-income countries while the other half outright donate these drugs. The Neg argument here is that when companies face profit losses they will have to either increase prices or cut back on donations, hurting people in lower-income countries and decreasing access. While many people are running this argument due to its seemingly large impact, the argument itself is pretty nebulous. There is no quantification for how extreme these price increases or cuts in donations will be. It is also unclear what the incentives to donate or sell in the first place are and why they would change in an Aff world. With the same link of a decrease in revenue, the Neg can also make the argument that Medicare-For-All would lead to drug shortages as companies would not be able to handle the rising demand for drugs with less profit. The one argument relating to pharmaceutical companies that do not rely on financing is the argument about delays. The argument is that government negotiations delay market entry because there is often insufficient data available for the government to set the price. Not only do delays to medicine kill people, but delays also spill over to other markets as well.

Finally, let's briefly talk about some of the economic arguments on the Neg. In addition to my commentary on economic arguments as a whole mentioned on the Aff side, there are a couple that are unique to the Neg. First is an argument about the stock market. The healthcare industry comprises a large amount of the American economy meaning that there is not only the potential for job loss when Medicare-For-All eliminates all private insurance, but also that eliminating private healthcare could collapse the stock market or cause major damage, leading us into a greater recession. Secondly, the debt arguments have a much larger and more strategic implication on the Neg. Even if debt has no economic limit, which is heavily contested anyways, Congress often tries to limit our deficit spending over time in fear that citizens will not

reelect them with ballooning debt or higher taxes. Thus, if Medicare-For-All increases our debt drastically, it actually could lead to both the defunding of other programs and the defunding of the Medicare-For-All system itself, linking into the financing arguments I discussed earlier in the long run and exacerbating all of the issues we would have under even a fully financed system. While this argument is not inherently offensive, it allows the Neg to link into a more long term picture of Medicare-For-All, one that is particularly bleak.

## Conclusion

This topic, unlike many, is surprisingly well balanced with both sides having almost equally compelling arguments on every main issue. That means that being able to prove precedent or show the judge why your argument is more true is particularly important on this topic. It also makes it much easier for teams to get "caught in the weeds" in the round. What I mean by this is try not to forget the big picture of the topic and remember that the round is not about winning every argument, but rather winning one argument and showing why it is the most important. Finally, because of the rise of summer debate institutes, you can always expect there to be new evidence and new arguments that come out on the topic. Trying to know everything about every single argument is futile. Understanding the arguments you are reading and how they interact with other arguments in the round will help you avoid debates where you feel hopeless against a team with more evidence or knowledge than you. Remember: evidence is there to back up the arguments you are making, not the other way around. Have a great couple of months - this topic is a really fun one!

**About Sara Catherine Cook**

Sara Catherine Cook grew up in Birmingham, Alabama, and competed for The Altamont School for three years in Public Forum Debate. She was one of the first teams from her school to qualify for the Tournament of Champions and NSDA Nationals, being the only team from her state to qualify for the TOC in the 2018-2019 season. She now coaches Public Forum Debate in her free time and does Parliamentary Debate at Dartmouth College in Hanover, New Hampshire, where she plans to study Mathematics.

**Topic Analysis by Jakob Urda**

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

**Introduction**

“The proposal, which Sanders also introduced in 2017, establishes a government-run health care system that covers all Americans. The plan would allow patients to visit doctors with no out-of-pocket fees. The inclusive coverage would only require patients to pay for prescription drugs.” - Catharine Kim, VOX News.

Healthcare is the average American's most important policy area, and few issues are more contentious than Medicare For All. The 2019 Medicare for All bill would overhaul the entire United States Healthcare system, and shift it from a shared-burden between employees and employers to an almost entirely government-funded model. The 2019 Medicare for All bill would eliminate most out of pocket expenses and provide the vast majority of Americans with a generous benefits package. On the other hand, concerns have been raised about America's ability to pay for such a program, the effectiveness of state-administered healthcare, and the secondary effects on innovation. Almost every American, and therefore almost every judge in a debate round, is likely to harbor strong opinions about the benefits and viability of Medicare for All.

Debaters should remember that on politically charged topics, it is best not to presume that the judge agrees with one's assumptions or worldview. The arguments that win will be those who are able to appeal to a broad swath of judges, by being relatable and resonating with

common values. Debaters must be careful not to alienate judges of different political backgrounds than them and must be able to engage with their opponents on any argument. Similarly, on policy heavy topics it is tempting to get lost in statistics, but this topic has a wealth of statistical evidence from both sides. The best debaters will be able to clearly articulate the mechanics and logic of the healthcare market to judges and contextualize studies, instead of appealing to authority.

## **Strategic Considerations/Framing of the Debate**

One of the most important considerations for any policy resolution is "inherency." Inherency means debating the topic as it would happen if it were to be affirmed in the real world, that is to say, looking at the most likely implementation of the topic. The resolution is fairly broad. It only discusses the bill text which would be approved, but in practice, many other actors would have a say. There would be debates over funding (the plan itself does not specify how the government would collect new revenues), over the actual health details covered, and over the precise level of money paid out to pharma companies for their products by the government. The courts would also likely have a say, adjudicating the difference between all manner of disputes that would inevitably arise from such a contentious law being passed. Inherency is important because the debaters do not get to plan out and choose who these myriad issues are resolved, they must only look to how the real world would likely manifest them. Debaters must, therefore, make arguments about how these issues would resolve themselves.

Inherency is incredibly important because it sets the terms of the debate. The arguments that both sides make will be framed and contextualized by the many issues which are affected by inherency. For instance, the financial burden of Medicare for All shifts radically if the bill is funded via debt versus if it is funded by progressive taxes. Similarly, the outlook for pharmaceutical innovation looks much different if the government buys drugs from producers at-cost versus if they buy them at a steep markup.

To evaluate inherency considerations debaters should think about political will and similar test cases. Look at statements by politicians about the knock-on effects of passing the bill, or what supporting measures they would be most likely to pass along slide it. Other countries, or states with expanded Medicare programs, serve as useful examples of inherency by demonstrating models of the resolution that debaters can base their understanding on.

Two big inherency questions which most teams will have to answer are:

- How will the bill most likely be funded?
- What will the level of coverage be, and how much money will the government pay pharmaceutical companies compared to their current profit levels

These questions will have an outsized impact on the debate. If a debater can win the inherency clash over them, they will be able to set very favorable terms of engagement for the rest of the round. For instance, they might be able to deny their opponent any offense related to debt and financing. Inherency sets the stage for the rest of the debate. Good debaters will be able to articulate what the most likely manifestation of the resolution will be and capitalize on the places where their opponents misalign to that scenario.

## Affirmative Arguments

The affirmative has the benefit of having an easily weighable terminal impact, lives. The idea that Americans are dying because of a lack of access to quality healthcare is nothing new, and dissatisfaction with the status quo is the reason behind Medicare for All's recent rise in popularity. Even after President Obama's landmark Affordable Care Act was passed tens of millions of Americans still were forced to live without coverage, and millions more made due to substandard coverage. The affirmative should start their research from the most intuitive place – the idea that accessing healthcare saves lives. They should execute this research by drawing as many possible links into expanding coverage and saving lives as possible and concentrate on building out robust frontlines to those arguments. This strategy has the benefit that even if the negative wins most of their arguments, the affirmative will likely still win the round as long as they are able to do even cursory weighing. The truth of the matter is that the jump from not having healthcare to having healthcare will dramatically increase many Americans' quality of life and prove a more appealing impact than a marginal expansion of the federal debt or a marginal decrease in innovation.

The 2019 Medicare for all plan would cover a wide array of benefits. It would cover hospital visits, primary care, medical devices, lab services, maternity care, and prescription drugs as well as vision and dental benefits. This means there would be no charge when you go to the doctor, no copayments when you visit the emergency room. Even the current Medicare program is not this generous, with emergency room visits costing patients around 20 percent of the total bill. This would make healthcare dramatically more accessible to most Americans.

Pro teams need to anticipate common negative responses. Typical objections to Medicare for All include issues with cost and decreases in innovation funding. Pro teams should have these two arguments blocked out solidly before starting to debate. For costs, there are studies that argue that Medicare for All will result in net savings for the US GDP because the plan would allow the government to access economies of scale with healthcare providers, cut out middlemen, and give them more leverage. According to a study conducted by the OECD, the United States spends more money on healthcare administrative overhead than any other country in the world. As for innovation spending, pro teams can argue that the government will reward companies for innovating by providing cash "prizes" in the order of millions of dollars for breakthroughs. This would increase the incentive to innovate in the healthcare space.

## Negative Arguments

The Negative needs to find a way of outweighing the pro's arguments about increasing coverage and savings lives. Relying on blocks to mitigate the argument is a losing strategy because it puts the negative at the perpetual burden to both win all of their defense AND win case arguments, while the pro only needs to win case arguments. Thus, the negative's case impacts must be at least as large as the pro's case impacts.

The negative can make several arguments that can be weighed against the pro's arguments about expanding care. Two common negative arguments are innovation and cost. Innovation is the argument that price caps on medicine will reduce the pharma company's incentive to develop new drugs and find breakthroughs. This argument must be tied to lives saved in order to be successfully weighed against the points of expanding coverage. This can be done by citing

a study that estimates the lives saved from a breakthrough on a currently incurable disease. By doing this, the negative can show that the negative health impacts of expanding coverage might outweigh the direct positive effects.

Many negative teams will run the argument that "Medicare for all is too expensive." This argument by itself weighs poorly against the argument of expanding coverage because saving lives typically weighs more heavily than saving money. However, there are a few ways that the negative can still make the cost savings argument but link it into a more weighable impact. One way is rollback – if spending is so excessive that the government needs to eventually cut health services, it might reduce coverage in the long term. This has happened in several states where very generous pension programs eventually had to be cut severely because of cost overruns. There is reason to believe that this is a possibility. Republicans have already mobilized against the heightened spending of the Affordable Care Act and nearly repealed it after the 2016 election. Their cries to reign in the budget would only increase if a far more expensive plan were passed. Republicans have long proposed welfare reform packages such as turning Medicare into a voucher system, which might make it more affordable for the government but would also decrease coverage and access.

The negative must be familiar with affirmative arguments that Medicare for All will pay for itself. This will be a common response to negative concerns about costs. Proponents say that because it saves lives and makes people healthier, Medicare for All will pay for itself by increasing worker productivity and taxes. Negative teams must be able to respond to this claim, possibly by making the argument that the *average* quality of care will go down which will hurt

health outcomes among workers, even if access is increased. Or, that overcrowding will limit health gains. Either way, this functions as a block to the "Medicare pays for itself" argument.

This topic is rich for interesting, provocative rounds. The topic will reward those who diligently research and think creatively. Good luck and have fun!

### **About Jakob Urda**

Jakob grew up in Brooklyn, New York. He attends the University of Chicago, where he will receive a BA in Political Science, and is interested in security studies and political economy. Jakob debate for Stuyvesant High School where he won Blake, GMU, Ridge, Scarsdale, Columbia, the NCFL national championship, and amassed 11 bids. He coached the winners of the NCFL national tournament, Harvard, and Blake.

**Topic Analysis by Tucker Wilke**

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

**Introduction**

Welcome to the 2020-2021 debate season! If you're brand new to the wonderful world of debate, gear up for one of the most intense and rewarding extracurricular activities out there. If you're returning, good luck on what promises to be your best season yet. Debate is obviously going to look quite a bit different this year than it normally does, but online tournaments certainly have the potential to be every bit as enjoyable and rewarding as in-person tournaments. Online tournaments present the opportunity for debaters to participate in tournaments they would otherwise never be able to, allowing debaters to be exposed to different styles and meet many new people, both of which are key parts of the immense benefits of debate. As usual, students will spend the first two months of the year debating the "September" topic, which means that they must be ready to know all the ins and outs of the resolution. Luckily, debaters could not have asked for a more timely topic, as it is "Resolved The United States federal government should enact the Medicare-For-All Act of 2019." This topic manages to be both very interesting in a debate sense and will give students excellent knowledge to engage in the extremely important broader societal discussion about health care. If there were ever an instance to prioritize seeking out the truth in a resolution rather than making a good debate argument, it would certainly be this one. With that, let's dive into the topic that will be dominating everyone's minds for the next two months!

## Strategic Considerations

Tournaments are going to look quite a bit different than usual in these two months, as they are going to be conducted fully online. The most important thing for debaters of all experience levels to keep in mind is to be patient: especially at the start of the year, everyone will need time to figure out all of the kinks with online tournaments, not to mention the inevitable troubles with running anything online in real-time. Be as understanding as possible with all technical difficulties and be ready to accept the potential limitations of the format. That mentality will help make online tournaments run very smoothly and give them a pleasant atmosphere, which has never been more important. Debate can provide an excellent escape from the anxieties of life right now, so take it upon yourself to help make online tournaments that positive space.

Another thing to keep in mind is that online debate knocks down many barriers to interstate travel, meaning that tournaments will likely draw a much more geographically diverse field than in prior years. This provides many great benefits, as it will likely help to increase access to national circuit tournaments for debaters who otherwise would not get a chance to attend. Furthermore, it will expose debaters to the many different styles of debate that exist across the country, allowing them to develop the unique skills that each style of debate provides, from the hyper-technical to the lay-focused. From a strategic perspective, debaters should be extra ready to adapt to different styles based on the background of their judge. While debaters have always had to be prepared to switch between styles, the regional homogeneity of local circuits still kept things pretty consistent, but debaters will quickly realize that "flow judges" from the northeast, southeast, midwest, west coast, and south all judge very

differently. Thus, debaters should be extra careful to read paradigms and ask relevant questions before the round. Amidst all of this, however, debaters should keep in mind the core principles of warranted and weighed argumentation, principles which are the key to winning rounds no matter who is in the back of the room.

A final thing to note regards the excess of topic knowledge that often exists with the September topic. Many debaters spend weeks of their summer at camp researching the topic, an effect heightened by the explosion of more affordable online camps that popped up this summer. Even debaters who didn't attend camp have no doubt had some downtime this summer that they may have used to delve into the resolution at hand. In general, getting a deep background on a topic is incredibly important, and this is one is no different, but debaters should also beware of the double-edged sword that this knowledge creates: spending weeks speaking only to people who know a ton about the issues often causes debaters to go into rounds assuming their judge also knows a lot about it, even if that is not the case. Debaters should, therefore, remember to remove all jargon surrounding the topic, define any keywords, and explain all relevant background, especially to lay judges. Similarly, debaters who didn't go to camp should not be intimidated by jargon and technicalities from those who did; at the end of the day, it's all about the arguments. Another important thing for debaters to keep in mind is the flexibility required for sustained success over the two months. The arguments that are working well at the beginning of very well may not be the ones that work at the end of October; debaters should keep working on their cases and be ready to change up their arguments to adapt to what is working best.

## Affirmative Argumentation

If there were ever a moment that revealed the flaws in the American Healthcare system, the current global pandemic is certainly it. For the majority of Americans, healthcare is provided by their employer, meaning that coverage is tied to employment. This means that if people lose their jobs, as millions have during the pandemic, they are no longer covered. As such, as the Kaiser Family Foundation estimated that as of July, 27 million Americans had lost their health insurance since the start of the pandemic.<sup>1</sup> That many people losing health coverage is always awful, but that many losing it in the midst of a pandemic might just be enough to shift the public mood towards public insurance. So here enters the Medicare for All Act of 2019.

Unsurprisingly, pro teams will likely want to capitalize on the national climate around healthcare when crafting their argument. The US Healthcare System, however, did not end up in shambles overnight. Pro teams will likely want to tell a story about a system that has prioritized profits over people for decades and has become so bloated and inefficient that the US spends twice as much per person on healthcare than other developed countries, despite having far worse outcomes.<sup>2</sup> Thus, as much as pandemic shows the issues in our healthcare system, aff teams should not let themselves become limited by the current moment, as that can allow con teams to try to isolate this instance a once-in-a-lifetime catastrophe. Instead, aff

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<sup>1</sup> <https://www.nytimes.com/2020/07/13/us/politics/coronavirus-health-insurance-trump.html#:~:text=The%20nonpartisan%20Kaiser%20Family%20Foundation,family%20members%20of%20the%20insured>.

<sup>2</sup> <https://www.healthaffairs.org/do/10.1377/hblog20200319.920962/full/>

teams should use the pandemic to reveal the fundamental issues in the entire system of private health insurance that has existed for decades.

As is often the case, the most intuitive argument on this topic – increasing access and affordability of healthcare – promises to be one of the strongest, so let's start there. Medicare for All eliminates private insurance, and the cost-sharing model of deductibles, premiums, and co-payments that burden Americans right now. It ends the link between employment and health insurance, which would prevent the massive loss in health coverage that wreaks havoc on Americans during economic recessions. It will also cover services such as dental care, hearing aids, eyeglasses, and care for people with disabilities, providing much more comprehensive coverage than the majority of Americans can afford right now. There is no shortage of statistics out there that show how much all of this coverage could benefit Americans who suffer from medical debt and lack of coverage, such as the horrifying stat that 42% of cancer patients are forced to exhaust their life savings in just two years.<sup>3</sup> Healthcare plays such a vital role in the lives of so many people that making it completely affordable and accessible to people would greatly increase happiness and well-being for millions upon millions of people. Pro teams should make sure that their argument reflects those stakes, with lots of emphasis on impacting, especially since the warranting of why healthcare becomes affordable under Medicare for All should be pretty simple to explain. The ability to save time on the link level and beef up the impacts is a huge benefit of running this simple and intuitive argument. The benefits to healthcare also, however, extend beyond just cost-saving, as there's also reason

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<sup>3</sup> <https://www.beckershospitalreview.com/finance/cancer-forces-42-of-patients-to-exhaust-life-savings-in-2-years-study-finds.html>

to believe that Medicare for All would make the healthcare system more efficient, as one expert said that "the provider will not be spending a bunch of time trying to figure out billing for 15 or 100 different payers and they will not be negotiating prices with 100 different payers, the provider will, presumably, be able to spend more of their time on providing care."<sup>4</sup> That increased efficiency and quality of care, combined with the huge increase in affordability, gives Medicare for All the chance to save a remarkable number of lives, as a study done by Galvani, Fitzpatrick, et al found that Medicare for All would save over 68,000 lives per year.<sup>5</sup>

In addition to the more obvious benefits to health outcomes, Medicare for All also has the potential to greatly help the economy. Right now, people spend an exorbitant amount of money on healthcare, as reflected by the incredibly high national expenditures on healthcare in the United States. Medicare for All, by eliminating copays and premiums and making the system more efficient overall, could lead to a large reduction in expenditure, as the same study cited above found that Medicare for All would lead to a "13% savings in national health-care expenditure, equivalent to more than US\$450 billion annually." By eliminating those expenditures, Medicare for All frees up disposable income and decreases the need for huge stockpiles of savings in the case of medical emergencies, which would increase disposable income. That increase in disposable income would lead to an increase in consumer spending, which stimulates economic growth and development. This effect is further heightened by the transfer of cost for healthcare; in addition to the fact that overall expenditures will be lower, the switch from premiums to taxes would likely mean that wealthy Americans would bear more

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<sup>4</sup> <https://www.salon.com/2019/07/14/this-is-what-doctor-visits-would-look-like-under-medicare-for-all/>

<sup>5</sup> [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)33019-3/fulltext#%20](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)33019-3/fulltext#%20)

of the brunt of the cost for healthcare, and lower-income families would see their household incomes increase. This is important because lower-income people tend to spend a higher portion of their pay raises than wealthy Americans, again making Medicare for All an efficient way to stimulate economic growth.

The impacts of this stimulus to economic growth are multifaceted. Debaters could highlight the present massive economic downturn to show why an increase in spending right now would be hugely beneficial in getting the economy back on track, as almost any introductory economics textbook will say that spending is the key to getting out of recessions. After all, one person's spending is another person's income, so the more people are able to spend during times like these, the better. Looking more broadly, Medicare for All could also help small businesses, as right now, big businesses are often able to provide much better healthcare benefits to their employees than small businesses. In turn, small businesses are forced to provide healthcare, which places a massive burden on them, both financially and in terms of the human capital required to manage the service. Medicare for All would relieve that burden off the shoulders of small businesses and level the playing field, helping small businesses grow and compete. This further creates the opportunity for long term economic improvement.

What's nice about both of these arguments is their relative simplicity. They get straight into the current discourse around healthcare and are exactly what judges will think about when they hear Medicare for All. Oftentimes, debaters fall into the trap of thinking that stock or intuitive arguments are less effective, and so they go looking for more niche arguments that end up confusing judges. When properly warranted and weighed, these arguments provide an

excellent foundation for affirmative cases that will immediately create an uphill battle for con teams.

## Negative Argumentation

A first question for con teams to consider when crafting their cases is the age-old question when it comes to progressive policy: how are we going to pay for it? Nobody knows quite how much Medicare for All would cost, but one study from the center-left think tank The Urban Institute finds that it would cost \$34 trillion in additional federal spending over its first decade in operation, so the financing of the plan certainly has large ramifications. The problem is that the plan as proposed by Sanders, taken literally, "lacks a funding mechanism" according to a study by UPenn. Given the incredible unpopularity of tax increases, recent trends would suggest that this plan would likely be financed by an increase in the federal debt. That being said, the plan includes some taxes, specifically payroll taxes, that would increase to try and finance the plan, but some estimates say that those taxes would only cover 25% of the cost of the plan, so some noticeable increase in debt is almost certain to occur as a result.

So what's wrong with a debt increase? Well, for a start, it increases interest rates, which makes taking out future debt more expensive. As interest rate payments increase, it crowds out spending in other areas. Even in their current state, interest payments are projected only to increase, eventually on a path to dwarf our entire discretionary spending budget of over \$1 trillion. If we go into even more debt, and interest rates rise even further, the government's ability to spend on other social programs such as Social Security, which is responsible for

keeping 27 million people out of poverty each year, becomes a much more difficult task.<sup>6</sup> As the US plunges further into debt and doubt about our ability to pay it back creeps in, interest payments will only grow larger, further swallowing government spending until a future generation must foot the bill.

Since debt raises interest rates, it also makes starting a business harder. Starting a business almost always involves taking out a loan from a bank, and as the government borrows more money, interest rates for the whole country rise, making it harder for people to take out loans to start businesses. This is called "crowding out," and while it might not be a problem now, given the state of the economy, it can significantly hamper a healthy economy. Fewer businesses mean less economic growth and fewer jobs.

Finally, debt can also crowd out stimulus spending. As we have all seen right now when the economy crashes, the government must go into debt to pass stimulus packages to keep the economy afloat and allow people to put food on the table for their families. The problem is that when the debt is already so large, politicians are more hesitant to delve deeper into it to pass a stimulus package. As Seidmen of the National Association for Business Economics explains, the largest congressional obstacle to passing a stimulus during times of recession is the national debt, and it directly prevented the expansion of the '08 stimulus that would have ended the recession years earlier.<sup>7</sup> We're also seeing this play out now, as the massive debt has no doubt contributed to the stalling of additional stimulus payments. The more the government plunges

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<sup>6</sup> <https://www.nytimes.com/2018/09/25/business/economy/us-government-debt-interest.html>

<sup>7</sup> <https://www.jstor.org/stable/23491767?seq=1>

into debt with Medicare for All, the harder it is to fulfill their role of kickstarting the economy when they need to.

It's also worth noting that increasing Payroll Taxes, as Sanders himself suggested, comes with its baggage. Payroll taxes are taxes that are imposed on employers or employees of companies, and if they are levied on employers, it costs employees money for the workers that they hire. This largely negates any benefits to the lower cost of starting a business that comes from Medicare for All, as even if employers are no longer responsible for providing health coverage, they will still be paying for it through payroll taxes. To compensate, employers may lower wages, since the payroll tax is ostensibly a wage they have to pay to their workers, meaning that Medicare for All could make it harder to survive as a small business, decrease jobs, and depress wages. At the end of the day, there is a reason that, despite decades of criticism of private healthcare, the US has yet to pass a universal system. The funding for the plan is a huge question, as no matter what mechanism the government employs, there will be issues that come along. Another benefit of this cost argument is that it will be the immediate and intuitive reservation that many laypeople have when it comes to Medicare for All: it will be the first thing many parents judge think of when they hear the resolution. This likely means they will be extra-receptive to this argument since it is simple, yet very powerful.

Another argument that con teams can make is about decreasing medical innovation. For all of the problems with the private healthcare industry, there is no denying that pharmaceutical and medical innovation over the past few decades has done an enormous amount of good. One needs to look no further than the massive increases in life expectancy around the world to see that. Indeed, one study found that pharmaceutical innovation has

accounted for 73% of the increase in life expectancy in 30 developed and developing countries.<sup>8</sup>

The problem is that this research is incredibly risky and expensive, as millions of dollars must be poured into decades-long research on any individual drug or medical therapy. Many of these

drugs never see the light of day, which means that investing in them is a risk for companies.

This is what makes innovation so risky for firms, and it's why high pieces and profits are often

required to incentivize that investment. The issue is that Medicare for All allows the

government to negotiate lower drug prices with corporations, reducing pharma's profits. Since

pharmaceutical companies already operate in a somewhat risky place when it comes to medical

innovation, any substantial decrease in profits could put a large dent in their ability to research

and create new drugs and therapies. One study concluded that as a result of this drop in profits,

Medicare for All could decrease pharmaceutical innovation by up to 32% across the industry<sup>9</sup>.

So why is this such a big deal? Well, if pharmaceutical innovation is responsible for such a large

portion of the increase in life expectancy, then a decrease in that innovation would certainly

halt the global increase in life expectancy. Furthermore, in its ideal form, medical innovation

leads to a long term decrease in prices, since companies can define various techniques to make

them as efficient as possible. If innovation goes down, the prevalence and availability of new

medical therapies would also decrease, which could certainly disrupt all of the progress that has

been made over the past few decades. Critically, while Medicare for All is a primarily domestic

impact, as its benefits are localized to the United States, medical innovation benefits the entire

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<sup>8</sup> <https://itif.org/publications/2017/05/30/fact-week-pharmaceutical-innovation-accounted-73-percent-increase-life>

<sup>9</sup> <https://www.forbes.com/sites/theapothecary/2017/10/06/the-4-reason-bernie-sand>

world. Efficient medical innovations make life-saving drugs affordable in developing countries that lack overall health infrastructure, which is why pharmaceutical innovation has accounted for such a large portion of the increase in life expectancy in developing countries. People in developing companies are often comparatively worse off than people in the US, so even if Medicare for All helps US citizens, if it harms those in developing countries, it very well may be harmful on net. Of course, the resolution does specify the US government as the actor, and generally, the US government makes policy decisions based on the well-being of its citizens, rather than those of other countries. This certainly does not mean that con teams cannot run arguments about other countries, it just means that they need to be ready to show exactly why the judge should care about countries outside the US when making their decisions, especially in front of lay judges who are likely to find that idea to be less intuitive. That being said, this argument presents an excellent foil to the arguments I outlined on the pro side since it refuses to allow the pro side to monopolize impacts on health and medicine. Furthermore, the impacts to the developing world in this argument provide con teams with an excellent route to outweigh may pro arguments, especially in front of more flow judges, who tend to be more receptive to those impacts. Good luck!

### About Tucker Wilke

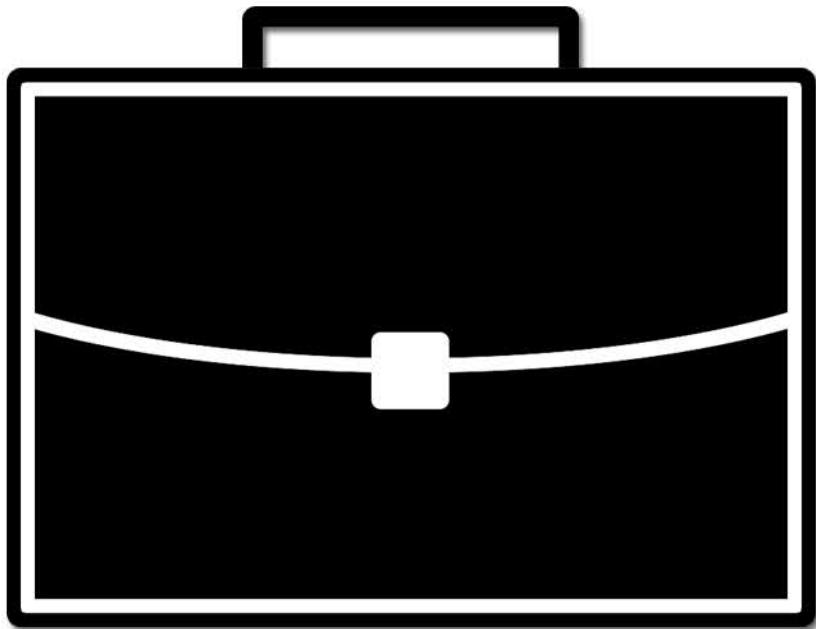
Tucker is from Westchester, New York, where he attended the Hackley School. He is now attending Brown University, where he debates for the Brown Debating Union and studies English and Economics. Over the course of his career, Tucker amassed 8 bids to the Tournament

of Champions. In addition, he reached the Quarterfinals at Bronx, Glenbrooks, UK, Ridge and Princeton, Semifinals at Penn and Columbia, and championed the Scarsdale Invitational. He was ranked as high as 7th in the country in his senior year. As a coach for Hackley, his students have reached semifinals at Blake and Quarters at Penn.

# **Champion Briefs**

## **Sept/Oct 2020**

### **Public Forum Brief**



## **General Information**

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

**Foreword:** We, at Champion Briefs, feel that having deep knowledge about a topic is just as valuable as formulating the right arguments. Having general background knowledge about the topic area helps debaters form more coherent arguments from their breadth of knowledge. As such, we have compiled general information on the key concepts and general areas that we feel will best suit you for in- and out-of-round use. Any strong strategy or argument must be built from a strong foundation of information; we hope that you will utilize this section to help build that foundation.

### What is Medicare-for-All?

According to Stephanie Booth of Healthline:

As far as the current legislation on the table like the Sanders and Jayapal bills, "the simplest explanation is that these bills would move the United States from our current multi-payer healthcare system to what is known as a single-payer system," explained Keith.

Right now, multiple groups pay for healthcare. That includes private health insurance companies, employers, and the government, through programs like Medicare and Medicaid.

Single-payer is an umbrella term for multiple approaches. In essence, single-payer means your taxes would cover health expenses for the whole population, according to a definition of the term from the Journal of General Internal MedicineTrusted Source. The objective is for a single publicly funded health system, like that in Canada, the United Kingdom, and Australia.

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### What are the main elements of the bill?

Sanders' and Jayapal's bills (S. 1129 and H.R. 1384, respectively) share many similarities, such as:

- comprehensive benefits
- tax financed
- a replacement for all private health insurance, as well as the current Medicare program
- lifetime enrollment

- no premiums
- all state-licensed, certified providers who meet eligible standards can apply

### **The History of American Healthcare:**

According to Jeff Griffin of the Griffin Group, “The American history of medicine and organized healthcare is quite a bit different than that of most other first world countries.

While the Civil war propelled the progress of American medicine much faster than what would have probably transpired without it, our staunch belief in capitalism has prevented us from developing the kind of national healthcare the United Kingdom, France, and Canada have used for decades.

As a result, we have our own unique system that has evolved drastically over the past century into something that is both loved and hated by its citizens.

Whichever end of the spectrum you lean toward, there’s no doubt about it: the history of medicine and organized healthcare in America is a long and winding road.”

### **Medicare versus Medicaid**

Medicare is a policy designed for U.S. citizens age 65 and older who have difficulty covering the expenses related to medical care and treatments. This program provides support to senior citizens and their families who need financial assistance for medical needs. People under the age of 65 living with certain disabilities may also be eligible for Medicare benefits. Each case is evaluated based on eligibility requirements and the details of the program. Those in the final stage of kidney disorders can also apply for the benefits of a Medicare policy.

Medicaid is a program that combines the efforts of the U.S. state and federal governments in order to assist households in low-income groups with healthcare expenses, such as major hospitalizations and treatments as well as routine medical care. It's designed to help those unable to afford quality medical care and who don't have other forms of medical coverage due to strained finances.

### **The Affordable Care Act**

In recent history, the Affordable Care Act expanded coverage dramatically by denying insurance companies to discriminate against people based on preexisting conditions. It also expanded access to prenatal and maternal care.

As a result, JP Griffin Group writes that, "the ACA has covered an average of 11.3 million annually since its inception, though 8.5% of the U.S. population (roughly 27.5 million Americans) remain uninsured, as reported by the KKF in 2018.

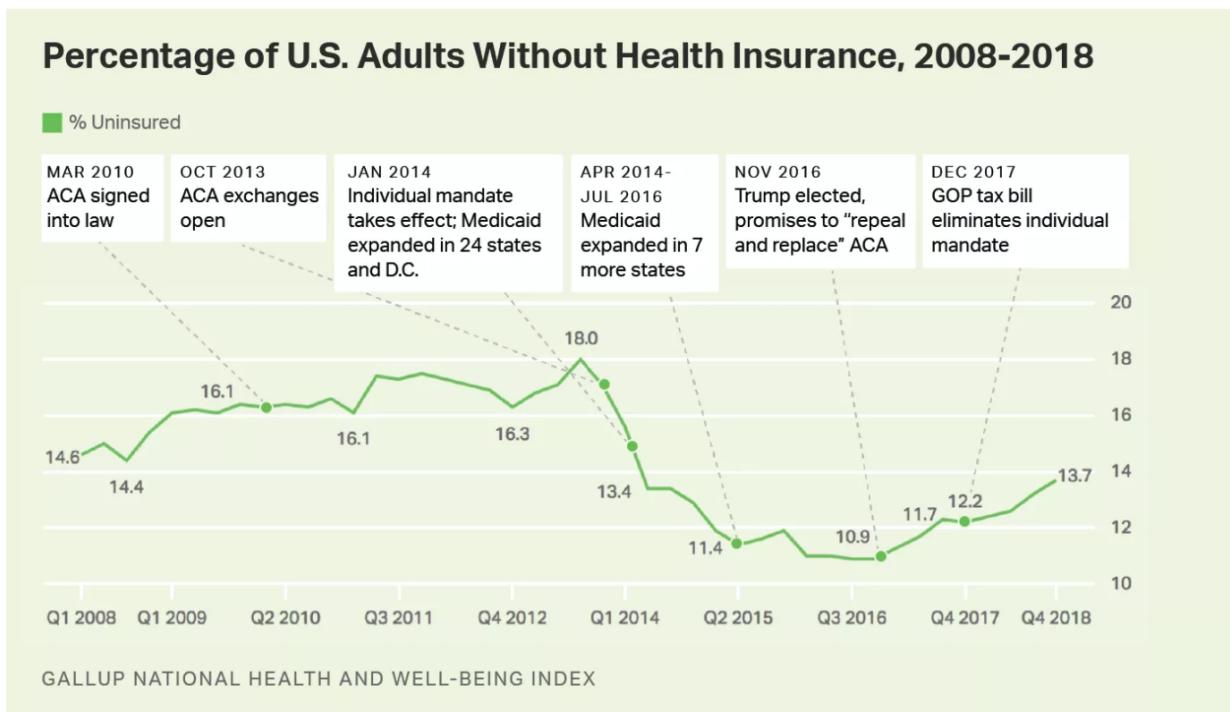
Many who study our healthcare system wonder why, even after the passage of the ACA, such a large number of people remain uninsured. While there are several reasons for this, the primary factors include; undocumented immigrants who are ineligible for Medicare or Marketplace coverage, people eligible for financial assistance under the ACA but unaware that assistance exists, and poor adults living in states that did not expand Medicaid."

### **How many people don't have insurance?**

According to the Kaiser Family Foundation, "For the second year in a row, the number of uninsured increased. In 2018, 27.9 million nonelderly individuals were uninsured, an increase of nearly 500,000 from 2017. Since 2016 when the number of uninsured reached historic lows, the number of people who lack health insurance coverage has grown by 1.2 million. Despite these

recent increases, the uninsured rate remains substantially lower than it was in 2010, when the first ACA provisions went into effect and prior to the full implementation of Medicaid expansion and the establishment of Health Insurance Marketplaces. Data show substantial gains in public and private insurance coverage and historic decreases in the number of uninsured people under the ACA, with nearly 20 million gaining coverage."

**The number of people without insurance has been on the rise in the past few years...**



### Recent Trends in Insurance Coverage

According to Vox, “The uninsured rate is still well below where it was in 2013, before the Affordable Care Act’s expansion of health insurance coverage began. But under the Trump administration, a trend of Americans gaining coverage through the private marketplaces and the Medicaid expansion appears to be reversing.

Certain demographic groups are experiencing a greater loss of coverage than others. Gallup data shows, for example, that Americans who are younger and lower-income have seen a greater decline in insurance coverage than those who are older and wealthier. Women have had insurance rates decline more quickly than men.

This trend is especially surprising given that over the same time period, the unemployment rate has been declining. Usually, when more people have jobs, it means more people with access to employer-sponsored health insurance. But even during this period of job growth, America’s uninsured rate keeps climbing.”

How does insurance work in general?

## What's a deductible?

A deductible is the amount of money that you pay before the insurance company will start to help with your medical bill.

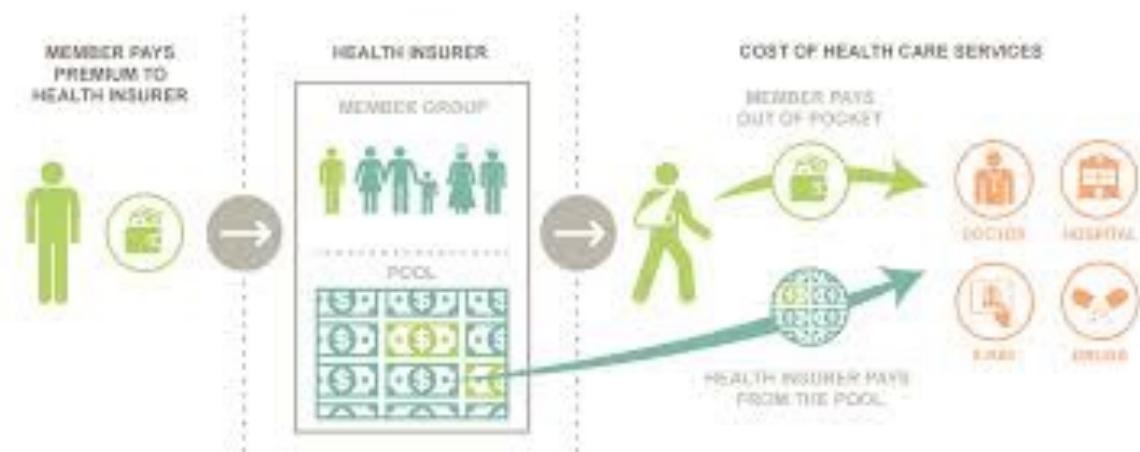
### How does deductible work?

Let's assume you have health plan with a **\$1,000 deductible**, 20% coinsurance, and a \$6,000 out-of-pocket maximum.



If you incur a **\$50,000 medical bill**, you will first need to pay your \$1,000 deductible. That would leave you with \$5,000 left before you reach your \$6,000 out-of-pocket maximum.

eHealth®



### An Explanation of Health Insurance:

According to Stanford University, "Health care in the United States can be very expensive. A single doctor's office visit may cost several hundred dollars and an average three-day hospital stay can run tens of thousands of dollars (or even more) depending on the type of care provided. Most of us could not afford to pay such large sums if we get sick, especially since we don't know when we might become ill or injured or how much care we might need. Health insurance offers a way to reduce such costs to more reasonable amounts.

The way it typically works is that the consumer (you) pays an up front premium to a health insurance company and that payment allows you to share "risk" with lots of other people (enrollees) who are making similar payments. Since most people are healthy most of the time, the premium dollars paid to the insurance company can be used to cover the expenses of the (relatively) small number of enrollees who get sick or are injured. Insurance companies, as you can imagine, have studied risk extensively, and their goal is to collect enough premium to cover medical costs of the enrollees. There are many, many different types of health insurance plans in the U.S. and many different rules and arrangements regarding care."

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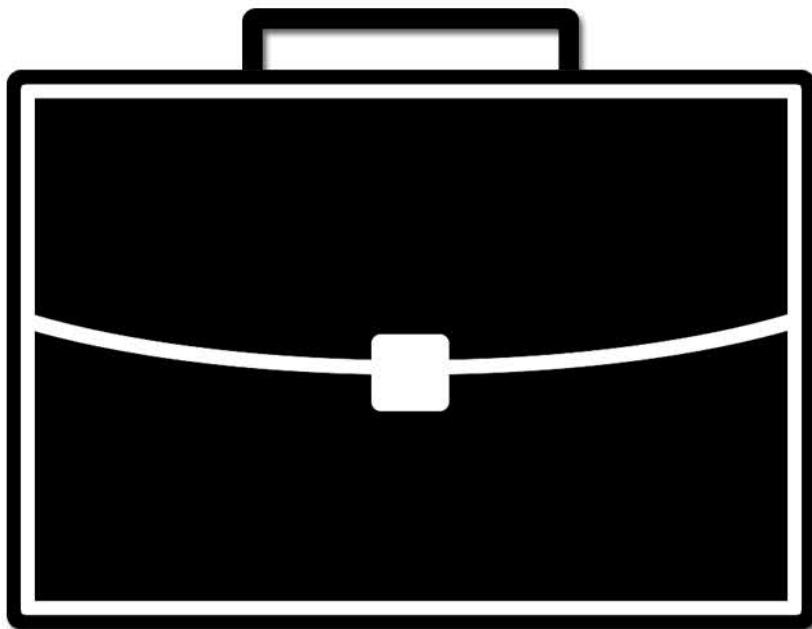
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<https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>.

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<https://vaden.stanford.edu/insurance/health-insurance-overview/how-us-health-insurance-works>.

# Champion Briefs

## Sept/Oct 2020

### Public Forum Brief



## Pro Arguments

### PRO: Medicare for All would help victims of domestic violence

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**Argument:** Many people receive health insurance through their spouse. When victims of domestic violence want to leave their spouse, fear of losing health insurance can be one of the reasons victims stay. Medicare for All solves by giving everyone access to health insurance irrespective of their marital or employment status.

**Uniqueness:** Nearly a quarter of women under 64 receive health insurance through their spouse.

Lazarus, David. "Column: If You're on a Spouse's Health Plan, What Happens If the Worst Should Happen?" Los Angeles Times, 4 July 2017,  
[www.latimes.com/business/lazarus/la-fi-lazarus-spouse-health-insurance-20170704-story.html](http://www.latimes.com/business/lazarus/la-fi-lazarus-spouse-health-insurance-20170704-story.html).

She finally brought the conversation home by asking: "What happens if something happens to you?" It's a question that should resonate with many families. **As of 2015, according to the Kaiser Family Foundation, nearly a quarter of women in the United States under age 64 received health coverage through their spouse's employer-sponsored plan.** "Because women are more likely than men to be covered as dependents, a woman is at greater risk of losing her insurance if she becomes widowed or divorced, her spouse loses a job, or her spouse's employer drops family coverage or increases premium and out-of-pocket costs to unaffordable levels," the foundation noted.

**Uniqueness:** Victims of violence are almost twice as likely to have difficulty obtaining healthcare than other women.

Collins, Karen. "Violence and Abuse | Commonwealth Fund."

Www.Commonwealthfund.Org, 91 May 1999,

[www.commonwealthfund.org/publications/other-publication/1999/may/violence-and-abuse](http://www.commonwealthfund.org/publications/other-publication/1999/may/violence-and-abuse).

Women who have experienced violence or abuse appear to have greater difficulty accessing health care than other women. More than one-third who had experienced violence or abuse reported a time they did not get needed care. **Victims of violence were nearly twice as likely as other women to say that they have had an “extremely,” “very,” or “somewhat” difficult time obtaining health care (22% vs. 13%).** Among women who had been victims of any violence or abuse, 31 percent believed that at some time they had needed to see a mental health professional, but only slightly more than half of those were able to do so.

**Warrant:** Unaffordable insurance makes victims dependent on their abusers.

Buchanan, Maggie. Texas Journal of Women and the Law Volume 23 FIGHTING DOMESTIC VIOLENCE THROUGH INSURANCE: WHAT THE AFFORDABLE CARE ACT DOES AND CAN DO FOR SURVIVORS. Dec. 2016, <https://www.acesdv.org/wp-content/uploads/2016/12/What-the-ACA-can-do-for-survivors.pdf>

Insurance discrimination contributes significantly to the cycle of abuse because of the resulting economic sanctions against survivors. Abusers frequently have financial control over their survivors."'" The result of this control is well documented in contexts outside of healthcare. For example, shelters typically limit the time survivors and their children may stay, and many survivors report feeling forced to return to or stay with their partners because they cannot pay rent or buy a home after being forced to leave a shelter. **A lack of reasonably priced insurance for these survivors has the same**

effect. Because insurance is either unavailable or too expensive, survivors become more dependent on their partners to meet their—and their children's—healthcare needs. And when survivors are aware of the effects that calling the police or seeking medical help may have on their ability to buy insurance, they will be even more unlikely to leave the relationship and find help.

**Solvency:** Medicare for All would allow victims to leave abusive relationships without fear of medical debt.

Pruter, Lauren. "Medicare for All Is Moral Choice." Pantagraph.Com, 30 Mar. 2019, [www.pantagraph.com/opinion/letters/medicare-for-all-is-moral-choice/article\\_d3be4291-304a-5c31-818c-2b75f5043e93.html](http://www.pantagraph.com/opinion/letters/medicare-for-all-is-moral-choice/article_d3be4291-304a-5c31-818c-2b75f5043e93.html).

America's employer-based healthcare system is failing us. A single medical emergency can quickly put a person into thousands of dollars of debt. Women are at a higher risk of being uninsured or underinsured because they are more likely to be covered as dependents through working spouse's employer-sponsored plans. The CDC recommends improving systems of economic support to prevent intimate partner violence. When a wealthy country like the USA denies healthcare to their citizens, they are complicit in domestic and financial abuse. **A single payer system like Medicare for All would free healthcare from employment and expand coverage to all United States residents. Free at the point of service means that healthcare costs will be financed through tax contributions: no copays, no fees, no deductibles, no premiums, and no choice between one's health or happiness. Expanding Medicare would mean that women would be able to leave abusive relationships and not live in fear of sudden medical debt.** Medicare for All is the moral thing to do.

**Impact:** A quarter of women and 1 in 7 men experience intimate partner violence in their lifetime.

Huecker, Martin R. "Domestic Violence." PubMed, StatPearls Publishing, 26 June 2020, [www.ncbi.nlm.nih.gov/books/NBK499891/#:~:text=According%20to%20the%20CDC%2C%201](http://www.ncbi.nlm.nih.gov/books/NBK499891/#:~:text=According%20to%20the%20CDC%2C%201).

Intimate Partner Violence. According to the CDC, **1 in 4 women and 1 in 7 men will experience physical violence by their intimate partner at some point during their lifetimes.** About 1 in 3 women and nearly 1 in 6 men experience some form of sexual violence during their lifetimes. Intimate partner violence, sexual violence, and stalking are high, with intimate partner violence occurring in over 10 million people each year.

**Impact:** Financial abuse is present in 99% of domestic violence cases in the U.S.

Snow, Lucy. "Money: A Critical Component of Domestic Abuse." Futures Without Violence, 30 Nov. 2017, [www.futureswithoutviolence.org/money-domestic-abuse/](http://www.futureswithoutviolence.org/money-domestic-abuse/).

But for many DV survivors, money – or lack of it – is a critical component in their abuse. **In the US, financial abuse is present in 99% of domestic violence cases, according to the National Network to End Domestic Violence.** Financial abuse is where an abuser controls his partner's access to money or other resources. Some perpetrators steal funds or possessions from their partners. But more often than not, the abuse is much more subtle.

**Analysis:** This argument can be weighed on magnitude. Medicare for All would help people in the most vulnerable situations, while likely only marginally harming already well-off people. This argument can also be run with a deontological framework. Pro teams can say that victims of domestic violence should never be used as a means to an end of the con's advocacy.

### PRO: Medicare for All improves the quality of research

**Argument:** In the status quo, drug companies are incentivized to slightly tweak drugs in order to circumvent existing patents and charge higher prices. This prevents drug companies from investing in drugs with clinical value. Medicare for All allows the government to negotiate drug prices, aligning the incentives of companies and consumers.

**Uniqueness:** In the status quo, 90% of new drugs provide few or no clinical advantages.

Light, Donald. "Pharmaceutical R&D - What Do We Get for All That Money?"

ResearchGate, Aug. 2012,

[www.researchgate.net/publication/285134123\\_Pharmaceutical\\_RD\\_-\\_What\\_do\\_we\\_get\\_for\\_all\\_that\\_money](https://www.researchgate.net/publication/285134123_Pharmaceutical_RD_-_What_do_we_get_for_all_that_money).

The preponderance of drugs without significant therapeutic gains dates all the way back to the “golden age” of innovation. Out of 218 drugs approved by the FDA from 1978 to 1989, only 34 (15.6%) were judged as important therapeutic gains.<sup>12</sup> Covering a roughly similar time period (1974-94), the industry’s Barra report on all internationally marketed new drugs concluded that only 11% were therapeutically and pharmacologically innovative.<sup>13</sup> **Since the mid-1990s, independent reviews have also concluded that about 85-90% of all new drugs provide few or no clinical advantages for patients.**<sup>14-19</sup> This small, steady increase in clinically superior drugs contrasts with the FDA granting “priority” review status to 44% of all new drugs from 2000 to 2010.<sup>20</sup> The percentage of drugs with a priority designation began to increase in 1992 when companies started funding the FDA’s approval process. Other regulatory agencies have classified far fewer of the same medicines as needing accelerated reviews.<sup>21</sup> Post-market evaluations during the same period are much less generous in assigning significant therapeutic advances to medications. **This is the real innovation crisis: pharmaceutical research and development turns out mostly minor variations on**

**existing drugs, and most new drugs are not superior on clinical measures.** Although a steady stream of significantly superior new drugs enlarges the medicine chest from which millions benefit, medicines have also produced an epidemic of serious adverse reactions that have added to national healthcare costs

**Uniqueness:** High drug prices crowd out valuable drug development projects.

Canoy, Marcel. "Lower Drug Prices Can Improve Innovation." European Competition Journal, vol. 14, no. 2–3, 2 Sept. 2018, pp. 278–304, [editorialexpress.com/cgi-bin/conference/download.cgi?db\\_name=EARIE45&paper\\_id=550, 10.1080/17441056.2018.1512231](http://editorialexpress.com/cgi-bin/conference/download.cgi?db_name=EARIE45&paper_id=550, 10.1080/17441056.2018.1512231).

The framework shows that – purely from an innovation perspective - incentives are socially optimal if the pharmaceutical company can appropriate the entire benefit of a new drug to society. In this case the pharmaceutical company internalizes all the public benefits and costs of the drug. If a company extracts less than the entire benefit of a new drug to society, innovation incentives can be too low from a social point of view. Apart from investing too little money in the project, it may result in the company's decision not to develop the drug at all even though this would be in the public interest. However, **if companies gain more than the benefit of the drug to society, we show that this creates two inefficiencies in innovation.** First, companies invest too many resources in projects where they expect to be able to gain more than the drug is worth to society. Second, **pharmaceutical companies invest too few resources in other valuable drug development projects. As a result, high drug prices lead to crowding out of valuable drug development projects. In these instances, enforcing lower prices does not harm innovation but improves it, because as a result of lowering those prices future investments will be geared towards projects that are more desirable for society.**

**Solvency:** Medicare for All would allow the government to negotiate drug prices with corporations.

Lawson, Alex. "Medicare For All Will Drastically Lower Prescription Drug Prices by Taking on Pharma's Greed." Salon, Salon.com, 3 Mar. 2019, [www.salon.com/2019/03/03/medicare-for-all-will-drastically-lower-prescription-drug-prices-by-taking-on-pharmas-greed\\_partner/](http://www.salon.com/2019/03/03/medicare-for-all-will-drastically-lower-prescription-drug-prices-by-taking-on-pharmas-greed_partner/).

Rep. Pramila Jayapal's (D-WA) recently introduced Medicare for All Act of 2019 is a powerful and comprehensive plan to make health care a right for every American. Drastically lowering the prices of prescription drugs, while ensuring that patients are always able to get the medications they need, is an essential part of that plan.

**The Medicare for All Act includes a key provision, modeled after the Medicare Negotiation and Competitive Licensing Act, which would lower drug prices for all Americans by allowing the government to negotiate lower drug prices with corporations.** And if a corporation refused to lower the price and threatened patients' access to the medication, generic competition would be allowed using a competitive license.

**Solvency:** There is only a tradeoff between innovation and market access if prices remain high.

Mohanlal, Ramon. "Strategies to Avoid Innovation/Market Access Trade-Off." [Www.Thepharmaletter.Com](http://Www.Thepharmaletter.Com), 29 Nov. 2016, [www.thepharmaletter.com/article/strategies-to-avoid-innovation-market-access-trade-off](http://www.thepharmaletter.com/article/strategies-to-avoid-innovation-market-access-trade-off).

Generally, a high degree of product innovation and product differentiation are strong justifications for a high price point, particularly in areas of high unmet medical needs. **Pharmaceutical companies often argue that high price points for innovative drugs are**

**essential to recoup the cost of research and development (R&D), which results from a perceived innovation/market access trade-off. Such a trade-off, however, only occurs if higher innovation would be linked to higher prices.** Avoidance of innovation/market access trade-off could also be achieved through a volume-driven strategy, rather than a price-driven strategy.

**Impact:** Each new drug brought to market saves 11,200 life years each year.

Shepherd, Joanna. "The Prescription for Rising Drug Prices: Competition or Price Controls?" *Health Matrix: The Journal of Law-Medicine*, 6 July 2020.  
<https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1609&context=healthmatrix>.

Consumers will suffer from reductions in innovation. Research shows that pharmaceutical innovation has produced significant health benefits to consumers. **Empirical estimates of the benefits of pharmaceutical innovation indicate that each new drug brought to market saves 11,200 life years each year.** 154 Another study finds that the health improvements from each new drug can eliminate nineteen billion dollars in lost wages by preventing lost work due to illness.155 Additionally, because new effective drugs reduce medical spending on doctor visits, hospitalizations, and other medical procedures, data show that for every incremental dollar spent on new drugs, total medical spending decreases by more than seven dollars.156 Brand companies, and the profit incentives that motivate them, are largely responsible for pharmaceutical innovation. Thus, actions that reduce brand innovation will have long-term negative effects on consumer health and healthcare spending.

**Impact:** In Germany's centralized healthcare system, manufacturers were 10 times more likely to withdraw products that lacked clinical benefit.

Kost, Danielle. "Germany May Have the Answer for Reducing Drug Prices." HBS Working Knowledge, 11 Sept. 2019, [hbswk.hbs.edu/item/germany-may-have-the-answer-for-reducing-drug-prices](https://hbswk.hbs.edu/item/germany-may-have-the-answer-for-reducing-drug-prices).

If the panel deems a product equally or less beneficial than one or more drugs already available, the manufacturer can withdraw it from the market, price it no higher than comparable products, or negotiate a price with the association that represents Germany's statutory health insurers, a potentially costly process. **Stern and her co-authors studied 171 new drugs that Germany's IQWiG reviewed between 2012 and 2016. They found that manufacturers were 10 times more likely to withdraw products that lacked any evidence of added benefit than ones that performed better.** Equally important, 98 percent of drugs with added benefits remained on the market, including all treatments for heart and respiratory diseases. "The drugs that left the market were 'me too' drugs—only one of these drugs was shown to have added benefit over comparable therapies, but that decision was actually reversed in a later evaluation. That means that none of the drugs that left the market were, ultimately, ones that had additional patient benefit," Stern says. "Innovative, high-value drugs that were found to lead to better patient outcomes all remained on the market."

**Analysis:** This argument can be weighed on timeframe. In the short term, innovation is incredibly urgent for dealing with the pandemic. In the long term, productive innovation is necessary in order to keep up with evolving diseases and prevent future outbreaks. Access to medicine doesn't matter if there aren't effective drugs in the first place.

### PRO: Medicare for All would help small businesses

**Argument:** Healthcare costs are currently a major expense for businesses. While big businesses can generally afford to offer high-quality healthcare to employees, small businesses do not have the resources to do so — driving away potential employees. Medicare for All would solve this problem by eliminating employee-sponsored health insurance.

**Uniqueness:** In the status quo, health care costs take a toll on small businesses.

Haefner, Morgan. “‘Medicare for All’ Gaining Traction among Small Business CEOs.”

Becker’s Hospital Review, 10 June 2019, [www.beckershospitalreview.com/payer-issues/medicare-for-all-gaining-traction-among-small-business-ceos.html](http://www.beckershospitalreview.com/payer-issues/medicare-for-all-gaining-traction-among-small-business-ceos.html).

This research reaffirms what both policymakers and stakeholders know to be true: **health care costs are taking a toll on small businesses in terms of money and time. Small-business owners often lack a human resources professional or the personnel enjoyed by their large competitors.** They often make decisions quickly and then have to take more time down the road to adjust a health plan that has grown too costly to continue. Small-business owners are taking steps to alleviate the problem. Unfortunately, without policy action their tools remain limited. They need support from policymakers to address the issue in a way that ensures they can continue to compete and employ millions of Americans in the future. For policy and lawmakers looking to support small employers, the time to act on health care is now.

**Uniqueness:** Economies of scale in healthcare costs put small businesses at a disadvantage in attracting employees.

Sandrosky, Seth. “MultiBrief: Why Medicare for All Could Be a Boon for Startups, Entrepreneurs.” Exclusive.Multibriefs.Com, 24 Feb. 2020,

[exclusive.multibriefs.com/content/why-medicare-for-all-could-be-a-boon-for-startups-entrepreneurs/business-management-services-risk-management](http://exclusive.multibriefs.com/content/why-medicare-for-all-could-be-a-boon-for-startups-entrepreneurs/business-management-services-risk-management).

"The impact of Medicare for All will be significant and lead to an acceleration in new business startups," he told MultiBriefs via email. "The current system in the United States, in which a majority of working-age adults get coverage through an employer, is a major impediment to business startups. **“Our employer-based system favors large employers that have the resources to self-insure. Small businesses cannot do that. Consequently, they have to pay insurance companies more than larger employers to cover their workers.” Advantage goes to big business in attracting new hires seeking employer-based health insurance versus smaller firms that are unable to do so.** "Small businesses are also at a disadvantage when it comes to recruiting and retaining employees because they typically cannot afford to provide the same level of benefits as large employers," said Potter.

**Solvency:** There is increased entrepreneurship when people don't have to fear losing health insurance if they switch jobs.

Yglesias, Matthew. "Universal Health Care Would Boost Entrepreneurship."

ThinkProgress, 28 May 2009, [thinkprogress.org/universal-health-care-would-boost-entrepreneurship-c7f24dc547f4/](http://thinkprogress.org/universal-health-care-would-boost-entrepreneurship-c7f24dc547f4/).

There are fewer direct studies of the impact of job lock on entrepreneurship. But the most convincing research, by Alison Wellington, mirrors the findings of other job mobility studies: **Americans who have an alternative source of health insurance, such as a spouse's coverage, are much more likely to be self-employed than those who don't. Wellington estimates that universal health care would therefore likely increase the share of workers who are self-employed (currently about 10 percent of the workforce) by another 2 percent or more. A system that provides universal access to**

**health insurance coverage, then, is far more likely to promote entrepreneurship than one in which would-be innovators remain tied to corporate cubicles for fear of losing their family's access to affordable health care.** Indeed, even the Galtians among us should be celebrating the expanded potential for individual enterprise once the chains tying them to a job that provides insurance have been broken.

**Solvency:** Medicare for All would equalize healthcare costs for businesses.

Haefner, Morgan. "'Medicare for All' Gaining Traction among Small Business CEOs."

Becker's Hospital Review, 10 June 2019, [www.beckershospitalreview.com/payer-issues/medicare-for-all-gaining-traction-among-small-business-ceos.html](http://www.beckershospitalreview.com/payer-issues/medicare-for-all-gaining-traction-among-small-business-ceos.html).

Universal healthcare would likely reduce healthcare costs. Several healthcare researchers and physicians have conducted studies finding that annual savings from moving from a multipayer to a single-payer system could be in the billions, most of which would be gained from less spending on administrative and billing functions.

**Universal healthcare would equalize healthcare costs for businesses. Competitive U.S. businesses already pay large sums of money to offer health insurance to their employees, the report stated. Financing a single-payer system would require different taxing mechanisms on businesses, but reports indicate businesses would not likely pay more than they already do — and many may actually pay less.** This would especially help small business owners, the report said. Taylor Lincoln, research director of Public Citizen's Congress Watch division and author of the report, said in a news release the issue is nonpartisan, but it has been absorbed by partisan factions at both ends of the aisle.

**Impact:** Small businesses drive economic growth.

Office of Advocacy. "Small Businesses Generate 44 Percent of U.S. Economic Activity."

SBA's Office of Advocacy, 30 Jan. 2019, [advocacy.sba.gov/2019/01/30/small-businesses-generate-44-percent-of-u-s-economic-activity/](http://advocacy.sba.gov/2019/01/30/small-businesses-generate-44-percent-of-u-s-economic-activity/).

**Small businesses are the lifeblood of the U.S. economy: they create two-thirds of net new jobs and drive U.S. innovation and competitiveness. A new report shows that they account for 44 percent of U.S. economic activity.** This is a significant contribution, however this overall share has declined gradually. U.S. gross domestic product (GDP) is the market value of the goods and services produced by labor and property located in the United States. Across the 16 years from 1998 to 2014, the small business share of GDP has fallen from 48.0 percent to 43.5 percent. Over the same period, the amount of small business GDP has grown by about 25 percent in real terms, or 1.4 percent annually. However, real GDP for large businesses has grown faster, at 2.5 percent annually.

**Impact:** U.S. economic growth spills over to emerging and developing economies.

Kose, Ayhan. "Understanding the Global Role of the US Economy | VOX, CEPR Policy Portal." Voxeu.Org, 17 Feb. 2017, [voxeu.org/article/understanding-global-role-us-economy](http://voxeu.org/article/understanding-global-role-us-economy).

Given its role in global commodity markets (the US is both the world's largest gas and oil consumer and producer), changes in US growth prospects can affect global commodity prices. This affects activity, fiscal and balance of payment developments in commodity exporters. **Estimates indicate that a percentage-point increase in US growth could boost growth in advanced economies by 0.8 of a percentage point, and in emerging market and developing economies by 0.6 of a percentage point after one year** (Figure 2.A). Investment could respond even more strongly. A boost to investment could come for instance from fiscal stimulus measures – but the effect would largely depend on the

circumstances of the implementation of these measures, including the amount of remaining economic slack, the response of monetary policy, and the adjustment of household and business expectations to the prospect of higher deficit and debt levels. A faster tightening of US monetary policy than previously expected could, for instance, lead to sudden increases in borrowing costs, currency pressures, financial market volatility, and capital outflows for more vulnerable emerging market and developing economies.

**Analysis:** This argument can be weighed on timeframe. In the current recession, now is an especially urgent time to boost business. It can also be weighed on scope, since U.S. economic growth often has global impacts.

### PRO: Medicare for All would decrease medical discrimination

**Argument:** The uninsured and underinsured are disproportionately marginalized groups, including minorities, members of the LGBTQ+ community, and undocumented immigrants. Medicare for All solves by giving every resident of the U.S. insurance — irrespective of income, race, gender, or immigration status.

**Uniqueness:** Race, gender and income have a bigger role in predicting health outcomes than they did in the past.

Neilson, Susie. "The Gap Between Rich And Poor Americans' Health Is Widening."

Npr.Org, 2019, [www.npr.org/sections/health-shots/2019/06/28/736938334/the-gap-between-rich-and-poor-americans-health-is-widening](http://www.npr.org/sections/health-shots/2019/06/28/736938334/the-gap-between-rich-and-poor-americans-health-is-widening).

The study drew from annual health survey data collected by the Centers for Disease Control and Prevention from 1993 to 2017, including around 5.5 million Americans ages 18-64. The researchers focused on two questions from the survey recommended by the CDC as reliable indicators of health: 1. Over the last 30 days, how many healthy days have you had? 2. On a scale of 1 to 5, how would you rate your overall health? What they found: **Across all groups, Americans' self-reported health has declined since 1993. And race, gender and income play a bigger role in predicting health outcomes now than they did in 1993. Overall, white men in the highest income bracket were the healthiest group.** "And actually, what's happening to the health of wealthier people is that it's remaining relatively stagnant, but the health of the lowest income group is declining substantially over time," says Frederick Zimmerman, the study's lead author and a professor at the UCLA Fielding School of Public Health.

**Solvency:** Medicare for All would be a step toward eliminating racial inequities by giving everyone access to insurance.

Saxe, Jessica. "Medicare for All Would Reduce Racial Inequities in America."

[Www.Thecharlottepost.Com](http://Www.Thecharlottepost.Com), 13 Aug. 2020,

[www.thecharlottepost.com/news/2020/08/13/opinion/medicare-for-all-would-reduce-racial-inequities-in-america/](http://www.thecharlottepost.com/news/2020/08/13/opinion/medicare-for-all-would-reduce-racial-inequities-in-america/).

Medicare is the most popular health insurance in the country. Black Americans should take particular pride in it, as Dr. Montague Cobb, president of the National Medical Association, led Black doctors in supporting Medicare, while the almost entirely white American Medical Association opposed it. Because of the hard work of the NMA and the NAACP, hospitals had to integrate to accept Medicare money. Just as Medicare led to hospital integration in 1966, **Medicare for All can be a major step toward eliminating racism and racial inequities. With everyone in the same system, everyone would be eligible for high-quality care. By cutting the connection with employment, no one would lose their coverage if they lost their job. Everyone could get care during a pandemic, protecting their health and that of the public.** People with high-risk conditions wouldn't feel forced to work just to keep their insurance. And everyone could get their necessary preventive or chronic illness care, pandemic or not.

**Solvency:** Medicare for All would give every American access to free mental health treatment, which is especially impactful for the LGBTQ community.

Golina, Nicolas. "Medicare for All as an LGBTQ Issue." Data For Progress, 11 Oct. 2019, [www.dataforprogress.org/blog/2019/10/11/medicare-for-all-as-a-lgbtq-issue](http://www.dataforprogress.org/blog/2019/10/11/medicare-for-all-as-a-lgbtq-issue).

Since LGBTQ individuals experience significantly worse health-care outcomes in the American health-care system, these benefits of **Medicare for All would benefit the**

LGBTQ community in many ways. Perhaps most importantly, the policy would provide every American with free access to mental-health treatment without the fear of medical debt or medical bankruptcy, while saving the US healthcare system 2 to 2.93 trillion dollars. With depression, suicide, and mental-health crises proving to be some of the most devastating challenges for members of the LGBTQ community, enacting Medicare for All would be a revolutionary improvement in the standard of living and happiness—and possibly a lifesaver—for LGBTQ individuals. Now, contrary to the claims by Mayor Pete Buttigieg in the September 2019 Democratic debate that Medicare for all would eliminate freedom of choice, actually Medicare for all would expand healthcare freedoms in 4 ways.

**Solvency:** Medicare for All would provide coverage for undocumented immigrants.

Wolf, Zachary. "Here's What Bernie Sanders' Medicare for All Proposal Actually Says."

Www.Cnn.Com, 2 Mar. 2020,

[www.cnn.com/interactive/2020/03/politics/medicare-for-all-annotated/](http://www.cnn.com/interactive/2020/03/politics/medicare-for-all-annotated/).

The first thing to note is that Sanders' proposal has only 14 co-sponsors in the Senate. That's not even a majority of Democrats. That's less than a third of the 60 votes usually required to overcome a filibuster and pass major legislation, although he has said he would use budget rules to maneuver around the practice of the filibuster in order to get Medicare for All passed. **In Sanders' proposal, everyone who is a US resident, including undocumented immigrants, gets coverage.** That would be a likely point of contention with this plan. There is a prohibition on traveling to the US for free medical care. Medicare for All is meant to be an extremely egalitarian proposal in which everyone has access to any provider. That's certainly not the current system in the US, in which there are extreme differences based on the quality of a patient's insurance and wealth.

**Impact:** Uninsured adults are 25% more likely to die prematurely than those with health insurance.

National Immigration Law Center. "The Consequences of Being Uninsured." Aug. 2014.

People who are uninsured suffer significant health consequences as a result of not having

insurance. **Being uninsured has been correlated with poorer quality of health care, lower rates of preventive care, and greater probability of death.<sup>5</sup> Uninsured adults are more than 25 percent more likely to die prematurely than adults with health insurance.**<sup>6</sup> The Institute of Medicine estimates that, in the year 2000, lack of health insurance led to the death of 18,000 adults, making it the sixth most frequent cause that year of death among people aged 18 to 64.<sup>7</sup>

**Impact:** Passing Medicare for All would fundamentally shift America's framing of healthcare to be understood as a human right.

Caruso, Dominic. "Single-Payer Health Reform: A Step Toward Reducing Structural Racism in Health Care | Harvard Public Health Review: A Student Publication." Harvardpublichealthreview.Org, July 2015, [harvardpublichealthreview.org/single-payer-health-reform-a-step-toward-reducing-structural-racism-in-health-care/](http://harvardpublichealthreview.org/single-payer-health-reform-a-step-toward-reducing-structural-racism-in-health-care/).

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. 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.

**Analysis:** This argument can be weighed on magnitude. Helping marginalized groups has more of an impact than marginally harming already well-off people. Pro teams can also run this argument with a deontological, as opposed to utilitarian, framework. This type of framework would argue that harm to marginalized groups should not be used as a means to an end of any other broader goal.

### PRO: Medicare for All increases access to healthcare

**Argument:** Millions of people in the U.S. are uninsured or underinsured. When those without sufficient insurance need treatment, they either forgo important medical care or go into medical debt. Medicare for All solves this issue because the government would pay for healthcare instead of the individual. It would also eliminate out-of-pocket expenses.

**Uniqueness:** As of 2018, there are 27.9 million uninsured Americans.

Tolbert, Jennifer. "Key Facts about the Uninsured Population." KFF, 13 Dec. 2019, [www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=In%202018%2C%2027.9%20million%20nonelderly](http://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=In%202018%2C%2027.9%20million%20nonelderly).

How many people are uninsured? For the second year in a row, the number of uninsured increased. **In 2018, 27.9 million nonelderly individuals were uninsured, an increase of nearly 500,000 from 2017. Since 2016 when the number of uninsured reached historic lows, the number of people who lack health insurance coverage has grown by 1.2 million.** Despite these recent increases, the uninsured rate remains substantially lower than it was in 2010, when the first ACA provisions went into effect and prior to the full implementation of Medicaid expansion and the establishment of Health Insurance Marketplaces. Data show substantial gains in public and private insurance coverage and historic decreases in the number of uninsured people under the ACA, with nearly 20 million gaining coverage.

**Uniqueness:** 29 percent of people with insurance are underinsured.

The Commonwealth Fund. "Underinsured Rate Rose From 2014-2018, With Greatest Growth Among People in Employer Health Plans | Commonwealth Fund." [Www.Commonwealthfund.Org, 7 Feb. 2019,](http://Www.Commonwealthfund.Org, 7 Feb. 2019,)

[www.commonwealthfund.org/press-release/2019/underinsured-rate-rose-2014-2018-greatest-growth-among-people-employer-health.](http://www.commonwealthfund.org/press-release/2019/underinsured-rate-rose-2014-2018-greatest-growth-among-people-employer-health)

People who are “underinsured” have high health plan deductibles and out-of-pocket medical expenses relative to their income and are more likely to struggle paying medical bills or to skip care because of cost. **Among adults who were insured all year, 29 percent were underinsured in 2018, up from 23 percent in 2014**, according to results from the Commonwealth’s Fund’s latest Biennial Health Insurance Survey, released today.

**Warrant:** If implemented correctly, Medicare for All would reduce total costs for the majority of Americans.

Berwick, Donald M. “Stop Fearmongering about ‘Medicare for All.’ Most Families Would Pay Less for Better Care.” USA TODAY, USA TODAY, 22 Oct. 2019, [www.usatoday.com/story/opinion/2019/10/22/medicare-all-simplicity-savings-better-health-care-column/4055597002/](http://www.usatoday.com/story/opinion/2019/10/22/medicare-all-simplicity-savings-better-health-care-column/4055597002/).

With costs rising painfully, insurance companies denying care and nearly 30 million people still uninsured, America desperately needs an honest health policy discussion. That’s why it has been so disappointing over the past several weeks to watch multiple candidates parrot right-wing attacks on "Medicare for All," like claiming that it will greatly increase spending on health care or ringing alarms about raising taxes on the middle class. The truth is the opposite: **Medicare for All would sharply reduce overall spending on health care. It can be thoughtfully designed to reduce total costs for the vast majority of American families, while improving the quality of the care they get.** Over my career, I have witnessed the problems with our health care system firsthand. As a pediatrician, I have seen how our fragmented, expensive system hurts children and families. As a researcher at Harvard Medical School, I have studied the causes of waste

and overspending in our system. And as President Barack Obama's head of the Centers for Medicare and Medicaid Services, I led the existing Medicare system and helped stand up Obamacare.

**Solvency:** Medicare for All would give everyone in the U.S. insurance and eliminate other payments.

Sanger-Katz, Margot. "The Basics of 'Medicare for All.'" The New York Times, 25 Feb. 2020, [www.nytimes.com/2020/02/25/upshot/medicare-for-all-basics-bernie-sanders.html](http://www.nytimes.com/2020/02/25/upshot/medicare-for-all-basics-bernie-sanders.html).

Would it be a big change? Yes. When you think about Medicare for all, it is more helpful to focus on the "all" part than the "Medicare" part. Mr. Sanders's proposal would set up a brand-new government health insurance system, with many more benefits than Medicare. **Everyone in the United States would get health insurance from this new, generous government system. Existing private health insurance plans would be eliminated. So would insurance premiums, deductibles and co-payments.** Medicare for all insurance would cover many services that most health plans omit now, including dental care, eyeglasses, hearing aids and home-based long-term care for people with disabilities.

**Impact:** Giving all Americans health care would save 68,000 lives per year

Galvani, Alison P. "Improving the Prognosis of Health Care in the USA." *The Lancet*, vol. 395, no. 10223, Feb. 2020, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)33019-3/fulltext#%20](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)33019-3/fulltext#%20)

The entire system could be funded with less financial outlay than is incurred by employers and households paying for health-care premiums combined with existing government allocations. This shift to single-payer health care would provide the greatest relief to lower-income households. **Furthermore, we estimate that ensuring health-care access for all Americans would save more than 68 000 lives and 1·73 million life-years every year compared with the status quo.**

**Impact:** Improved access to medicine would decrease non-adherence, which causes 125,000 preventable deaths annually.

Boylan, Lisa. "The Cost of Medication Non-Adherence." NACDS, 20 Apr. 2017, [www.nacds.org/news/the-cost-of-medication-non-adherence/#:~:text=Medication%20non%2Dadherence](http://www.nacds.org/news/the-cost-of-medication-non-adherence/#:~:text=Medication%20non%2Dadherence).

The New York Times reported this week on an “out of control epidemic” in the U.S. that costs more and affects more people in the U.S. than any disease Americans are concerned about right now—and it is 100 percent preventable. The culprit? Medication non-adherence. **A review in the Annals of Internal Medicine estimates that a lack of adherence causes nearly 125,000 deaths, 10 percent of hospitalizations and costs the already strained healthcare system between \$100–\$289 billion a year.** The article points to findings from studies NACDS has often referenced in advocacy efforts to improve medication adherence—including that 20–30 percent of medication prescriptions are never filled and approximately 50 percent of medications for chronic disease are not taken as prescribed. Significantly, the study authors found the strongest evidence yet that improved medication adherence was accompanied by pharmacist-led high blood pressure management. In addition, the study showed that “education with behavioral support; reminders; and pharmacist-led, multicomponent interventions enhanced adherence...”

**Analysis:** This argument can be weighed on probability. While there are many con arguments about the potential negative side effects of M4A, there are very few responses that can be made on the link level that M4A would somehow not actually give more people access to healthcare.

### PRO: Medicare-for-All decreases job lock

**Argument:** Decoupling healthcare and employment will make people more willing to leave their jobs to look for a better one

**Warrant:** Insurance coverage keeps people at their current jobs

Ingraham, Christopher. "Analysis | Medicare-for-All Would Be a Boon to the American Labor Market, Study Finds." Washington Post, 5 Mar. 2020.  
[www.washingtonpost.com,](http://www.washingtonpost.com/business/2020/03/05/medicare-for-all-jobs-labor/)  
[https://www.washingtonpost.com/business/2020/03/05/medicare-for-all-jobs-labor/.](https://www.washingtonpost.com/business/2020/03/05/medicare-for-all-jobs-labor/)

Beyond that, Medicare-for-all would directly address one of the most economically devastating aspects of losing a job today: the loss of health insurance. "Fundamental health reform that, like M4A, guarantees access to insurance regardless of one's current job status is a key part of making [job] transitions easier," Bivens writes. **Under the current system, in which health-care benefits are tied to specific jobs, many millions of workers are discouraged from seeking jobs that better match their skills because they don't want to lose the insurance their current job supplies. One 2015 estimate finds this "job lock" reduces turnover among workers with employer-provided insurance by 15 to 25 percent.** This isn't a good thing, because in an optimal labor market people would be freer to pursue better jobs.

**Warrant:** The difficulty of providing insurance prevents small business formation

Ingraham, Christopher. "Analysis | Medicare-for-All Would Be a Boon to the American Labor Market, Study Finds." Washington Post, 5 Mar. 2020.  
[www.washingtonpost.com,](http://www.washingtonpost.com/business/2020/03/05/medicare-for-all-jobs-labor/)

[https://www.washingtonpost.com/business/2020/03/05/medicare-for-all-jobs-labor/.](https://www.washingtonpost.com/business/2020/03/05/medicare-for-all-jobs-labor/)

Then there's the issue of small business formation. The United States has the lowest rate of self-employment — roughly 6 percent — among the world's wealthy democracies. In Canada, that number is 8 percent, while many European countries exceed 10 percent. Similarly, the share of U.S. workers employed by a company with fewer than 50 employees is the lowest of the nearly three dozen Organization for Economic Cooperation and Development countries. Again, a big reason for this is the cost and difficulty of obtaining health insurance for people who aren't employed by a large- or medium-size company. "Because health care is nearly universally provided in other rich countries, workers choosing to start their own businesses in those countries do not face a cost confronting would-be entrepreneurs in the U.S.," Bivens writes. On top of that, U.S. health-care costs are so prohibitive for small businesses that those with fewer than 50 employees are exempt from the federal requirement to provide insurance. So while Medicare-for-all would undoubtedly be a challenge to implement, Bivens underscores that it could bring considerable economic opportunities as well.

**Warrant:** Changing insurance policies could allow employees to keep their insurance

Tanner, Michael. "5 Ways to Solve Health Care." Cato Institute, 9 June 2012,  
<https://www.cato.org/publications/commentary/5-ways-solve-health-care>.

As a result of this shift in tax policy, employers would gradually substitute higher wages for insurance, allowing the worker to shop for the insurance policy that most closely matched his or her needs. That insurance would be more likely to be true insurance, protecting the worker against catastrophic risk, while requiring out-of-pocket payment for routine, low-dollar costs, and it would belong to the worker, not the employer, meaning that workers would be able to take it from job to job and

**would not lose it if they became unemployed.** And, since workers could maintain continuous coverage, the issue of preexisting conditions becomes far less of a problem. Putting workers in charge of their own insurance would significantly reduce the cost of insurance. A study by Stephen Parente of the University of Minnesota suggests that making this change would increase the number of people with health insurance by 21–27 million, nearly as many as projected under ObamaCare.

**Impact:** Medicare for all would increase job quality and quantity

DERYSH, IGOR. "Medicare for All Would Lead to Job Boom, Experts Say." Salon, 14 Mar. 2020, <https://www.salon.com/2020/03/14/medicare-for-all-would-lead-to-job-boom-experts-say/>.

**In contrast, there are 6.4 million unfilled jobs in the US economy right now, according to the Bureau of Labor Statistics. Medicare for All would inherently "increase job quality substantially by making all jobs 'good' jobs in terms of insurance coverage and by increasing the potential for higher wages" by decoupling insurance from employment, Bivens writes.** And many of these workers, and those in billing and administration that could also be threatened with layoffs, would be able to find new jobs in an expanding health care sector, the report argues. Past research published by the Political Economy Research Institute estimates that "expanded access to health care could increase demand for health services by up to \$300 billion annually," Bivens wrote. "Given the current level of health spending and employment, this would translate into increased demand for 2.3 million full-time-equivalent workers in providing healthcare."

**Analysis:** This is a good argument because it can outweigh in the long term. Even if the con can prove that the economy is hurt right now, this is not true of the long run. With more flexibility to leave their jobs, more people will be able achieve upward economic mobility.

### PRO: Medicare For All saves people from bankruptcy

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**Argument:** Medicare for all prevents uninsured people from being forced into bankruptcy due to medical bills.

**Context:** More than one fourth of Americans are underinsured

Patrick, Malissa. Study Finds More than 1/4 of Adults in the U.S. Are under-Insured Because of High Deductibles | NKyTribune. 23 Oct. 2017,  
<https://www.nkytribune.com/2017/10/study-finds-more-than-14-of-adults-in-the-u-s-are-under-insured-because-of-high-deductibles/>.

**More than one-fourth of U.S. adults with health insurance were under-insured in 2016, including 44 percent who got their coverage from the federal marketplace and almost 25 percent who got their coverage from employer plans, according to a recent study.** Using data from The Commonwealth Fund's 2016 Biennial Health Insurance Survey, a report from the fund found that of all working-age adults who had health insurance for a full year in 2016, **28 percent, or about 41 million people, were underinsured.** This was up from 23 percent in 2014 and 12 percent in 2003, the first year the survey asked questions on the topic. **People in the study were considered underinsured if they had health insurance plans with high deductibles and high out-of-pocket expenses relative to their income.**

**Warrant:** A large percentage of Americans are afraid of bankruptcy from medical bills

Stevens, Lance. "Americans Fear Personal and National Healthcare Cost Crisis." Gallup.Com, 2 Apr. 2019,

<https://news.gallup.com/opinion/gallup/248108/americans-fear-personal-national-healthcare-cost-crisis.aspx>.

The study revealed more than 3 in 4 Americans believe they pay 'too much' for healthcare relative to the quality of care they receive. **Furthermore, 45% of the American public is concerned that a major health event could result in personal bankruptcy.** Surprisingly, this concern remains relevant for Americans in the top 10% of earners. **Of Americans who reported earning more than \$180,000 a year, 1 in 3 were "concerned" or "extremely concerned" that a major health event could result in personal bankruptcy.** But the anxiety induced by healthcare costs goes beyond worry over personal finances. Three quarters of Americans (77%) say they are concerned healthcare costs will result in significant and lasting damage to the U.S. economy.

**Warrant:** Serious change to the system is necessary to save people from bankruptcy

Leonhardt, Megan. Would Medicare for All Plans Actually Save You Money on Health Care? 12 Sept. 2019, <https://www.cnbc.com/2019/09/12/will-medicare-for-all-plans-save-americans-money-on-healthcare.html>.

"Medicare for All would require a major change in the way in which health coverage and care is organized and financed in the U.S.," Tricia Neuman, director of KFF's program on Medicare policy, said during a testimony in front of Congress earlier this year. **But major changes may be exactly what's needed to solve the financial burdens facing many Americans who need medical help, according to candidates such as Senators Bernie Sanders (I-Vt.) and Elizabeth Warren (D-Mass.). Both candidates have indicated they supported ending private insurance, with Warren taking aim at insurance companies' business model during the June debate.** The goal of these companies, she says, is to "bring in as many dollars as they can in premiums and pay out as few dollars as possible for your health care," Warren said. "That leaves families with rising premiums, rising co-

pays, and fighting with insurance companies to try to get the health care that their doctors say that they and their children need."

**Impact:** Two thirds of all bankruptcies are related to medical bills

Leonhardt, Megan. Would Medicare for All Plans Actually Save You Money on Health Care? 12 Sept. 2019, <https://www.cnbc.com/2019/09/12/will-medicare-for-all-plans-save-americans-money-on-healthcare.html>.

And those health-care costs can skyrocket when faced with unexpected or persistent expenses. One in six Americans say they had a surprise medical bill, despite having insurance. The average out-of-pocket cost for an unexpected out-of-network emergency room visit in 2016 was about \$628, while those who were admitted paid an average of \$2,040, according to a 2019 study published in JAMA Internal Medicine. **Research from the New York Times, the Commonwealth Fund and the Harvard T.H. Chan School of Public Health found that nearly a third of those who are routinely sick, even though they had medical insurance, still spent all of their savings. In fact, a study released earlier this year found that two-thirds of bankruptcies in the U.S. are tied to medical debts.** On the surface, the average person currently spends less on out-of-pocket costs when using a private, employer-based insurance than Medicare. But there are a lot of factors not captured in the data, including the fact that Medicare currently serves a predominantly elderly population who typically require more health care and therefore spend more.

**Analysis:** This is a good argument because it can outweigh on strength of link. Even if healthcare quality goes down, people will not need to go to the doctor as much if they are healthier. Having more money allows people to afford nutritious food that keeps up health so that doctors visits become increasingly rare.

### PRO: Medicare For All creates jobs

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**Argument:** Medicare for all will free up money for employers who will no longer have to pay for their employees' health insurance, which will allow them to expand and hire more workers.

**Context:** Employers spend more and more on health insurance benefits

Newman, Rick. "Medicare for All" Could Save Businesses Trillions of Dollars. 6 Aug. 2018, <https://finance.yahoo.com/news/medicare-save-businesses-trillions-dollars-190500400.html>.

Sen. Bernie Sanders' "Medicare for all" plan has gained traction among some mainstream Democrats, including possible presidential contenders such as Senators Cory Booker and Kamala Harris. And buried in the details of some recent analyses is an intriguing notion: American businesses, now the biggest source of health care coverage in the United States, could completely exit the business of providing health care, if national or even statewide single-payer coverage ever takes root. **That could make American firms more competitive globally and leave a lot more money for employee raises and other benefits. The United States is the only advanced economy where employers are the primary source of health care. Famed investor Warren Buffett has called employer-provided health care the "tapeworm of American competitiveness," because it forces American firms to bear a costly bureaucratic burden their foreign competitors don't have to deal with. As health care costs have soared during the last three decades, employers have set aside more and more for benefits, leaving less for raises.** In theory, there are reasons for the business community to support a single-payer system that would relieve them of an onerous obligation completely unrelated to most companies' business models.

**Warrant:** Medicare for all will free up money for employers

Sanders, Bernie. "The Medicare for All Act of 2019." Sen. Bernie Sanders, 2020,  
<https://www.sanders.senate.gov/download/medicare-for-all-2019-summary>.

**A Medicare-for-all system not only benefits individuals and families, it would benefit the business community. Small- and medium-sized businesses would be free to focus on their core business goals instead of wasting precious energy and resources navigating an incredibly complex system to provide health insurance to their employees.** Bottom line: If every major country on earth can guarantee health care to all and achieve better health outcomes, while spending substantially less per capita than we do, it is absurd for anyone to suggest that the United States of America cannot do the same.

**Quantification:** This could save businesses trillions of dollars

Newman, Rick. "Medicare for All" Could Save Businesses Trillions of Dollars. 6 Aug. 2018,  
<https://finance.yahoo.com/news/medicare-save-businesses-trillions-dollars-190500400.html>.

Still, the tradeoffs for businesses could be attractive. Federal tax revenue from individuals and businesses will total about \$3 trillion this year. So taxes would need to more than double to cover a giant new health care plan. Doubling everybody's taxes sounds like a death wish for politicians. But it might not be as crazy as it sounds.

**Businesses now pay about \$1.2 trillion in health care costs per year, which provides coverage for about 49% of the American population. Federal income tax payments for businesses will only total around \$243 billion this year. So corporate America pays 5 times as much for health care benefits for employees as it pays in federal taxes.** If you tripled or even quadrupled corporate income taxes, while eliminating all their spending on health care, it would still amount to a net savings for businesses.

**Impact:** Medicare for all will expand the job market by millions of jobs

Press Release. "Medicare for All Would Boost Wages, Expand Workers' Options, and Likely Create Jobs." Economic Policy Institute, 5 Mar. 2020,  
<https://www.epi.org/press/medicare-for-all-would-boost-wages-expand-workers-options-and-likely-create-jobs/>.

**A new report from EPI research director Josh Bivens finds that Medicare for All would bolster the labor market, strengthen economic security for millions of U.S. households, and would likely boost the number of jobs in the U.S. labor market.**

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

**Analysis:** This is a good argument because it can be argued that poor economic status can be the root of bad health. If people cannot afford basic healthy food and preventative care, they will be more likely to get sick. So even if the con can prove that overall the healthcare system suffers, this does not matter as much as lifting people out of poverty.

### PRO: Medicare For All increases disposable income

**Argument:** Medicare for all will free up money otherwise paid in insurance costs, thus giving people more disposable income to work with.

**Context:** The US spends more on healthcare than any other developed country

Papanicolas, Irene, et al. "Health Care Spending in the United States and Other High-Income Countries." JAMA, vol. 319, no. 10, American Medical Association, Mar. 2018, pp. 1024–39. [jamanetwork.com/doi/10.1001/jama.2018.1150](https://jamanetwork.com/doi/10.1001/jama.2018.1150).

**In 2016, the United States spent nearly twice as much as 10 high-income countries on medical care and performed less well on many population health outcomes. Contrary to some explanations for high spending, social spending and health care utilization in the United States did not differ substantially from other high-income nations.** Prices of labor and goods, including pharmaceuticals and devices, and administrative costs appeared to be the main drivers of the differences in spending. Meaning Efforts targeting utilization alone are unlikely to reduce the growth in health care spending in the United States; a more concerted effort to reduce prices and administrative costs is likely needed. Importance **Health care spending in the United States is a major concern and is higher than in other high-income countries, but there is little evidence that efforts to reform US health care delivery have had a meaningful influence on controlling health care spending and costs.**

**Warrant:** A Typical family insurance plan costs over 28,000 dollars

Weltz, Scott. 2020 Milliman Medical Index. Milliman Institute 21 May 2020,  
<https://www.milliman.com/en/insight/2020-Milliman-Medical-Index>.

In 2020, the cost of healthcare for a hypothetical American family of four covered by an average employer-sponsored preferred provider organization (PPO) plan is \$28,653, according to the Milliman Medical Index (MMI). Cost increases have continued to be mostly “moderate.” For an average person, healthcare cost grew by approximately 4.1% from 2019 to 2020. That rate is roughly consistent with rates over the past five years, and is definitely moderate relative to rates from 10 years ago, which were twice as high. Nevertheless, the cost increases continue to outpace gross domestic product (GDP) growth, which is roughly half the rate of healthcare cost growth.<sup>3</sup> Recently, hospital costs have taken center stage, growing more quickly than costs for other services, climbing approximately 15% over the past three years, versus 10% for all other services combined.

**Warrant:** The Medicare for all plan will save people thousands of dollars

Sanders, Bernie. “The Medicare for All Act of 2019.” Sen. Bernie Sanders, 2020,  
<https://www.sanders.senate.gov/download/medicare-for-all-2019-summary>.

At a time when health care in 2018 for a typical family of four with an employer-sponsored PPO plan now costs more than \$28,000, the reality is that a Medicare-for-all system would save the average family significant sums of money. **A study by RAND found that moving to a Medicare-for-all system in New York would save a family with an income of \$185,000 or less about \$3,000 a year, on average. Citizens for Tax Justice found that middle class families would see their after-tax income go up by about \$3,240 a year under Medicare for All.** Another study found that middle class families would spend about 14 percent less of their income on health care than they do today. Even the projections from the Mercatus Center suggest that the average American could save about \$6,000 under Medicare for all over a 10-year period.

**Impact:** Every dollar counts as most Americans would be put in debt over a 500 dollar bill

Pichii, Aime. A \$500 Surprise Expense Would Put Most Americans into Debt. 12 Jan.

2017, <https://www.cbsnews.com/news/most-americans-cant-afford-a-500-emergency-expense/>.

While the jobless rate is down and wages are up, most Americans nevertheless remain one misstep away from a financial crisis. **Fifty-seven percent of Americans don't have enough cash to cover a \$500 unexpected expense, according to a new survey from Bankrate, which interviewed 1,003 adults earlier this month. While that may appear dire, it reflects a slight improvement from 2016, when 63 percent of U.S. residents said they wouldn't be able to handle such an expense.** The improvement reflects the stronger U.S. economy, but is still far from ideal, Bankrate.com said. The findings shed light on how many households continue to struggle with their basic finances more than seven years after the official end to the recession. Despite steady job growth during the Obama administration, wages have been slow to recover, with the typical American household still earning 2.4 percent below what they brought home in 1999, when income peaked. At the same time, costs for essentials such as housing and child care have surged faster than the rate of inflation, placing stress on household budgets.

**Analysis:** This is a good argument because it has far reaching impacts on the whole economy, which can allow you to outweigh on scope. More spending in the economy means that businesses will grow everywhere and offer more people jobs. This will impact people all across the economy at all income levels, making it an easy impact to weigh.

### PRO: Medicare For All saves hospitals from closure

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**Argument:** Medicare for all offers grants to hospitals at risk of closure, which saves them from closing.

**Warrant:** Thousands of rural hospitals are at risk of closure

Alexander, Brian. "America's Rural Hospitals Are Dangerously Fragile." *The Atlantic*, 9 Jan. 2018, <https://www.theatlantic.com/business/archive/2018/01/rural-hospitals/549050/>.

Following that, Berger would most likely be integrated into a larger regional system, probably the Columbus-based nonprofit Ohio Health, with which Berger has an ongoing relationship. The hospital and the local leaders campaigned hard for that approval, but not because it was the ideal future they envisioned. They feared that Berger wouldn't survive any other way. **Hospitals have been struggling—especially independent public and/or nonprofit hospitals located in smaller cities and rural towns. Last year, for example, the National Rural Health Association, a nonprofit, estimated that 673 rural facilities (with a variety of ownership structures) were at risk of closure, out of over 2,000.** And with the new tax legislation, and events like the merger of the drugstore chain CVS and the insurer Aetna, the turmoil looks to get worse. In response, stand-alone nonprofit hospitals have been auctioning off their real estate to investors, selling themselves to for-profit chains or private-equity firms, or, like Berger, folding themselves into regional health systems.

**Warrant:** Hundreds of hospitals have already closed

Topchik, Michael. Rural Hospital Vulnerability Study. August 2020, <https://www.ivantageindex.com/rural-hospital-vulnerability-study/>.

**Over the course of the last 10 years, more than 120 rural hospitals have ceased operations further limiting access to care for populations which are older, less healthy and less affluent than urban counterparts. Using a multilevel logistic regression model, The Chartis Center for Rural Health has identified 453 rural facilities which can be considered ‘vulnerable’ to closure based on performance levels.** “Our model provided us with the opportunity to conduct a more nuanced examination of the path toward closure and better understand the breadth of vulnerability across the nation. None of the metrics we track to measure the stability of the rural health safety net are improving, and this research allows us to quantify just how severe the implications could be if the current situation worsens.”

**Warrant:** The bill will pay hospitals in lump sums

Luthi, SUSANNAH. “New Medicare for All Draft Bill Sets a Global Budget Model.”  
Modern Healthcare, 7 Feb. 2019,  
<https://www.modernhealthcare.com/article/20190207/NEWS/190209939/new-medicare-for-all-draft-bill-sets-a-global-budget-model>.

**A draft version of House Democrats' upcoming Medicare for All bill proposes a national system that would pre-pay hospitals with lump sums while keeping a fee-for-service model for individual physicians.** The 127-page draft, obtained by Modern Healthcare and dated Jan. 14, in many ways tracks with the system laid out in the 2017 bill from Sen. Bernie Sanders (I-Vt.) who brought Medicare for All to the forefront of progressive Democratic policy. But where the Sanders bill sidestepped the question of how the system would be funded by leaving it to the executive branch, the proposal from Rep. Pramila Jayapal (D-Wash.) lays out specific details of a nationalized global budget system. First, the bill would set up regional directors tasked with overseeing all hospitals, healthcare facilities and physicians in specific geographic areas. The HHS

secretary would appoint those overseers. **The regional directors would then negotiate each year with the facilities to set a lump sum, or global budget, that the government would pay out in advance to all institutional providers.** These include hospitals, nursing homes, federally qualified health centers, home health agencies and independent dialysis facilities.

**Impact:** Hospital closure increases mortality rates

McCausland, Phil. "Rural Hospital Closings Lead to More Deaths, Study Finds." NBC News, 6 Sept. 2019, <https://www.nbcnews.com/news/us-news/rural-hospital-closings-cause-mortality-rates-rise-study-finds-n1048046>.

**More than 100 rural hospitals have closed in the United States since 2010 and another 430 are at risk of closing, which a new study says could have life-or-death implications for rural communities.** University of Washington researchers examined 92 rural hospital closings in California from 1995 to 2011. They found that while the closings of urban hospitals had no impact on their surrounding communities, rural closings caused their populations — which have limited access to health care and other services — to see mortality rates rise 5.9 percent. That could have real implications for communities across the United States given that 113 hospitals have already closed since 2010 and more face financial difficulties, according to data compiled by the University of North Carolina.

**Analysis:** This is a good argument because it preempts what a lot of con teams are likely to argue. One of the most common weighing strategies on con is to say that even if Medicare for all increases access to medical insurance, this won't matter if there are no hospitals to go to. This preempts this and states that voting pro actually increases the availability of hospital care.

### PRO: Medicare For All Increases Options for Long Term Care

**Argument:** Many types of care, such as home and community based solutions, are not covered under existing plans. Medicare for all would unlock cheaper, effective healthcare options

**Warrant:** Long term care is currently very expensive

Eagan Kemp. "THE CASE FOR MEDICARE-FOR-ALL". Public Citizen. February 2019.

[https://www.citizen.org/wp-content/uploads/migration/the\\_case\\_for\\_medicare-for-all\\_-\\_february.pdf](https://www.citizen.org/wp-content/uploads/migration/the_case_for_medicare-for-all_-_february.pdf)

"Instituting a Medicare-for-All system would offer an excellent opportunity to improve our approach to providing long-term care. These reforms would improve the quality of life of patients that need long-term care while also bringing down the cost of care, both for consumers and for the country as a whole. **Under our current system, Medicaid is the largest payer of long-term care, accounting for more than half of the approximately \$300 billion spent on long-term care each year."**

**Warrant:** Medicare for all would expand community and home options for long term care of chronic or age related conditions

Eagan Kemp. "THE CASE FOR MEDICARE-FOR-ALL". Public Citizen. February 2019.

[https://www.citizen.org/wp-content/uploads/migration/the\\_case\\_for\\_medicare-for-all\\_-\\_february.pdf](https://www.citizen.org/wp-content/uploads/migration/the_case_for_medicare-for-all_-_february.pdf)

**"The current system discourages providing home and community-based services, despite such services being less expensive to provide than nursing home care. The policies that guide Medicaid long-term care are biased in favor of patients ending up in nursing homes because state Medicaid programs are required to cover institutional**

**services, like nursing homes, but home and community-based services are optional for states to provide.** As such, the availability of home and community-based services varies widely by state. A number of states have expanded access to home and community-based services coverage through requesting waivers of certain federal Medicaid requirements. However, even states with waiver programs often have waiting lists for their programs and face challenges ensuring access to services for all who need them.”

**Warrant:** Without a solution, this could become a crisis issue

Eagan Kemp. “THE CASE FOR MEDICARE-FOR-ALL”. Public Citizen. February 2019.

[https://www.citizen.org/wp-content/uploads/migration/the\\_case\\_for\\_medicare-for-all\\_-\\_february.pdf](https://www.citizen.org/wp-content/uploads/migration/the_case_for_medicare-for-all_-_february.pdf)

**“Around 70 percent of people over 65 will require at least some long-term care in their lifetimes. Given our changing demographics—by 2030 all baby boomers will be 65 or older and by 2035 Americans age 65 and older will outnumber the number of children under 18 for the first time in U.S. history—we must ensure that we are providing access to needed long-term care in the most humane and efficient way possible.** Medicare-for-All would meet both of these goals and begin the crucial transition from the institutional bias of our current long-term care system to a system that serves patients in the setting and community of their choice.”

**Warrant:** Long term care is a major expense

Kimberly Amadeo. “Why Preventive Care Lowers Health Care Costs”. The Balance. June 2020. <https://www.thebalance.com/preventive-care-how-it-lowers-aca-costs-3306074>

“Some disabilities and chronic conditions, such as diabetes, result in a need for care whether one is 47 or 97. Today 80% of at-home care is provided by an unpaid caregiver. Two thirds of the caregivers are women. If someone requires paid care, the costs can be enormous—the national average for a private room in a nursing home is almost \$7,700 per month; for a one-bedroom unit in an assisted living facility, the average is over \$3,600 per month.”

**Warrant:** Affordable long term care would save people from financial disaster

Kimberly Amadeo. “Why Preventive Care Lowers Health Care Costs”. The Balance. June 2020. <https://www.thebalance.com/preventive-care-how-it-lowers-aca-costs-3306074>

**“The good news is that Bernie Sanders’ Medicare for All bill (S. 1804) incorporates both Medicare and Medicaid coverage for long-term care. It covers long-term care and palliative care, such as hospice. When this bill passes, it will be a crucial step in ensuring that no one has to choose between medications and food. Families will not be left impoverished with long-term care having eaten up their savings.** As it says at Bernie Sanders’ Medicare for All site, “Seniors and people with serious or chronic illnesses could afford the medications necessary to keep them healthy without worry of financial ruin.”

**Analysis:** This argument is strong because the light is powerful. It is an undeniable fact that long term care in the United States is bad and getting worse. Weigh this certainty of impact against nebulous harms your opponent might have.

### PRO: Medicare For All Increases Preventative Care

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**Argument:** When healthcare is free, more people will get regular checkups and preventative care. This will make America healthier

**Warrant:** Lack of insurance stops people from getting preventative care

Kao-Ping Chua "The Case for Universal Health Care." AMSA., 2006.

<https://www.amsa.org/wp-content/uploads/2015/03/CaseForUHC.pdf>

"The uninsured are less likely to have a regular source of health care. 40% of the uninsured do not have a regular place to go when they are sick or need medical advice, compared to less than 10% of the insured. As a result, 20% of the uninsured say their usual source of care is the emergency room, compared to just 3% of the insured. **The uninsured are less likely to get needed preventive care. When compared to the insured, uninsured, non-elderly adults are 50% less likely to receive preventive care such as pap smears, mammograms, blood pressure checks, sigmoidoscopies, cholesterol screening, and prostate exams.**"

**Warrant:** The uninsured are far more likely to miss early warnings and delay treatment for diseases

Kao-Ping Chua "The Case for Universal Health Care." AMSA., 2006.

<https://www.amsa.org/wp-content/uploads/2015/03/CaseForUHC.pdf>

**"The uninsured are more likely to be forced to delay medical services, affecting the timeline of diagnosis and thus the prognosis of the disease process.** In one study, the time to diagnosis of late-stage cancer was compared between uninsured and privately insured patients. The **uninsured patients were**

**1.7, 2.6, 1.4, and 1.5 times more likely to be diagnosed late for colorectal cancer, melanoma, breast cancer, and prostate cancer, respectively.”**

**Warrant:** Preventive care catches health issues before they become serious

Kimberly Amadeo. “Why Preventive Care Lowers Health Care Costs”. The Balance. June 2020. <https://www.thebalance.com/preventive-care-how-it-lowers-aca-costs-3306074>

“Preventive care is any medical service that defends against health emergencies. It includes doctor visits, such as annual physicals, well-woman appointments, and dental cleanings. Some medicines are preventive, such as immunizations, contraception, and allergy medications. Screenings, such as tests for skin cancer, high cholesterol, and colonoscopies, are effective preventive measures. **The goal of preventive care is to help people stay healthy. The idea is to nip diseases in the bud before they become catastrophic. That keeps health care costs low. Preventive care also keeps people productive, enabling them to keep earning well into their senior years. Health care problems forced 48% of retired people into an early retirement before they were financially ready.**”

**Warrant:** Preventive care is better for saving money

Kimberly Amadeo. “Why Preventive Care Lowers Health Care Costs”. The Balance. June 2020. <https://www.thebalance.com/preventive-care-how-it-lowers-aca-costs-3306074>

**“Preventive care helps lower health care costs in America by preventing diseases before they require emergency room care. Why is this a problem? Hospital care is very**

expensive, making up one-third of all health care costs in America. In 2010, 21.4% of adults went to the emergency room each year. By 2017, that had decreased to 18.6%.

**One reason is that a lot of adults use the emergency room as their primary care physician. Almost half of them or 46.3% went because they really had no other place to go for health care.<sup>3</sup> The other half went because their doctor sent them.** The uninsured are most likely to use the emergency room as their primary care doc. The cost of emergency room care for the uninsured can be extremely high.<sup>4</sup> When the uninsured can't afford to pay it, the cost gets shifted to your health insurance premiums and to Medicaid."

**Warrant:** Lack of preventive care drove up costs for the Parkland Hospital astronomically

Kimberly Amadeo. "Why Preventive Care Lowers Health Care Costs". The Balance. June 2020. <https://www.thebalance.com/preventive-care-how-it-lowers-aca-costs-3306074>

**"Parkland Hospital is in a low-income section of Dallas, Texas. Almost 85% of its patients are either uninsured or on Medicaid. The hospital spent \$871 million on uncompensated care, over half its budget. It's also 2% of all unpaid hospital care in the United States. One reason is that only two-thirds of Dallas's citizens have health insurance. To cut emergency room costs, Parkland focused on preventive care for its "frequent flyers.""**

**Analysis:** This argument makes the point that by intervening early through preventative care, Medicare for all will save money and lives. The strength of this argument is its intuitive appeal to judges – most people understand that it is better to empower people to be healthy than to treat disease.

### PRO: Medicare For All is Politically Popular

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**Argument:** Democracies should embrace policies which are widely popular. Not doing so is a subversion of the will of the people and tantamount to elitism.

**Warrant:** Medicare for all is very popular

"Two-thirds of voters support providing Medicare to every Americans." PNHP, April 24, 2020. <https://pnhp.org/news/two-thirds-of-voters-support-providing-medicare-to-every-american/>

"Support for Medicare for All has remained consistently strong over the past two years, according to a new Hill-HarrisX poll. **Sixty-nine percent of registered voters in the April 19-20 survey support providing Medicare to every American, just down 1 percentage point from an Oct. 19-20, 2018 poll, and within the poll's margin of error.** Popularity for Medicare for All grew slightly among Democratic voters, with a 2 percentage point increase from 2018."

**Warrant:** Medicare for all is popular among independents and even has decent Republican support

"Two-thirds of voters support providing Medicare to every Americans." PNHP, April 24, 2020. <https://pnhp.org/news/two-thirds-of-voters-support-providing-medicare-to-every-american/>

**"Support among independent voters was steady at 68 percent. However, support among Republican voters declined 6 percentage points over the course of two years, from 52 percent support in 2018 to 46 percent in 2020.** Progressive lawmakers have been pointing to the coronavirus crisis to make a case for the need for Medicare for All

as millions of Americans are kicked off their employee-based health insurance due to the economic fallout of the pandemic. “Crises are moments of opportunity for policy change,” Robert Griffin, Research Director of the Democracy Fund Voter Study Group, told Hill.TV.”

**Warrant:** The COVID crisis has accelerated support for the Sanders Medicare for All plan

“As Coronavirus Surges, ‘Medicare for All’ Support Hits 9-Month High”. Morning Consult. April 1. 2020, <https://morningconsult.com/2020/04/01/medicare-for-all-coronavirus-pandemic/>

**“In the midst of a pandemic that has spurred an economic crisis and put Americans’ health care costs in stark contrast with the rest of the industrialized world, support for “Medicare for All” has risen to its highest point in about nine months, according to new Morning Consult/Politico data. The sweeping health reform package championed by Sen. Bernie Sanders (I-Vt.) that would provide all Americans with health insurance through the government now has support from 55 percent of registered voters, per a March 27-29 survey of 1,997 respondents, taken as the United States became the global epicenter of the coronavirus. Thirty-five percent of voters continue to oppose the proposal, putting net support — the share who support minus those who oppose — at 20 points, a 9-point jump from mid-February..”**

**Warrant:** COVID is making Medicare for All more attractive

“As Coronavirus Surges, ‘Medicare for All’ Support Hits 9-Month High”. Morning Consult. April 1. 2020, <https://morningconsult.com/2020/04/01/medicare-for-all-coronavirus-pandemic/>

"Though Democrats drove the movement in the most recent poll, they didn't do so alone: For the first time since June 2019, a majority of independents are in favor of Medicare for All (52 percent), sparking an 8-point increase in net support among this demographic since February. **As the domestic COVID-19 caseload spirals and economists predict a historic surge in unemployment, millions of Americans are bracing for potentially untenable health care costs and lapses in coverage, reviving questions about the viability of a health system that relies on binding insurance to employment..”**

**Warrant:** Philosophically, Democracies generate legitimacy by abiding to democratic principles such as popular will

"Political Legitimacy". Stanford Encyclopedia of Philosophy. June 2017.

<https://plato.stanford.edu/entries/legitimacy/>

"The contrasting position in contemporary political philosophy is that democratic forms of political organization are necessary for political legitimacy, independently of their instrumental value (Buchanan 2002). What conceptions of democratic legitimacy, as I use the term here, have in common is that they demand that political institutions respect democratic values. Some such proceduralist conceptions of democratic legitimacy are also monistic. What is commonly called pure proceduralism is an example of a monistic view. According to pure proceduralism only procedural features of decision-making are relevant for democratic legitimacy."

**Analysis:** This argument is simple and straightforward. Democracies ought to pass popular policies, their moral legitimacy depends on it. Medicare for all is very popular. Even if there are practical harms, we live in a self determining society which ought to be able to exercise choice over itself.

### PRO: Medicare For All Reduces National Healthcare Expenses

**Argument:** Having the government run healthcare would alleviate some of the massive economic pressure that wasteful healthcare spending in the status quo has on the economy

**Warrant:** The current healthcare system is incredibly expensive

“FACT CHECK: Medicare for All Would Save the U.S. Trillions; Public Option Would Leave Millions Uninsured, Not Garner Savings.” Public Citizen, February 21, 2020.

<https://www.citizen.org/news/fact-check-medicare-for-all-would-save-the-u-s-trillions-public-option-would-leave-millions-uninsured-not-garner-savings/>

“Medicare for All opponents repeatedly claim that Medicare for All is “too expensive” by presenting misleading numbers without the proper context of our unsustainable health care spending. Here are the facts: We can’t afford NOT to implement Medicare for All.

**Our health care spending is estimated to continue rising and will reach nearly \$6 trillion a year by 2027. That means according to the federal government, we will spend around \$42.9 trillion on health care over the next decade if we maintain the status quo.”**

**Warrant:** Medicare for all would allow the government to negotiate drug costs down, saving money

“FACT CHECK: Medicare for All Would Save the U.S. Trillions; Public Option Would Leave Millions Uninsured, Not Garner Savings.” Public Citizen, February 21, 2020.

<https://www.citizen.org/news/fact-check-medicare-for-all-would-save-the-u-s-trillions-public-option-would-leave-millions-uninsured-not-garner-savings/>

**"A recent study by Yale epidemiologists found that Medicare for All would save around 68,000 lives a year while reducing U.S. health care spending by around 13%, or \$450 billion a year. Medicare for All spending would be approximately \$37.8 trillion between 2017 and 2026, according to a study by the Political Economy Research Institute (PERI) at the University of Massachusetts Amherst. That amounts to about \$5 trillion in savings over that time. These savings would come from reducing administrative costs and allowing the government to negotiate prescription drug prices. Other studies by think tanks and government agencies have analyzed single-payer proposals at the state and federal levels. Most found Medicare for All would reduce our total health care spending. Even a study by the Koch-funded Mercatus Center found that Medicare for All would save around \$2 trillion over a 10-year period.."**

**Warrant:** Costs would be lower on the individual level

**"FACT CHECK: Medicare for All Would Save the U.S. Trillions; Public Option Would Leave Millions Uninsured, Not Garner Savings."** Public Citizen, February 21, 2020.  
<https://www.citizen.org/news/fact-check-medicare-for-all-would-save-the-u-s-trillions-public-option-would-leave-millions-uninsured-not-garner-savings/>

**"With Medicare for All, most families would spend less on health care than they do now on premiums, copays and deductibles. Some additional taxes would be needed to pay for Medicare for All, but most Americans would spend less on health care than they do right now. Overall, working families that make around \$60,000 a year would pay up to 14% less on their annual health care costs. As the debate grows on how to overhaul the health care system, Medicare for All is being pitted against a public option. It's important to highlight the differences between the policies."**

**Quantification:** There are many measures of non-administrative cost savings

“Medicare for All Would Save \$450 Billion and 68,000 Lives: Study”. Yahoo News. February 18. 2020, <https://finance.yahoo.com/news/medicare-save-450-billion-68-232211541.html>

“The researchers found that the proposed system would reduce total health-care expenditures by about 13% based on 2017 spending levels. Savings would come from a variety of sources. Here are some of the major savings the researchers found with Medicare for All, based on the 2017 total health care expenditure of **nearly \$3.5 trillion:** **Reducing pharmaceutical prices via negotiation: \$219 billion, Improving fraud detection: \$191 billion, Reducing reimbursement rates for hospitals, physician, and clinical services: \$188 billion, Reducing overhead: \$102 billion, Eliminating uncompensated hospitalization fees: \$78 billion in savings.**”

**Impact:** Savings are crucial for economic stability

Jonas Elmerraji. “How Savings Can Save the Economy”. Investopedia. June 19, 2020. <https://www.investopedia.com/financial-edge/0310/savings-are-a-blessing-in-a-slow-recovery.aspx>

**To be sure, higher savings reserves mean that consumers have cushions that can help absorb overwhelming expenses without digging the hole deeper. But just as importantly, having a higher portion of income allocated to savings means that living expenses are lower—and consumers can adjust their budgets to spend a larger chunk of income on increased mortgage payments or better compensate if they lose their jobs. That ability to cope with financial hardship ultimately means that the economy recovers much faster.** After all, when the bills are being paid, the banks, utilities, and grocery stores can keep their doors open—and their workers employed.

**Analysis:** This argument is strong because it acts as a turn on common neg contentions. By showing that Medicare actually saves the country money you can win whatever impact a con team who is advocating that “Medicare will cost the country too much money” has.

### PRO: Medicare for All is the best option

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**Argument:** Alternatives do not go far enough

**Warrant:** A public option allows healthcare corporations to continue to exploit people

Eagen Kemp. "Why Medicare for All, Not a Public Option, Is the Best Solution." The Public Citizen, June 2019. <https://www.citizen.org/article/why-medicare-for-all-not-a-public-option-is-the-best-solution/>

Too many lesser reforms, including public options or buy-ins, would mean that millions would remain uninsured or underinsured and subject to unnecessary out-of-pocket costs, including copays and deductibles. **Public option proposals, including Medicare for America, would leave more than 100 million Americans at the whim of private for-profit insurance corporations, meaning they would continue to face rising out-of-pocket costs and premiums, as well as narrowing networks and the constant fear of disruption when their employer changes plans or they lose or change jobs.** Small businesses would also continue to struggle with whether they could afford to provide insurance to their employees.

**Warrant:** Abolishing private insurance is the only way to eliminate waste

Eagen Kemp. "Why Medicare for All, Not a Public Option, Is the Best Solution." The Public Citizen, June 2019. <https://www.citizen.org/article/why-medicare-for-all-not-a-public-option-is-the-best-solution/>

**Unlike a public option or a Medicare buy-in, Medicare for All would eliminate the need for the wasteful and unnecessary insurance companies that are focused on profiting from illness instead of keeping enrollees healthy.** Hundreds of insurance

companies and plans spend time and resources on denying coverage for needed care. Patients, providers and hospitals fight to get care – even crucial cancer treatments – covered. **This wasteful system is a key reason administrative costs in the U.S. are more than double the average in other wealthy countries, with between a quarter and a third of our health care dollars spent on administrative functions.** Under Medicare for All, doctors would provide the care a patient needs and then send the bill to Medicare. **There would be no more patients or doctors haggling with insurers about what's covered and what isn't. Given that Medicare already has a track record for keeping administrative costs down – even as private insurance costs rise – Medicare for All could save more than \$500 billion a year.**

**Warrant:** Medicare for all is popular, other plans are less desirable

**Quantification:** Medicare for all polls very well among Americans

Gabriella Shult. "Two-thirds of voters support providing Medicare to every American."

PNHP, April 2020. <https://pnhp.org/news/two-thirds-of-voters-support-providing-medicare-to-every-american/>

**Support for Medicare for All has remained consistently strong over the past two years, according to a new Hill-HarrisX poll. Sixty-nine percent of registered voters in the April 19-20 survey support providing Medicare to every American,** just down 1 percentage point from an Oct. 19-20, 2018 poll, and within the poll's margin of error. Popularity for Medicare for All grew slightly among Democratic voters, with a 2 percentage point increase from 2018. Support among independent voters was steady at 68 percent. However, support among Republican voters declined 6 percentage points over the course of two years, from 52 percent support in 2018 to 46 percent in 2020.

**Warrant:** Momentum for Medicare for all has grown

Gabriella Shult. "Two-thirds of voters support providing Medicare to every American."

PNHP, April 2020. <https://pnhp.org/news/two-thirds-of-voters-support-providing-medicare-to-every-american/>

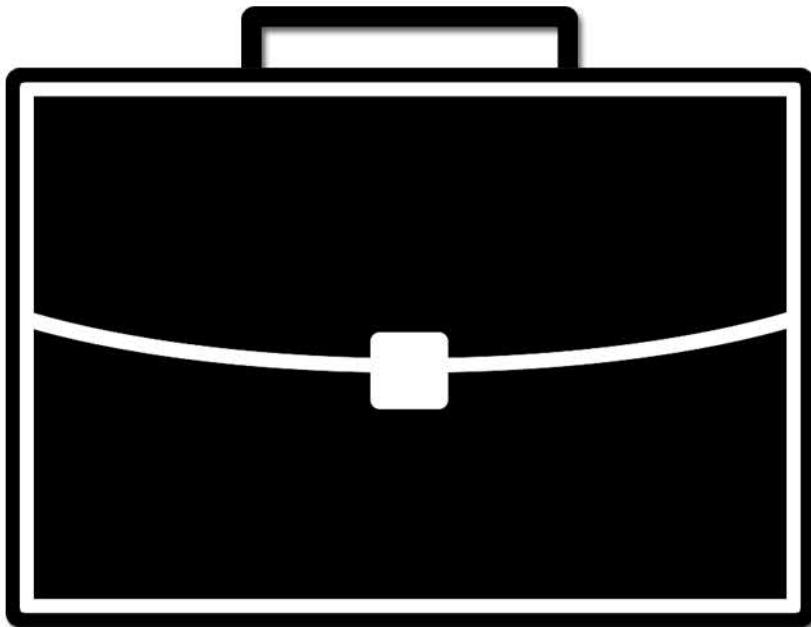
**Progressive lawmakers have been pointing to the coronavirus crisis to make a case for the need for Medicare for All as millions of Americans are kicked off their employee-based health insurance due to the economic fallout of the pandemic. "Crises are moments of opportunity for policy change,"** Robert Griffin, Research Director of the Democracy Fund Voter Study Group, told Hill.TV. "But it's not a sure thing, it's not going to happen automatically. It does require leadership at the end of the day," he added. President and CEO of the Roosevelt Institute, Felicia Wong, believes support for Medicare for All will only grow amid the coronavirus crisis. **"These progressive policies have been popular for a long time. I think COVID-19 will make them more popular as it becomes clear just how fragile our American political economy really is,"** Wong told Hill.TV.

**Analysis:** In a debate about healthcare policy, both teams are likely to address the alternatives that have been proposed. Realistically, the key here as a pro team would be proving that the best case scenario would be Medicare for All, given that the con team will presumably suggest that another plan would work better.

# Champion Briefs

## Sept/Oct 2020

### Public Forum Brief



### Pro Responses to Con Arguments

### A/2: Medicare for All is Unconstitutional under the Freedom of Religion Acts

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**Response:** The Entire Medicare for All Act won't be undone just for one element.

**Delink:** Despite the religious exemptions, the ACA is still in existence.

Norris, Louise. "Understanding Health Insurance Changes for 2020".

Verywellhealth.com. 1 Mar 2020. <https://www.verywellhealth.com/health-insurance-changes-facts-before-enrollment-4151694>

**Other than the individual mandate penalty repeal (and the delay of a few of the ACA's taxes, including the Cadillac Tax), the ACA is still fully in effect, including the premium subsidies, the cost-sharing reductions (aka, cost-sharing subsidies), Medicaid expansion, the employer mandate, protections for people with pre-existing conditions, essential health benefits, medical loss ratio rules, etc.**

**Response:** Taxpayers already pay for things they don't agree with all the time.

**Non-unique:** Many refuse or are morally opposed to vaccinations for religious reasons.

Pelčić, Gordana et al. "Religious exception for vaccination or religious excuses for avoiding vaccination." *Croatian medical journal* vol. 57,5 (2016): 516-521.  
doi:10.3325/cmj.2016.57.516. Oct 2016.  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5141457/>

Vaccination refusal among the parents of pediatric population is emerging globally, regardless of religious or political background or geographical location. In many countries legal systems advise how to react to vaccination refusal (44). For example, in

Croatia vaccination is mandatory, the law is clear, but the practice of vaccination and the court judgments are not standardized. The legislators are unlikely to enact legal limitations of religious or philosophical exemption

**Non-unique:** Individuals opposed to vaccinations and contraceptives still pay taxes which pays for Medicare, Medicaid and CHIP

### **"Policy Basics: Where Do Our Federal Tax Dollars Go?" Center on Budget and**

**Policy Priorities.** 9 April 2020. <https://www.cbpp.org/research/federal-budget/policy-basics-where-do-our-federal-tax-dollars-go>

**The federal government collects taxes to finance various public services. As policymakers and citizens weigh key decisions about revenues and expenditures, it is instructive to examine what the government does with the money it collects.**

**Medicare, Medicaid, CHIP, and marketplace subsidies:** Four health insurance programs — Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and Affordable Care Act (ACA) marketplace subsidies — together accounted for 25 percent of the budget in 2019, or \$1.1 trillion. Nearly three-fifths of this amount, or **\$651 billion, went to Medicare, which provides health coverage to around 61 million people who are over age 65 or have disabilities. The rest of this category funds Medicaid, CHIP, and ACA subsidy and marketplace costs. In a typical month, Medicaid and CHIP provide health care or long-term care to about 82 million low-income children, parents, elderly people, and people with disabilities.** (Both Medicaid and CHIP require matching payments from the states.) In 2019, 9.6 million of the 11.4 million people enrolled in health insurance through the ACA marketplace received subsidies that lower premiums and out-of-pocket costs, at an estimated cost of about \$56 billion.

**Warrant:** Medicare, CHIP and Medicaid provide immunizations and other contraceptive services.

“Children’s Health Insurance Program”. Utah Department of Health/Medicaid. 2020.

<https://medicaid.utah.gov/childrens-health-insurance-program/#:~:text=The%20Children's%20Health%20Insurance%20Program,health%20services%20and%20dental%20care>.

**The Children’s Health Insurance Program (CHIP) is a state health insurance plan for children who do not have other insurance. It provides well-child exams, immunizations, doctor visits, hospital, emergency care, prescriptions, hearing and eye exams, mental health services and dental care. Preventative services (well-child visits, immunizations, and dental cleanings) do not require a co-pay.**

**Warrant:** Taxpayers opposed to taking life pay taxes for programs that could take lives.

“Breaking Down the US Federal Budget” Itsuptous.org. 3 June 2020.

<https://www.itsuptous.org/blog/breaking-down-us-federal-budget-charts-and-graphs>

**More than half of the \$1.438 trillion discretionary spending budget is for defense-related departments, such as military spending and Veteran's Affairs. This also includes spending for the Department of Defense and Homeland Security. According to The Balance, \$633 billion of that budget was given to the Department of Defense (DoD).**

**Analysis:** Taxpayer funds continually pay for contraceptives and other programs that individuals or businesses may morally or religiously oppose so paying taxes for Medicare for All coverage would not be any different than the status quo. And even if it were to be found an issue, the entirety of the Medicare for All Bill would not be struck down for one aspect that could be modified to allow for the religious oppositions.

### A/2: Medicare for All does not solve for undocumented Immigrants

**Response:** non unique/delink: Undocumented immigrants will receive care with or without m4a-

**Warrant:** Hospitals won't refuse service and we are already covering undocumented workers through taxes in the status quo.

Anderson, Ron J. "Why we should care for the Undocumented". *Virtual Mentor*. 2008;10(4):245-248. doi: 10.1001/virtualmentor.2008.10.4.oped1-0804.  
<https://journalofethics.ama-assn.org/article/why-we-should-care-undocumented/2008-04>

**"The spirit of these national legislative mandates is that medical care, especially emergency care, should not be denied on the basis of one's social status, ethnicity, or place of origin.**

This, in fact, is the position of the hospital system that I administer. **Care must be based upon a patient's medical need and not upon medically unrelated and irrelevant factors such as race, creed, color, or nationality. A hospital is not the place to negotiate or enforce immigration policies.** I believe that we *do* need to identify those who are working in the U.S. without the proper paperwork and make health care coverage part of the social contract between them and their employers, but this should not be the responsibility of a hospital or physician.

Contrary to some views, undocumented immigrants are not the cause of crowding in our emergency department. Today, most emergency rooms are crowded with patients seeking treatment because they do not have access to an ongoing source of primary care (i.e., they have no "medical home"). Texas has the highest rate of people without medical insurance in the nation, the majority of whom seek care in our emergency

department for urgent, but not necessarily emergent problems. Also, because many counties adjacent to ours do not have public, tax-payer-supported health systems, many out-of-county residents who are U.S. citizens come to us for care. Thus, it is unfair and inaccurate to place the blame of overcrowding in our health system on the backs of undocumented workers.

Moreover, despite claims to the contrary, **undocumented workers do pay taxes. They pay sales taxes on purchases, ad valorem taxes through rent or home ownership, and many pay social security, Medicare, and worker's compensation via payroll deductions.** In my home state of Texas, there is no personal income tax; thus, there is no dodging of state income tax by undocumented workers because the bulk of state revenues are raised through sales and ad valorem taxes.

**Local governments also receive federal level assistance to provide extra funding for services that many undocumented workers and their families use. According to the Institute of Medicine, the U.S. reaped a \$50 billion surplus from taxes paid by undocumented immigrants to all levels of government in 1997 [2]. The government spends these dollars in a variety of ways, but some of it assists schools, hospitals and health systems, and other local human services, all of which are commonly used by undocumented immigrants.**

**In 2007 Texas received \$43 million in federal funds through the Medicaid Section 1011 program for the first 48 hours of emergency care provided for undocumented residents, of which my health system received \$3 million. In addition, Medicaid Type 30, which is funding for ineligible aliens (both legal and illegal) with emergency conditions, contributed roughly \$36 million. We also receive federal dollars in the form of Disproportionate Share and Upper Payment Limit Medicaid adjustments. Taken together, these federal programs provide funding to support the care of undocumented immigrant patients and lessen the burden on the local tax payer. Although my institution is supported by local taxes, approximately 70 percent of the funding we receive for patient care services comes from traditional payer sources such**

as Medicare, Medicaid, and commercial insurance, and the other 30 percent comes from ad valorem taxes.

**Warrant:** Health care services are already providing services regardless of immigration status and that will not change under m4a.

Hoffman, Jan. "*What Would Giving Health Care to Undocumented Immigrants Mean?*". *New York Times*. 3 July 2019.

<https://www.nytimes.com/2019/07/03/health/undocumented-immigrants-health-care.html>

Many illegal immigrants receive primary care and prescription drugs for a sliding-scale fee at 1,400 federally funded health care centers spread across 11,000 communities. Those centers are required to treat anyone, regardless of ability to pay, and administrators do not ask patients about their citizenship status. The centers serve some 27 million people, but do not have estimates on how many are undocumented. Of course, when undocumented immigrants arrive at hospitals for medical emergencies, they will be treated.

**Warrant:** In spite of increased regulations and policies, hospitals and healthcare systems create initiatives for undocumented immigrants outside of insurance companies and will not end with M4A bans on insurance.

Johnson, Steven Ross. "Safety net systems step up care for immigrants barred from ACA coverage". Modernhealthcare.com. 15 Oct 2016.

<https://www.modernhealthcare.com/article/20161015/MAGAZINE/310159967/safety-net-systems-step-up-care-for-immigrants-barred-from-aca-coverage>

**"The leaders of public health systems see the services as part of their long-standing mission to deliver care to patients regardless of their ability to pay.**

**"We think it's the right thing to do," said Dr. Jay Shannon, CEO of the Cook County Health & Hospitals System in Chicago. The system provides between \$400 million and \$500 million a year in uncompensated care to the county's uninsured, which includes an estimated 200,000 undocumented residents. In September, county officials approved a program to allow uninsured residents who do not qualify for Medicaid and earn up to 200% of the federal poverty level to get access to primary-care services.**

The program is slated to launch by next year with initial costs expected to be about \$2 million.

**"These individuals are residents of our county," Shannon said. "They pay taxes in our county, and because they are part of the population, they contribute in a meaningful way to the health status or lack of health status in our county."**

**Solvency:** Current Safety nets and programs are not enough and m4a is needed to solve.

Wallace, Steven, et all. "UNDOCUMENTED and UNINSURED Barriers to Affordable Care for Immigrant Populations." UCLA Center for Health Policy Research. August 2013.

[https://www.commonwealthfund.org/sites/default/files/documents/\\_\\_media\\_files\\_publications\\_fund\\_report\\_2013\\_aug\\_1699\\_wallace undocumented uninsured\\_barriers\\_immigrants\\_v2.pdf](https://www.commonwealthfund.org/sites/default/files/documents/__media_files_publications_fund_report_2013_aug_1699_wallace undocumented uninsured_barriers_immigrants_v2.pdf)

**Under current laws, Medicaid covers low-income, undocumented individuals for life-saving emergency care, labor and delivery, and, in some states, dialysis for end-stage renal disease. Many states do not cover prenatal care, outpatient dialysis services, or life-saving chemotherapy. Limited disease-specific screening and treatment is also available, regardless of immigration status. Most safety-net clinics provide free or low-**

cost primary care services to all uninsured persons based on their ability to pay, regardless of immigration status. Prenatal care regardless of immigration status is available in some states through the Children's Health Insurance Program (CHIP), which was reauthorized under the Affordable Care Act through 2015. Local level initiatives, such as the Los Angeles Healthy Kids program, offer health insurance coverage to all low income children who are not eligible for other coverage, including undocumented children, but do not cover all eligible children because of high demand and limited funding. Because the number and proportion of undocumented immigrants without health insurance are not projected to change much, these individuals will make up a larger share of the shrinking group of U.S. residents who remain uninsured after the law is fully implemented. Assuming full implementation of Medicaid expansion by all states, undocumented immigrants are estimated to account for 24.5 percent of the remaining uninsured population in the United States by 2016, up from 9.5 percent in 2012. This figure is higher in states with large undocumented immigrant populations. Undocumented immigrants will account for up to twofifths (41%) of the remaining uninsured in California and at least a third of the uninsured population in Arizona, Florida, North Carolina, and Texas.

Undocumented immigrants will constitute a significant proportion of the remaining uninsured population and their concentration in a small number of states and localities places an uneven burden on the safety-net facilities in those areas. The United States is not the only country facing these issues. A recent survey of European countries<sup>18</sup> illustrates policy approaches that would improve access to care for undocumented immigrants and assist providers who face uncompensated care burdens. These include: providing comprehensive insurance coverage to some or all undocumented immigrants; providing coverage for specified services; and decreasing the out-of-pocket health care costs of undocumented immigrants by increasing direct funding to providers who offer free or low-cost services.

**Warrant:** solvency: Even with current systems for health care and the rates of usage, it is not providing the preventative care that they need and deserve and costing more in emergent uncompensated/publicly funded care.

**Goldman, Dana; Smith, James; and Sood, Neeraj. "Immigrants And The Cost Of Medical Care". Health Affairs Vol 25 No. 6. Nov/Dec 2006.**

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.25.6.1700>

**"A remarkably large fraction of the foreign-born had almost no contact with the formal health care system. One-quarter had never had a medical checkup, and one in nine had never visited a doctor—rates twice those of the native-born. This lack of contact is noteworthy among male undocumented immigrants: 40 percent never received a medical checkup, and 23 percent had never seen a doctor (Exhibit 2 ). Even among women, where such contact is more common, undocumented women stood out. One of every five undocumented women had never received a checkup—four times the rate for native-born women—and 7 percent had never seen a physician (compared with 1 percent of native-born women).. Immigrants' medical costs are closely linked with uncompensated care. MEPS imputes these costs for public hospitals and clinics based on utilization, so our models account for this use. 18 MEPS misses indirect payments that cannot be tied to specific medical events, as well as charity care from private sources that did not generate payments. Because such spending is so disparate—ranging from Medicaid hospital subsidies to Medicare payments for direct medical education—we assumed, as other researchers have done, that the incidence of these costs is borne by everyone in proportion to their health care spending."**

**Warrant:** The ACA currently precludes Undocumented immigrants from enrolling in market plans.

Norris, Louise. "How immigrants can obtain health coverage". Healthinsurance.org. 2020 <https://www.healthinsurance.org/obamacare/how-immigrants-are-getting-health-coverage/>

**"Although the ACA provides benefits to U.S. citizens and lawfully present immigrants alike, it does not directly provide any benefits for undocumented immigrants."**

**The ACA specifically prevents non-lawfully present immigrants from enrolling in coverage through the exchanges [section 1312(f)(3)]. And they are also not eligible for Medicaid under federal guidelines. So the two major cornerstones of coverage expansion under the ACA are not available to undocumented immigrants."**

**Analysis:** The idea of undocumented immigrants losing access to health care is not unique because it already exists in the status quo, and the limited safety nets already in place will not disappear simply because of M4A. Hospitals and drs will always continue to care for patients despite status based on medical need. However, M4A is necessary to solve as the safety nets are not enough for undocumented immigrants because of the limitations on what they can and cannot access despite paying taxes and contributing to society. Despite their fears, the access to preventative care and services will save more lives, increase quality of life, and provide them with care they are already paying for in taxes.

### A/2: Medicare for All increases poverty and its detrimental impacts

**Response:** Medicare for All would actually help small businesses.

**Delink:** Small and large businesses will save money on dealing with insurance and give them the freedom to increase wages.

“Medicare for All Helps Small Businesses.” Citizen.org. 2020.

<https://www.citizen.org/article/medicare-for-all-helps-small-businesses/>

Most American workers are all too familiar with wages not keeping up with rising costs, meaning many are effectively getting paid less and less for doing the same job. **The rising cost of employer-sponsored health insurance is keeping wages flat for hard-working Americans while insurers pay larger salaries and bonuses to their CEOs. Employer-sponsored insurance is not only consuming larger shares of wages; it also costs employers significant time and money as they try to navigate our fragmented system on behalf of their employees. Medicare-for-All would give employers more freedom to keep wages in line with rising costs and would also free up small businesses to devote their energy to innovation and production instead of endless paperwork and phone calls with insurers. Medicare-for-All would also be great for the self-employed. Starting your own small business, holding multiple part-time jobs or working short-term “gigs” would no longer jeopardize your health coverage**

**Warrant:** Businesses would actually save money for businesses and the country as well.

“Medicare for All would be Good for Business” PNHP.org. 2020.

<https://pnhp.org/news/medicare-for-all-would-be-good-for-business/>

“Nationalized health care provision is then seen as the counter to that. **But Medicare has been able to function for more than 50 years without having to resort to nationalized health care by a regime of strict payment controls and regulations.** Another drawback is we would have to add to Medicare what it currently doesn’t have, a tax to pay for it. All of that would be hard to do. Perhaps impossible in the current political climate. But **there is no question it would be a boon to American business.** Employer health insurance subsidies cost American employers nearly \$1 trillion a year. Some of the savings would be eaten up by a new Medicare tax, but that tax would be spread among all Americans meaning employers would still see significant savings just in the absent subsidy alone. But there would be additional, ancillary savings. Most American businesses, on top of paying the insurance subsidy, spend hundreds of billions of dollars a year just managing their employees’ health insurance plans. Whole armies of human resources and benefits employees are needed to manage health care plans. American hospitals and doctors’ offices spend billions on staff and technology to keep track of all the insurance plans patients have, filling out forms and fighting with insurance companies to get paid. All of that goes away with single payer. Those savings would more than offset the tax to pay for it. Obamacare could save American employers billions. **Medicare for all could save it more than a \$1 trillion. That’s a lot of potential profit. And isn’t that what it’s all about?”**

**Delink:** Job loss and economic decline won’t happen.

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

But despite oft-repeated claims of large-scale job losses, a national program that would guarantee health insurance for every American **would not profoundly affect the total number of jobs in the U.S. economy. In fact, such reform could boost wages and jobs**

and lead to more efficient labor markets that better match jobs and workers. Specifically, it could: Boost wages and salaries by allowing employers to redirect money they are spending on health care costs to their workers' wages. Increase job quality by ensuring that every job now comes bundled with a guarantee of health care—with the boost to job quality even greater among women workers, who are less likely to have employer-sponsored health care. Lessen the stress and economic shock of losing a job or moving between jobs by eliminating the loss of health care that now accompanies job losses and transitions. Support self-employment and small business development—which is currently super low in the U.S. relative to other rich countries—by eliminating the daunting loss of/cost of health care from startup costs. Inject new dynamism and adaptability into the overall economy by reducing “job lock”—with workers going where their skills and preferences best fit the job, not just to workplaces (usually large ones) that have affordable health plans. Produce a net increase in jobs as public spending boosts aggregate demand, with job losses in health insurance and billing administration being outweighed by job gains in provision of health care, including the expansion of long-term care.

**Solvency:** Medicare for all would help end Job lock, increase jobs, and reduce unemployment.

Sterret, David, Ashley Bender, and David Palmer. "A Business Case for Universal Healthcare: Improving Economic Growth and Reducing Unemployment by Providing Access for All." *Health Law & Policy Brief* 8, no. 2 (2014): 41-55.

Our employer-reliant system has caused health insurance to become an overriding consideration in Americans' career decisions. This phenomenon has resulted in lower “employment dynamics,” which are “the rate at which workers and businesses exchange jobs.” An employee’s unwillingness to change jobs for fear of losing health insurance benefits is known as “job lock.” Job lock inhibits workers from gravitating to the jobs most suited to them or pursuing entrepreneurial endeavors. Likewise, it

frustrates employers' ability to find and hire the best potential employees. Studies have found that job lock reduces mobility by 22.5 percent, makes employees sixty percent less likely to leave their jobs, and decreases the rate of self-employment by two-to-four percent. A system that provides universal access to health coverage, on the other hand, is "far more likely to promote entrepreneurship than one in which would-be innovators remain tied to corporate cubicles for fear of losing their family's access to affordable healthcare," wrote Jonathan Gruber, who was one of the chief architects of the healthcare reform law passed in Massachusetts in 2005 and whose work greatly influenced the structure of the ACA. It is estimated that 1.6 million small business workers suffer from job lock and that providing universal healthcare coverage would bring that number close to zero. In addition, instituting a system to ensure universal coverage would add 1.5 million entrepreneurs, which would significantly increase our gross domestic product (GDP), according to a study by the Kauffman Foundation. The Kauffman Foundation study goes further to explain how eliminating job lock benefits the economy on a micro-level. Through the process of new and expanding businesses replacing the market share of established companies and the ongoing efforts of businesses and workers seeking their most productive matches, entrepreneurs create new products, which allows employees to accomplish more tasks in less time and ultimately creates more jobs. This increased activity is associated with higher economic growth. By enabling workers to do the type of work that they do best and enjoy the most, eliminating job lock increases the GDP. By looking at the experience of close to seventy million workers in thirty-eight industries over nineteen years, the researchers measured the impact of rates of growth of healthcare costs in certain industries and extrapolated that data across the United States economy.<sup>37</sup> The average excess healthcare costs over the period in which the Rand study was conducted (1986-2005) were 2.2 percent.<sup>38</sup> Meanwhile, the Rand study found that an excess healthcare cost of just 0.2 percent—one-tenth the actual experience for the period—would exact a toll of 120,803 lost jobs. Taken together, Rand study findings yield the conclusion that excess healthcare costs led to the loss of

more than a million jobs over a twenty-year period. This means that businesses were left with about a million fewer employed potential customers. Instituting a system that provides care to all Americans would end the problem of nonportable healthcare benefits, freeing the United States economy from a long-standing burden and create jobs.

**Analysis:** The current system actually creates job loss, and hurts the economy. Medicare for all will actually help businesses by freeing up money, give them the ability to hire more, create more jobs and free individuals to move to better jobs or go into their own business without the worry of insurance costs. All of this would also increase the gdp, economic growth, and job creation, decreasing unemployment and the harms that go with it.

### A/2: Medicare for All will adversely hurt people of color

**Response:** Low income families will not have to pay taxes.

**Delink:** Based on the current sliding scale tax code, most low income families do not pay income/payroll taxes.

"A Citizen's guide to the Fascinating (though often complex) elements of the US Tax System." Tax policy center, Urban Institute& Brookings Institute. 2020.

<https://www.taxpolicycenter.org/briefing-book/how-does-federal-tax-system-affect-low-income-households>

**In many cases, low-income households owe no income tax.** All households can claim a standard deduction to reduce their taxable income, and many families with children can offset income taxes with the child tax credit. **In 2020, the standard deduction is \$24,800 for married couples, \$18,650 for single parents, and \$12,400 for singles.** Prior to the Tax Cuts and Jobs Act, families could also reduce the amount of income they owed tax on by a per-person exemption. The TJCA reduced the personal exemption to \$0. **Households with income above the standard deduction often still do not owe federal income because they can claim child tax credits, which can offset up to \$2,000 of taxes for each child under 17 and \$500 for other dependents, including older children.**

**Turn/Solvency:** The current ACA system places a greater burden on low income families and single payer will shift the burden to wealthier demographics.

Zezza, Mark A., Sandman, David. "Single Payer Or Not: Matching Problems With Solutions" Healthaffairs.org. 19 MAY, 2020.  
<https://www.healthaffairs.org/do/10.1377/hblog20200512.121763/full/>

The Affordable Care Act (ACA) expanded Medicaid coverage and created access to subsidized health insurance for households with income up to 400 percent of the federal poverty level. But even with those efforts, health care costs are generally a greater burden on lower-income households than higher-income households. In New York State, for example, health care costs have been estimated to amount to approximately 35 percent of income for the average household making less than \$50,000. The cost burden declines as income rises, such that the average household earning more than \$400,000 has health care costs comprising roughly 23 percent of income. Under many single-payer proposals, consumers would no longer pay premiums and a large portion of out-of-pocket expenses (for example, copayments and deductibles). New progressive taxes would be enacted to substitute for that reduced funding. These taxes would shift the health care cost burden from lower-income households to higher-income households. A simulation of costs under a single-payer plan for New York State predicts that the distribution of costs by income would essentially be flipped compared to the status quo: Health care spending would amount to less than 20 percent of household income on average for the lowest earners and 35 percent for the highest earners. The plan provides redistributive economic justice. The same plan however would require monumental tax increases, one of the biggest political sticking points.

**Response:** Government Health Care expansions have shown improvement for people of color.

**Solvency:** Under the ACA disparity in treatment and access has gotten better.

Baumgartner, Jesse C, et all. "How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care." Commonwealthfund.org. 16 Jan 2020. <https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access>

The coverage gains under the ACA made it easier for people to get health care.<sup>7</sup> Adults with low income have benefited the most from the law's insurance subsidies, out-of-

pocket cost protections, and expansion in Medicaid eligibility.<sup>8</sup> Black and Hispanic adults are almost twice as likely as white adults to have low income (less than 200% of the federal poverty level, or FPL) (Table 1) and, prior to 2013, they reported significantly higher rates of cost-related problems getting care. After the ACA's major coverage expansions in 2014, they experienced the largest overall improvements in access (Table 4). Twenty-three percent of black adults reported avoiding care because of cost in 2013, compared to 17.6 percent in 2018. Cost-related access problems among Hispanic adults fell from 27.8 percent to 21.2 percent, while those reported by whites dropped from 15.1 percent to 12.9 percent. As a result, differences narrowed between white adults and black and Hispanic adults in cost-related access problems. The black–white disparity shrank from 8.1 percentage points in 2013 to 4.7 points in 2018, while the Hispanic–white difference fell from 12.7 points to 8.3 points (Table 3). Again, most of that improvement occurred between 2013 and 2016. To illustrate the potential effects of further Medicaid expansion, we analyzed two Southern states with large black adult populations. Louisiana chose to expand Medicaid in 2016, while Georgia has yet to do so. As the exhibit shows, **white and black adults with incomes under 200 percent of the federal poverty level (which is \$24,980 for an individual and \$51,500 for a family of four in 2020)** experienced coverage gains from 2013 to 2015 in **both states**. But after Louisiana expanded Medicaid in July 2016, uninsured rates for both groups dropped an additional 12.2 points to 16.0 points. Georgia's uninsured rates, meanwhile, did not improve after 2016 (Table 5). **Because an estimated 54 percent of black working-age adults in Louisiana have low incomes (Table 1), Medicaid expansion helped drive the state's overall black adult uninsured rate down to 11.3 percent in 2018 (Table 5).** This was lower than the rate for black adults (19.2%) and white adults (14.9%) in Georgia.

**Solvency:** Medicare for All would decrease racial disparities by treating it as a human rights issue.

Himmelstein, Caruso D; D, Woolhandler S. "Single-payer health reform: a step toward reducing structural racism in health care." *Harvard Public Health Review*. Summer 2015;7. <http://harvardpublichealthreview.org/single-payer-health-reform-a-step-toward-reducing-structural-racism-in-health-care/>

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.<sup>22</sup>

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].<sup>23</sup>

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.

**Warrant:** Medicare for all is supported by the minority communities to solve for poverty, health, and racial injustices.

Smather, James. "Medicare for All is a 'Racial Equity Policy'". Citizen.org. 2020

<https://www.citizen.org/article/medicare-for-all-is-a-racial-equity-policy/>

**Racial justice organizations have been on the front lines on improving the health care system and many such organizations, including the NAACP, Black Women's Health Imperative, League of United Latin American Citizens (LULAC) and United We Dream, strongly support Medicare for All.** Many of these organizations have been fighting for health care justice for decades, including the National Medical Association – which itself was formed in part due to the racist policies of the AMA not allowing Black doctors to join at the turn – playing a key role in the passage of the original Medicare and Medicaid programs.

**"Communities of color need a health care system that rectifies these long-standing structural biases and challenges. Medicare for All is that system,"** the groups wrote in a letter to Congress. **"Medicare for All universal health care would support the health and economic security of patients of color, including finally providing full health coverage for all reproductive health services, alongside controlling the costs of prescription drugs – both glaring affordability and access issues for low and moderate-income patients of color."**

**Warrant:** The Medicare program shows the progress made in treating not only health and poverty, but also equity issues and Medicare for All is the next step.

Saxe, Jessica Schorr MD. "Medicare for All would reduce racial Inequities in America Pandemic Exposes, widens gaps in health Care". The Charlotte Post: The Voice of the Black Community. 13 Aug 2020. .  
<http://www.thecharlottepost.com/news/2020/08/13/opinion/medicare-for-all-would-reduce-racial-inequities-in-america/>

**Black Americans suffered disproportionately from the COVID-19 pandemic? Multiple reasons include inadequate insurance prior to the pandemic, loss of access due to loss**

of employment, being essential workers, and having less ability to work from home. Black Americans are also more likely to have underlying conditions that put them at higher risk for complications or and death. These conditions are not due to genetics, but to racism, indirectly through its effects on education, economic security, housing, and exposure to air pollution; and directly through the stress of racism itself. Medicare is the most popular health insurance in the country. Black Americans should take particular pride in it, as Dr. Montague Cobb, president of the National Medical Association, led Black doctors in supporting Medicare, while the almost entirely white American Medical Association opposed it. Because of the hard work of the NMA and the NAACP, hospitals had to integrate to accept Medicare money.

Just as Medicare led to hospital integration in 1966, Medicare for All can be a major step toward eliminating racism and racial inequities. With everyone in the same system, everyone would be eligible for high-quality care. By cutting the connection with employment, no one would lose their coverage if they lost their job. Everyone could get care during a pandemic, protecting their health and that of the public. People with high-risk conditions wouldn't feel forced to work just to keep their insurance. And everyone could get their necessary preventive or chronic illness care, pandemic or not. It's now more obvious than ever that our employer-based health system has failed us. As the pandemic has so harshly proved, it's time for Medicare for All.

**Analysis:** Medicare for all will not overburden low income minorities with taxation, but will in fact shift that burden away from them. Also, with the access to the health care that they need without worry, it will continue the strides of racial justice as well as assist people of color to have better health and quality of life despite employment or economic status, thus eliminating the impacts of poverty that disproportionately affects communities of color.

## A/2: Medicare for All will harm other countries

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**Response:** Innovation will not be harmed by price caps.

**Delink:** Innovation still continues in places with single Payer systems

Liu, Angus. "Which pharma companies are the most innovative? Roche, AstraZeneca top the list". Fiercepharma.com. 9 April 2020. Web.

<https://www.fiercepharma.com/pharma/which-pharma-companies-are-most-innovative-roche-astrazeneca-top-list>

**"Roche (Switzerland) jumped seven spots to land first on the innovation index, the first time the Swiss drugmaker has done so in the 10 versions IDEA has compiled to date.**

**Roche's multiple sclerosis blockbuster Ocrevus also saw multiple successes. For example, the drug showed it could significantly cut the risk of requiring a wheelchair among patients with the primary progressive form of the disease if given early.**

**Roche's Swiss compatriot Novartis jumped six places for innovation, landing at No.3, while it continued to hold the No.4 spot for invention. IDEA elevated Novartis after it had "a historic year" with five novel drug approvals—Adakveo, Beovu, Mayzent, Piqray and Zolgensma—in 2020.**

**In its latest two indices, IDEA Pharma has ranked AstraZeneca (UK) at the top of the pharma invention scale—awarding it "best pipeline" honors—and crowned Roche king in the land of innovation.**

**IDEA handed AZ the honor mainly because of two drugs. First, after multiple failures in the field, AZ's potentially first-in-class anti-IFNAR1 antibody anifrolumab succeeded in a phase 3 lupus trial after a mid-study endpoint tweak. The drug did better than placebo on a composite lupus disease activity score.**

And COPD triplet Breztri Aerosphere demonstrated it could significantly cut the rate of disease exacerbations compared with two other Aerosphere delivery tech-based dual-drug combos. The fact that it could do that even when patients received just half the standard dosage of the budesonide component was remarkable in IDEA's view.

**Warrant:** Single Payer countries are included in the top listing of health care industry innovators.

Branigan, David. "Global Innovation Index 2019 Released, Focus On The Future of Medical Innovation" Health Policy Watch. 24 July 2019.<https://healthpolicy-watch.news/global-innovation-index-2019-released-focus-on-the-future-of-medical-innovation/>

The Global Innovation Index 2019 found that overall, "Switzerland is the world's most-innovative country followed by Sweden, the United States of America (U.S.), the Netherlands and the United Kingdom (U.K.)," according to a World Intellectual Property Organization (WIPO)

**Warrant:** UK National Health System is working with Pharma companies in innovation during the COVID Pandemic.

"What are Pharmaceutical Companies Doing to Combat COVID 19" The Association of the British Pharmaceutical Industry. 2020. <https://www.abpi.org.uk/medicine-discovery/covid-19/what-are-pharmaceutical-companies-doing-to-tackle-the-disease/>

"AbbVie is partnering with global authorities to determine the effectiveness of HIV drugs in treating COVID-19. AbbVie is supporting clinical studies and basic research, working closely with European health authorities and the U.S. Food and Drug Administration (FDA), Centers for Disease Control and Prevention, National Institutes of

Health and the Biomedical Advanced Research and Development Authority to coordinate these efforts. Alexion, a global biopharmaceutical company focused on serving patients and families with rare and devastating disorders, has initiated a Phase III clinical trial of one of its medicines in hospitalised adult patients with severe COVID-19 pneumonia or acute respiratory distress syndrome (ARDS). NHS centres are also conducting their own clinical trial with this Alexion medicine. Alexion and Lilly are working with the NIHR Cambridge Biomedical Research Centre and the Cambridge Clinical Trials Unit as they test whether two drugs that are already in use to treat other immune-related conditions can prevent the development of severe COVID-19 infection. The partnership will ensure that, if either is successful, production is ready to be scaled up to ensure that there is a suitable supply available to treat those who need it."

### **Delink:** Innovation will continue and cost less

"Pharmaceutical Industry Profile".Government of Canada. 6 Nov 2019-  
[https://www.ic.gc.ca/eic/site/lsg-pdsv.nsf/eng/h\\_hn01703.html](https://www.ic.gc.ca/eic/site/lsg-pdsv.nsf/eng/h_hn01703.html)

New medicines and drug candidates are increasingly being developed externally via partnerships with academia, small and medium sized enterprises (SMEs), government and research centres as well as contract research organizations (CROs). Drug research and development is increasingly done via external partners, as over the past decade, 60% of innovator small molecules and 82% of innovator biologics have their roots outside of big pharmaceutical companies (source: Accenture). As a result, the innovation activities of large pharmaceutical firms have diversified, and Canadian CROs perform an increasingly important share of R&D.

3, the pharmaceutical industry is first ahead of the Communication and Telecommunication equipment and Information Technology (IT) sectors in R&D intensity. Twenty-five pharmaceutical and biotechnology companies are listed in the Top 100 Corporate R&D Spenders 2018 in Canada.

R&D costs per drug averaged US\$1.4 billion over 12–13 years (Tufts Center for the Study of Drug Development). Full costing (including amortization of research failures and opportunity cost of capital) raised average costs significantly. A generic drug may take 2 to 3 years and requires \$3 to \$10 million of R&D to develop and prove equivalency with the original drug.

**Analysis:** This response will delink/mitigate the impact of innovation loss claims. Plenty of companies around the world that reside in single payer systems are still innovating, and competitive with the United States, despite price caps or loss of revenue.

**Response:** Companies will still donate/provide for lower costs to developing countries.

**Delink:** Companies in single payer health care systems continue to be at the top for donations and assistance to developing nations.

“Pharmaceutical industry doing more to improve access to medicine in developing countries; performance on some aspects lags” Amsterdam, the Netherlands, 17 November 2014  
<https://accesstomedicinefoundation.org/newsroom/pharmaceutical-industry-doing-more-to-improve-access-to-medicine-in-developing-countries-performance-on-some-aspects-lags>

**The Access to Medicine Index is an independent initiative that ranks the world’s leading pharmaceutical companies according to what they are doing for the millions of people in developing countries who do not have reliable access to safe, effective and affordable medicines and vaccines.** It is published every two years. **It scores companies on their performance, innovation, transparency and commitments across seven areas of activity considered key to improving access to medicine.** The companies are graded on 95 factors covering these areas, including product research and development, **to what extent they facilitate or resist efforts to create generic versions of their drugs,**

and how they approach pricing in developing countries. GSK (UK Company) tops the Index for the fourth time. This is driven by robust performance across most areas, with several innovative practices. It has an innovative business model focused on Africa, a large relevant portfolio, a large share of its pipeline dedicated to relevant diseases, and numerous access-oriented intellectual property sharing partnerships. Novo Nordisk (Danish company) has made the most progress, improving in five of the seven areas the Index focuses on. This has resulted in a remarkable leap from 6th to 2nd place, which is partly due to the fact that its access activities are well managed, integrated into its business strategy, and well targeted to local needs. It also applies access-oriented pricing strategies to diabetes products in all Least Developed Countries.

**Warrant:** Pharma companies in single payer countries continue to engage in philanthropic work like the Swiss Company Novartis.

“Mission Statement.” The Novartis Foundation. 2020.

<https://www.novartisfoundation.org/>

The Novartis Foundation strives for a transformational and sustainable impact on the health of low-income communities. In recent years, we focused on programmatic work that reached over 30 million people, plus health outcomes research, and the translation of new evidence into health policy. In 2019, the Novartis Foundation sharpened its focus to concentrate fully on exploring an emerging challenge: How can digital tech reimagine health and care systems around the world, so they change from being reactive to becoming proactive and even predictive?

**Analysis:** This response is critical to the link chain basis of the argument in that companies don't just stop giving because they are in single payer health care systems like m4a. Even with price

caps and low return on investments, companies from various different countries, with various degrees of single payer systems, are still very much donating or providing low cost medications and treatments to developing countries.

## A/2: Medicare For All Would Hurt Innovation

**Response:** Innovation matters less than expansion of care

**Warrant:** Innovation is speculative

Sarah Kiliff. "Bernie Sanders's Medicare-for-all plan, explained". 18 Oct. 2017. VOX,  
<https://www.vox.com/2019/4/10/18304448/bernie-sanders-medicare-for-all>

For one thing, **socialized healthcare improves health outcomes now and it's at best speculative that innovation will maybe, down the line, save more lives. Innovation is to a significant extent a matter of luck. Does it really make sense to hold off on providing everyone with the medical care they deserve because it might harm innovation**, which might sometime in the future save more lives?

**Outweigh:** It is unfair to weigh the lives of people in the future more heavily than people in the present.

Ben Burgis. "The Many Bad Arguments Against Medicare For All". Current Affairs. 23 January 2020. VOX, <https://www.currentaffairs.org/2020/01/the-many-bad-arguments-against-medicare-for-all>

Think about one of the statistics references above—the much higher rate of infant mortality in the U.S. as compared to Canada and the U.K. If you're an uninsured or underinsured American parent, anyone making the Medical Innovation Argument is essentially saying, "Sure, if we gave you national health insurance, your baby would have a greater chance of surviving right now, but by letting your baby die—by in effect sacrificing it to the hungry gods of the free market—we're creating financial incentives that will lead to the development of new treatments that will save other babies in the future. So you really have no legitimate complaint!" Medicare for All advocates believe

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

**Analysis:** This argument allows the pro to weigh favorably against the con. Not only does the pro save lives now, but the con's numbers are mere projections of possible saved lives.

**Mitigation:** Healthcare innovation is slow and fails to produce results

**Warrant:** Healthcare innovation has disappointed people in the status quo

Regina Hurzlinger. "Why Innovation in Health Care Is So Hard." Harvard Business Review, May 2006. <https://hbr.org/2006/05/why-innovation-in-health-care-is-so-hard>

**Despite this enormous investment in innovation and the magnitude of the opportunity for innovators to both do good and do well, all too many efforts fail, losing billions of investor dollars along the way.** Some of the more conspicuous examples: the disastrous outcome of the managed care revolution, the **\$40 billion lost by investors to biotech ventures, and the collapse of numerous businesses aimed at bringing economies of scale to fragmented physician practices.**

**Warrant:** The Healthcare market is not conducive to innovation

Regina Hurzlinger. "Why Innovation in Health Care Is So Hard." Harvard Business Review, May 2006. <https://hbr.org/2006/05/why-innovation-in-health-care-is-so-hard>

**Nonprofit, for-profit, and publicly funded institutions quarrel over their respective roles and rights. Patient advocates seek influence with policy makers and politicians, who may have a different agenda altogether—namely, seeking fame and public adulation through their decisions or votes. The competing interests of the different groups aren't always clear or permanent.** The AMA and the tort lawyers, bitter foes on the subject of physician malpractice, have lobbied together for legislation to enable people who are wrongly denied medical care to sue managed-care insurance plans. **Unless innovators recognize and try to work with the complex interests of the different players, they will see their efforts stymied..**

**Analysis:** This argument shows the judge that the con's point is nonunique. Innovation is not happening in either world so it should not be a voting issue.

### A/2: The 2019 Medicare for All Bill Precludes Other, Better Options

**Response:** Alternatives do not go far enough

**Warrant:** A public option allows healthcare corporations to continue to exploit people

Eagen Kemp. "Why Medicare for All, Not a Public Option, Is the Best Solution." The Public Citizen, June 2019. <https://www.citizen.org/article/why-medicare-for-all-not-a-public-option-is-the-best-solution/>

Too many lesser reforms, including public options or buy-ins, would mean that millions would remain uninsured or underinsured and subject to unnecessary out-of-pocket costs, including copays and deductibles. **Public option proposals, including Medicare for America, would leave more than 100 million Americans at the whim of private for-profit insurance corporations, meaning they would continue to face rising out-of-pocket costs and premiums, as well as narrowing networks and the constant fear of disruption when their employer changes plans or they lose or change jobs.** Small businesses would also continue to struggle with whether they could afford to provide insurance to their employees.

**Turn:** Abolishing private insurance is the only way to eliminate waste

Eagen Kemp. "Why Medicare for All, Not a Public Option, Is the Best Solution." The Public Citizen, June 2019. <https://www.citizen.org/article/why-medicare-for-all-not-a-public-option-is-the-best-solution/>

**Unlike a public option or a Medicare buy-in, Medicare for All would eliminate the need for the wasteful and unnecessary insurance companies that are focused on profiting from illness instead of keeping enrollees healthy.** Hundreds of insurance

companies and plans spend time and resources on denying coverage for needed care. Patients, providers and hospitals fight to get care – even crucial cancer treatments – covered. **This wasteful system is a key reason administrative costs in the U.S. are more than double the average in other wealthy countries, with between a quarter and a third of our health care dollars spent on administrative functions.** Under Medicare for All, doctors would provide the care a patient needs and then send the bill to Medicare. **There would be no more patients or doctors haggling with insurers about what's covered and what isn't. Given that Medicare already has a track record for keeping administrative costs down – even as private insurance costs rise – Medicare for All could save more than \$500 billion a year.**

**Analysis:** This response lets you compare Medicare for all with the relevant policy alternatives and show the judge that there are unique benefits which are not achieved by alternative solvencies.

**Response:** Medicare for all is popular, alternative solvency is not needed

**Quantification:** Medicare for all polls very well among Americans

Gabriella Shult. "Two-thirds of voters support providing Medicare to every American."

PNHP, April 2020. <https://pnhp.org/news/two-thirds-of-voters-support-providing-medicare-to-every-american/>

**Support for Medicare for All has remained consistently strong over the past two years, according to a new Hill-HarrisX poll. Sixty-nine percent of registered voters in the April 19-20 survey support providing Medicare to every American, just down 1 percentage point from an Oct. 19-20, 2018 poll, and within the poll's margin of error. Popularity for Medicare for All grew slightly among Democratic voters, with a 2 percentage point increase from 2018. Support among independent voters was steady at 68 percent.**

However, support among Republican voters declined 6 percentage points over the course of two years, from 52 percent support in 2018 to 46 percent in 2020.

### **Warrant:** Momentum for Medicare for all has grown

Gabriella Shult. "Two-thirds of voters support providing Medicare to every American."

PNHP, April 2020. <https://pnhp.org/news/two-thirds-of-voters-support-providing-medicare-to-every-american/>

**Progressive lawmakers have been pointing to the coronavirus crisis to make a case for the need for Medicare for All as millions of Americans are kicked off their employee-based health insurance due to the economic fallout of the pandemic. "Crises are moments of opportunity for policy change,"** Robert Griffin, Research Director of the Democracy Fund Voter Study Group, told Hill.TV. "But it's not a sure thing, it's not going to happen automatically. It does require leadership at the end of the day," he added. President and CEO of the Roosevelt Institute, Felicia Wong, believes support for Medicare for All will only grow amid the coronavirus crisis. **"These progressive policies have been popular for a long time. I think COVID-19 will make them more popular as it becomes clear just how fragile our American political economy really is,"** Wong told Hill.TV.

**Analysis:** This argument is a turn because it says the impact of moral hazard is actually good. Even if your opponent wins a small increase in unnecessary consumption, the vast majority of healthcare is essential

## A/2: Medicare for All Causes Resource Overuse

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**Response:** Medicare for all will not cause moral hazard

**De-link:** People will not want to increase consumption of healthcare, even when free

Malcom Gladwell. "The Moral-Hazard Myth." The New Yorker, May 2009.

<https://www.spanohio.org/index.php/news/33-the-moral-hazard-myth>

The moral-hazard argument makes sense, however, only if we consume health care in the same way that we consume other consumer goods, and to economists like Nyman this assumption is plainly absurd. We go to the doctor grudgingly, only because we're sick. **"Moral hazard is overblown," the Princeton economist Uwe Reinhardt says. "You always hear that the demand for health care is unlimited. This is just not true. People who are very well insured, who are very rich, do you see them check into the hospital because it's free? Do people really like to go to the doctor? Do they check into the hospital instead of playing golf?"**

**Turn:** Moral Hazard's effect is not large

Amanda Kowalski. "Tradeoff between risk protection and moral hazard." NBER, May 2012. <https://pnhp.org/news/tradeoff-between-risk-protection-and-moral-hazard/>

I illustrate the properties of my model by estimating it using data on employer sponsored health insurance from a large firm. Within my empirical context, the average deadweight losses from moral hazard substantially outweigh the average welfare gains from risk protection. However, the welfare impact of moral hazard and risk protection

are both small relative to transfers from the government through the tax preference for employer sponsored health insurance and transfers from some agents to other agents through a common premium.

**Analysis:** This response lets you delink the claim that usage of healthcare will go up because people simply will not try to consume it more. The empirics show that overall additions to the national healthcare burden are small.

**Turn:** Increased consumption of healthcare is good

**Warrant:** The nonessential care consumed is much less than the coverage extended to people who need it

Amanda Kowalski. "Tradeoff between risk protection and moral hazard." NBER, May 2012. <https://pnhp.org/news/tradeoff-between-risk-protection-and-moral-hazard/>

**The lesson to take home from this study is that the cost of trading up for more risk protection is almost negligible when the price paid is a very small increment in additional spending on largely beneficial health care that might otherwise have been foregone.** This is crucial in the continued debate over health care reform. **There is considerable political pressure to shift price sensitivity to health care consumer/patients through consumer-directed high-deductible plans, health savings accounts, vouchers for Medicare plans, lower-tier plans in insurance exchanges, and other devious innovations that insurers will no doubt introduce in the future.** **These concepts are to deter the false bogeyman of moral hazard, but at the profound cost of threatening financial security for those of us with health care needs.**

**Warrant:** More consumption leads to better health outcomes

Malcom Gladwell. "The Moral-Hazard Myth." The New Yorker, May 2009.

<https://www.spanohio.org/index.php/news/33-the-moral-hazard-myth>

**The focus on moral hazard suggests that the changes we make in our behavior when we have insurance are nearly always wasteful. Yet, when it comes to health care, many of the things we do only because we have insurance—like getting our moles checked, or getting our teeth cleaned regularly, or getting a mammogram or engaging in other routine preventive care—are anything but wasteful and inefficient. In fact, they are behaviors that could end up saving the health-care system a good deal of money.**

**Analysis:** This argument is a turn because it says the impact of moral hazard is actually good. Even if your opponent wins a small increase in unnecessary consumption, the vast majority of healthcare is essential

## A/2: Medicare for All is Too Expensive

**Response:** Medicare for all would save money by reducing health expenses

**De-link:** The government would reduce administrative waste

Sarah Kiliff. "Bernie Sanders's Medicare-for-all plan, explained". 18 Oct. 2017. VOX,  
<https://www.vox.com/2019/4/10/18304448/bernie-sanders-medicare-for-all>

One of Sanders's main arguments in favor of his health care bill is that American health spending is out of control and single-payer would rein it in. "There is broad consensus — from conservative to progressive economists — that the Senate Medicare for All bill, as written, would result in substantial savings to the American people," a paper released by his office argues. **There are certainly policies in the Sanders plan that would reduce American health care spending. For one, moving all Americans on to one health plan would reduce the administrative waste in our health care system in the long run.** American doctors spend lots of money dealing with insurers because there are thousands of them, each negotiating their own rate with every hospital and doctor. **An appendectomy, for example, can cost anywhere from \$1,529 to \$186,955, depending on how good of a deal an insurer can get from a hospital.**

**Outweigh:** Administrative costs are astronomical

Sarah Kiliff. "Bernie Sanders's Medicare-for-all plan, explained". 18 Oct. 2017. VOX,  
<https://www.vox.com/2019/4/10/18304448/bernie-sanders-medicare-for-all>

**One 2003 article in the New England Journal of Medicine estimates that the United States spends twice as much on administrative costs as Canada. A 2011 study in the journal Health Affairs estimates American doctors spend four times as much dealing**

**with insurance companies compared with Canada.** A single-payer health plan would have the authority to set one price for each service; an appendectomy, for example, would no longer vary so wildly from one hospital to another. Instead, the Sanders plan envisions using current Medicare rates as the new standard price for medical services in the United States. Medicare typically has lower prices than those charged by private insurance plans that cover Americans under 65. This suggests that switching to the Medicare fee schedule would be another policy change that would tug health spending downward..

**Turn:** Medicare for All will Grow the economy

**Warrant:** Medicare for all will stimulate job growth

EPI. "Medicare for All would boost wages". March 2020. EPI,  
<https://www.epi.org/press/medicare-for-all-would-boost-wages-expand-workers-options-and-likely-create-jobs/>

But while **Medicare for All** would indeed lead to lower demand for labor in the health insurance and billing administration sector, it **would boost demand for other types of jobs overall. For example, expanded access to health care could increase demand for health services by up to \$300 billion annually, which would translate into an increased demand for 2.3 million full-time health care workers.**

**Warrant:** Medicare has both direct and indirect positive effects on the labor market

EPI. "Medicare for All would boost wages". March 2020. EPI,  
<https://www.epi.org/press/medicare-for-all-would-boost-wages-expand-workers-options-and-likely-create-jobs/>

Further, several **Medicare for All plans have provisions to pay for long-term care services, which would create jobs. In 2018, U.S. households provided roughly 34 billion hours in unpaid long-term care. If divided up among full-time workers, it would require 17 million new positions.** Even if 10% of this unpaid care was converted to paid positions, it would create enough jobs to essentially offset the displacement of the health insurance and billing administration workers.

**Analysis:** This argument is a turn on the impacts of federal spending because it shows even larger job gains. Show the judge that Medicare for all will actually INCREASE the demand for healthcare labor and have positive ripple effects in the economy

## A/2: Medicare for All Harms Rural Hospitals

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**Warrant:** A provision in M4A states that there would be a safety net for rural hospitals

Barb Kalbach, 9-11-2019, "For rural America, Medicare for All is a matter of life or death," Guardian. 11 September, 2019. Web. 15 August, 2020.

<https://www.theguardian.com/commentisfree/2019/sep/11/medicare-for-all-rural-america>

We won't be so easily fooled. Americans know that we deserve guaranteed, comprehensive healthcare, including hospital visits, dental, vision, mental health care and dignified long-term care. We know that no one should have to beg for help on GoFundMe to pay for life-saving care. We know that doctors and hospitals can't keep paying the cost of care for patients who can't afford insurance. Medicare for All means that rural hospitals would no longer be burdened by uncompensated care. A little-known provision of the Washington representative Pramila Jayapal's Medicare for All bill is that it includes funding to invest directly in areas without enough health coverage, including rural and low-income urban areas.

**Turn:** M4A would give more funds to rural hospitals

Diane Archer, 3-11-2020, "453 rural hospitals are failing — Medicare for All would save them," TheHill. 11 March 2020. Web. 15 August 2020 .

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

Beyond struggling to meet their health care needs, rural patients are often burdened with sky-high medical debt. Many are low-wage workers, with little hope of paying off their hospital and medical bills. Rural hospitals and doctors have taken to suing patients

for the cost of their care. Thousands of rural Americans are jailed or threatened with jail each year when they don't show up in court for unpaid medical bills. **With Medicare for All, Congress would ensure the viability of rural hospitals. Rural hospitals would be properly compensated for the care they deliver, strengthening their balance sheets.** Medicare for All's guaranteed health care coverage would ensure that rural Americans could get the health care they need, without fear of medical debt. Medicare for All eliminates deductibles and coinsurance, treating rich and poor equally instead of rationing care based on ability to pay. The cruel and discriminatory logic of the marketplace should not mean that rural Americans go without needed care.

**Warrant:** The Affordable Care Act shows that big pharma drives the fear surrounding rural hospitals with M4A

Barb Kalbach, 9-11-2019, "For rural America, Medicare for All is a matter of life or death," Guardian. 11 September, 2019. Web. 15 August, 2020.  
<https://www.theguardian.com/commentisfree/2019/sep/11/medicare-for-all-rural-america>

With Medicare for All gaining steam, it's no surprise that big pharma and multibillion-dollar for-profit insurance companies are responding with distortions and scare tactics. We have seen this before. The same industry-backed tricksters fought hard – and failed – to defeat the Affordable Care Act (ACA). In spite of their fearmongering, the ACA didn't cause disaster. In fact, states who expanded Medicaid under the ACA saw fewer hospitals close while states who refused saw rural hospital closures spike. The greatest concentration of hospital closures has been in the south, where a number of states have not expanded Medicaid. Now, industry front groups such as the Partnership for America's Health Future (founded to stop Medicare for All, according to their own documents) and America's Health Insurance Plans (AHIP) are pouring millions into deceptive advertising to scare voters about Medicare for All and attack any plan that

could undermine their ability to make billions off patients. Medicare for All means that rural hospitals would no longer be burdened by uncompensated care. We won't be so easily fooled. Americans know that we deserve guaranteed, comprehensive healthcare, including hospital visits, dental, vision, mental health care and dignified long-term care.

**Warrant:** Medicare is linked to a decrease likelihood of rural hospital closure

Dylan Scott 2-18-2020, "1 in 4 rural hospitals is vulnerable to closure, a new report finds," Vox. 18 February 2020. Web. 15 August 2020.

<https://www.vox.com/policy-and-politics/2020/2/18/21142650/rural-hospitals-closing-medicaid-expansion-states>

**According to Chartis, being in a Medicaid expansion state decreases by 62 percent the likelihood of a rural hospital closing. Conversely, being in a non-expansion state makes it more likely a rural hospital will close.** The states that have experienced the most rural hospital closures over the last 10 years (Texas, Tennessee, Oklahoma, Georgia, Alabama, and Missouri) have all refused to expand Medicaid through the 2010 health care law. It seems their rural hospitals are paying the price. Of the 216 hospitals that Chartis says are most vulnerable to closure, 75 percent are in non-expansion states. Those 216 hospitals have an operating margin of negative 8.6 percent. **Research has consistently shown Medicaid expansion improves hospitals' financial performance by reducing the amount of uncompensated care.** The only question is by how much, as Medicaid payments can sometimes not be enough to match the cost of providing care to Medicaid patients, which can partially offset the savings in uncompensated care

**Analysis:** It simply seems illogical that the government would allow half of rural hospitals to close under M4A and the bill writers seem to have already thought about this hurdle. There is compelling literature that suggests rural hospitals may not be hurt, rather they may be saved by M4A. Aff teams should carefully look into the wording of M4A bills to understand what

provisions they contain to protect the interest of rural hospitals. If aff teams can turn the rural hospitals argument, they then can link into all the strong impacts about how important rural hospitals are to rural communities.

## A/2: Medicare for All Causes Hospital Closures

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**Mitigation:** The outcomes of M4A implementation would be highly varied.

Salvador Rizzo. 07-3-2019. "Would Medicare for All Mean Hospitals for None?" The Washington Post. 3 July 2019. Web. 15 August 2020.

<https://www.washingtonpost.com/politics/2019/07/03/would-medicare-for-all-mean-hospitals-none/>

This chain has many links: from patients to doctors, drugmakers to hospitals. Each of these parties would be making decisions and adjustments affecting how a single-payer system would end up working in practice. **We asked health-care experts to game out what would happen if Sanders's Medicare-for-all proposal became law. Their assessments varied, but all rejected Delaney's claim that the Sanders bill "will have every hospital closing."** Some could close. Others might find themselves flush with new revenue. Some hospitals could take a financial hit, lay off staff, close a wing or two, but remain open. The government, meanwhile, could step in to control rates if needed.

**Warrant:** Current bills ensure that there would not be massive hospital revenue loss.

Christopher Cai, 12-9-2019, "Medicare For All Would Improve Hospital Financing," Health Affairs. 9 December 2019. 15 August 2020,  
<https://www.healthaffairs.org/do/10.1377/hblog20191205.239679/full/>

These projections assume that hospitals will continue to be paid on a per-patient basis under single payer, with reimbursement rates plummeting to Medicare levels. However, **Elizabeth Warren's financing proposal keeps per-patient billing but raises**

reimbursements to 110 percent of Medicare levels, which would approximate operating costs of hospitals. Congressional bills go further. The House bill would abandon per-patient payments and instead fund hospitals through “global budgets.” (The Senate version also calls for global budgets for hospitals but suggests that some elements of Medicare’s current payment approach might persist.) **Under global budgeting, hospitals would receive an annual lump sum, distributed in monthly installments, similar to how US fire departments or hospitals in Canada are financed.** Under this system, hospitals would receive extra funding in the case of unexpected deficits and would not keep surpluses for themselves. At present, surpluses (or the expectation of future surpluses available to pay back loans or bonds) is the main source of funding for hospital upgrades or expansion.

**Turn:** M4A saves money through administrative costs

Diane Archer, 2-24-2020, "22 studies agree: 'Medicare for All' saves money," The Hill. 24 February 2020. Web. 15 August 2020. <https://thehill.com/blogs/congress-blog/healthcare/484301-22-studies-agree-medicare-for-all-saves-money>

**The evidence abounds: A "Medicare for All" single-payer system would guarantee comprehensive coverage to everyone in America and save money.** Christopher Cai and colleagues at three University of California campuses examined **22 studies on the projected cost impact for single-payer health insurance in the United States** and reported their findings in a recent paper in PLOS Medicine. Every single study **predicted that it would yield net savings over several years. In fact, it's the only way to rein in health care spending significantly in the U.S.** All of the studies, regardless of ideological orientation, showed that long-term cost savings were likely. Even the Mercatus Center, a right-wing think tank, recently found about \$2 trillion in net savings over 10 years from a single-payer Medicare for All system. Most importantly, everyone in America would have high-quality health care coverage. **Medicare for All is**

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

**Turn:** M4A saves money by correcting wasteful private patient recruitment

Diane Archer, 2-24-2020, "22 studies agree: 'Medicare for All' saves money," The Hill. 24 February 2020. Web. 15 August 2020. <https://thehill.com/blogs/congress-blog/healthcare/484301-22-studies-agree-medicare-for-all-saves-money>

Currently, **hospitals have incentives to invest their surpluses in capital projects that will maximize future profits/surpluses, for example, operating rooms or other facilities serving mostly privately insured orthopedic patients.** Reflecting those incentives, the number of knee and hip replacements at small rural hospitals increased 42 percent between 2008 and 2013. Yet, such capital investments may not fit communities' most urgent needs or be appropriate at all: Thirty-day mortality for elective surgeries in small rural hospitals can be twice as high as in other hospitals, likely due to low patient volume. **The race to expand lucrative services has led to a self-reinforcing cycle of rising hospital costs. As recently as 2000, Medicare level reimbursements were sufficient to cover hospital operating expenses but since then a wasteful cycle has emerged. Rising costs—driven, in part, by hospitals' investments in expensive development projects—have increased incentives to court privately insured patients, leading to increased costs and an even greater need to court the privately insured.** Our current financing system incentivizes hospitals to engage in other wasteful behaviors. To handle bills from multiple payers, hospitals have created massive administrative apparatuses for billing: Currently, administrative costs consume 25.3 percent of total US hospital expenditures, roughly double that of Scotland or Canada, which operate under single-payer global budget systems. Hospitals have attempted to become more

profitable primarily by increasing prices, investing in technology, or taking fewer publicly insured patients, rather than becoming more efficient or cutting expenses.

**Turn:** M4A saves money for hospitals by removing the strain of uncompensated care

Public Citizen, 1-9-2020, "Rural Hospitals Would Be Better Off Under Medicare for All," 9 January 2020. Web. 15 August 2020. <https://www.citizen.org/news/rural-hospitals-would-be-better-off-under-medicare-for-all/>

Since 2005, more than 160 rural hospitals in the U.S. have closed, and nearly a quarter are at risk of closing, mostly due to financial challenges under our for-profit health insurance system. **Around 51% of rural hospitals and about 45% of all hospitals serve a disproportionate share of patients who lack adequate coverage, and those hospitals are forced to take on the cost of that uncompensated care. Each year, these uncompensated costs continue to increase and place a heavier financial burden on these hospitals. Under Medicare for All, no patient would show up to the emergency room without insurance, and, as a result, the incidence of uncompensated care would disappear.**

**Analysis:** There is strong literature suggesting various ways in which hospitals save more money with M4A. Because of that, aff teams should view this neg argument as an opportunity to not just coopt neg offense, but also to incorporate offense into their responses. Aff teams should have developed turns (turns that have impacts) to maximize the offense they can gain coming out of rebuttal off of this argument.

### A/2: Medicare for All Increases Wait Times

**Non-Unique:** Wait times are already high

Thomas Waldrop, 10-18-2019, "The Truth on Wait Times in Universal Coverage Systems," Center for American Progress. 18 October 2019. Web. 15 August 2020.  
<https://www.americanprogress.org/issues/healthcare/reports/2019/10/18/475908/truth-wait-times-universal-coverage-systems/>

**Discussions of wait times often ignore the fundamental reality that, for many patients, wait times are already long. Where a patient lives has a significant effect on their wait time, largely due to provider concentration in more urban areas compared with more rural ones. For example, a 2017 analysis of hospital wait times found that mid-size metropolitan areas—cities such as Hartford, Connecticut—had 32.8 percent longer wait times than large metropolitan areas such as Washington, D.C.**<sup>3</sup> A recent article in the *Journal of the American Medical Association* further supports this idea.<sup>4</sup> The study found that wait times at private-sector hospitals ranged from 16.5 days in New York City to 57.33 days in Boston, Massachusetts. The same study compared wait times between a similar set of private and U.S. Department of Veterans Affairs (VA) hospitals and found that VA hospitals had “significantly shorter” wait times than private hospitals, in part because wait times at VA hospitals have improved in recent years—now averaging 20 days—while wait times at private hospitals have stagnated at around 41 days.<sup>5</sup>

**Delink:** Wait times increasing doesn't have anything to do with the form of healthcare system

Aaron Carroll. 7-25-2012, "Single payer does not equal increased wait-times," PNHP. 25

July 2012. Web. 15 August 2020. <https://pnhp.org/news/single-payer-does-not-equal-increased-wait-times/>

I can't count the number of times I've been told this week that it's just a "fact" that single payer systems lead to increased wait times. It appears that pointing out that this is not true is "rude". So be it. Let's start with some simple facts. **Wait times occur when there are too many patients and too few appointment slots. That can happen when there are too few doctors or when there are too many people who want appointments. So, yes, if you have a doctor shortage, you can get increased wait times. If the system wants to keep spending low by limiting visit slots, you can get increased wait times. If you increase the number of insured people dramatically, you will get increased wait times. Note that any of those things can occur with or without a single payer system.** They can occur with an entirely private system. If you massively decrease the number of uninsured, as the ACA will attempt to do, it's entirely possible we will get wait times. This will happen whether people become insured through private insurance in the exchanges or through government insurance (Medicaid). The type of insurance is irrelevant. If there are way more patients calling for appointments, and the number of doctors is static, wait times will likely increase. So if wait times are your main concern, then you're likely against reducing the number of uninsured by any means. The outcome is the same. None of this has anything to do with single payer.

**Turn:** Countries with universal coverage have shorter wait times

Thomas Waldrop, 10-18-2019, "The Truth on Wait Times in Universal Coverage Systems," Center for American Progress. 18 October 2019. Web. 15 August 2020. <https://www.americanprogress.org/issues/healthcare/reports/2019/10/18/475908/truth-wait-times-universal-coverage-systems/>

**Data from other nations show that universal coverage does not necessarily result in substantially longer wait times.** In fact, there are a variety of circumstances in which the United States' peer nations have shorter wait times. While the White House's fact sheet largely focused on the United Kingdom's health care system, no candidate currently running for president is proposing nationalizing health care providers like the U.K.'s National Health Service.<sup>12</sup> The most comprehensive source of international comparative data on health care is the Commonwealth Fund's "Mirror, Mirror" series, which, in 2017, examined a variety of metrics across 10 European countries and the United States. Four of these metrics were particularly useful for studying wait times.<sup>13</sup>

- Patients reported that they saw a doctor or nurse on the same or next day the last time they sought medical care.
- Doctors reported that patients often experience difficulty getting specialized tests—for example, CT and MRI scans.
- Patients reported that they waited two months or longer for a specialist appointment.
- Patients reported that they waited four months or longer for elective or nonemergency surgery.

**On each of these metrics, the United States performed worse than several nations with universal coverage,** though no individual nation outperforms the United States on every metric. For example, only 51 percent of U.S. patients reported being able to see a provider within a day, compared with 53 percent, 56 percent, and 67 percent of patients in Germany, France, and Australia, respectively.<sup>14</sup> Similarly, nearly 30 percent of U.S. doctors reported that their patients have difficulty getting a specialized test, compared with only 11 percent and 15 percent of doctors in Australia and Sweden, respectively.<sup>15</sup> U.S. outcomes on the other two metrics were better across the board but still show that the United States performs worse than other nations with more equitable health care coverage systems. For instance, in the United States, 4 percent of patients reported waiting four months or longer for nonemergency surgery, compared with only 2 percent of French patients and 0 percent of German patients.<sup>16</sup> For specialist appointments, the situation is

even worse: 6 percent of U.S. patients reported waiting two months or longer for an appointment, compared with only 4 percent of French patients and 3 percent of German patients.<sup>17</sup>

**Warrant:** M4A would not increase wait times: historical precedent proves

Thomas Waldrop, 10-18-2019, "The Truth on Wait Times in Universal Coverage Systems," Center for American Progress. 18 October 2019. Web. 15 August 2020. <https://www.americanprogress.org/issues/healthcare/reports/2019/10/18/475908/truth-wait-times-universal-coverage-systems/>

**Expansions of coverage in the United States, while not resulting in universal coverage, show that passing any of the universal coverage proposals currently being discussed in Congress would not significantly increase wait times.** For example, in 2006, Massachusetts passed significant health reform legislation—similar to the Affordable Care Act—that expanded Medicaid eligibility and encouraged health insurance enrollment through an individual mandate.<sup>18</sup> The law was extremely effective at its goals: Massachusetts continues to have the lowest uninsured rate in the country, currently estimated at 2.8 percent.<sup>19</sup> While wait times did increase in the short term following the implementation of the Massachusetts law, researchers have found no evidence that this increase had any negative impact on preventable hospitalizations.<sup>20</sup> Other, more recent research has examined primary care appointment wait times in 2012 and 2016, finding that while most states saw decreases in wait times of less than a week and increases in those of more than 30 days, Massachusetts saw the opposite.<sup>21</sup> For both privately insured patients and Medicaid beneficiaries in the state, wait times improved during this period.<sup>22</sup> This suggests that the impact of health coverage expansions diminishes over time as provider supply rises to meet the new demand. Policymakers can therefore be reassured that patients

will not have worse health outcomes as a result of expanded coverage and that policies can be included in any expansion to help mitigate the effect in the short term and accelerate provider supply increases.

### A/2: Medicare for All Leads to Doctor Shortages

**Mitigation:** There is already a doctor shortage

Stuart Heiser. 04-23-2019. "New Findings Confirm Predictions on Physician Shortage," AAMC. 23 April 2019. Web. 16 August 2020. <https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage>

**The United States will see a shortage of up to nearly 122,000 physicians by 2032 as demand for physicians continues to grow faster than supply, according to new data published today by the AAMC (Association of American Medical Colleges).** The projected shortfall is similar to past projections and ranges from 46,900 to 121,900 physicians. **"The nation's population is growing and aging, and as we continue to address population health goals like reducing obesity and tobacco use, more Americans will live longer lives. These factors and others mean we will need more doctors,"** said AAMC President and CEO Darrell G. Kirch, MD. "Even with new ways of delivering care, America's doctor shortage continues to remain real and significant." Conducted by the Life Science division of IHS Markit, a global information company, this fifth annual study, The Complexities of Physician Supply and Demand: Projections from 2017-2032, includes scenarios that have been refined and updated based on input from stakeholders, and new modeling that examines the impact of emerging health care delivery trends on physician shortages.

**Delink:** Historically, physicians have not been deterred by medicare patients

Aaron Carroll. 10-30-2019. "The myth of a Physician Exodus Under Medicare for All." PNHP. 30 October 2019. Web. 16 August 2020. <https://pnhp.org/news/the-myth-of-a-physician-exodus-under-medicare-for-all/>

As “Medicare for all” gains steam in the Democratic primary, many physicians are concerned about reduced revenues from the program compared with private insurance. Even an expansion of the program, as many candidates’ plans call for “Medicare for more,” causes angst. **Inevitably, some physicians will threaten to opt out of Medicare and refuse to see patients.** Such calls are, for the most part, bluffs. We need only examine how many physicians have followed through on past threats to see that. For years, the Association of American Physicians and Surgeons claims that it’s simpler for physicians to opt out of Medicare than to stay in. Physicians have not been listening. It’s important to understand that even when physicians threaten to opt out periodically, very few ever do. In 2010, for the first time ever, the number of physicians who had officially opted out of the program with the Centers for Medicare & Medicaid Services (CMS) reached triple digits—a total of 130. That’s out of the 850 000 or so licensed physicians in the United States that year. The Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, made it easier for physicians to get out if they wanted to. Before that, physicians needed to re-file with the program every 2 years. After 2015, however, opt-outs could be permanent, lasting until physicians filed affidavits to opt in again. With that, opt-outs climbed to their historically highest level in 2016. Even then, though, there were only 7400. That number represents fewer than 1% of physicians. And, as a Kaiser Family Foundation infographic in JAMA pointed out, more than 40% of them were psychiatrists.

**Turn:** M4A helps doctors- reducing administrative burden

Srivats Narayanan, 7-19-2019, "A Remedy for the Primary Care Doctor Shortage:

“Medicare for All,” Medium. 19 July 2019. Web. 16 August 2020.

<https://medium.com/@srivats.narayanan/a-remedy-for-the-primary-care-doctor-shortage-medicare-for-all-c2e811527546>

**Medicare for All, a popular policy supported by a majority of clinicians and Americans, would be an excellent solution to the primary care shortage.** Although the policy has

gained a lot of attention for its ability to cut healthcare costs and expand access to care, conservatives at The Heritage Foundation, Fox News, and The Federalist have alleged that the bill would worsen doctor shortages. They contend that a single-payer healthcare system like Medicare for All would reduce physician incomes and encourage doctors to leave the field entirely. However, the opposite is true for a few reasons. **First, Medicare for All would consolidate all billing for PCPs, which would save a lot of time for physicians who unnecessarily spend hours every week with insurance hassles and administrative concerns.** Doctors would have streamlined, straightforward billing services through a national health insurance plan like Medicare for All, instead of the previously mentioned redundant forms and complicated procedural rules. Under Medicare for All, physicians wouldn't exhaust their time with administrative duties and would have newly available time to see significantly more patients. **Medicare for All would ensure that many more people can afford care and would free up time for office visits, so PCPs will get paid more. With single-payer, money that would otherwise be going into the pockets of health insurance executives would instead go to medical practitioners.**

**Turn:** M4A helps doctors- cutting administrative costs

Srivats Narayanan, 7-19-2019, "A Remedy for the Primary Care Doctor Shortage:

"Medicare for All," Medium. 19 July 2019. Web. 16 August 2020.

<https://medium.com/@srivats.narayanan/a-remedy-for-the-primary-care-doctor-shortage-medicare-for-all-c2e811527546>

**Fourth, the US would save trillions of dollars if we had Medicare for All, according to the Political Economy Research Institute.** A national healthcare plan would drastically reduce overhead costs, since less administrative staff and insurance staff would be required. **Medicare for All would slash administrative costs that are responsible for a massive 31% of healthcare spending, because the private insurance industry wouldn't**

**be able to take control of healthcare pricing. The trillions in savings that Medicare for All would bring about would mean that PCPs' salaries would be kept up.** As Dr. Carol Paris, the president of Physicians for a National Health Program, remarked, **single-payer "works by cutting administrative waste, not doctors' income."**

**Turn:** M4A helps doctors- medical malpractice insurance

Srivats Narayanan, 7-19-2019, "A Remedy for the Primary Care Doctor Shortage:

"Medicare for All," Medium. 19 July 2019. Web. 16 August 2020.

<https://medium.com/@srivats.narayanan/a-remedy-for-the-primary-care-doctor-shortage-medicare-for-all-c2e811527546>

**Third, PCPs would pay much less in malpractice insurance under Medicare for All. A sizable portion of a PCP's income goes to malpractice insurance premiums, but other countries with single-payer healthcare have far smaller malpractice insurance costs.** Medicare for All would improve the relationships that PCPs have with their patients since it would place an emphasis on continuity of care, which lessens the risk of malpractice lawsuits. **Malpractice settlements are also not as large under Medicare for All, which means that PCPs will pay less in malpractice insurance and as a result have more take-home pay.**

**Analysis:** While neg claims that doctors will be deterred from entering the field if their salaries are cut, aff teams should combat this claim on two levels: whether the salaries will be cut and whether the doctors would leave even if their salaries did decrease. For the former, aff teams can find compelling evidence surrounding how M4A could make doctors jobs easier and maintain salary. For the latter, neg teams should look into historical precedent on what kinds of situations made doctors leave jobs.

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**A/2: Medicare for All Causes Drug Shortages**

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**Warrant:** High drug prices have bad impacts

Hagop Kantarjian, 12-12-2016, "The Harm of High Drug Prices," US News & World Report. 12 December 2016. Web. 16 August 2020.

<https://www.usnews.com/opinion/policy-dose/articles/2016-12-12/the-harm-of-high-drug-prices-to-americans-a-continuing-saga>

**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.

**Warrant:** Decreasing drug prices good

Donald Berwick, 10-22-2019., "Stop fearmongering about 'Medicare for All.' Most families would pay less for better care.," USA Today. 10 October 2019. Web. 16 August 2020. <https://www.usatoday.com/story/opinion/2019/10/22/medicare-all-simplicity-savings-better-health-care-column/4055597002/>

**Health care costs are crushing the middle class, taking more and more money straight from the wallets of workers and families.** Small businesses simply cannot afford coverage anymore, and governments at all levels know that uncontrolled health care costs crowd out other priorities, like roads, schools and the social safety net. Every "Made in America" product has these sky-high costs built into its price. **The average premium for a family of four in 2019 is a staggering \$20,576 — a toll that is eating into their wages, while their out-of-pocket costs soar. Since 2009, premiums have increased 54% and workers' contributions to premiums have increased 71%, but wages have risen only 26%.**

**Delink:** A study of 163 drugs that experiences shortages did not conclude shortages were caused by Medicare

FDA. 10-31-2019, "The 3 root causes of America's drug shortages, according to FDA," Advisory Board. 31 October 2019. Web. 16 August 2020.  
<https://www.advisory.com/daily-briefing/2019/10/31/drug-shortage>

**The researchers found that, among the 163 drugs they analyzed: 63% of the drugs' shortages stemmed from supply disruptions tied to product quality or manufacturing issues; 18% stemmed from unknown reasons; 12% stemmed from an unanticipated increases in demand; 5% occurred after natural disasters; and 3% stemmed from product discontinuations.** Based on their overall findings, the researchers determined there are three root causes of increasing drug shortages in the United States:

**Non Unique:** COVID is likely to cause drug shortages

Robert Roos, 3-27-2020, "Experts say COVID-19 will likely lead to US drug shortages," CIDRAP. 27 March 2020. Web. 16 August 2020.

<https://www.cidrap.umn.edu/news-perspective/2020/03/experts-say-covid-19-will-likely-lead-us-drug-shortages>

**Researchers at the University of Minnesota say the COVID-19 pandemic stands a good chance of leading to shortages of critically needed medications in the United States,** given the nation's heavy dependence on drugs made in other countries, especially India and China. That concern is among the preliminary findings of a study of the US medication supply chain, revealed this week by the university's Center for Infectious Disease Research and Policy (CIDRAP), publisher of CIDRAP News. The effort, called the Resilient Drug Supply Project, aims to provide a detailed map of the entire supply chain for important drugs used in the United States. CIDRAP leaders hope to induce drug companies to share more information about their inventories and supply chains so that shortages can be prevented or their impact blunted. They say little information is currently available.

**Non-Unique:** Prior to Covid, there was a drug shortage

Didi Martinez, 11-2-2019, "U.S. hospitals, FDA grapple with shortages of lifesaving drugs," NBC News. 2 November 2019. Web. 16 August 2020.

<https://www.nbcnews.com/health/health-news/u-s-hospitals-fda-grapple-shortages-life-saving-drugs-n1074821>

**And it's a similar story for hospitals around the country. According to the FDA, there are currently 116 drug shortages, including vincristine, a critical medication for treating children with cancer.** The reason behind many of these shortages? Many involve older drugs that cost less, leaving little financial incentive for manufacturers to continue to produce them. As drug makers exit the market, one or two companies may be the only ones left to supply the drugs. In the case of vincristine, for example, the

medication was only made by two companies. One of them, Teva Pharmaceutical Industries, ended production in July, leaving Pfizer as the only manufacturer. The FDA calls it a "broken marketplace." In a statement, Teva said that at the time "there was no indication of a possibility of a shortage," and added, "We are looking any and all options to contribute to the solution now." In an Oct. 18 letter on the FDA website, Pfizer said it was "expediting shipments" of the drug and expected "to fully meet market need."

**Analysis:** Neg assumes that drug prices decline in the aff world, which benefits the aff strategy for rebuttal. High drug prices in the status quo cause financial and medical suffering for families, which means that aff can link turn negs argument.

### A/2: Americans hate Medicare for All

**Response:** There is growing support for Medicare for All

**De-Link:** The COVID crisis has accelerated support for Medicare for All

"As Coronavirus Surges, 'Medicare for All' Support Hits 9-Month High". Morning Consult. April 1. 2020, <https://morningconsult.com/2020/04/01/medicare-for-all-coronavirus-pandemic/>

**"In the midst of a pandemic that has spurred an economic crisis and put Americans' health care costs in stark contrast with the rest of the industrialized world, support for "Medicare for All" has risen to its highest point in about nine months, according to new Morning Consult/Politico data. The sweeping health reform package championed by Sen. Bernie Sanders (I-Vt.) that would provide all Americans with health insurance through the government now has support from 55 percent of registered voters, per a March 27-29 survey of 1,997 respondents, taken as the United States became the global epicenter of the coronavirus. Thirty-five percent of voters continue to oppose the proposal, putting net support — the share who support minus those who oppose — at 20 points, a 9-point jump from mid-February.."**

**De-Link:** COVID is making people realize they support Medicare for All

"As Coronavirus Surges, 'Medicare for All' Support Hits 9-Month High". Morning Consult. April 1. 2020, <https://morningconsult.com/2020/04/01/medicare-for-all-coronavirus-pandemic/>

"Though Democrats drove the movement in the most recent poll, they didn't do so alone: For the first time since June 2019, a majority of independents are in favor of

Medicare for All (52 percent), sparking an 8-point increase in net support among this demographic since February. **As the domestic COVID-19 caseload spirals and economists predict a historic surge in unemployment, millions of Americans are bracing for potentially untenable health care costs and lapses in coverage, reviving questions about the viability of a health system that relies on binding insurance to employment..”**

**Warrant:** Medicare for all is very popular in 2020 polling numbers

“Two-thirds of voters support providing Medicare to every Americans.” PNHP, April 24, 2020. <https://pnhp.org/news/two-thirds-of-voters-support-providing-medicare-to-every-american/>

“Support for Medicare for All has remained consistently strong over the past two years, according to a new Hill-HarrisX poll. **Sixty-nine percent of registered voters in the April 19-20 survey support providing Medicare to every American, just down 1 percentage point from an Oct. 19-20, 2018 poll, and within the poll’s margin of error.** Popularity for Medicare for All grew slightly among Democratic voters, with a 2 percentage point increase from 2018.”

**De-Link:** Medicare for all is popular among right-leaning voters and independents

“Two-thirds of voters support providing Medicare to every Americans.” PNHP, April 24, 2020. <https://pnhp.org/news/two-thirds-of-voters-support-providing-medicare-to-every-american/>

**“Support among independent voters was steady at 68 percent. However, support among Republican voters declined 6 percentage points over the course of two years, from 52 percent support in 2018 to 46 percent in 2020.** Progressive lawmakers have

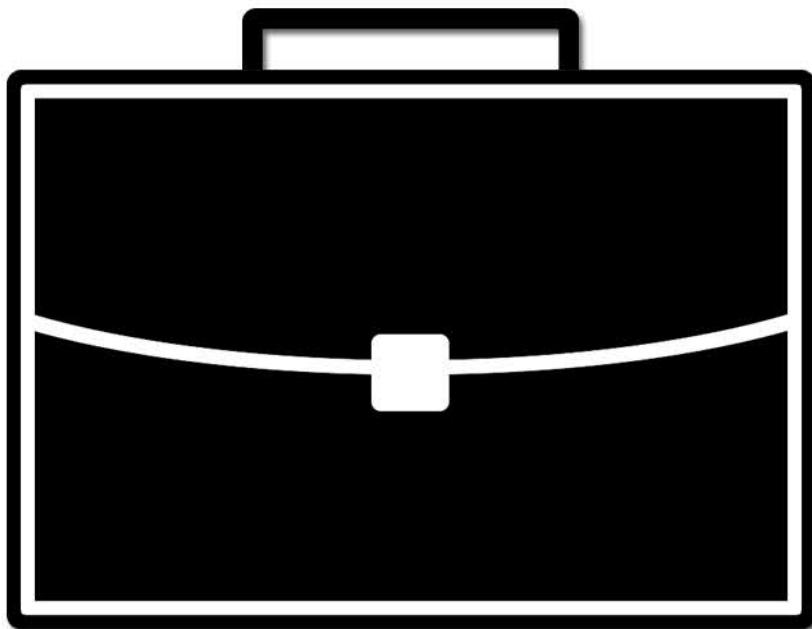
been pointing to the coronavirus crisis to make a case for the need for Medicare for All as millions of Americans are kicked off their employee-based health insurance due to the economic fallout of the pandemic. “Crises are moments of opportunity for policy change,” Robert Griffin, Research Director of the Democracy Fund Voter Study Group, told Hill.TV.”

**Analysis:** While there are large numbers of Americans who are staunchly opposed to Medicare for All, recent circumstances have changed things. The COVID crisis and the Sanders campaign have changed many peoples’ mind, from both political parties, creating more support among voters

# Champion Briefs

## Sept/Oct 2020

### Public Forum Brief



## Con Arguments

### CON: The 2019 Bill Precludes Other, Better Options

**Argument:** There are other healthcare reform bills which are better than the 2019 Medicare for All bill and have a realistic shot at passing. America should not pass the 2019 bill because it would preclude these better options.

**Warrant:** There are 9 competing visions for the future of healthcare among democrats

Sarah Kliff and Dylan Scott. "We read 9 Democratic plans for expanding health care.

Here's how they work." VOX. June 21. 2019.

<https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal>

"These plans are the universe of ideas that Democrats will draw from as they flesh out their vision for the future of American health care. While the party doesn't agree on one plan now, they do have plenty of options to choose from — and many decisions to make. **The nine plans fall into two categories. There are some that would replace private insurance and cover all Americans through the government. Then there are the others that would allow all Americans to buy into government insurance (like Medicare or Medicaid) if they wanted to, or they could continue to buy private insurance.**"

**Warrant:** Many of the alternative proposals would increase coverage to similar levels as Medicare for All

Sarah Kliff and Dylan Scott. "We read 9 Democratic plans for expanding health care.

Here's how they work.." VOX. June 21. 2019.

<https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal>

**"Medicare for America (DeLauro and Schakowsky):** This health care plan, informed by the work of the Center for American Progress and Yale professor Jacob Hacker, **would achieve universal coverage for all legal residents, through a combination of private and public insurance — at least for the next few decades. It eventually foresees getting to a very similar level of coverage as the Medicare-for-all proposals in Congress, by enrolling all newborns into a government health plan and taking steps that would diminish the role of employer-sponsored coverage."**

**Warrant:** Alternative proposals have real built in funding mechanisms

Sarah Kliff and Dylan Scott. "We read 9 Democratic plans for expanding health care. Here's how they work.." VOX. June 21. 2019.  
<https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal>

**"Medicare for America (DeLauro and Schakowsky): There is a more detailed financing plan laid out in the Medicare for America legislation. The Republican tax cuts would be rolled back. An additional 5 percent tax on income over \$500,000 would be applied. Payroll taxes for Medicare would also be hiked, as would the net investment income tax rate. New excise taxes on tobacco, alcohol and sugary drinks would be introduced. The bill also requires states to continue making payments to the federal government equivalent to what they pay right now for Medicaid's costs."**

**Warrant:** Other plans have better policies around cost sharing

Ed Dolan. "Medicare for America: A health care plan worth a closer look". Salon Magazine. June 20, 2019., <https://www.salon.com/2019/06/20/medicare-for-america-a-health-care-plan-worth-a-closer-look/>

**"The coinsurance rate is set at 20 percent, up to an income-dependent out-of-pocket maximum. For households below 200 percent of the poverty line, the maximum is zero. Above 600 percent, the maximum is \$3,500 for an individual and \$5,000 for a family. Between those limits, the out-of-pocket maximum varies according to a linear sliding scale. Coinsurance and deductibles each have their advantages. People subject to deductibles get a stronger market signal to economize on expenditures. On the other hand, for a given out-of-pocket maximum, coinsurance extends over a broader range of spending, so the market signal, although weaker, applies to more transactions. Studies show that both forms of cost sharing sometimes lead consumers to forego appropriate, cost-effective care rather than only avoiding care that is inappropriate or overpriced."**

**Warrant:** Allowing for a small private sector under alternative plans is good

Ed Dolan. "Medicare for America: A health care plan worth a closer look". Salon Magazine. June 20, 2019., <https://www.salon.com/2019/06/20/medicare-for-america-a-health-care-plan-worth-a-closer-look/>

**"One is that allowing a small private sector would reduce costs of the public program by reducing demand for its services. Anything that reduced the cost of the program without degrading the quality of services, would, in turn, improve its political prospects. On the contrary. Although they would not pay premiums, if concierge clients had high incomes (as would presumably be the case for most of them), they would still be subject to payroll tax and income tax surcharges. Second, the very existence of a small private sector would help to alleviate one of the greatest sources of resistance to universal or near-universal government health care: the fear of long waiting periods. The experience of the British National Health Service provides some lessons in that regard. In the years before Tony Blair became prime minister of the U.K., waiting**

times in the National Health Service grew alarmingly for procedures like hip replacements. As waits grew longer, the British private sector, normally a small niche market, began to grow. That growth, in turn, acted as a spur to reforms by the Blair government that significantly shortened waiting times. Since then, the private sector has again become smaller."

**Analysis:** This argument shows that there are other, more politically realistic options to Medicare for All. Make the case that because healthcare reform is so difficult and requires so much political energy, we need to go with the best plan in order to get it right

### CON: Medicare For All Would Hurt Innovation

**Argument:** Medicare for all would misalign innovation incentives resulting in fewer breakthroughs

**Warrant:** The original Medicare passage hurt innovation because it hurt competition

Jakob Rich. "Medicare for All means Innovation for None." Reason, April 16, 2019.

<https://reason.org/commentary/medicare-for-all-means-innovation-for-none/>

**"In 1965, American life expectancy was 70 years — it is now just 78 years, a modest improvement at best. The fact that the last 54 years of unprecedented American innovation has been accompanied by only eight years of increased life expectancy is quite concerning.** During that period, rotary phones transformed into pocket-sized supercomputers, but most Americans still live fewer years than many of the Founding Fathers. Public health enthusiasts often challenge this correlation, noting that medical care has also greatly improved. They are partially correct. **This innovation has been unequally distributed. Ailments mostly reserved to the elderly in many cases persist, even as those that plague the young are cured en masse. Diseases like Alzheimer's, Parkinson's, and dementia are all just as prevalent among seniors and untreatable today as they were in 1965. The lack of innovation is staggering, but is enabled by an equal lack of competition among health care providers for seniors, most of whom are on Medicare rather than private plans."**

**Warrant:** Medicare diminishes the incentive to innovate

Jakob Rich. "Medicare for All means Innovation for None." Reason, April 16, 2019.

<https://reason.org/commentary/medicare-for-all-means-innovation-for-none/>

**"Public health care has little incentive to introduce new technologies and prolong life. Rich countries like the United Kingdom and Canada provide universal health care but have lower cancer survival rates than America. That's why many more American seniors today have health insurance than in 1965, yet their health outcomes are still often terrible. And more funding isn't enough — Medicare already indiscriminately funds treatments, but lacks the mechanisms and competition to decide which are effective. This might be why up to 20 percent of Medicare claims are fraud and waste."**

**Warrant:** Non Medicare demographics have seen dramatic results in health outcomes

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

**"A National Institutes of Health study published in 1993 concluded that "The lack of significant improvement in median survival in the last 40 years for those older than 60 years of age stands in stark contrast to the remarkable improvement for younger patients. Acute leukemia in older patients demands new and probably different therapeutic strategies." Medicare has yet to address this disparity, which is typical for conditions that affect older people. In contrast, outcomes related to treatments for seniors that overlap age groups have seen major improvements. For example, breast cancer survival increased from 64.9 percent in 1975 to 82.8 percent by 2002, but half of women who are diagnosed are under the age of 62, when most patients still privately fund their health and incentivize innovation. Testicular cancer also saw a 95 percent death rate in 1975 become a 95 percent cure rate by 2010, but testicular cancer is also the most common cancer for males between the ages of 15 and 35.."**

**Warrant:** Many Economists Agree that Medicare for All would stifle innovation

"Leading economists warn 'Medicare for All' would trigger shortages, stifle innovation".

The Washington Times. Monday 23, 2020.,

<https://www.washingtontimes.com/news/2020/mar/23/leading-economists-warn-medicare-all-would-trigger/>

**"More than 50 leading U.S. economists and professors have signed an open letter warning that the proposed "Medicare for All" plans to place Americans on a government-run system would trigger shortages, degrade quality and discourage medical innovation.** "Americans should have access to the health care they need and have insurance protection for medical expenses they cannot afford," said the letter released last week. "We, the undersigned economists, believe the proposed Medicare for All plans would lead to shortages throughout the health sector that would restrict access to care, undermine quality, lead to innovation-stifling price controls, and adversely impact the economy."

**Impact:** Markets are needed to encourage medical innovation

"Leading economists warn 'Medicare for All' would trigger shortages, stifle innovation".

The Washington Times. Monday 23, 2020.,

<https://www.washingtontimes.com/news/2020/mar/23/leading-economists-warn-medicare-all-would-trigger/>

**"The solution is creating a more efficient market for medical care and medical insurance that would restrain costs through competition, improved and transparent information, and consumer incentives rather than through destructive methods such as price controls and limits on private care choices,"** they said. The Coalition Against Socialized Medicine, a free-market group whose members include the American Conservative Union, Heritage Action and FreedomWorks, said the COVID-19 pandemic

**has illustrated the importance of encouraging innovation in health care.**

“Unfortunately, the stakes now have been put into stark relief as the world faces the grim challenge of the coronavirus,” said coalition executive director Marc Palazzo. “As humanity battles this common threat together, our hopes are pinned to the very innovation that these policies would ultimately destroy.”

**Analysis:** This argument shows that the long term health effects of Medicare for All are negative. By stopping breakthrough cures like those to COVID, Medicare for All will doom Americans to stagnating quality of care and flattening life expectancy.

### CON: Medicare for All Causes Resource Overuse

**Argument:** Free health care triggers moral hazard, dramatically increasing the usage of hospital resources costing money and increasing wait times

**Warrant:** Medicare for all will dramatically increase the amount people consume healthcare

Chris Conover. "The #2 Reason Bernie Sanders' Medicare-for-All Single-Payer Plan Is A Singularly Bad Idea." Forbes. September 13. 2017.

<https://www.forbes.com/sites/theapothecary/2017/09/30/the-2-reason-bernie-sanders-medicare-for-all-single-payer-plan-is-a-singularly-bad-idea/#4b0c394e29bb>

"The #2 reason this plan is a bad idea is the enormous amount of waste it would create due to moral hazard. **Moral hazard is the technical term used by health economists, but it refers to something every reader intuitively understand even if the term itself is unfamiliar. If you give something to someone for free, they will use more of it and they also will be less likely shop vigorously for a lower price. In short, such consumers will typically use more and pay more (i.e., be willing to accept a higher price) for "free" services. You might think this wouldn't apply to health care: after all, do people really have a choice about whether to go to the hospital if they're in a car accident? And would they realistically shop around for the best price in such a circumstance? In that instance, of course not. But the reality is that most medical care is not of an emergency flavor.."**

**Warrant:** Up to 30% of free healthcare is wasted

Chris Conover. "The #2 Reason Bernie Sanders' Medicare-for-All Single-Payer Plan Is A Singularly Bad Idea." Forbes. September 13. 2017.

<https://www.forbes.com/sites/theapothecary/2017/09/30/the-2-reason-bernie-sanders-medicare-for-all-single-payer-plan-is-a-singularly-bad-idea/#4b0c394e29bb>

“The reason I can say this with certainty is because the **RAND Health Insurance Experiment--a randomized controlled trial (i.e., the gold standard of scientific evidence)--proved it about 4 decades ago. The HIE randomly assigned thousands of families to different types of health insurance plans ranging from a free care plan virtually identical to Bernie Sanders' single-payer plan to the equivalent of a very high deductible plan having a huge amount of cost sharing, but also having an upper limit on cost sharing that no family spent more than a certain fraction of family income (this capped was set at 5, 10 or 15%). The bad news for single-payer enthusiasts is that free care of the sort provided under Canada's single-payer health system or under Senator Sanders's version of Medicare-for-All results in 30% wasted spending. Of the roughly \$6,000 in annual spending per person in the free care group, more than \$1,850 (>30%) was wasted [1]. Put another way, the value of spending for this group was less than 70% of the total amount of spending paid for by the free care plan (note that all figures count only medical expenses and exclude insurance administrative costs).”**

**Warrant:** The extra care used is not essential to health outcomes

Chris Conover. “The #2 Reason Bernie Sanders' Medicare-for-All Single-Payer Plan Is A Singularly Bad Idea.” Forbes. September 13. 2017.

<https://www.forbes.com/sites/theapothecary/2017/09/30/the-2-reason-bernie-sanders-medicare-for-all-single-payer-plan-is-a-singularly-bad-idea/#4b0c394e29bb>

“**The RAND HIE deep-sixed another favorite talking point of single-payer enthusiasts. RAND scientists systematically compared health outcomes--including the risk of death-**

-across all plan participants. What they discovered might astonish some readers. There was not a dime's worth of difference in health outcomes for the average patient. **More scientifically, we can say there was no statistically significant difference in health outcomes (including risk of death) when those who got free care were compared to those with cost-sharing plans (including those in high-deductible plans whose actuarial value was only 54%!).**"

**Warrant:** Many Economists Agree that Medicare for All would stifle innovation

"Leading economists warn 'Medicare for All' would trigger shortages, stifle innovation".

The Washington Times. Monday 23, 2020.,

<https://www.washingtontimes.com/news/2020/mar/23/leading-economists-warn-medicare-all-would-trigger/>

**"More than 50 leading U.S. economists and professors have signed an open letter warning that the proposed "Medicare for All" plans to place Americans on a government-run system would trigger shortages, degrade quality and discourage medical innovation.** "Americans should have access to the health care they need and have insurance protection for medical expenses they cannot afford," said the letter released last week. "We, the undersigned economists, believe the proposed Medicare for All plans would lead to shortages throughout the health sector that would restrict access to care, undermine quality, lead to innovation-stifling price controls, and adversely impact the economy."

**Impact:** The status quo minimizes moral hazard while Medicare for all would exacerbate it

Jeffery Miron "How Many Uninsured? It Does Not Matter". CATO Institute. January 24, 2009., <https://www.cato.org/blog/how-many-uninsured-it-does-not-matter>

**“Policy must therefore accept a trade-off: subsidizing health insurance will increase some people’s perceptions of fairness, but it will make the health care market less efficient. A reasonable balancing of these two concerns suggests subsidizing insurance for the truly poor, but no more. In fact, the U.S. already does that via Medicaid. The uninsured are mainly people with too much income to qualify for Medicaid, or people eligible but fail to apply. Thus expansion of subsidized insurance to the currently uninsured, whatever their number, is likely to generate substantial inefficiency relative to any increase in “fairness” it creates..”**

**Analysis:** This argument shows that the long term health effects of Medicare for All are negative. By stopping breakthrough cures like those to COVID, Medicare for All will doom Americans to stagnating quality of care and flattening life expectancy.

### CON: Medicare For All is Too Expensive

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**Argument:** The cost of the government running the nation's healthcare would be prohibitive and lead to a fiscal crisis

**Warrant:** Medicare for All would be incredibly expensive

Ronald Brownstien. "The Eye-Popping Cost of Medicare for All." *The Atlantic*, 16 October 2019. <https://www.theatlantic.com/politics/archive/2019/10/high-cost-warren-and-sanders-single-payer-plan/600166/>

"The Urban Institute, a center-left think tank highly respected among Democrats, is projecting that a plan similar to what Warren and Senator Bernie Sanders are pushing would require **\$34 trillion in additional federal spending over its first decade in operation. That's more than the federal government's total cost over the coming decade for Social Security, Medicare, and Medicaid combined, according to the most recent Congressional Budget Office projections.**"

**Warrant:** Medicare for all would require unimaginable tax increases

Ronald Brownstien. "The Eye-Popping Cost of Medicare for All." *The Atlantic*, 16 October 2019. <https://www.theatlantic.com/politics/archive/2019/10/high-cost-warren-and-sanders-single-payer-plan/600166/>

"In recent history, only during the height of World War II has the federal government tried to increase taxes, as a share of the economy, as fast as would be required to offset the cost of a single-payer plan, federal figures show. **There are "no analogous peacetime tax increases," says Leonard Burman, a public-administration professor at**

Syracuse University and a former top tax official in both the Bill Clinton administration and at the CBO. Raising that much more tax revenue “is plausible in the sense that it is theoretically possible,” Burman told me. “But the revolution that would come along with it would get in the way.”

**Warrant:** It would be very difficult to raise the needed funding

Ronald Brownstien. “The Eye-Popping Cost of Medicare for All.” The Atlantic, 16 October 2019. <https://www.theatlantic.com/politics/archive/2019/10/high-cost-warren-and-sanders-single-payer-plan/600166/>

**“How big a lift is it to raise \$32 trillion? It’s almost 50 percent more than the total revenue the CBO projects Washington will collect from the personal income tax over the next decade (about \$23.3 trillion). It’s more than double the amount the CBO projects Washington will collect over the next decade from the payroll tax that funds Social Security and part of Medicare (about \$15.4 trillion). A \$32 trillion tax increase would represent just over two-thirds of the revenue the CBO projects the federal government will collect from all sources over the next decade (just over \$46 trillion.) Taxes that can fill that big of a hole are not easy to identify. Even by Warren’s own estimates, which some liberal economists consider too optimistic, her proposed wealth tax on personal fortunes exceeding \$50 million would raise just \$2.75 trillion over the next decade.”**

**Warrant:** Measures to pay for Medicare for All would be catastrophic

“Choices for Financing Medicare for All”. Committee for a Responsible Budget. 17 May 2019., <http://www.crfb.org/papers/choices-financing-medicare-all>

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

**Impact:** Even deficit financing for Medicare would be economically harmful

"Choices for Financing Medicare for All". Committee for a Responsible Budget. 17 May 2019., <http://www.crfb.org/papers/choices-financing-medicare-all>

**Deficit financing Medicare for All would also harm the economy, mainly by crowding out investment in productive capital. PWBM finds it would reduce projected GDP by 5.9 percent in 2030 – the equivalent of about \$5,300 per person – and gross national product would likely fall by significantly more. PWBM also finds that deficit financing Medicare for All would reduce hours worked by nearly 10 percent – the equivalent of 14 million full-time equivalent jobs. Lastly, PWBM estimates that charging mandatory premiums, while subsidizing low-income beneficiaries, would reduce GDP by 2.3 percent – the equivalent of \$2,100 per person. It would reduce hours worked by 7 percent – the equivalent of 10 million full-time equivalent jobs.**

**Analysis:** This contention makes the argument that Medicare for all is simply unaffordable. The impact is economic growth and jobs, which can be weighed against expanding coverage

because even if healthcare is more accessible without a job people are subject to many lifestyle illnesses and cannot afford other necessities.

### CON: Medicare for All is Unconstitutional

**Argument:** Medicare for All is Unconstitutional under the Freedom of Religion Acts

**Warrant:** The Medicare for All Bill 2019 covers Comprehensive Reproductive services, and is not excluded within the Bill.

Sanders, Bernard. "Medicare for All Bill 2019". Congress.gov. 4 Nov 2019.

<https://www.congress.gov/bill/116th-congress/senate-bill/1129/text#toc-id25c91cb96228483495ad9de0b47b79f8>

#### SEC. 201. COMPREHENSIVE BENEFITS.

(5) Mental health and substance abuse treatment services, including inpatient care.

(6) Laboratory and diagnostic services.

#### **(7) Comprehensive reproductive, maternity, and newborn care.**

(8) Pediatrics, including early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r) of the Social Security Act (42 U.S.C. 1396d(r))).

(9) Oral health, audiology, and vision services.

(10) Short-term rehabilitative and habilitative services and devices.

#### SEC. 203. EXCLUSIONS AND LIMITATIONS.

(a) IN GENERAL.—Benefits for services are not available under this Act unless the services meet the standards specified in section 201(a), as defined by the Secretary.

#### **(b) TREATMENT OF EXPERIMENTAL SERVICES AND DRUGS.—**

(1) IN GENERAL.—In applying subsection (a), the Secretary shall make national coverage determinations with respect to services that are experimental in nature. Such determinations shall be consistent with the national coverage

determination process as defined in section 1869(f)(1)(B) of the Social Security Act (42 U.S.C. 1395ff(f)(1)(B)).

**Warrant:** Any Medicare for All Legislation is confirmed that they will cover abortions.

Zaldibar, Ricardo. "Medicare For All' Legislation Raises Thorny Issues For Democrats".

WBUR.org: Common Health. 25 Mar 2019

<https://www.wbur.org/commonhealth/2019/03/25/medicare-for-all-legislation-raises-thorny-issues-for-democrats>

**On abortion, both bills essentially would sweep away the Hyde amendment, the term for federal laws stretching back more than 40 years that prohibit taxpayer money for abortions, except in cases of rape, incest, or to save the life of the woman. Such restrictions would not apply to Medicare for All, and comprehensive reproductive care would be a covered benefit. Sanders' and Dingell's offices confirmed that abortion would be covered.**

**Warrant:** The Supreme Court has repeatedly ruled that federal tax dollars cannot be used for abortions nor that they have the obligation to do so.

"Abortion: Judicial History and Legislative Response." Congressional Research Service

Updated 9 Sept 2019.

<https://crsreports.congress.gov/RL33467>  
<https://fas.org/sgp/crs/misc/RL33467.pdf>

In *Rust v. Sullivan*, the Court upheld on both statutory and constitutional grounds the Department of Health and Human Services' Title X regulations restricting recipients of federal family planning funding from using federal funds to counsel women about

abortion.<sup>33</sup> While Rust is probably better understood as a case involving First Amendment free speech rights rather than a challenge to the constitutionally guaranteed substantive right to abortion, **the Court**, following its earlier public funding cases (*Maher v. Roe*<sup>34</sup> and *Harris v. McRae*)<sup>35</sup>, **did conclude that a woman's right to an abortion was not burdened by the Title X regulations.** The Court reasoned that there was no constitutional violation because the government has no duty to subsidize an activity simply because it is constitutionally protected and because a woman is “in no worse position than if Congress had never enacted Title X.” The Supreme Court, in three related decisions, ruled that the states have neither a statutory nor a constitutional obligation to fund elective abortions or provide access to public facilities for such abortions.<sup>1</sup> The 1977 Supreme Court decisions left open the question of whether the Hyde Amendment and similar state laws could validly prohibit the governmental funding of therapeutic abortions. In ***Harris v. McRae***, the Court ruled **5-4 that the Hyde Amendment's abortion funding restrictions were constitutional.**<sup>133</sup> The majority found that the Hyde Amendment did not violate the due process or equal protection guarantees of the Fifth Amendment or the Establishment Clause of the First Amendment. **The Court also upheld the right of a state participating in the Medicaid program to fund only those medically necessary abortions for which it received federal reimbursement.**<sup>134</sup> In *Williams v. Zbaraz*, a companion case raising similar issues, the Court held that an Illinois statutory funding restriction that was comparable to the Hyde Amendment also did not contravene the constitutional restrictions of the Equal Protection Clause of the Fourteenth Amendment.<sup>135</sup> The Court’s rulings in *McRae* and *Zbaraz* indicate that there is no statutory or constitutional. **Under Department of Justice appropriations, funding of abortions in prisons is prohibited, except where the life of the mother is endangered, or in cases of rape or incest.** First enacted as part of the FY1987 continuing appropriations measure,<sup>156</sup> this provision has been reenacted as part of the annual spending bill in each subsequent fiscal year.<sup>157</sup> Finally, since 1979, restrictive abortion provisions have been included in appropriations measures for the District of Columbia (DC). The passage of the District of Columbia Appropriations Act,

1989, marked the first successful attempt to extend such restrictions to the use of DC funds, as well as federal funds.<sup>158</sup> **Under the so-called “Dornan Amendment,” DC was prohibited from using both appropriated funds and local funds to pay for abortions.** In 2009, Congress lifted the restriction on the use of DC funds to pay for abortions. Under the Consolidated Appropriations Act, 2010, only federal funds were restricted.<sup>159</sup> The Dornan Amendment has since been reimposed.<sup>1</sup> In addition to the temporary funding limitations included in appropriations bills, abortion restrictions of a more permanent nature have been enacted in a variety of contexts since 1970. For example, **the Family Planning Services and Population Research Act of 1970 bars the use of funds for programs in which abortion is a method of family planning.**<sup>160</sup> **The Legal Services Corporation Act of 1974 prohibits lawyers in federally funded legal aid programs from providing legal assistance for procuring nontherapeutic abortions and prohibits legal aid in proceedings to compel an individual or an institution to perform an abortion, assist in an abortion, or provide facilities for an abortion.**<sup>161</sup> The Pregnancy Discrimination Act provides that employers are not required to pay health insurance benefits for abortion except to save the life of the mother, but does not preclude employers from providing abortion benefits if they choose to do so.<sup>162</sup> **The Civil Rights Restoration Act of 1988 states that nothing in the measure either prohibits or requires any person or entity from providing or paying for services related to abortion.**<sup>163</sup> The Civil Rights Commission Amendments Act of 1994 prohibits the commission from studying or collecting information about U.S. laws and policies concerning abortion.

**Impact:** Medicare for All may be delayed through injunctions and court cases, as well as held unconstitutional.

**Warrant:** Lawsuits on religious grounds would plague the Medicare for All implementation.

Ollstein, Alice and Tahir, Darius.” Death by a thousand lawsuits’: The legal battles that could dog ‘Medicare for All’” Politico.com. 10 June 2019.

<https://www.politico.com/story/2019/06/10/medicare-lawsuit-1356592>

Depending on how aggressively Democratic lawmakers enshrine women's access to abortion and birth control, **religious groups could challenge such mandates on religious liberty grounds — as they did for Obamacare's birth control coverage rules**, sparking two Supreme Court cases. Currently, Medicare for All legislation guarantees free coverage of all forms of contraception and abortion.

**Warrant:** Minimal contraceptive mandates in the ACA have already been ruled to violate religious rights and have received exemptions.

Luth, Susannah. "Supreme Court Uphold's Trump's rollback of birth control mandate". 8 July 2020. Politico.com. <https://www.politico.com/news/2020/07/08/supreme-court-upholds-trumps-limits-on-birth-control-coverage-352385>

"**It is clear from the face of the statute that the contraceptive mandate is capable of violating [the religious freedom laws],**" Justice Clarence Thomas wrote in the opinion. Justices Elena Kagan and Stephen Breyer agreed that the Trump administration had the authority to grant religious exemptions to the birth control mandate, but they said the case should be sent back to lower court for further review. In a concurring opinion written by Kagan, they questioned whether the Trump administration followed proper administrative procedure in creating them and said the carve out is overly broad and "causes serious harm" to birth control access.

**Warrant:** The Supreme Court has held up injunctions for corporations as individuals in religious exemptions.

Gerais, Reem. "Burwell v Hobby Lobby." The Embryo Project Encyclopedia. 26 Feb 2017 <https://embryo.asu.edu/pages/burwell-v-hobby-lobby-2014>

In December 2012, Hobby Lobby appealed Heaton's decision to the US Court of Appeals for the Tenth Circuit in Denver, Colorado. The Tenth Circuit Court disagreed with the district court's decision, stating that for-profit organizations could claim rights to religious freedom and that Hobby Lobby had standing to sue the HHS. On 27 June 2013, the Tenth Circuit reversed the district court's initial denial of injunction. The appeals court sent the case back to Heaton who granted Hobby Lobby's request for an injunction on 19 July 2013. That meant that employee health care plans offered by Hobby Lobby Inc. would not be required to meet the contraceptive mandate and that the tax penalties associated with the ACA would not apply to Hobby Lobby for the duration of the trial.

On 30 June 2014, the US Supreme Court decided Burwell v. Hobby Lobby. The Supreme Court voted 5 to 4 in favor of Hobby Lobby. Five Justices, Samuel Alito, John Roberts, Antonin Scalia, Anthony Kennedy, and Clarence Thomas, joined the majority opinion authored by Alito. In that opinion, Alito argued that the contraceptive mandate of the ACA placed a burden on the exercise of religion of Hobby Lobby, a corporation that indeed counted as an individual with the ability to practice religion. Hobby Lobby, Alito argues, was protected under RFRA. The ACA, Alito argued, violated Hobby Lobby's rights under RFRA by compelling Hobby Lobby to provide certain contraception methods that burdened the corporation's religious beliefs, but failed to do so in the least restrictive manner.

**Impact:** Individual doctors and hospitals could refuse to cover contraceptives and abortions even if mandated under M4A.

**Warrant:** Religious freedom prevents the federal government from forcing individuals from paying for or participating in anything that goes against what they believe.

"Federal Law Protections for Religious Liberty: A Notice by the Justice Department".

Federal Register. 26 October 2017.

<https://www.federalregister.gov/documents/2017/10/26/2017-23269/federal-law-protections-for-religious-liberty>

**The Free Exercise Clause protects not just the right to believe or the right to worship; it protects the right to perform or abstain from performing certain physical acts in accordance with one's beliefs.** Federal statutes, including the Religious Freedom Restoration Act of 1993 ("RFRA"), support that protection, broadly defining the exercise of religion to encompass all aspects of observance and practice, whether or not central to, or required by, a particular religious faith

**The Free Exercise Clause protects not just persons, but persons collectively exercising their religion through churches or other religious denominations, religious organizations, schools, private associations, and even businesses.**

Constitutional protections for religious liberty are not conditioned upon the willingness of a religious person or organization to remain separate from civil society. Although the application of the relevant protections may differ in different contexts, **individuals and organizations do not give up their religious-liberty protections by providing or receiving social services, education, or healthcare; by seeking to earn or earning a living; by employing others to do the same; by receiving government grants or contracts; or by otherwise interacting with federal, state, or local governments.**

**RFRA applies to all sincerely held religious beliefs, whether or not central to, or mandated by, a particular religious organization or tradition. Religious adherents will often be required to draw lines in the application of their religious beliefs, and government is not competent to assess the reasonableness of such lines drawn, nor would it be appropriate for government to do so.** Thus, for example, a government agency may not second-guess the determination of a factory worker that, consistent with his religious precepts, he can work on a line producing steel that might someday make its way into armaments but cannot work on a line producing the armaments themselves. **Nor may the Department of Health and Human Services second-guess the**

determination of a religious employer that providing contraceptive coverage to its employees would make the employer complicit in wrongdoing in violation of the organization's religious precepts.

Because the government cannot second-guess the reasonableness of a religious belief or the adherent's assessment of the religious connection between the government mandate and the underlying religious belief, the substantial burden test focuses on the extent of governmental compulsion involved. In general, a government action that bans an aspect of an adherent's religious observance or practice, compels an act inconsistent with that observance or practice, or substantially pressures the adherent to modify such observance or practice, will qualify as a substantial burden on the exercise of religion. For example, a Bureau of Prisons regulation that bans a devout Muslim from growing even a half-inch beard in accordance with his religious beliefs substantially burdens his religious practice. Likewise, a Department of Health and Human Services regulation requiring employers to provide insurance coverage for contraceptive drugs in violation of their religious beliefs or face significant fines substantially burdens their religious practice, and a law that conditions receipt of significant government benefits on willingness to work on Saturday substantially burdens the religious practice of those who, as a matter of religious observance or practice, do not work on that day.

**Analysis:** Whether or not one agrees or disagrees with the Hyde Agreement, the Federal Government and Supreme court have ruled that protecting religious freedoms and rights of individuals and corporations have remained upheld. From tax payers being free from paying for something they feel is immoral, to not having to participate in an activity they feel is immoral as a part of their job are all part of rulings and law that would render the Medicare for All 2019 act unconstitutional.

### CON: Medicare for all does not help undocumented immigrants

**Argument:** M4A does not solve for undocumented Immigrants

**Warrant:** M4A is only automatic for residents of the United States and the Secretary will determine eligibility working with immigration to determine eligibility of "others."

Sanders, Bernard. "Medicare for All Act of 2019". US Congress. 4 Oct 2019.

<https://www.congress.gov/bill/116th-congress/senate-bill/1129/text#toc-idDAB9323B56D9497F8638F85510E78898>

**SEC. 102. UNIVERSAL ENTITLEMENT.** (a) **In General.**—Every individual who is a resident of the United States is entitled to benefits for health care services under this Act. The Secretary shall promulgate a rule that provides criteria for determining residency for eligibility purposes under this Act. (b) **Treatment Of Other Individuals.**—The Secretary— (1) may make eligible for benefits for health care services under this Act other individuals not described in subsection (a) and regulate their eligibility to ensure that every person in the United States has access to health care; and (2) shall promulgate a rule, consistent with Federal immigration laws, to prevent an individual from traveling to the United States for the sole purpose of obtaining health care services provided under this Act.

**Warrant:** The Definition of Legal Resident by the Dept of Homeland Security is:

"Lawful Permanent Residents". Dept of Homeland Security. 24 Feb. 2020.

<https://www.dhs.gov/immigration-statistics/lawful-permanent-residents>

**Lawful permanent residents (LPRs), also known as "green card" holders, are non-citizens who are lawfully authorized to live permanently within the United States.**

LPRs may accept an offer of employment without special restrictions, own property, receive financial assistance at public colleges and universities, and join the Armed Forces.

**Warrant:** Other countries with Universal Health care do not offer undocumented immigrants automatic coverage.

Hoffman, Jan. “**What Would Giving Health Care to Undocumented Immigrants Mean?”**. New York Times. 3 July 2019.

<https://www.nytimes.com/2019/07/03/health/undocumented-immigrants-health-care.html>

If the United States were to begin providing comprehensive health coverage to undocumented immigrants, it would be an outlier, health policy experts say. **Even countries with universal, government-run coverage like Norway place tough restrictions on health care for undocumented immigrants. Most immigrants can get emergency care but have to pay other costs.** Thailand, with waves of migrant workers, is considered to offer one of the most generous programs, screening immigrants for diseases and allowing them to buy into the national health insurance.

**Warrant:** Perceptual Fear of using the Medicare for all would further keep undocumented immigrants from using even Emergency rooms as Gov hospitals collect data

Sanders, Bernard. “Medicare for All Act of 2019”. US Congress. 4 Oct 2019.

<https://www.congress.gov/bill/116th-congress/senate-bill/1129/text#toc-idDAB9323B56D9497F8638F85510E78898>

**(C) The provider agrees to furnish such information as may be reasonably required by the Secretary, in accordance with uniform reporting standards**

established under section 401(b)(1), for—(i) quality review by designated entities; (ii) making payments under this Act, including the examination of records as may be necessary for the verification of information on which such payments are based; (iii) statistical or other studies required for the implementation of this Act; and (iv) such other purposes as the Secretary may specify.

**Warrant:** Currently more than half of undocumented immigrants have access to health care.

Artiga, Samantha and Diaz, Maria. “Health Coverage and Care of Undocumented Immigrants”. KFF.org. 15 July 2019. <https://www.kff.org/disparities-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/#:~:text=Medicaid%20helps%20offset%20costs%20borne,but%20for%20their%20immigration%20status>.

Undocumented immigrants are at high risk of being uninsured. Among the total nonelderly population, **45% of undocumented immigrants were uninsured** compared to about one in four (23%) lawfully present immigrants and less than one in ten citizens (8%) as of 2017 (Figure 2).

Current coverage among undocumented immigrants reflects a limited array of private coverage and some state- or locally-funded programs. **Some undocumented immigrants may get coverage through their employer or as a spouse or dependent of an employee. Undocumented immigrants can also purchase private coverage on the individual market outside of the ACA Marketplaces**, although many may not be able to afford this coverage due to their limited incomes and lack of subsidies to offset the costs of this coverage. **Some undocumented immigrants may also be covered through student health programs. Six states (CA, IL, MA, NY, OR, and WA) and DC use state-**

only funds to cover income-eligible children regardless of immigration status.<sup>7</sup> In June 2019, California approved an expansion in coverage for income-eligible young undocumented immigrant adults through age 25. Although the Democratic presidential candidates have indicated support for expanding coverage to undocumented immigrants, to date, there are no detailed proposals. The impact and costs of such an expansion would depend on how individuals are covered (e.g., through private coverage, Medicare, or Medicaid), what benefits are provided, and premium and cost-sharing levels. (...)The state has budgeted \$98 million dollars for the expansion in the first year, which is estimated to cover 90,000 people. Even if coverage is expanded, fears among immigrant families could limit participation

**Warrant:** In the UK, with their universal health care system undocumented workers have limited to no access and there is a Fear of hospitals and drs for deportation.

British Medical Journal. "UK failing to provide universal health coverage by Charging undocumented migrant kids" Medical Xpress. 14 March 2019.  
<https://medicalxpress.com/news/2019-03-uk-universal-health-coverage-undocumented.html>

In 2017 further legislation in England introduced mandatory upfront charging before treatment for those unable to prove their eligibility, and denial of non-urgent care for those unable to pay. Emergency and primary care treatment are currently exempt, as are some infectious diseases. Other urgent care or treatment deemed immediately necessary, such as maternity care, can be provided, but can still be charged later on. And as the authors point out, anyone with unpaid NHS debts of £500+ is referred to the Home Office after two months, and this can affect their immigration status or asylum application. "Therefore, families may face legitimate concerns that seeking care for their sick child may result in immigration enforcement such as detention, deportation and even family separation," explain the authors. Henry J. Kaiser Family

**Foundation.** “But parents are often fearful of enrolling their children, even though they are eligible, because they don’t want to put the rest of the family in jeopardy.”

**Impact:** Perceptual fears will Keep undocumented immigrants from receiving care.

Hacker, Karen et al. “Barriers to health care for undocumented immigrants: a literature review.” Risk management and healthcare policy vol. 8 175-83. 30 Oct. 2015, doi:10.2147/RMHP.S70173

With the unprecedented international migration seen in recent years, policies that limit health care access have become prevalent. **Barriers to health care for undocumented immigrants go beyond policy and range from financial limitations, to discrimination and fear of deportation.**

Finally, there was evidence of widespread discriminatory practices within the health care system itself. **The individual level focused on the immigrant’s fear of deportation, stigma, and lack of capital (both social and financial) to obtain services.**

**Impact:** Millions will now face uncertainty of deportation

Krogstad, Jens Manuel and Lopez, Mark Hugo. “Americans favor medical care but not economic aid for undocumented immigrants affected by COVID-19”. Pew Research Center. 20 May 2019. <https://www.pewresearch.org/fact-tank/2020/05/20/americans-favor-medical-care-but-not-economic-aid-for-undocumented-immigrants-affected-by-covid-19/>

**A little over a tenth of the nation’s 60 million Latinos are undocumented (or unauthorized) immigrants (7.6 million). In a December survey, 45% of U.S. Latino adults said they personally know someone who is in the country illegally. The same**

survey found that 44% of Latinos said they worry a lot or some that they themselves, a family member or close friend could be deported.

**Impact:** Without access for the approx 50% of undocumented immigrants through private insurance and expanded Medicaid will lead to loss of life, lower quality of life and other short and long term impacts

Beck et all. "Medical Care for Undocumented Immigrants". Primary Care The Clinics. 2016. [https://www.primarycare.theclinics.com/article/S0095-4543\(16\)30062-8/pdf](https://www.primarycare.theclinics.com/article/S0095-4543(16)30062-8/pdf)

**Most of the emergency health care services used by UIs are for childbirth.** A study of emergency Medicaid expenditures for undocumented and recent immigrants in North Carolina between 2001 and 2004 found that more than **82% of health care spending was related to childbirth and complications of pregnancy. Of the remaining health care expenditures, one-third was spent on the treatment of acute injuries and poisoning**, possibly related to exposure to pesticides or other toxins in the workplace. These uses of health care services reflect not only the young age of most UIs but also the type of work that they perform. **Beyond pregnancy and acute injury, chronic renal failure, cerebrovascular disease, and heart disease were major contributors to emergency Medicaid use.** Various factors associated with undocumented status are thought to erode the health advantage of the undocumented at a faster rate than their documented counterparts. Specifically, limited access to quality health care; increased vulnerability caused by low income and occupational status; and the stressors associated with undocumented status, such as fear of deportation, have been implicated. In addition, **UIs with chronic and infectious medical conditions are negatively affected because of poor access to care.** Perinatal health of undocumented women and their US-born children is a specific area of concern. Consistent with much of the health literature, several studies have found that undocumented women engage in few health risk behaviors while pregnant and seem to have low rates of low-birth-

weight or preterm babies.<sup>33–36</sup> However, the beneficial effects of better health behaviors during pregnancy are counteracted by the effects of lower rates of prenatal care among UIs. **Poor (and late) prenatal care has been associated with higher risk for adverse perinatal outcomes. In addition, stressors related to undocumented status, such as fear of deportation or experiences of discrimination and stigma, may adversely affect the physical and emotional health of UIs, with potential consequences for their US-born children.**<sup>38,39</sup> Findings from a qualitative study of 85 immigrant families experiencing the arrest of at least 1 parent by immigration authorities, showed an increase in the children's behavioral problems, speech and developmental concerns, and declines in school performance. Little is known about the mental health issues of UIs. However, the literature suggests that **UIs have a unique risk profile that may contribute to different mental health outcomes** compared with their documented counterparts. Themes specific to UIs include failure in the country of origin, dangerous border crossings, limited resources, restricted mobility, marginalization/isolation, stigma/blame and guilt/shame, vulnerability/exploitability, fear and fear-based behaviors, and stress and depression.

**Analysis:** While the Medicare for All Act of 2019 may have the intentions to cover undocumented immigrants, the lack of specificity of who would actually be covered, what the process is, and how the Secretary would define it based on political swings makes the actuality of the ideal unknown. With that uncertainty comes a loss of access to private insurance that approx. 50% of undocumented immigrants receive through various means, and more fear free access to ERs and free clinics. However, with M4A all private insurance would be banned, undocumented immigrants may or may not have access to the m4a and have to pay for it (with an unknown cost) all with a greater fear of data collection by the hospitals to be in compliance with M4A/government that could lead to arrest, deportation leading to an avoidance of obtaining/seeking health care putting lives, quality of life, health and mental health all at risk with unknown potential impacts for the future.

## CON: Medicare for All increases poverty and its detrimental impacts

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**Warrant:** M4a will eliminate skilled positions and put millions out of work.

Rosenthal, Elisabeth. "Analysis: A Health Care Overhaul Could Kill 2 Million Jobs, And That's OK" Keiser Health News. 24 May 2019. <https://khn.org/news/analysis-a-health-care-overhaul-could-kill-2-million-jobs-and-thats-ok/>

The first casualties of a Medicare for All plan, said Dr. Kevin Schulman, a physician-economist at Stanford, would be the "intermediaries that add to cost, not quality." For example, **the armies of administrators, coders, billers and claims negotiators who make good middle-class salaries and have often spent years in school learning these skills.** There would be far less need for drug and device sales representatives who ply their trade office to office and hospital to hospital in a single-payer system, or one in which prices are set at a national level.

Some geographic areas would be hit particularly hard. **A single hospital system is by far the biggest employer in many post-manufacturing cities like Pittsburgh and Cleveland. Hospitals and hospital corporations make up the top six employers in Boston and two of the top three in Nashville.** Hartford is known as the insurance capital of the world. Where would New Jersey be if drugmakers took a big hit, or Minnesota if device makers vastly shrank their workforce? (That may be why some Democratic representatives and senators from these left-leaning states have been quiet or inconsistent on Medicare expansion.)

**Stanford researchers estimate that 5,000 community hospitals would lose more than \$151 billion under a Medicare for All plan; that would translate into the loss of 860,000 to 1.5 million jobs. A Navigant study found that a typical midsize, nonprofit hospital system would have a net revenue loss of 22%.**

**Robert Pollin, an economist at the Political Economy Research Institute of the University of Massachusetts-Amherst, is frustrated not just by the doomsday predictions but also by how proponents of Medicare for All tend to gloss over the jobs issue.**

**“Every proponent of Medicare for All — including myself — has to recognize that the biggest source of cost-saving is layoffs,” he said. He has calculated that Medicare for All would result in job losses (mostly among administrators) “somewhere in the range of 2 million” — about half on the insurers’ side and half employed in hospitals and doctors’ offices to argue with the former. Supporters of Medicare for All, he said, have to think about a “just transition” and “what it might look like.”**

**Warrant:** M4A would hurt the economy and increase taxes to more than what they are paying now putting even more into poverty or at risk.

“Medicare For All Could ‘Decimate’ The Economy” Partnership for America’s Healthcare Future. 2 May 2020. <https://americashealthcarefuture.org/medicare-for-all-could-decimate-the-economy/>

**The one-size-fits-all government health insurance system “could decimate the economy,”** the Washington Examiner adds. This contributes to the mounting evidence that Medicare for All would burden American families with unaffordable new costs, as the Urban Institute finds “that federal spending on health care would increase by roughly \$34 trillion under a single-payer plan similar to Medicare for All,” CNN reports. The Committee for a Responsible Federal Budget (CRFB) finds that “fully offsetting the cost would require higher taxes on the middle class” and would “require the equivalent of tripling payroll taxes or more than doubling all other taxes.” Senator Sanders previously acknowledged that Americans making more than \$29,000 per year would “pay more in taxes” for Medicare for All. “No matter how you cut the numbers, there is absolutely no way to pay for Medicare for all without tax increases – or

spending cuts – on the middle class,” Marc Goldwein of CRFB told POLITICO. “**There’s no question it hits the middle class,**” Kenneth Thorpe, Chairman of the Health Policy and Management Department, Emory University told The Washington Post. “**Although [Medicare for All’s supporters]** have frequently stressed that the middle class would see overall costs go down, a wide range of experts ... say it is impossible to make those guarantees based on the plans that the candidates have outlined so far ... ‘It’s impossible to have an ‘everybody wins’ scenario here,’ said Kenneth Thorpe, chairman of the health policy department at Emory University ... ‘There’s no question it hits the middle class,’ he added. John Holahan, a health policy expert at the nonpartisan Urban Institute agreed: ‘Even though high-income people are going to pay a lot more, this has to hit the middle class.’ ... ‘Most of the proposals to move to Medicare-for-all would involve substantial tax increases that would affect most people,’ said **Katherine Baicker, an economist at the University of Chicago who specializes in health policy.** ‘These are going to be big tax increases.’ ... ‘I think it seems likely under most proposals taxes would have to go up substantially unless you dramatically cut the health care you’re getting,’ she added,” The Washington Post reports. And, “**economists say that most taxpayers would pay more in taxes than they would save from having the federal government absorb the cost of health-care premiums,**” The Post also reports. Additionally, “**71% of households with private insurance would wind up paying more than they would under the current system,**” Kenneth Thorpe, chairman of the health policy and management department at Emory University, told The Wall Street Journal. Meanwhile, a study by Tom Church, Daniel L. Heil, and Lanhee J. Chen, Ph.D. of the Hoover Institution with support from the Partnership for America’s Health Care Future reveals that the public option – often branded a “moderate” alternative to Medicare for All – “could require tax increases on most Americans, including middle-income families” and could “add over \$700 billion to the 10-year federal deficit, with dramatically larger losses in subsequent years.” According to the new study, “**a politically realistic public option would add over \$700 billion to 10-year deficits. By 2049, the plan would increase long-run debt projections by 30 percent of GDP or**

require tax increases equal to nearly 20 percent of projected income tax revenue. These tax increases may affect even middle-income taxpayers, raising their marginal income tax rates by several percentage points.” This would make the public option “the third largest line item on the federal budget, behind only Medicare and Social Security.”

**Warrant:** Job loss reduces collection of taxes, increases the burden on the tax system and disincentivises companies from hiring, keeping unemployment high.

Simpson, Stephen. “The Cost of Unemployment to the Economy” Investopedia. 15 April 2020. <https://www.investopedia.com/financial-edge/0811/the-cost-of-unemployment-to-the-economy.aspx>

The economic costs of unemployment are probably more obvious when viewed through the lens of the national checkbook. **Unemployment leads to higher payments from state and federal governments for unemployment benefits, food assistance, and Medicaid. In January 2020 payments from state and federal governments for unemployment benefits totaled \$2.95 billion.<sup>12</sup> At the same time, state and federal governments are no longer collecting the same levels of income tax as before**—forcing these governments to borrow money, which defers the costs and impacts of unemployment into the future, or cut back on other spending. **Unemployment is also a dangerous state for the U.S. economy. More than 70% of what the U.S. economy produces goes to personal consumption and unemployed workers.**<sup>13</sup> Even those receiving government support cannot spend at prior levels. **The production of those workers leaves the economy, which reduces the gross domestic product (GDP) and moves the country away from the efficient allocation of its resources.** For those who subscribe to Jean-Baptiste Say’s theory that products are paid for by products, that is a serious issue.<sup>14</sup> **It is also worth noting that companies pay a price for high unemployment as well. Unemployment benefits are financed largely by taxes**

assessed on businesses.<sup>15</sup> When unemployment is high, states will often look to replenish their coffers by increasing their taxation on businesses—counter-intuitively discouraging companies from hiring more workers. Not only do companies face less demand for their products, but it is also more expensive for them to retain or hire workers.

**Warrant:** M4A raises taxes and costs to businesses and employees.

Pipes, Sally. "Small Businesses Are Making A Big Mistake By Supporting Single-Payer".

Forbes. 2 March 2020.

<https://www.forbes.com/sites/sallypipes/2020/03/02/small-businesses-are-making-a-big-mistake-by-supporting-single-payer/#4c78c5d54e80>

For these folks, Medicare for All might seem like a welcome reprieve. But **a closer look reveals that a government-run healthcare system would be no less difficult to deal with than the status quo—and would actually raise costs for employers and employees.** Then there's the issue of cost. One of the small-business owners profiled by Kaiser Health News said that he spent about 10% of his payroll on health benefits. That sounds like a deal, compared to Medicare for All. These days, Medicare for All's chief advocate, **Senator Bernie Sanders, has been mum about how he'd pay for it.** A few years ago, he floated several ideas for financing a less comprehensive version of Medicare for All than the one he's pitching on the campaign trail now. Those ideas included a new 7.5% payroll tax on employers, and a 4% "income-based premium" paid by households. For some employers, that tax tab could be a heck of a lot higher than what they're currently paying for health insurance. Medicare for All would also eliminate the tax break for employer-sponsored coverage by, well, outlawing employer-sponsored coverage. Under the status quo, many families receive thousands of dollars in untaxed compensation in the form of health benefits. Even if they recapture that compensation dollar for dollar in the form of cash wages—a debatable

proposition—they'll be worse off, since that compensation will be subject to income tax. Indeed, according to analysis by Emory University economist Kenneth Thorpe, **70% of privately-insured households would pay more for health coverage under Medicare for All than they do now.** Nor would Medicare for All insulate employers from the yearly rise in costs they've faced as health insurance premiums have marched upward. As envisioned by Senator Sanders, Medicare for All is massively underfunded—despite the historic tax increases he's promising. **Studies from the Urban Institute, the RAND Institute, and the Mercatus Center estimate the ten-year cost of Medicare for All at about \$30 trillion to \$40 trillion. The revenue from his new taxes, including new taxes on the wealthy and large financial institutions, would amount to only \$17 trillion over ten years.** Eventually, the federal government would have to hit employers of all sizes and their employees with huge tax hikes to keep single-payer afloat. Absent such tax hikes, the government would have to add to its already historic debt load, which would exert an enormous drag on the economy over time. **An analysis by researchers at the University of Pennsylvania's Wharton School estimates that, by 2060, a Medicare for All program financed through deficit spending would reduce economic growth by an astounding 24%. For small businesses struggling with the cost of health coverage, the prospect of taxpayer-funded health care for everyone might seem appealing. In reality, Medicare for All would lead to worse benefits, long waits, rationed care, and higher healthcare costs for employers and workers alike**

**Impact:** Job Loss impacts individuals and their families beyond financial poverty.

Brand, Jennie E. "The Far-Reaching Impact of Job Loss and Unemployment." Annual review of sociology vol. 41 (2015): 359-375. doi:10.1146/annurev-soc-071913-043237 <https://www.annualreviews.org/doi/abs/10.1146/annurev-soc-071913-043237>

Job loss is an involuntary disruptive life event with a far-reaching impact on workers' life trajectories. Its incidence among growing segments of the workforce, alongside the

recent era of severe economic upheaval, has increased attention to the effects of job loss and unemployment. As a relatively exogenous labor market shock, the study of displacement enables robust estimates of associations between socioeconomic circumstances and life outcomes. **Research suggests that displacement is associated with subsequent unemployment, long-term earnings losses, and lower job quality; declines in psychological and physical well-being; loss of psychosocial assets; social withdrawal; family disruption; and lower levels of children's attainment and well-being. While reemployment mitigates some of the negative effects of job loss, it does not eliminate them.**

**Impact:** Overall impacts of job loss and poverty hurt individuals, society and government

Pettinger, Trjvan. "Economic costs of unemployment" Economicshelp.org. 28 June 2019.  
<https://www.economicshelp.org/macroeconomics/unemployment/costs/>

### Personal Costs of unemployment

- **Loss of earnings to the unemployed. Unemployment is one of the biggest causes of poverty in the UK. Prolonged periods of unemployment can push households into debt and increase rates of relative poverty.**
- **Potential homelessness. Loss of income can leave people without sufficient income to meet housing costs. Rises in unemployment often exacerbate the rates of homelessness. (BBC)**
- **Harms future prospects. Those who are unemployed will find it more difficult to get work in the future (this is known as the hysteresis effect)**
- **Lost human capital. If people are out of work, they miss out on 'on the job training' This is a vital component of human capital and labour skills; high rates of unemployment can reduce labour productivity. If someone is out of work for two years, they miss out on the latest working practices and trends. Being**

unemployed can also affect the confidence of the unemployed and they become less employable in the future.

- Unemployment and depression/mental health
- Stress and health problems of being unemployed. Amongst studies of unemployed men, signs of depression, mental anxiety, and health problems are noticeably higher. (Effects of unemployment on health (US Library of Health)  
According to a study by Gallup, “**About one in five Americans who have been unemployed for a year or more say they currently have or are being treated for depression — almost double the rate among those who have been unemployed for five weeks or less.**”
- Another study found that common outcomes of unemployment include depression, substance abuse, admissions to psychiatric hospitals, death by suicide, and violence. (1)
- Cost of unemployment to Government
- Increased government borrowing. Higher unemployment will cause a fall in tax revenue because there are fewer people paying income tax and also spending less (hence lower VAT). Also, the government will have to spend more on unemployment and related benefits. The government doesn't just pay unemployment benefit, but a family who has unemployment will be more likely to receive housing benefit and income support. One study shows that the cost to the Exchequer for one person being unemployed is £6,243 a year in benefits and lost tax revenue. (Independent)
- Costs of unemployment to society
- Lower GDP for the economy. High unemployment indicates the economy is operating below full capacity and is inefficient; this will lead to lower output and incomes. The unemployed are also unable to purchase as many goods, so will contribute to lower spending and lower output. A rise in unemployment can cause a negative multiplier effect. Increase in social problems. Areas of high unemployment (especially youth unemployment) tend to have more crime and

vandalism. It can lead to alienation and difficulties in integrating young unemployed people into society.

**Analysis:** While Medicare for All 2019 is an effort to provide access and lift individuals out of poverty while also helping businesses, the initial job losses along will decimate the economy, increase taxes on businesses and individuals, even those already in poverty, bring those in the middle class into or at risk of poverty. The Impact of short and long term unemployment on poverty goes beyond the financial into health, mental health, education, societal violence, government loss of tax revenue from those who are unemployed, creating a cycle of unemployment, government debt, and increased burdens on citizens. Life without quality of life is no life at all.

### CON: Medicare for All will disproportionately harm people of color

**Argument:** M4A will adversely hurt people of color.

**Warrant:** Approximately more than half of all those living in poverty are in minority groups.

Mather, Mark. "Race/Ethnic Income Gap Growing Among U.S. Working Poor Families".

Population Reference Beureu. 16 March 2015

- Among the 10.6 million U.S. low-income families with an employed adult in 2013, racial/ethnic minorities constitute 58 percent, despite only making up 40 percent of all working families nationwide.
- The economic gap between non-Hispanic white and all minority working families is now 25 percentage points.
- There are 24 million children growing up in low-income working families and 14 million, well over half, are racial/ethnic minorities.

**Warrant:** Low Socioeconomic status is more prevalent in minority communities, including unemployment and the detrimental effects of poverty.

"Ethnic and Racial Minorities & Socioeconomic Status" American Psychological Association. July 2017. <https://www.apa.org/pi/ses/resources/publications/minorities>

- **In the United States, 39 percent of African-American children and adolescents and 33 percent of Latino children and adolescents are living in poverty**, which is more than double the 14 percent poverty rate for non-Latino, White, and Asian children and adolescents (Kids Count Data Center, Children in Poverty 2014).
- **Minority racial groups are more likely to experience multidimensional poverty** than their White counterparts (Reeves, Rodriguez, & Kneebone, 2016).

- American Indian/Alaska Native, Hispanic, Pacific Islander and Native Hawaiian families are more likely than Caucasian and Asian families to live in poverty (U.S. Census Bureau, 2014).
- Although the income of Asian American families often falls markedly above other minorities, these families often have four to five family members working (Le, 2008). African-Americans (53 percent) and Latinos (43 percent) are more likely to receive high-cost mortgages than Caucasians (18 percent; Logan, 2008).
- **African American unemployment rates are typically double that of Caucasian Americans. African-American men working full-time earn only 72 percent of the average earnings of comparable Caucasian men and 85 percent of the earnings of Caucasian women** (Rodgers, 2008). **Education** Despite dramatic changes, large gaps remain when minority education attainment and outcomes are compared to white Americans.
- **African-Americans and Latinos are more likely to attend high-poverty schools** than Asian-Americans and Caucasians (National Center for Education Statistics, 2007).
- From 2000 to 2013 the dropout rate between racial groups narrowed significantly. However, high school dropout rates among Latinos remain the highest, followed by African-Americans and then Whites (National Center for Education Statistics, 2015).
- **In addition to socioeconomic realities that may deprive students of valuable resources, high-achieving African American students may be exposed to less rigorous curriculums, attend schools with fewer resources, and have teachers who expect less of them academically than they expect of similarly situated Caucasian students** (Azzam, 2008).
- **12.4 percent of African-American college graduates between the ages of 22 and 27 were unemployed in 2013**, which is more than double the rate of unemployment among all college graduates in the same age range (5.6 percent; J. Jones & Schmitt, 2014). **Physical Health.** Institutional discrimination creates barriers to health care access. Even when stigmatized groups can access care, cultural racism reduces the quality of care they receive (Williams & Mohammed, 2013).

- Racial and ethnic minorities have worse overall health than that of White Americans. Health disparities may stem from economic determinants, education, geography and neighborhood, environment, lower quality care, inadequate access to care, inability to navigate the system, provider ignorance or bias, and stress (Bahls, 2011).
- Socioeconomic status and race/ethnicity have been associated with avoidable procedures, avoidable hospitalizations, and untreated disease (Fiscella, Franks, Gold, & Clancy, 2008).
- At each level of income or education, African-Americans have worse outcomes than Whites. This could be due to adverse health effects of more concentrated disadvantage or a range of experiences related to racial bias (Braveman, Cubbin, Egerter, Williams, & Pamuk, 2010).
- Low birth weight, which is related to a number of negative child health outcomes, has been associated with lower SES and ethnic/minority status (Fiscella et al., 2008).
- There are substantial racial differences in insurance coverage. In the preretirement years, Hispanics and American Indians are much less likely than Whites, African-Americans, and Asians to have any health insurance (Williams, Mohammed, Leavell, & Collins, 2010).

**Warrant:** Medicare for all would increase taxes on can afford it the least

Haislmaier, Edmund and Bryan, James. "How "Medicare for All" Harms Working Americans" Hall SPECIAL REPORT No. 219 | November 19, 2019 INSTITUTE FOR FAMILY, COMMUNITY, AND OPPORTUNITY t <http://report.heritage.org/sr219>

Proposals to impose a government-run health care system, such as the pending "Medicare for All" legislation, on the American public would leave most households financially worse off. **Workers would have to pay additional taxes—21.2 percent of all wage and salary income—raising the total federal payroll tax rate to 36.5 percent for most workers. Average disposable income (after taxes and private medical expenses)**

for all households would decline by \$5,671 per year. We also find that nearly two-thirds of American households (65.5 percent, comprising 73.5 percent of the population) would pay more in taxes than they would save from no longer paying health insurance premiums and the absence of out-of-pocket medical spending. For households with employer-sponsored insurance, 87.2 percent would be worse off financially. Advocates of this idea suggest that Americans currently covered by private health plans would be financially better off, even after their taxes are raised to fund the proposed new government program. For example, Senator Bernie Sanders (I–VT) has said: “Are people going to pay more in taxes? Yes. But at the end of the day, the overwhelming majority of people are going to end up paying less for health care because they aren’t paying premiums, co-payments or deductibles.”<sup>2</sup> That assertion is incorrect. Our analysis finds that in order to fund such a program, it would be necessary for the federal government to impose substantial, broad-based taxes equal to 21.2 percent of all wage and salary income. Those taxes would be in addition to the payroll taxes that most workers already pay for the existing Social Security and Medicare programs, bringing total payroll taxes to 36.5 percent for most workers.<sup>3</sup> We also find that nearly two-thirds of American households (65.5 percent, comprising 73.5 percent of the population) would experience reductions in their disposable income, making them financially worse off. Those households would pay more in new taxes to fund the program than they would save as a result of the program eliminating their current spending on private health insurance and out-of-pocket medical expenses. After accounting for both the tax increases and the reductions in private spending for health insurance and medical care, we find that average annual household disposable income would decline by \$5,671 (or 11 percent) under a new government-run health care program. Among households with employer-sponsored health benefits, 87.2 percent would be worse off financially under a new government-run health care program, and their annual disposable income would be \$10,554 lower, on average. That would occur despite those households receiving wage increases, as employers responded to the new program by converting the value of current tax-free, employer-provided health benefits

into additional taxable cash income.<sup>4</sup> The reason: Workers would pay much higher taxes to fund the cost of the new program because workers would need to (1) replace their own private spending, (2) replace non-workers' private spending, and (3) pay for the additional spending that would result from the program stimulating increased use of medical care. Example 2: A **Lower-Middle-Income Married Couple with Children and Employer Health Benefits Would be \$1,619 Worse Off.** A married couple with two children, cash income near \$50,000, and covered by employer-sponsored insurance would have \$1,619 less in disposable income under a government-run health care program. While this family's total income including employer-paid benefits would remain unchanged, the portion subject to tax would increase by \$12,386 (the sum of the \$8,430 value of the employer contribution and \$3,957 employee contribution toward the employer-sponsored insurance plan, which are currently untaxed).

**Impact:** Poverty for people of color leads to intergenerational poverty, increased health and mental health issues, as well as higher mortality rates with lower life expectancy.

"Poverty". Healthypeople.gov. 14 Aug 2020.

<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/poverty>

Many factors can contribute to inequitable access to resources<sup>8</sup> and opportunities, which may result in poverty.<sup>7, 9 10</sup> Marital status, education, social class, social status, income level, and geographic location (e.g., urban vs. rural) can influence a household's risk of living in poverty.<sup>1, 7, 11–14</sup> For example, in 2012, 17.7% of people in rural areas were living in poverty, compared to 14.5% of people in urban areas.<sup>15, 16</sup> Racial and ethnic minorities are more likely than non-minority groups to experience poverty at some point in their lives.<sup>9, 17</sup> In addition, children from families that receive welfare assistance are 3 times more likely to use welfare benefits when they become adults than children from families who do not receive welfare.<sup>12</sup> Studies also report that

migrant status<sup>18</sup> is a risk factor for poverty.<sup>9, 19–21</sup> Residents of impoverished neighborhoods or communities are at increased risk for mental illness,<sup>22, 23</sup> chronic disease,<sup>17, 24</sup> higher mortality, and lower life expectancy.<sup>7, 8</sup> Some population groups living in poverty may have more adverse health outcomes than others. For example, the risk for chronic conditions such as heart disease, diabetes, and obesity is higher among those with the lowest income and education levels.<sup>17</sup> In addition, older adults who are poor experience higher rates of disability and mortality.<sup>25</sup> Finally, people with disabilities are more vulnerable to the effects of poverty than other groups.<sup>25–27</sup> Racial and ethnic minorities living in poverty (defined by socioeconomic status) may also have more adverse health outcomes.<sup>9</sup> For example, a study of health outcomes among those living in poverty found that African American men are more likely to die from prostate cancer than any other racial group.<sup>28–30</sup> The same study found that African American women are more likely to suffer from breast and cervical cancer than any other racial group.<sup>28</sup>

**Analysis:** While the intention of the Medicare for All is to help minorities to obtain better medical access and care, it will not solve for the root problems of poverty which pervades. With a majority of those in poverty coming from communities of color, and taxes increased on low income workers, leaving less money for families to use for basic needs, the cycle of poverty and the health impacts will remain or worsen, defeating the purpose of the Medicare for All Act 2019 and therefore there is no solvency.

### CON: Medicare for All will harm other countries

**Argument:** M4A will harm individuals in other countries.

**Warrant:** US Pharmaceutical companies provide millions of vaccines for deadly, but preventable, illnesses to global populations--particularly developing nations, saving millions of lives every year.

Rovner, J. "Pharmaceutical companies pledge vaccines for developing countries."

Lancet (London, England) 11 March 2000. vol. 355,9207 (2000): 908.

doi:10.1016/S0140-6736(05)74114-3

<https://pubmed.ncbi.nlm.nih.gov/10752716/>

**"After the opening of the Millennium Vaccine Initiative (MVI), a program which aims to help lower the toll of infectious disease, four pharmaceutical companies pledge to develop vaccines to fight infectious diseases in the developing world. The agreement by Merck, American Home Products, SmithKline Beecham, and Aventis Pharma came as President Clinton continued to advance the MVI program. Merck announced that it would give 5 million doses of its hepatitis B vaccine over the next 5 years; American Home Products stated that it would donate 10 million doses of its Hemophilus influenzae type b vaccine. Moreover, SmithKline Beecham announced it would do pediatric trials of its malaria vaccine in Africa and renewed a pledge made in 1998 to work with WHO to donate 5 billion doses of albendazole over the next 20 years to eradicate lymphatic filariasis. In addition, Aventis Pharma promised 50 million doses of its polio vaccine for war-torn nations in Africa."**

**Warrant:** Pharma company innovation and donations for Neglected Tropical Diseases are particularly important for treatment in developing nations.

WHO. "Evaluation of Neglected Tropical Diseases" Who.int. 2019.  
[https://www.who.int/docs/default-source/documents/evaluation/evaluation-ntd-report.pdf?sfvrsn=351a363f\\_2](https://www.who.int/docs/default-source/documents/evaluation/evaluation-ntd-report.pdf?sfvrsn=351a363f_2)

**"There has been great success for the NTD medicine donation programme, with 1.762 billion treatments delivered to 1 billion people in 2017 across five PC diseases (i.e. lymphatic filariasis, onchocerciasis, soil-transmitted helminthiasis, schistosomiasis, and trachoma)16,17. This is a significant and commendable achievement by WHO and many partners, including through the donation of the pharmaceutical industry. "**

**Warrant:** Drug companies create thousands of new drugs for developing nations every year through r&d saving millions of lives.

"The Value of Medical Innovation". Health Care Institute of New Jersey. 2019.  
<https://hinj.org/value-of-medical-innovation/>

- The research and development-driven (R&D) biopharmaceutical sector generates high-quality jobs and powers economic output for the U.S. economy, serving as the “the foundation upon which one of the United States’ most dynamic innovation and business ecosystems is built,” according to the Battelle Technology Partnership Practice.
- **The U.S. biopharmaceutical sector accounts for the single largest share of all U.S. business R&D, representing 4 percent of all domestic R&D funded by U.S. businesses in 2013.**
- **91 percent of drugs are developed by the private sector with no direct government role.**
- **More than 7,000 medicines currently are in development — or in the “pipeline” — around the world, including for cancers, cardiovascular disorders, diabetes, HIV/AIDS, immunological disorders and infectious diseases.**

- Of those 7,000 treatments, approximately 3,400 medicines are being developed in the U.S., an increase of 40 percent since 2005.
- Of those 7,000 treatments, 70 percent are potential first-in-class therapies, meaning they use a completely new approach to fighting a disease.
- Of those 7,000 treatments, 42 percent have the potential to be personalized medicines, a term described as providing “the right patient with the right drug at the right dose at the right time.”
- Over the past decade, 42 percent of the late-stage R&D pipeline is now specialty medicines up from 33 percent ten years ago.

**Warrant:** Millions rely on pharma donations and it is imperative to global health

Global Alliance for Patient Access. “The Role of Drug Donations in Expanding Access to Medicines”. GAFBA.org 2017. [http://gafpa.org/wp-content/uploads/GAFPA\\_Drug\\_Donations\\_August-2017.pdf](http://gafpa.org/wp-content/uploads/GAFPA_Drug_Donations_August-2017.pdf)

**“Millions of low-income people in countries and communities around the world depend upon the generosity of donated drugs. Over the past two decades, the appropriateness of donations—that is, how well donor offerings reflect actual need—has improved dramatically.<sup>1,2,3</sup> Whether donated from surplus stock, through philanthropic contributions, as part of disaster responses, or through longerterm development programs, drug donations are critical to global health. “ “Drug donations can make treatment accessible for patients and communities in need. They also have a more far-reaching impact, such as strengthening health systems, securing sustainable supply chains, and fostering markets and public services that promote patient access. Drug donations to low- and middle-income countries in particular can free up funds that would otherwise have been spent purchasing drugs through third-party or local vendors at a higher price. These funds can instead support critical resources such as infrastructure, human resources, and capacity for health systems”**

**Warrant:** Companies are balancing profit and innovation in order to be part of initiatives that help save lives in developing nations.

"Profits and Social Responsibility: Chastened Drug Makers Step Up Efforts to Bring Affordable Medicines to Poor Countries." Knowledge@Wharton. The Wharton School, University of Pennsylvania, 10 February, 2011. Web. 11 August, 2020 <<https://knowledge.wharton.upenn.edu/article/profits-and-social-responsibility-chastened-drug-makers-step-up-efforts-to-bring-affordable-medicines-to-poor-countries/>>

**For drug makers, serving poor nations in Africa, Asia and Latin America calls for striking a balance between meeting public health needs and maximizing profits.** Guiding the companies are codes of ethics and corporate responsibility for doing business. "There is a special duty when you are selling medicine as opposed to pantyhose or hubcaps," says Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania. When drug companies put short-term gains ahead of social responsibility, he adds, they often pay a price in bad publicity and a backlash from regulators. Put differently, "**The issue of who gets drugs developed for them is a very important ethical issue and cuts to the heart of the strength and weakness of markets,**" says Michael A. Santoro, a Rutgers Business School professor and co-editor of the 2005 book, *Ethics and the Pharmaceutical Industry: Business, Government, Professional and Advocacy Perspectives*. "**On the one hand, we don't like it that markets are harsh and unjust,**" Santoro says. "**But on the other hand, it's the power of the market that creates the therapies in the first place.**"

**Impact:** M4a price caps will reduce pharm innovation that would save lives.

Jillian Chown, Assistant Professor of Management & Organizations, et al. "Would

'Medicare for All' Really Reduce Healthcare Costs in the U.S.?" Kellogg Insight, 4 Oct 2019. [insight.kellogg.northwestern.edu/article/medicare-for-all-reduce-healthcare-costs-prescription-drugs](https://insight.kellogg.northwestern.edu/article/medicare-for-all-reduce-healthcare-costs-prescription-drugs).

**"On the pharmaceutical side, the researchers predicted that whether or not a government chose to use its heft to suppress drug prices should depend on the size of the market. The logic is that if a major drug-buying country puts downward pressure on pharma prices, it could have a large effect on drug companies' bottom line, which could have negative consequences down the road. "There are a lot of drugs that never pan out," Chown says, "and the companies need to recoup the costs of developing those so they can continue to invest in innovation." Thus, larger countries have an incentive not to lower drug prices too far, lest they deter pharma companies from developing new products, which could eventually harm their own citizens. "Canada's not afraid to lower drug prices because it doesn't have an effect on drug supply," Dranove says. "They're too small a market." However, that's likely not the case for the U.S., where such a move could put a major dent in pharma profits, preventing many drugs from ever coming to market, as manufacturers would have less incentive to invest in innovation and development. "If Canada lowers prices, it doesn't affect the global market size for drugs," says Chown. "If the U.S. does, it's much more disruptive.""**

**Outweigh:** Without the profits to donate and the funds for innovation millions of lives will be directly impacted, as well as poverty and life expectancy/quality of life. The HINJ '20 quantifies that globally, US drug development from just 2000 to 2009 is directly responsible the increase in life expectancy and lives saved.

"The Value of Medical Innovation". Health Care Institute of New Jersey. 2019.  
<https://hinj.org/value-of-medical-innovation/>

**"The President's Council of Advisors on Science and Technology in 2012 reported that innovative medicines had played a "profound role" in this impressive life-expectancy progress.**

- **Globally, between 1960 and 1997, new therapies accounted for 45 percent of the increase in life expectancy in 30 developing and high-income countries.**
- **Between 2000 and 2009, new therapies accounted for 73 percent of the increased life expectancy for these same 30 developing and high-income countries.**
- **The HIV/AIDS death rate has dropped nearly 85 percent since the introduction of highly active antiretroviral treatment (HAART) in 1995.**
- **An estimated 862,000 premature HIV/AIDS deaths were avoided in the U.S. alone as a result of this class of drugs (HAART) and all the medical innovations that followed.**
- **A range of hepatitis C treatments today offer cure rates upwards of 90 percent, with few side effects in as few as 8 weeks, up from 41 percent, though with debilitating side effects, in 2010.**
- **Over 161,000 patients started treatment for hepatitis C in 2014, nearly ten times more than in the previous year."**

**Outweigh:** WHO '19 reports that the NTD medicine donation program has been crucial, with 1.762 billion treatments delivered to 1 billion people in one year alone.

WHO. "Evaluation of Neglected Tropical Diseases" Who.int. 2019.

[https://www.who.int/docs/default-source/documents/evaluation/evaluation-ntd-report.pdf?sfvrsn=351a363f\\_2](https://www.who.int/docs/default-source/documents/evaluation/evaluation-ntd-report.pdf?sfvrsn=351a363f_2)

As per Table 7, only one out of five PC diseases (onchocerciasis) has met the coverage target for 2017. **The coverage of individuals receiving PCT has increased year over year, from 857 million in 2014 to 1.1 billion in 2017.** While there has been varied percentage of coverage over time, the trend line is increasing across these PC diseases.

**Impact Poverty and lives:** According to the **Center for Disease Control '18**, NTDs are tropical contagious diseases that primarily affect the world's poorest billion people in the world's poorest countries.

"World NTD Day" CDC. 29 Jan 2020. <https://www.cdc.gov/globalhealth/ntd/index.html>

**Neglected tropical diseases (NTDs) are a group of parasitic and bacterial diseases that cause substantial illness for more than one billion people globally. Affecting the world's poorest people, NTDs impair physical and cognitive development, contribute to mother and child illness and death, make it difficult to farm or earn a living, and limit productivity in the workplace. As a result, NTDs trap the poor in a cycle of poverty and disease."**

**Analysis:** The US Pharmaceutical Industry is a leader in the innovation of new drugs/treatments/vaccines. Through their agreements and philanthropic missions, they use the profits to reinvest in R&D for NDT, orphan drugs, and other innovations in order to provide donations or reduced cost contracts to countries that don't have access to these life saving treatments. These countries are then able to use money saved to reinvest in their infrastructure, economy, and bettering their own health care systems. Millions of lives are saved, as well as the quality of life for millions of others, all while also helping to alleviate the impacts of poverty and the poverty that comes with illnesses. This compounds over the years to date and into the future. Medicare for All would put price caps on medications, lowering profits which will reduce the ability for companies to donate, provide at lower costs, and innovate as they will not be able to recoup costs. This will in turn lead to the deaths of millions relying on those treatments, lower the quality of life with debilitating affects of illnesses and poverty for millions more compounding over time.

### CON: Medicare for All Harms Rural Hospitals

**Argument:** Rural hospitals are among the most vulnerable and important institutions in America. Under M4A, however, it is unclear if these rural hospitals would be able to survive.

**Warrant:** Rural Hospitals are vulnerable

Clary Estes, 2-24-2020, "1 In 4 Rural Hospitals Are At Risk Of Closure And The Problem Is Getting Worse," Forbes. 24 Feb. 2020. Web. 15 Aug. 2020.

<https://www.forbes.com/sites/claryestes/2020/02/24/1-4-rural-hospitals-are-at-risk-of-closure-and-the-problem-is-getting-worse/#561a9cde1bc0>

As of January 1, 2020, **the rural hospital closure crisis has claimed 120 facilities across the nation over the past 10 years** according to a recent study released by the Chartis Center for Rural Health. The rural hospital closures were tracked by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina. The study found a sharp uptick in recent years in the number of rural hospital closures from 2017 (when rural hospital closures slowed somewhat to 10 total hospitals closing that year), to 2019, which proved to be the worst year for rural hospital closures, finding 19 hospitals closing their doors that year. With 60 million Americans living in rural communities (roughly 19.3% of the population) and access to healthcare in these regions already being a daily struggle, the study sheds light on an issue that requires rapid attention by policy makers, as well as local and state governments.

**Weighing:** Rural hospitals serve the most vulnerable populations

Clary Estes, 2-24-2020, "1 In 4 Rural Hospitals Are At Risk Of Closure And The Problem Is Getting Worse," Forbes. 24 Feb. 2020. Web. 15 Aug. 2020.

<https://www.forbes.com/sites/claryestes/2020/02/24/1-4-rural-hospitals-are-at-risk-of-closure-and-the-problem-is-getting-worse/#561a9cde1bc0>

Across the US there are currently 1,844 rural hospitals, so the closure of 120 of them over 10 years (about 7%) is a substantial hit to the rural healthcare system, especially when **the regions with the highest number of rural hospital closures are some of the nation's poorest and most vulnerable.** According to the study, States in the Southeast and lower Great Plains (Midwest) bore the greatest brunt of the closure crisis with the highest number of rural hospital closures since 2010 being in; Texas (20), Tennessee (12), Oklahoma (7), Georgia (7), Alabama (6) and Missouri (6). Unfortunately, the trend for these regions does not seem to be abating. The study found that today, "453 rural hospitals (i.e. Critical Access Hospitals and Rural & Community Hospitals) are vulnerable to closure based on performance levels which are similar to rural hospitals at the time of their closure." And they are all similarly in the Southeast and lower Great Plains Region.

**Warrant:** M4A would lose money for rural hospitals

Reed Abelson, 4-21-2019, "Hospitals Stand to Lose Billions Under 'Medicare for All,'" The New York Times. 21 April 2020. Web. 15 August 2020.

<https://www.nytimes.com/2019/04/21/health/medicare-for-all-hospitals.html>

The yawning gap between payments to hospitals by Medicare and by private health insurers for the same medical services may prove the biggest obstacle for advocates of "Medicare for all," a government-run system. **If Medicare for all abolished private insurance and reduced rates to Medicare levels — at least 40 percent lower, by one estimate — there would most likely be significant changes throughout the health care industry,** which makes up 18 percent of the nation's economy and is one of the nation's largest employers. **Some hospitals, especially struggling rural centers, would close virtually overnight, according to policy experts.**

**Warrant:** Over half of rural hospitals could be put at risk under M4A

Kelly Gooch, 8-7-2019, "Medicare public option could put 55% of rural hospitals at high

risk of closure, analysis finds." Becker's Hospital CFO Report. 7 August 2020.

Web. 15 August 2020.

<https://www.beckershospitalreview.com/finance/medicare-public-option-could-put-55-of-rural-hospitals-at-high-risk-of-closure-analysis-finds.html>

A Medicare public option, meaning adding a government-sponsored health insurance option into the marketplace, could have a significant effect on rural hospital closures across the country, according to a new analysis. **The Navigant Consulting analysis, supported by the Partnership for America's Healthcare Future, found that a public option could put up to 55 percent of U.S. rural hospitals, or 1,037 hospitals in 46 states, at "high risk of closure."** The finding was based on Navigant's study of various public option scenarios on the revenue of nearly 1,900 critical access and short-term acute care hospitals in rural areas. Researchers found that:

- A Medicare public option applying to uninsured people and existing individual ACA market participants could put 28 percent of rural hospitals at high risk of closure.
- A Medicare public option where employers move 25 percent to 50 percent of their covered workers to the option could put 51 percent to 55 percent of rural hospitals at high risk of closure, and 39 percent to 41 percent of rural hospitals at moderate risk. Navigant estimated that Medicare would have to boost payments to hospitals for a public option 40 percent to 60 percent above current Medicare rates to prevent the financial consequences associated with public option scenarios.

**Impact:** Rural hospital closures increases mortality rates of rural communities by 8%

Kitee Gujral. 06-2020. "Impact of Rural and Urban Hospital Closures on Inpatient

Mortalities." The National Bureau of Economic Research. June 2020. Web. 15 August 2020. <https://www.nber.org/papers/w26182>

**This paper uses a difference-in-difference approach to examine the impact of California's hospital closures occurring from 1995-2011** on adjusted inpatient mortality for time-sensitive conditions: sepsis, stroke, asthma/chronic obstructive pulmonary disease (COPD) and acute myocardial infarction (AMI). Outcomes of admissions in hospital service areas (HSAs) with and without closure(s) are compared before and after the closure year. The paper focuses on: 1) the differential impacts of rural and urban closures, 2) the aggregate patient-level impact across several post-closure mechanisms, and 3) the effect on Medicare as well as non-Medicare patients. Results suggest that when treatment groups are not differentiated by hospital rurality, closures appear to have no measurable impact, i.e. there is no general impact of closures. **However, estimating differential impacts shows that rural closures increase inpatient mortality by 0.78% points (an increase of 8.7%), whereas urban closures have no measurable impact.** Subgroup analyses indicate the existence of a general impact for stroke and AMI patients (4.4% increase in inpatient mortality) and relatively worse impacts of rural closures for Medicaid patients and racial minorities (11.3% and 12.6%, respectively).

**Analysis:** The strength of this argument is at the impact level: Rural hospital closures have clear and severe impacts. Neg teams should look into . While the strength is the impacts, the weakness lies within establishing that rural hospitals will be harmed in the first place (see further in the A2 section). Neg teams should be prepared to have a strongly contested debate at the warrant level before they can access impacts.

## CON: Medicare for All Causes Hospital Closures

**Argument:** Because Medicare for All would decrease the amount of revenue that hospitals bring in, it would lead to the closures of hospitals around America.

**Warrant:** M4A is expensive

Charles Blahous, 9-17-2019, "Why Medicare for All Is Already Looking More Expensive," Foundation For Economic Education. 17 Sep. 2019. Web. 15 Aug. 2020.  
<https://fee.org/articles/why-medicare-for-all-is-already-looking-more-expensive/>

After my study of the costs of Medicare for All (M4A) was published last July, a fierce debate erupted over whether M4A, while dramatically increasing the costs borne by federal taxpayers, might nevertheless reduce total U.S. health expenditures. Now, just one year after my findings, **we have substantial additional evidence that M4A would further increase, not reduce, national health spending.** To be clear, no one on either side of this debate questioned my central finding that **M4A would increase federal costs by an unprecedented amount, likely between \$32.6 trillion and \$38.8 trillion over ten years—a federal tab so large that even doubling all projected federal individual and corporate income taxes couldn't finance it.** Yet M4A advocates continued to believe that it could bring national health spending down. That's become substantially more difficult to argue in light of subsequent events.

**Uniqueness:** Currently, Medicare does not pay the full cost of coverage for medical care

Salvador Rizzo. 07-3-2019. "Would Medicare for All Mean Hospitals for None?" The

Washington Post. 3 July 2019. Web. 15 August 2020.

<https://www.washingtonpost.com/politics/2019/07/03/would-medicare-for-all-mean-hospitals-none/>

**"Medicare payments to health care providers are below the cost of providing care,"** Delaney spokesman Will McDonald wrote in an email. The Centers for Medicare and Medicaid Services, he said, "has found that 'more than two-thirds of hospitals are losing money on Medicare inpatient services,' and according to the New York Times, **Medicare pays hospitals 'only 87 cents for every dollar of their costs.'** John has been asking this question at the rural hospitals he has visited over the course of the campaign, which also informs his statement." McDonald added: "Under the Sanders Medicare for All bill, the government is the only payer (aka 'single-payer'). **Asking hospitals and providers to operate at 13% below cost is not sustainable."**

**Quantification:** Medicare for all could lose billions of dollars for hospitals

Reed Abelson, 4-21-2019, "Hospitals Stand to Lose Billions Under 'Medicare for All', The New York Times, 21 April 2019. Web. 15 August 2020.

<https://www.nytimes.com/2019/04/21/health/medicare-for-all-hospitals.html>

But those in favor of the most far-reaching changes, including Senator Bernie Sanders, who unveiled his latest Medicare for all plan as part of his presidential campaign, have remained largely silent on **the question of how the nation's 5,300 hospitals would be paid for patient care. If they are paid more than Medicare rates, the final price tag for the program could balloon from the already stratospheric estimate of upward of \$30 trillion over a decade.** Senator Sanders has not said what he thinks his plan will cost, and some proponents of Medicare for all say these plans would cost less than the current system. The nation's major health insurers are sounding the alarms, and pointing to the potential impact on hospitals and doctors. David Wichmann, the chief

executive of UnitedHealth Group, the giant insurer, told investors that these proposals would “destabilize the nation’s health system and limit the ability of clinicians to practice medicine at their best.” **Hospitals could lose as much as \$151 billion in annual revenues, a 16 percent decline, under Medicare for all, according to Dr. Kevin Schulman, a professor of medicine at Stanford University** and one of the authors of a recent article in JAMA looking at the possible effects on hospitals.

**Warrant:** Because of money shortages, hospitals will close.

Samantha Liss, 5-10-2019, "Private insurers pay hospitals more than double Medicare rates," Healthcare Dive. 10 June 2019. Web. 15 August 2020.

<https://www.healthcaredive.com/news/private-insurers-pay-hospitals-more-than-double-medicare-rates/554543/>

"Simply shifting to prices based on artificially low Medicare payment rates would strip vital resources from already strapped communities, seriously impeding access to care," the group said in a statement Thursday. **"Hospitals would not have the resources needed to keep our doors open, innovate to adapt to a rapidly changing field and maintain the services communities need and expect."** Fed up with the cost of healthcare and lack of improved results, some employers have decided to cut out the middlemen and negotiate directly with health systems. General Motors in Detroit now contracts directly with the Henry Ford Health System, and the contract stipulates quality and price measures. In April, General Motor's head of healthcare, Sheila Savageau, said the car company's contract was holding Henry Ford accountable to a zero trend in terms of medical cost increases.

**Impact:** Hospital closures lead to increases in unemployment

Kara Leigh Lofton, 09-10-2019. "Hospital Closures Can Have a Profound Impact on the

Local Economy," West Virginia Public Broadcasting. 10 September 2019. Web. 15 August 2020. <https://www.wvpublic.org/post/hospital-closures-can-have-profound-impact-local-economy>

Altogether, **the closures will directly impact about 1,100 jobs**. But, indirectly, it could affect the entire economy of the area. “What we found is **when a hospital closed, as you might expect, unemployment increased and that was a major impact initially**,” said Mark Holmes, director of the North Carolina rural health research program at the University of North Carolina. Holmes published a study in 2006 that looked at the impact of rural hospital closures on community economic health.

**Analysis:** This argument is quite simple: M4A is expensive which puts a strain on hospitals. The neg should be aware of responses to the aff claim that there is no monetary loss with M4A. Strategic neg teams may want to look into what happens when hospitals are strained for money (wing closures, layoffs) rather than putting all their eggs into the hospital closures basket.

### CON: Medicare for All Increases Wait Times

**Argument:** With the increase in insured Americans with M4A, more people would be able to have access to doctors which would drastically increase wait times for procedures

**Warrant:** Due to the influx of patients under M4A, there would be shortages

Chris Talg , 12-22-2019, “Opinion: Medicare for All would be disastrous,” Independent. 22 December 2019. Web. 16 August 2020.  
<https://www.indeonline.com/opinion/20191222/opinion-medicare-for-all-would-be-disastrous>

Third, **M4A (with its inherent price controls) almost assuredly would lead to health care rationing. Basic economics (and common sense) suggest if the government provides 330 million Americans with “free” health care without increasing health care supply, shortages and rationing would be inevitable.** Don’t believe this can happen in America? Well, just take a peek at what has happened to our neighbor to the north, which implemented a single-payer health care system in 1984. Almost four decades after it enacted universal health care, Canada’s health care system is rife with excruciatingly long wait times, along with several other problems. In fact, medical wait times in Canada are so appalling that “1,040,791 patients who waited for medically necessary treatment last year each lost \$1,822 (on average) due to work time lost,” according to the Canada-based Fraser Institute.

**Warrant:** Waitlists are inherent to universal health care systems

Chris Pope. 11-19-2019. “Examining Medicare for All, Comparing Health-Care Models.”

Manhattan Institute. 19 November 2019. Web. 16 August 2020.

<https://www.manhattan-institute.org/using-lessons-from-international-health-care-medicare-for-all>

This means that it is possible to draw general conclusions about single-payer health care to an extent that is not possible for any other particular model. Single-payer systems share the common feature of limiting access to care according to what can be raised in taxes. Government revenues consistently lag the growth in demand for medical services resulting from increased affluence, longevity, and technological capacity. **As a result, single-payer systems deliver consistently lower quality and access to high-cost specialty care or surgical procedures without reducing overall out-of-pocket costs.** Across the countries in this paper, limitations in access to care are closely tied to the share of the population enrolled in private insurance—with those in Britain and Canada greatly limited, Australians facing moderate restrictions, and those in the other countries studied being more able to get care when they need it. **Waiting lists are inherent to single-payer systems; they are not produced by the very limited role of private insurance that is allowed to operate around them.** The concern that private demand for medical services will deprive public programs of staff and facilities, rather than enable scarce public funds to be supplemented by additional private resources, is ultimately a problem only to the extent that the supply of medical resources is fixed.[241] This is most likely to be a problem for skilled labor and is better addressed by expanding its supply, rather than by trying to suppress wages by depriving patients of private access to care.[242] **Indeed, restrictions on private health-care spending are likely to exacerbate any physician shortage over the long run.** Nonetheless, in dual-payer and segmented-payer systems, public and private payers constantly endeavor to shift costs to each other—an enterprise for which the complexity of health-care payment affords a near-limitless set of opportunities. There is also a continual confusion of responsibility and an absence of accountability. Under employer-sponsored insurance in the U.S., the separation of responsibility between those in charge of procuring care

and those responsible for paying for it has led to the development of increasingly expensive sources of care with little attention to costs.[243] The segmented-payer system generates the most funding for health care overall. However, in fully accommodating individuals' willingness to pay for care, this approach increases the intensity of care to an extent that is painfully expensive for a minority that falls between gaps in entitlements and employer-sponsored insurance.

**Example:** Canada, a country with single payer healthcare, has much longer wait times than America

Kevin Pham, 7-17-2019, "America Outperforms Canada in Surgery Wait Times—And It's Not Even Close," Foundation for Economic Education. 17 July 2019. Web. 15 August 2020. <https://fee.org/articles/america-outperforms-canada-in-surgery-wait-times-and-its-not-even-close/>

The Fraser Institute study did not examine where Canadians traveled for surgery, but given proximity and our much better metrics, most probably came here. Surgeries are scheduled after patients are seen by the surgeon, and most people see surgeons only after a referral by either their primary care physician in America, or their general practitioner in Canada. **In the United States, 70 percent of patients are able to be seen by specialists less than four weeks after a referral. In Canada, less than 40 percent were seen inside of four weeks. After being advised that they need a procedure done, only about 35 percent of Canadians had their surgery within a month, whereas in the United States, 61 percent did. After four months, about 97 percent of Americans were able to have their surgery, whereas Canada struggled to achieve 80 percent.** America is significantly outperforming Canada in surgery wait times even as it's likely that tens of thousands of Canadians come here to use the American system.

**Impact:** Increased wait times increases mortality rates.

Sarah Klein. 09-23-2011. "Association Between Waiting Times and Short Term Mortality and Hospital Admission After Departure from Emergency Department: Population Based Cohort Study from Ontario, Canada." The Commonwealth Fund. 23 August 2011. Web. 16 August 2020.  
<https://www.commonwealthfund.org/publications/journal-article/2011/aug/association-between-waiting-times-and-short-term-mortality>

**Patients who visited EDs during shifts with longer waiting times were at increased risk of death and admission in the subsequent seven days, regardless of their health status at the time of the initial visit.** In contrast, patients who were well enough to leave without being seen were not at higher risk of short-term adverse events. **Reducing mean length-of-stay by an average of one hour could have potentially decreased the number of deaths in the study by 6.5 percent among the higher-acuity patients and by 12.7 percent among the lower-acuity patients.**

**Impact:** In Canada, thousands of women have died due to high wait times

Bacchus Barua. 05-2014. "The Effect of Wait Times on Mortality in Canada." Fraser Institute. May 2014. Web. 16 August 2020.  
<https://www.fraserinstitute.org/sites/default/files/effect-of-wait-times-on-mortality-in-canada.pdf>

Justices of the Supreme Court of Canada have noted that **patients in Canada die as a result of waiting lists for universally accessible health care.** Numerous studies point not only to this reality but also to the reality that wait times can have an impact on general

health and well-being, which may also result in untimely demise. The unanswered question has been how many died due to limitations in accessing timely care? **Our analysis estimates that between 25,456 and 63,090 (with a middle value of 44,273) Canadian women may have died as a result of increased wait times between 1993 and 2009.** This estimated increase in the Canadian mortality rate associated with waiting for medical treatment was unnecessary and is the result of a health policy regime that imposes longer wait times on Canadians than are found in the universal access healthcare systems of other developed nations.

**Analysis:** This argument resides at the heart of the main conflict in M4A rounds: is it worth expanding healthcare if the quality of healthcare suffers tremendously because of the expansion. For neg teams to win this argument, they must prove that wait times increase and outweigh the expansion of coverage. If they can do that, this argument has well researched impacts.

### CON: Medicare for All Causes Drug Shortages

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**Argument:** M4A may lead to different ways drugs are priced leading to potential drug shortages.

**Warrant:** Medicare is linked to drug shortages

Mireille Jacobson, 5-29-2012, "Prescription Drug Shortages: Reconsidering The Role Of Medicare Payment Policies," Health Affairs. 29 May, 2012. Web. 16 August 2020.  
<https://www.healthaffairs.org/do/10.1377/hblog20120529.019758/full/>

**Numerous government reports and articles have explored the causes of shortages.** A recent report by the HHS Assistant Secretary for Planning and Evaluation (ASPE) pointed to ongoing manufacturing problems, increases in drug volume, consolidation in manufacturing, regulatory burdens in approving new manufacturing sources, and unusually high rates of patent expirations. **Many experts cite declining profit margins for generic drugs as the fundamental cause of the increase. In particular, they implicate a major Medicare payment reform established under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that dramatically reduced profits for many Part-B physician-administered drugs.** However, despite the intuitive connection between this payment reform and drug shortages, the data suggest that the link is not as obvious as some claim. Further research is needed on the role of payment policies and, alternatively, other more episodic events in causing prescription drug shortages. **How might the MMA payment reform contribute to drug shortages? By reducing profit margins and establishing a fixed percent mark-up, the new payment system implicitly favors high cost brand name drugs over generics.** As physicians switch towards higher cost drugs, manufacturers may respond by sacrificing the production of cheaper generic drugs in favor of more lucrative options, thereby causing generic drug shortages. Additionally, a two-quarter lag in price updating introduced by the new system may have prolonged shortages by reducing price

responsiveness. Instead of allowing prices to rise during shortages – inducing manufacturers to enter the market to fill production gaps – the Medicare payment system dampens the influence of short-run price adjustments on current reimbursement levels, leading to price “stickiness.”

**Warrant:** Drug pricing systems under M4A may lead to restrictions on drug access

Matthew Pakizegee. 07-2019. "Ramifications of “Medicare for All” and Implications for Clinical Pathways," Journal of Clinical Pathways, July 2019. Web. August 16 2020.<https://www.journalofclinicalpathways.com/article/ramifications-medicare-all-and-implications-clinical-pathways>

CBO evaluated the following methods single payers use to control drug costs:

- Value-based pricing. Cost-effectiveness and long-term studies of a drug will be prioritized in this system since linking these data to a national health technology assessment along with a proposed price will be the basis of price negotiations.
- Direct pricing negotiation. A single-payer system would have more negotiating leverage with manufacturers than private insurers have, since they determine coverage for a whole country but may face political backlash if a drug is excluded from a national formulary.
- Reference pricing. External reference pricing bases prescription drug prices on a median or average price of a group of countries, while internal reference pricing would use existing prices for drugs in the same class or therapeutic area as a benchmark for negotiations.
- Administered pricing. Prices are set by the government or a monopoly.

The “who” side of the equation is complicated as it remains unclear whether pathways would continue to be payer-developed like the AIM Pathways by Anthem, provider-created/provider-facing pathways like Via Pathways, or institutionally developed in-house pathways like Moffitt Cancer Center’s. The “who” is typically driven by the needs

of the organization. In the case of M4A—with payers having limited involvement and providers shifting back to more independent practices and away from total-cost-of-care responsibilities and unknown quality metrics—the needs are also uncertain. **While it is not clear whether government organizations will develop clinical pathways or independent organizations will still develop them, if M4A is implemented, patients will most likely look to be active in clinical pathway development to ensure that clinically appropriate pathways are followed rather than ones that may be too restrictive under a M4A system. However, pathways may eventually be forced to limit access, ie, ration care to control cost.** Rationed care is often seen in other single-payer countries where the government can choose to not fund certain treatments based on cost, even for conditions like cancer.

**Warrant:** Government price controls leads to drug shortages

Thomas Sullivan, 5-6-2018, "Increasing Generic Drug Shortages Linked to Government Price Controls," Policy and Medicine. 6 June 2018. Web. 16 August 2020.  
<https://www.policymed.com/2012/03/increasing-generic-drug-shortages-linked-to-government-price-controls.html>

First, the number of suppliers of generic drugs has dwindled. There were 26 U.S. vaccine makers in 1967; today there are only six. Supply disruptions are common, including the possibility that a facility completely shuts down for a protracted time because of quality or safety problems. Second, unlike in most consumer-goods industries, many pharmaceutical manufacturers have failed to invest in the technology and quality-control improvements that would reduce the risks of partial or complete facility shutdowns—and this despite the FDA's regularly issued current guidelines for good manufacturing practices (cGMPs). **Behind both problems are the government's tight**

price controls for generic drugs, especially when purchased by Medicare and Medicaid. Low prices induce drug makers to exit various markets, or at least to reallocate their manufacturing capacity toward more profitable, patented pharmaceuticals. Low prices also tend to eliminate the rationale for investments in better manufacturing technologies and processes, as shown in a 2009 study conducted by the author and published in the Journal of Management Science. Government price controls on generic drugs limit the manufacturers' margin to 6% in many cases.

**Impact:** Drug shortages financially harm hospitals

Jennifer Gershman, 07-02-2019, "New Study Shows Drug Shortages Have a Large Impact on Hospitals," Pharmacy Times. 2 July, 2019. Web. 16 August 2020.

<https://www.pharmacytimes.com/contributor/jennifer-gershman-pharmd-cph/2019/07/new-study-shows-drug-shortages-have-a-large-impact-on-hospitals>

The survey included 365 participants across both acute and nonacute facilities, and the study was conducted March 6-April 4, 2019.<sup>2</sup> The most common roles of the participants included director of pharmacy, pharmacy buyer, pharmacy manager, clinical coordinator, clinical pharmacist/specialist, supply chain leader, and vice president of pharmacy. The study found that 100% of the facilities surveyed were affected by drug shortages, and it's estimated that hospitals spend an additional 8.6 million personnel hours annually managing the impact of drug shortages.<sup>2</sup> It is estimated that drug shortages are costing facilities at least \$359 million per year in labor costs for implementing mitigation strategies to improve patient care.<sup>2</sup> The top 5 drug categories with drug shortages found to have the most impact on hospitals were controlled substances, local anesthetics, crash cart drugs, antibiotics, and electrolytes.

**Unfortunately, 38% of hospitals reported 1 or more drug shortage-related medication errors.**<sup>2</sup> This study provided important information regarding the impact of drug shortages in hospital settings. Since it was a survey, cause and effect cannot be determined but associations can be drawn for future research.

**Analysis:** Drug shortages would lead to obvious harms, both economic and healthwise. If there is a lack of medicine under M4A, then neg teams can attempt to outweigh quality of care over access. To gain offense off of this argument, neg teams must successfully prove that there is a significant enough drug shortage to show the shortage is more important than uninsured Americans getting healthcare.

### CON: Medicare for All Leads to Doctor Shortages

**Argument:** With the revenue cuts from hospitals under M4A, hospitals may need to find places to cut funds. These cuts could come from doctor salaries, creating the issue of a doctor shortage.

**Warrant:** Hospitals lose money with M4A

Rich Daly. 7-24-2019, "'Medicare for All' to cost hospitals \$200 billion annually, analysis finds," Healthcare Financial Management Association. 24 July, 2019. Web 16 August, 2020. <https://www.hfma.org/topics/news/2019/07/medicare-for-all-cost-hospitals-200-billion-annually.html>

**Although a slice of hospitals might financially benefit from a single-payer model based on Medicare rates, 90% would face cuts totaling \$200 billion each year, according to a new industry analysis.** Crowe, a consulting, accounting and technology firm, analyzed its transaction database for more than 1,000 hospitals to project revenue impacts under "Medicare for All" legislation, which would create a single-payer system that pays most hospitals at Medicare rates. The database encompasses hospitals in 45 states and includes 605 hospitals in Medicaid expansion states and 409 in non-expansion states. If all hospital payments switched to Medicare rates, the report found, financial impacts would include:

- An average per-case outpatient payment cut for hospital-based services of \$143 (21.9%)
- An average per-patient inpatient payment cut of less than 1%
- **A cut in net revenue for 90.2% of the hospitals studied**
- **A decrease in payment across all hospitals of \$200 billion**

The divergent impacts on inpatient and outpatient care would likely magnify the significance of the overall financial impact, according to Crowe, because many hospitals

have “robust” outpatient managed care contracts, while many others use a “case rate” payment system that is similar to Medicare’s DRG system. The impact at specific hospitals likely will depend on their mix of payer types. The largest revenue cut (53.5%) at any hospital studied would occur at a 246-bed facility with a nongovernment managed-care payer mix of nearly 50%. The largest revenue increase (24%) would occur at a 97-bed facility with a government payer mix of nearly 90%. The findings echo previous projections, including **an April JAMA report that concluded a "Medicare for All" system that extends the current fee schedule to all patients would cut net revenue by more than \$150 billion.**

**Quantification:** Cuts to hospital revenue would lead to a 30% decrease in doctor’s salaries.

Charles Blahous, 10-10-2018, "How Much Would Medicare for All Cut Doctor and Hospital Reimbursements?," Economics21. 10 October 2018. Web. 16 August 2020. <https://economics21.org/m4a-reimbursements-blahous>

Fourth, no clarifying purpose is served by obscuring the ~40% payment cuts. When a study or article explains that **private insurance payment rates would be cut by more than 40% on average to bring them down to Medicare payment rates**, no accurate reader misinterprets this as a cut in Medicare’s own payment rates. The only effect of blending a real 40% cut with a non-cut in Medicare’s own payment rates is to obscure the cut’s actual size. **The text of the M4A bill specifies large and immediate reductions in payments to providers now treating patients under private insurance, cuts of more than 40% for hospitals and 30% for physicians, with these respective cuts growing more severe over time.** We do not know the extent to which these cuts would disrupt the supply and timeliness of U.S. healthcare services. But without them, the costs of

M4A would be substantially greater than \$32.6 trillion in added federal costs over the first ten years.

**Warrant:** M4A may causes reductions to doctor's salaries

Robert E. Moffit, Ph.D., 3-15-2019, "How "Medicare for All" Bills Would Worsen the Doctor Shortage," Heritage Foundation,  
<https://www.heritage.org/medicare/commentary/how-medicare-all-bills-would-worsen-the-doctor-shortage>

Projecting a dramatic 40 percent reduction in provider reimbursement relative to private insurance, Charles Blahous, a former Medicare trustee, observes, "The cuts in the Sanders M4A bill would sharply reduce provider reimbursements for treatments now covered by private insurance, which represent a substantially greater (more than 50 percent larger) share of national health spending than does Medicare." True, American physicians are among the most highly paid medical professionals in the world. Overall, in 2018 the average American primary care physician earned \$223,000, while specialists earned \$329,000. In 2018, American staff nurses earned \$73,287 on average, clinical nurse specialists earned \$88,271, and nurse anesthetists earned \$150,833. **Of course, liberals in Congress could cut American medical workforce compensation to "single payer" levels. Examining comparative 2016 data – including compensation in "single payer" Britain and Canada – researchers writing in the Journal of the American Medical Association found that American general physicians earn an average annual salary of \$218,173. The comparable compensation for Canadian generalists was \$146,286, while British generalists received just \$134,671.**

**Warrant:** Decreased salaries discourages future generation from becoming doctors

FTI Consultants. 01-2020. "Medicare for All and the Future of America's Healthcare Workforce." FTI Consulting. January 2020. Web. 16 August 2020.  
<https://www.fticonsulting.com/~/media/Files/us-files/insights/reports/2020/jan/medicare-future-americas-health-care-workforce.pdf>

FTI Consulting examined the impact of Medicare for All on the supply of physicians, finding a significant increase in the projected shortage of both specialists and primary care physicians in future years as a result of rate setting and subsequent reductions in provider income. **American physicians enter the workforce with an average student debt load of nearly \$200,000,<sup>12</sup> a factor that may drive graduates away from specialties with particularly low Medicare reimbursements, such as primary care, under the current system. For experienced physicians, declining Medicare reimbursements can play a role in the decision to retire early.**<sup>13</sup> FTI's analysis demonstrates these factors would be amplified under Medicare for All, discouraging the next generation from entering the practice of medicine and prompting a greater number of older physicians to retire early.

**Quantification:** M4A may lead to a doctor and nurse shortages

FTI Consultants. 01-2020. "Medicare for All and the Future of America's Healthcare Workforce." FTI Consulting. January 2020. Web. 16 August 2020.  
<https://www.fticonsulting.com/~/media/Files/us-files/insights/reports/2020/jan/medicare-future-americas-health-care-workforce.pdf>

- Medicare for All, when fully implemented, could result in a nationwide loss of 44,693 physicians by 2050 relative to current projections.
- By 2050, urban and rural areas alike could see a decrease of 5.4% in the supply of physicians.
- The impact of Medicare for All on the primary care workforce would be particularly acute, resulting in a loss of 10,286 primary care physicians by 2050.
- Shifting the entire U.S. population to Medicare would result in an estimated 16% cut to spending on patient care provided by physicians.
- Medicare for All's reimbursement cuts would result in 90% of hospitals across the country running consistent deficits, increasing the risk of hospital closures nationwide and negatively impacting the health care workforce.
- The nursing workforce, already projected to reach shortage levels in seven states by 2030,<sup>3</sup> could see a reduction of 1.2 million nationally by 2050 under Medicare for All.

**Impact:** More doctors means a lower mortality rate

Beth Duff Brown. 02-18-2019. "More Primary Care Physicians Leads to Longer Life Spans." Stanford Medicine. 18 February 2019. Web. 16 August 2020.  
<https://med.stanford.edu/news/all-news/2019/02/more-primary-care-physicians-lead-to-longer-life-spans.html#:~:text=Every%2010%20additional%20primary%20care,Medicine%20and%20Harvard%20Medical%20School>.

**Life expectancy grows when there are more primary care physicians in the field, yet their numbers are shrinking as medical students saddled with debt turn to more lucrative fields, according to a study led by researchers at Stanford and Harvard. New research shows us just how important primary care physicians are in prolonging our lives. Every 10 additional primary care physicians per 100,000 people in the United States was associated with a 51.5-day increase in life expectancy during the decade**

from 2005 to 2015, according to a study led by researchers at the Stanford University School of Medicine and Harvard Medical School. By comparison, the researchers found that an increase of 10 specialists per 100,000 corresponded to only a 19.2-day increase. “Greater primary care physician supply was associated with improved population mortality, suggesting that observed decreases in PCP supply may have important consequences for population health,” the study said.

**Analysis:** In order to win this argument, Neg teams must win the internal link into the argument of M4A creating a significant revenue loss. If they are able to do this, they can compete in the access vs quality debate with aff with the advantage of arguing that access decreases with a decrease in physicians. Neg teams interested in this argument should look specifically into which kinds of doctors are most likely to suffer losses in an M4A world and look for corresponding impacts.

### CON: Americans hate Medicare for All

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**Argument:** Medicare for all is supported by the people

**Warrant:** Universal Healthcare does not have overwhelming support

Jordan Weissman. "Medicare for all is getting less popular". October, 2019. SLATE,

<https://slate.com/business/2019/10/medicare-for-all-is-getting-less-popular.html>

"According to the Kaiser Family Foundation's latest Health Care Tracking poll, **a small majority of adults still say they would favor putting all Americans on a single national health plan, with 51 percent in favor and 47 percent opposed. But the margin of support has shrunk significantly from the beginning of this year, when as many as 57 percent backed such a proposal, and only 37 percent were opposed..**"

**Warrant:** Medicare for all, specifically, has low support

Jordan Weissman. "Medicare for all is getting less popular". October, 2019. SLATE,

<https://slate.com/business/2019/10/medicare-for-all-is-getting-less-popular.html>

**Recent polling by other organizations has shown even lower levels of support for a single-payer system. An NBC/Wall Street Journal survey last month found just 41 percent said they backed one, with 56 percent against, while a Fox News poll found 46 percent in favor and 48 percent against. But polling results on health care can be extremely sensitive to how the question is phrased. What makes the Kaiser Family Foundation survey interesting is that it's been asking the public the same version of its**

question for more than two years now—"Do you favor or oppose having a national health plan, sometimes called Medicare-for-all, in which all Americans would get their insurance from a single government plan?"—giving us a picture of how public opinion has evolved.

**Argument:** Medicare for all is very polarizing

**Warrant:** Medicare for all is hated by Republicans

Chris Conover. "The #2 Reason Bernie Sanders' Medicare-for-All Single-Payer Plan Is A Singularly Bad Idea". 18 Oct. 2017. Forbes.

<https://www.forbes.com/sites/theapothecary/2017/09/30/the-2-reason-bernie-sanders-medicare-for-all-single-payer-plan-is-a-singularly-bad-idea/#75e116c529bb>

**When asked about support for or opposition to enrolling all Americans in a single government-run health plan, as would be the case under Medicare for All, 42.3 percent of Democrats expressed support versus 13.3 percent of Republicans.** On the other hand, 52.8 percent of Republicans opposed Medicare for All versus 12.3 percent of Democrats. Democrats were more likely to neither support nor oppose Medicare for All than were Republicans (43.5 percent versus 32.6 percent).

**Warrant:** Detractors oppose many crucial elements of Medicare for All

Chris Conover. "The #2 Reason Bernie Sanders' Medicare-for-All Single-Payer Plan Is A Singularly Bad Idea". 18 Oct. 2017. Forbes.

<https://www.forbes.com/sites/theapothecary/2017/09/30/the-2-reason-bernie-sanders-medicare-for-all-single-payer-plan-is-a-singularly-bad-idea/#75e116c529bb>

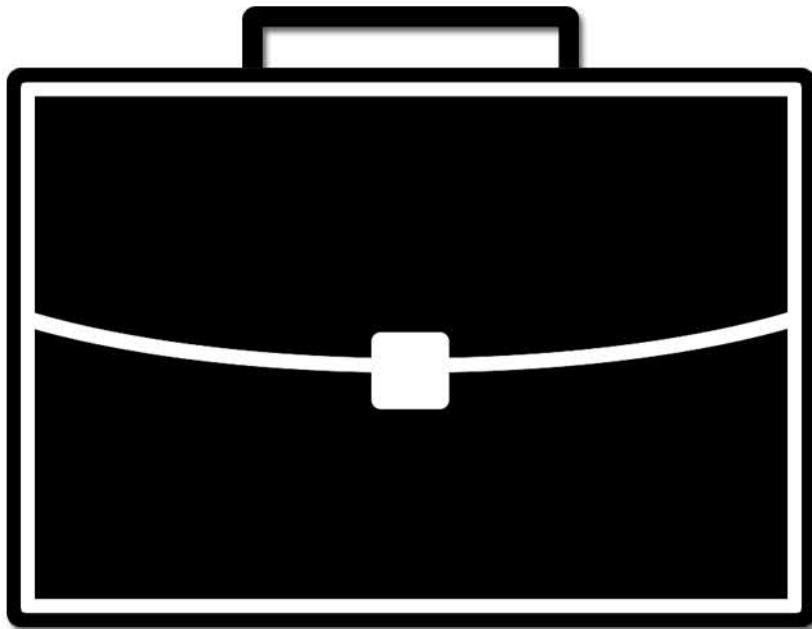
**Of those who opposed Medicare for All, 73.6 percent reported that an important factor in their decision was that most people would not be able to keep their current insurance coverage, and 81.2 percent reported higher federal taxes to finance a national health program as an important factor.** Other important factors to opponents were that it might be harder to get an appointment with health care providers (82.8 percent) and that there might be less medical innovation (77.1 percent). Opponents were about half as likely as supporters (45.0 percent versus 91.0 percent) to report that everyone having coverage was important in their decision about whether to support Medicare for All.

**Analysis:** Overwhelmingly Americans do not support Medicare for All. While it has many vocal supporters, the average American is generally not in favor of ballooning the size of the healthcare system.

# Champion Briefs

## Sept/Oct 2020

### Public Forum Brief



Con Responses to  
Pro Arguments

## A/2: Medicare for All would help victims of domestic violence

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**Delink:** There are numerous reasons besides access to health insurance why victims may feel pressured to stay with an abusive partner.

**Warrant:** Leaving can escalate violence.

The Women's Community. "Why Don't I Leave." [Womenscommunity.Org, 2020,  
womenscommunity.org/understanding-abuse/why-dont-i-leave/.](http://Womenscommunity.Org, 2020, womenscommunity.org/understanding-abuse/why-dont-i-leave/)

What keeps people in abusive relationships? It could be any one, or a combination of, the following: Fear. If leaving an abusive relationship guaranteed a victim's safety, she would leave. But **leaving does not guarantee safety — in fact, it often escalates the violence. When a victim attempts to leave or threatens to leave, the abuser may feel he has lost control and escalate the violence.** Most domestic violence-related homicides occur after the victim has left, attempted to leave or has threatened to leave. Victims live in fear of what will happen to themselves and/or their children if they try to leave. If they are without they need resources that can help them remain safe.

**Warrant:** Many victims fear leaving will put their children in danger.

Buel, Sarah. "Fifty Obstacles to Leaving, a.k.a., Why Abuse Victims Stay." *The Colorado Lawyer*, Oct. 1999, [www.ncdsv.org/images/50\\_Obstacles.pdf](http://www.ncdsv.org/images/50_Obstacles.pdf).

11. Family Pressure: Family pressure is exerted by those who either believe that there is no excuse for leaving a marriage or have been duped into denial by the batterer's charismatic behavior.<sup>17</sup> 12. Fear of Retaliation: **Fear of losing child custody can immobilize even the most determined abuse victim. Since batterers know that nothing will devastate the victim more than seeing her children endangered, they**

frequently use the threat of obtaining custody to exact agreements to their liking.

Custody litigation becomes yet another weapon for the abuser, heightening his power and control tactics to further terrify the victim.<sup>19</sup> Moreover, counsel should not provide false assurance to victims regarding the likelihood of the court awarding custody to the nonviolent parent.

**Delink:** The Affordable Care Act already attempted to fix many of the barriers survivors face in getting access to insurance.

**Warrant:** The Affordable Care Act prohibited classifying victims of domestic violence as having a pre-existing condition.

healthshera. "Domestic Violence and the ACA: What You Need to Know." HealthSherpa Blog, 17 July 2018, [www.healthshera.com/blog/domestic-violence-and-the-aca-what-need-know/](http://www.healthshera.com/blog/domestic-violence-and-the-aca-what-need-know/).

If you or someone you know is experiencing domestic violence, you can call the National Domestic Violence Hotline at 1-800-799-SAFE (1-800-799-7233) or 1-800-787-3224 for anonymous, confidential help. If you're in immediate danger, call 911. **Before the ACA went into effect, people with pre-existing conditions (like being a domestic violence survivor) were often denied coverage. Those who could get coverage were often charged much more, only given health insurance policies that didn't cover their pre-existing condition, or made to have long waiting periods before coverage for those conditions began. Beginning on Jan. 1, 2014, that practice was no longer allowed thanks to the ACA.** What else does the ACA say about domestic violence and health insurance? All ACA-compliant plans must cover essential health benefits, including preventive services and mental health services. These free preventive services include domestic and interpersonal violence screening and counseling for women.

**Warrant:** The ACA offers access to affordable health insurance not tied to peoples' partners.

James, Lisa. "3 Things at Stake for Domestic Violence Survivors If Obamacare Is Repealed." Futures Without Violence, 10 Jan. 2017, [www.futureswithoutviolence.org/3-things-at-stake-aca/](http://www.futureswithoutviolence.org/3-things-at-stake-aca/).

Even if reform efforts keep the protections against plans using domestic violence as pre-existing conditions remain – but cut access to affordable care – these protections are meaningless. **For survivors who have stayed in unhealthy and unsafe relationships for fear of losing their health insurance, the ACA offers options to access affordable healthcare not tied to their partner.** In addition, for those who work in jobs that do not offer health insurance, or for families with low and middle incomes, the ACA provides subsidized coverage on a sliding scale through the Health Insurance Marketplace and Medicaid. **These policies have helped millions of women purchase health insurance, opening doors for them to get the services they need. Health insurance is especially imperative to survivors, as many need ongoing or critical care related to their abuse.** If the Marketplace (healthcare.gov) is repealed or if the financial subsidies are eliminated, women who purchased coverage in the Marketplace are at risk of losing their coverage. This could mean either no plans will be available, or coverage will become unaffordable and out of reach. We know violence takes a serious toll on health and mental health – making health access even more critical to survivors of abuse.

**Analysis:** This response can be weighed on probability. The Affordable Care Act already included several provisions specifically to protect victims of domestic violence from losing health insurance. Yet access to health insurance among victims is still lacking — which is indicative that domestic violence is a more structural issue than health care legislation may be able to solve.

## A/2: Medicare for All improves the quality of research

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**Delink:** U.S. innovation is productive in the status quo.

**Warrant:** Drug companies have recently been very productive; 48 new medicines were approached in 2019.

Jarvis, Lisa M. "The New Drugs of 2019." Chemical & Engineering News, American Chemical Society, 8 July 2019, [cen.acs.org/pharmaceuticals/drug-development/new-drugs-2019/98/i3](http://cen.acs.org/pharmaceuticals/drug-development/new-drugs-2019/98/i3).

Although pharmaceutical companies last year were unable to top the record-shattering 59 new drugs approved in the US in 2018, they were still on a roll. **In 2019, the Food and Drug Administration green-lighted 48 medicines, a crop that includes myriad modalities and many new treatments for long-neglected diseases. Taken together, the past 3 years of approvals represent drug companies' most productive period in more than 2 decades.** Still, some analysts caution that the steady flow of new medicines could mask troubling indications about the health of the industry. The year brought several notable trends. The first was an uptick in the number of novel mechanisms on display in the new drugs. Roughly 42% of the medicines were first in class, meaning they had new mechanisms of action; this is a jump over the prior 4 years, when that portion ranged between 32 and 36%. Another trend was the influx of newer modalities. While small molecules continue to account for the lion's share of new molecular entities (NMEs), making up 67% of overall approvals in 2019, the list also includes several antibody-drug conjugates, an antisense oligonucleotide therapy, and a therapy based on RNA interference (RNAi).

**Warrant:** The U.S. leads the world in new drugs.

Easton, Robert. "Price Controls Would Stifle Innovation in the Pharmaceutical Industry." Stat News, STAT, 22 Jan. 2018, [www.statnews.com/2018/01/22/price-controls-pharmaceutical-industry/](http://www.statnews.com/2018/01/22/price-controls-pharmaceutical-industry/).

Yet there remain huge unmet needs for new and better treatments for most cancers; all neurological problems, especially Alzheimer's disease; most autoimmune diseases; most major gastrointestinal disorders; macular degeneration; and diabetes — not to mention the global scourge of drug-resistant bacterial and viral infections. Advances in these areas will come if money continues flowing to pharmaceutical companies and their primary sources of innovation, biotechnology startups. But if U.S. drug prices come under bureaucratic control, as they have in most of Europe and Japan, it will be a different story. **Little pharmaceutical innovation occurs in price-control jurisdictions.** **The United States has always, by a large margin, led the world as a source of new drugs, and that lead has widened as Japan and Germany have imposed price controls over the past few decades.** All major international pharmaceutical companies, without exception, have instituted R&D and commercial operations in the U.S. to take advantage of its pricing environment.

**Turn:** Lower drug prices discourage research & development.

**Warrant:** Drug development is risky; companies need to recoup the cost of failures.

Kennedy, Joe. "The Link Between Drug Prices and Research on the Next Generation of Cures." Information Technology & Innovation Fund, 9 Sept. 2019.  
<https://itif.org/publications/2019/09/09/link-between-drug-prices-and-research-next-generation-cures> DOA: 7/4/20) ESM

Drug development is extremely costly for three main reasons. The first is the heavily regulated nature of the drug markets. Second, and partly due to this regulation, drug-

development time is very lengthy, taking an average of 10 to 20 years. Because future revenues are worth less than those received today, a dollar of revenue in ten years will not come close to offsetting a dollar of research paid for today. Finally, **drug development pushes at the boundaries of biological and chemical science, causing roughly 90 percent of all drug projects to fail.**<sup>19</sup> In order to survive, companies must recoup the costs of these failures in the revenues from the relatively rare successes. A recent study by the Congressional Budget Office (CBO) estimates pharmaceutical companies need to make a margin of 62.2 percent on their successful products in order to average a 4.8 percent rate of return on all of their assets.

**Impact:** Between 330 and 365 drugs would not have been brought to market if there were price controls.

Giacotto, Carmelo. "Drug Prices and Research and Development Investment Behavior in the Pharmaceutical Industry." *The University of Chicago Press Industries*, April 2005,  
<https://www.jstor.org/stable/pdf/10.1086/426882.pdf?refreqid=excelsior%3Af304cadfd786cd406840f73dda80dfcb> DOA: 7/10/20) ESM

In addition to reporting forgone R&D, we also calculate a rough first approximation of what this might have translated into in terms of fewer new drugs brought to market. To perform this calculation, we divide our estimate of forgone R&D by \$802 million, DiMasi, Hansen, and Grabowski's estimate of the cost of bringing a new drug to market. Our calculations are reported in Table 2. As Table 2 shows, **the cumulative costs associated with pharmaceutical price controls (as defined in our policy experiment) are substantial. Between \$265 billion and \$293 billion of capitalized R&D expenditures would have been lost.** These forgone R&D expenditures translate to roughly 28–31 percent of the actual capitalized R&D expenditures observed over this time period. **Using DiMasi, Hansen, and Grabowski's estimated cost of \$802 million per new drug,**

this suggests that between 330 and 365 new drugs would not have been brought to market in the global economy, *ceteris paribus*. To be certain, our calculations involve several critical assumptions and should not be extrapolated over future time horizons where industry and market conditions may be quite different. In addition, our estimates of the loss in R&D spending and new drugs from a price control regime are subject to the following considerations.

**Analysis:** This turn can be weighed on probability. Companies' goals are to turn a profit, and it's unlikely that they would invest in risky projects if they don't recoup their money. Drug companies would more likely reallocate money to advertising than turn to socially beneficial research if their profits are slashed.

## A/2: Medicare for All would help small businesses

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**Turn:** Most businesses would pay more in taxes than they would save in healthcare costs.

**Warrant:** Medicare for All would lead businesses to pay more in taxes.

Pipes, Sally. “‘Medicare for All’ Is A Trap for Businesses and Employees.” Forbes, 24 June 2019, [www.forbes.com/sites/sallypipes/2019/06/24/medicare-for-all-is-a-trap-for-businesses-and-employees/#111a8f943b50](http://www.forbes.com/sites/sallypipes/2019/06/24/medicare-for-all-is-a-trap-for-businesses-and-employees/#111a8f943b50).

A deeper look at Medicare for All shows that it will cost businesses a fortune. And their employees won't like the care they receive. True, **Medicare for All will eliminate the health insurance line item on businesses' budgets. But it'll vastly increase their tax bills. Senator Bernie Sanders, the pied piper of single-payer health care, has floated several ideas for paying for Medicare for All. Among them: a 7.5% employer payroll tax that will extract \$3.9 trillion over ten years from employers.** Large financial institutions could be hit with \$117 billion in taxes over ten years. Sanders has even called for changes to accounting rules that would result in \$112 billion in additional corporate taxes. Those are just the taxes that hit businesses directly. Many business owners take low salaries but realize most of their income as capital gains or dividends. Sanders would raise taxes on capital income for those who make more than \$250,000 a year.

**Warrant:** New payroll taxes could decrease wages and disincentivize business growth.

Michel, Adam. “‘Medicare for All’ Proposes Economy-Crushing Taxes on Middle Class.” The Heritage Foundation, 1 Nov. 2019, [www.heritage.org/taxes/commentary/medicare-all-proposes-economy-crushing-taxes-middle-class](http://www.heritage.org/taxes/commentary/medicare-all-proposes-economy-crushing-taxes-middle-class).

New Payroll Tax: The largest tax increase would be a new \$8.8 trillion payroll tax or mandatory premium payment to approximate what employers currently pay for health care benefits. Although the initial tax is proportional to actual health care spending, over time taxes would equalize to a national average, increasing on employers who have kept health care costs down and rewarding employers who provide more comprehensive benefits. **When taxes rise on the half of employers below the national average for health care spending, their employees will be worse off, as increasing taxes means slower wage growth.** Under the plan, big publicly traded businesses with highly paid executives likely also would pay a higher payroll tax rate to compensate for a temporary preferential rate given to businesses with union contracts. The size of the business is also important under the plan. **The tax is waived for very small employers, but increases with the size of the business—an incentive not to grow the business or add employees.** Turning current health care benefits into taxes would create winners and losers at all income levels and businesses sizes.

**Turn:** Employee sponsored health insurance helps businesses differentiate and aligns market incentives.

**Warrant:** Medicare for All helps employers differentiate themselves to attract talent.

Pipes, Sally. “‘Medicare for All’ Is A Trap for Businesses and Employees.” Forbes, 24 June 2019, [www.forbes.com/sites/sallypipes/2019/06/24/medicare-for-all-is-a-trap-for-businesses-and-employees/#111a8f943b50](http://www.forbes.com/sites/sallypipes/2019/06/24/medicare-for-all-is-a-trap-for-businesses-and-employees/#111a8f943b50).

Historically, Congress has postponed Medicare payment cuts to doctors and hospitals just about every time it's had the chance. If those lower payment rates never come about, then businesses and individuals will be looking at much higher taxes than Sanders and company suggest. Finally, **Medicare for All would take away one of the**

**primary ways employers differentiate themselves in the quest for talent—their benefits plans.** According to the U.S. Census, more than 180 million people received health insurance through work in 2017. **Research from Gallup shows that seven in 10 people with employer-sponsored coverage are satisfied with their plan.** They won't be satisfied under Medicare for All. That's in part because they'll have to wait for care.

**Warrant:** Businesses and employees incentives to have high-quality health insurance are aligned.

Batniji, Rajaie. "Employer-Sponsored Health Insurance Isn't Going Away. That's a Good Thing." Stat News, 4 Sept. 2018, [www.statnews.com/2018/09/04/employer-sponsored-health-insurance-is-a-good-thing/](http://www.statnews.com/2018/09/04/employer-sponsored-health-insurance-is-a-good-thing/).

Everywhere you look across health care, incentives seem to be misaligned. Health care providers mostly get paid per service, so they want to provide more services. Insurers make profits of 15 percent to 20 percent of premium dollars, so they want premiums to go up. **Employers are the exception. They have an incentive to achieve sustainable cost control since they pay directly for most health care costs. They aim to keep their employees for years, so they take a longer-term view than private insurers. And they know that providing better coverage is good for them in two keys ways: it gives them a competitive advantage and it gives them healthy employees, who are more productive.** Appetite for rapid change. Unlike the relatively slow process of pushing change through regulation, employers have demonstrated the capacity to rapidly adopt innovation. Technology and new approaches to care are giving employers greater control over their health care investments than ever before. Unfortunately, the data-driven decision making that defines medicine has been alarmingly absent in decisions about health care services offered or the design of health care coverage, though that is changing. Employers now have a host of new solutions available to them, from

delivering care digitally to measuring how programs are working. Over \$3.4 billion was invested in digital health in the first half of 2018 alone.

**Analysis:** This response can be weighed on risk of solvency. The majority of people are satisfied with their employee-sponsored healthcare now, so changing up the system runs the risk of only making the situation worse.

### A/2: Medicare for All would decrease medical discrimination

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**Delink:** There are alternate causes of discrimination that prevent marginalized groups from getting high-quality health care.

**Uniqueness:** Controlling for insurance coverage, African Americans still have worse health outcomes than whites due to structural racism.

Abramson, Corey. "How Structural Racism Affects Healthcare." [Www.Kevinmd.Com](http://www.Kevinmd.Com), 14 Jan. 2020, [www.medpagetoday.com/blogs/kevinmd/84362](http://www.medpagetoday.com/blogs/kevinmd/84362).

More than 20 years later, have we really built a better future? In a word, no. Today, a black woman is 22% more likely to die from heart disease than a white woman. A black woman is 71% more likely to die from cervical cancer than a white woman. A black woman is 243% more likely to die from pregnancy or childbirth-related causes than a white woman. **Even after controlling for age, gender, marital status, region of residence, employment status, and insurance coverage, African Americans have worse health outcomes than whites in nearly every illness category. Expanding healthcare coverage is more of a temporary Band-Aid than a long-term solution.** Instead, reducing racial health disparity requires acknowledging the effects structural racism has on health status and then working toward sweeping, transformative change in our society as a whole.

**Warrant:** Discrimination from medical staff is a large barrier to getting health care.

Mirza, Shabab. "Center for American Progress." Center for American Progress, Center for American Progress, 18 Jan. 2018, [www.americanprogress.org/issues/lgbtq-rights/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/](http://www.americanprogress.org/issues/lgbtq-rights/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/).

Discrimination in health care settings endangers LGBTQ people's lives through delays or denials of medically necessary care. **For example, after one patient with HIV disclosed to a hospital that he had sex with other men, the hospital staff refused to provide his HIV medication. In another case, a transgender teenager who was admitted to a hospital for suicidal ideation and self-inflicted injuries was repeatedly misgendered and then discharged early by hospital staff. He later committed suicide.** Discrimination affects LGBTQ parents as well: In Michigan, an infant was turned away from a pediatrician's office because she had same-sex parents. Even though many states, such as Michigan, lack explicit statewide laws against LGBTQ discrimination in health care, Section 1557 of the ACA provides federal protections.

**Analysis:** This response can be weighed on probability. There are so many factors that create structural inequities, and Medicare for All can't fully solve medical discrimination. It's highly unlikely the pro will get full solvency here.

**Turn:** State expansion of Medicaid is solving for coverage gaps in the status quo — without any of the harms of Medicare for All.

**Warrant:** The pandemic is putting pressure on states to expand Medicaid coverage.

Mann, Cindy. "The COVID-19 Crisis Is Giving States That Haven't Expanded Medicaid New Reasons to Reconsider | Commonwealth Fund." [Www.Commonwealthfund.Org](http://www.Commonwealthfund.Org), 15 Apr. 2020, [www.commonwealthfund.org/blog/2020/covid-19-crisis-giving-states-havent-expanded-medicaid-new-reconsideration](http://www.commonwealthfund.org/blog/2020/covid-19-crisis-giving-states-havent-expanded-medicaid-new-reconsideration).

The debate over Medicaid expansion is hardly new. It began in 2012 after the Supreme Court made expansion voluntary for states under the Affordable Care Act. On January 1, 2014, when the law's coverage components became effective, 23 states immediately expanded Medicaid eligibility. In the years since, additional states have expanded their programs, and no state has dropped it. **Today, 36 states are providing coverage through the expansion. (In addition, Nebraska has adopted expansion but not yet implemented.) The arguments for and against expansion have become familiar, but we are now in a starkly different time. A massive public health emergency and deepening economic crisis offer new and compelling reasons to reconsider Medicaid expansion.** The Health Crisis First, of course, is the COVID-19 public health crisis, which has put everyone in the country at risk and placed extraordinary strain on our health care system. States are responding with their own resources; federal policymakers also have responded, providing new flexibilities and funding. Nonetheless, many states rightly wonder whether those funds will be sufficient.

**Impact:** Medicaid expansion would make 4.7 million uninsured adults eligible for Medicaid by 2021.

Singh, Rakesh. "4.7 Million Uninsured Adults Could Become Eligible for Medicaid by 2021 If All Remaining States Expanded the Program under the ACA." KFF, 25 June 2020, [www.kff.org/uninsured/press-release/4-7-million-uninsured-adults-could-become-eligible-for-medicaid-by-2021-if-all-remaining-states-expanded-the-program-under-the-aca/](http://www.kff.org/uninsured/press-release/4-7-million-uninsured-adults-could-become-eligible-for-medicaid-by-2021-if-all-remaining-states-expanded-the-program-under-the-aca/).

About 4.7 million uninsured adults could gain eligibility for Medicaid by 2021 if the 14 remaining non-expansion states were to expand Medicaid under the Affordable Care Act, a new KFF analysis finds. That figure includes an estimated 2.8 million adults who already were uninsured prior to the coronavirus pandemic and would fall in the “coverage gap” – meaning they have incomes too high to qualify for Medicaid but too low for ACA marketplace subsidies – as well as 1.9 million more people who are at risk of losing health insurance due to job loss during the pandemic and otherwise would end up in the coverage gap. An additional 3.3 million adults could become newly eligible for Medicaid coverage instead of ACA marketplace coverage if the remaining 14 states expanded Medicaid. Medicaid is more comprehensive than marketplace coverage and the federal government would pay ninety percent of the bill but that would require additional state expenditures.

**Analysis:** This turn can be weighed on probability. Expanding a program that's already been popular has a greater chance of working than overhauling the whole healthcare system. Medicaid expansion has the benefit of increased coverage, without risking wait times, shortages, decreased R&D, etc.

## A/2: M4A increases access to healthcare

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**Delink:** Access to health insurance doesn't necessarily lead to better health outcomes.

**Warrant:** Education is a more significant predictor of health outcomes.

Center on Society and Health. "Health Care: Necessary But Not Sufficient."

Societyhealth.Vcu.Edu, 13 Feb. 2015, societyhealth.vcu.edu/work/the-projects/health-care-necessary-but-not-sufficient.html.

Will improved access to health care remove the health disadvantage that exists for people with less education? Will health care reform make high school dropouts as healthy as college graduates? Not necessarily. Health care is necessary but not sufficient for improved health; in fact, **health care accounts for only about 10–20% of health outcomes, according to some experts.**<sup>2</sup> Having access to good doctors and medicines is certainly important. And health care has a bigger impact for people with limited education than for those with more education,<sup>3</sup> but access to health care by itself doesn't eliminate the relationship between education and health. **People with fewer years of education have worse health than those with more education—even when they have the same access to health care.** Consider data from Kaiser Permanente, one of the nation's oldest health systems, where all members of the plan have access to a similar level of care and network of providers. In a 2011 survey of members of Kaiser Permanente of Northern California, 69 percent of adults aged 25–64 with a college education described their health as "very good" or "excellent," compared to only 32 percent of those lacking a high school diploma (Figure 1).

**Warrant:** Empirically, Medicaid coverage has been shown to have no effect on health outcomes.

Pipes, Sally. "Medicare For All Won't Result In Better Health Outcomes." Forbes, 18 Mar. 2019, [www.forbes.com/sites/sallypipes/2019/03/18/medicare-for-all-wont-result-in-better-health-outcomes/#2addd46e4f48](http://www.forbes.com/sites/sallypipes/2019/03/18/medicare-for-all-wont-result-in-better-health-outcomes/#2addd46e4f48).

Another study looked at a Medicaid expansion scheme in Oregon that predated Obamacare. In 2008, Oregon used a lottery to determine who would be able to enroll. **Researchers analyzed the health outcomes of 6,400 people who won the lottery and gained Medicaid coverage compared to 5,800 who remained uninsured. The study concluded the Medicaid beneficiaries showed "no significant improvements in measured physical health outcomes in the first two years."** In some cases, Medicaid coverage seemingly yields worse health outcomes. A 2010 study conducted by researchers at the University of Virginia looked at nearly 900,000 major surgeries between 2003 and 2007. Patients with Medicaid coverage were 13% more likely to die after surgery than uninsured patients.

**Turn:** Medicare for All would overwhelm the healthcare system and lead to delays

**Warrant:** M4A would increase demand for healthcare, leading to delays.

Pipes, Sally. "Medicare For All Won't Result In Better Health Outcomes." Forbes, 18 Mar. 2019, [www.forbes.com/sites/sallypipes/2019/03/18/medicare-for-all-wont-result-in-better-health-outcomes/#2addd46e4f48](http://www.forbes.com/sites/sallypipes/2019/03/18/medicare-for-all-wont-result-in-better-health-outcomes/#2addd46e4f48).

In some cases, Medicaid coverage seemingly yields worse health outcomes. A 2010 study conducted by researchers at the University of Virginia looked at nearly 900,000 major surgeries between 2003 and 2007. Patients with Medicaid coverage were 13% more likely to die after surgery than uninsured patients. **Shoving everyone into a Medicare for All plan with no premiums or cost-sharing would greatly increase the demand for health care. People would visit the doctor's office for all of their medical**

**issues -- no matter how minor. That would overwhelm the medical system, delay care, and lead to worse health outcomes.** For proof, look at our neighbors to the north.

Canada's single-payer system offers care free at the point of service -- and is the model for Senator Sanders's bid for Medicare for All. Canadian patients wait months for care.

In 2018, they idled a median of 19.8 weeks for specialist treatment after obtaining a referral from a general practitioner.

**Impact:** Long wait times contributed to the deaths of at least 44,000 Canadian women in the past two decades.

Pipes, Sally. "Canadians Can't Wait Any Longer For Healthcare Justice." Pacific Research Institute, 11 May 2018, [www.pacificresearch.org/canadians-cant-wait-any-longer-for-healthcare-justice/](http://www.pacificresearch.org/canadians-cant-wait-any-longer-for-healthcare-justice/).

Long waits aren't merely inconvenient; they're dangerous. Consider the case of Walid Khalfallah, a British Columbian boy with severe scoliosis profiled by the Vancouver Sun in 2012. The Sun reported that he faced a three-year wait for spinal surgery, even though medical guidelines recommended a maximum wait of three months. **Delays can even prove fatal. Long waits have contributed to the deaths of more than 44,000 Canadian women in the past two decades, according to a Fraser Institute study.** Many patients would gladly pay extra to receive care more quickly. But British Columbian law makes it effectively impossible to do so.

**Analysis:** This response can be weighed as a prerequisite. If Medicare for All merely provides access to a waiting list, health outcomes will not improve. This response can also be weighed on timeframe. Long wait times make it less likely people will get preventative care, eventually leading more people to get sick and creating even more demand for healthcare down the road. This leads to a vicious cycle of continuously increasing demand and decreasing supply.

### A/2: Medicare for All decreases job lock

**Disadvantage:** Medicare for all will increase taxes

**Warrant:** Medicare for all would cost over 30 trillion

Sullivan, Peter. "New Study: Full-Scale 'Medicare for All' Costs \$32 Trillion over 10 Years." TheHill, 16 Oct. 2019, <https://thehill.com/policy/healthcare/465894-new-study-full-scale-medicare-for-all-costs-32-trillion-over-10-years>.

**A new study finds that a full-scale single-payer health insurance program, also called "Medicare for All," would cost about \$32 trillion over 10 years. The study from the Urban Institute and the Commonwealth Fund found \$32.01 trillion in new federal revenue would be needed to pay for the plan, highlighting the immense cost of a proposal at the center of the health care debate raging in the presidential race.** The study did not analyze the exact proposals from any presidential candidates, but the proposal it examined is roughly similar to the one put forward by Sen. Bernie Sanders (I-Vt.) and backed by Sen. Elizabeth Warren (D-Mass.).

**Warrant:** We might need a value added tax of 25 percent

Brownstein, Ronald. "The Eye-Popping Cost of Medicare for All." The Atlantic, 16 Oct. 2019, <https://www.theatlantic.com/politics/archive/2019/10/high-cost-warren-and-sanders-single-payer-plan/600166/>.

Burman told me that the broad-based income-tax increases that Sanders has discussed using to fund single payer—including raising the top income-tax rate past 50 percent and ending reduced taxation for capital gains—would likely cover about half of the proposal's cost. **If Warren or Sanders tried to cover the other half with a value-added**

tax—a sort of national sales tax that many European nations use to fund their social safety net—the rate would likely need to be set at about 25 percent, he estimated.

“All of the things Sanders proposed plus a high VAT by European standards might get you there,” Burman said.

**Disadvantage:** Medicare for all debt will crowd out private investors

**Warrant:** Rising interest rates from debt could shrink the economy 24 percent

Staff. “Medicare For All Could ‘Decimate’ The Economy.” The Partnership for America’s Health Care Future, 4 Feb. 2020,

<https://americashealthcarefuture.org/medicare-for-all-could-decimate-the-economy/>.

A new analysis from Penn Wharton reveals that Medicare for All could “could shrink U.S. GDP by as much as 24% by the year 2060,” **Yahoo Finance reports.** ... [T]he model warns, if the plan is deficit-financed – paid for by government borrowing – “the negative effects of larger deficits on labor supply, capital accumulation and GDP would significantly outweigh the positive effects on the economy that come from a larger and healthier workforce.” ... According to studies, the cost of Medicare for all sits at roughly \$32 trillion over the next decade. But, as the analysis notes, [Senator Bernie] Sanders’ universal health care plan doesn’t have a built-in financing mechanism ... Sanders’ wealth tax would generate \$1 trillion less in revenue than he stated ... The real trouble comes when Medicare for all is financed by deficits. **With government borrowing, universal health care could shrink the economy by as much as 24% by 2060, as investments in private capital are reduced**

**Impact:** Debt financing could cut the equivalent of 14 million jobs

Staff. "Choices for Financing Medicare for All." Committee for a Responsible Federal Budget, 17 Mar. 2020, <https://www.crfb.org/papers/choices-financing-medicare-all>.

Deficit financing Medicare for All would also harm the economy, mainly by crowding out investment in productive capital. **PWBM finds it would reduce projected GDP by 5.9 percent in 2030 – the equivalent of about \$5,300 per person – and gross national product would likely fall by significantly more. PWBM also finds that deficit financing Medicare for All would reduce hours worked by nearly 10 percent – the equivalent of 14 million full-time equivalent jobs. Lastly, PWBM estimates that charging mandatory premiums, while subsidizing low-income beneficiaries, would reduce GDP by 2.3 percent – the equivalent of \$2,100 per person. It would reduce hours worked by 7 percent – the equivalent of 10 million full-time equivalent jobs.** Over the long run, PWBM estimates the effects of a payroll tax and especially deficit financing would become more pronounced. By 2060, raising payroll taxes to finance Medicare for All would reduce projected GDP by 15 percent, while deficit financing Medicare for All would reduce GDP by 24 percent. Premium-financed Medicare for All, on the other hand, would have virtually no impact on long-run GDP; beyond 2060, it might even improve the economy.

**Analysis:** An increase in interest rates will make it even harder to start a business. This directly turns the argument by showing that even if people are able to leave their jobs with the intention of starting a new business, that doesn't mean funding for it will be easy to secure. In fact, it will be much harder with higher interest rates.

## A/2: Medicare for All saves people from bankruptcy

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**Disadvantage:** Medicare for all will increase taxes

**Warrant:** Medicare for all would lead to less disposable income

Haislmaier, Edmund. "How 'Medicare for All' Harms Working Americans." The Heritage Foundation, 19 Nov. 2019, <https://www.heritage.org/health-care-reform/report/how-medicare-all-harms-working-americans>.

Proposals to impose a government-run health care system, such as the pending "Medicare for All" legislation, on the American public would leave most households financially worse off. **Workers would have to pay additional taxes—21.2 percent of all wage and salary income—raising the total federal payroll tax rate to 36.5 percent for most workers. Average disposable income (after taxes and private medical expenses) for all households would decline by \$5,671 per year.**

**Warrant:** 49 percent of Americans would spend more in taxes than they would save

Haislmaier, Edmund. "How 'Medicare for All' Harms Working Americans." The Heritage Foundation, 19 Nov. 2019, <https://www.heritage.org/health-care-reform/report/how-medicare-all-harms-working-americans>.

Half (51 percent) of Medicare households include no workers (essentially, these are fully retired people). Those households would all be financially better off by an average of \$5,368 if the new program was funded entirely through payroll taxes. See Appendix A for a discussion of the results from applying alternative assumptions of partial or full financing through higher income taxes. This subset of households also accounts for 85

percent of all households without workers. **The other half (49 percent) of Medicare households—those with workers—would be financially worse off by an average of \$2,768 under a government-run health plan because 53.8 percent of them would pay more in taxes than they would save as a result of the new program eliminating their current of out-of-pocket health spending.**

**Analysis:** Higher taxes will just mean that businesses are not able to expand as much, which will cause stagnation in the economy. This will make it harder to afford basic needs, and actually increase the odds of bankruptcy. This can thus qualify as a turn to the pro's argument.

**Disadvantage:** Medicare for all will increase interest rates

**Warrant:** Medicare for all would be over 60 percent of all national spending

Brownstein, Ronald. "The Eye-Popping Cost of Medicare for All." *The Atlantic*, 16 Oct. 2019, <https://www.theatlantic.com/politics/archive/2019/10/high-cost-warren-and-sanders-single-payer-plan/600166/>.

The 10-year cost of \$34 trillion that the study forecasts nearly matches the CBO's estimate of how much money the federal government will spend over that period not only on all entitlement programs, but also on all federal income support, such as the Supplemental Nutrition Assistance Program. Former Vice President Joe Biden said incorrectly at the debate that the single-payer plan would cost more annually than the total existing federal budget—it would cost less. (The CBO says Washington will spend about \$4.6 trillion in 2020.) **But over the next decade, the plan on its own would represent a nearly 60 percent increase in total expected federal spending, from national defense to interest on the national debt, according to CBO projections.**

**Warrant:** Financing medicare for all through debt would lead to soaring interest rates

Smith. "Medicare-for-All Would Be Costly for Everyone." Bloomberg.Com, 27 Aug. 2018,  
<https://www.bloomberg.com/opinion/articles/2018-08-27/medicare-for-all-would-be-costly-for-everyone>.

The financing for such an ambitious program may derail these hopes. According to a study by Charles Blahous a researcher at the Mercatus Center at George Mason University, Sanders's proposal could end up costing the federal government at least \$32 trillion over 10 years. Some of the cost of a Medicare-for-all plan would be offset by decreasing expenditures of states and private health insurers. Depending on how successful Medicare-for-all would be at negotiating lower prices — especially physicians' fees — overall health spending could even decline under universal Medicare. **A program of this size simply can't be financed by deficit increases. Any attempt to do so would lead to soaring interest rates, as the Federal Reserve would move to offset a potentially rapid increase in inflation.**

**Analysis:** This response proves that there will be less investment in the economy and thus less opportunity overall for low income Americans. This outweighs the pro's argument about bankruptcy. Even if people are able to not go into debt over medical bills specifically, the likelihood of going into debt at all goes up.

### A/2: Medicare for All creates jobs

**Turn:** Medicare for all will leave millions unemployed

**Warrant:** Lost hospital revenue will leave millions unemployed

Rosenthal, Elisabeth. "Analysis: A Health Care Overhaul Could Kill 2 Million Jobs, And That's OK." Kaiser Health News, 24 May 2019, <https://khn.org/news/analysis-a-health-care-overhaul-could-kill-2-million-jobs-and-thats-ok/>.

**Stanford researchers estimate that 5,000 community hospitals would lose more than \$151 billion under a Medicare for All plan; that would translate into the loss of 860,000 to 1.5 million jobs. A Navigant study found that a typical midsize, nonprofit hospital system would have a net revenue loss of 22%.** Robert Pollin, an economist at the Political Economy Research Institute of the University of Massachusetts-Amherst, is frustrated not just by the doomsday predictions but also by how proponents of Medicare for All tend to gloss over the jobs issue. "Every proponent of Medicare for All — including myself — has to recognize that the biggest source of cost-saving is layoffs," he said. **He has calculated that Medicare for All would result in job losses (mostly among administrators) "somewhere in the range of 2 million" — about half on the insurers' side and half employed in hospitals and doctors' offices to argue with the former.** Supporters of Medicare for All, he said, have to think about a "just transition" and "what it might look like."

**Warrant:** 1.8 million jobs in the private insurance industry would be lost

Pradhan, Rachana. "Medicare for All's Jobs Problem." POLITICO, 25 Nov. 2019, <https://www.politico.com/news/agenda/2019/11/25/medicare-for-all-jobs-067781>.

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

**Disadvantage:** Medicare for all will raise taxes

**Warrant:** Medicare for all would cost over 30 trillion

Luthra, Shefali. "Would 'Medicare For All' Cost More Than U.S. Budget? Biden Says So. Math Says No." Kaiser Health News, 14 Feb. 2020, <https://khn.org/news/does-medicare-for-all-cost-more-than-the-entire-budget-biden-says-so-but-numbers-say-no/>.

**Sanders has said publicly that economists estimate Medicare for All would cost somewhere between \$30 trillion and \$40 trillion over 10 years. Research by the nonpartisan Urban Institute, a Washington, D.C., think tank, puts the figure in the \$32 trillion to \$34 trillion range.** We pointed out to Biden's campaign that comparing 10-year spending estimates to one-year budgets is like comparing apples to oranges. The campaign suggested that if you take 10 times the current federal budget, you get a figure smaller than the estimated cost of Medicare for All over that 10-year window. That calculation would lead you to multiply \$4.1 trillion by 10 to get \$41.1 trillion. That

result is close to the high mark Sanders set for his program's cost but well above the \$34 trillion that Urban researchers projected.

**Warrant:** Medicare for all would require taxes on the middle class

Staff. "Would Medicare for All Require a Middle-Class Tax Hike?" Committee for a Responsible Federal Budget, 22 Oct. 2019, <https://www.crfb.org/blogs/would-medicare-all-require-middle-class-tax-hike>.

While the list above does not technically include all possible taxes that could be imposed on the wealthy, the policies it does include are extremely aggressive, more aggressive than may be politically or even technically possible. A top individual rate of 70 percent would almost certainly bring top marginal tax rates above their revenue-maximizing levels (including state and local rates). A 42 percent corporate income tax rate would put the total corporate tax rate at close to twice the international average and a third higher than the next highest developed nation. A wealth tax would likely lead to constitutional challenges. Moreover, these policies are likely to reduce incentives to work and invest, slowing economic growth and reducing their combined revenue stream. **It is unlikely that policymakers could agree to enact anywhere close to \$11 trillion in tax increases only on the wealthy and corporations, let alone the \$30 trillion needed to fund Medicare for All. As a result, funding Medicare for All will almost certainly require broad-based taxes that apply to the middle class, either directly or indirectly (for example through an employer payroll tax or consumption tax).**

**Analysis:** This is a good response because it can outweigh on scope. Given the sheer number of people in America who will have to face this tax increase, this is sure to affect a much larger number of people than the number who see gains in income or job opportunities. The impact of tax increases can also lead to lower job options, thus turning the argument as well.

## A/2: Medicare for All increases disposable income

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**Turn:** Medicare for all will increase taxes

**Warrant:** Medicare for all would cost more than the whole national budget

Luthra, Shefali. "Would 'Medicare For All' Cost More Than U.S. Budget? Biden Says So. Math Says No." Kaiser Health News, 14 Feb. 2020, <https://khn.org/news/does-medicare-for-all-cost-more-than-the-entire-budget-biden-says-so-but-numbers-say-no/>.

Medicare for All's price — and whether it's worth it — is a subject of fierce discussion among Democratic presidential candidates. But we had never heard this figure before. It caught our attention, so we decided to dig in. **Biden's campaign directed us to the 2018 federal budget, which totaled \$4.1 trillion. It compared that amount with the estimated cost of Sanders' single-payer proposal: between \$30 trillion and \$40 trillion over a decade. The math, they said, shows Medicare for All would cost more than the national budget.** But it turns out, based on the numbers and interviews with independent experts, Biden's comparison of Medicare for All's price to total federal spending misses the mark because the calculation is flawed.

**Warrant:** Medicare for all would require 32 percent higher taxes on workers

Sarlin, Benjy. "Study: 'Medicare for All' Means Taxes on the Middle Class, but It Could Save Them Money." NBC News, 29 Oct. 2019, <https://www.nbcnews.com/politics/2020-election/study-medicare-all-means-middle-class-taxes-could-save-them-n1073431>.

**Paying for "Medicare for All" could require raising payroll taxes by 32 percent on workers and businesses, among other options, according to a new report from a think tank that advocates for balanced budgets.** But the report, released Monday by the Committee for a Responsible Federal Budget, also suggested that middle class families could save money overall, even with significantly higher taxes. The study comes as Sens. Bernie Sanders, I-Vt., and Elizabeth Warren, D-Mass., both presidential candidates, face pressure from rivals to detail how they would pay for their proposal to move the country onto a more generous Medicare program with no premiums and minimal out-of-pocket costs. Warren has said she is working on such a plan.

**Analysis:** Higher taxes will make people have even less disposable income. This is crucial because even though people might be saving money from not having to spend on private insurance, they will have to spend even more in higher taxes. This turns the argument and makes it a reason to vote con.

**Disadvantage:** Medicare for all will increase national debt

**Warrant:** Medicare for all would cost 30 trillion

Brownstein, Ronald. "The Eye-Popping Cost of Medicare for All." *The Atlantic*, 16 Oct. 2019, <https://www.theatlantic.com/politics/archive/2019/10/high-cost-warren-and-sanders-single-payer-plan/600166/>.

Senator Elizabeth Warren's refusal to answer repeated questions at last night's debate about how she would fund Medicare for All underscores the challenge she faces finding a politically acceptable means to meet the idea's huge price tag—a challenge that only intensified today with the release of an eye-popping new study. **The Urban Institute, a center-left think tank highly respected among Democrats, is projecting that a plan similar to what Warren and Senator Bernie Sanders are pushing would require \$34**

trillion in additional federal spending over its first decade in operation. That's more than the federal government's total cost over the coming decade for Social Security, Medicare, and Medicaid combined, according to the most recent Congressional Budget Office projections.

**Warrant:** Medicare for all would significantly raise the national debt

Staff. "ARCHIVE: Choices for Financing Medicare for All: A Preliminary Analysis." Committee for a Responsible Federal Budget, 28 Oct. 2019,  
<http://www.crfb.org/papers/choices-financing-medicare-all-preliminary-analysis>.

More than double the national debt to 205 percent of the economy. Federal debt held by the public currently totals about \$17 trillion, or 79 percent of GDP. Under current law, debt is projected to reach 97 percent of GDP by 2030. **Assuming no changes in projected interest rates or economic growth, deficit-financing Medicare for All over the next decade would require about \$34 trillion of new borrowing including interest, which is the equivalent of 108 percent of GDP by 2030. As a result, debt would rise above 205 percent of GDP, more than double its currently projected level. This would put debt in 2030 at almost five times its historic average of 42 percent and nearly twice the historic record of 106 percent (set after World War II). Under this scenario, debt would continue to grow rapidly beyond 2030.**

**Analysis:** This is a good response because increasing the national debt will raise interest rates, which will make it harder for businesses to expand. This will in turn leave people with fewer jobs and thus less disposable income. Again, this response ultimately makes the issue a reason to vote con, not pro.

### A/2: Medicare for All saves hospitals from closure

**Non-unique:** Hospitals are already closing

**Warrant:** 98 Rural hospitals have closed in the last 10 years

Seigel, Jessica. "Rural Hospital Closures Rise to Ninety-Eight"- NRHA. 20 Feb. 2019,  
<https://www.ruralhealthweb.org/blogs/ruralhealthvoices/february-2019/rural-hospital-closures-rise-to-ninety-seven>.

After a brief break in rural hospital closures, the numbers began to rapidly rise this summer. **The rash of closures has only continued as temperatures have dropped, leaving hundreds more rural American out in the cold. Just last week, two more rural hospitals closed, bringing the number of rural hospital closures up to 98 since 2010.** **Hundreds more are likely to follow.** Currently, 46% of rural hospitals operate at a loss, compared to 44% in 2018 and 40% in 2017. **Due to financial strains, nearly 700 rural hospitals are financially vulnerable and at high risk of closure.** In rural areas, health care is so much more than what happens within the walls of a hospital or facility. Health care is the center of the rural economy, creating jobs and opportunities for residents, encouraging families to move to a county, and incentivizing businesses to open their doors. Without a rural hospital, a community will crumble. The most recent hospital closures will leave communities across the country without local care and will devastate rural economies nationwide.

**Warrant:** 210 hospitals are at high risk of closure

Corey, Lindsey. New Report Indicates 1 in 3 Rural Hospitals at Risk. 2 Feb. 2016,  
[https://www.ruralhealthweb.org/NRHA/media/Emerge\\_NRHA/PDFs/02-02-16PI16NRHAreleaseonIVantagestudy.pdf](https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/PDFs/02-02-16PI16NRHAreleaseonIVantagestudy.pdf).

**New research indicates that sustained Medicare cuts threaten the financial viability of more than one-third of rural hospitals in America. As rural hospital closures continue to escalate, the National Rural Health Association calls on Congress to act swiftly.**

According to data released today by iVantage Analytics, the rural hospital closure crisis has significantly worsened. The report, “2016 Rural Relevance: Vulnerability to Value Study,” indicates 673 rural hospitals are at risk of closure, which means 11.7 million patients would lose much-needed health care access. And 210 of these hospitals are at an “extreme risk” of closure. Since 2010, 66 rural hospitals have closed. The closure rate is increasing. It was six times higher in 2015 than in 2010. “Closures of this magnitude would mean millions of rural patients across the country will lose access to their closest emergency room, and rural economies will suffer a devastating blow,” said Alan Morgan, CEO of the National Rural Health Association.

**Analysis:** This is a good response because it proves that the argument is entirely nonunique. If hospitals are already closing today, then there is no way for medicare for all to save them. This means that medicare for all is too little too late, and the pro team is unable to garner any impact.

**Turn:** Medicare for all increases hospital closures

**Warrant:** Medicare for all would cut hospital funding 40 percent

Atlas, Scott W. “Opinion | The Dangers of Medicare for All.” The New York Times, 9 Mar. 2020. NYTimes.com, <https://www.nytimes.com/2020/03/09/opinion/medicare-for-all-cost.html>.

**The estimated \$32 trillion cost of Medicare for All includes the immediate cuts of about 40 percent to hospitals and about 30 percent to doctors now treating patients**

**under private insurance, with these cuts likely growing more severe over time.** Will these cuts occur without hurting timeliness or quality of care for patients? Here's another truth — abolishing private insurance would harm today's retirees on Medicare, because more than 70 percent of them use private insurance in addition to or instead of traditional Medicare. About 29 percent of those enrolled in traditional Medicare (A and B) buy "Medigap" plans, state-based private insurance that supplements non-drug Medicare benefits.

**Quantification:** Half of all hospitals would lose funding overall

Atlas, Scott W. "Opinion | The Dangers of Medicare for All." The New York Times, 9 Mar. 2020. NYTimes.com, <https://www.nytimes.com/2020/03/09/opinion/medicare-for-all-cost.html>.

**Beyond that, Medicare for All will radically change health care for retirees because the services they get from hospitals and doctors are in effect subsidized by higher payments from privately insured patients.** According to a report by the Centers for Medicare and Medicaid Services, while private insurance often pays over 140 percent of the cost of care, Medicare and Medicaid pay an estimated 60 percent of what private insurance pays for inpatient services, and an estimated 60 percent to 80 percent for physician services. Most hospitals, skilled nursing facilities and in-home health care providers already lose money per Medicare patient. **By 2040, under today's system, approximately half of hospitals, roughly two-thirds of skilled nursing facilities and over 80 percent of home health agencies would lose money overall.**

**Analysis:** This is a good response because it shows that medicare for all will actually do the opposite of what your opponents say. This turns their argument into a reason to vote for the con side in the debate. Even if hospitals get some more block grants, this will be more than offset by lower medical care prices across the board.

### A/2: Medicare For All Increases Options for Long Term Care

**Response:** Medicare for all will hurt the elderly

**Disadvantage:** Costs will increase for the elderly

Chris Pope. "Medicare for all would be terrible for seniors". October 26, 2018. National Review, <https://www.nationalreview.com/2018/10/medicare-for-all-plan-harmful-to-seniors/>

"Indeed, Schumer revealingly didn't dispute the estimated tax increase of \$32.6 trillion over ten years (over \$26,000 per household per year) cited in Trump's op-ed, which would be required to fund "Medicare for All." **Such a tax increase would vastly exceed the value of expanded benefits to retirees — even if its burden were distributed so that most seniors faced smaller-than-average tax hikes. Seniors are already able to cover all their out-of-pocket costs by purchasing Medigap's Plan F at an average premium of \$1,712 per year.**"

**Disadvantage:** Hospitals would close, hurting the elderly

Chris Pope. "Medicare for all would be terrible for seniors". October 26, 2018. National Review, <https://www.nationalreview.com/2018/10/medicare-for-all-plan-harmful-to-seniors/>

**By destroying America's system of focused public assistance, "Medicare for All" would necessarily subject those currently enrolled in the program to similar restrictions in timely access to quality care.** Even with an extra \$32.6 trillion in tax revenue, the "Medicare for All" proposal would cover only 87 percent of hospital costs — **leaving two**

thirds of facilities in the red, forcing them to cut services in a struggle to keep their doors open..

**Analysis:** This argument is strong because it controls the impact of the Pro contention. It makes the point that elderly people would actually be hurt in terms of money and access to care. This is largely a similar demographic as those who use long term care.

**Response:** Medicare for all would decrease quality of coverage

**Warrant:** Medicare is full of perverse incentives for low quality care

Michael Cannon. "M4A Would Deliver Authoritarian, Unaffordable, Low-Quality Care". April 2020. CATO. <https://www.cato-unbound.org/print-issue/2614>

**A single-payer system, no matter what form it takes, cements in place one set of perverse incentives and eliminates the competitive pressures that would otherwise rescue patients from the low-quality care that results.** Take Medicare, which is the largest purchaser of health care services in the United States and likely the world. Medicare has spent five decades rewarding low-quality care and punishing high-quality care. **Former Medicare administrator Tom Scully complained, "Everyone with an M.D. or D.O. degree gets the same rate [from Medicare], whether they are the best or worst doc in town.** Every hospital gets the same payment for a hip replacement, regardless of quality."

**Warrant:** Medicare has no incentive to reduce accidents

Michael Cannon. "M4A Would Deliver Authoritarian, Unaffordable, Low-Quality Care". April 2020. CATO. <https://www.cato-unbound.org/print-issue/2614>

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

**Analysis:** This argument is strong because it makes the pro argument seem non-credible. Even if there is MORE long term care, if the quality is substantially worse the judge will not grant the pro team their impact.

### A/2: Medicare For All Increases Preventative Care

**Response:** The insurance does not actually decrease emergency room use

**De-link:** Universal coverage increases ER visits

Carolyn Johnson. "The uninsured are overusing emergency rooms — and other health-care myths". June 2017. Washington Post,  
<https://www.washingtonpost.com/news/wonk/wp/2017/12/27/the-uninsured-are-overusing-emergency-rooms-and-other-health-care-myths/>

""It would be nice if giving people insurance did get them so healthy and so much access to other care that they didn't need to go to the emergency department, but that does not seem to be the case," said Katherine Baicker, dean of the University of Chicago's Harris School of Public Policy. "It seems clear to me that expanding insurance, in and of itself, does not contain spending. It increases spending, by giving people who had very limited access to care the ability to get their health-care needs met."

**De-link:** Studies show ER usage does not go down

Carolyn Johnson. "The uninsured are overusing emergency rooms — and other health-care myths". June 2017. Washington Post,  
<https://www.washingtonpost.com/news/wonk/wp/2017/12/27/the-uninsured-are-overusing-emergency-rooms-and-other-health-care-myths/>

**The idea that uninsured people are clogging emergency rooms looks more and more like a myth, according to a recent study published in Health Affairs. Uninsured adults used the emergency room at very similar rates to people with insurance — and much**

**less than people on Medicaid.** Providing insurance to people can have many benefits, but driving down emergency room utilization doesn't appear to be one of them.

**Analysis:** This argument is a straight de-link. It is simply not empirically true that the uninsured overuse emergency rooms.

**Response:** Medicare for all is not the solution to people going to the emergency room when they are sick

**Turn:** Healthcare actually increases ER usage

Katherine Baicker and Amitabh Chandra. "Myths And Misconceptions About U.S. Health Insurance". 2008. Health Affairs.

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.6.w533>

**This is a common and deceptively appealing argument for expanding insurance coverage: we could spend less and get more, and who could be against that? But as with most prescriptions that promise something for nothing, this misconception finds little empirical support.** Yes, emergency room (ER) care for the uninsured is inefficient and might have been avoided through more diligent preventive care and disease management. Diabetes treatment is a good example; it is much cheaper to manage diabetes well than to wait for a hospitalization that requires a leg amputation. Having health insurance may lower spending on ER visits and other publicly provided care used by the uninsured through better prevention and medical management. **But empirical research also demonstrates that insured people use more care (and have better health outcomes) than uninsured people do—so universal insurance is likely to increase, not reduce, overall health spending**

**Warrant:** People will consume more expensive healthcare because of Moral Hazard

Katherine Baicker and Amitabh Chandra. "Myths And Misconceptions About U.S. Health Insurance". 2008. Health Affairs.

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.6.w533>

**Why does insurance cause greater consumption of health care? Insurance, particularly insurance with low cost sharing, means that patients do not bear the full cost of the health resources they use.** This is a good thing—having just made the case for the importance of the financial protections that insurance provides—but it comes with the side effect of promoting greater consumption of health resources, even when their health benefit is low. **This well-documented phenomenon is known as “moral hazard,” even though there is nothing moral or immoral about it. The RAND Health Insurance Experiment (HIE),** the largest experiment in social science, measured people's responsiveness to the price of health care. Contrary to the view of many noneconomists that using health care is unpleasant and thus not likely to be responsive to prices, the HIE found that it was responsive: people who paid nothing for health care used 30 percent more care than did those with high deductibles.<sup>4</sup> This is not done in bad faith: patients and their physicians evaluate whether the value of the care exceeds the out-of-pocket costs, rather than the higher total costs.

**Analysis:** This argument is a turn, it makes the point that when healthcare is free consumption goes up. This means that on net, expensive ER usage also goes up, driving up costs

## A/2: Medicare for All is Politically Popular

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**Response:** Medicare for all is not actually that popular

**De-link:** Universal Healthcare does not have overwhelming support

Jordan Weissman. "Medicare for all is getting less popular". October, 2019. SLATE,  
<https://slate.com/business/2019/10/medicare-for-all-is-getting-less-popular.html>

"According to the Kaiser Family Foundation's latest Health Care Tracking poll, **a small majority of adults still say they would favor putting all Americans on a single national health plan, with 51 percent in favor and 47 percent opposed. But the margin of support has shrunk significantly from the beginning of this year, when as many as 57 percent backed such a proposal, and only 37 percent were opposed..**"

**De-link:** Medicare for all, specifically, has low support

Jordan Weissman. "Medicare for all is getting less popular". October, 2019. SLATE,  
<https://slate.com/business/2019/10/medicare-for-all-is-getting-less-popular.html>

**Recent polling by other organizations has shown even lower levels of support for a single-payer system. An NBC/Wall Street Journal survey last month found just 41 percent said they backed one, with 56 percent against, while a Fox News poll found 46 percent in favor and 48 percent against. But polling results on health care can be extremely sensitive to how the question is phrased. What makes the Kaiser Family Foundation survey interesting is that it's been asking the public the same version of its**

question for more than two years now—"Do you favor or oppose having a national health plan, sometimes called Medicare-for-all, in which all Americans would get their insurance from a single government plan?"—giving us a picture of how public opinion has evolved.

**Analysis:** This block demonstrates that Medicare for all does not actually enjoy overwhelming support. This means that there is no popular mandate to pass it.

**Turn:** Medicare for all is Hyper Divisive

**Warrant:** Medicare for all is hated by Republicans

Chris Conover. "The #2 Reason Bernie Sanders' Medicare-for-All Single-Payer Plan Is A Singularly Bad Idea". 18 Oct. 2017. Forbes.

<https://www.forbes.com/sites/theapothecary/2017/09/30/the-2-reason-bernie-sanders-medicare-for-all-single-payer-plan-is-a-singularly-bad-idea/#75e116c529bb>

**When asked about support for or opposition to enrolling all Americans in a single government-run health plan, as would be the case under Medicare for All, 42.3 percent of Democrats expressed support versus 13.3 percent of Republicans.** On the other hand, 52.8 percent of Republicans opposed Medicare for All versus 12.3 percent of Democrats. Democrats were more likely to neither support nor oppose Medicare for All than were Republicans (43.5 percent versus 32.6 percent).

**Warrant:** Detractors oppose many crucial elements of Medicare for All

Chris Conover. "The #2 Reason Bernie Sanders' Medicare-for-All Single-Payer Plan Is A Singularly Bad Idea". 18 Oct. 2017. Forbes.

<https://www.forbes.com/sites/theapothecary/2017/09/30/the-2-reason-bernie-sanders-medicare-for-all-single-payer-plan-is-a-singularly-bad-idea/#75e116c529bb>

**Of those who opposed Medicare for All, 73.6 percent reported that an important factor in their decision was that most people would not be able to keep their current insurance coverage, and 81.2 percent reported higher federal taxes to finance a national health program as an important factor.** Other important factors to opponents were that it might be harder to get an appointment with health care providers (82.8 percent) and that there might be less medical innovation (77.1 percent). Opponents were about half as likely as supporters (45.0 percent versus 91.0 percent) to report that everyone having coverage was important in their decision about whether to support Medicare for All.

**Analysis:** This argument shows that Medicare for all has broad based, entrenched opposition. Even if a slight majority of people support the bill, there is not sweeping popular mandate to do so.

### A/2: Medicare For All Reduces National Healthcare Expenses

**Response:** Medicare for all actually costs a lot of money

**De-link:** Medicare for all in practice will not actually reduce administrative costs

Sarah Kiliff. "Bernie Sanders's Medicare-for-all plan, explained". 18 Oct. 2017. VOX,  
<https://www.vox.com/2019/4/10/18304448/bernie-sanders-medicare-for-all>

"Medicare for All's supporters promise that this time will be different. Once a single-payer program is implemented, they argue, the government will save billions of dollars by slashing payments to drug-makers, doctors, and hospitals. **Although cuts of that magnitude would severely affect patient care, there's no need to worry. If past is prologue, they will never occur. Time after time, providers have blunted initiatives designed to economize at their expense. There's no reason to think this Congress will succeed when virtually every past Congress has failed to reduce the flow of Medicare dollars.**"

**Outweigh:** High Healthcare costs are actually a result of socialized healthcare

Charles Silver and David A. Hyman. "No, Medicare for All Won't Save Money". November 25, 2019. CATO, <https://www.cato.org/publications/commentary/no-medicare-all-wont-save-money>

The fundamental problem is that Medicare for All's supporters have cause and effect reversed. They think Americans need universal comprehensive coverage because health care is expensive. In reality, **we spend too much on health care because we rely so heavily on third parties—Medicare, Medicaid, and private insurers—to pay our bills. In 1960, when patients paid about \$1.73 out of pocket for every \$1 paid by an insurer,**

health care spending per capita was \$165. In 2010, when patients paid out 16 cents for every insurance dollar, spending per capita was \$8,400.

**Turn:** Healthcare use will increase, driving up costs

**Warrant:** Medicare for all will stimulate job growth

Chris Conover. "The #2 Reason Bernie Sanders' Medicare-for-All Single-Payer Plan Is A Singularly Bad Idea". 18 Oct. 2017. Forbes.

<https://www.forbes.com/sites/theapothecary/2017/09/30/the-2-reason-bernie-sanders-medicare-for-all-single-payer-plan-is-a-singularly-bad-idea/#75e116c529bb>

**The bad news for single-payer enthusiasts is that free care of the sort provided under Canada's single-payer health system or under Senator Sanders's version of Medicare-for-All results in 30% wasted spending.** What do I mean by this? Of the roughly \$6,000 in annual spending per person in the free care group, more than \$1,850 (>30%) was wasted. Put another way, the value of spending for this group was less than 70% of the total amount of spending paid for by the free care plan (note that all figures count only medical expenses and exclude insurance administrative costs). This is a point estimate: simulations by RAND researchers showed that the waste could range anywhere from 28.6% to 33.9%

**Warrant:** Medicare has both direct and indirect positive effects on the labor market

Chris Conover. "The #2 Reason Bernie Sanders' Medicare-for-All Single-Payer Plan Is A Singularly Bad Idea". 18 Oct. 2017. Forbes.

<https://www.forbes.com/sites/theapothecary/2017/09/30/the-2-reason-bernie-sanders-medicare-for-all-single-payer-plan-is-a-singularly-bad-idea/#75e116c529bb>

[sandersons-medicare-for-all-single-payer-plan-is-a-singularly-bad-idea/#75e116c529bb](#)

**Assuming that 90% of the remaining spending is for people in the non-group market and the rest for those covered with employer-sponsored insurance, I have calculated that shifting all of these individuals (i.e., Medicare, non-group and ESI) into Medicare-for-All would increase the amount of waste associated with their current care by anywhere from \$324 billion to \$473 billion. So the grand total net increase in waste resulting from Senator Sanders' single-payer plan would be \$524 billion**

**Analysis:** This argument is a good disadvantage because it allows you to win the impact (net spending) even if you lose the link. This argument makes the point that even if costs per treatment go down, the amount of treatments will go so far up that it outweighs.

## A/2: Medicare for All is the best option

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**Answer:** There are other healthcare reform bills which are better than the 2019 Medicare for All bill and have a realistic shot at passing. America should not pass the 2019 bill because it would preclude these better options.

**Warrant:** There are 9 competing visions for the future of healthcare among democrats

Sarah Kliff and Dylan Scott. "We read 9 Democratic plans for expanding health care.

Here's how they work.." VOX. June 21. 2019.

<https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal>

"These plans are the universe of ideas that Democrats will draw from as they flesh out their vision for the future of American health care. While the party doesn't agree on one plan now, they do have plenty of options to choose from — and many decisions to make. **The nine plans fall into two categories. There are some that would replace private insurance and cover all Americans through the government. Then there are the others that would allow all Americans to buy into government insurance (like Medicare or Medicaid) if they wanted to, or they could continue to buy private insurance.**"

**Warrant:** Many of the alternative proposals would increase coverage to similar levels as Medicare for All

Sarah Kliff and Dylan Scott. "We read 9 Democratic plans for expanding health care.

Here's how they work.." VOX. June 21. 2019.

<https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal>

**"Medicare for America (DeLauro and Schakowsky):** This health care plan, informed by the work of the Center for American Progress and Yale professor Jacob Hacker, **would achieve universal coverage for all legal residents, through a combination of private and public insurance — at least for the next few decades. It eventually foresees getting to a very similar level of coverage as the Medicare-for-all proposals in Congress, by enrolling all newborns into a government health plan and taking steps that would diminish the role of employer-sponsored coverage."**

**Warrant:** Alternative proposals have real built in funding mechanisms

Sarah Kliff and Dylan Scott. "We read 9 Democratic plans for expanding health care. Here's how they work.." VOX. June 21. 2019.  
<https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal>

**"Medicare for America (DeLauro and Schakowsky): There is a more detailed financing plan laid out in the Medicare for America legislation. The Republican tax cuts would be rolled back. An additional 5 percent tax on income over \$500,000 would be applied. Payroll taxes for Medicare would also be hiked, as would the net investment income tax rate. New excise taxes on tobacco, alcohol and sugary drinks would be introduced. The bill also requires states to continue making payments to the federal government equivalent to what they pay right now for Medicaid's costs."**

**Warrant:** Other plans have better policies around cost sharing

Ed Dolan. "Medicare for America: A health care plan worth a closer look". Salon Magazine. June 20, 2019., <https://www.salon.com/2019/06/20/medicare-for-america-a-health-care-plan-worth-a-closer-look/>

**"The coinsurance rate is set at 20 percent, up to an income-dependent out-of-pocket maximum. For households below 200 percent of the poverty line, the maximum is zero. Above 600 percent, the maximum is \$3,500 for an individual and \$5,000 for a family. Between those limits, the out-of-pocket maximum varies according to a linear sliding scale. Coinsurance and deductibles each have their advantages. People subject to deductibles get a stronger market signal to economize on expenditures. On the other hand, for a given out-of-pocket maximum, coinsurance extends over a broader range of spending, so the market signal, although weaker, applies to more transactions. Studies show that both forms of cost sharing sometimes lead consumers to forego appropriate, cost-effective care rather than only avoiding care that is inappropriate or overpriced."**

**Warrant:** Allowing for a small private sector under alternative plans is good

Ed Dolan. "Medicare for America: A health care plan worth a closer look". Salon Magazine. June 20, 2019., <https://www.salon.com/2019/06/20/medicare-for-america-a-health-care-plan-worth-a-closer-look/>

**"One is that allowing a small private sector would reduce costs of the public program by reducing demand for its services. Anything that reduced the cost of the program without degrading the quality of services, would, in turn, improve its political prospects. On the contrary. Although they would not pay premiums, if concierge clients had high incomes (as would presumably be the case for most of them), they would still be subject to payroll tax and income tax surcharges. Second, the very existence of a small private sector would help to alleviate one of the greatest sources of resistance to universal or near-universal government health care: the fear of long waiting periods. The experience of the British National Health Service provides some lessons in that regard. In the years before Tony Blair became prime minister of the U.K., waiting**

times in the National Health Service grew alarmingly for procedures like hip replacements. As waits grew longer, the British private sector, normally a small niche market, began to grow. That growth, in turn, acted as a spur to reforms by the Blair government that significantly shortened waiting times. Since then, the private sector has again become smaller.”

**Analysis:** Realistically, Medicare for All should be recognized for what it is – one of many policy proposals designed to overhaul the American healthcare system. So long as your team can prove that there is a viable alternative that would be preferable, you should be able to convincingly win any debate.