Closing the Gaps  
A/T Pro by "Coach Vance" Trefethen

# Medicare For All Act of 2019

**Full text of the Medicare For All Act of 2019 is here**

<https://www.congress.gov/bill/116th-congress/senate-bill/1129/text>

**A/T “How do you pay for it?” – We’re already paying for it. We’ll pay a lot less if we do the bill**

*Sen. Bernie Sanders 2019. (I-Vt.) “Financing Medicare for All”* [*https://www.sanders.senate.gov/download/medicare-for-all-2019-financing?id=860FD1B9-3E8A-4ADD-8C1F-0DEDC8D45BC1&download=1&inline=file*](https://www.sanders.senate.gov/download/medicare-for-all-2019-financing?id=860FD1B9-3E8A-4ADD-8C1F-0DEDC8D45BC1&download=1&inline=file)

“How are you going to pay for it?” That is the question that bookends nearly every media conversation that takes place on Medicare for All. The straightforward answer is, we already are. Unlike other government outlays – for example, a ship for the Navy – Medicare for All does not represent any new spending at all. Instead, it represents a rebalance of how our current dollars are spent. If Congress were to authorize the Navy to procure an aircraft carrier, and appropriate the necessary funding, the federal government would spend approximately $13 billion building that ship. If Congress does not authorize and appropriate the funding, then the ship will not get built. People will not individually purchase an aircraft carrier, nor will any private corporation. Health care is fundamentally different. If the status quo stays in place, between 2022 and 2031 the federal government will spend $59.65 trillion.1 According to estimates from the conservative Mercatus Center, under the Senate’s Medicare for All legislation, those expenditures will drop by approximately $2 trillion.2 Another study released by PERI at the University of Massachusetts found that “Medicare for All could reduce total health care spending in the U.S. by nearly 10 percent,” resulting in more than $5 trillion in savings.

**Universal Health Coverage (UHC) can’t be attained by voluntary insurance due to adverse selection**

*World Health Organization 2013 “Arguing for Universal Health Coverage”* [*https://www.who.int/health\_financing/UHC\_ENvs\_BD.PDF*](https://www.who.int/health_financing/UHC_ENvs_BD.PDF)

Because of adverse selection and the exclusion of the poor, no country in the world has managed to come close to UHC by using voluntary insurance as its primary financing mechanism.

**Adverse selection = “Death Spiral”**

**[Adverse selection = higher costs to cover the sicker enrollees = healthier people drop out because it’s too expensive = sicker people are the only ones left = prices go up even more = more healthy drop out = higher prices = only the sickest remain… until it becomes completely unaffordable and collapses]**

*Kern G. Jolibois 2020 (PhD candidate in Health Policy at University of the Sciences in Philadelphia) “Health Insurer Competition and Premium Growth in Employer-Sponsored Health Insurance”* [*https://search.proquest.com/openview/3a53dd8128c7c47f69e839b1ae721edc/1?pq-origsite=gscholar&cbl=18750&diss=y*](https://search.proquest.com/openview/3a53dd8128c7c47f69e839b1ae721edc/1?pq-origsite=gscholar&cbl=18750&diss=y)

For group plans that charge relatively the same premium to everyone enrolled, adverse selection can be costly, and can lead to higher rates. Cutler and Zuckerhaus (2000) have referred to decades of research that have suggested that adverse selection is generally quantitatively large (Cutler & Zeckhauser, 2000). In a report, Cutler and Reber (1996) characterized adverse selection as a factor that could reduce the benefits of the most competitive policies and even lead to a death spiral, where the most generous plans disappear from the market over time (Cutler & Reber, 1996). Therefore, adverse selection has significant effects on the insurance market, and is of importance to insurers and governments, and has implications for health policies.

**Health care spending in the US = $3.6 trillion = 17.7% of the entire economy**

*Kern G. Jolibois 2020 (PhD candidate in Health Policy at University of the Sciences in Philadelphia) “Health Insurer Competition and Premium Growth in Employer-Sponsored Health Insurance”* [*https://search.proquest.com/openview/3a53dd8128c7c47f69e839b1ae721edc/1?pq-origsite=gscholar&cbl=18750&diss=y*](https://search.proquest.com/openview/3a53dd8128c7c47f69e839b1ae721edc/1?pq-origsite=gscholar&cbl=18750&diss=y)

Healthcare in the United States (U.S.) is predominantly a market-based system that relies mainly on insurance for the delivery and payment of health services, through private or public insurance programs. In 2018, health care spending in the U.S. grew by 4.6%, reaching 3.6 trillion dollars. This total includes both public and private funding of health care, and is equivalent to 17.7% of the nation’s gross domestic product (GDP) (CMS, 2019).

**40 million Americans are uninsured + 30 million are underinsured. Impact: Sickness and bankruptcy**

*Eagan Kemp 2019 (expert in health care policy with Public Citizen; formerly senior policy analyst at the U.S. Government Accountability Office; master’s degree in sociology from Simon Fraser University in Vancouver) “Why Medicare for All, Not a Public Option, Is the Best Solution” (ethical disclosure: Article is undated but references material published in 2019)* [*https://www.citizen.org/article/why-medicare-for-all-not-a-public-option-is-the-best-solution/*](https://www.citizen.org/article/why-medicare-for-all-not-a-public-option-is-the-best-solution/)

More than [40 million Americans are underinsured](https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_oct_collins_underinsured_biennial_ib.pdf), meaning they are unable to afford to use their for-profit insurance. Because of this, far too many Americans must depend on GoFundMe or other forms of public begging to afford lifesaving care. Further, around [30 million Americans remain uninsured](https://www.vox.com/2019/4/19/18507540/cbo-uninsured-rate-obamacare), meaning they likely have unmet health care needs and face the risk of medical debt or bankruptcy when they get sick.

**People shouldn’t have to use “GoFundMe” to get life-saving medical care**

*Sen. Bernie Sanders 2019. (I-Vt.) “Financing Medicare for All”* [*https://www.sanders.senate.gov/download/medicare-for-all-2019-financing?id=860FD1B9-3E8A-4ADD-8C1F-0DEDC8D45BC1&download=1&inline=file*](https://www.sanders.senate.gov/download/medicare-for-all-2019-financing?id=860FD1B9-3E8A-4ADD-8C1F-0DEDC8D45BC1&download=1&inline=file)

GoFundMe has reported that one in three of the site’s campaigns are to pay for medical bills. The site hosts more than 250,000 of these campaigns, raising more than $650 million each year. In November 2018, Spectrum health rejected a candidate for a heart transplant because it did not believe she could afford the regimen of immunosuppressive drugs required after surgery. The rejection letter recommended “a fundraising effort of $10,000.” This gets to the heart of why the rebalancing of the chart above is necessary. Fundamentally, our dysfunctional system not only puts health care out of financial reach for millions of Americans who cannot afford necessary drugs such as insulin, it is regressive in its individual financial impact.

**A/T “Markets solve” – Health care markets are failing massively**

*Ed Yong 2020 (journalist) , 4 Aug 2020 THE ATLANTIC “How the Pandemic Defeated America”* [*https://www.theatlantic.com/magazine/archive/2020/09/coronavirus-american-failure/614191/*](https://www.theatlantic.com/magazine/archive/2020/09/coronavirus-american-failure/614191/)

Compared with the average wealthy nation, [America spends nearly twice as much](https://jamanetwork.com/journals/jama/article-abstract/2674671) of its national wealth on health care, about [a quarter of which is wasted](https://jamanetwork.com/journals/jama/fullarticle/2752664) on inefficient care, unnecessary treatments, and administrative chicanery. The U.S. gets [little bang for its exorbitant buck](https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019). It has the lowest life-expectancy rate of comparable countries, the highest rates of chronic disease, and the fewest doctors per person. This profit-driven system has scant incentive to invest in spare beds, stockpiled supplies, peacetime drills, and layered contingency plans—the essence of pandemic preparedness. America’s hospitals have been pruned and stretched by market forces to run close to full capacity, with little ability to adapt in a crisis.

**A/T “Public option + private insurance” – Won’t work. Only M. For All guarantees affordable coverage**

*Eagan Kemp 2019 (expert in health care policy with Public Citizen; formerly senior policy analyst at the U.S. Government Accountability Office; master’s degree in sociology from Simon Fraser University in Vancouver) “Why Medicare for All, Not a Public Option, Is the Best Solution” (ethical disclosure: Article is undated but references material published in 2019)* [*https://www.citizen.org/article/why-medicare-for-all-not-a-public-option-is-the-best-solution/*](https://www.citizen.org/article/why-medicare-for-all-not-a-public-option-is-the-best-solution/)

**Coverage under Medicare for All would be guaranteed and more comprehensive than under a public option.** Most Americans agree that we need major changes to our health care system. But a competing public option and buy-in proposals would leave more than a [100 million Americans](https://www.nytimes.com/2019/09/25/health/employer-health-insurance-cost.html) at the mercy of for-profit insurers. By building on the promises of the Affordable Care Act and incorporating the lessons learned from decades of public programs like Medicare and Medicaid, Medicare for All would ensure that everyone has access to the care they need, including primary care, reproductive health, mental health services, dental, vision and long-term care. Only Medicare for All can make that guarantee.

**A/T “Problems in Canada” – They have long waits for some surgeries, but overall the system delivers better results than Status Quo USA**

*WASHINGTON POST 2019 “Americans have questions about Medicare-for-all. Canadians have answers” 18 Nov 2019* [*https://www.washingtonpost.com/health/americans-have-questions-about-medicare-for-all-canadians-have-answers/2019/11/18/7971c78e-d4d6-11e9-9610-fb56c5522e1c\_story.html*](https://www.washingtonpost.com/health/americans-have-questions-about-medicare-for-all-canadians-have-answers/2019/11/18/7971c78e-d4d6-11e9-9610-fb56c5522e1c_story.html)

“Meekly accepting excessive wait times as the price of a functioning health care system in Canada is the exact opposite of what we should be doing,” the Toronto Sun editorialized after the studies were released. Even so, Canada has better health outcomes than the United States while spending far less on care. Canadians’ life expectancy is 82 on average — more than three years longer than Americans’, according to a 2019 report from the Organization for Economic Cooperation and Development (OECD) based on 2017 data. It also boasts a far lower rate of deaths from treatable causes, at 59 per 100,000 residents, compared with 88 per 100,000 residents in the United States. The infant mortality rate in Canada is 4.5 per 1,000 live births, compared with the U.S. rate of 5.8.

**A/T “Problems in Canada” – Single payer (like Canada) would be far better than Status Quo USA**

*WASHINGTON POST 2019 “Americans have questions about Medicare-for-all. Canadians have answers” 18 Nov 2019* [*https://www.washingtonpost.com/health/americans-have-questions-about-medicare-for-all-canadians-have-answers/2019/11/18/7971c78e-d4d6-11e9-9610-fb56c5522e1c\_story.html*](https://www.washingtonpost.com/health/americans-have-questions-about-medicare-for-all-canadians-have-answers/2019/11/18/7971c78e-d4d6-11e9-9610-fb56c5522e1c_story.html)

Hospitals’ budgets, staffing and equipment in Canada are set by provincial governments, which make those decisions based on a community’s size and needs, rather than on whether a hospital can bring in enough revenue from private and public insurance to keep its doors open, as in this country. Rural hospitals occasionally close, but it’s usually because of challenges in recruiting doctors to far-flung towns or because a facility has low occupancy rates that no longer justify the cost of keeping it open. Hospitals are also susceptible to national or provincial budgetary woes — several rural hospitals closed in the 1990s in Saskatchewan as a result of a recession — but politicians typically face fierce pressure from constituents to protect their health-care services. By comparison, “rural health care in the U.S. is a train wreck,” said Lee Green, chair of the department of family medicine at the University of Alberta, who was a professor at the University of Michigan for 26 years. “Single-payer would be the best thing that ever happened to rural hospitals and rural family doctors in America — not to mention the patients.”