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PUBLIC FORUM DEBATE

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

This topic brief was written by Jesse Meyer. Jesse is a two-diamond coach, recipient of the Donald Crabtree Service Award, the state of Iowa's 2015 Coach of the Year, member of the TOC's PF advisory board, and board member of the Iowa Forensics League. He is currently an assistant coach at Iowa City West High School. He can be reached at jessemeyer@gmail.com.

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Topic Analysis

We are facing a healthcare crisis in America, and both political parties realize that the system is broken. The key difference between the two groups is how we go about fixing the situation. With millions of Americans either uninsured or unable to afford insurance, the situation grows worse each day we do not take some sort of action.

After the 1997 update to the Medicare system, beneficiaries were formally given the option to receive their Original Medicare benefits through capitated health insurance Part C health plans. Rebranded in 2003 as "Medicare Advantage," public Part C Medicare Advantage are required to offer coverage that meets or exceeds the standards set by Medicare but they do not have to cover every benefit in the same way. The plan must be actuarially equivalent to Original Medicare benefits. After approval by the Centers for Medicare, if a Part C plan chooses to cover less than Medicare for some benefits, the savings may be passed along to consumers.

Public Part C Medicare Advantage health plan members typically also pay a monthly premium in addition to the Medicare Part B premium to cover items not covered by traditional Medicare. Changes were again made in 2003. The 2003 amendment succeeded in increasing the percentage of rural and inner-city poor that could take advantage of Part C plans. With these changes, enrollment in public Part C health plans, including Medicare Advantage plans, grew from about 1% of total Medicare enrollment in 1997 to about 37% in 2019.

The changes prescribed for this bill would open the Medicare part C plans to the entirety of the United States. In effect, this would extend a semi single payer option to everyone in the United States. Although not a traditional single payer system as prescribed by the likes of Elizabeth Warren and Bernie Sanders, it is a step in the direction of a single payer system. Proponents argue that this expanded service would allow the government to provide competition on the open market where some areas or states only have one or two providers on the marketplace. Furthermore, the federal funding would provide a free insurance program for every American while using the surplus taxes from the wealthy to fund the program. This bill establishes a national health insurance program that is administered by the Department of Health and Human Services (HHS).

Among other requirements, the program must (1) cover all U.S. residents; (2) provide for automatic enrollment of individuals upon birth or residency in the United States; and (3) cover items and services that are medically necessary or appropriate to maintain health or to diagnose, treat, or rehabilitate a health condition, including hospital services, prescription drugs, mental health and substance abuse treatment, dental and vision services, and long-term care.

The bill prohibits cost-sharing (e.g., deductibles, coinsurance, and copayments) and other charges for covered services. Additionally, private health insurers and employers may only offer coverage that is supplemental to, and not duplicative of, benefits provided under the program.

Health insurance exchanges and specified federal health programs terminate upon program implementation. However, the program does not affect coverage provided through the Department of Veterans Affairs or the Indian Health Service.

The bill also establishes a series of implementing provisions relating to (1) health care provider participation; (2) HHS administration; and (3) payments and costs, including the requirement that HHS negotiate prices for prescription drugs.

Individuals who are age 18 or younger, age 55 or older, or already enrolled in Medicare may enroll in the program starting one year after enactment of this bill; other individuals may buy into the program at this time. The program must be fully implemented two years after enactment.

Topic Evolution

Having had two weekends to debate this topic as well as an entire summer of camps that chose to use this topic as their education topic, we have seen a progression based on how much people understood about the topic as well as an evolution that is based on current events.

As debate moved forward on this topic, there was a mystery on how this proposal would be funded, implemented, what would it cover, and other fine details. At first, it looked like this would devolve into the UBI topic from last February where no specifics were given so each pro team was a liberty to run or craft their own UBI based on what literature base they found. However, many debaters soon discovered that this was a specific piece of legislation. As such, the pro had a preset "plan text" with all issues of implementation, funding, and coverage already set out.

Although the major stock arguments of economics, patient care, and doctor burnout were the camp favorites, debaters at the most recent tournaments like the University of Kentucky Season Opener found creative ways to argue the topic. One of the new favorites was the rise of the rural hospital argument. This argument focuses on the impact that the current healthcare system has on rural hospitals and what if any impact the Medicare for All system will have on their stability. Debates also focused on issues like drug innovation as a major argument. Likely drawn in after reading that Medicare for All would limit prices for drugs, debaters began to reach for their backfiles from the prescription drug cap topic.

Specialist specific cases have emerged. Opioids has become a favorite among some teams. This is accessed as drug rehab is not covered under most major insurance companies while under a Medicare for All system, opioid treatment would be covered. The other flavor of this argument is that a government-controlled healthcare system would be more likely to spot an over prescription of these drugs and thus, the government would be able to stop the distribution before it became a problem. Mental health care is a huge case argument as suicide is in the top ten of leading causes of death for all Americans, and in the status quo, few health care plans cover the cost of mental health visits. Women's health is another area that has seen attention. Abortion treatment, birth control, cancer screenings, and childcare are all provided under the Medicare for All legislation. Women's rights advocates argue that this is a step forward for a healthcare system that has ignored women for too long.

The final big area that has emerged out of the first few tournaments was the focus on race, fueled by the "defund the police" movements of the summer and the Black Lives Matter movement. Significant research exists to show that persons of color are more likely to live without insurance, not have access to a doctor, or die from a treatable illness. This system of harm and oppression dates to the early days just after the Civil War as segregation forced African Americans into poorer quality hospitals and clinics. A Medicare for All system would provide insurance for everyone, thus allowing everyone to access the same hospitals and doctors.

The topic continues to evolve. As more and more teams start their fall practices and as more and more new debaters start their cases, the arguments will centrally continue to evolve.

Pro Arguments

1. Negotiation and lower prices

One of the primary reasons that health care is so expensive today is that the medical industry has massive leverage over patients and health insurance companies when it comes to setting prices. Individual providers and hospitals do not have the buying power to demand lower prices. However, if the government serves as the sole purchaser of healthcare-related goods and services, it could command monopsonist-level control over the prices offered to those who provide healthcare goods and services, saving billions of dollars for the consumers and hospitals, and as a result of the single payer system.

Medical care accounts for 35% of the $3.5 trillion spent annually on healthcare. This is a huge amount of money. As the old saying goes, “Money talks.” Today, the current government funded Medicare pays hospitals less than private insurance does for many of the same services. Medicare pays hospitals 86.8% of hospitals estimated average costs, while private insurance pays hospitals 144.8% of hospitals' average costs. Hospitals would accept these lower prices because under a single-payer healthcare system, the government is the only player in town, so to speak.

With over 350 million Americans in the United States, if we had a single payer system, they would all be located under one plan. This would mean that the sheer size and force of a government at the negotiating table would have the full force of a country rather than individual hospitals or insurance carriers. And because many Americans would be purchasing the same drugs, bulk purchasing can and will happen. Americans pay relatively high prices for their prescription drugs because they cannot effectively band together to demand lower prices from monopolistic drug companies. In many countries with a single payer system, the ability to set the price has lowered costs considerably for the purchasing of prescription drugs.

2. Lower administrative costs

Medical officers that wish to accept payment from patients' health insurance companies must employ huge billing departments to deal with dozens of insurance plans, send bills to patients, deal with the customers who do not have insurance, and do this all while following government guidelines for fair billing practices.

This problem is magnified when it comes to small and independent physician offices. Small physician offices often need to hire multiple office workers to handle all of the different types of paperwork. In some cases, the humbler estimation of full-time employees needed for this was one for every 10 patients that a doctor sees. Assuming that each billing agent makes the national average of $40,000, a small officer is a that has 30 patients will spend $120,000 pear year on administrative assistants who do nothing but bill out insurance companies. This administrative complexity adds an estimated $265 billion per year in wasteful, unnecessary costs to the system.

Under Medicare For All, hospitals and medical offices would not need so many workers to handle so many different systems of claims administration paperwork because with only one payer, there would just be one consolidated system of paperwork.

Current Medicare has lower administrative costs than the private sector by roughly 15%. Costs range from 13 minutes of time and roughly $20 in administration for a simple primary care visit, to upwards of 100 minutes of time and over $215 spent for every inpatient surgery.

3. Health Care as a right

Before the passage of the Affordable Care Act in 2010, roughly 46.5 million Americans, although that number has decreased today, we have seen a boom in the number of people who are found to be "under insured." Due to high deductibles, copays, or out of pocket minimums, they are unable to access their insurance benefits. Between those that are uninsured and underinsured, we have, at any given time, 50 to 60 million Americans that are considered "insurance risks."

To access healthcare as a right, we need to make sure that every person has health insurance coverage. Medicare For All would achieve this goal as it would provide everyone living in the United States government healthcare. Proponents of the system such as Bernie Sanders argue that the free market has failed to bring down the costs to levels that are accessible to all Americans and thus, it is the right of the government under a just social contract to step in and provide this as a basic right.

No more insurance premiums, deductibles or co-payments. Further, this bill improves Medicare coverage to include dental, hearing and vision care. As Senator Sanders would say, this bill would do exactly what should be done in a civilized and democratic society.

4. Freedom for employment

Due to the nature of the current insurance system and according to the mandates set out by the ACA, the vast majority of people with insurance in the United States receive their coverage through a job. As of 2020 (pre pandemic), 156 million people received their health insurance their employer. This can create an undesirable situation known as "job lock" in which people feel that they cannot leave their job because they will risk losing their insurance. Again, Senator Sanders states that this limits the freedom of Americans to follow their passions and dreams.

Under Medicare for All, employees would be free to leave their jobs to look for new ones without fear of facing a lapse in their insurance. Individuals would no longer be limited to the health insurance options that their employer pick for them. This also works to the benefit of business as well. Employers would be free to put the funds they would normally provide for health care into the business, provide pay raises, or provide profits for the investors.

Con Arguments

1. Cost

Senator Sanders's proposed Medicare For All bill would cost the federal government approximately $32 trillion in spending over the first 10 years of the program. Proponents of Medicare For All concede that we would have to raise taxes in order to pay for the program. However, they also do not appreciate how large the increases would be. According to the CBO when scoring Senator Sander's bill, the potential tax increase on the individual would equate to a 25% increase to the family and 32% to business. This equates to an additional $7500 per family. This is magnified by the recent tax overhaul which eliminated several key deductions for families and set the standard deduction at a lower rate per child. This means that families will feel the brunt of the cost more than proponents might think.

The economic model used in the study to come up with the overall cost figure assumes that reimbursements to doctors will be roughly 40 percent lower than they are today. Since it is far from certain that these savings will materialize as predicted, current estimates represent a best-case scenario that understates the cost of the program. With a national debt of almost 24 trillion dollars and the economy still in critical condition due to the pandemic, our debt and spending must be taken into consideration.

2. Kills innovation and rationing

In the free market, supply and demand rules prices and accessibility. As supply draws lower, prices rise. As demand rises, prices increase. These are held in balance by a steady flow of consumers entering the market. This steady flow allows the market to adjust and recover and rebuild their stockpiles. When there is only one buyer and that buyer demands a price for goods or services that the seller considers too low, the provider will offer fewer options as they consolidate their supplies to allow for a concentrated profit center. This means that under a single payer system, fewer options will be available for the consumer which will have a direct impact on their care. This is empirically proven by the limited options in Europe and Canada for common ailments.

The other issue is that if the government pushes its hand too far and sets their prices too low, the profit margins on things like drugs, equipment, and other medical goods, they risk setting prices too low. Physicians will stop taking new patients. Hospitals will stop scheduling needed surgeries. Drug companies use their profits to fund research for new drugs. As profits decrease, pharmaceutical companies will be forced to limit their research, limiting the number of new medicines that are entering the market. As an added disadvantage, profits are often used to offset the cost of medical donations for developing nations. Drug companies use profits to provide AIDS, TB, and malaria drugs to developing countries that might not be able to afford these. We might not like the free market, but it does provide a sense of regulation for the market.

3. No solvency

As we discussed on the pro arguments section, the pro side is likely to discuss the inefficiency of the current status quo system. No one will deny that there is inefficiency in the current system. However, we must look at the overall system and the projected efficacy that the pro believes they can leverage before we decide.

In the medical world, there are two basic systems of medical authorization. In one type, the doctor must call ahead to the insurance provider to get authorization for a test, procedure, or medication prescription. The other system allows for common treatments and tests to be done at the discretion of the doctor. Under the system that required a call ahead, unless the request is an emergency, the insurance company can deny requests while recommending a doctor or hospital that is lower in cost. This is because hospitals and doctors are free to set their own prices. What can cost a few hundred dollars at one hospital can cost a few thousand at another hospital just a few miles away. This can help keep prices down overall. Medicare for All would not have prior authorization. Not having prior authorization might make healthcare more convenient for patients, but it diminishes the claim that Medicare For All will be cheaper due to administrative savings.

Fraud prevention is another administrative check that is missing from Medicare For All. Private insurance companies spend much more on protecting against fraud than the government does. In 2018, the Centers for Medicare and Medicaid Services spent just two-tenths of one percent of its budget on combating waste, fraud, and abuse. When a private insurance company spends money to prevent fraud, it is recorded as an administrative expense. When a government program fails to spend money on fraud prevention, it looks as though it has low administrative costs when it is losing money to scammers and cheaters.

4. Wait times

Although one might get caught up in the idea that if everyone had insurance, they would all have health care, a critical analysis of the idea finds fault in this. Just because everyone has a means to pay for something does not guarantee access or treatment. Take for example the idea of getting into a store on Black Friday. Just because you might have gotten in, you are not guaranteed of getting one of the flat screen TVs.

Under Medicare For All, out government will be able to boost that 350 million people have health care. Surely this is a huge bragging point. However, as the analogy above demonstrates, just because they have insurance, care is not a given. In Canada, where all citizens have coverage under their National Health Insurance model, patients on average wait 4.3 weeks for a garden variety CT scan, 10.6 weeks for an MRI scan, and 3.9 weeks for an ultrasound. In England, instead of reporting average wait times for diagnostic services such as MRI scans and CT scans, the NHI reports the number of patients forced to wait six weeks or more. In October 2019, the total number of patients in England who had been waiting six weeks or more for one of 15 common diagnostic tests was 33,200.

This also leads to a burnout in the medical profession. As more and more patients flood the hospitals and clinics due to healthcare, the workload for the average doctor will increase. Patient numbers per day will increase. Rather than getting to know their patients, doctors will be forced into a “fast food” style of treatment that rushes people in and out. This overload causes doctors and nurses to feel the stress of a rushed system more. As the stress compounds, the risk that people leave the profession grows. Furthermore, as doctors grow more and more stressed, their risk for mental health issues grows. Dependency on drugs and alcohol will grow. Doctors will risk becoming sleep deprived. In this state, mistakes will happen, and these mistakes will cost human lives.

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Basic Definition

Medicare for All

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Single-payer national health insurance, also known as "Medicare for all," is a system in which a single public or quasi-public agency organizes health care financing, but the delivery of care remains largely in private hands. Under a single-payer system, all residents of the U.S. would be covered for all medically necessary services, including doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug and medical supply costs.

The program would be funded by the savings obtained from replacing today's inefficient, profit-oriented, multiple insurance payers with a single streamlined, nonprofit, public payer, and by modest new taxes based on ability to pay. Premiums would disappear; 95 percent of all households would save money. Patients would no longer face financial barriers to care such as co-pays and deductibles and would regain free choice of doctor and hospital. Doctors would regain autonomy over patient care.

The Expanded and Improved Medicare for All Act, H.R. 676, based on PNHP's AJPH-published Physicians' Proposal, would establish an American single-payer health insurance system.

Definition unclear

Sparer et al 9 (Michael Sparer-Chair and Professor Health Policy and Management at Columbia, Lawrence David Brown is Miers Busch Professor and Professor of Statistics at the Wharton School of the University of Pennsylvania in Philadelphia, Pennsylvania. Lawrence R. Jacobs is the Walter F. and Joan Mondale Chair for Political Studies at the Humphrey School of Public Affairs and the Department of Political Science at the University of Minnesota. "Exploring the Concept of Single Payer", Journal of Health Politics, Policy and Law, Vol. 34, No. 4, August 2009 DOI 10.1215/03616878-2009-010 , Accessed 9/7/17, N.G.)

Why is it that the term "single payer" generates such fierce and conflicting rhetoric? Even among those willing to support reform, why is a singlepayer model so appealing to some and worrisome to others? **What does the term even mean? It turns out that the rhetorical certitude is matched by widespread definitional confusion**. Most policy analysts would suggest that the phrase is simply a shorthand description of the Canadian system: government-financed insurance for core coverage delivered by privatesector providers. Others might add to the definition "national health systems" such as the one in the United Kingdom in which the

government is the primary source of funding and delivery. Still others might (rhetorically) conflate the term with any government effort to ensure universal coverage and federal regulation of the overall health care system. In May 2008, JHPPL, the Hubert H. Humphrey Institute of Public Affairs, and the Academic Health Center at the University of Minnesota hosted a conference designed to explore the concept of "single-payer" health systems. The goal was to consider the concept from a variety of perspectives. This issue of the journal publishes several of the papers presented at that conference, along with thoughtful commentaries by some of the conference participants.1 A common theme in the conference and in many of the papers is that diversity and pluralism characterize health care systems that are often described as single payer. There is a rhetorical tendency in the public debate to assume a degree of uniformity in single-payer health care systems that is, in reality, unusual. The articles in this issue show that the administration of health care delivery and financing is diverse across countries that are often described as single payer, as well as even within these countries.

Pro Evidence

Underinsurance causes 44k preventable deaths a year

Ray E. Drasga & Lawrence H. Einhorn 14. St Clare Clinic for the Indigent, Crown Point; and Indiana University School of Medicine, Indianapolis, IN. 01/01/2014. "Why Oncologists Should Support Single-Payer National Health Insurance." Journal of Oncology Practice, vol. 10, no. 1, pp. 7–11.

Being **uninsured** is **bad for your health**. Having no insurance is associated with a 1.40 hazard ratio for mortality compared with those with insurance.28 The uninsured have a **higher risk of death** when compared with the privately insured, even after taking into account socioeconomic status, health behaviors, and baseline health. This translates into approximately **44,000 preventable deaths in the United States per year**. Uninsured patients with cancer are 1.6× more likely to die within 5 years than their insured counterparts, according to a 2008 study by American Cancer Society researchers.29

Single payer solves health insurance for all US residents

Gaffney et al 16 – Adam Gaffney, M.D. (Pulmonary & Critical Care Fellowship Program, Massachusetts General Hospital), David U. Himmelstein, M.D. (Professor of Public health, City University of New York; Lecturer in Medicine, Harvard Medical School), Steffie Woolhandler, M.D., M.P.H. (Professor of Public Health, City University of New York; Lecturer in Medicine, Harvard Medical School), and Marcia Angell, M.D. (Former Editor-in-Chief, New England Journal of Medicine; Senior Lecturer, Department of Global Health and Social Medicine, Harvard Medical School). "Beyond the Affordable Care Act: A Physicians' Proposal for Single-Payer Health Care Reform." American Journal of Public Health, June 2016. http://www.pnhp.org/beyond_aca/Physicians_Proposal.pdf

Introduction In the United States the right to medical care remains a dream deferred, despite passage of the Affordable Care Act (ACA). The U.S continues to spend strikingly more on health care than other industrialized nations,1 while our **health outcomes lag behind**. Even with the ACA fully implemented, an estimated twenty-seven million will remain uninsured,2 while many more face rising copayments and deductibles that compromise access to care and leave them vulnerable to ruinous medical bills.3-9 We propose **a single-payer National Health Program** (NHP) covering all Americans for all needed medical care. The design of such a program has been previously described,10,11 but intervening developments – notably the proliferation of large integrated delivery systems – require revisions. The NHP can be conceptualized as an expansion of Medicare to the entire population, with correction of that system's deficiencies – most glaringly, high cost sharing, limitations on coverage, and subcontracting to wasteful private plans. By dramatically reducing administrative costs and other inefficiencies, the NHP could eliminate both uninsurance and underinsurance without any increase in overall health care expenditures. It would sever the problematic link between employment and insurance, and minimize patients' and physicians' paperwork burden. Although the system we envision would be publicly financed, it would rely largely on **existing private hospitals, clinics and practitioners** to provide care. However, because investor ownership of health care providers is known to **compromise quality** and divert funds from clinical care to overhead and profits,12-14 the **NHP would not include such providers**. Following are the essential features of the proposed system. Coverage A single-payer NHP would cover every American for all medically necessary services, including mental health, rehabilitation and dental care, without copayments or deductibles. Covered services would be determined by boards of experts and patient advocates; ineffective services would be excluded from coverage. Patient cost sharing blocks access to vital care (e.g. by delaying care for patients with myocardial infarction); reduces adherence to medications; and selectively burdens the sick and the poor.5,15-19 Moreover, cost sharing has proven ineffective at containing system-wide costs, in part because collecting and tracking co-payments and deductibles entails substantial administrative effort and cost. The NHP would, like Medicare, ban private insurance that duplicates the public coverage to forestall the emergence of **a two-tiered health care system**, in which insurers would compete by lobbying to underfund the public part of the system. Moreover, in the NHP, as in Medicare, inclusion of the affluent would serve as an important guarantor of adequate coverage. Hospital Payment The NHP would fund each hospital with a "global budget," a lump sum covering all operating expenses, **eliminating per-patient billing**. Global budgets would be negotiated annually between hospitals and the NHP based on previous years' operating expenses, changes in demand and input prices, and proposed service enhancements. Global budgets would cover operating expenses, but could not be used for expansion or modernization, which the NHP would fund separately through explicit capital allocations. **Nor could operating funds be used for advertising, profit, or bonuses.** For-profit hospitals would be converted to nonprofit governance and their owners compensated for past investments. In some instances, the NHP might fold hospital budgets into global operating budgets paid to non-profit or public integrated systems that provide primary through tertiary care. At present, hospital CEOs anticipate their institution's budget for the upcoming year, but garner funds from thousands, even millions of individual transactions. Hospital billing offices tabulate lengthy itemized bills and charge a multitude of payers using inefficient, complex and separately negotiated rate schedules. Current payment systems have also encouraged rampant gaming through "upcoding" (exaggerating the severity of patients' illnesses), "cherry picking" (concentrating on lucrative services for well-insured patients), and other financial maneuvering.20 Global budgeting with separate, explicit capital allocation would provide a "cost-neutral" payment framework, minimizing hospitals' incentives to avoid (or seek out) particular patients or services, inflate volumes, or upcode. **Global budgets would also eliminate hospital billing and relieve clinicians of billing- related documentation, freeing up resources to**

enhance clinical services. In Scotland and Canada, which fund hospitals through global budgets, administration consumes about 12% of hospital spending vs. 25% in the U.S. – suggesting that an NHP could shift about $150 billion annually from hospital administration to patient care.21 Payment for Physicians and Outpatient Care The NHP would accommodate two different modes of payment for physicians and other outpatient practitioners: fee-for-service using a simple binding fee schedule, or salaries for those working in nonprofit hospitals, clinics, capitated group practices, HMOs, and integrated health care systems. While conventional wisdom blames the failings of our health care system (especially cost)22 on fee-for- service incentives, every mode of payment has pitfalls. Yet other countries have found fee-for- service – as well as capitation and salaried practice – compatible with quality and cost containment, as long as the fees do not unduly reward procedure-oriented specialists compared with primary care providers. Regardless of the payment mode, the NHP would prohibit the diversion of operating revenues to profits or capital investments, and the payment of bonuses tied (either positively or negatively) to utilization or to institutional profitability. The NHP would shrink physicians' overhead expenses by simplifying (under fee-for-service) or virtually eliminating (under salaried practice) billing-related tasks. For fee-for-service practitioners, the NHP and organizations representing the practitioners would negotiate a simple, binding fee schedule. The NHP could draw on a number of tools that other countries have found effective in countering the inflationary tendency of fee-for-service, including: monitoring for extreme practice patterns; adjusting fee schedules to attenuate discrepancies between cognitive and procedural care; enforcing regional caps on fee-for-service payments; and facilitating education on low-value medical interventions. Practitioners could also choose salaried practice in non-profit globally budgeted providers such as hospitals, clinics, group practices, etc. Where appropriate, the global budget could include funding for community programming (e.g. needle exchange programs or school-based services) not attributable (or billable) to individual patients. Integrated health care systems would also employ salaried practitioners. In such systems, hospitals might be paid through a separate global budget, or through a unified global budget for the entire organization. Integrated provider networks and accountable care organizations (ACOs) offer potential benefits, but also the threat that they will exploit oligopoly market power to drive up costs and profits, and pressure physicians to help achieve these goals. Hence, the NHP would allow, even encourage integrated systems, but would mandate that regionally dominant systems be publicly controlled. Long-Term Care (LTC) The NHP would fund the full spectrum of LTC for the disabled of all ages. Local public agencies employing expert panels of social workers, nurses, therapists, and physicians would assess eligibility and coordinate care. These agencies would receive a global budget from the NHP to LTC for all individuals within their catchment area. They would contract with individual caregivers, as well as nonprofit and public agencies and facilities. Alternatively, integrated provider organizations could receive an augmented capitation fee or global budget to provide LTC as well as acute care services. Countries such as Japan and Germany with universal LTC coverage provide more and better care, yet spend no more than the U.S.23 The NHP would emphasize LTC provided in patients' homes and communities rather than institutions.

Medicare-for-all is feasible and affordable – it massively expands coverage with huge cost-savings and no spending increases

Gaffney et al. 16 - The Working Group on Single-Payer Program Design,

Introduction

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clinicians of billing- related documentation, freeing up resources to enhance clinical services. In Scotland and Canada, which fund hospitals through global budgets, administration consumes about 12% of hospital spending vs. 25% in the U.S. – suggesting that an NHP could shift about $150 billion annually from hospital administration to patient care.21 **Payment for Physicians and Outpatient Care** The NHP would accommodate two different modes of payment for physicians and other outpatient practitioners: fee-for-service using a simple binding fee schedule, or salaries for those working in nonprofit hospitals, clinics, capitated group practices, HMOs, and integrated health care systems. While conventional wisdom blames the failings of our health care system (especially cost)22 on fee-for- service incentives, every mode of payment has pitfalls. Yet other countries have found fee-for- service – as well as capitation and salaried practice – compatible with quality and cost containment, as long as the fees do not unduly reward procedure- oriented specialists compared with primary care providers. Regardless of the payment mode, the NHP would prohibit the diversion of operating revenues to profits or capital investments, and the payment of bonuses tied (either positively or negatively) to utilization or to institutional profitability. The NHP would shrink physicians' overhead expenses by simplifying (under fee-for-service) or virtually eliminating (under salaried practice) billing-related tasks. For fee-for-service practitioners, the NHP and organizations representing the practitioners would negotiate a simple, binding fee schedule. The NHP could draw on a number of tools that other countries have found effective in countering the inflationary tendency of fee-for-service, including: monitoring for extreme practice patterns; adjusting fee schedules to attenuate discrepancies between cognitive and procedural care; enforcing regional caps on fee-for-service payments; and facilitating education on low-value medical interventions. Practitioners could also choose salaried practice in non-profit globally budgeted providers such as hospitals, clinics, group practices, etc. Where appropriate, the global budget could include funding for community programming (e.g. needle exchange programs or school-based services) not attributable (or billable) to individual patients. Integrated health care systems would also employ salaried practitioners. In such systems, hospitals might be paid through a separate global budget, or through a unified global budget for the entire organization. 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Alternatively, integrated provider organizations could receive an augmented capitation fee or global budget to provide LTC as well as acute care services. Countries such as Japan and Germany with universal LTC coverage provide more and better care, yet spend no more than the U.S.23 The NHP would emphasize LTC provided in patients' homes and communities rather than institutions. **Health Planning and Explicit Capital Funding** The NHP would fund all major capital investments through explicit appropriations. Regional health planning boards would allocate capital funds for new facilities and expensive new equipment based on medical need, project quality and efficiency. Private donations for projects that would entail increases in NHP operating expenses would be proscribed. When capital funding and operating payments are combined in a single revenue stream, as is now the case, profitable health care institutions are able to expand and modernize, regardless of medical need, while those with less favorable bottom lines fall further behind. Too often, profitability reflects not efficiency or quality, but the avoidance of unprofitable patients and services, a willingness to game payment systems, and the exercise of market clout. As a result, the implicit capital allocation process has created both medical deserts – areas of great need and few resources – and lavish, often redundant medical palaces that compete for lucrative patients and are tempted to provide unneeded care. Planning should also assure that training programs produce an appropriate mix of health professionals. Residency programs (already publicly funded) must train generalists and specialists in proportions that reflect societal needs. Currently, debts incurred by medical students are, over the long run, paid off from medical salaries and fees, and skew students' career choices toward high-income specialties. Instead, we advocate that the NHP fully subsidize the education of physicians, as well as that of nurses, public health professionals and other health care personnel. **Medications, Devices, and Supplies** The NHP would cover all medically necessary prescription medications, devices and supplies. It would directly negotiate prices with manufacturers, **producing substantial savings**. An expert panel would establish and update a national formulary, which would specify the use of the lowest cost medications among therapeutically equivalent drugs (with exceptions where clinically required). Full drug coverage is an essential component of an NHP. Copayments reduce adherence to medications and worsen clinical outcomes. The NHP would, like other large purchasers, use its market clout and formularies to negotiate lower drug prices with manufacturers. For instance, the Veterans Administration pays only 56-63% as much as Medicare does for drugs,24 because Medicare is prohibited from negotiating for lower prices. **Cost Containment** A single-payer system would trim administration, reduce incentives to over-treat, lower drug prices, minimize wasteful investments in redundant facilities, and eliminate almost all marketing and investor profits. These measures would yield the substantial savings needed to fund universal care and new investments in currently under-funded services and public health activities – **without any net increase in national health spending.** Private insurers' overhead currently averages 12.0%,26 as compared with only 2.1% for fee-for- service Medicare.27 The complexity of reimbursement systems also forces physicians and hospitals to waste substantial resources on documentation, billing and collections. As a result, U.S. health care administration costs are about double those in Canada, where the single-payer system pays hospitals global budgets and physicians via simplified fee schedules. Reducing U.S. administrative costs to Canadian levels would save over $400 billion annually.25 **Funding** Total expenditures under the NHP would be limited to approximately the same proportion of GDP as the year prior to its establishment. While the needed funds could be garnered in a variety of ways, we favor the use

of progressive taxes in order to reduce income inequality – itself an important social determinant of poor health. During a transition period, all public funds currently spent on health care – including Medicare, Medicaid, and state and local health care programs – would be redirected to the unified NHP budget. Such public spending – together with tax subsidies for employer- paid insurance and government expenditures for public workers' health benefits – already accounts for 60% of total U.S. health expenditures.28 Additional funds would be raised through taxes, though importantly these would be fully offset by a decrease in out-of-pocket spending and premiums. During the transition period, these additional public funds could be raised through a variety of measures, e.g. redirecting employers' health benefit spending to the NHP through payroll taxes. In the longer term, however, direct funding through progressive taxes would be fairer. By unburdening employers, **the NHP would facilitate entrepreneurship while increasing the global competitiveness of American business**.

No disruption—international and historical experiences prove

Himmelstein and Woolhandler 5-10-17 - *professors of health policy and management at the City University of New York School of Public Health and lecturers in medicine at Harvard Medical School, Co-founders, Physicians for a National Health Program

The Urban Institute and the Tax Policy Center today released analyses of the costs of Sen. Bernie Sanders' domestic policy proposals, including single-payer national health insurance. They claim that Sanders' proposals would raise the federal deficit by $18 trillion over the next decade.¶ We won't address all of the issues covered in these analyses, just single-payer Medicare for all. To put it bluntly, the estimates (which were prepared by John Holahan and colleagues) are ridiculous. They project outlandish increases in the utilization of medical care, ignore vast savings under single-payer reform, and ignore the extensive and well-documented experience with single-payer systems in other nations - which all spend far less per person on health care than we do.¶ The authors' anti-single-payer bias is also evident from their incredible claims that physicians' incomes would be squeezed (which contradicts their own estimates positing a sharp rise in spending on physician services), and that patients would suffer huge disruptions, despite the fact that the implementation of single-payer systems elsewhere, as well as the start-up of Medicare, were disruption-free.¶ We outline below some of the most glaring errors in the Holahan analysis (which served as the basis for Tax Policy Center's estimates) regarding health care spending under the Sanders plan.¶ 1. Administrative savings, Part 1: Holahan assumes that insurance overhead would be reduced to 6 percent of total health spending from the current level of 9.5 percent. They base this 6 percent estimate on figures for Medicare's current overhead, which include the extraordinarily high overhead costs of private Medicare HMOs run by UnitedHealthcare and other insurance firms. However, Sen. Sanders' proposal would exclude these for-profit insurers, and instead build on the traditional Medicare program, whose overhead is less than 3 percent. Moreover, even this 3 percent figure is probably too high, since Sanders' plan would simplify hospital payment by funding them through global budgets (similar to the way fire departments are paid), rather than the current patient-by-patient payments. Hence a more realistic estimate would assume that insurance overhead would drop to Canada's level of about 1.8 percent. Cutting insurance overhead to 2 percent (rather than the 6 percent that Holahan projects) would save an additional $1.7 trillion over the next 10 years.¶ 2. Administrative savings, Part 2: Holahan completely ignores the huge savings on hospital administration and doctors' billing under a streamlined single-payer system. Every serious analyst of single-payer reform has acknowledged these savings, including the Congressional Budget Office, the Government Accountability Office, the Lewin Group (a consulting firm owned by UnitedHealth Group), and even Kenneth Thorpe (a former Clinton administration official who has criticized Sanders' plan, although his recent estimates of savings are far lower than those he made prior to the current presidential campaign).¶ These provider savings on paperwork would, in fact, be much larger than the savings on insurance overhead. At present, U.S. hospitals spend one-quarter of their total budgets on billing and administration, more than twice as much as hospitals spend in single-payer systems like Canada's or Scotland's. Similarly, U.S. physicians, who must bill hundreds of different insurance plans with varying payment and coverage rules, spend two to three times as much as our Canadian colleagues on billing.¶ Overall, these administrative savings for doctors and hospitals would amount to about $2.57 trillion over

10 years. Additional savings of more than $1.5 trillion from streamlined billing and administration would accrue to nursing homes, home care agencies, ambulance companies, drug stores and other health care providers.¶ In total, the Holahan analysis underestimates administrative savings by about $6 trillion over 10 years.¶ 3. Drug costs: Holahan projects that a single-payer plan would have to pay 50 percent higher drug costs than those paid at present by Medicaid. Moreover, their estimate assumes that the U.S. would continue to pay much higher prices for drugs than other nations, despite the fact that a U.S. single-payer system would have much greater negotiating leverage with drug companies than other national health insurance schemes.¶ Reducing drug prices to the levels currently paid by European nations would save at least $1.1 trillion more than Holahan posits over 10 years. ¶ 4. Utilization of care: Holahan projects a massive increase in acute care utilization, but does not provide detailed breakdowns of how big an increase they foresee for specific services like doctor visits or hospital care. However, it is clear that the medical care system does not have the capacity to provide the huge surge in care that he posits.¶ For instance Holahan's figures for the increase in acute care suggest that Sanders' plan would result in more than 100 million additional doctor visits and several million more hospitalizations each year. But there just aren't enough doctors and hospital beds to deliver that much care. Doctors are already working 53 hours per week, and experience from past reforms tells us that they won't increase their hours, nor will they see many more patients per hour.¶ Instead of a huge surge in utilization, more realistic projections would assume that doctors and hospitals would reduce the amount of unnecessary care they're now delivering in order to deliver needed care to those who are currently not getting what they need. That's what happened in Canada. Doctors and hospitals can adjust care to meet increasing demand, as happens every year during flu season.¶ Moreover, no surge materialized when Medicare was implemented and millions of previously uninsured seniors got coverage. Between 1964 (before Medicare) and 1966 (the year when Medicare was fully functioning) there was absolutely no increase in the total number of doctor visit in the U.S.; Americans averaged 4.3 visits per person in 1964 and 4.3 visits per person in 1966. Instead, the number of visits by poor seniors went up, while the number of visits by healthy and wealthy patients went down slightly. The same thing happened in hospitals. There were no waiting lists, just a reduction in the utilization of unneeded elective care by wealthier patients, and the delivery of more care to sick people who needed it.¶ Bizarrely, despite projecting a roughly $1.6 trillion increase in total payments to doctors over 10 years, Holahan says in his discussion that "Physician incomes would be squeezed by the new payment rates."¶ 5. Holahan's argument that the Sanders plan would cause a huge disruption of health care: This argument mirrors scare tactics used by Medicare's opponents in 1963. Back then, there were claims that doctors would boycott Medicare, and Wall Street Journal headlines warned of a "Patient Pileup," as "flocks of Medicare beneficiaries ... suddenly clog the nation's 7,200 hospitals." Nothing like that ever happened, nor did it happen when Taiwan implemented single payer more recently. And there's no reason to think it would happen here.¶ Moreover, surveys show that most doctors would welcome national health insurance, and thousands of doctors have recently issued a call (and detailed proposal) for single-payer reform in the American Journal of Public Health.¶ In summary, Holahan grossly underestimates the administrative savings under single payer; projects increases in the number of doctor visits and hospitalizations that far exceed the capacity of doctors and hospitals to provide this added care; and posits that our country would continue to pay much more for drugs and medical equipment than people in every other nation with national health insurance.¶ Rather than increasing national health spending, as Holahan claims, Sanders' plan (and the plan proposed by Physicians for a National Health Program) would almost certainly decrease total health spending over the next 10 years.

Single-payer passes the "solvency advocates that assume Trump" test

Frank 3-24-17 - economics professor at the Johnson Graduate School of Management at Cornell University Robert H., What Comes Next for Obamacare? The Case for Medicare for All, New York Times, https://www.nytimes.com/2017/03/24/upshot/health-insurance-medicare-obamacare-american-health-care-act.html?_r=0

Republicans are in a bind. They've been promising to repeal Obamacare for seven years, and having won control of the White House and Congress, they had to try to deliver. But while their bitter denunciations of the Affordable Care Act may have depressed its approval numbers, they didn't make replacing it any easier.¶ On the contrary, the repeal-and-replace bill designed by House Speaker Paul D. Ryan drew withering criticism from the left and the right. Liberals condemned its use of reductions in health coverage for the poor to pay for large tax cuts for the wealthy, while conservatives bemoaned its retention of many subsidies adopted under Obamacare.¶ In the end, the repeal effort's biggest hurdle may have been loss aversion, one of the most robust findings in behavioral science. As numerous studies have shown, the pain of losing something you already have is much greater than the pleasure of having gained it in the first place. And the nonpartisan Congressional Budget Office estimated that Mr. Ryan's American Health Care Act (A.H.C.A.) would have caused more than 14 million people to lose coverage in the first year alone, with total losses rising to 24 million over the next decade. Many Republicans in Congress were nervous about the **political firestorm** already provoked by the **mere prospect** of such losses.¶ Loss aversion actually threatened the repeal effort on two fronts: voters' fear of losing their coverage, and lawmakers' fear of losing their seats. Like the first fear, the second appeared well grounded. Republican voters wouldn't have been the only ones losing coverage, of course, but early studies suggested that losses would have been concentrated among people who voted for President Trump. The Congressional Budget Office estimated, for example, that the A.H.C.A. would have caused premiums to rise more than sevenfold in 2026 for 64-year-olds making $26,500.¶ Now that Republicans have withdrawn Mr. Ryan's bill from consideration, attention shifts to **what comes next**. In an earlier column, I suggested that Mr. Trump has the political leverage, which President Obama did not, to jettison the traditional Republican approach in favor of a form of the single-payer health care that most other countries use. According to Physicians for a National Health Program, an advocacy group, "Single-payer national health insurance, also known as 'Medicare for all,' is a system in which a single public or quasi-public agency organizes health care financing, but the delivery of care remains largely in private hands." Christopher Ruddy, a friend and adviser of the president, recently urged him to consider this option.¶ Many Republicans who want to diminish government's role in health care view the single-payer approach with disdain. But Mr. Trump often seems to take pleasure in being unpredictable, and since he will offend people no matter which way he turns, he may want to consider why liberals and conservatives in many other countries have embraced the single-payer approach.¶ Part of the appeal of Medicare for all is that single-payer systems reduce financial incentives that generate waste and abuse. Mr. Ryan insisted that by relegating health care to private insurers, competition would lead to lower prices and higher quality. Economic theory tells us that this is a reasonable expectation when certain conditions are met. A crucial one is that buyers must be able to compare the quality of

offerings of different sellers. In practice, however, people have little knowledge of the treatment options for the various maladies they might suffer, and policy language describing insurance coverage is notoriously complex and technical. Consumers simply cannot make informed quality comparisons in this industry.¶ In contrast, they can easily compare the prices charged by competing insurance companies. This asymmetry induces companies to compete by highlighting the lower prices they're able to offer if they cut costs by degrading the quality of their offerings. For example, it's common for insurance companies to deny payment for procedures that their policies seem to cover. If policy holders complain loudly enough, they may eventually get reimbursed, but the money companies save by not paying others confers a decisive competitive advantage over rivals that don't employ this tactic. Such haggling is uncommon under single-payer systems like Medicare (though it is sometimes employed by private insurers that supplement Medicare).¶ Consider, too, the mutually offsetting expenditures on competitive advertising and other promotional efforts of private insurers, which can exceed 15 percent of total revenue. Single-payer plans like Medicare spend nothing on competitive advertising (although here, also, we see such expenditures by supplemental insurers).¶ According to the Kaiser Family Foundation, administrative costs in Medicare are only about 2 percent of total operating expenditures, less than one-sixth of the rate estimated for the private insurance industry. This difference does not mean that private insurers are evil. It's a simple consequence of a difference in the relevant economic incentives.¶ American health care outlays per capita in 2015 were more than twice the average of those in the 35 advanced countries that make up the Organization for Economic Cooperation and Development. Yet despite that spending difference, the system in the United States delivers significantly less favorable outcomes on measures like longevity and the incidence of chronic illness.¶ But advertising expenses and administrative costs are not the most important reason the United States spends so much more. The main difference is that prices for medical services are so much lower in other countries. In France, for example, a magnetic resonance imaging exam costs $363, on average, compared with $1,121 in the United States; an appendectomy is $4,463 in France, versus $13,851 in America. These differences stem largely from the fact that single payers — which is to say, governments — are typically able to negotiate more favorable terms with service providers.¶ In short, **Medicare for all could deliver quality care at much lower cost than private insurers do now**. People would of course be free to supplement their public coverage with private insurance, as they now do in most other countries with single-payer systems, and as many older Americans do with Medicare.¶ As a candidate, Mr. Trump repeatedly promised that everyone in the country would be covered at reasonable cost under an amazing new health plan. But it is now clear that the A.H.C.A. could not have delivered on that promise. The president, who has not always had a close relationship with Mr. Ryan, may consider changing course and working across party lines to develop support for universal access to Medicare.¶ Then again, he may fear that move would be seen as a sign of weakness or defeat. But the research findings on loss aversion make one thing clear: Any setback from that change in strategy would pale in comparison to the damage he would have suffered if the A.H.C.A. had actually become law.

Single payer accesses a variety of advantages premised upon the flaws of an employer-provided insurance—economy, competitiveness, democracy and others

Levin-Waldman 3-14-17 - Ph.D., Professor at the Graduate School for Public Affairs and Administration at Metropolitan College of New York, Research Scholar at the Binzagr Institute for Sustainable Prosperity, as well as faculty member in the Milano School for International Affairs, Management, and Urban Policy at the New School

Aside from these ethical claims, there is the obvious question of how healthcare reform affects the labor market. Let's consider our options at the moment. Under the ACA, employers with more than 50 employees are supposed to provide insurance to those working a minimum of 30 hours a week. Those who aren't offered insurance through their employers are eligible to buy insurance through exchanges and get subsidies to purchase insurance. A family of four, then, earning 400 times the poverty level, roughly $96,000 a year, would qualify for a subsidy. Additionally, insurance companies must accept people with preexisting conditions and individuals are required to purchase insurance or pay a penalty if they do not.¶ Critics have argued that the employer mandate to insure workers only encourages employers to cut worker hours. Workers who cannot afford insurance or who choose not to purchase it will simply opt to pay the penalty. Employers might also find it more cost-effective to pay the penalties for not providing insurance. The individual mandates that were supposed to broaden the insurance pool thereby lowering premiums, has done anything but.¶ On the contrary, because all plans offered must meet certain standards and provide certain minimum benefits, premiums have been driven up. For those purchasing at the bottom of the exchange, the deductibles for many are prohibitively expensive, effectively putting many back in the same position they were in prior to the ACA.¶ Now we have been introduced to the Ryan plan which will replace subsidies with refundable, but lower tax credits and end the individual mandate. The argument is that if individuals aren't forced to buy insurance, Insurance companies will be forced to compete with each other and lower premiums in efforts to attract customers. And yet, if premiums are still too high, healthy individuals will still opt not to buy, thereby contracting the insurance pool and driving up the premiums for everybody else. The other problem, however, is that the healthcare market is not like any other.¶ In a normal market, prices would drop if there is insufficient demand. Because employers are the main purchasers of insurance, there aren't the same numbers of individuals purchasing insurance, as might be the case were individuals purchasing their own. There is less competition among insurance companies for customers.¶ There is another aspect here which works to drive up costs. Because all hospitals are required to treat anybody who comes in, regardless of whether they have insurance or can pay, hospitals only end up overcharging everybody else in an effort to make up the difference. In a normal free market, one who cannot afford services would simply be denied services. In competitive markets, goods are rationed on the basis of price. If you can afford it you get it; if you cannot you do not. Were the healthcare market to operate like other markets, the harsh reality is that poor people simply would not have access to healthcare at all. In other words, the healthcare market cannot be a normal market because of moral obligations.¶ With all of the problems of the ACA, it may still be preferable to the Ryan plan, although not by much. One of the chief problems with employer provided health insurance is that as premiums rise it only cuts into the

money wages that employees receive. A worker's compensation is equal to money wages plus benefits. One of the principal reasons for stagnant wages over the last several decades has been rising benefit costs. The other reason has been the deterioration of labor market institutions.¶ Another problem with employer provided insurance is that it creates job-lock. Workers afraid of losing their insurance, especially prior to the change mandating insurance for pre-existing conditions, were afraid to look for other jobs that might have paid more money wages. Although employers have often complained about rising healthcare costs, they have enjoyed the control this benefit has afforded them over their workers.¶ Lastly, employer-provided insurance ~~retards~~ [hurts] competitiveness in a global economy. Countries where insurance is made available to all by the states are able to sell products at reduced prices. Consider that **the cost of providing insurance to auto workers adds at least $1500 to each car produced by the big three U.S. automobile makers.**¶ Ideally, we would have a single payer system similar to the National Health Insurance System in Canada. Workers would be free to leave one employer for another in search of better money wages and/or working conditions. Employers could be more competitive because health insurance would no longer be part of the price for goods and services. Physicians' groups would no longer have to employ three insurance specialists for each physician in order to deal with insurance companies and reimbursement. Because all physicians and hospitals would all be billing the one National Health Insurance, everybody would be able to truly choose their doctors and hospitals they want to go to.¶ **A single payer system would also be good for democracy**. Currently with private insurers decisions about what will be covered are made by business executives in consultation with nurses. A publicly provided single payer system would force these decisions to become a matter of public debate. In other words, what is covered and whom is covered could be decided in a democratic framework, rather than behind closed doors.¶ Lastly, a single payer system could upend the political system in a way unseen since Bill Clinton was president. Clinton used to practice triangulation whereby he would take policies of the opposing party and make them his own. In other words, here is a golden opportunity for Trump. In the past he supported a single payer system. He could endorse a single payer system as the replacement for the ACA and dare Democrats to oppose him. This would truly make for exciting politics. Historically Democrats favored a single payer system, and some might oppose it now only because it was endorsed by Trump. Republicans, of course, will be opposed, but given that in the absence of a viable alternative the ACA is here to stay, some might come around. For Trump who ran on as populist platform, this would truly fit the bill.

Single Payer would save 18,000 lives per year

Woolhandler, MD, MPH and Himmelstein, MD, professors CUNY School of Public Health, 2017 [David Himmelstein and Steffie Woolhandler, founders of Physicians for a National Health Program, "Lack of Insurance is Deadly Single Payer Saves Lives", Single Payer Action, June 27, 2017, available at: https://www.singlepayeraction.org/2017/06/27/lack-of-insurance-is-deadly-single-payer-saves-lives/ accessed 7/29/17 TOG

That's according to a comprehensive review of studies published today in the Annals of Internal Medicine. The review updated a 2002 study conducted by the Institute of Medicine (IOM – now called the National Academy of Medicine) that concluded that 18,000 persons died each year from lack of health insurance.\ The authors carried out an intensive search for all research examining whether health insurance coverage affects overall mortality among adults age 18-64. They found that multiple studies published since the completion of the IOM study have confirmed that insurance lowers mortality. They cite consistent findings from a randomized trial carried out in Oregon, as well as multiple quasi-experimental and observational studies. The studies indicate that insurance decreases the odds of dying among adults by at least 3% and as much as 29%.

Single payer improves rural coverage

Adam Gaffney 17, Adam Gaffney is a physician whose work has appeared in Salon, Dissent, and In These Times., 6-19-2017, "The Washington Post Is Selling Snake Oil," Jacobin, https://www.jacobinmag.com/2017/06/single-payer-health-care-universal-medicare-for-all

After essentially dismissing this as a source of savings, the Post proceeds to assert that if single payer is to wring any real savings out of the system, they will be by necessity painful and divisive. Here it engages in a divide-and-conquer approach which we will likely see more of in coming days: doctors will have to be paid less, **rural America will have to give up its "expensive medical facilities** that serve relatively few people," and "patients would have to accept different [i.e. worse] standards of access and comfort." This is **nonsense**. Canadian doctors get reimbursed perfectly well for their labor. Rural areas **might actually be better served, not worse**, under a national health program (NHP) that **consciously plans the construction of new health-care capital**. And the whole point of single payer is to **improve access for all patients**: as we replace insurance networks with "one big network" of NHP providers, and **eliminate uninsurance and underinsurance**, **barriers to care** — financial and otherwise — will **decline**.

Otherwise, coverage will collapse. That creates a food supply crisis that spikes costs globally and independently tanks the economy.

David Alemian 16, Vice President - Capital Crest Financial Group, 11-8-2016, "Rural Healthcare Is a Matter of National Security," MD Magazine, http://www.mdmag.com/physicians-money-digest/contributor/david-alemian-/2016/11/rural-healthcare-is-a-matter-of-national-security

Value-based healthcare has made the problem of talent retention and recruitment in rural America a matter of national security. Talent shortages make it nearly impossible for rural health organizations to successfully transition to value-based healthcare. **Without the needed high quality talent, rural health organizations will be unable to deliver high quality healthcare**. As a result, Medicare and Medicaid would financially penalize them. Rural health organizations are already struggling with enormous turnover rates and costs that run up into the millions of dollars each year. The additional financial burden of penalties from Medicare and Medicaid will put many rural health organizations at risk of going out of business. If too many rural health organizations go out of business, it then becomes a matter of national security and here's why: In most rural communities, the healthcare organization is the largest employer. When the largest employer goes out of business, the community collapses and people move away. What was once a thriving community then becomes a ghost town. **Rural America produces the food that feeds the rest of the country. What will happen when our amber waves of grain turn to desert wastelands because there is no one to work our great farmlands? As the source of food dries up, and store shelves empty, the price of food will go through the roof. As food prices go up, hyperinflation will become a reality, and our printed money will become worthless. Almost overnight, Americans will begin to go hungry because they won't be able to afford to put food on the table.**

Studies Show that expanding Health Insurance improves health; including the Oregon Study properly understood – and better studies after

Rutledge research economist at the Center for Retirement Research at Boston College 2016 [Matthew S. Rutledge research economist at the Center for Retirement Research at Boston College, "The interconnected relationships of health insurance, health, and labor market outcomes", CRR WP 2016-2 July 2016 available at http://hdl.handle.net/2345/bc-ir:107007 accessed 7/27/17 TOG, p.5-11]

In contrast to the RAND HIE, but consistent with the vast majority of observational studies, most quasi-experiments documented by Levy and Meltzer (2004, 2008) and McWilliams (2009) conclude that health insurance does make adult enrollees healthier.3 Many of these studies take advantage of the fact that most uninsured Americans become eligible for Medicare coverage at age 65. Card, Dobkin, and Maestas (2008) find only modest improvements in self-reported health status and no statistically significant change in mortality upon Medicare eligibility at the population level in cross-section. Finkelstein and McKnight (2005) similarly find no effect on mortality after Medicare's implementation in 1965. But studies using other techniques report more positive effects. Decker and Remler (2004) use a triple-differences framework, comparing the differential changes in high- and low-income adults before and after age 65 in the United States and Canada, finding that lower coverage rates pre-65 explain more than half of the income-related gap in self-reported health in the United States. Polsky et al (2006) and McWilliams et al (2007) follow previously uninsured adults longitudinally and find that acquiring coverage slows the rate of age-related health decline. Other studies have attempted to account for unobservable differences between the uninsured and privately insured using instrumental variables. The studies have generally found that the privately insured are statistically significantly healthier and have greater access to care (Pauly 2005; Dor, Sudano, and Baker 2006; Hadley and Waidmann 2006). But these studies have been criticized for their choice of instruments; some of the proposed variables, such as involuntary job loss, immigration status, the state-level unemployment rate, and marital status, have been shown to affect health directly, making them invalid instruments for health insurance coverage (Levy and Meltzer 2008, McWilliams 2009). In addition, some studies have compared enrollees who lose coverage to those who maintained coverage when budgetary pressure induced cutbacks. Lurie et al (1986) find that beneficiaries kicked off of Medi-Cal in 1982 had significant increases in blood pressure. Fihn and Wicher (1988) found that patients at the Seattle Veterans Administration Medical Center in 1983 whose benefits were terminated had substantial increases in blood pressure and were much more likely to report health declines than those who maintained coverage. These programs were both covering relatively low-income populations on a much smaller scale than Medicare or private insurance, and so the external validity of these results to a larger population is unknown. In addition, whereas most policy reforms have aimed at increased coverage, these studies estimate the effects of coverage cutbacks, and the effect of insurance coverage on health may not be symmetric.4 Across studies, as expected, the gains in health are especially strong among previously uninsured adults with chronic conditions such as HIV/AIDS, cardiovascular disease, or diabetes that require management and regular access to care (Goldman et al 2001; McWilliams et al 2007). Patients requiring acute care after a car accident, heart attack, or other events requiring immediate care such as a stroke or hip fracture also receive more and better care and have lower mortality rates (Doyle 2005; Volpp et al 2003; Card, Dobkin, and Maestas 2007). The use of quasi-experiments, rather than simpler observational studies, appears to be increasing. In Levy and Meltzer's earlier review (2004), they categorize only three out of 131 studies in the Institute of Medicine's (2002) review as quasi-experiments or experiments.5 But the tide turned soon after: both Levy and Meltzer (2008) and McWilliams (2009) report that more recent research has tended to use quasi-experimental techniques rather than simply relying on observed correlations. Indeed, in the years since these reviews, more quasi-experimental studies have taken advantage of recent policy changes to identify otherwise-similar treatment and control groups and compare their health outcomes. 6 In fact, two policy changes might be better characterized as experiments, finally breaking the RAND HIE's hold as the only true experiment.

The Oregon Medicaid Study. The larger and better-known of the two new experiments took place in Oregon. In 2008, after prior budgetary cutbacks, the Oregon state government announced plans to expand Medicaid to 10,000 additional low-income enrollees other than the "categorically eligible" (children, pregnant women, the disabled, the elderly, and welfare beneficiaries). Nearly 90,000 individuals registered for a chance to obtain coverage via lottery. Finkelstein et al (2012) obtained permission to link lottery registrants to public records from hospitals, mortality records, and the TransUnion credit bureau, and supplemented this administrative information with surveys of both the winners and losers of the lottery. Lottery losers make for a suitable control group because they were just as motivated to seek coverage as the lottery winners, and Finkelstein et al demonstrate that the two groups are similar in observable characteristics.7 The results of Oregon's experiment suggest that winning the lottery greatly increased access to health care, decreased unmet health needs, and virtually eliminated catastrophic out-ofpocket expenditures (Baicker et al 2013). Positive outcomes,

however, were not limited to access and financial conditions. The coverage expansion led to a substantial and statistically significantly improvement in depression screenings, and lottery winners were about 10 percent more likely to report improved quality of life, particularly in self-reported mental health. One concern is that, at least through the first two years, coverage had only a weak positive effect on physical health conditions. Blood pressure readings, hypertension, and high cholesterol failed to improve. Though diabetes diagnoses increased and diabetes treatment increased, glycated hemoglobin readings – which indicate the degree to which diabetes is kept in check – were virtually unchanged. But Carroll, Frakt, and Richardson (2013) point out that the experiment – even with 12,000 individuals combined between the treatment and control groups – is likely underpowered. The fact that pre-experiment rates of high blood pressure, hypertension, high cholesterol, and diabetes were small suggests that not much improvement could be expected. Furthermore, two years may be too short a period to expect substantial improvements in physical health conditions; a short-run effect that is expected to be small is even harder to find in an underpowered experiment. The Social Security Accelerated Benefits Demonstration. The other experiment conducted in the last decade was the Social Security Accelerated Benefits (AB) Demonstration, conducted among Social Security Disability Insurance (SSDI) beneficiaries. This demonstration came about because of concerns that the 24-month waiting period for Medicare eligibility (or 29 months after onset of disability) was unfair to individuals whose health needs had already been demonstrated to be severe enough to prevent work (Weathers et al 2010). The Ticket to Work legislation aimed at removing barriers to workforce reentry authorized a demonstration project that would waive the waiting period for some SSDI beneficiaries. Between 2007 and 2009, researchers recruited participants during their first six months of SSDI who lacked health insurance. About half of the participants were randomly assigned to receive a health benefits package.8 In addition to the health benefits, 20 percent of the full sample received health care coaching and counseling designed to facilitate a return to work; the group receiving these extra services is the "AB-Plus" group, while the group receiving only the health benefit treatment is the "AB" group. The remaining half of the sample makes up the control group.

By the time of their one-year follow-up survey, members of both the AB and AB-Plus groups had seen statistically significant health improvements (Michaelopoulous et al 2012).9 Members of the two treatment groups were about 50 percent more likely to report that their health had improved from the baseline period, relative to the control group. Unlike the Oregon experiment, treatment group participants reported improvements in both physical and mental health conditions; however, as with Oregon, mental health improvements were more clear-cut. These improvements are consistent with increases in health care use and decreases in unmet needs, though more than half of each of the treatment group still reported at least one unmet medical need even with the health benefits. 10 In summary, the only two true, large-scale experiments since the RAND HIE both indicate that insurance has at least a slight positive impact on health, particularly mental health. The Oregon experiment indicates that gaining coverage improved mental health, quality of life, and financial outcomes. And while physical health was not affected in any statistically significant way, neither can the Oregon authors rule out positive physical health effects for new Medicaid recipients. The AB Demonstration also finds improvements in mental health among SSDI beneficiaries gaining access to health coverage, and more substantial physical health improvements than in Oregon. Massachusetts reform. The last decade has also seen new quasi-experiments arise as a result of policy reforms that increased coverage. The expansion of health insurance coverage in Massachusetts, implemented in 2007, served as a model for the ACA just a few years later, so researchers have been following its outcomes closely. Like the federal law, the Massachusetts reform expanded Medicaid; created an exchange of private plans with standardized benefits, guaranteed issue, guaranteed renewal, and no rescission; required individuals to attain coverage or pay a penalty when filing their tax returns; and required employers (other than the smallest firms) to offer coverage to their workers (Holahan and Blumberg 2006). While most research on Massachusetts has focused on the reform's effect on insurance coverage and access to health care,11 the studies examining its effect on health outcomes are universally positive. Most of these studies use nationally representative datasets – the Behavioral Risk Factor Surveillance System (BRFFS) or National Health Interview Survey (NHIS) – in a difference-in-differences framework to compare the cross-sectional change in selfreported health status among Massachusetts residents to the change over that same time frame in similar states.12 Across studies, Massachusetts residents were more likely to report being in excellent health than before the reform's implementation (Miller 2012a), with improvements in both physical and mental self-assessed health (Van der Wees, Zaslavsky, and Ayanian 2013).13 They also reported fewer days in poor physical or mental health, fewer days with health limitations or activity-limiting joint pain, and lower body mass index scores (Courtemanche and Zapata 2014). These results were even stronger for lower-income individuals. Perhaps no study on Massachusetts reform has received more attention than Sommers, Long, and Baicker (2014). The authors compared mortality rates by cause of death in Massachusetts counties to a control group of counties in non-reform states chosen by propensity score matching to duplicate the Massachusetts' counties demographic and economic profile. Mortality fell by 2.9 percent, or 4.5 percent just for causes of death that are amenable to health care; both estimates are statistically significant and are larger for the lower-income

counties that stood to see the largest gains in coverage rates. The uniformity of the estimated positive effects of Massachusetts health reform – across metrics, data sources, control groups, and samples – stands in contrast to the less consistent results from Oregon's Medicaid expansion. Oregon saw improvements in mental health and self-assessed quality of life but little improvement in more objective physical health measures. While evidence on physical health metrics such as blood pressure and cholesterol readings is, as of this writing, less available for Massachusetts residents, the magnitude of the mortality effect suggests that coverage expansion clearly improved overall health. Even health insurance reform skeptics have conceded, to some degree. McArdle (2014) and Douthat (2014) run through potential confounders such as the possibility that the Great Recession had a less severe effect in Massachusetts, but they ultimately admit that coverage expansion can have a positive effect on mortality. McArdle also points out that the stronger effect in Massachusetts is in part due to the much larger scale of the quasi-experiment: 3.9 million Massachusetts residents versus 6,000 Oregonians; indeed, Frakt (2013) demonstrates how the larger sample size vastly reduces the confidence interval, making the effect easier to find.

Healthcare access doesn't solve every health variable- but it matters- it's a pre-req and it reduces death and suffering

Bodenheimer, 16-- UC San Francisco School of Medicine professor

[Thomas Bodenheimer, MD, MPH, and Kevin Grumbach, UC San Francisco Family and Community Medicine department chair, San Francisco General Hospital Family and Community Medicine chief, Understanding Health Policy: A Clinical Approach, 7th Edition, 2-29-16, AccessMedicine,

Health outcomes are determined by multiple factors. Socioeconomic status is the dominant influence on health status; yet medical care and public health interventions are also important. **The advent of the polio vaccine markedly reduced the number of paralytic polio cases. From 1970 to 2010, age-adjusted death rates from stroke decreased by 150%—a successful result of hypertension diagnosis and treatment** (U.S. Department of Health and Human Services, 2013). **Early prenatal care can prevent** low–birth-weight and **infant deaths**. **Irradiation and chemotherapy have transformed the prognosis of some cancers** (e.g., Hodgkin disease) **from a certain fatal outcome toward complete cure**. **Moreover, the health care system provides patients with chronic disease welcome relief from pain and suffering and helps them to cope with their illnesses. Access to health care does not guarantee good health, but without such access, health is certain to suffer.**

Single payer is the critical first step towards eliminating racial bias in health care—it reduces barriers to care that disproportionately affect minorities

Gaffney, Fellow in Pulmonary and Critical Care at Massachusetts General, 2016 (Adam, "Is the Path to Racial Health Equity Paved with "Reparations"? The Politics of Health, Part II", Los Angeles Review of Books, https://lareviewofbooks.org/article/is-the-path-to-racial-health-equity-paved-with-reparations-the-politics-of-health-part-ii/#!,

Tweedy, for instance, sees firsthand the harm inflicted on the uninsured when he works at the rural health clinic described earlier. But, even so, like Matthew, he gives insufficient attention in his book to the fact that, **even *with* the reforms of the Affordable Care Act, we will continue to lack universal health care**.[22] For instance, **under current reforms, 27 million are expected to remain uninsured 10 years from now,** according to an approximation of the Congressional Budget Office. **We know that Hispanics and blacks are disproportionately represented among the uninsured**.[23] **Covering these excluded millions seems critical. Moreover, neither author discusses the fact that the US health care system imposes substantial financial burdens at the "point of use," in the form of copayments, deductibles, and co-insurance for medical care, which may deter care for those who need it. Some have legitimately suggested that these forms of cost-sharing disproportionately harm minorities, who have lower median income and net wealth**.[24] In other words, the potential harm of, say, a $2,000 medical deductible is dependent on your income and assets: those with fewer resources may lose out on important health care. And finally, though Tweedy refers to the shortcomings of Medicaid, neither he nor Matthew emphasizes that **a health care system with a separate tier of access for the poor may be inherently unequal.**

But would "true" universal health care do much to combat racial health inequalities, if it were, say, a single-payer system that eliminated out-of-pocket expenses and was equally accessible by all, without tiers or walls?[25] Or would it replicate current biases and inequalities? To some extent, **the answer is yes** to both questions. But even so, **a body of research has suggested that, even if these biases persist, a fully universal system might nonetheless be a powerful tool in reducing racial health care inequalities. That evidence comes from what is arguably a quasi-single-payer system located in the US: the** Veterans' Administration **(VA**). Notwithstanding recent scandals that are indeed of great concern, **the modern-era VA has justifiably earned praise for delivering** a high — indeed, comparatively superior — **quality** of health **care**.[26] **There is also evidence that it may indeed effectively reduce, even potentially eliminate, *some* racial health inequalities**.

Last fall, a study published in *Circulation,* the premier journal of the American Heart Association, received wide coverage in the media for some provocative findings. "**The** US Veterans Health Administration (**VHA**)," as the study notes in its introductory section, "**is a healthcare system that does not impose the typical access barriers of the US healthcare system that may disproportionately impede enrollment of blacks." The investigators therefore hypothesized that racial inequalities in cardiovascular outcomes and mortality found in the general population might be reduced in the VA, a "healthcare system that allows enrollment independent of race or socioeconomic status.**"[27] Consistent with previous studies, **in their analysis of data from the** general (**non-VA**) **population, they found racial inequalities much as they expected to find them: blacks had a much higher mortality** (after adjusting for various other factors) as compared to whites (indeed, approximately 40 percent to 50 percent higher).[28]

In striking contrast**, in the VA population, even though the risk of stroke was either higher or similar among blacks as compared to whites depending on which statistical adjustments were used, the risk of coronary heart disease as well as overall death was actually *lower* among blacks**. This is, of course, only a single study, albeit a rather large one with more than three million subjects. An accompanying editorial concedes that a number of factors may be at play. Nonetheless,

the fact is that, as described by the investigators, **these findings build on an existing literature consisting of multiple studies that together point to a reduction of racial health inequalities within the VA for critically important outcomes like mortality**.[29]

No doubt, **there are still discriminatory practices in some or all of these facilities, and we can assume that there are conscious or unconscious biases at work in the minds of some of its clinicians, as there are elsewhere. Indeed, other studies clearly show that, even after the significant reorganization and reform of the VA in the late 1990s, there are still racial disparities in the VA.[30] If we moved to a single-payer system on a national level, such biases would still need to be addressed** along the lines Matthew argues. **But the point is that a more egalitarian *structure* of the health care system itself might go even further in reducing them. Indeed, in light of this research, it seems fair to say that health care universalism could be a very powerful tool in combatting ubiquitous racial health inequities. Attaining health care equality, in other words, requires true equality of access**. And yet this simple notion is all too often ignored entirely in any discussion of health "disparities."

There is an ethical and economic imperative to address racial disparities in health care

Ayanian ’15 [John, MD and director of the Institute for Healthcare Policy and Innovation and the Alice Hamilton Professor of Medicine at the University of Michigan, “The costs of racial disparities in health care,” October 1, https://hbr.org/2015/10/the-costs-of-racial-disparities-in-health-care, accessed via google August 19, 2017,

Racial disparities in life expectancy are a key indicator of inequity in health outcomes. Although the United States has made progress in narrowing the gap in life expectancy between blacks and whites, from 7.6 years in 1970 to 3.8 years in 2010, a disparity remains — largely from blacks’ higher death rates at younger ages from heart disease, diabetes, and cancer, as well as higher risks for HIV infection, homicide, and infant mortality. **Leaders in government, business, and health care must address these** persistent disparities at the national, state, and local levels, **as both an ethical and an economic imperative**. In fact, **eliminating racial disparities in health care is vital to pushing the entire health care system toward improving quality while containing costs** — so-called value-based care. In its 2001 “Crossing the Quality Chasm” report, the Institute of Medicine identified equitable care as one of six core aims of high-value health care systems. And since 2003, Congress has mandated that the federal government produce the annual National Healthcare Disparities Report as part of the effort to monitor national progress in this domain.

By initiating a conversation about the structural impacts of the status quo health system, the aff functions to break the barrier between the academic ivory tower and community engagement—it teaches communication skills that allows for conversation between those providing services in the public policy community and those being served.

Damodaran et al, writing in the Harvard Public Health Review, 2015 (Swathi Damodaran, Rebecca A. Gourevitch, Tiffany Lin, Nikhil A. Patel, Rosemary Phu, Kerrilynn Rice, the Health Equity and Leadership Conference (HEAL) Committee at Harvard Medical School, July, "Climbing Down the Ivory Tower: Challenging Racial Injustice Through Community Health", Harvard Public Health Review, http://harvardpublichealthreview.org/climbing-down-the-ivory-tower-a-student-run-health-equity-conference-on-challenging-racial-injustice-through-community-health/,

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane." Most of us know these famous words by Dr. Martin Luther King Jr. In fact, some of us even referenced them in our applications to graduate school. They stirred within us a call for action and allowed us to connect our fascinations with the human body, epidemiology, and biostatistics to a movement bigger than ourselves. For us, **medicine and public health represented a means to an end – tools we would use to work towards our social justice goals as we sought to improve public health and reform the health care system from within.** When we came to Harvard, we had a strong sense of purpose; **this was our opportunity to engage with the intricate issues affecting health and health care systems, and to begin working towards solutions to the inequities that enraged us**. For some of us, this meant learning statistical techniques for mining through data sets, looking for patterns, and identifying cause-effect relationships. For others, it was learning physiology and how to diagnose diseases. **But somewhere between directed acyclic graphs and Charcot's triad, we became locked in the academic ivory tower**. Our myopia focused us on brown-bag series and grand rounds presentations – the epicenters of the academic world. **Although we were elbow-deep in discussions of the social determinants of health and postulating ways to provide patient-centered care, we missed the opportunity to look upwards, and most importantly, outwards. We remained comfortable in our place of privilege and engaged less with the very real issues facing our own communities. But historic events outside our academic bubble shattered our sense of comfort in working towards these goals from behind the walls of the ivory tower, and reminded us of the ways power and privilege frame our society. In the wake of the non-indictments of the police officers who fatally shot Michael Brown in Ferguson, MO and strangled Eric Garner in Staten Island, NY, a movement attempting to confront systemic racism and its violent manifestations swept across the nation. In our own academic community** at Harvard, **we discussed how structural racism is intrinsically linked to racial disparities in health and access to health care.** We lamented the limited opportunities to discuss and learn about these issues with our classmates, our professors, our school administration, and the larger Boston-area community. **We reflected on our own contribution to this inequity by failing to engage with community groups working to dismantle the very injustices we were so diligently studying. And we were humbled by challenging conversations about the power dynamics in our own institutions and the racial biases implicit in the work we study** and strive to emulate. We, the Health Equity and Leadership Conference (HEAL) Committee, sought to re-energize student-community engagement around these issues by bringing together students, community members, and local organizations for a day of honest discussion and reflection. HEAL was formed in 2012 by a group of Harvard graduate students dedicated to generating discourse and action to resolve issues related to health inequities in the Boston and Cambridge communities. This year's conference, *Challenging Racial Injustice Through Community Health*, held in early February, brought together a diverse group of students, faculty, and community members to discuss the ways in which institutional racism impacts health, and how community health work can address these inequities. The student-led initiative was organized by students at the Harvard T.H. Chan School of Public Health (Harvard Chan) and Harvard Medical School (HMS) with generous support and funding from the Center for Primary care at HMS and Harvard Chan's Office of Diversity and Inclusion. A diverse group of over twenty speakers from 18 organizations joined us for discussions ranging from "Primary Care and Health Disparities" to "Coalition Building for Community Health" and "Addressing Needs of Formerly Incarcerated and Homeless Individuals." Over 175 participants attended the conference, most of whom were students from Boston-area universities and community members from a myriad of organizations. We connected over our shared inspiration for careers in medicine and public health, but lamented about the lack of focus on activism and community engagement in our universities. Through these connections, participants left the HEAL conference feeling empowered to improve racial health equity on a local level, with new ideas and concrete solutions to

address these issues in our community. While the conference was a refreshing opportunity for students to connect with community organizations and leaders, **we know that the conversation cannot end after one afternoon. Universities and academic centers must climb down from their ivory towers and incorporate themselves into their surrounding communities. They need to support student activism around pressing public health challenges related to structural and social inequities. They need to provide safe spaces for honest insight into how they themselves deepen inequities both within their own contours and in the communities that surround them. We recognize that this effort will not be easy, as Dr. King also wisely observed, "Human progress is neither automatic nor inevitable. Every step toward the goal of justice require[s] sacrifice, suffering, and struggle, the tireless exertions and passionate concern of dedicated individuals."** To continue our dedication to this struggle, we plan to host HEAL events throughout the spring semester and in the future so that students have venues to engage with social justice and community leaders. **We want our work to embody our idealistic visions by developing sustainable community partnerships to find pragmatic solutions to the shocking and inhumane inequalities that enraged and inspired us into action. The stakes are too large for us to remain in this ivory tower freeze.**

Con Evidence

The bill crushes the economy and turns the case

Moffit 8 --- Ph.D., is Director of the Center for Health Policy Studies at The Heritage Foundation (Robert E. Moffit, 10-5-2008, "How a Public Health Plan Will Erode Private Care," Heritage Foundation, http://www.heritage.org/health-care-reform/report/how-public-health-plan-will-erode-private-care,

What a New Public Plan Would Look Like There are two broad, yet very different, models for a government health plan among the leading health reform proposals: Medicare and the Federal Employees Health Benefits Program (FEHBP). Under an earlier proposal advanced by the Commonwealth Fund, a prominent liberal think tank based in New York, the new government health plan would be "Medicare Extra," a plan based on Medicare for the under-65 population. Under Senator Baucus's proposal, the new public plan would also resemble Medicare. Under Senator Daschle's proposal, the new plan would be created by his proposed Federal Health Board, a powerful independent government agency, in consultation with Medicare officials. Under President-elect Obama's proposal, the new public plan would be created by Congress with benefits similar to those found in the FEHBP and would compete with private plans in the National Health Exchange. While Obama has not been very specific about the functions of the Exchange, he has made it clear that it is to be a "watchdog," a powerful regulatory as well as administrative agency, and that it would enforce a common set of insurance and health policy rules, including guaranteed issue, rating limitations, and payment rules for health insurance, as well as rules governing benefits, quality, and efficiency standards. In Obama's proposal, small businesses and individuals without access to group coverage through their workplace would be eligible for enrollment in the new public plan, as would those who are ineligible for existing public health programs such as Medicaid and SCHIP. Like Baucus and Daschle, Obama proposes combining a public health plan with an employer mandate, whereby employers who do not or cannot afford to offer private coverage are required to pay an as yet unspecified tax that would, in turn, help to finance coverage in the public program.[10] Under Obama's proposal, insurance rules would include guaranteed coverage, including the elimination of any restrictions on pre-existing medical conditions, as well as a requirement that the public plan and its competitors offer a fair set of premiums with minimal co-payments. Rules would apply to the new government plan and presumably any of the government plan's private competitors. For low-income people, special premium subsidies would allow them to enroll in the new public plan and the private health plans that would compete with it in the National Health Exchange. A Medicare Model. Senator Baucus, as noted, has said that he favors a new public plan "similar to Medicare."[11] Likewise, Senator Daschle has called for a public plan to be developed by his proposed Federal Health Board in consultation with Medicare officials. Details matter. In developing a public health plan, Congress would have to determine whether the plan should really be "like" Medicare or whether it should simply expand Medicare itself as proposed by a sizeable number of congressional champions of a single-payer system of national health insurance. As a practical matter, Medicare expansion would be the easiest and simplest option, but it would also mean expanding a financially troubled government program that is already facing disastrous liabilities. Governance. If a simple expansion of Medicare is not on the table, the task becomes a bit more challenging. If Congress were to create a new public plan "like Medicare," then Congress would have to decide on its governance and presumably would recreate a system of central planning and administrative pricing that is at least broadly similar to the system that characterizes the existing Medicare program. This would include centralized benefit setting, financing, and regulation (a vast regime of rules, regulations, and guidelines, which consume tens of thousands of pages); Medicare-style decision-making with respect to medical necessity and appropriateness of medical services for reimbursement, claims processing and denial, or conditions that determine when and how patients could legally contract with private physicians outside the Medicare-like plan (if such private contracting were permitted at all); Medicare-style audits and investigations for fraud and abuse; and the often laborious grievance and appeals process for denial of patients' medical services or physicians' reimbursements. Medicare's governance problems are legendary,[12] but it is unlikely that Congress could invent a Medicare-like program without reinventing the managerial and administrative paraphernalia and the inflammatory process of political decision-making that characterizes Medicare, including the ugly special-interest pleading, unless it were to abdicate its responsibilities for governing the new program and transfer them, as Senator Daschle has recommended, to a super agency, proudly unaccountable to doctors or patients and "insulated" from normal political influence in its disposition of benefits, drugs, or medical treatments. This is, of course, the idea behind the parallel creation of a supremely powerful council, institute, or Federal Health Board.[13] The notion that a politically appointed body would also be "insulated" from politics is charmingly naïve. Benefit Setting. Based on Medicare's historical record, health benefit setting, particularly the adoption of new therapies, devices, or medical technologies, does not occur as rapidly in Medicare as it does in private health insurance. In fact, Medicare's benefit setting is often a slow and highly politicized process. The addition of a significant medical benefit in the Medicare program or a change in its payment rate often becomes a point of highly contentious congressional debate, as evidenced by the long and bitter multiyear battle over the addition of a Medicare drug benefit, which reached a fever pitch in the enactment and then the rapid repeal of the Medicare Catastrophic Coverage Act of 1988 and culminated in the enactment of the Medicare Modernization Act of 2003. In creating a new public health plan, if Congress (as the board of directors of this new plan) does not transfer its responsibilities to a separate and powerful board or council as recommended by Daschle and Baucus, respectively, it must determine how precisely it would address breakthroughs in medical innovation and the fruits of that innovation in the form of medical benefits and treatments. If a new treatment

becomes available and is priced according to market conditions in private plans, either Congress or a body authorized by Congress must first determine whether it will become available in the public plan (not a sure thing) and then decide how the treatment will be priced and under what conditions it will be reimbursed. Once again, the idea behind the public health plan, at least as presented by its champions in the incoming Administration and Congress, is that it would **compete directly** with private health plans for the **allegiance of employers**--**who will make the business decision to enroll their employees**--or employees who do not have employer-based coverage or are self-employed. But any serious market competition would require a **level playing field for the competitors**. In order to create and maintain this level playing field, any benefit standard established in the public plan would also be applied to private health plans. Congress, therefore, would have to **mandate an equality of benefits at some level between the public plan and the private plans**, and that would require **either adding or subtracting benefits or fixing the prices for these benefits** by legislative action to keep the contest at least **superficially fair**. As Michael Tanner, a senior fellow at the Cato Institute, has observed, "Private insurance companies would still exist, but they would operate much like public utilities with the government involved in deciding what benefits they offer, what they can charge, and how they operate."[14] Tanner's observation, however, begs an obvious question: **If the rules and standards, financing and benefits, reserve and solvency requirements, and consumer protections and guarantees are all the same for competing private plans and the public plan, then, logically, why should there be a public plan at all? A common set of market rules for insurers would be sufficient** to achieve whatever public good is envisioned to **ensure affordable coverage and fair competition**. Otherwise, it would seem that the only reason to create a public plan would be **simply to have a public plan**--**a meaningless exercise, unless the goal is public monopoly**. **Payments**. A second major issue for Congress to settle is the crucial one of how exactly it would set payments and prices of medical services in a new "Medicare-like" plan. In the Commonwealth Fund's version of the new government plan, "**Medicare Extra**," there would be no change: Payments to doctors and hospitals would be the same as they are in traditional Medicare.[15] In traditional Medicare, medical services and procedures are priced according to the program's existing system of administrative pricing, a **bewildering alphabet soup of fee schedules and payment formulas**: the Diagnosis Related Groups (DRGs) for hospitals; the Resource Based Relative Value Scale (RBRVS) for physicians;[16] the Sustainable Growth Rate (SGR) for physician payment updates;[17] and the various administrative payment formulas for medical devices and Part B drugs. Most Members of Congress are firmly committed to Medicare's administrative payment systems, regardless of their manifest weaknesses, strongly opposing even modest reforms like competitive bidding for durable medical equipment.[18] When the Medicare physician fee schedule was authorized by the House Ways and Means Committee in 1986 in the face of determined opposition from the Reagan Administration, it took another **three years for the proposal to be enacted** and another **five years for the payment reform to be fully implemented**. For Congress, it would be a **formidable task to re-invent an entirely new system of administrative payment for all medical professionals, as well as for drugs, devices, and technology**, assuming that it would truly be different from Medicare or Medicaid. Meanwhile, Congress has been either **unwilling or unable to fix the obviously broken payment systems** that now govern the financially troubled Medicare program. This is especially true of the physician-payment-update formula, **automatically threatening massive Medicare payment cuts to doctors** and setting off the ridiculous annual spectacle of Congressmen desperate to meet a yearly statutory deadline in time to undo their own handiwork. **Big Impact**. **Payment formulas** for the new government plan, like the size of the eligible pool of enrollees, are **crucial details**. The degree to which Medicare payment is reproduced in the new government health plan is **profoundly consequential in its impact** on the **doctors**, **hospitals**, and **private-sector health plans** that are supposed to compete with it. There is a big payment gap between public and private health care programs. Compared to payments in the private commercial markets, Medicare and Medicaid **pay doctors and hospitals significantly less**. According to the Lewin Group, the most recent data indicate that Medicare payments **amount to 81 percent** of private payments to **doctors**, while Medicaid payments to doctors amount to only 56 percent of private payments.[20] For **hospitals**, Medicare

payment **amounts to 71 percent** of private payment, while Medicaid payment is 67 percent of private payment.[21] **Artificially low government payments** by Medicare and Medicaid to doctors and hospitals guarantee that the **true costs are shifted back to the private sector** and **generate even higher premiums for individuals and families in their private and employment-based health insurance**. According to a recent report by Milliman Inc., a prominent actuarial consulting firm, **this "hidden tax"** amounts to **$88.8 billion a year**, or an additional annual cost of $1,788 in insurance for a family of four.[22] For individuals and families that would remain in private health insurance, assuming that their coverage survived, similarly low payment schedules for a new government health plan would **guarantee an even larger shift to them in higher health care costs**. In other words, even if their coverage remained unchanged, it is **highly unlikely that they would see a promised reduction in their health insurance premiums**. Champions of the government health plan often claim to be sincerely committed to "fair" competition between private health plans and their proposed public plan, but **it is impossible to have a functioning national market** in which pricing in one portion of the market (private plans) is **driven by free-market conditions** of supply and demand and pricing in the other (the **public plan**) is **dictated by the government**, either in the form of **administrative pricing or through a system of price controls**. To establish a level playing field, Congress would have to refrain from trying to set prices for thousands of medical treatments and procedures, as it does today for Medicare, and let the market determine those prices equally for the public plan and the private plans that are supposed to compete with it. The government plan and its managers would have to succeed, and therefore profit from their success in offering consumers what they want and need, or fail, lose market share, and absorb losses on their own--in which event, unlike other government-sponsored enterprises, the public plan should be **permitted to go out of business without another taxpayer bailout**: admittedly an unlikely scenario. Alternatively, Congress would have to impose a universal system of administrative pricing on the public and private health plans alike, thus reintroducing the old Nixonian price controls for the health care sector of the economy. But importing Medicare- or Medicaid-style payment systems is also to import the annual congressional warfare over Medicare payment for doctors and other medical professionals into what is now left of the private sector. With government controlling the benefits as well as the price of the benefits, whether or not the payer is singular or plural, the result would be a government-run system. Yet another option is for Congress simply to let the public health plan, with its administratively set, artificially low prices, undercut the private health plans and **accelerate employer dumping of millions of employees into the "cheap" government health plan**, thus rapidly **driving private health plans out of business** and rapidly **eroding the provision of private health insurance altogether**. **FEHBP Model**. The second option for a government health plan actually does not exist, except in recent political rhetoric, and that is something called the "FEHBP Plan." President-elect Obama's proposed new public health insurance program would give "individuals the choice to buy affordable health coverage that is similar to the plan available to federal employees."[23] But Obama would also prescribe a comprehensive standardized benefits package not only for the public health plan, but also **for any private health plans that would compete** with the public plan in his proposed National Health Exchange. It would be "similar" to the benefit package available to Members of Congress. Obama's presentation on this point is confusing, because in 2008 there were no fewer than 283 health plans, with different benefit packages, competing in the FEHBP. Under the FEHBP payment formula, the government, as an employer, makes an annual defined contribution that by law cannot exceed 75 percent of the premium costs of any given health plan in the program. FEHBP **plans differ greatly**. For example, for 2009, the Blue Cross Blue Shield "standard option" plan, one of the most popular of the FEHBP's national plans, has an annual premium of $13,450, while the Mail Handlers-Value plan, a union plan offered on a national basis, has an annual premium of just $5,340. As American Enterprise Institute scholar Joseph Antos and his colleagues have noted, if the Blues' standard-option FEHBP plan were to be the fixed standard, the **costs of coverage would be very high for many families**: Families would not be able to purchase less expensive coverage, since all other insurance would be required to offer benefits at least as generous as those of the NHP (measured on an

actuarial basis). This would create a **large new entitlement**, **raising concerns** about the **fiscal sustainability of reform**.[24] In the Obama version, enrollees' payments would be standardized to make sure that premiums are "fair" and that co-payments are "minimal." Families that are ineligible for Medicaid or SCHIP would receive low-income subsidies to help them buy coverage either in the public plan or in the approved private plans that would compete with it in the National Health Exchange. Deviation from FEHBP. Few topics in the American health care policy debate are more **subject to misrepresentation**--some of it deliberate, some of it rooted in ignorance--than the Federal Employees Health Benefits Program. Americans should not be under any illusions about how the FEHBP actually works, compared with the way it is often described. There are three significant differences between President-elect Obama's **proposal and the reality** of the FEHBP. The federal government **does not** enter a government-financed health plan into the competition with private insurers, either nationally or in any of the states where private health plans compete. The national and state competition in the FEHBP--to the extent that one wants to liken it to competition in a health insurance exchange--is a competition among risk-bearing private health plans only. The FEHBP is a premium-support system. There is no such thing as one "benefit package" or an "FEHBP Plan" that covers Members of Congress. There is a wide variety of packages that change annually and vary with plan type--ranging from high-deductible health savings account plans (HSAs) to managed care plans (HMOs and PPOs) and "fee for service" offerings--and that reflect yearly requests by the U.S. Office of Personnel Management (OPM), as an employer, in call letters (the federal government's annual communications to private health plans) before annual summer negotiations, as well as the different responses of health insurers in negotiations with the OPM staff and the ever-changing demand of consumers for health insurance products. The false impression often left with ordinary Americans is that there is a very special, single set of idealized health benefits uniquely and exclusively available to Members of Congress and federal workers and retirees. Under Obama's public plan, participants are to be charged "fair" premiums and "minimal co-payments." In other words, the federal government would, out of necessity, fix premiums to make them "fair" and standardize other insurance payments. In the FEHBP, premiums and co-payments are determined by supply and demand. While the OPM negotiates rates and benefits with private carriers as an employer, its main regulatory job is consumer protection of its employees and retirees, which is understood as making sure that the premiums bear a reasonable relationship to the benefits offered and that plans are solvent and compatible with basic marketing rules. OPM does not in any way get into the business of imposing price controls on premiums or forcing health insurers to adopt a standard set of co-payments. In this key respect, the Obama proposal **differs radically** from the principles and practice of the FEHBP. **How Private Coverage Could Change** Based on independent assessments, there is no doubt that there would be a **significant reduction in the number of uninsured Americans** under Obama's proposal. There is also no doubt that private health insurance coverage would erode significantly--that it would be **crowded out**--with a government health plan operating within a national health insurance exchange. Much would depend on the as yet unknown specifications that Congress would determine for eligibility for enrollment in the public plan, the size and scope of the proposed employer mandate and its tax, the exact functions of the proposed National Health Exchange, the payment and pricing of medical services in the new government health plan, and the private plans that are supposed to compete with it. Again, details matter. The Lewin Group recently projected the impact of a new public plan based on the size of the eligible pool of enrollees and its payment rates. In terms of eligibility, if employees in small firms, the self-employed, and individuals were eligible for enrollment in the government health plan, there would be major increases in enrollment in the government plan and corresponding declines in private health insurance coverage. Assuming payment levels for doctors and hospitals at a midpoint between existing private payment and Medicare payment, Lewin estimates that enrollment in the national public plan would jump to 31.5 million Americans, while 21.5 million Americans would either lose their employer-based coverage or give up private health insurance coverage.[25] If the government health plan is offered with Medicare payment rates for doctors and hospitals, which are significantly lower than those found in the private sector, the impact would be greater: 42.7 million Americans would enroll in the government plan, and 31.8 million fewer Americans would have private health insurance.[26] If employees in all firms, as well as self-employed persons and individuals, were eligible for enrollment in the government health plan, **the impact would be enormous**. In that case, at payment rates at a midpoint between the private sector and Medicare, Lewin estimates that 77.5 million Americans would be enrolled in the government plan, while 67.5 million

Americans would be transitioned out of employer-based or private health insurance coverage. If Medicare payment rates were adopted in the government plan and the scope of eligibility was greatly expanded--encompassing all firms and all self-employed and other individuals--then the **shifts in coverage would be titanic**: 130.5 million people would be enrolled in the government health plan, and **118.5 million Americans would no longer have private health insurance**.[27] The **Cost of a New Government Plan** With the creation of a new taxpayer-subsidized public health plan combined with an employer mandate, as recommended by President-elect Obama and Senator Baucus, Congress would be **imposing new costs on businesses** and almost certainly **shifting more costs to private health plans**. In the meantime, federal spending on health care would have to **increase significantly**, and their proposed health care delivery reforms would be **unlikely to secure serious cost control**.[28] **Fiscal discipline is unlikely**. Senator Baucus has already indicated that the "pay as you go" rule--requiring spending cuts or tax increases--to finance health reform may **not apply**.[29] Taxpayers are also being promised that health care reform will somehow pay for itself, based on **fanciful projections of future savings from various delivery initiatives**. **These savings will probably never materialize**. Based on a **rich history of failed government predictions** with respect to health care costs, especially in Medicare, the projected costs of government health programs are almost **always much greater** than the government officials promise. With regard to the specific impact of the new government plan itself, there is some early econometric analysis. The impact on different sectors of the health care industry, as well as the taxpayers, would vary by the payment levels and the pool of eligible enrollees in the new government plan--that is, whether the pool of eligible enrollees would be "broad," encompassing employees in all firms as well as individuals and the self-employed, or "narrow" and restricted to employees in small firms as well as individuals and the self-employed. Another key factor is the details of the employer mandate: the size and scope of the mandate and the tax penalty imposed on firms for not offering health insurance to their employees as prescribed by Congress. **Employer mandates**, as economists have generally noted, would result in a **reduction in wages** and other compensation for employees and provide **powerful incentives for firms to "dump" employees** from private coverage into public coverage along with the payment of the as yet unknown tax. For doctors and hospitals, the costs of the new government health plan in terms of lost revenues would be balanced somewhat by projected reductions in payments of administrative costs and uncompensated care costs as more and more patients were covered by the government's health insurance program. **Hospitals**. According to the Lewin Group, levels of payment at a midpoint between the private sector and Medicare would yield a net change for hospitals that would range from a positive increase of $14.9 billion (assuming a narrower pool of eligible enrollees) to a negative $7.3 billion. As Lewin estimates, however, if one assumes Medicare payment levels, the **hospital payment reductions could be drastic**: a loss of as much as **$36.5 billion annually** based on a broad eligibility of employees in all firms.[30] **Doctors**. For doctors, whether the eligibility pool is broad or narrow, or whether the payment levels were at midpoint or at Medicare levels, there would be a net reduction in physician revenues. The most drastic reduction in physician revenue would come with the adoption of the government health plan that encompassed employees in all firms as eligible and paid physicians on the basis of Medicare rates: **$36.4 billion in reduced physician revenue**.[31] **Taxpayers**. For taxpayers, there is as yet no clear answer to the specific question of how great the true costs of the new public health plan in particular, or whatever the incoming Obama Administration and the congressional leadership propose for health reform in general, will be. The new public health plan, however, **would be subsidized by the taxpayers**, and the taxpayers would presumably **assume all of its risks and liabilities**, including **inevitable unfunded liabilities** of a health plan that promises **artificially low premiums and co-payments.** Unlike many state legislatures, Congress is unburdened by any legal requirement in the federal Constitution to balance the federal budget and can therefore simply make good any yearly losses or expansions by making a run on the Treasury or relying on **deficit financing** and the **printing press**. The creation of a new government health plan beyond Medicare, Medicaid, and SCHIP would entail some hard thinking on the part of Congress as to how it would finance this new plan and what measures it would put in place to establish some modicum of fiscal discipline. It is understandable that some Members of Congress, as Senator Daschle has claimed, would be tempted to surrender some tough decisions affecting coverage and related costs to an enormously powerful Federal Health

Board or some other unelected body insulated from the inflammatory process of democratic decision-making. The **Eternal Bailout**. A new public plan would **entail new public liabilities**. In any case, Congress would have to decide whether or not to finance the new plan as Medicare is financed, put the bulk of spending on autopilot like spending on physician and drug benefits, and make up losses through increased taxation or debt. Or Congress would have to develop other alternatives. Once again, these details matter. If Medicare itself or a newly created "part" of Medicare, as some suggest, is to serve as the new public plan in a national health insurance exchange, then Congress will have to determine whether its liabilities would be established separately and apart from the existing Medicare program or included within it. From the taxpayers' standpoint, it would not make much difference: They would still be stuck with a much bigger bill either way. If liabilities were incurred as part of Medicare, for example, Congress would be adding to Medicare's **long-term debt**, which alone amounts to an **enormous $36 trillion**.[32] Yet no one in Congress and no one in either the outgoing Bush Administration or the incoming Obama Administration has yet indicated how Americans are going to absorb the hideously high entitlement costs that have already been incurred. Conclusion A new public insurance plan to compete with private health plans through a "national health insurance exchange" is **a Trojan horse for government control and the progressive destruction of Americans' private health insurance coverage**. The creation of a "Medicare-like" plan, in particular, would entail the creation of a Medicare-like financing system--a **shell game** in which prices are held artificially below market rates while costs are shifted to private carriers and gr**owing liabilities are shifted to the next generation of taxpayers**. Congress would thus **add to entitlement burdens that are already enormous**. Meanwhile, it is indeed hard to imagine how Congress or the Administration could remain neutral in the national competition with private health plans: a competition in which they would staff, manage, and fund their own creation. President-elect Obama claims that providing a public plan through a National Health Exchange would enhance personal choice and health plan competition. That is highly unlikely. Rather, such a system would erode private health insurance. Short of a revolution in Washington's thinking, either Congress or a powerful Federal Health Board operating under its authorization would become increasingly prescriptive over health benefits, the adoption of medical technology and new medical treatments and procedures, and the pricing of these items, as well as the mechanisms that private health plans may or may not use to manage health care risks. While private health coverage would start to disappear more or less rapidly, hardly any aspect of remaining private health plans' business operations would be free from government control. **That is not a prescription for the kind of choice or competition that would drive innovation, improve quality, or enhance the productivity of the health care sector of the economy**. It would severely weaken private health insurance pools and **guarantee a severe loss of economic prosperity** and--most important--personal liberty.

Uncontrolled increases in entitlement spending collapse the economy

Tanner '15 – is a Senior Fellow at the Cato Institute where he heads research into a variety of domestic policies with a particular emphasis on poverty and social welfare policy, health care reform, and Social Security (Michael D., "Deficits, Debt, and the Entitlement Crisis: Going for Broke", 2015, Cato Institute, pg 24, https://object.cato.org/sites/cato.org/files/pubs/pdf/going-for-broke.pdf)//CW

Our nation faces a massively growing debt that threatens our economic future. But as bad as that debt is, it is merely a symptom of a larger disease: a rapidly growing government that is consuming an ever-larger share of our national economy. **Unless decisive action is taken, government at all levels in the United States will consume roughly 60 percent of GDP by the middle of the century and will rise to unimaginable levels thereafter**. **A government of that size is a threat** not just **to economic growth** but to our liberty and our way of life. Our looming fiscal train wreck has been amply abetted by both political parties. But unless the United States learns to live within its means, a true economic disaster beckons. That means Congress is going to have to cut spending at all levels. Both discretionary and defense spending will have to be scrutinized and pared back to affordable—not to mention constitutional—levels. But **no meaningful effort** to control the size and cost of the federal government can occur without dealing with entitlement spending, **in particular by restraining and reforming Medicare, Medicaid, and Social Security**. Continuing to duck entitlement reform may well be "politically convenient," but doing so will condemn our children and our grandchildren to a world of mounting debt and higher taxes.

Their evidence is quite hypotheticals about what the world would look like if the US already had single payer, the reality is that it would be a massive shock that halts the economy

Khazan 2017 – Citing multiple industry experts
Olga, "Are you sure you want single payer?," Aug 21,
https://www.theatlantic.com/health/archive/2017/08/are-you-sure-you-want-single-payer/537456/

The biggest problem with Medicare for all, according to Bob Laszewski, an insurance-industry analyst, is that Medicare pays doctors and hospitals substantially less than employer-based plans do. "Now, call a hospital administrator and tell him that his reimbursement for all the employer-based insurance he gets now is going to be cut by 50 percent, and ask him what's going to happen," he said. "I think you can imagine—he'd go broke." (As it happens, the American Hospital Association did not return a request for comment.) The reason other countries have functional single-payer systems and we don't, he says, is that they created them decades ago. Strict government controls have kept their health-care costs low since then, while we've allowed generous private insurance plans to drive up our health-care costs. The United Kingdom can insure everyone for relatively cheap because British providers just don't charge as much for drugs and procedures. Laszewski compares trying to rein in health-care costs by dramatically cutting payment rates to seeing a truck going 75 miles an hour suddenly slam on the brakes. The first 10 to 20 years after single payer, he predicts, "would be ugly as hell." Hospitals would shut down, and waits for major procedures would extend from a few weeks to several months. Craig Garthwaite, a professor at the Kellogg School of Management at Northwestern University, says "we would see a degradation in the customer-service side of health care." People might have to wait longer to see a specialist, for example. He describes the luxurious-sounding hospital where his kids were born, a beautiful place with art in the lobby and private rooms. "That's not what a single-payer hospital is going to look like," he said. "But I think my kid could have been just as healthily born without wood paneling, probably." He cautions people to think about both the costs and benefits of single payer; it's not a panacea. "There aren't going to be free $100 bills on the sidewalk if we move to single payer," he said. He also predicts that, if single payer did bring drug costs down, there might be less venture-capital money chasing drug development, which might mean fewer blockbuster cures down the line. And yes, he added, "you would lose some hospitals for sure." Amitabh Chandra, the director of health-policy research at Harvard University, doesn't think it would be so bad if hospitals shut down—as long as they're little-used, underperforming hospitals. Things like telemedicine or ambulatory surgical centers might replace hospital stays, he suspects. And longer waits might not, from an economist's perspective, be the worst thing, either. That would be a way of rationing care, and we're going to desperately need some sort of rationing. Otherwise "Medicare for all" would be very expensive and would probably necessitate a large tax increase. (A few years ago, Vermont's plan for single payer fell apart because it was too costly.) If the United States decided not to go that route, Chandra says, we would be looking at something more like "Medicaid for all." Medicaid, the health-insurance program for the poor, is a much leaner program than Medicare. Not all doctors take it, and it limits the drugs and treatments its beneficiaries can get. This could work, in Chandra's view, but many Americans would find it stingy compared to their employers' ultra-luxe PPO plans. "Americans would say, 'I like my super-generous, employer-provided insurance. Why did you take

it away from me?'" he said. Indeed, that's the real hurdle to setting up single payer, says Tim Jost, emeritus professor at the Washington and Lee University School of Law. Between "80 to 85 percent of Americans are already covered by health insurance, and most of them are happy with what they've got." It's true that single payer would help extend coverage to those who are currently uninsured. But policy makers could already do that by simply expanding Medicaid or providing larger subsidies to low-income Americans. Under single payer, employers would stop covering part of their employees' insurance premiums, as they do now, and people would likely see their taxes rise. "As people started to see it, **they would get scared**," Jost said. And that's before you factor in how negatively Republican groups would likely paint single payer in TV ads and Congressional hearings. (Remember death panels?) It would just be a very hard sell to the American public. "As someone who is very supportive of the Democratic party," Jost said, "I hope the Democrats don't decide to jump off the cliff of embracing single payer."

The bill would end the insurance industry, that would put half a million people out of work overnight

Hartwig 2015 - immediate past president of the Insurance Information Institute
Robert P, "Insurance Industry Employment Trends: 1990-2015 (June 2015)," Aug 12, www.iii.org/presentation/insurance-industry-employment-trends-1990-2015-june-2015-081215

The health carrier segment has been gaining jobs quite steadily for decades. In June 2015 vs. June 2014 it rose sharply (up 26,100, or 5.3 percent) to 517,100 [five-hundred-and-seventeen-thousand and one-hundred]. At least some of this growth is undoubtedly connected with the flood of health insurance applications, purchases, and claims attributable to the Affordable Care Act (ACA), and some to population growth, but it is important to acknowledge that this rate of growth has been characteristic of this sector for decades—long before the ACA was proposed.

As taxes sky-rocket, 11.6 million people lose their jobs

Feyman 2016 - Fellow and deputy director of health policy with the Manhattan Institute
Yevegeniy, "The Single-Payer Sacrifice: 11.6 Million Jobs," Feb 11,
www.realclearpolicy.com/blog/2016/02/11/single-payer_sacrifice_116_million_jobs_1551.html

Democratic candidate Bernie Sanders recently released his health-care plan: a government-run single-payer system for the U.S., similar to what many European countries have. Criticism of the plan has so far focused on its lack of political feasibility, but there is an even more important reason to be wary: Accounting for costs and tax increases, it would reduce labor supply by 11.6 million. In a struggling economy, with tepid wage growth, hurting employment should be the last thing on any politician's agenda. The plan truly promises everything under the sun. Not only will everyone be able to get any medical treatment needed — with no cost at the point of service — but the plan won't require a terribly high tax increase. The funding mechanism boils down to an increase in payroll taxes: an "income-based premium" of 2.2 percent for individuals and a tax of 6.2 percent on employers. Because economists, as well as the non-partisan Congressional Budget Office and the Joint Committee on Taxation, recognize that the "employer share" of payroll taxes is mostly borne by workers in the form of lower wages, this translates to an 8.4 percentage point increase overall. These elements of the plan were the first to draw criticism. Not only do most single-payer countries fund their health-care systems with higher taxes on the middle class, but they also typically exclude a variety of services and drugs from coverage. Without being able to say no to some expensive drugs and services, the government would have a tough time driving down prices. But perhaps the most stinging rebuke came from veteran health economist Kenneth Thorpe of Emory University. In Thorpe's estimation, Sanders' plan would require a total tax hike of 20 percentage points, and would cost $1.1 trillion more each year than the campaign has estimated. This is at least partly because the government would have to pay more than Medicare's low rates to keep doctors and hospitals in the system, and making health care free at the point of delivery would also increase use of health-care services. These criticisms alone should make Sanders' plan a nonstarter. But that's not the end of the laundry list of problems with the proposal. Few economists would dispute that tax rates can affect people's decision to work. The higher a person's marginal tax rate, the bigger the disincentive to work more; a 50 percent rate, for instance, means that earning another dollar nets only an extra 50 cents. This is what economists call the "substitution" effect. But there is a countervailing effect as well. As you pay more in taxes, you may want to try to maintain your previous standard of living, and thus decide to work more. This is called the "income effect." The ultimate effect of taxes on the workforce depends on which of these forces is stronger. The CBO, for instance, has come to the conclusion that the Affordable Care Act's combination of taxes, tax credits, and mandates will reduce full-time equivalent employment (one full-time equivalent employee works 40 hours per week; two part-time workers equal one full-time equivalent) by about 2 million in 2025. As it turns out, the ACA's many taxes are relatively insignificant compared with those in the Sanders plan. Applying the CBO's approach and assumptions, along with tax data from the National Bureau of Economic Research, to the Sanders plan indicates that the campaign's assumed taxes would reduce employment by 4.9 million full-time equivalent workers in 2025. Not an insignificant number. When we take Thorpe's more realistic assumptions and apply the same approach, the fully-implemented plan reduces employment by a

whopping 11.6 million full-time equivalent workers. Under these assumptions, the average marginal tax rate would grow from around 22 percent to 42 percent, while the average total tax rate would increase from 11 percent to 31 percent. At the upper end of income, total tax rates would be far beyond 50 percent. And none of this factors in state and local taxes. Of course, some of drop in employment might be considered “voluntary.” Some would stop working because they no longer needed to be employed to receive health insurance — escaping "job lock," as House Minority Leader Nancy Pelosi once put it. But others would simply find it meaningless to put in extra hours or look for more lucrative positions when so much of their earnings get sucked away as taxes.

Single payer tax hikes decimate the U.S. economy

Pipes 16 (Sally C. - president and chief executive officer of the Pacific Research Institute, “The Ugly Reality of Single-Payer,” 1/21/16, https://www.usnews.com/debate-club/is-single-payer-health-care-a-good-idea/the-ugly-reality-of-single-payer)

Late Sunday night, just hours before the fourth Democratic presidential debate, Vermont Sen. Bernie Sanders unveiled what's probably the purest expression to date of his unreconstructed 1970s radicalism: a plan for "universal" single-payer health care in the United States. Proudly titled "Medicare-for-All," the Sanders scheme would eliminate the private insurance industry and establish a single, federally run insurance pool open to all. Sanders promises a healthcare utopia – a future of "no more co-pays, no more deductibles and no more fighting with insurance companies." During Sunday's debate, the candidate claimed that his health care plan would "save the average middle-class family thousands of dollars a year." This is complete nonsense. **Every other single-payer system around the world delivers subpar care at astronomical cost.** Worse still, **the multitrillion-dollar tax hikes** – that's "trillion," with a "t" – that Sanders has **proposed to finance his single-payer monstrosity would decimate the American economy.** Voters in need of a definitive reason to dismiss Vermont's "democratic socialist" as a legitimate candidate now have one. [SEE: Political Cartoons on Obamacare] Sanders's "Medicare-for-All" proposal would require $14 trillion in new public spending over the next decade and would expand the size of the federal government by over 50 percent. He plans to cover those costs by ratcheting up taxes on virtually everyone. He wants to hike income tax rates by 2.2 percentage points and levy a new 6.2 percent payroll tax on employers. He'd also dramatically crank up income tax rates for families making over $250,000 year. And he'd set the estate tax at 65 percent. **These new taxes would slow our economy to a halt. They'd rob businesses of capital to invest in expansion and job creation. The returns on entrepreneurship would dwindle. Corporations would direct investments to friendlier environs abroad.** Sanders ought to be intimately familiar with the eye-popping costs of single-payer. They just prevented leaders in his home state from implementing a single-payer scheme within their borders. Four years ago, the Vermont legislature approved a plan to create a state-level single-payer system with basically all the features of Sanders's "Medicare-for-All." But last month, Gov. Peter Shumlin announced that he'd be killing the project, specifically because the requisite tax increases on individual earners and businesses "might hurt our economy." The Sanders "Medicare-for-All" plan is specific about how much lucre it'll extract from the American public, but short on the details about how it would actually be administered. How will physicians' compensation be determined? Who will they work for? For those that refuse to leave private employment, what will the punishment be? Who will own hospitals? The list of unanswered questions goes on and on. Sanders and his ilk are pushing for single-payer in the United States in large part because they admire socialized health care systems in other countries like the United Kingdom and Canada. In their romanticized view, single-payer is more efficient, more egalitarian, more humane and less costly. [SEE: Editorial Cartoons on the 2016 Presidential Elections] But the facts don't fit that portrayal. Single-payer systems typically use price controls to control the cost of health care goods and services. Those price controls cause the purveyors of health care goods and services to limit the supply that they'll deliver. Limited supply meets unlimited patient demand – after all, health care appears "free" – and shortages result. There isn't enough equipment. There aren't enough doctors. And patients, while technically insured, have to endure long wait times before they actually receive care. Take the United Kingdom. Over 3.4 million British patients are currently stuck on waiting lists for care, the biggest total in nearly a decade. That includes 6,100 that have been forced to wait for at least a year. Those waiting lists have consequences. According to one major study, some 13,000 Brits died unnecessarily while in government hospitals between 2005 and 2012. Researchers unearthed systemic abuse and negligence. Sick patients were left to waste away in soiled beds without food or water In Canada, over 40 percent of patients have been forced to wait two months or more to see a specialist. In rural provinces, the problem is even worse. A recent report found that 90 percent of spine surgery patients in Alberta have had to wait at least six months to get treated. This is the ugly reality of single payer. And it's what Sanders would bring to America if he becomes president

Government control of the health market ensures premium skyrocketing---guts coverage.

Patton 15. (Mike Patton, Economy contributor to Forbes. U.S. Health Care Costs Rise Faster Than Inflation. June 29, 2015. https://www.forbes.com/sites/mikepatton/2015/06/29/u-s-health-care-costs-rise-faster-than-inflation/#c644b936fa10)

One of the promises of Obamacare was that it would reduce health care costs. Since its passage on March 23, 2010, has this promise been kept? In this article, we'll examine this issue by looking at the annual rate of inflation for the Consumer Price Index, compared to the inflation rate for health care. What Causes Health Care Inflation? Generally speaking, prices rise when demand increases relative to supply. Health care is no different. However, there are other forces that influence the cost of health care. **One would be political decisions such as additional taxes and increased regulations can impact health care costs.** An increase in lawsuits which influence the cost of malpractice insurance for medical practitioners are another factor. For several years during the 2000s, health care costs were rising rapidly, causing concern among patients and insurance companies. According to the November 2013 issue of the Journal of the American Medical Association (JAMA), the primary reason for the rise in health care costs between 2000 and 2011 accounting for 91%, was an increase in the price of drugs, medical devices, and hospital care. Since medical devices were one of the primary contributors to the rise in health care inflation, should Congress have eliminated the 2.3% medical device tax contained in the Affordable Care Act? This tax will be passed on to consumers and insurance companies, causing the price of medical devices to rise further. Rising health care inflation prompts insurance companies to raise premiums. The following chart shows the percentage increase in overall inflation as measured by the consumer price index (all items) and health care inflation from 2005 through May 31, 2015. As you can see, health care inflation has outpaced the CPI in each year except 2008. Moreover, in 2007, 2009, 2010, 2014, and thus far in 2015, the difference is quite significant. It seems that **over-regulation, excessive taxation, and a few additional issues are the root of this problem**. What can be done to reduce health care costs? Health care, like any other industry, **needs competition** to push prices lower. Unfortunately, **because each policy must cover the 10 essential health benefits, insurance companies have no latitude to create innovative, customized policies.** It reminds me of the original Model-T Ford. You could buy a Model-T in any color you desired, as long as it was black. In my next article, we'll examine the rising cost of health insurance premiums and compare this to personal income. If premiums increase at a faster rate than income, the consumer suffers. This is one article you won't want to miss!

Single-payer decks manufacturing

Goodman et al 4 – *libertarian economist, founding chief executive of the free-market thinktank the National Center for Policy Analysis, **President of Economics America, and ***health economist and senior fellow with the National Center for Policy Analysis [John C. Goodman*, Devon M. Herrick**, and Gerald L. Musgrave***, 2004, Chapter 14: International Competitivene, Lives at Risk: Single-Payer National Health Insurance Around the World, Google Books]

MYTH NO. 14: A SINGLE-PAYER NATIONAL HEALTH CARE SYSTEM WOULD IMPROVE U.S. COMPETITIVENESS IN INTERNATIONAL MARKETS AND BENEFIT AMERICAN WORKERS

Nearly two-thirds of Americans receive health care coverage through their employer. Some critics argue that the high health care costs borne by employers make U.S. products less competitive in the international marketplace and therefore harm American workers.1 They assert that the cost of employerprovided health insurance adds to the price of American products, whereas a single-payer system would make American manufacturers more competitive by relieving employers of those costs. However, these **assertions are wrong**. There is **no evidence** that the cost of private health insurance adds anything to the price of goods and services sold in the marketplace.2 Health insurance is simply one element in a workers'total compensation package. It is a nontaxable fringe benefit provided to workers in lieu of money wages. Benefits for most American workers have grown from less than 19 percent of payroll in 1951 to nearly 39 percent today.3 This reflects the fact that workers, faced with taxes on wage income, have increasingly preferred to receive a larger portion of their compensation in the form of nontaxed benefits.4 However, workers' total compensation depends on what they produce, not what they consume. The fact that Americans spend a greater proportion of their income on health care and a smaller proportion on other goods and services does not put us at a competitive disadvantage relative to other countries.5 The same principle applies to other countries. For example, the Japanese spend a greater proportion of their income on food, but that doesn't mean that food consumption adds to the price of a Japanese car. Canadians spend a greater proportion of their income on education, but that doesn't mean that education adds to the price of Canadian lumber. These international differences merely reflect consumer preferences and consumer product prices. A single-payer health insurance system, however, would **reduce our international competitiveness**. Consider the impact such systems have already had on the competitiveness of European countries. Taxes are a higher percentage of national income in all of these countries than in the United States, and health expenditures are a higher proportion of government budgets. High tax burdens are associated with **lower rates of economic growth**, **job creation** and **income**. Thus, national health insurance has contributed to **high unemployment** and **increasing labor costs** in Europe. Health insurance benefits voluntarily provided by employers do not raise their labor costs. But when employers are required to pay the government for each worker they employ at a rate that bears no relation to the cost of health care consumed by those employees or the value of their work, it **raises an employer's labor costs.** For example, Germany's sickness insurance funds are financed by compulsory contributions of 13.5 percent of payroll, shared equally by employers and employees.6 In France, health care is financed by a payroll tax of 12.8 percent on employers and 0.75 percent on employees; additionally, employees pay 7.5 percent of all income (including interest, dividends and other earnings) as a general social contribution, most of which goes to health insurance. Many also contribute an additional 2.5 percent to insurers for a total cost of more than 20 percent of payroll for heath care.7 Not only would a single-payer health insurance system require additional taxes on American industries, it would also **redistribute income** among producers in different industries. On the whole, a single-payer health insurance system would impose **extra taxes on U.S. exporting industries** and use the proceeds of those taxes to **subsidize** other industries. The industries

that would receive subsidies contribute mostly to domestic rather than international markets. The industries that would be penalized are the **manufacturers that provide most of our exports**.8 Almost a quarter of the federal budget goes to defense spending, whereas our trading partners spend far less. Yet, taxes are lower in the United States than in most other developed countries. As figure 14.1 shows, only Japan currently has a tax burden as low as ours.9 Moreover, the United States regularly ranks as the most economically competitive nation in the world.10 Evidently, the lack of single-payer health care has not harmed its ability to compete.

Single-payer causes supply gaps, reduced quality of treatment and crowds-out *newly developing models* that reduce costs

Seegert 16 (Liz, senior fellow at the Center for Health, Media & Policy at Hunter College in New York City, "What Single-Payer Healthcare would mean for Doctors," May 25th, Medical Economics, online)

Michael D. Tanner, senior fellow at the libertarian-leaning Cato Institute, has argued that in nations with universal healthcare, "attempts to control costs through governmental fiat have led to problems with access to care, either **delays** in receiving care or outright **rationing**." He advocates more competition among insurers and providers within a free market system to generate cost savings.

He has warned previously that an unlimited single payer model could bankrupt the country.

Political, not medical, decisions will drive healthcare should single payer come to pass, predicts Robert E. Moffit, PhD., senior fellow at the conservative Heritage Foundation's Center for Health Policy Studies. When unlimited demand collides with limited supply, "government officials will determine who, and under what circumstances, patients receive care," he says.

Basic economics dictates that the government cannot control demand, but it can control supply through a global budget or price controls on services. Under that scenario **supply does not keep up with rising demand**. At best, Moffit says, quality of care suffers. At worst, there will be unnecessary deaths. "And let's not even get started on how it will further intrude on doctor-patient relationships," he says.

Moffit points to **overcrowded hospitals**, long **waiting lists** for simple procedures and **poor quality** of care under Britain's **N**ational **H**ealth **S**ervice as examples of what can happen when healthcare becomes an unlimited entitlement. As for reduced paperwork, "CMS issues tens of thousands of pages of rules and edicts. The idea that physicians could escape paperwork is fantasy' Increased demand, combined with reduced access will fuel more dissatisfaction among patients. That, in turn, could lead to **more complaints** and **malpractice claims**, Kominski says. He's also concerned about the overall impact on patients' health. Sanders' plan in particular lacks detail about what will happen to value-based care or patient-centered care—models that CMS is promoting to improve outcomes and keep patients healthier.

"I don't want to see those advances **thrown out the window** because we have a single payer system and are basically saying you can go to any doctor or hospital you want," Kominski says.