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AFFIRMATIVE EXTENTIONS

Inherency: Number of Uninsured Americans Has Decreased

Number of uninsured decreased in 2007
Herrick, '08

[Devon Herrick, PhD, Senior policy fellow at the National Center for Policy Analysis, "Crisis of the Uninsured: 2008." National Center for Policy Analysis, August 28, 2008. Date downloaded: April 14, 2009]

Despite claims that there is a health insurance crisis in the United States, the number of U.S. residents without health insurance actually fell in 2007, according to new Census Bureau numbers. The Census says the number of uninsured fell from 47.0 million to 45.7 million. Furthermore, the proportion of uninsured fell half a percentage-point, from 15.8 percent to 15.3 percent.

In fact, the proportion of people without health insurance was a percentage-point lower in 2007 than a decade earlier (16.3 percent in 1998). The slight increase in the number of uninsured over the past decade is largely due to immigration and population growth — and to individual choice.

Inherency: Uninsured By Choice

70% of uninsured could easily obtain insurance but have chosen to forgo coverage
Herrick, '08

[Devon Herrick, PhD, Senior policy fellow at the National Center for Policy Analysis, "Crisis of the Uninsured: 2008." National Center for Policy Analysis, August 28, 2008. Date downloaded: April 14, 2009]

In 2007, according to Census Bureau data:

- Nearly 85 percent (253.5 million) of U.S. residents were privately insured or enrolled in a government health program, such as Medicare, Medicaid and the State Children's Health Insurance Programs (S-CHIP).
- Nearly 18 million of the uninsured lived in households with annual incomes above $50,000 and could likely afford health insurance.
- Up to 14 million uninsured adults and children qualified for government programs in 2004 but had not enrolled, according to the BlueCross BlueShield Association.

In theory, therefore, about 32 million people, or 70 percent of the uninsured, could easily obtain coverage but have chosen to forgo insurance. That means that about 95 percent of United States residents either have health coverage or access to it. The remaining 5 percent live in households that earn less than $50,000 annually. This group does not qualify for Medicaid and (arguably) earns too little to easily afford expensive family plans costing more than $12,106 per year. A uniform tax credit would go a long way toward helping this group afford coverage.

Inherency: Uninsured By Choice

25% of all uninsured are eligible for public assistance
Dubay, et al., '06

> [Lisa Dubay, John Holahan, and Allison Cook, Lisa Dubay is a research scientist at the Johns Hopkins Bloomberg School of Public Health, in Baltimore, Maryland. John Holahan (jholahan@ui.urban.org) is director of the Health Policy Center, Urban Institute, in Washington, D.C.; Allison Cook is a research assistant there. "The Uninsured and The Affordability Of Health Insurance Coverage." Urban Institute, November 30, 2006. Date downloaded: April 14, 2009]

Looking at the uninsured by whether they are eligible for public coverage, not eligible for public coverage but in families that would need assistance to make coverage affordable, and not eligible but for whom coverage is likely affordable provides critical information regarding the types of strategies that would be needed to address the problem of uninsurance (Exhibit 3). **A quarter of the uninsured are eligible for public coverage but not enrolled.** Another 56 percent would need financial assistance to make the purchase of private non-group insurance affordable. The remaining 20 percent are not currently eligible for public coverage and live in families whose incomes deem the purchase of private non-group coverage affordable. Thus, the majority of the uninsured have sufficiently low incomes that at least partial financial assistance would be necessary to make coverage affordable. This overall picture masks the variation in the distribution of the eligible, "need assistance," and affordable groups for children, parents, and childless adults (Exhibit 2).

Inherency: Many Uninsured Are Immigrants

27% of uninsured are immigrants
Herrick, ‘08

[Devon Herrick, PhD, Senior policy fellow at the National Center for Policy Analysis, “Crisis of the Uninsured: 2008.” National Center for Policy Analysis, August 28, 2008. Date downloaded: April 14, 2009]

About 12.4 million foreign-born residents lack health coverage — accounting for 27 percent of the uninsured. In 2007, 44 percent of foreign-born noncitizen residents were uninsured. According to a recent Employee Benefits Research Institute report, immigrants accounted for 55 percent of the increased in the uninsured since 1994. Income may be a factor — but not the only one. A partial explanation for this disparity is that many immigrants come from cultures without a strong history of paying premiums for private health insurance. In addition, immigrants do not qualify for public coverage until they have been legal residents for more than five years.

Inherency: Poverty Level Is Too High

Living standards have improved even though the U.S. poverty rate has remained stagnant Shurtleff, '09

[Sean D. Shurtleff, policy analyst, "Reforming the U.S. Poverty Standard." National Center for Policy Analysis, January 20, 2009. Date downloaded: April 14, 2009]

A country's poverty rate should decline as real incomes rise and living standards increase, but the U.S. poverty rate has remained stagnant. Census Bureau household data show:

* In 1968, the official poverty rate was 12.8 percent, meaning 25.4 million people were considered poor.

* In 2007, the poverty rate was 12.5 percent, and 37.3 million people were considered poor.

However, household consumption indicates that basic living standards have improved significantly. For instance:

* In 1970, only 36 percent of the entire U.S. population had air conditioning, compared to nearly 80 percent of poor households in 2005, according to a 2007 Heritage Foundation study.

* In 1980, only 27 percent of the poor had microwave ovens compared to 85 percent in 2005, according to University of Chicago Prof. Bruce D. Meyer.

This increased consumption shows that the living standards of low-income families have improved. In fact, according to the U.S. Department of Labor, the poor actually consume about $2 for every $1 dollar of reported income. How is that possible? The discrepancy is due to unreported or underreported income, savings, credit and welfare benefits.

Inherency: Poverty Level Is Too High

Poverty calculations only count cash as income and do not count government benefits Swarns, '08

[Rachel Swarns, "Bipartisan Calls for New Federal Poverty Measure." New York Times, September , 2008. Date downloaded: April 16, 2009.

Officials also point out that the current measure only counts cash as income. They say a more accurate model would include government assistance like food stamps, housing subsidies and tax credits. Such aid has been devised to help support the poor, but its impact is not calculated by the current measure.

"We have done a whole number of things to help low-income families, and it doesn't show up in the poverty figures," said Rebecca M. Blank, an economist and senior fellow at the Brookings Institution. "Therefore, we misinterpret the effect of these policies."

A/T: High Costs

A/T: High Costs

Costs are rising for Medicaid because the program uses a cost-based payment plan and procedures, rather than results.
Bond, Goodman, et al., '03

[Michael Bond, Director Center for Health Care Policy, The Buckeye Institute; John C. Goodman, President and CEO, National Center for Policy Analysis; Ronald Lindsey, Senior Fellow, National Center for Policy Analysis and Former Commissioner, Texas Department of Human Services; and Richard Teske, Senior Fellow, National Center for Policy Analysis. "Reforming Medicaid." National Center for Policy Analysis, Poly Report No. 257, February 2003. Date downloaded: April 22, 2009.]

Reason for Rising Costs**.** Why are Medicaid costs rising so rapidly? Part of the reason is that many states are paying for health care in ways that needlessly contribute to rising health care costs. Another problem is that most states have not taken advantage of cost-control techniques widely used in the private sector. For example:

● Because Texas' method of paying for hospital care is largely cost-based, Medicaid pays some Dallas hospitals three times as much as other hospitals for the same services.

● Because Ohio's method of paying for nursing home care is essentially cost-based, the state is paying for 13,000 empty beds.

● In virtually every state, Medicaid pays for inputs rather than outputs. This means that the more physicians and facilities do, the more they earn — even if patients would have been better off if less were done.

● Medicaid patients also have incentives to waste resources; the only way they can realize more benefits is by consuming more health care.

A/T: High Costs

States cannot afford ballooning Medicaid costs; will bankrupt them
Bond, Goodman, et al., '03

[Michael Bond, Director Center for Health Care Policy, The Buckeye Institute; John C. Goodman, President and CEO, National Center for Policy Analysis; Ronald Lindsey, Senior Fellow, National Center for Policy Analysis and Former Commissioner, Texas Department of Human Services; and Richard Teske, Senior Fellow, National Center for Policy Analysis. "Reforming Medicaid." National Center for Policy Analysis, Poly Report No. 257, February 2003. Date downloaded: April 22, 2009.]

Problem: Escalating Costs. The National Governors Association claims that 49 states, faced with stagnant revenues and exploding Medicaid costs, are in a real fiscal emergency.3 Medicaid and other health expenses already account for about 20 percent of state spending nationally, and those costs rose 13 percent last year — "the largest increase in a decade," according to a National Governors Association report.4 Left unreformed, Medicaid will bankrupt every state in as little as 20 years — absorbing 80 to 100 percent of all state revenues.5 Delay is not an option. States and the federal government must act now to avoid a real human and fiscal disaster. What can be done?

A/T: High Costs

Medicaid system encourages waste and fraud in the system. People abuse their free health care.

Bond, Goodman, et al., '03

[Michael Bond, Director Center for Health Care Policy, The Buckeye Institute; John C. Goodman, President and CEO, National Center for Policy Analysis; Ronald Lindsey, Senior Fellow, National Center for Policy Analysis and Former Commissioner, Texas Department of Human Services; and Richard Teske, Senior Fellow, National Center for Policy Analysis. "Reforming Medicaid." National Center for Policy Analysis, Poly Report No. 257, February 2003. Date downloaded: April 22, 2009.]

Since its inception, fraud, waste and abuse have plagued Medicaid programs. For example, a 1993 investigative report of the Illinois Medicaid system by the Chicago Tribune found that:

● In one year, 71,064 Medicaid patients had more than 11 visits to a doctor's office (compared to a national average of six visits per year), while four patients had more than 300 visits in one year.

● In one day, one patient saw five doctors, made seven visits to a pharmacy and had 22 prescriptions filled with 663 pills. The report also uncovered some "Medicaid mills," whose freely prescribed drugs, syringes and other medical products were bought with American tax dollars and sold on the street.

A/T: High Costs

Fraud claims nearly 10% of the Medicaid budget
Bond, Goodman, et al., '03

[Michael Bond, Director Center for Health Care Policy, The Buckeye Institute; John C. Goodman, President and CEO, National Center for Policy Analysis; Ronald Lindsey, Senior Fellow, National Center for Policy Analysis and Former Commissioner, Texas Department of Human Services; and Richard Teske, Senior Fellow, National Center for Policy Analysis. "Reforming Medicaid." National Center for Policy Analysis, Poly Report No. 257, February 2003. Date downloaded: April 22, 2009.]

Fraud**.** Medicaid is especially vulnerable to fraud. It is a large program with a rapidly growing budget. It generates more than $1 billion in medical claims per year, nationwide. The General Accounting Office estimates that fraud and abuse may be a high as 10 percent of Medicaid spending.63 State Medicaid agencies claims data and other medical information could be used to identify fraud abuse, overuse and unnecessary care, but it seldom is. Most abuse is identified through tips or other unreliable means. The numerous jurisdictions having responsibility in a fraud case confounds detecting and prosecuting fraud.

A/T: High Costs

Government health care expenditures increase health care costs for all
Senate Republican Policy Committee, '08

["Health Care Costs and their Impact of Middle-Class Wages." U.S. Senate Republication Policy Committee, October 1, 2008. Date downloaded: April 16, 2009.]

Policymakers also cannot overlook the cost of government-sponsored health care and the increasing share of both the federal and state budgets it consumes. In 2006, health care costs made up 32 percent of state budgets on average.[14] Emanuel and Fuchs note that these increased costs are passed on to consumers in the form of higher taxes and other fees, potentially including increased tuition to state universities: "[T]he increasing cost of Medicaid and other government health care programs are a primary reason for the substantial increase in tuition and fees for state colleges and universities. Middle-class families finding it more difficult to pay for their children's college are unwittingly falling victim to increasing state health care costs. Not an easy—but a necessary—connection to make."[15]

A/T: High Costs

Canadian drug prices are much higher because of government regulation
Skinner and Rover, '09

[Brett J. Skinner & Mark Rover, Generic drugs in Canada: Overpriced and underused." Fraser Institute, February 2009. Date downloaded: April 14, 2009]

Generic drugs are often an economical alternative to brand-name medicines. As the World Health Organization notes, generic drugs are "usually intended to be interchangeable with an innovator product … [and] are frequently as effective as, but much cheaper than, brand-name drugs" (WHO, 2008). In Canada, however, generic drug prices are quite high relative to prices in the United States. Due to various pharmaceutical policies in Canada, Canadians pay much more for generic drugs than they otherwise would if prices were determined by competitive market forces.

Our annual study, *Canada's Drug Price Paradox*, compares Canadian and American prices for an identical group of the 100 most commonly prescribed brand-name drugs and the 100 most commonly prescribed generic drugs in Canada.1 The most recent edition of the study found that, although brandname drugs were more expensive in the United States, generic drugs were significantly more expensive in Canada in 2007 (Skinner and Rovere, 2008). This is the third year the study has been performed, and these results are generally consistent with the previous two reports. After adjusting for the purchasing power parity of the US and Canadian dollars, Canadian retail prices for identical brand-name drugs sold in 2007 were on average 53% lower in Canada than they were in the United States (figure 1). This is slightly different from relative prices in 2006 and 2003, when average prices for brand-name drugs in Canada were 51% and 43% lower, respectively. This means that average Canadian prices for identical brand-name drugs have decreased over the last five years relative to American prices.

A/T: High Costs

Individuals will over-use free medical services
Herrick, '05

[Devon M. Herrick, Ph.D. "Consumer Driven Health Care: The Changing Role of the Patient." National Center for Policy Analysis, May 2005. Date downloaded: April 14, 2009]

By contrast, most patients have few incentives to be prudent consumers of medical services in the current health care system. The reason: Third parties — government, employers or insurance companies — pay for about 86 percent of all health care.[3] As a result, the economic incentive for patients is to consume medical services until they are worth only 14 cents on the dollar.

Excessive physician visits is one way in which patients waste health care dollars. Up to one-quarter of physician visits are for conditions patients could easily have treated themselves, according to employee benefits experts.[4] A recent report by the Agency for Healthcare Research and Quality even suggests that an annual physical is of little value.[5] Patients also waste money through nonemergency visits to hospital emergency room. Even though these are one of the most costly ways to obtain routine treatment, 55 percent of the 103 million visits to hospital emergency rooms are judged unnecessary. Overall, the total cost of unnecessary physician office visits and unnecessary emergency department visits is just under $31 billion annually, or about $300 per American household per year.[6]

A/T: High Costs

Reforms are unsustainable because of skyrocketing spending
Sack, '09

[Kevin Sack, "Massachusetts Faces Costs of Big Health Care Plan." New York Times, March 15, 2009. Date downloaded: April 14, 2009]

Thanks to new taxes and fees imposed last year, the health plan's jittery finances have stabilized for the moment. But government and industry officials agree that the plan will not be sustainable over the next 5 to 10 years if they do not take significant steps to arrest the growth of health spending.

A/T: High Costs

Massachusetts has only increased costs without benefits
Scandlen, '09

[Greg Scandlen is director of Consumers for Health Care Choices at The Heartland Institute. "Mandatory Health Insurance Fails in Theory and in Massachusetts." Heartland Institute, February 1, 2009. Date downloaded: April 14, 2009.]

The mandate approach isn't going so well in Massachusetts, which remains the highest-profile state to implement an individual insurance mandate. In fact, if the demands for "evidence-based medicine" were applied equally to public policy, policymakers would run away from the idea of mandatory coverage as fast as possible.

"Republican governor (and former presidential candidate) Mitt Romney proclaimed that 'every uninsured citizen in Massachusetts will soon have affordable health insurance,' that costs would be reduced through 'market reforms' encouraging 'personal responsibility,' and that the plan would require 'no new taxes ... and no government takeover,'" wrote Dr. Paul Hsieh, president of the Foundation for Individual Rights in Medicine, in the Fall 2008 issue of the Objective Standard.

However, "two years after its inception, the Massachusetts plan has failed to achieve either of its goals. Instead," wrote Hsieh, "the plan has increased costs for individuals and the state, reduced revenues for doctors and hospitals, and left Massachusetts officials in the awkward position of having to admit that their 'universal coverage is not likely to be universal any time soon.'"

A/T: Poor Health Outcomes

Government provided healthcare does not guarantee care. There are often long waiting times to even see a doctor.
Schwartz, 2008
[Brain Schwartz, "Universal Health Care: The Wrong Prescription," Hawaii Reporter, February 29, 2008.]

"Access to a waiting list is not access to healthcare," wrote Canadian Chief Justice McLachlin when striking down legislation banning private insurance in 2005. Last year a New York Times read: "As Canada's Slow-Motion Public Health System Falters, Private Medical Care Is Surging."

And England? The BBC reports that "up to 500 heart patients die each year while they wait for potentially life-saving surgery." The Times claims that a British woman "will be denied free National Health Service treatment for breast cancer if she seeks to improve her chances by paying privately for an additional drug." A Daily Telegraph headline reads: "Sufferers pull out teeth due to lack of dentists." Another article says that "doctors are calling for NHS treatment to be withheld from patients who are too old or who lead unhealthy lives."

Consider politically-controlled health care in America: Medicaid and Medicare. Doctors are five times more likely to refuse seeing new Medicaid patients than privately-insured patients. Increasing reimbursement rates won't help much; more than two-thirds of doctors reported being overwhelmed by Medicaid's billing requirements, paperwork, and delays in payment.

A/T: Poor Health Outcomes

Under a government health care system, politicians will decide who gets the limited care available.
Shore, 2004
[Scott Shore, "The Nightmare of Universal Health Care," Intellectual Conservative, March 3, 2004.]

With limited dollars and a universal "entitlement," somebody -- politicians in the case of government -- will have to decide who gets how much health care and the quality of the care. Should Parkinson's patients get more access to the system than Alzheimer's patients? What about cardiac patients? How much for heart failure, valve problems or heart attacks? How much money is set aside for various types of cancer patients? Should money be allocated by the severity of sickness or the chance of cure? Should society determine the economic value of different patients -- for example a breadwinner for six would get more money than a single person? If we establish a standard for age should we favor the young (who have many more years of life) or the old (who need care chronically)? What procedures get preference? Do we use the most economical (serve the most people) or the most effective (fewer patients but better outcomes) procedures? Should social outcasts, "unproductive" artists, non-taxpayers or those with a criminal record be at the bottom of the priority list for health care? In essence, we have given enormous power of choice over our lives and body to the State. Some government sponsored "Medical Board" will choose Life and Death for its citizens? Is this really what the leftist, civil liberties crowd wants??

A/T: Poor Health Outcomes

Government health care doesn't guarantee any right, except the right to be skipped in line
Goodman, '06

[Dr. John C. Goodman, President and CEO of the National Center for Policy Analysis, "Health Care in a Free Society Rebutting the Myths of National Health Insurance." CATO Institute, January 27, 2005. Date downloaded: April 14, 2009]

In fact, no country with national health insurance has established a right to health care. Citizens of Canada, for example, have no right to any particular health care service. They have no right to an MRI scan. They have no right to heart surgery. They do not even have the right to a place in line. The 100th person waiting for heart surgery is not entitled to the 100th surgery. Other people can and do jump the queue.

A/T: Poor Health Outcomes

Waiting times for treatment in single payer countries undermine the health of patients. Goodman, Herrick, Musgrave, 2004

[John C. Goodman, Founder and President of the National Center for Policy Analysis, Devon Herrick, National Center for Policy Analysis, Dr. Gerald L Musgrave, President of Economics America, "Lives at Risk: Single-Payer Health Insurance Around the World," 2004.]

Patients queuing for treatment in single-payer systems are often waiting in pain. Many are risking their lives. An investigation by a British newspaper, The Observer, finds that delays in Britain for colon cancer treatment are so long that 20 percent of the cases considered curable at time of diagnosis are incurable by the time of treatment. A study of cancer patients in Glasgow, Scotland, finds the same is true for lung cancer patients. Twenty-five percent of British cardiac patients die while waiting their turn to receive treatment. According to government reports, one in six people on the National Health Service waiting lists for elective surgery are removed without ever being treated.

A/T: Poor Health Outcomes

In countries with government health care people are denied the care they need because of long waiting times.
Tanner, Cannon, 2007

[Michael Tanner, Cato Institute Director of health and welfare studies, Michael Cannon, Director of Policy Studies at the Cato Institute, "Universal Healthcare's Dirty Little Secrets," Los Angeles Times, April 5, 2007.]

Simply saying that people have health insurance is meaningless. Many countries provide universal insurance but deny critical procedures to patients who need them. Britain's Department of Health reported in 2006 that at any given time, nearly 900,000 Britons are waiting for admission to National Health Service hospitals, and shortages force the cancellation of more than 50,000 operations each year. In Sweden, the wait for heart surgery can be as long as 25 weeks, and the average wait for hip replacement surgery is more than a year. Many of these individuals suffer chronic pain, and judging by the numbers, some will probably die awaiting treatment. In a 2005 ruling of the Canadian Supreme Court, Chief Justice Beverly McLachlin wrote that "access to a waiting list is not access to healthcare."

Supporters of universal coverage fear that people without health insurance will be denied the healthcare they need. Of course, all Americans already have access to at least emergency care. Hospitals are legally obligated to provide care regardless of ability to pay, and although physicians do not face the same legal requirements, we do not hear of many who are willing to deny treatment because a patient lacks insurance.

A/T: Poor Health Outcomes

The government health care system in Canada has resulted in long waiting times for care. Patients wait an average of 17.8 weeks to be treated after being referred to a specialist. Esmail, Walker, Wrona, 2006

[Nadeem Esmail, Michael Walker and Dominika Wrona, "Waiting Your Turn: Hospital Waiting Lists in Canada, 16th Edition," Fraiser Institute, Critical Issues Bulletin, October 2006.]

The Fraser Institute's sixteenth annual waiting list survey found that Canada-wide waiting times for surgical and other therapeutic treatments increased slightly in 2006. Total waiting time between referral from a general practitioner and treatment, averaged across all 12 specialties and 10 provinces surveyed, increased from 17.7 weeks in 2005 to 17.8 weeks in 2006. This small nationwide deterioration in access reflects waiting- time increases in 7 provinces, while concealing decreases in waiting time in Alberta, Ontario, and Newfoundland. Among the provinces, Ontario achieved the shortest total wait in 2006, 14.9 weeks, with Alberta (16.3 weeks), and Manitoba (18.0 weeks) next shortest. New Brunswick exhibited the longest total wait, 31.9 weeks; the next longest waits were found in Saskatchewan (28.5 weeks) and Prince Edward Island (25.8 weeks).

The numbers of procedures for which people are waiting were also calculated. For the 2006 edition, we have continued to use the methodology first introduced in the eleventh edition, which allows the Institute to more accurately measure the number of procedures for which people are waiting. As well, a significant improvement in our estimation methodology implemented in 2003 allows us to more accurately estimate the number of procedures for which patients are waiting in 2006. Throughout Canada, the total number of procedures for which people are waiting in 2006 is 770,641, a decrease of 1.6 percent from the estimated 782,936 procedures in 2005. The number of procedures for which people waited rose in British Columbia, Saskatchewan, Quebec, Nova Scotia, and Prince Edward Island. Assuming that each person was waiting for only one procedure, 2.39 percent of Canadians were waiting for treatment in 2006, which varied from a low of 1.80 percent in Alberta to a high of 5.84 percent in Saskatchewan. However, as noted in previous years, government of Saskatchewan data suggest that many patients in that province are admitted for multiple procedures, meaning that the estimate of the number of people waiting in that province may be greatly exaggerated.

Among the various specialties, the shortest total waits (i.e., between referral by a general practitioner (GP) and treatment) existed for medical oncology (4.9 weeks), radiation oncology (5.0 weeks), and elective cardiovascular surgery (8.0 weeks). Conversely, patients waited longest between a GP visit and orthopedic surgery (40.3 weeks), plastic surgery (35.4 weeks), and neurosurgery (31.7 weeks). There were large increases between 2005 and 2006 in the waits for neurosurgery (+12.9 weeks) and otolaryngology (+2.9 weeks), while the wait times for orthopedic surgery (+0.3 weeks) and internal medicine (+0.6 weeks) increased slightly. These increases were offset by improvements for patients receiving treatment in urology (-1.2 weeks), plastic surgery (-0.8 weeks), radiation oncology (-0.7 weeks), medical oncology (-0.6 weeks), gynecology (-0.5 weeks), general surgery (-0.3 weeks), elective cardiovascular surgery (-0.3 weeks), and ophthalmology (-0.2 weeks).

Breaking waiting time down into its two components, there is also variation among specialties. With regard to GP-to-specialist waiting, the shortest waits are in radiation oncology (1.5 weeks), medical oncology (2.8 weeks), and cardiovascular surgery (3.0 weeks), while the longest waits are for neurosurgery (21.0 weeks), orthopedic surgery (16.2 weeks), and ophthalmology (15.4 weeks). For specialist-to-treatment waiting, patients wait the shortest intervals for urgent cardiovascular surgery (0.7 weeks), medical oncology (2.1 weeks), and radiation oncology (3.4 weeks), and wait longest for orthopedic surgery (24.2 weeks), plastic surgery (20.1 weeks), and ophthalmology (11.8 weeks).

A/T: Poor Health Outcomes

Government discourages individual responsibility; individuals are given an incentive for reactive measures.
Herrick, '08

[Devon Herrick, PhD, Senior policy fellow at the National Center for Policy Analysis, "Crisis of the Uninsured: 2008." National Center for Policy Analysis, August 28, 2008. Date downloaded: April 14, 2009]

Many people do not enroll in government health insurance programs because they know that free health care is available once they get sick. Federal law forbids hospital emergency rooms from turning away critical care patients regardless of insurance coverage or ability to pay. A recent Urban Institute study estimates full-year uninsured individuals receive $1,686 in medical care each year. Of this, $583 is paid out-of-pocket while the remaining $1,103 is public and private charity care. This does not include the more than $300 billion the federal and state governments spend annually on such "free" public health insurance as Medicaid and S-CHIP. Furthermore, there is little incentive to enroll in public programs because families can always sign up when the need arises.

A/T: Poor Health Outcomes

Mass. reforms took away free care from many and now requires copayments
Nardin, '09

[Dr. Rachel Nardin, Assistant Professor of Neurology, Harvard Medical School, with Drs. David Himmelstein and Steffie Woolhandler (both Associate Professors of Medicine,m Harvard Medical School). "Massachusetts' Plan: A Failed Model for Health Care Reform." Physicians for a National Health Plan, February 18, 2009. Date downloaded: April 14, 2009]

Many low-income residents had been eligible for completely free care (including medications) under the state's old free care system, including all residents earning less than 200% of poverty. Access to care was often excellent for low-income residents living near a safety-net provider such as a public hospital or community clinic, but less than adequate for those living further away.

The new insurance policies that replaced the free care system require co-payments for office visits and prescriptions, which are difficult for many low-income patients to pay. For instance, at Cambridge Health Alliance, doctors and nurses have cared for patients who were forced to interrupt care for HIV and even Hodgkins lymphoma, two serious but highly treatable conditions, because they were unable to afford the new co-payments

A/T: Poor Health Outcomes

Many low-income patients who previously receive free care now must pay a co-pay for services under the Mass plan.
Nardin, '09

[Dr. Rachel Nardin, Assistant Professor of Neurology, Harvard Medical School, with Drs. David Himmelstein and Steffie Woolhandler (both Associate Professors of Medicine,m Harvard Medical School). "Massachusetts' Plan: A Failed Model for Health Care Reform." Physicians for a National Health Plan, February 18, 2009. Date downloaded: April 14, 2009]

While the number of people lacking health insurance in Massachusetts has been reduced, several recent surveys demonstrate that substantial problems in access to care remain in the state. While the new health insurance improved access to care for some residents, many low-income patients who previously received completely free care under the state's old free care progam now face co-payments, premiums and deductibles that stop them from getting needed care. In addition, cuts to safety-net providers have reduced health resources available to the state's remaining uninsured, as well as to others who rely on safety-net providers for services in short supply in the private sector. These safety-net services include emergency room care, chronic mental health care, and primary care. The net effect of this expensive reform on access to care is at best modest, and for some patients, negative.

A/T: Poor Health Outcomes

More coverage increases waiting time for medical services
Tanner and Cannon, '07

[MICHAEL TANNER is director of health and welfare studies and MICHAEL CANNON is director of health policy studies at the Cato Institute. "Universal healthcare's dirty little secrets." Los Angeles Times, April 5, 2007 Date downloaded: April 14, 2009]

Simply saying that people have health insurance is meaningless. Many countries provide universal insurance but deny critical procedures to patients who need them. Britain's Department of Health reported in 2006 that at any given time, nearly 900,000 Britons are waiting for admission to National Health Service hospitals, and shortages force the cancellation of more than 50,000 operations each year. In Sweden, the wait for heart surgery can be as long as 25 weeks, and the average wait for hip replacement surgery is more than a year. Many of these individuals suffer chronic pain, and judging by the numbers, some will probably die awaiting treatment. In a 2005 ruling of the Canadian Supreme Court, Chief Justice Beverly McLachlin wrote that "access to a waiting list is not access to healthcare."

A/T: Right To Healthcare

Right to health care precludes individual liberty, which is more important
Kelley, '94

[David Kelley, "Is There a Right to Health Care?" A speech delivered at multiple venues in 1993-94. Atlas Society, 1994. Date downloaded: April 14, 2009]

In all the ways I have described, any attempt to implement a "right" to health care necessarily sacrifices our genuine rights of liberty. We have to choose between liberty rights and welfare rights. They are logically incompatible. It is because I believe in the rights of liberty that I say there is no such thing as a right to health care. So I want to end by explaining why I think the rights of liberty are paramount, and by trying to anticipate some of the questions and objections you may have.

The rights of liberty are paramount because individuals are ends in themselves. We are not instruments of society, or possessions of society. And if we are ends in ourselves, we have the right to be ends for ourselves: to hold our own lives and happiness as our highest values, not to be sacrificed for anything else.

A/T: Right To Healthcare

Personal needs are only rationally met by the fruit of the individual's labor
Kelley, '94

[David Kelley, "Is There a Right to Health Care?" A speech delivered at multiple venues in 1993-94. Atlas Society, 1994. Date downloaded: April 14, 2009]

No rational basis for this principle has ever been offered. The fact is that our needs have to be satisfied by production, not by taking from others. And production comes from those who take responsibility for their lives, who apply their minds to the challenges we face in nature and find new ways of meeting those challenges. Ayn Rand said it best, in her novel *The Fountainhead*: "Men have been taught that the highest virtue is not to achieve, but to give. Yet one cannot give that which has not been created. Creation comes before distribution—or there will be nothing to distribute. The need of the creator comes before the need of any possible beneficiary."[8] The creator's need, in any field, is the freedom to act, the freedom to dispose of the fruits of his labor as he chooses, and the freedom to interact with others on a voluntary basis, by trade and mutual exchange.

A/T: Right To Healthcare

A positive right to health care would destroy principles of American government
Busch, '09

[Andrew E. Busch, "Is Health Care a Right?" Claremont Institute, March 16, 2009. Date downloaded: April 14, 2009]

The great danger of health-care-as-a-right is that it threatens to supplant the American republic's key political principles. Accepting a positive government obligation to fund social services claimed as a matter of right would lead inexorably to government without limits. How could one fence off claims on government resources or demands for the exercise of government power, if the right to the pursuit of happiness, for example, became a font of positive economic rights? When applied to health care, this principle could easily lead to individual rights, traditionally understood, being eaten up by confiscatory taxation, health regimentation and rationing, and insurance mandates.

Solvency: Not Enough Doctors

More coverage means overloaded physicians
Sack, '08

[Kevin Sack, "In Massachusetts, Universal Coverage Strains Care." New York Times, April 5, 2008. Date downloaded: April 14, 2009]

In pockets of the United States, rural and urban, a confluence of market and medical forces has been widening the gap between the supply of primary care physicians and the demand for their services. Modest pay, medical school debt, an aging population and the prevalence of chronic disease have each played a role.

Now in Massachusetts, in an unintended consequence of universal coverage, the imbalance is being exacerbated by the state's new law requiring residents to have health insurance.

Solvency: Not Enough Doctors

America is facing a shortage of doctors
Sack, '08

[Kevin Sack, "In Massachusetts, Universal Coverage Strains Care." New York Times, April 5, 2008. Date downloaded: April 14, 2009]

But there is little dispute that the general practice of medicine is under strain at a time when there is bipartisan consensus that better prevention and chronic disease management would not only improve health but also help control costs. With its population aging, the country will need 40 percent more primary care doctors by 2020, according to the American College of Physicians, which represents 125,000 internists, and the 94,000-member American Academy of Family Physicians. Community health centers, bolstered by increases in federal financing during the Bush years, are having particular difficulty finding doctors.

Solvency: Not Enough Doctors

Surge in insured patients leads to lack of doctors
Brown, ‘08

[Karen Brown, Kaiser Foundation Fellow. “Mass. Health Care Reform Reveals Doctor Shortage.” National Public Radio, November 30, 2008. Date downloaded: April 14, 2009]

"A urologist, in one procedure, makes more than I make in two days of seeing patients," Atkinson says.

Massachusetts Dr. Dan Levy, who left primary care for medical administration, says that's only getting worse with universal health care, since newly insured patients tend to come with a pile of saved-up complaints.

"You have someone on your hands with five separate medical problems, 15 minutes to see them. If you spend the extra half hour, you don't get paid for it, so the pressure is to refer them to a subspecialist," Levy explains. "It takes a lot of the pleasure and fun out of doing medicine."

Western Massachusetts is a rural area — the doctor shortage is more acute here than in cities like Boston. But it's a problem everywhere. In a national study released this fall by the Physicians' Foundation, 80 percent of primary care doctors called the job unrewarding; half of them plan to scale back or stop practicing within three years. At the same time, most medical students are choosing specialty tracks, like surgery.

Solvency: Still Largely Unaffordable For Many

Many plans still unaffordable
Nardin, '09

[Dr. Rachel Nardin, Assistant Professor of Neurology, Harvard Medical School, with Drs. David Himmelstein and Steffie Woolhandler (both Associate Professors of Medicine,m Harvard Medical School). "Massachusetts' Plan: A Failed Model for Health Care Reform." Physicians for a National Health Plan, February 18, 2009. Date downloaded: April 14, 2009]

The state has failed to ensure the availability of comprehensive plans at affordable prices. Despite the merging of the small group and individual insurance markets, which was expected to lower costs in the individual market, premiums continue to be unaffordable for even the least comprehensive (skimpiest) plans. For instance, the reform law specifically exempts uninsured families from fines if no affordable private plan is available. About 79,000 Massachusetts uninsured residents received this exemption in 2007, which excused them from fines, but left them uninsured.

Solvency: Still Largely Unaffordable For Many

Obstacles still exist to complete coverage
King, '09

[Suzanne King, MD. "Mass. healthcare reform is failing us." Boston Globe, March 2, 2009. Date downloaded: April 14, 2009]

First, it has not achieved universal healthcare, although the reform has been a boon to the private insurance industry. The state has more than 200,000 without coverage, and the count can only go up with rising unemployment.

Second, the reform does not address the problem of insurance being connected to jobs. For individuals, this means their insurance is not continuous if they change or lose jobs. For employers, especially small businesses, health insurance is an expense they can ill afford.

Solvency: Still Largely Unaffordable For Many

Many cannot afford the new policy
King, '09

[Suzanne King, MD. "Mass. healthcare reform is failing us." Boston Globe, March 2, 2009. Date downloaded: April 14, 2009]

Third, the program is not affordable for many individuals and families. For middle-income people not qualifying for state-subsidized health insurance, costs are too high for even skimpy coverage. For an individual earning $31,213, the cheapest plan can cost $9,872 in premiums and out-of-pocket payments. Low-income residents, previously eligible for free care, have insurance policies requiring unaffordable copayments for office visits and medications.

Fifth, reform does not assure access to care. High-deductible plans that have additional out-of-pocket expenses can result in many people not using their insurance when they are sick. In my practice of child and adolescent psychiatry, a parent told me last week that she had a decrease in her job hours, could not afford the $30 copayment for treatment sessions for her adolescent, and decided to meet much less frequently.

Solvency: Private Is Better

Without government taxes, private assistance would increase
Rockwell, '95

[Llewellyn H. Rockwell, "Welfare Reform: True and False." Mises Institute, December 1995. Date downloaded: April 9th, 2009]

The point is not the rate of growth of spending, but the destruction that taxes and spending are causing right now. If this destruction were ended immediately, masses of people would be reintroduced to the work ethic, taxpayers would have more money in their pockets, and voluntary spending on private charity would go up. Until then, poverty, sloth, and bureaucracy will continue to be subsidized by you and me.

People would love the opportunity to give more to actually help the less fortunate, especially in their own families and communities. But taxes, including Social Security, are draining people's discretionary income and creating a disincentive to give. A real welfare reform would address this problem first.

Solvency: Private Is Better

Government spending subverts private spending
Lehman, '01

[Joseph R Lehman, "Does Charity Begin at Home-or with Government?." Mackinac Center for Public Policy, March 3, 2001. Date downloaded: April 9th, 2009]

Bush hopes to infuse successful faith-based programs with new cash—and infuse federally funded projects with more success. He proposes a panoply of new government grants, amended rules, and tax changes. Let's address each of these.

Bush's multibillion-dollar "compassion capital fund" would, among other things, grant seed money to groups venturing into social services. But to the extent the fund consists of tax money, it would actually subvert the goals of the charities it tries to help. That's because government welfare spending displaces private charity. Writing in 1984 for the Journal of Political Economy, Russell Roberts found that private relief spending in America rose steadily until 1932, but then declined consistently thereafter as government welfare spending rose. His conclusion: government welfare crowds out private giving almost dollar-for-dollar. When government takes tax dollars for "charity," not only does it betray the voluntary nature of true charity, taxpayers in turn give less to private groups.

Bush also wants to amend "charitable choice" rules of the 1996 welfare reform law. Religious groups would have easier access to billions of dollars in federal grants and social services contracts. Government at all levels already contracts with church-affiliated organizations for social services, which some argue is tantamount to government establishment of religion. But a bigger risk is government corruption of religion.

Solvency: Private Is Better

Reducing government spending will increase private
Matthews, et al., 1998

[Merrill Matthews Jr, Peter S. Barwick, Grace-Marie Arnett, Stanley W. Carlson-Thies and Robert Rector, "Charity Tax Credits--and Debits." Policy Review, January/February 1998. Date downloaded: April 9th, 2009]

If people were able to direct their tax dollars to private charities, they would scale back their overall commitment to aiding the poor.

In fact, just the opposite would likely occur. Most economists recognize what is called the "crowding out" effect: When government spending increases, private spending declines. In a 1984 article in the *Journal of Political Economy*, Russell Roberts found that private relief expenditures rose steadily in the United States until 1932, and declined steadily thereafter as government welfare spending rose. An article in the *National Tax Journal* that same year found that cuts in government spending resulted in increased interest in private contributions. Thus it is entirely possible that reducing government welfare spending through a tax credit for charitable giving might result in an increase in total spending on the needy.

Solvency: Private Is Better

The Massachusetts model should not be followed because it did not improve the situation and it made health care quality worse.
Ralston, '06

[RICHARD E. RALSTON, Executive director of Americans for Free Choice in Medicine in Newport Beach. "The Orange Grove: Don't follow Massachusetts' lead." Orange County Register, November 30, 2006. Date downloaded: April 14, 2009]

The best way to avoid mistakes is to take a principled stand for individual rights. Insurance buyers should never be forced to do anything, but should be allowed as many options as possible. It is important to understand that mandatory insurance is not, as some conservatives have maintained, consistent with individual responsibility. Being forced to obey government orders is not "individual responsibility."

The most expensive of mistakes are easily avoided. The obvious ones, evident in the Massachusetts plan, can be avoided as follows:

•Do not create a huge category of patients who are entitled, as a supposed "right," to all the medical treatment they demand, with no co-payments or deductibles, and no responsibility to contribute a penny to their own health care.

•Do not replace the current, heavily regulated insurance market with something even worse, like a statewide "connector" which just replaces what is left of a free insurance market with a government monopoly – with the additional regulations and requirements that add cost and limit choice.

•Do not create and add any new government agencies or bureaucracies. Massachusetts kept the regulatory functions of the state health departments and insurance commission, and added four more.

California and other states must resist the illusion that more government regulation, more government bureaucracy, and more government spending will help us pay our insurance and medical bills.

Solvency: Private Is Better

Medicaid patients do not have access to quality care.
Herrick, '09

[Devon Herrick. "Exposing the Myths of Universal Health Coverage." NCPA, April 9, 2009. Date downloaded: April 14, 2009]

Myth No. 4: Expanding Government Insurance Improves Access to Care. Expanding eligibility for Medicaid or the State Children's Health Insurance Program (S-CHIP) would improve access to care for lower-middle income families.

Reality: In practice, things are different. On paper, Medicaid coverage appears more generous than the benefits the vast majority of Americans receive through private health insurance. Potentially, Medicaid enrollees can see any doctor or enter any facility and pay nothing. In fact, the uninsured and Medicaid patients do tend to get their care at the same hospitals, clinics and emergency rooms. But the availability of other providers is limited: Nationally, one-third of doctors do not accept any Medicaid patients and, among those who do, many limit the number they will treat. Studies have shown that access to care at ambulatory (outpatient) clinics is also limited for Medicaid patients, as is access to specialist care.

Another problem is that expanding public coverage encourages people to drop their private health plan to take advantage of the free program - leading to a phenomenon known as "crowd-out." For instance:

- For every new dollar of spending on Medicaid expansions in the 1990s, between 49 and 74 cents went to people who had dropped private coverage.
- The crowd-out rate for S-CHIP averages is about 60 percent.
- Hawaii recently abandoned its universal child health care program after state officials discovered 85 percent of newly enrolled kids had dropped private coverage.

As income rises, so does the likelihood that families will be covered by private insurance. Thus, increasing eligibility for public coverage also increases the likelihood that a family will drop better quality private coverage.

Counterplan: Private Is Better

Public spending crowds out private, leading to slower economic growth
Westbury and Stein, '09

[*Brian S. Wesbury is chief economist and Robert Stein senior economist at First Trust Advisors in Wheaton, Ill.* "Government Gone Wild." Forbes magazine, March 31, 2009. Date downloaded: April 13th, 2009]

But all of this is just a pipe dream. Government spending does not cause a net increase in jobs over the long run; it costs jobs. Every dollar the government spends is either taxed or borrowed from the private sector, which means it "crowds out" private sector job creation. And because government spending is less efficient than private sector spending, the economy actually grows more slowly in the long run as the government gets bigger.

Counterplan: Private Is Better

Consumer Driven Health Care is the key to low-cost, high-qualify health care.
Goodman

[Dr. John Goodman, "Health Plan." National Center for Policy Analysis. Date downloaded: April 14, 2009]

To confront America's health care crisis, we do not need more spending, more regulations or more bureaucracy. We do need people, however, including every doctor and every patient. All 300 million Americans must be free to use their intelligence, their creativity and their innovative ability to make the changes needed to create access to low-cost, high-quality health care.

Counterplan: Must Be Consumer Driven

Consumer-driven health care will be better
Herrick, '05

[Devon M. Herrick, Ph.D. "Consumer Driven Health Care: The Changing Role of the Patient." National Center for Policy Analysis, May 2005. Date downloaded: April 14, 2009]

Consumer driven health care is a new paradigm for health care delivery. Defined narrowly, consumer driven health care refers to health plans in which individuals have a personal health account, such as a health savings account (HSA) or a health reimbursement arrangement (HRA), from which they pay medical expenses directly. The phrase is sometimes used more broadly to refer to defined contribution health plans, which allow employees to choose among various plans, often with a fixed dollar contribution from an employer. Those who opt for plans with rich benefits may have to contribute a significant amount of their own money in addition to an employer's contribution. Those with more basic coverage contribute less of their own money.

Counterplan: Private Is Better

Private sector enrollment will allow Medicaid enrollees increased flexibility, access, and quality health care
Bond, Goodman, et al., '03

[Michael Bond, Director Center for Health Care Policy, The Buckeye Institute; John C. Goodman, President and CEO, National Center for Policy Analysis; Ronald Lindsey, Senior Fellow, National Center for Policy Analysis and Former Commissioner, Texas Department of Human Services; and Richard Teske, Senior Fellow, National Center for Policy Analysis. "Reforming Medicaid." National Center for Policy Analysis, Poly Report No. 257, February 2003. Date downloaded: April 22, 2009.]

Medicaid enrollees should be allowed to enroll in private sector plans, including employer plans and individually owned insurance plans. To qualify to accept Medicaid enrollees, a health plan should have to offer benefits at least as generous as any of the plans currently offered to state employees. In addition, the state should authorize a new type of plan that incorporates a health care savings account.

Although the private sector plans may appear less generous on paper than the current Medicaid program, they usually would allow enrollees access to a greater range of providers and facilities. Put differently, this proposal would allow Medicaid enrollees to participate in the same kinds of health plans as other citizens.

Counterplan: Private Is Better

Consumer driven health care will increase efficiency; eliminating perverse government incentives.

Bond, Goodman, et al., '03

[Michael Bond, Director Center for Health Care Policy, The Buckeye Institute; John C. Goodman, President and CEO, National Center for Policy Analysis; Ronald Lindsey, Senior Fellow, National Center for Policy Analysis and Former Commissioner, Texas Department of Human Services; and Richard Teske, Senior Fellow, National Center for Policy Analysis. "Reforming Medicaid." National Center for Policy Analysis, Policy Report No. 257, February 2003. Date downloaded: April 22, 2009.]

Patient Power Cost-Control Devices. When patients have first-dollar coverage for health care services, they have no incentive to avoid waste or insure that they get a dollar's worth of value for each dollar they spend. To the contrary, if the out-of-pocket costs are zero, patients have an incentive to utilize health care services until their value approaches zero, at the margin. Similarly, doctors treating patients with first-dollar insurance coverage have an incentive to provide services as long as those services offer any positive medical benefit (or probability of benefit), even if the value of the benefit is well below its cost.

Managed care arose to try and counteract these perverse incentives. But all too often managed care consisted of an impersonal bureaucracy that put cost control ahead of patient welfare. As an alternative, many employers across the country are empowering employees by letting them manage some of their own health care dollars and experience the costs and benefits of prudent health care consumption.

Counterplan: HIFA Background

HIFA waivers allow states the flexibility to alter benefits or plans to better meet the needs of their population.
Bond, Goodman, et al., '03

[Michael Bond, Director Center for Health Care Policy, The Buckeye Institute; John C. Goodman, President and CEO, National Center for Policy Analysis; Ronald Lindsey, Senior Fellow, National Center for Policy Analysis and Former Commissioner, Texas Department of Human Services; and Richard Teske, Senior Fellow, National Center for Policy Analysis. "Reforming Medicaid." National Center for Policy Analysis, Policy Report No. 257, February 2003. Date downloaded: April 22, 2009.]

On entering office, President Bush and Health and Human Services (HHS) Secretary Tommy Thompson announced a streamlined section 1115 waiver process named the Health Insurance Flexibility and Accountability (HIFA) initiative. The section 1115 waiver, granted by the Centers for Medicare and Medicaid Services (CMS), has traditionally been the chief research and demonstration process to test innovative comprehensive Medicaid reform. The idea is to enable states to perform as "laboratories for democracy." Since August of 2001, states have had the opportunity through waivers**:**

● To reduce some benefits in return for increases in other benefits;
● To reduce benefits in return for increases in the number of people eligible for those benefits; or
● To reduce benefits for some people in order to create a new set of benefits for others.

Suppose a state wants to expand eligibility to a new population (and qualify for federal matching funds for its spending on that group) without increasing the total amount of federal spending on health care. Under a HIFA waiver the state can have access to three sources of funds to pay its share of costs for the newly eligible:

● Disproportionate Share Hospital (DSH) funds, which are federal and state funds available to hospitals treating a disproportionate share of Medicaid and charity care patients.
● Unspent State Children's Health Insurance Program (S-CHIP) funds.
● Savings from the reduction of Medicaid benefits for currently eligible populations or the reduction in eligible populations.

Furthermore, the benefits created for the newly eligible group can be more limited than the benefits that were available to the previously eligible group. There are certain restrictions on the waivers.35 Usually, they are valid for three years (although they can be renewed). They must be budget neutral (the federal government must not expect to expend any additional funds). The state must be trying to "research an idea" (not just cutting costs). Certain populations must be "held harmless" (usually pregnant mothers and children). Certain benefits must be protected. Essentially, however, states can adjust almost all the benefits, eligibility and reimbursement standards. They need only CMS approval, not any congressional or judicial approval. If the waiver proves unsuccessful at any time, the state can unilaterally cancel after not adding any new enrollees for six months.

Counterplan: HIFA Works

HIFA plan would allow the states to offer quality care, save costs, and increase access
Bond, Goodman, et al., '03

[Michael Bond, Director Center for Health Care Policy, The Buckeye Institute; John C. Goodman, President and CEO, National Center for Policy Analysis; Ronald Lindsey, Senior Fellow, National Center for Policy Analysis and Former Commissioner, Texas Department of Human Services; and Richard Teske, Senior Fellow, National Center for Policy Analysis. "Reforming Medicaid." National Center for Policy Analysis, Policy Report No. 257, February 2003. Date downloaded: April 22, 2009.]

The Need for Federal Waivers. In order to take full advantage of private sector techniques and private sector opportunities, states should apply for a federal waiver, called a HIFA waiver. For example, a waiver might work like this:

● All "mandated" Medicaid enrollees would have the opportunity to enroll in employer plans or other private sector plans with premium subsidies from the state.

● To qualify, the private insurance would have to be similar to the plans currently offered to state employees.

● Those beneficiaries who do not qualify for an employer plan would have the opportunity to enroll annually in a plan of their choice through an insurance exchange (a health mart), organized and operated by the state.

● At least one of the plans offered would make use of a Medicaid Benefit Account (MBA), which would be similar to a medical savings account, except that the funds could be used only to pay health care expenses or health insurance premiums, now and in the future.

● Projected savings (in a static sense) from these changes would be used to enroll additional, "optional" people in Medicaid (this is a necessary condition to get approval for a HIFA waiver).

● The optional enrollees, consisting of additional people with disabilities and low-income families, could be offered a limited set of benefits (e.g., primary care benefits only) or they could be given the same options as other Medicaid enrollees — with premium support from the state diminishing as family income rises.

Medicaid 1AC (1/12)

Inherency

Low-wage workers cannot afford health care and do not qualify for government benefits
Dubay, et al., '06

[Lisa Dubay, John Holahan, and Allison Cook, Lisa Dubay is a research scientist at the Johns Hopkins Bloomberg School of Public Health, in Baltimore, Maryland. John Holahan (jholahan@ui.urban.org) is director of the Health Policy Center, Urban Institute, in Washington, D.C.; Allison Cook is a research assistant there. "The Uninsured and The Affordability Of Health Insurance Coverage." Urban Institute, November 30, 2006. Date downloaded: April 14, 2009]

Another group has incomes above Medicaid and SCHIP eligibility levels but finds coverage too costly given their incomes. Health insurance premiums have risen dramatically in recent years: Premiums for private-sector employees of all firm sizes averaged about $3,700 for individuals and $10,000 for families in 2004. Given high and rising premiums, some firms—particularly smaller firms with low-wage workers—do not offer coverage. Other workers have an offer of coverage, but employers pay only a relatively small share of the cost, particularly for dependent coverage, leaving a large share for the employee. Moreover, some firms that offer coverage do not make all workers eligible—for example, new employees or seasonal and temporary workers. Self-employed workers and others without an offer of employer-sponsored coverage often find coverage unaffordable.

Medicaid 1AC (2/12)

Inherency

Levels of uninsured are high and will continue to rise in the current economic crisis
Greenstein, et al., '08

[Robert Greenstein, Sharon Parrott and Arloc Sherman. "Poverty and Share of Americans Without Health Insurance Were Higher in 2007 - And Median Income for Working-Age Households Was Lower - Than at the Bottom of Last Recession." Center for Budget and Policy Priorities, August 26, 2008. Date downloaded: April 20, 2009.]

In 2007, some 45.7 million Americans — 15.3 percent of the population — were uninsured. These figures represent an improvement over the figures for 2006, but marked deterioration since 2001, when nearly 6 million fewer Americans lacked insurance.

The main reason for the increase in the uninsured population over this period is that the percentage of people with employer-sponsored health insurance decreased significantly from 2001 — when 63.2 percent of Americans had employer-sponsored coverage — to 2007, when 59.3 percent did. Employer-sponsored coverage rates are likely to decline further in 2008, in part due to the economic downturn.

Employer-based coverage declined once again between 2006 and 2007, from 59.7 percent to 59.3 percent. The reason that the percentage and number of uninsured people fell in 2007 is that more Americans were able to obtain government-funded health insurance. The percentage of Americans with insurance through a public program increased from 27.0 percent in 2006 to 27.8 percentage in 2007, primarily as a result of gains in coverage through Medicare and Medicaid.

The ability of public programs like Medicaid to offset erosion in employer-sponsored health insurance could disappear in 2008 or 2009. Medicaid programs face a risk of cuts in numerous states, because a growing majority of the states face budget deficits due to the economic slowdown. Since nearly every state is required to balance its budget each year, an increasing number of states may consider scaling back Medicaid benefits and eligibility in the year ahead. Congress could help states to avert or minimize such cuts by temporarily increasing the federal share of Medicaid costs, as it did in response to the last economic downturn.

Medicaid 1AC (3/12)

Harm: High Health Care Costs

The uninsured increase costs for all in health care system
Dubay, et al., '06

[Lisa Dubay, John Holahan, and Allison Cook, Lisa Dubay is a research scientist at the Johns Hopkins Bloomberg School of Public Health, in Baltimore, Maryland. John Holahan (jholahan@ui.urban.org) is director of the Health Policy Center, Urban Institute, in Washington, D.C.; Allison Cook is a research assistant there. "The Uninsured and The Affordability Of Health Insurance Coverage." Urban Institute, November 30, 2006. Date downloaded: April 14, 2009]

To begin with, lack of insurance coverage has adverse effects on the uninsured themselves. Despite being in worse health status than people with coverage, the uninsured use fewer services and face higher out-of-pocket spending than their insured counterparts. Moreover, medical expenses by the uninsured have been shown to be an important contributor to U.S. bankruptcy filings. In addition, hospitals and other providers face increasing demands for care by the uninsured for which there is little or no reimbursement. This places fiscal stress on these institutions and on the local governments and philanthropies that support them.

Medicaid 1AC (4/12)

Harm: High Health Care Costs

Health care costs led to bankruptcy
National Coalition on Health Care, '08
["Health Insurance Costs." National Coalition on Health Care, 2008. Date downloaded: April 16, 2009.]

A recent study by Harvard University researchers found that the average out-of-pocket medical debt for those who filed for bankruptcy was $12,000. The study noted that 68 percent of those who filed for bankruptcy had health insurance. In addition, the study found that 50 percent of all bankruptcy filings were partly the result of medical expenses.[6] Every 30 seconds in the United States someone files for bankruptcy in the aftermath of a serious health problem.

Medicaid 1AC (5/12)

Harm: Poor Health Outcomes

Studies demonstrate that being uninsured drastically decreases life span
New York Times, '08
["No Insurance, Poor Health." New York Times, January 3, 2008. Date downloaded: April 16, 2009.]

One study by researchers at Harvard Medical School, published in the Journal of the American Medical Association, found that uninsured near-elderly people got sicker at a faster rate than comparable people with insurance. Those disparities were sharply reduced when people turned 65 and became eligible for Medicare. Those who previously had insurance reported no significant change in their health as they transitioned to Medicare, but those with little or no prior coverage reported a substantial slowing of the decline of their health. It was strong proof of the value of Medicare's universal coverage for elderly Americans.

The value was particularly evident for previously uninsured individuals suffering from heart disease, stroke, high blood pressure or diabetes. Once on Medicare, they benefited greatly from medical management of blood pressure, cholesterol and glucose levels and quicker access to effective treatments and prescription drugs. They had 10 percent fewer major cardiac complications, such as heart attacks or heart failure, than would have been expected by age 72 based on their previous health trends.

A second study, by researchers at the American Cancer Society, found substantial evidence that lack of adequate health insurance coverage was associated with less access to care and poorer outcomes for cancer patients. The uninsured were less likely to receive recommended cancer screening tests and more likely to have their cancers diagnosed at a later stage, when they are less curable. They had lower survival rates than those with private insurance for several cancers for which there are screening tests and effective treatments, including breast and colorectal cancer.

Medicaid 1AC (6/12)

Harm: Poor Health Outcomes

Poverty reduces lifespan and leads to poor health outcomes
GAO, '07

[" POVERTY IN AMERICA: Economic Research Shows Adverse Impacts on Health Status and Other Social Conditions as well as the Economic Growth Rate." Government Accountability Office, January 2007. Date downloaded: April 13th, 2009]

Health outcomes are worse for individuals with low incomes than for their more affluent counterparts. Lower-income individuals experience higher rates of chronic illness, disease, and disabilities, and also die younger than those who have higher incomes. As reported by the National Center on Health Statistics, individuals living in poverty are more likely than their affluent counterparts to experience fair or poor health, or suffer from conditions that limit their everyday activities (fig.1). They also report higher rates of chronic conditions such as hypertension, high blood pressure, and elevated serum cholesterol, which can be predictors of more acute conditions in the future. Life expectancies for individuals in poor families as compared to non-poor families also differ significantly. One study showed that individuals with low incomes had life expectancies 25 percent lower than those with higher incomes.

Medicaid 1AC (7/12)

Harm: Right to Health Care

Right to health care is founded on human dignity and an essential safeguard of human life Ascension Health, '07

[Ascension Health, America's largest nonprofit Catholic health care provider network. "The Right to Health Care." 2007. Date downloaded: April 14, 2009]

From the perspective of Catholic moral teaching, the "right to health care" for all is not an optional stance. Rather, the right to health care is a human right founded on human dignity and the common good. Considered as such, health care is more than a commodity in so far as it is an essential safeguard of human life and dignity that ought to be provided for and to everyone. This absolute right to health care, however, should not be understood as an unlimited entitlement, but as a right that carries with it corresponding duties regarding justice, stewardship and the common good.

Medicaid 1AC (8/12)

Harm: Right To Health Care

Health care is a core human right
Carmalt and Zaidi

[Jean Carmalt is the Legal Coordinator at CESR. Jean was previously with the International Justice Program at the Lawyers Committee for Human Rights, and also taught HIV/AIDS Education in Kyrgyzstan. Sarah Zaidi is Director and co-founder of CESR.. "THE RIGHT TO HEALTH IN THE UNITED STATES OF AMERICA: WHAT DOES IT MEAN?" The Center for Economic and Social Rights. Date downloaded: April 14, 2009]

Health care policy needs to be about the right to health. The current debate over health care reform tends to bog down in ideological disputes and arguments over economic efficiency. In contrast, a human rights approach would focus on the *underlying purpose* of the health care system. The core human rights demand is for outcomes consistent with internationally-recognized standards—regardless of whether the health system is private or public. Framing health care reform as a matter of right establishes a mechanism for government accountability and encourages public participation in the decisions that affect our lives and well-being.

Medicaid 1AC (9/12)

Plan Text

The United States Federal Government should expand Medicaid to 200% of the Federal Poverty Level [FPL], and provide health insurance at a subsidized rate to those who do not qualify for Medicaid and have incomes under 300% of the FPL.

Medicaid 1AC (10/12)

Solvency: Plan Decreases Prices

Commonwealth Care provides individuals w/low-cost insurance
Sack, '09

[Kevin Sack, "Massachusetts Faces Costs of Big Health Care Plan." New York Times, March 15, 2009. Date downloaded: April 14, 2009]

The threat seems to have been heard. Insurers seeking to participate in the state's subsidized insurance program, Commonwealth Care, recently submitted bids so low that officials announced last week that they would keep premiums flat in the coming year. That may provide cover for the program as the state seeks ways to fill a nearly $4 billion gap in its 2010 budget.

Medicaid 1AC (11/12)

Solvency: Public Plans Save Consumers Money

A national public plan could be ~30% cheaper -- government spending is not inherently worse
Shelis and Haught, '09

[John Sheils and Randy Haught "The Cost and Coverage Impacts of a Public Plan: Alternative Design Options." Lewin Group, April 6, 2009 Date downloaded: April 14, 2009]

Consequently, in this paper, we present impact estimates under several variations on the public plan model. Under each variation, we assume that the public plan is implemented together with President Obama's coverage expansion proposals, which we estimate would cover about 28 million uninsured people.

If Medicare payment levels are used in the public plan, premiums would be up to 30 percent less than premiums for comparable private coverage. On average, the monthly premium in the public plan for a typical benefits package would be $761 per family compared with an average of $970 per family in the private market for the same coverage.

If as the President proposed, eligibility is limited to only small employers, individuals and the self-employed, public plan enrollment would reach 42.9 million people. The number of people with private coverage would fall by 32.0 million people. If private payer reimbursement levels are used by the public plan, enrollment would be lower, with only 10.4 million people switching to the public plan from private insurance.

Medicaid 1AC (12/12)

Solvency: Massachusetts Increase Medicaid Rolls

Massachusetts had 2nd highest Medicaid growth rate
Ellis, et al., '08

[Eileen R. Ellis, Dennis Roberts (Health Managament Associates), David Rouseau, MPH, Karyn Schwartz, MPH. "Medicaid Enrollment in the 50 States." Kaiser Family Foundation, January 2008, Date downloaded: April 14, 2009.]

All Kids builds upon Illinois's Medicaid and State Children's Health Insurance Programs (SCHIP) to cover children in families with incomes above Medicaid and SCHIP eligibility levels using state-only dollars.[5] As the enrollment data reported here indicate, the broad-based marketing and outreach for this universal program was an effective tool in reaching uninsured Medicaid-eligible children and resulted in strong growth in Medicaid enrollment at a time when national enrollment levels were falling. Similarly, Massachusetts experienced the nation's second highest growth in Medicaid enrollment during the period (5.2%) while implementing Medicaid eligibility expansions for both children and adults in July 2006 as part of their broader Massachusetts Health Care Reform Plan.

Inherency: Uninsured

Number of uninsured rising
Dubay, et al., '06

[Lisa Dubay, John Holahan, and Allison Cook, Lisa Dubay is a research scientist at the Johns Hopkins Bloomberg School of Public Health, in Baltimore, Maryland. John Holahan (jholahan@ui.urban.org) is director of the Health Policy Center, Urban Institute, in Washington, D.C.; Allison Cook is a research assistant there. "The Uninsured and The Affordability Of Health Insurance Coverage." Urban Institute, November 30, 2006. Date downloaded: April 14, 2009]

During the past five years, the number of uninsured Americans increased by more than six million, rising from 39.6 million in 2000 to 46.1 million (nonelderly) in 2005.

Inherency: Poverty Linked To Insurance Availability

In New York, poverty keeps many from health insurance
Munford, '07

[Tracey Munford, "Uninsured New Yorkers are linked to poverty." Community Service Society, September 4, 2007. Date downloaded: April 21, 2009.]

The "Unheard Third" survey interviewed 1,551 low and high wage New Yorkers in July and August, 2007. The survey reveals that the lack of affordable health insurance is the biggest worry for the people 100-200 percent of the federal poverty line. The "Unheard Third" over the last three years has documented a pronounced decline in the percentage of full-time working poor respondents who report being offered health insurance by their employers, (from a high of 58 percent in 2003-2004 to a low of 27 percent in 2005-2006). Ms. Benjamin, in her testimony stated that fewer and fewer people are receiving health insurance in their workplaces. The research shows that of those below 200 percent of the federal poverty level, 55 percent do not receive health insurance for themselves and 67 percent do not receive health insurance for their families through their jobs. This year, we found that only 37 percent of working poor people receives health insurance through their jobs. The central reason for this decline is that health insurance has simply become unaffordable for low and moderate-income New Yorkers.

Inherency: Poverty Linked To Insurance Availability

Income is the only guarantee of insurance, even some full-time workers do not have insurance
Johnson, '08

[Teddi Dineley Johnson, "Census Bureau: Number of U.S. Uninsured Rises to 47 Million Americans are Uninsured: Almost 5 Percent Increase Since 2005." The Nation's Health, 01/08/2008. Date downloaded: April 21, 2009.]

The likelihood of having health coverage rises with income levels. However, while the nation's official poverty rate declined slightly for the first time this decade, decreasing from 12.6 percent in 2005 to 12.3 percent in 2006, the actual number of people in poverty in 2006 — 36.5 million — was not statistically different from 2005, according to the Census Bureau.

The number of uninsured full-time workers increased from 20.8 million in 2005 to 22 million in 2006, while the number of uninsured part-time workers, 5.6 million, remained the same as in 2005. The number of Americans insured by Medicaid and Medicare in 2006 also remained the same as in 2005, at 38.3 million and 40.3 million respectively.

Inherency: MassCare

Massachusetts reform altered eligibility for adults and children
Ellis, et al., '08

[Eileen R. Ellis, Dennis Roberts (Health Managament Associates), David Rouseau, MPH, Karyn Schwartz, MPH. "Medicaid Enrollment in the 50 States." Kaiser Family Foundation, January 2008, Date downloaded: April 14, 2009.]

Massachusetts had an enrollment increase of 5.2% following implementation of provisions of the Massachusetts Health Care Reform Plan in July 200 that expanded eligibility for Medicaid to children up to 300% of the federal poverty line and increased the caps on enrollment for existing Medicaid programs for adults.

Inherency: MassCare

MassCare provides subsidies and waives premiums for all below poverty level
Valentine, '06
[Vikkie Valentine, "Key details of the bill." National Public Radio. April 5, 2006. Date downloaded: April 14, 2009]

As of July 1, 2007, all individuals must have coverage.

-- Those below 300 percent of the federal poverty level (about $38,500 for a family of three), but not eligible for Medicaid, will have their private insurance plans subsidized at a sliding-scale rate.

-- Children whose families earn below 300 percent of the federal poverty level (FPL) will be given free coverage through Medicaid.

-- Individuals with incomes below the FPL ($9,600) will have premiums waived on private insurance. (Currently most childless adults, no matter what their income, are not eligible for coverage under the state's Medicaid plan.)

-- Those who can afford insurance will be increasingly penalized for not buying coverage. In the first year, they'll lose their state personal income tax exemption.

-- Family coverage will be extended to cover young adults up to the age of 25.

-- Allows the use of "health savings accounts" with cheaper high-deductible "catastrophic" coverage plans. HSAs allow consumers to invest money and withdraw it "tax free" to cover health-care costs.

Inherency: Commonwealth Care

State plan offers insurance beyond Medicaid
Herrick, '07

[Devon Herrick, Senior policy analyst, NCPA, "Insuring the Uninsured: Five Steps to Improve the Massachusetts Plan."National Center for Policy Analysis, April 19, 2007. Date downloaded: April 14, 2009]

Low-income families, workers in small firms and the self-employed will obtain coverage through the state-run Commonwealth Health Insurance Connector. Ed Haislmaier of the Heritage Foundation describes the Connector as a health insurance market designed to work like CarMax: one giant dealer selling numerous brands with a variety of makes and models.

Inherency: Commonwealth Care

Massachusetts' Commonwealth Care offers subsidized insurance for those earning up to 300% of the federal poverty level
Commonwealth Connector, '09

["Frequently Asked Questions." Massachusetts Commonwealth Connector Authority, 2009. Date downloaded: April 21, 2009.]

You may be eligible for subsidized Commonwealth Care insurance if you earn up to 300% of the Federal Poverty Level. 300% of the Federal Poverty Level is $30,636 per year for an individual or $61,956 for a family of 4.

Inherency: Doctors Support National Health Plan

59 percent of doctors favor switching to a national health care plan
Reuters, '08
["US doctors support universal health care – survey." Reuters, March 31, 2008. Date downloaded: April 14, 2009]

More than half of U.S. doctors now favor switching to a national health care plan and fewer than a third oppose the idea, according to a survey published on Monday.

The survey suggests that opinions have changed substantially since the last survey in 2002 and as the country debates serious changes to the health care system.

Of more than 2,000 doctors surveyed, 59 percent said they support legislation to establish a national health insurance program, while 32 percent said they opposed it, researchers reported in the journal Annals of Internal Medicine.

The 2002 survey found that 49 percent of physicians supported national health insurance and 40 percent opposed it.

Inherency: Poverty Level Is Already Too Low

The poverty line is far to low because of rapid increases in cost of living
Frank, '04

[Ellen Frank is senior economic analyst at the Poverty Institute at Rhode Island College and a member of the Dollars & Sense collective. "Dear Dr. Dollar." Dollars and Sense, 2004. Date downloaded: April 15, 2009.]

The poverty threshold concept was originally devised by Social Security analyst Mollie Orshansky in 1963. Orshansky estimated the cost of an "economy food plan" designed by the Department of Agriculture for "emergency use when funds are low." Working from 1955 data showing that families of three or more spent one-third of their income on food, Orshansky multiplied the food budget by three to calculate the poverty line. Since the early 1960s, the Census Bureau has simply recalculated Orshansky's original figures to account for inflation.

The poverty line is widely regarded as far too low for a household to survive on in most parts of the United States. For one thing, as antipoverty advocates point out, since 1955 the proportion of family budgets devoted to food has fallen from one-third to one-fifth. Families expend far more on nonfood necessities such as child care, health care, transportation, and utilities today than they did 50 years ago, for obvious reasons: mothers entering the work force, suburbanization and greater dependence on the auto, and soaring health care costs, for example. Were Orshansky formulating a poverty threshold more recently, then, she would likely have multiplied a basic food budget by five rather than by three.

Inherency: Poverty Level Is Too Low

Poverty calculations do not count expenses that have emerged since the original calculations
Swarns, '08

[Rachel Swarns, "Bipartisan Calls for New Federal Poverty Measure." New York Times, September , 2008. Date downloaded: April 16, 2009.]

Today, however, families typically spend about one-seventh of their income on food, census officials say. Families spend much more on housing, transportation and child care, expenses that are not taken into account by the federal poverty measure. (The measure has remained unchanged aside from adjustments for price increases over time.)

Harm: Poor Health Outcomes

Relative poverty increases risk of death by 40%
Minkler, '99

> [Meredith Minkler, "For Want of Resources, Millions Face Early Death and Ill Health." Park Ridge Center, July, 1999. Date downloaded: April 14, 2009.]

The pervasive impact of poverty on health is evident regardless of how poverty is measured. David Williams and his colleagues at the University of Michigan thus found that people with annual incomes of under $10,000 had more than three times the risk of dying in a given year as those who made more than $30,000. Dozens of other studies have produced similar findings, regardless of whether income, education, or occupation was used as the marker of low socioeconomic status. Finally, and moving the unit of analysis from the individual to the community, the now-classic Alameda County Study in California demonstrated that residence in a poor neighborhood itself, regardless of the individual's income, resulted in a risk of dying 40 percent higher than would be expected on the basis of age, gender, and even smoking history.

Harm: Poor Health Outcomes

Poverty kills more than genocide or nuclear war
Gilligan, '97

[Dr. James Gilligan (director of Harvard Center for the Study of Violence), "Violence: Reflections on a National Epidemic," Vintage Press, 1997, pg196.]

In other words, every fifteen years, on average, as many people die because of relative poverty as would be killed in a nuclear war that caused 232 million deaths; and every single year, two to three time as many people die from poverty throughout the world as were killed by Nazi genocide of the Jews over a six-year period. This is, in effect, the equivalent of an ongoing, unending, in fact accelerating, thermonuclear war, or genocide, perpetrated on the weak and poor every year of every decade, throughout the world.

Harm: Poor Health Outcomes

Poverty decreases brain function in children
Toppo, '08

[Greg Toppo, "Study: Poverty dramatically affects children's brains." USA Today, December 10, 2008. Date downloaded: April 13th, 2009]

The study [by UC-Berkeley] adds to a growing body of evidence that shows how poverty afflicts children's brains. Researchers have long pointed to the ravages of malnutrition, stress, illiteracy and toxic environments in low-income children's lives. Research has shown that the neural systems of poor children develop differently from those of middle-class children, affecting language development and "executive function," or the ability to plan, remember details and pay attention in school.

Such deficiencies are reversible through intensive intervention such as focused lessons and games that encourage children to think out loud or use executive function.

Solvency: High Health Care Costs

Providing health care to the uninsured will alleviate financial burdens on communities National Coalition on Health Care, '08

["The Impact of Rising Health Care Costs on the Economy," National Coalition on Health Care, October 31, 2008. Date downloaded: April 21, 2009.]

Unreimbursed expenditures for health services delivered to uninsured persons are borne by private and public payers, employers, and by federal taxpayers as well as state and local residents.

Providing affordable health insurance to all Americans would alleviate substantial financial demands on communities, especially those local areas disproportionately affected by high uninsurance rates. Local community officials and health care providers should be part of a national discussion to develop solutions to address the impacts of uninsurance.

In order to address the issues of uncompensated care and uninsurance affecting communities, we need comprehensive health care reform where all Americans have health insurance which includes equitable health insurance financing in order to reduce cost shifting from payer to payer and patient to patient.

Impact: High Health Care Costs

High health care costs erodes wage growth
Senate Republican Policy Committee, '08

["Health Care Costs and their Impact of Middle-Class Wages." U.S. Senate Republication Policy Committee, October 1, 2008. Date downloaded: April 16, 2009.]

The economic anxiety of the middle-class is often blamed on larger economic conditions without appropriate recognition for the impact of higher health care costs. While macroeconomic issues are certainly significant, the connection between wages and health care costs is less obvious. For example, during the 2000-2008 period, the cost of the average health care plan for a family doubled from $6,348 ($7,643.48 in inflation-adjusted dollars) to $12,680.[2] The $6,300 increase in health care costs over this period ultimately comes out of workers' wages, regardless of whether it is paid by the employer or with employee contributions. This persistent rise in health care costs has slowly but steadily eaten into the take-home pay for American workers. A recent article in the *Journal of the American Medical Association* (JAMA) argues that the "health care cost-wage trade-off" has resulted in relatively flat wages for 30 years. While health care premiums have gone up 78 percent from 2001-2007, workers' earnings have only risen by 19 percent.

Impact: High Health Care Costs

High health care prices costs jobs and reduces competitiveness of American companies Carpenter, '08

[Elizabeth Carpenter, "COST: Impact of Health Care Costs on Global Economy and U.S. Jobs." New America Foundation, May 7, 2008. Date downloaded: April 21, 2009.]

As the *LA Times*' Lisa Girion explains this morning in her report on their work, "Many economists have pooh-poohed the idea that U.S. businesses are hurt by their comparatively high healthcare costs. Instead, they have suggested that companies would pass those costs onto workers by lowering wages or onto consumers by raising prices." Not likely, according to Nichols and Axeen, who argue that employers face various constraints and labor market realities that make it unlikely for them to be able to shift health care costs into wages in the short run, especially since health care costs have grown so rapidly and unpredictably for decades. Plus, it's the 21st century and being able to compete globally means low prices. Manufacturers can't just push the price of health care into goods because of stiff international competition. This is not good news for U.S. manufacturers who spend $2.38 per worker per hour for health benefits compared to their foreign trading partners who spend $0.96.As Jane Sarasohn-Kahn of HealthPopuli posted, "[this all] adds up to one big competitive disadvantage which ultimately results in lost jobs for Americans."

Impact: High Health Care Costs

High uninsured rates can drive out business investment in a community
National Coalition on Health Care, '08

["The Impact of Rising Health Care Costs on the Economy," National Coalition on Health Care, October 31, 2008. Date downloaded: April 21, 2009.]

An increasing or high uninsured rate, and the attendant high public costs, may discourage employers from locating or continuing to operate in a given locale.
The costs of treating patients with little or no health insurance (known as uncompensated care) are passed on to employers and taxpayers. It is estimated that $32 billion (some experts are estimating the cost is $42 billion in 2008) uncompensated care was provided to uninsured patients in 2006 (that number is expected to be much higher in 2007 and 2008 as the uninsured numbers have climbed)1,2. These costs are passed on to private sector patients in the form of higher hospital bills resulting ultimately in higher premiums for employers in the community with high uninsurance rates.

Impact: High Health Care Costs

Access to health care is necessary to preserve civil society and fairness
Englehard and Garson, '08

[Carolyn L. Engelhard, MPA and Arthur Garson, Jr., MD, MPH, "THE RIGHT TO HEALTH CARE AND THE ROLE OF GOVERNMENT IN HEALTH POLICY." Miller Center for Public Affairs, University of Virginia, April 4, 2008. Date downloaded: April 16, 2009]

The belief in a right to health care has its basis in two moral principles: 1) the "social justice" argument that health care maintains an individual's normal functioning and therefore preserves the ability to participate in the social and economic life of society; and 2) the "utilitarian" view that guaranteeing health services increases the welfare of the greatest number of people.[4] The first principle is advanced by John Rawls who argued that a just society would guarantee personal freedoms as long as they did not limit the freedom of others and would promote equality of opportunity. The social justice model benefits the least advantaged in society because it advocates keeping people close to normal functioning in order to allow them a "fair share" in the full participation in society. Viewed in this way, access to health, broadly speaking, and by extension, to health services, preserves for people the ability to participate in the political, social, and economic life of their society.[5]

Impact: High Health Care Costs

Health care should be guaranteed because it promotes the greatest welfare
Englehard and Garson, '08

[Carolyn L. Engelhard, MPA and Arthur Garson, Jr., MD, MPH, "THE RIGHT TO HEALTH CARE AND THE ROLE OF GOVERNMENT IN HEALTH POLICY." Miller Center for Public Affairs, University of Virginia, April 4, 2008. Date downloaded: April 16, 2009]

Utilitarianism is an ethical doctrine that supports actions according to the balance of their positive and negative consequences, and advocates that a society ought to always produce the optimal positive value. Utilitarian philosophers argue that certain positive values in society, like health, should be guaranteed because they increase the welfare of the greatest number of people.[6] While the social justice model supports individual health in order to protect normal functioning, utilitarianism primarily protects the aggregate welfare of the larger society. Countries that promote a right to health care often combine the two moral principles by creating an entitlement to a basic level of health services, to enhance normal functioning, and then organize the delivery of health services through a compulsory social insurance model with set limits in order to be affordable. According to Daniel Callahan, early on these countries realized the "economic iron law of universal health care plans: to be affordable they must be limited."[7]

Solvency: Public Is Better

Innovator of private, managed care claims private sector is not the answer
Englehard and Garson, '08

[Carolyn L. Engelhard, MPA and Arthur Garson, Jr., MD, MPH, "THE RIGHT TO HEALTH CARE AND THE ROLE OF GOVERNMENT IN HEALTH POLICY." Miller Center for Public Affairs, University of Virginia, April 4, 2008. Date downloaded: April 16, 2009]

Opponents to this view argue just as loudly that in order for markets to work there must be adequate information about price and quality, and that such information is not currently available in today's health care system. They also argue, with data, that the majority of Americans don't want all that data – they just want to be told what to do by their doctor, just like taking their car to the mechanic. Paul Ellwood, MD, best known as the "father of managed care," concurs. In an open letter to President Bush published in Stanford University's *Managed Care Magazine*, Ellwood wrote, "Until recently I was convinced that consumers, given adequate information about their choices, could effectively influence both the cost of health insurance and the quality of health care.…I was wrong.…Studies show that despite the greater public access to sound health information, market forces…do not exert sufficient influence over the quality of health services."[19]

Solvency: Public Is Better

Government plan will harness administrative efficiencies and purchasing power of the government
Holahan and Blumberg, '08

[John Holahan, Linda J. Blumberg, "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?" Urban Institute, October 3, 2008. Date downloaded: April 14, 2009]

The intent of the competing public plan is to use the administrative efficiencies of government-run health insurance plans, as well as the purchasing power of government to control costs. The underlying argument is that individual insurers do not have (or are unwilling to use) the market power to counter the pricing power of many hospital systems or physician specialties. This seems likely to remain true even if reforms lead to more aggressive competition in insurance/managed care markets. Thus, the power of a larger purchaser motivated to contain costs is needed to control rising health care expenditures.

Solvency: Government Provided Health Care Works

Hip replacements demonstrate the effectiveness of government health care
Krugman, '07

[Paul Krugman, leading economist at Princeton and Nobel Prize nominee, The Conscious of a Liberal. 2007.]

We endlessly hear that Canadians have to wait longer than Americans for hip replacements, which is true. But that's a peculiar example to choose, because most hip replacements are paid for by Medicare. Now, Medicare is a government program, although it's not clear if everyone knows that – health policy experts often repeat the story of how former Sentator John Breaux was accosted by a constituent who urged him not to let the government get its hands on Medicare. The point, however, is that the hip-replacement gap is a comparison of the two government insurance systems, whit the U.S. system more lavishly funded.

Solvency: Overall Sucess

Reform has increased access without crowding out private insurers
Holahan and Blumberg, '09

[John Holahan, Linda J. Blumberg, "Massachusetts Health Reform: Solving the Long-Run Cost Problem." Urban Institute, January 9, 2009. Date downloaded: April 14, 2009]

Many of the features included in the Massachusetts health reform law, passed in early 2006, are being discussed as part of national reform. This paper is intended to inform the national debate and ongoing work in Massachusetts. To date, the Massachusetts reform has had positive impacts on insurance coverage and access to medical care. The number of uninsured has fallen by more than half — with no evidence that subsidized coverage has "crowded out" private insurance. Unmet needs for a range of medical services have dropped, as have financial burdens associated with health care.

A/T: "Socialized Medicine"

Socialized medicine and subsidized insurance are different
Krugman, '07

[Paul Krugman, leading economist at Princeton and Nobel Prize nominee, The Conscious of a Liberal. 2007.]

A word on terminology: Opponents of government health insurance sometimes call it "socialized medicine,' but that's misleading – it's socialized *insurance*, which isn't at all the same thing. In Canada and most European countries, the doctors are self-employed or work mainly for privately owned hospitals and clinics. Only Britain, among major nations, has actual socialized medicine, in which the government runs the hospital and doctors and government employees.

A/T: Uninsured By Choice

100% enrollment is impossible and doesn't indict the system
McCane, '06

[Don McCane, M.D., Fellow at Physicians for a National Health Plan. "Re: Can the uninsured afford insurance?" Physicians for a National Health Plan, November 30, 2006. Date downloaded: April 15, 2009.]

Even though many children are eligible for Medicaid and the SCHIP programs, 100 percent enrollment can never be achieved because of financial, administrative, and logistical barriers. Attrition is also inevitable because of these same barriers plus fluctuations in eligibility. The only effective way to ensure that all children are covered is to enroll them at birth in a program that is permanent and not subject to any eligibility requirement such as the payment of premiums. That is not possible as long as we continue to segregate children from low-income families into separate medical welfare programs.

What about the 20 percent of uninsured individuals who can afford coverage? In this study, the threshold of affordability was defined as 300 percent of the poverty level. At this level, a family policy would cost 17.2 percent of family income, and that does not include out-of-pocket expenses for deductibles, coinsurance and non-covered services. It also ignores those who are uninsurable because of preexisting medical problems. In considering reform, this group should not be cast aside based on the dubious claim that they have the resources to make it on their own. They should automatically be included as well.

A/T: Politix DA

Reform plan is a political compromise
Harlow, '07

[John Harlow. "Despite Broad Goals, Questions Remain for Massachusetts Health Care Initiative." Public Broadcasting Company, April 6, 2007. Date downloaded: April 14, 2009]

Hailed as a legislative milestone, the Massachusetts plan appeared to strike the perfect political compromise: pleasing fiscal conservatives and liberals alike by keeping the system private and cost-effective but also promising to make quality health care affordable for all.