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

# Pro

#### We stand in affirmation of the following:

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

### Definitions

#### The Medicare-For-All Act of 2019

Pramuk 19

Jacob Pramuk (Staff reporter at CNBC), CNBC, "Democrat Pramila Jayapal introduces Medicare-for-all health care bill", 2/27/19, <https://www.cnbc.com/2019/02/27/democrat-pramila-jayapal-introduces-medicare-for-all-health-care-bill.html> -CD

House Democrats introduced a plan Wednesday to insure all Americans through Medicare, as the push for a sweeping shift to universal health coverage gains more traction ahead of pivotal elections next year. The “Medicare-for-all” proposal, introduced by Rep. Pramila Jayapal, D-Wash., will face backlash from critics who have warned about its potentially enormous cost — and Republicans who aim to cast Democrats as radicals drifting toward socialism. Here’s what Jayapal’s legislation would do: It would create a single-payer, government-funded health-care program within two years, eliminating the age 65 threshold for Medicare eligibility. It would not charge beneficiaries copays, premiums or deductibles. The plan would cover prescription drugs, vision, dental, mental health, substance abuse and maternal care. It would also provide universal coverage for long-term care for people with disabilities.

### Framework

#### Cost benefit analysis

The framing for today’s round ought to be cost benefit analysis. If we demonstrate that the Medicare-For-All Act of 2019 would do more good than harm, we should win the round.

### Contention 1: Universal Coverage

#### Tens of millions of Americans are un or under insured

Galvin 19

Gaby Galvin (Gaby Galvin is a staff writer at U.S. News & World Report, covering public health issues for the Healthiest Communities section.), US News, "Lack of Health Insurance Coverage Leads People to Avoid Seeking Care | Healthiest Communities", 2/7/19, https://www.usnews.com/news/healthiest-communities/articles/2019-02-07/lack-of-health-insurance-coverage-leads-people-to-avoid-seeking-care -CD

MORE AMERICANS ARE insured than in the past, but millions are enrolled in skimpy health plans that often keep them from seeking care, according to a new report from The Commonwealth Fund. Researchers estimate that in 2018, 45 percent of working-age adults, or 87 million people, were either underinsured or had no coverage for at least part of the last year – a share that is essentially unchanged from 2010, despite monumental shifts in health policy during that time. The Affordable Care Act, which was enacted in 2010 and saw key provisions put in effect in 2014, expanded Medicaid eligibility and subsidized coverage for millions of Americans who were low-income or didn't have access to health insurance through their employers, but largely left employer-based coverage alone. Nearly 20 million people gained access to health coverage as a result. RELATED CONTENT Number of Uninsured Rises Yet the country also is now grappling with a larger pool of people who are underinsured – meaning they have health coverage, but also have high out-of-pocket health care costs relative to their incomes and are more likely to put off care or struggle to pay medical expenses, according to the report. "U.S. working-age adults are significantly more likely to have health insurance since the ACA became law in 2010," Sara Collins, lead author of the study and The Commonwealth Fund's vice president for health care coverage and access, said in a statement. "But the improvement in uninsured rates has stalled (and) more people have health plans that fail to adequately protect them from health care costs." More than half of adults under age 65 are insured through their jobs, while about a quarter are enrolled in Medicaid or have insurance through the individual market, the report said. Among those with health coverage, 29 percent said they were underinsured in 2018, up from 23 percent in 2014, the survey found. In 2018, 41 percent of underinsured adults said they had delayed care and 47 percent said they had trouble paying their medical bills. Among those with adequate health coverage, meanwhile, 23 percent said they had put off care, while 25 percent said they had problems with medical expenses. "Inadequate insurance coverage leaves people exposed to high health care costs, and these expenses can quickly turn into medical debt," the report said. The increase in Americans with leaner health coverage has largely been driven by employer-based plans, not the ACA's individual marketplaces, The Commonwealth Fund found. As health care costs have risen, employers have asked workers to shoulder some of the burden by offering plans with higher deductibles or requiring them to pay a larger share of premiums. About 42 percent of people with individual health coverage said they were underinsured in 2018, compared with 28 percent of those with job-based coverage, the report found. Yet from 2010 to 2018, the greatest growth in the underinsured rate was among adults with employer-based plans. The findings indicate efforts to get people onto job-based plans aren't enough to get them access to care, and that policymakers should address the "relatively quick erosion of employer coverage and its impact on workers," Dr. David Blumenthal, president of the Commonwealth Fund, said in a statement. Coverage gaps due to reasons like job loss also affect people's ability to access care, even if these lapses are temporary. While coverage gaps tend to be shorter now than before the ACA, adults with continuous health insurance were more likely to get their recommended primary care and cancer screenings than those with gaps in coverage, the survey found, even if they were underinsured. That's due in part because the ACA requires insurers and employers to cover these services without cost-sharing, the report notes.

#### Of those, millions more cannot get access to sufficient insurance in the current health insurance landscape because of preexisting conditions

Shure 18

Natalie Shure (Natalie Shure is a TV producer and writer whose work has appeared in the Atlantic, Slate, Pacific Standard, and elsewhere.), Jacobin, "A Health System That Punishes the Sick", Nov 2018, https://www.jacobinmag.com/2018/11/preexisting-conditions-medicare-for-all-obamacare -CD

Before the ACA, the landscape for Americans with preexisting conditions was undeniably grim. For-profit insurers could refuse to sell insurance plans to individuals with pricy health needs (or charge exorbitant rates), offer coverage that carved out exceptions for certain types of care, and impose lifetime caps on what they’d pay out for a given person’s treatment. The result was that people with a history of illness encountered extraordinary challenges getting the care they needed: those who weren’t rejected as clients outright were bilked outrageously, or stuck with junk insurance plans that didn’t actually cover anything important. The ACA famously introduced several measures to alleviate these problems: a “guaranteed issue” rule requiring insurers to sell plans to anyone who wanted them, premiums that could only take into account age and smoking status, and plans that had to cover a minimum of “ten essential health benefits” with no lifetime caps. And yet, since the ACA’s implementation, the health insurance industry has still placed ever-increasing financial and administrative responsibility onto individual patients. Over 40 percent of Americans with private insurance have high deductibles, frequently exceeding what the average household has in liquid assets. This year, the maximum out-of-pocket expense for individual ACA marketplace policyholders is over $7,000 for in-network care — an eye-popping sum by any measure, but especially so when you consider the rise of surprise out-of-network bills. Medical debt, the avoidance of necessary treatment because of costs, and medicine rationing all remain quite high, even after the ACA. All of these amount to a tax on the sick, because they naturally fall on the shoulders of those with the most frequent encounters with the healthcare system: people with preexisting conditions. Cost-sharing in health insurance — shifting the price of care onto patients themselves, on the basis of use — has the gravest impact on sick people, by definition. That so many Americans feel defensive of people with preexisting conditions is laudable. But this immoral situation won’t be solved by tinkering with the current market-based system, which individualizes the responsibility for health. Until we all bear the costs of health care according to our ability to pay, rather than our bodies’ relative need for it, people with preexisting conditions will still be made to suffer more than those lucky enough to have perfect health. The only solution is a universal, public, Medicare-for-All systeam. Until then, we’re preserving a system that profits from harming people with preexisting conditions — we’re just squabbling over how much.

#### The COVID-19 pandemic is causing new coverage crisis

Chokshi & Murthy 20

Dave Chokshi (Dave A. Chokshi is a physician at Bellevue Hospital, clinical associate professor at the NYU School of Medicine and the Gould Visiting Scholar at the United Hospital Fund.), Vivek Murthy (Vivek H. Murthy served as surgeon general of the United States), USA Today, "Deaths caused by COVID-19 go beyond the virus, lack of health care contributes", 7/2/20, https://www.usatoday.com/story/opinion/2020/07/02/deaths-caused-covid-19-virus-lack-health-care-column/5356887002/ -CD

The dangers of lacking health care Delayed and foregone care, as in this patient’s case, contribute to suffering beyond the direct effects of COVID-19. Screening for cervical, colon and breast cancer were down between 86% and 94% in May, compared to the prior three years. Beyond cancer, immunizations for children have dropped precipitously, raising the specter of outbreaks of measles and other vaccine-preventable diseases. Kaiser Permanente reported a decline of almost half of patients with heart attacks who would have been expected to present to their hospitals during springtime. Emergency room in New York City. Why is this happening? Certainly, some patients are fearful of the risk of COVID-19 associated with visiting hospitals and clinics. But COVID-19 has also unmasked pre-existing barriers in accessing care. The 28 million Americans who were uninsured before the pandemic often face a wrenching choice between paying for care or paying for other basic needs, like food or rent. Another 25 million people have lost their employer-sponsored health insurance due to the economic recession, according to the Urban Institute. As the economy reopens, patients like ours will feel pressure to go back to work just to maintain their health coverage — even, and perhaps especially, if they are ill. The number of COVID-19 deaths recently surpassed the 116,516 Americans who died during World War I. Evidence published yesterday in JAMA suggests that 1 in 3 “excess deaths” — number of deaths above expected baseline levels — nationally could not be attributed to COVID-19. We know from other crises that deferred care compounds suffering. For example, after Hurricane Maria hit Puerto Rico, the leading cause of death was interrupted access to care.

#### The Medicare for All Act of 2019 provides universal coverage which sufficiently protects those tens of millions

Robertson 19

Lori Robertson (Managing Editor for FactCheck.org), FactCheck.org, The Annenberg Public Policy Center, "The Facts on Medicare for All", April 24, 2019, https://www.factcheck.org/2019/04/the-facts-on-medicare-for-all/ -CD

As the name indicates, the plan would expand Medicare, which now covers primarily those age 65 and older and some with disabilities, to everyone, creating a new universal, single-payer health care system in the United States. The country would move from a fragmented system — in which nearly half the population has employer-sponsored, private insurance with the rest a mix of Medicaid, Children’s Health Insurance Program, Medicare, private individual market coverage and no insurance at all — to a system in which everyone’s insurer is Medicare. Or nearly everyone. Under the plan, the Veterans Health Administration and Indian Health Service would remain. What health care services would be covered? The new “universal Medicare program,” as the bill calls it would cover: hospital inpatient and outpatient services, ambulatory services, primary and preventive care, prescription drugs and medical devices, mental health and substance abuse treatment, lab and diagnostic services, reproductive and maternity, newborn care and pediatrics, dental/hearing/vision services, short-term rehab, emergency care, transportation for low-income and disabled individuals to receive these services, and home and community-based long-term care. The bill would eliminate the Hyde amendment, which now restricts federal funding of abortion to only cases of rape, incest or endangerment to the mother’s life. The secretary of the Department of Health and Human Services could change or expand the benefits. Current Medicare benefits would be expanded, since they don’t include dental, hearing or vision coverage now. Also, Sanders’ bill calls for virtually no out-of-pocket costs at the point of service for these benefits. There would be no copays, deductibles or premiums, with the exception of prescription drugs and biologics (such as vaccines and gene therapy), which could carry copays totaling no more than $200 a year per person, indexed for inflation.

### Contention 2: Lack of healthcare leads to financial ruin

#### The vast majority of bankruptcies do so out of medical bills

Konish 19

Lorie Konish (Lorie Konish is a reporter covering personal finance at CNBC.), CNBC, "This is the real reason most Americans file for bankruptcy", 2/11/19, https://www.cnbc.com/2019/02/11/this-is-the-real-reason-most-americans-file-for-bankruptcy.html -CD

Two-thirds of people who file for bankruptcy cite medical issues as a key contributor to their financial downfall. While the high cost of health care has historically been a trigger for bankruptcy filings, the research shows that the implementation of the Affordable Care Act has not improved things. What most people do not realize, according to one researcher, is that their health insurance may not be enough to protect them. Filing for bankruptcy is often considered a worst-case scenario. And for many Americans who do pursue that last-ditch effort to rescue their finances, it is because of one reason: health-care costs. A new study from academic researchers found that 66.5 percent of all bankruptcies were tied to medical issues —either because of high costs for care or time out of work. An estimated 530,000 families turn to bankruptcy each year because of medical issues and bills, the research found. Other reasons include unaffordable mortgages or foreclosure, at 45 percent; followed by spending or living beyond one’s means, 44.4 percent; providing help to friends or relatives, 28.4 percent; student loans, 25.4 percent; or divorce or separation, 24.4 percent. While the findings are consistent with past studies on bankruptcy, the data also highlight a key new factor: whether the Affordable Care Act has reduced the burden of medical debt for people. “Despite gains in coverage and access to care from the ACA, our findings suggest that it did not change the proportion of bankruptcies with medical causes,” an article on the study published in the American Journal of Public Health states. The number of debtors who cited medical issues as a contributing reason for their bankruptcy actually increased slightly after the law’s implementation — 67.5 percent in the three years following the law’s adoption versus 65.5 percent prior. The culprit for the lack of improvement was inadequate health-care insurance, according to a co-author of the research, Dr. David U. Himmelstein, a distinguished professor at Hunter College and founder of advocacy group Physicians for a National Health Program. “Unless you’re Jeff Bezos, people don’t have very good alternatives, because the insurance that is available and affordable to people, or that most people’s employers provide them, is not adequate protection if you’re sick,” Himmelstein said. Most families do not have enough saved for a simple emergency, let alone thousands of dollars in unexpected medical costs. A recent study from personal finance website Bankrate found that only 40 percent of Americans have enough saved to cover a $1,000 emergency expense. To help combat this problem, Physicians for a National Health Program is advocating for a national Medicare for All program that would broaden insurance coverage for Americans.

### Contention 3: Lack of healthcare is deadly

#### Various studies conclude that tens of thousands of Americans die each year from a lack of insurance

Chalabi 17

Mona Chalabi (Mona Chalabi is data editor at Guardian US.), The Guardian, "Will losing health insurance mean more US deaths? Experts say yes | US healthcare | The Guardian", 7/24/17, https://www.theguardian.com/us-news/2017/jun/24/us-healthcare-republican-bill-no-coverage-death -CD

Various studies have looked at whether uninsured people have a higher risk of death. The most cited was published by the American Journal of Public Health in 2009 and found that nearly 45,000 Americans die each year as a direct result of being uninsured. Dr Andrew Wilper and a team at Harvard Medical School used two main datasets: they took a nationwide US survey of more than 30,000 people conducted by the Centers for Disease Control and Prevention (CDC) and checked it against the National Death Index, another national database collected by the CDC. The two sets of numbers allowed the researchers to examine something called hazard ratios, which are a way to measure risk. For example, if a clinical trial finds that drug users are three times more likely experience a certain side effect, that drug has a hazard ratio of three. In America, deep inequality can affect the usefulness of data like this. Lots of things can increase an American’s chances of being sick – being a person of color or being poor to name just two – and if those factors overlap with a lack of health insurance, it can be difficult to determine what exactly is affecting an individual’s risk of death. In the Harvard study, the researchers had 9,000 people in their dataset – enough that they were able to ensure they were really measuring the impact of a lack of health insurance. The researchers found that a lack of health insurance had a mortality hazard ratio of 1.40. In other words, they concluded that Americans without health insurance were 40% more likely to die than those with it, even after taking into account the individual’s “gender, age, race/ethnicity, poverty income ratio, education, unemployment, smoking, regular alcohol use, self-rated health, physician-rated health and body mass index”. The researchers calculated that in 2005, lack of health insurance resulted in 44,789 deaths of Americans age 18 to 64. Criticism Those who have sought to repeal the ACA have rejected this connection between health insurance and health. However many of them, such as Republican Raul Labrador when he spoke at a town hall event last month, have seemed unable to cite evidence in support of their position. There is scant evidence directly against the connection between mortality and health insurance. But that does not mean that studies such as the one published in 2012 are without flaws. For one thing, the numbers do not necessarily match up. A 2002 study published by the Institute of Medicine found that 18,000 people died each year due to lack of health insurance. A study published by the Urban Institute put the figure at 22,000 deaths in 2006. But while estimates disagree, the researchers who produce them often do not. In a 2013 Politifact interview, the author of the Urban Institute study, Stan Dorn, said: “It makes sense that as time goes by … health insurance coverage has greater impact on health outcomes.” The specific numbers might be hard to agree upon, and even harder to forecast if the Republican bill is passed. But the link is clear: a lack of health insurance could increase the risk of death for millions of Americans.

### Extra Cards

#### M4A wouldn’t cause employment crisis

Rosenthal 19

Elisabeth Rosenthal (Elisabeth Rosenthal worked as an emergency room physician before becoming a journalist. A former New York Times correspondent, she is the author of “An American Sickness: How Healthcare Became Big Business and How You Can Take It Back” and the editor in chief of Kaiser Health News.), NYT Opinion, "Opinion | ‘Medicare for All’ Could Kill Two Million Jobs, and That’s O.K. - The New York Times", 5/16/19, https://www.nytimes.com/2019/05/16/opinion/medicare-for-all-jobs.html -CD

Of course, if more people get health insurance under an expanded Medicare, there will be a greater need for some workers — like nurse practitioners and physician assistants. And there is a large unmet labor need in caring for an aging population. The latter are mostly low-wage jobs, however, and neither compensates for the losses. Dr. Pollin suggests that a transition to Medicare for all should be accompanied by a plan to give those made redundant up to three years of salary and help retraining for another profession. Despite the short-term suffering caused by any fundamental shift in our health care delivery system, reform would ultimately redirect resources in ways that are good for the economy, many experts say. “I’m sympathetic to the impact that changes will have on specific markets and employment — we can measure that,” Dr. Schulman said. “What we can’t quantify is the effect that high health care costs have had on non-health care industries.” The expense of paying for employees’ health care has depressed wages and entrepreneurship, he said. He described a textile manufacturer that moved more than 1,000 jobs out of the country because it couldn’t afford to pay for insurance for its workers. Such decisions have become common in recent years. “Yes, these are painful transitions,” said Dr. Baicker, who is now the dean of the University of Chicago’s Harris School of Public Policy. “But the answer is not to freeze the sectors where we are for all time. When agriculture improved and became more productive, no one said everyone had to stay farmers.”

#### M4A would significantly reduce national healthcare spending

Lazarus 20

David Lazarus, Los Angeles Times, "Column: $32 trillion for 'Medicare for all'? It's a bargain", 2/14/20, https://www.latimes.com/business/story/2020-02-14/medicare-for-all-cost -CD

More than a third of Democratic voters who turned out for New Hampshire’s first-in-the-nation primary this week said healthcare was the most important issue in this presidential election. Even Republicans say healthcare is one of their most pressing concerns, according to a recent Gallup poll. Yet critics of Medicare for all say the idea is a non-starter because of its astronomical cost. They cite a study published last year showing that if Vermont Sen. Bernie Sanders’ proposal for a comprehensive single-payer system were enacted, it would cost about $32 trillion in new federal revenue over 10 years. Thirty-two trillion! Many Americans couldn’t even tell you how many zeroes are in a number that grotesquely huge. What Democrats have done a terrible job communicating is that we’re currently spending $3.6 trillion a year on healthcare. That translates to $36 trillion over the next decade. But the status quo is actually way worse than that. The federal government estimates that national healthcare spending will total about $48 trillion over the next 10 years as costs keep going up. By 2027, according to the Centers for Medicare and Medicaid Services, we’ll be spending about $6 trillion annually on healthcare. Total spending over the subsequent 10 years likely will reach a staggering $60 trillion — at least. That’s the cost of doing nothing. It’s what opponents of healthcare reform are saying is our best option. And that, of course, is insane. “We’ve gotten ourselves into a big hole by letting expenditures get out of hand,” said Vivian Ho, a healthcare economist at Rice University. “It’s happening right before our eyes, and we’re not doing anything about it.” The American people already spend more for healthcare than citizens of any other developed country. Again, this is a message that Democrats fail to get across. The average American represents more than $10,500 a year in healthcare spending, according to the Organization for Economic Cooperation and Development. (The U.S. government has an even higher figure: $11,172 per person.) That compares with less than $6,000 per person in Germany, less than $5,000 in France and Canada, and about $4,000 in Britain, according to OECD statistics.

#### M4A is popular

Schute 20

Gabriea Schute (Column writer for The Hill), The Hill, "Poll: 69 percent of voters support Medicare for All | TheHill", 4/24/20, https://thehill.com/hilltv/what-americas-thinking/494602-poll-69-percent-of-voters-support-medicare-for-all -CD

Support for Medicare for All has remained consistently strong over the past two years, according to a new Hill-HarrisX poll. Sixty-nine percent of registered voters in the April 19-20 survey support providing medicare to every American, just down 1 percentage point from a Oct. 19-20, 2018 poll, and within the poll's margin of error. Popularity for Medicare for All grew slightly among Democratic voters, with a 2 percentage point increase from 2018. Support among independent voters was steady at 68 percent. However, support among Republican voters declined 6 percentage points over the course of two years, from 52 percent support in 2018 to 46 percent in 2020. This is consistent with recent data from the Kaiser Family Foundation which found Republican support for a single payer system has declined over time. Progressive lawmakers have been pointing to the coronavirus crisis to make a case for the need for Medicare for All as millions of Americans are kicked off their employee-based health insurance due to the economic fallout of the pandemic. "Crises are moments of opportunity for policy change," Robert Griffin, Research Director of the Democracy Fund Voter Study Group, told Hill.TV. "But it's not a sure thing, it's not going to happen automatically. It does require leadership at the end of the day," he added. President and CEO of the Roosevelt Institute, Felicia Wong, believes support for Medicare for All will only grow amid the coronavirus crisis. "These progressive policies have been popular for a long time. I think COVID-19 will make them more popular as it becomes clear just how fragile our American political economy really is," Wong told Hill.TV.

#### Lack of insurance leads to a lack of care

Garfield, Orgera, & Damico 19

Rachel Garfield (Rachel Garfield is Vice President at the Henry J. Kaiser Family Foundation and Co-Director for its Program on Medicaid and the Uninsured.), Kendal Orgera (Kendal Orgera is a Senior Data Analyst with KFF’s Program on Medicaid and the Uninsured and State Health Facts, where she develops and carries out quantitative analyses related to Medicaid policy, health reform, and coverage for the low-income population, as well as estimates of the effects of proposed changes to Medicaid and health coverage programs for low-income individuals.), and Anthony Damico (Contributor), Kaiser Family Foundation, "The Uninsured and the ACA: A Primer – Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act – How does lack of insurance affect access to care?", 1/25/19, https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/ -CD

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected. Compared to those who have health coverage, people without health insurance are more likely to skip preventive services and report that they do not have a regular source of health care. Adults who are uninsured are over three times more likely than insured adults to say they have not had a visit about their own health to a doctor or other health professional’s office or clinic in the past 12 months.1 They are also less likely to receive recommended screening tests such as blood pressure checks, cholesterol checks, blood sugar screening, pap smear or mammogram (among women), and colon cancer screening.2 Part of the reason for poor access among the uninsured is that half do not have a regular place to go when they are sick or need medical advice, while the majority of insured people do have a regular source of care (Figure 8).3 Figure 8: Barriers to Health Care Among Nonelderly Adults by Insurance Status, 2017 Uninsured people are more likely than those with insurance to report problems getting needed medical care. One in five (20%) uninsured adults say that they went without needed care in the past year because of cost compared to 3% of adults with private coverage and 8% of adults with public coverage.4 Many uninsured people do not obtain the treatments their health care providers recommend for them. In 2017, 19% of uninsured adults said they delayed or did not get a needed prescription drug due to cost, compared to 14% with public coverage and 6% with private coverage.5 And while insured and uninsured people who are injured or newly diagnosed with a chronic condition receive similar plans for follow-up care from their doctors, people without health coverage are less likely than those with coverage to obtain all the recommended services.6,7 Because uninsured people are less likely than those with insurance to have regular outpatient care, they are more likely to have negative health consequences. Because uninsured patients are also less likely to receive necessary follow-up screenings than their insured counterparts,8 they have an increased risk of being diagnosed at later stages of diseases, including cancer, and have higher mortality rates than those with insurance.9,10,11 In addition, when uninsured people are hospitalized, they receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.12,13,14,15

#### 137 million suffering from medical financial hardship

Yabroff et al. 19

Yabroff, K.R., Zhao, J., Han, X. et al. Prevalence and Correlates of Medical Financial Hardship in the USA. J GEN INTERN MED 34, 1494–1502 (2019). https://doi.org/10.1007/s11606-019-05002-w -CD

High patient out-of-pocket (OOP) spending for medical care is associated with medical debt, distress about household finances, and forgoing medical care because of cost in the USA. Objective To examine the national prevalence of medical financial hardship domains: (1) material conditions from increased OOP expenses (e.g., medical debt), (2) psychological responses (e.g., distress), and (3) coping behaviors (e.g., forgoing care); and factors associated with financial hardship. Design and Participants We identified adults aged 18–64 years (N = 68,828) and ≥ 65 years (N = 24,614) from the 2015–2017 National Health Interview Survey. Multivariable analyses of nationally representative cross-sectional survey data were stratified by age group, 18–64 years and ≥ 65 years. Main Measures Prevalence of material, psychological, and behavioral hardship and hardship intensity. Key Results Approximately 137.1 million (95% CI 132.7–141.5) adults reported any medical financial hardship in the past year. Hardship is more common for material, psychological and behavioral domains in adults aged 18–64 years (28.9%, 46.9%, and 21.2%, respectively) than in adults aged ≥ 65 years (15.3%, 28.4%, and 12.7%, respectively; all p < .001). Lower educational attainment and more health conditions were strongly associated with hardship intensity in multivariable analyses in both age groups (p < .001). In the younger group, the uninsured were more likely to report multiple domains of hardship (52.8%), compared to those with some public (26.5%) or private insurance (23.2%) (p < .001). In the older group, individuals with Medicare only were more likely to report hardship in multiple domains (17.1%) compared to those with Medicare and public (12.1%) or Medicare and private coverage (10.1%) (p < .001). Conclusions Medical financial hardship is common in the USA, especially in adults aged 18–64 years and those without health insurance coverage. With trends towards higher patient cost-sharing and increasing health care costs, risks of hardship may increase in the future.

#### Lack of coverage kills tens of thousands per year

Blocher 12

Kate Blocher, FamiliesUSA, "Dying for Coverage: The Deadly Consequences of Being Uninsured - Families Usa", 6/20/12, https://familiesusa.org/resources/dying-for-coverage-the-deadly-consequences-of-being-uninsured/ -CD

For millions of Americans, having health coverage can be the difference between life and death. The uninsured are less likely to have a usual source of medical care, and, as a result, are more likely to forgo preventive care or delay treating an illness. Without access to preventive screenings and care, many uninsured Americans suffer premature and preventable deaths-they are literally dying for coverage. For millions of Americans having health care coverage can be the difference between life and death. The uninsured are less likely to have a source of care outside the emergency room, and as a result are more likely to forgo preventative care or delay treating an illness. Without access to preventative screenings and care, many uninsured Americans are suffering premature and preventable deaths-they are literally dying for coverage. Thankfully, the Affordable Care Act will take steps to reduce the numbers of uninsured in America. Beginning in 2014, millions of Americans will be eligible for assistance with the cost of health coverage. In addition, insurance companies will no longer be able to deny coverage or charge higher premiums for people with pre-existing conditions. However, the fate of the health care law is in question, with the Supreme Court currently considering its the constitutionality. A decision to strike down the law could have dire consequences for the millions in need of health coverage. But just how many Americans are suffering due to being uninsured? In an effort to estimate the number of Americans who are dying for lack of health coverage, Families USA applied the methodology developed by the Institute of Medicine to state-level population and mortality data to create a state-by-state analysis of deaths due to lack of health insurance. The report, Dying for Coverage: The Deadly Consequences of Being Uninsured, found the following: Across the nation, 26,100 people between the ages of 25 and 64 died prematurely due to a lack of health coverage in 2010. The five states with the most premature deaths due to uninsurance in 2010 were California, Texas, Florida, New York, and Georgia. The numbers of uninsured will continue to rise, and thousands of Americans will continue to die preventable deaths if something isn’t done to mend our broken health care system. The Affordable Care Act will do this, but only if the Supreme Court does the right thing both morally and legally, and upholds the constitutionality of the law. This report shows just how important this law is to the millions of Americans suffering from lack of health coverage-for many, it is the difference between life and death.

# Con

#### We stand in negation of the following:

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

### Definitions

#### The Medicare-For-All Act of 2019

Committee for a Responsible Federal Budget 19

Committee for a Responsible Federal Budget, "How Much Will Medicare for All Cost? ", 2/27/19, http://www.crfb.org/blogs/how-much-will-medicare-all-cost -CD

Representative Pramila Jayapal (D-WA), a co-chair of the Medicare for All Caucus, released a bill today that would adopt a single-payer system, where the federal government replaces private health insurance companies as the sole provider of most health care financing. While we are not aware of any estimates of this particular proposal, similar proposals have been estimated to cost the federal government roughly $28-32 trillion over a decade. Representative Jayapal’s Medicare for All Act would replace nearly all current insurance with a government-run single-payer plan and extend that plan to those who currently lack health coverage. The plan itself would be far more generous than either Medicare or most private coverage, as it would include no deductibles or copayments, would not restrict beneficiaries to networks of care, and would offer a broad suite of benefits including dental care, vision care, transportation for disabled and low-income patients, certain dietary and nutritional care, long-term care, and other long-term services and support. The proposal also establishes a global health budget, moves away from fee-for-service and toward lump-sum payments for many providers, includes a number of measures to hold down drug prices, and makes a variety of other changes to the health care system. The proposal is broadly similar to Senator Sanders's proposed single-payer plan introduced during the 2016 Presidential campaign. While the campaign itself estimated that plan would cost the federal government about $14 trillion over a decade, most other estimates that we are aware of are at least twice that high. At the time, for example, the Committee for a Responsible Federal Budget estimated roughly that the plan would cost $28 trillion through 2026 (we estimated the Sanders plan in particular would also raise $11 trillion of revenue, leading to $17 trillion of net costs). All other estimates come to similar conclusions.

### Framework

#### Cost benefit analysis

The framing for today’s round ought to be cost benefit analysis. If we demonstrate that the costs of the Medicare-For-All Act of 2019 outweighs its benefits, we should win the round.

### Contention 1: Burden of Cost

#### M4A would be prohibitively expensive

Bhattacharya & Ketcham 20

Jay Bhattacharya (Professor of Medicine and Senior Fellow by Courtesy at the Freeman Spogli Institute for International Studies at Stanford University. ), Jonathan Ketcham (he Earl G. and Gladys C. Davis Distinguished Research Professor in Business in the W.P. Carey School of Business at Arizona State University), Cato Unbound, "The Economic Case against Medicare for All | Cato Unbound", 4/21/20, https://www.cato-unbound.org/2020/04/21/jay-bhattacharya/economic-case-against-medicare-all -CD

Cannon’s third point is a grim prophecy. Imposing one-size-fits-all coverage, shifting all pricing decisions and costs to the federal government, and prohibiting any outside option will harm Americans’ finances and freedoms with nothing to show for it in terms of health. About those cost savings. With the federal government fully financing our health care system, politicians have incentive to shift away from on-the-books budgetary costs to off-the-books but very real expenses. Headlining these costs is at least an additional $600 billion per year needed to finance the budgeted $2 trillion per year due to the economic drag caused by the excess burden of taxation. There are also palpable costs to individuals. Rather than paying through patient cost sharing, which is banned under Sanders’s plan, people would pay in the form of fewer services and lower intensity of treatment per encounter. These costs are direct consequences of the proposed slashes in providers’ payments and the need for draconian supply rationing to limit overuse in the absence of patient cost sharing. As documented in Japan and Canada, these policies result in more delays, more visits to resolve health problems, and lower productivity.

#### M4A would kill 1.8 million jobs

Tanner 19

Michael Tanner (Cato Institute Senior Fellow Michael Tanner heads research into a variety of domestic policies, with an emphasis on poverty and social welfare policy, health care, and Social Security and entitlement reform), Cato Institute, "The Questions Medicare for All Supporters Must Answer", 4/17/19, https://www.cato.org/publications/commentary/questions-medicare-all-supporters-must-answer -CD

What will happens after you wipe out the insurance industry? It is obvious that Sanders despises the insurance industry. Still, there would be real collateral damage from his plans to carpet‐​bomb the industry. Estimates suggest that as many as 1.8 million jobs in the insurance, benefits, and human‐​resources industries could be at risk. The median wage for these jobs runs in excess of $55,000 per year. These are the “good jobs at good wages” that the Democratic presidential candidates talk so much about. And while some might be absorbed into the new government bureaucracy, hundreds of thousands of others would likely have to find new work. It is not generally the government’s job to protect people from changes in the economy, but, even so, the government should generally try to avoid deliberately wiping out entire industries all by itself. Sanders and his backers have seemed strangely unconcerned with that prospect so far.

#### M4A puts a fifth of the US economy at risk

Abelson & Sanger-Katz 19

Reed Abelson (Reed Abelson has been a reporter for The New York Times since 1995. She currently covers the business of health care, focusing on health insurance and how financial incentives affect the delivery of medical care), Margot Sanger-Katz (Margot Sanger-Katz is a domestic correspondent for The New York Times, where she writes about health care for The Upshot, the Times site about politics, economics and everyday life.), NYT, "Medicare for All Would Abolish Private Insurance. ‘There’s No Precedent in American History.’ - The New York Times", 3/23/19, https://www.nytimes.com/2019/03/23/health/private-health-insurance-medicare-for-all-bernie-sanders.html -CD

But doing away with an entire industry would also be profoundly disruptive. The private health insurance business employs at least a half a million people, covers about 250 million Americans, and generates roughly a trillion dollars in revenues. Its companies’ stocks are a staple of the mutual funds that make up millions of Americans’ retirement savings. Such a change would shake the entire health care system, which makes up a fifth of the United States economy, as hospitals, doctors, nursing homes and pharmaceutical companies would have to adapt to a new set of rules. Most Americans would have a new insurer — the federal government — and many would find the health insurance stocks in their retirement portfolios much less valuable. “We’re talking about changing flows of money on just a huge scale,” said Paul Starr, a sociology professor at Princeton University and author of “The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry.” “There’s no precedent in American history that compares to this,” he said.

### Contention 2: Lost Access

#### M4A would inevitably lead to a shortage of medical professionals

Moffit 19

Robert E. Moffit, Ph.D. (Moffit specializes in health care and entitlement programs, especially Medicare.), The Heritage Foundation, "How “Medicare for All” Bills Would Worsen the Doctor Shortage", 3/15/19, <https://www.heritage.org/medicare/commentary/how-medicare-all-bills-would-worsen-the-doctor-shortage> Medicare for All" may sound good to some Americans – until they take a closer look at how it would actually work. -CD

Take something pretty basic: how it would affect the number of medical professionals we have in this country. "Medicare for All" would drive out many doctors and nurses – and compromise the accessibility and quality of medical care for millions of Americans. The reason: "Medicare for All" bills mandate major payment reductions for America's health care workforce. Vermont Sen. Bernie Sanders' bill, for example, would use today's Medicare payment system for reimbursing doctors, hospitals and other medical professionals. Medicare rates are fixed by law and regulation, not some private market-style "negotiation." Those rates are set significantly below private sector rates, and often do not cover the true costs of providing medical services. For example, in 2017 the American Hospital Association found that for every $1 American hospitals spent caring for Medicare patients, Medicare reimbursed hospitals only 87 cents. Likewise, in a study of major commercial insurers, the Congressional Budget Office reported that for 20 services provided by physicians, private payers paid amounts ranging from 11 to 139 percent more than Medicare paid. Doctors and hospitals routinely depend on private health insurance to close the gap. The Senate and House "Medicare for All" bills, however, would outlaw private health insurance, and thus eliminate the freedom of medical professionals to negotiate payments outside of the government monopoly. Under current law, we already have some idea what to expect with Medicare payment. Obamacare schedules major Medicare payment reductions for hospitals, nursing homes and home health agencies. In their 2018 report's most realistic scenario, Medicare's trustees warn that "by 2040, simulations suggest that approximately half of hospitals, roughly two thirds of skilled nursing facilities and over 80 percent of home health agencies would have negative total facility margins, raising the possibility of access and quality of care issues for Medicare beneficiaries." Medicare law also schedules physician payment decreases relative to private-sector payment. Today, Medicare enrollment totals more than 58 million Americans. Sanders's bill, however, would expand Medicare's payment rates to the coverage of more than 300 million U.S. residents. Projecting a dramatic 40 percent reduction in provider reimbursement relative to private insurance, Charles Blahous, a former Medicare trustee, observes, "The cuts in the Sanders M4A bill would sharply reduce provider reimbursements for treatments now covered by private insurance, which represent a substantially greater (more than 50 percent larger) share of national health spending than does Medicare." True, American physicians are among the most highly paid medical professionals in the world. Overall, in 2018 the average American primary care physician earned $223,000, while specialists earned $329,000. In 2018, American staff nurses earned $73,287 on average, clinical nurse specialists earned $88,271, and nurse anesthetists earned $150,833. Of course, liberals in Congress could cut American medical workforce compensation to "single payer" levels. Examining comparative 2016 data – including compensation in "single payer" Britain and Canada – researchers writing in the Journal of the American Medical Association found that American general physicians earn an average annual salary of $218,173. The comparable compensation for Canadian generalists was $146,286, while British generalists received just $134,671. Medicine is, however, a tough and often stressful profession, and medical students routinely incur large personal debts. In 2018, according to the American Association of Medical Colleges, the median medical school debt amounted to $195,000. Punitive payment cuts would surely be costly. By 2030, Americans [would] already face a serious and potentially dangerous physician shortage, ranging between 15,800 and 49,300 primary-care doctors, and between 33,800 and 72,700 non-primary care doctors. Accelerated retirements, job-based burnout and growing demoralization fuel that shortfall. Combining a mammoth pay cut with the abolition of private-sector alternatives would not only hurt morale. It would accelerate the shrinkage of the medical workforce. Patients will suffer. Blahous's Mercatus study of the Senate bill – projecting a 40 percent reduction in provider reimbursement – is thus far the only such estimate of its impact on medical compensation. The House bill – creating a global budget for American health spending and government fee systems for doctors and other providers – is yet to be subject to a similar econometric analysis. There is an obvious candidate to undertake such an analysis: The Office of the Actuary at the Center for Medicare and Medicaid Services. The Actuary has regularly estimated the impact of Obamacare's scheduled Medicare payment reductions. Congress and the Trump administration should ask the Actuary to conduct a similar analysis of the "Medicare for All" bills, not only assessing their impact on America's doctors and hospitals, but also Americans' access to high quality medical care. Congress must secure the best and most authoritative estimates of the impact of the House and Senate bills. Silly political promises won't cut it. American doctors and patients – that is, all of us – deserve an honest prognosis.

#### M4A would lead to the closing of hospitals around the country, particularly in poor and rural areas

Abelson 19

Reed Abelson (Reed Abelson has been a reporter for The New York Times since 1995. She currently covers the business of health care, focusing on health insurance and how financial incentives affect the delivery of medical care), NYT, "Hospitals Stand to Lose Billions Under ‘Medicare for All’ ", 4/21/19, https://www.nytimes.com/2019/04/21/health/medicare-for-all-hospitals.html -CD

The nation’s major health insurers are sounding the alarms, and pointing to the potential impact on hospitals and doctors. David Wichmann, the chief executive of UnitedHealth Group, the giant insurer, told investors that these proposals would “destabilize the nation’s health system and limit the ability of clinicians to practice medicine at their best.” Hospitals could lose as much as $151 billion in annual revenues, a 16 percent decline, under Medicare for all, according to Dr. Kevin Schulman, a professor of medicine at Stanford University and one of the authors of a recent article in JAMA looking at the possible effects on hospitals. “There’s a hospital in every congressional district,” he said. Passing a Medicare for all proposal in which hospitals are paid Medicare rates “is going to be a really hard proposition.” Richard Anderson, the chief executive of St. Luke’s University Health Network, called the proposals “naïve.” Hospitals depend on insurers’ higher payments to deliver top-quality care because government programs pay so little, he said. “I have no time for all the politicians who use the health care system as a crash-test dummy for their election goals,” Mr. Anderson said. The American Hospital Association, an industry trade group, is starting to lobby against the Medicare for all proposals. Unlike the doctors’ groups, hospitals are not divided. “There is total unanimity,” said Tom Nickels, an executive vice president for the association. “We agree with their intent to expand coverage to more people,” he said. “We don’t think this is the way to do it. It would have a devastating effect on hospitals and on the system over all.” Rural hospitals, which have been closing around the country as patient numbers dwindle, would be hit hard, he said, because they lack the financial cushion of larger systems. Big hospital systems haggle constantly with Medicare over what they are paid, and often battle the government over charges of overbilling. On average, the government program pays hospitals about 87 cents for every dollar of their costs, compared with private insurers that pay $1.45. Some hospitals make money on Medicare, but most rely on higher private payments to cover their overall costs. Medicare, which accounts for about 40 percent of hospital costs compared with 33 percent for private insurers, is the biggest source of hospital reimbursements. The majority of hospitals are nonprofit or government-owned. The profit margins on Medicare are “razor thin,” said Laura Kaiser, the chief executive of SSM Health, a Catholic health system. In some markets, her hospitals lose money providing care under the program. She says the industry is working to bring costs down. “We’re all uber-responsible and very fixated on managing our costs and not being wasteful,” Ms. Kaiser said. Over the years, as hospitals have merged, many have raised the prices they charge to private insurers. “If you’re in a consolidated market, you are a monopolist and are setting the price,” said Mark Miller, a former executive director for the group that advises Congress on Medicare payments. He describes the prices paid by private insurers as “completely unjustified and out of control.”

### Contention 3: Wait Times

#### M4A would lead to massive wait times for treatments and overall reduced access to care

Ponnuru 19

Ramesh Ponnuru (Ramesh Ponnuru is a Bloomberg Opinion columnist. He is a senior editor at National Review, visiting fellow at the American Enterprise Institute and contributor to CBS News.), Bloomberg Opinion, "Sanders-Warren Medicare for All? Be Ready to Wait in Line", 10/30/19, https://www.bloomberg.com/opinion/articles/2019-10-30/sanders-warren-medicare-for-all-be-ready-to-wait-in-line -CD

“Medicare for All” continues to be a top issue in the Democratic presidential campaign, and President Donald Trump isn’t waiting to see who wins to start attacking it. So far, the Democratic debate has centered on how a huge expansion of Medicare would affect private health insurance and middle-class taxes. But Trump is raising another big issue: wait times. “Medicare-for-All would force patients to face massive wait times for treatments and destroy access to quality care,” declares the White House website. Like everything else in the health-care debate, this is a disputed point. Thomas Waldrop, a health-care analyst with the Center for American Progress, a liberal group, has responded to Trump: “Wait time concerns amount to little more than fearmongering by those who oppose expansion of coverage.” We won’t know for sure who’s right, of course, unless we actually implement Medicare for All. But Trump’s concern should not be so easily dismissed. As Waldrop notes, the White House bases its pessimism largely on data from the U.K. He rejects that comparison because “no candidate currently running for president is proposing nationalizing health care providers like the U.K.’s National Health Service.” He then does an able job of showing that other countries have achieved higher levels of coverage than the U.S. has without suffering higher wait times across the board. Two-thirds of patients in Australia say they can see a medical provider within a day, for example, while only half of Americans do. But that’s not a good comparison either. The Medicare for All legislation endorsed by two of the leading Democratic candidates - Bernie Sanders and Elizabeth Warren - would create a single-payer system that effectively prohibits private health insurance. That’s not what Australia has. It’s not what several of the other countries the CAP website mentions have, either. The question Trump is raising is not whether high coverage can be achieved without long wait times. (Waldrop is right to say that it can.) It’s whether the specific way of achieving higher coverage levels that has become popular on the American left will increase wait times. In a forthcoming review of the international evidence for the conservative Manhattan Institute, Chris Pope finds that the single-payer systems “deliver consistently lower quality and access to high-cost specialty care or surgical procedures.” Looking at the various systems across different countries, access to care is higher the larger the percentage of the population with private insurance. The effects of Medicare for All could be significantly worse. Senator Sanders often argues for the idea by pointing out that other countries spend less while covering more people and having better health outcomes than we do. But no country has ever tried to socialize and downsize a health sector as large as ours. The Medicare for All legislation Sanders and Warren support stipulates that health-care providers will be reimbursed at the rates used by Medicare today, which amounts to a reduction of up to 40% from what private insurers pay. Only by slashing payment rates can proponents promise to cover so many more people, and provide more extensive coverage to those who now have insurance, at no additional cost. It’s hard to believe that such cuts wouldn’t reduce the supply of medical services, even as the new benefit promises increased demand. Waldrop himself writes that as part of a transition to a new system, payment rates for primary care should be raised in order to avoid long wait times. Even that expensive adjustment would not prevent wait lists for specialty care. If Sanders, Warren and other advocates of Medicare for All adjusted their plan by specifying that provider payments would not be cut, then their opponents’ wait-list argument would have considerably less force. But if they did that, the price tag would be much higher; both senators are already struggling to explain how the federal government would pay for even the lower-cost version. So long as Democrats are saying that overall costs won’t rise, or will even fall, it’s fair to warn that Medicare for All will mean many patients have reduced access to care. Because it probably will.

### Extra Cards

#### Enacting policy is easy, but actually implementing M4A over the next 4 years will be impossible

Brooks 19

David Brooks (David Brooks became an Op-Ed columnist for The New York Times in September 2003. He is currently a commentator on “PBS NewsHour,” NPR’s “All Things Considered” and NBC’s “Meet the Press.” ), NYT, "Opinion | ‘Medicare for All’: The Impossible Dream - The New York Times", 3/4/19, https://www.nytimes.com/2019/03/04/opinion/medicare-for-all.html -CD

It sounds good. But the trick is in the transition. First, patients would have to transition. Right now, roughly 181 million Americans receive health insurance through employers. About 70 percent of these people say they are happy with their coverage. Proponents of Medicare for all are saying: We’re going to take away the insurance you have and are happy with, and we’re going to replace it with a new system you haven’t experienced yet because, trust us, we’re the federal government! The insurance companies would have to transition. Lots of people work for and serve this industry. All-inclusive public health care would destroy this industry beyond recognition, and those people would have to find other work. Hospitals would have to transition. In many small cities the local health care system is the biggest employer. As Reihan Salam points out in The Atlantic, the United States has far more fully stocked hospitals relative to its population and much lower bed occupancy than comparable European nations have. If you live in a place where the health system is a big employer, think what happens when that sector takes a sudden, huge pay cut. The ripple effects would be immediate — like a small deindustrialization. Doctors would have to transition. Salary losses would differ by specialty, but imagine you came out of med school saddled with debt and learn that your payments are going to be down by, say 30 percent. Similar shocks would ripple to other health care workers. The American people would have to transition. Americans are more decentralized, diverse and individualistic than people in the nations with single-payer systems. They are more suspicious of centralized government and tend to dislike higher taxes. The Sanders plan would increase federal spending by about $32.6 trillion over its first 10 years, according to a Mercatus Center study that Blahous led. Compare that with the Congressional Budget Office’s projection for the entire 2019 fiscal year budget, $4.4 trillion. That kind of sticker shock is why a plan for single-payer in Vermont collapsed in 2014 and why Colorado voters overwhelmingly rejected one in 2016. It’s why legislators in California killed one. In this plan, the taxes are upfront, the purported savings are down the line. Once they learn that Medicare for all would eliminate private insurance and raise taxes, only 37 percent of Americans support it, according to a Kaiser Family Foundation survey. In 2010, Republicans scored an enormous electoral victory because voters feared that the government was taking over their health care, even though Obamacare really didn’t. Now, under Medicare for all, it really would. This seems like an excellent way to re-elect Donald Trump. The government would also have to transition. Medicare for all works only if politicians ruthlessly enforce those spending cuts. But in our system of government, members of Congress are terrible at fiscal discipline. They are quick to cater to special interest groups, terrible at saying no. To make single-payer really work, we’d probably have to scrap the U.S. Congress and move to a more centralized parliamentary system. Finally, patient expectations would have to transition. Today, getting a doctor’s appointment is annoying but not onerous. In Canada, the median wait time between seeing a general practitioner and a specialist is 8.7 weeks; between a G.P. referral and an orthopedic surgeon, it’s nine months. That would take some adjusting. If America were a blank slate, Medicare for all would be a plausible policy, but we are not a blank slate. At this point, the easiest way to get to a single-payer system would probably be to go back to 1776 and undo that whole American Revolution thing.

#### The COVID-19 pandemic shows the many likely failures of M4A

Silver & Hyman 20

Charles Silver (Charles Silver, MA, JD, holds the Roy W. and Eugenia C. McDonald Endowed Chair in Civil Procedure at the University of Texas School of Law), David Hyman (David A. Hyman is an adjunct scholar at the Cato Institute and a Professor of Law at Georgetown University), Cato Institute, "The Government's COVID-19 Failures Are an Argument Against Medicare for All | Cato Institute", 4/14/20, https://www.cato.org/publications/commentary/governments-covid-19-failures-are-argument-against-medicare-all -CD

Some have said the failure of America’s medical system to handle the surge in demand caused by COVID-19 is proof that the country needs Medicare for All. They couldn’t be more wrong. Many countries with nationalized, single‐​payer schemes, including England, France, Italy, and Spain, have seen their health‐​care systems stretched past the breaking point by the pandemic. More importantly, the responsibility for America’s lack of preparedness lies squarely with our dysfunctional government. The real lesson to be learned from our botched response to COVID-19 is that giving the government control of the entire health‐​care system would be an enormous mistake. No system that is sensibly designed to meet our normal needs for goods and services can respond instantly to a massive surge in demand. That’s why stores ran out of toilet paper, bottled water, face masks, antibacterial wipes, and other items when panicked shoppers went on buying sprees after the pandemic first hit. To increase production, manufacturers must acquire additional supplies, hire more workers, add shifts, expand facilities, make shipping arrangements, and so forth. Because doing these things takes time, in the short run supply is fixed. No one should want to nationalize the health‐​care system after this pandemic. The health‐​care system also faces short‐​term supply constraints. It takes years to produce the thousands of new doctors, nurses, pharmacists, and EMTs that are needed when a crisis hits. It takes time to make more hospital beds, ventilators, ambulances, and personal protective equipment too. That we ran short of these resources when the coronavirus reached our shores is not a sign of a poorly run system, but of one governed by basic economic imperatives: Health‐​care businesses sensibly kept only enough resources on hand to deal with expected demand, because maintaining excess capacity was not worth the expense. The pandemic caused demand to skyrocket past expected levels, so, as typically happens with mass disasters, we’ve faced shortages. Some can be eased by importing goods and workers from outside the affected region — think of New York, which is now asking for help from doctors in other states. But others can only be addressed by ramping up production, which can take weeks, months, or even years. Since markets discourage businesses from maintaining too much excess capacity, how should we prepare for catastrophes like COVID-19? The usual answer is that government must do the heavy lifting. Unfortunately, the government’s record of preparing for disasters is poor. The response to the COVID-19 crisis is a case study in governmental ineptness. In 2006, the federal government estimated that 70,000 ventilator machines would be needed in a moderate influenza epidemic. Instead of going with a large, established device maker, in 2010 HHS hired Newport Medical Instruments, a small one, to build a fleet of inexpensive portable devices. Before production started, however, NMI was purchased by Covidien, a larger device maker. Eventually, Covidien backed out of the contract, no ventilators were delivered, and the government enlisted a new vendor in 2019. The government also allowed a contract dispute to interfere with the maintenance of the ventilators it already had. Consequently, when COVID-19 hit, the federal supply of ventilators was far too small and thousands of the machines the government did have didn’t work. Fourteen years after the call for ventilators went out, the federal government is just starting to fill the need.

#### M4A would reduce access to specialized treatment and increase wait times

De Lea 19

Brittany De Lea (Brittany De Lea is a reporter for FOX Business.), Fox Business, "Medicare-for-all could increase patient wait times, reduce access to care - CBO | Fox Business", 5/2/19, https://www.foxbusiness.com/healthcare/medicare-for-all-increase-wait-times-reduce-access -CD

The idea behind the Medicare-for-all proposal is to expand coverage of the government-run program to all Americans, not just those over the age of 65. These types of plans would largely eliminate the role of the private insurance market. They would also eliminate deductibles, co-pays and insurance premiums. However, there are a number of ways such a system could be implemented and therefore, according to analysis released by the Congressional Budget Office (CBO), it is difficult to say how much it would cost to implement. The report did note that the system would require “substantially” more spending on behalf of the government. “Shifting such a large amount of expenditures from private to public sources would significantly increase government spending and require substantial additional government resources,” researchers said. It could not pinpoint an exact cost estimate due to policy uncertainty, though taxpayers could be on the hook for whatever that amount came out to be. Medicare-for-all could result in lower administrative costs by eliminating insurers’ profits and streamlining certain tasks. It could also encourage investment in preventive care which helps reduce overall healthcare costs. On the other hand, patients could experience reduced access to care and increased wait times, due to increased demand for care, and a potential lack of providers. Additionally, every American may not have their specific needs met, like access to new treatments. There could also be ripples into other sectors of the economy, according to the CBO. The House introduced a Medicare-for-all bill, as has Independent Vermont Sen. Bernie Sanders. Sanders’ bill includes long-term care coverage. It would also cover dental, vision and hearing. The legislation allows for a four-year phase-in period. More than a dozen other senators have signed onto the bill as co-sponsors. One estimate, which was disputed by Sanders’ campaign, forecast Medicare-for-all could cost more than $32 trillion over the course of a decade. On Tuesday, the House held its first hearing on the Medicare-for-all bill introduced in the chamber.

#### Increased wait times increases mortality rates of treatment

Prentice & Pizer 07

Prentice, Julia C, and Steven D Pizer. “Delayed access to health care and mortality.” Health services research vol. 42,2 (2007): 644-62. doi:10.1111/j.1475-6773.2006.00626.x -CD

Objective To measure the relationship between time spent waiting for health care services and patients' mortality. Data Source Data on the number of days until the next available appointment at 89 Veterans Affairs (VA) medical centers in 2001 were extracted from a VA administrative database. These facility-level data were merged with individual-level data for a sample of veterans who visited a VA geriatric outpatient clinic in 2001. The merged dataset includes facility-level data on waiting times and individual-level data on demographics, health status (e.g., diagnoses), and mortality. Study Design This was a retrospective observational study using secondary data from administrative sources. The dependent variable was mortality within a 6-month follow-up period. The main explanatory variable of interest was VA facility-level wait times for outpatient visits measured in number of days. Random effects logistic regression models were risk adjusted for prior individual health status and facility-level differences in case mix. Principal Findings Veterans who visited a VA medical center with facility-level wait times of 31 days or more had significantly higher odds of mortality (odds ratio = 1.21,p = 0.027) compared with veterans who visited a VA medical center with facility-level wait times of < 31 days. Conclusions Our findings support the largely assumed association between long wait times for outpatient health care and negative health outcomes, such as mortality. Future research should focus on the causes of long waits for health care (e.g., physician reimbursement levels), the consequences of long waits in other populations, and effective policies to decrease long waits for health care services.

#### Funding M4A via deficit funding would do enough damage to the economy, it would undo or outweigh any benefits the program has

Meyers 20

Kristin Myers (Kristin Myers is an award-winning journalist, producer, and communications professional that has helped launch Al Jazeera America, and has worked with other news organizations like Bloomberg News, NBC, and more. She is currently a reporter with Yahoo Finance, writing on the economy.), Yahoo Finance, "Bernie Sanders 'Medicare for all' plan could shrink GDP by as much as 24%", 1/30/20, https://finance.yahoo.com/news/bernie-sanders-medicare-for-all-plan-could-shrink-gdp-by-as-much-as-24-133030215.html -CD

According to analysis by the Penn Wharton Budget Model (PWBM), Medicare for all (M4A) could shrink U.S. GDP by as much as 24% by the year 2060, depending on how it is financed. Despite this hit to economic growth, the plan proposed by presidential candidate Bernie Sanders (I-VT) isn’t without benefits. According to the analysis, Medicare for all would improve population health overall, increasing life expectancy by roughly two years, grow the population of the United States by 3%, and boost worker productivity. The share of the population that is “seriously ill” would also decline, from 15% to 13%. But, the model warns, if the plan is deficit-financed — paid for by government borrowing — “the negative effects of larger deficits on labor supply, capital accumulation and GDP would significantly outweigh the positive effects on the economy that come from a larger and healthier workforce.”

#### Medicare is unsustainable as is, putting the whole country on it would be devastating

Newman 19

 Rick Newman (Rick Newman is a columnist for Yahoo Finance, offering insightful, provocative takes on many of the biggest stories of our time), Yahoo Finance, "Medicare for all doesn't have a chance", 4/22/19, https://finance.yahoo.com/news/medicare-and-social-security-report-164819544.html -CD

Bernie Sanders and several other prominent Democrats want to expand Medicare to cover the whole U.S. population. But a new update on the program’s finances shows the popular health plan for seniors can barely take care of the people it covers now. Medicare will begin to run short of money by 2026, according to the latest annual report published by the trustees who oversee the program. That’s the same forecast as the trustees made last year, which means there’s been no improvement in Medicare’s shaky finances, and we’re one year closer to a reckoning. Social Security has a longer lifespan, with enough financing to cover full payouts for retirees until 2034, which is a two-year improvement over last year’s forecast. Those deadlines don’t mean the two retirement programs will end. Instead, trust funds that are like a reserve fund financing a portion of the payments will run out of money. So the programs will only be able to pay out what they take in taxes dedicated to those two programs, plus a few other revenue sources. For Medicare Part A, which covers hospital stays and related services, the program would be able to cover 89% of costs once the trust fund runs dry in 2026. That portion would decline to 77% by 2046, then begin to rise gradually after that. Medicare Parts B and D, which cover outpatient services and prescription drugs, are in better shape, because they’re financed through premiums patients pay and general revenue from non-Medicare taxes. Those parts of Medicare should stay solvent indefinitely. Sen. Bernie Sanders, I-Vt., introduces the Medicare for All Act of 2019, on Capitol Hill in Washington, Wednesday, April 10, 2019. (AP Photo/Manuel Balce Ceneta)View photos Sen. Bernie Sanders, I-Vt., introduces the Medicare for All Act of 2019, on Capitol Hill in Washington, Wednesday, April 10, 2019. (AP Photo/Manuel Balce Ceneta) More Social Security payments for seniors will fall to about 75% of scheduled benefits once that trust fund empties out in 2034. Social Security also funds disability payments, with that trust fund likely to stay solvent until 2052. Combined, the two programs will begin to pay out more than they take in starting in 2020, the first time that has happened since 1982. That’s actually an improvement over last year’s outlook, which forecast outflows would exceed inflows at some point in 2018. This shouldn’t come as a surprise With baby boomers flooding into retirement, federal spending on programs for seniors has been gobbling up a growing portion of federal revenue. In 2018, Social Security and Medicare accounted for 45% of all federal spending, up from 42% the year before. As that spending goes up, the trust fund balances go down, jeopardizing future funding for both programs. None of this is a surprise. Budget experts have been warning for years that population trends and rising health costs would strain both programs—to the breaking point, if Congress doesn’t fix them. There are plenty of solutions, such as reducing benefits for the wealthy, raising the retirement age and hiking taxes, but none of those moves is likely to be popular if there’s no emergency-forcing action. Bernie Sanders rolled out his Medicare for all idea during the 2016 presidential campaign, and what once seemed like a fringe idea is catching on. Several Democrats running for president in 2020 now back the idea, including senators Cory Booker, Kamala Harris and Elizabeth Warren. But the fragility of the current system reveals how disruptive and complicated it would be to expand the program from around 43 million people now to essentially all 330 million Americans.

#### There’s just not enough money to adequately support M4A, California proves

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Dana Goldman (Dana Goldman is the Leonard D. Schaeffer Chair and Distinguished Professor of Pharmacy, Public Policy, and Economics at the University of Southern California), Brookings Institute, "Why Bernie Sanders’s plan for universal health care is only half right", 9/13/17, https://www.brookings.edu/blog/fixgov/2017/09/13/why-bernie-sanderss-plan-for-universal-health-care-is-only-half-right/ -CD

The part that Sanders gets wrong is that he would turn Medicare into a single-payer system for all, supplanting private insurers. That approach has lots of problems, not least of which is an enormous price tag. Consider what happened in California earlier this year when the state legislature briefly considered a single-payer bill. An appropriations committee estimated it would cost $400 billion, over twice the state’s annual budget. Such complications make the Sanders bill — and other Medicare for all proposals — virtually impossible to enact. People also forget that Medicare is a hidebound system. It took Congress more than 40 years to offer a prescription drug benefit, for example. Physicians are paid using an arcane system developed decades ago and that has now ballooned to more than 140,000 procedure codes, all of which is supervised (and gamed) by physicians themselves. Standard private sector cost-saving measures, like competitive bidding for routine services, are rarely used.