HEALTH CARE

A Topic Proposal for the
National Federation of High Schools Topic Selection Committee

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Note: This topic paper draws heavily on the health care topic proposal submitted in the intercollegiate topic selection process. That paper was prepared by Jacob Justice (Kansas); Bruce Najor (Wayne State University); Dr. Kelly M. Young (Wayne State University); Dr. John P. Koch (Vanderbilt); Jennifer Anton (Wayne State); Austin Oliver (George Mason University); Tyler Woodcock (Kansas). The sections of the paper drawn from the college topic proposal are used here by permission of the authors.
A consensus has emerged, both in Congress and in the country, that health care is a top national priority. For defenders of the Affordable Care Act (ACA), the key issue is access. For those in Congress attempting to repeal the ACA, the key issue is containing the cost of health care. These two aspects of the health care debate create an inevitable tension that is unlikely to be resolved by the beginning of the 2018-19 debate season. There is every reason to believe that the health care industry – one-sixth of the U.S. economy – will continue to be at the top of the political agenda.

The 2017-18 college debate topic (both for CEDA and NDT) is health care. The particular health care resolution has not yet been determined, but all resolutions are in the area of health care. College debaters often make up a significant portion of the judging pool for high school tournaments and the summer teaching staff for institutes. The fact that college debaters would have a year of experience on the topic has both advantages and disadvantages; members of the Topic Selection Committee should make their own judgment as to whether this creates an advantage or disadvantage for the topic area.

I. Introduction

“Nobody knew healthcare could be so complicated” – Donald J. Trump, 45th President of the United States of America (Trump, 2017).

On March 23rd 2010, President Obama signed into the law the Patient Protection and Affordable Care Act, shortened to ACA, and nicknamed Obamacare. Since then, its implementation has faced many obstacles. Federal judges have blocked key aspects, most recently a provision that insurers were banned from discriminating based on gender and sexual orientation. Legislators have stripped the law of key elements like the “Corridor provision,” a financing mechanism that was critical to getting new insurance companies to participate in the exchange systems. Most critically, the ACA was designed to be modified. Policymakers anticipated elements like the employer mandate, individual mandate, subsidy levels, etc. would need to be tweaked. However, many of those tweaks require Congressional approval, and Congress has only been interested in repeal votes (over 50 times), not fixing problems.

The result is a status quo that appears gridlocked on expanding (or reducing, given the failure to bring the American Health Care Act to a vote) health insurance coverage and healthcare access. Paul Krugman, of the New York Times writes on March 27th 2017:

So if Mr. Trump really wanted to honor his campaign promises about improving health coverage, if he were willing to face up to the reality that Obamacare is here to stay, there’s a lot he could do, through incremental changes, to make it work better. And he would get plenty of cooperation from Democrats along the way. Needless to say, I don’t expect to see that happen. Improving Obamacare requires doing more, not less, moving left, not right. That’s not what Republicans want to hear. (Krugman, 2017)

The United States is the only high-income country in the world without universal health care coverage. While the ACA has increased coverage, it has been ineffective at reducing insurance costs. Because the individual mandate penalty is too small, and the risk corridors have been phased out, many insurers have withdrawn from the marketplace. This leaves people who are too affluent to qualify for Medicaid, but lack employer-based insurance, with little or, in some cases, no options for coverage.

Van Newkirk, a staff writer for The Atlantic, outlines the problem:
Will anyone be able to figure out American health care? So far, perhaps the world’s most byzantine arrangement of doctors, hospitals, clinics, contractors, pharmaceutical companies, private insurers, public insurers, medical schools, nursing homes, and dozens of other stakeholders has been less a coherent system than a collection of discount-furniture bits and pieces thrown on a floor with no instructions for assembly. Each individual piece usually works well and America’s doctors especially do pretty good jobs—that’s why they earn the big bucks—but fusing these disparate components to make a coherent health economy has often looked more like alchemy than science. The Affordable Care Act has been the most recent attempt at transmuting the pieces of health care into a well-functioning whole. Recent news, however, including Aetna’s sudden exit from states’ health-insurance exchanges and forecasts of a spike in insurance premiums, has cast serious doubt on the chances of that undertaking succeeding. Is this turbulence to be expected or is it a sign that Obamacare is buckling under the strain of impossibility? (Newkirk, 2016)

II. Status Quo & Uniqueness

Health care reform has dominated the news leading up to and following the election. Despite promises to “repeal and replace” Republicans failed to get enough support to pass a replacement for the ACA. The most likely follow-up in the upcoming year is for states to seek Section 1332 waivers exempting them from implementation of ACA requirements. However, this will likely amount to little less than tinkering with the status quo. Section 1332 waivers do not allow states to reduce minimum coverage requirements, and are not allowed to add to the federal budget.

Molly E. Reynolds, Fellow at the Brookings Institution, and Elizabeth Mann, Fellow at the Brown Center on Education Policy, describe the current political stalemate:

With the failure of the American Health Care Act (AHCA), congressional Republicans and President Trump are left without an obvious legislative route to revising the Affordable Care Act (ACA). In this climate, the Trump administration may pursue alternative options to achieve health care reform, including soliciting and approving state waivers from the law. Secretary of Health and Human Services Tom Price recently issued a letter to the nation’s governors outlining the administration’s approach to Section 1332 waivers. Section 1332 of the Affordable Care Act authorizes the Secretaries of HHS and the Treasury to jointly approve waivers of certain ACA provisions to allow for “state innovation” to take effect on or after January 1, 2017. Under this waiver authority, states would not be subject to one or more parts of the ACA, but only if they provide a plan for alternative, state-level policies that would cover “as many state residents as would be covered absent the waiver.” The coverage provided under states’ substitute plans must also be as comprehensive and affordable as it would be without the waiver, and their implementation cannot increase the federal deficit. We reflect on how the administration might hope to use these waivers moving forward and, importantly, how states may respond to this strategy. (Reynolds & Mann, 2017)

III. Mainstream Options for Policy Change – Increasing Access or Expanding Coverage

The literature for reforming health care in the United States outlines two approaches: (1) Expanding health insurance coverage and (2) increasing access to health care services. Policy options to
improve access include, but expand beyond financial reforms. Increasing public clinics, reducing wait times, training more doctors, providing public transportation, etc., could all be understood as improving access. Accordingly, a topic that merely asks affirmatives to “increase access” could be overly broad. Besides the bidirectional risk that repealing the ACA may “improve access,” “access” itself skirts the core of the controversy, which is to expand the role of government in health insurance coverage. However, access could be included in the topic as long as it is modified by the need to increase coverage. In short, we are in favor of a topic that mandates that affirmatives increase coverage, which could take the form of a topic that mandates both an increase in coverage AND access.

**Expand Coverage**

“Expanding coverage” itself tends to have two meanings; (1) Covering more services, and (2) Covering more people. William B. Stason, of Harvard University, and his five co-authors, described some of the controversies related to coverage issues in a recent medical journal article:

Medicare conducted a payment demonstration for chiropractic services in 2005–2007 that expanded Medicare coverage from “manual manipulation of the spine to correct active subluxations and malfunction” to the full range of diagnostic and treatment procedures for neuromuscular and skeletal (NMS) conditions that chiropractors are trained and legally authorized to perform by the state or jurisdiction in which the treatment is provided. The demonstration responded to requests by the American Chiropractic Association (ACA) and was mandated by Congress. During it, coverage was extended beyond manipulation of the spine to include manipulation of the extremities, physical therapy, interventions such as electrostimulation and ultrasound, evaluation and management (E&M) visits, and diagnostic tests including blood tests, x-rays, computed tomography (CT) scans, and magnetic resonance images (MRIs). In advocating for the demonstration, the ACA argued that expanded coverage would attract additional patients to chiropractors, reduce out-of-pocket costs for beneficiaries, and have the potential to reduce the total costs of care by reducing the use of pain medications and reducing needs for other medical or surgical treatments for NMS conditions. Concerns over increased costs to Medicare, however, led to requirements that the Secretary of Health and Human Services ensure net budget neutrality by recouping any cost increases from Medicare-certified practicing chiropractors by reducing payments for subsequently billed chiropractic services. (Stason et al., 2016)

Juliette Cubanski, of Harvard University’s Kennedy School of Government, writing in an issue brief for the Commonwealth Fund, discussed the various dimensions of expanding coverage to include more people:

An Overview of Approaches to Expanding Coverage Following unsuccessful efforts at major health care reform in the early 1990s, policies to expand coverage have been incremental rather than comprehensive. Policies have been implemented to establish tax credits for health insurance premiums, expand private group coverage, and expand federal and state public programs. (Cubanski, 2004)

Cubanski continues
Federal and State Public Programs

Public programs such as Medicare, Medicaid, and SCHIP are important sources of coverage for millions of elderly and disabled individuals and low-income children and adults. Many policymakers support increasing coverage by expanding eligibility for existing public programs or creating new state-based programs. A more comprehensive approach is to cover all Americans under one program run by federal or state governments, known as a single-payer system. Expanding public programs would target many uninsured people who have no reliable, stable, or affordable link to employment-based coverage, such as low-income adults, children in low-income families, and people with disabilities or chronic health conditions that limit access to private coverage. In most states, eligibility for public programs remains tied to welfare cash assistance categories, including families with children, the elderly, and the disabled. As a result, most childless adults, with the exception of those with disabilities, are ineligible for public health insurance regardless of their income or medical need. Supporters of expanded eligibility for public programs argue that these programs have the administrative capacity to provide group coverage and thus offer ready vehicles for increasing coverage among vulnerable low-income populations. Public programs also could offer a stable source of coverage for those without access to job-based coverage or with less stable links to any one employer or other sources of private group insurance. Opponents are concerned about the substitution of public coverage for private coverage and also about the stress on state capacity to finance expansions without new federal matching arrangements. Proponents of a single-payer system argue that a standardized, national health insurance system is an equitable way to ensure coverage for the entire population and would lower the administrative, underwriting, marketing, and other insurance costs associated with a fragmented insurance system. Opponents are concerned that a single insurance system could prove less flexible and less able to adapt to different regional and market conditions. (Cubanski, 2004).

Proponents of “expanding coverage” tend to outline several distinct policy options. They include, but are not limited to (1) Single payer; (2) Public option; (3) Medicaid or Medicare expansion and (4) Community health clinic expansion.

IV. Specific Proposals for Policy Change:

This part of the paper will address specific proposals for expanding coverage and/or increasing access. Most of these areas would be topical under the “expand coverage” wording. However, in order to also examine “access” as a potential wording, we also cover a few access areas, namely planned parenthood and community clinics. This by no means represents a limit on the topic, as each individual proposal has nuance in implementation, but rather a sampling of proposals made in the literature.

Single Payer

Single-payer healthcare – i.e., a system where the state covers the healthcare costs of its citizens, as opposed to our current system, where individuals purchase healthcare plans from private insurers, is an idea that has long been a dream of progressive politicians and activists. In 1949 President Truman, attempting to build on President Franklin D. Roosevelt’s legacy of expanding the government’s role in social welfare, unveiled a universal national healthcare program, aimed at providing health insurance for every American. Truman’s efforts were unrealized thanks to furious opposition from the American
Medical Association and Cold War-era fears of creeping socialism. After the Democratic Party obtained large congressional majorities following the election of 1964, the dream of a national health insurance program was partially realized but largely deferred when President Johnson signed into law the Medicare and Medicaid health insurance programs, making the federal government “the insurer of first resort for the nation’s elderly and indigent citizens” but stopping short of covering everyone (Zelizer, 2015, p. 201).

The Democratic Party’s next successful attempt at healthcare reform would come in 2010 with the passage of the Affordable Care Act, which created incentives for individuals to purchase private insurance plans, while stopping short of creating a single-payer system. For a considerable period, it appeared as though single-payer was all but unachievable in America; the political right would not tolerate further government intervention into healthcare, while the political left had settled for compromise, market solutions like the ACA. Yet, unique political dynamics have coalesced to put the idea of single-payer healthcare back on the political radar. Senator Bernie Sanders of Vermont famously made single-payer healthcare part of his campaign platform in the 2016 Democratic primaries, promising to extend Medicare (which is currently available only to senior citizens) to every American. In addition, Donald Trump’s promise to repeal and replace the ACA with "insurance for everybody" that offers "great health care" at a “much less expensive and much better” price, inadvertently breathed new life into the idea of a national health insurance program (Zorn, 2017).

The failure of the GOP’s American Healthcare Act has created an opening for debate on all types of healthcare ideas, inviting politicians and wonks to forward their own plans. Earlier this month, Sanders and Senator Elizabeth Warren promised to introduce a “Medicare-for-all” bill in Congress “within a month” (Bradner, 2017). Although the bill stands very little chance of passage thanks to the Republican majorities in the Senate and House of Representatives, the introduction of such a bill indicates that the debate on single-payer healthcare has been reopened, guaranteeing ample literature assessing its merits and drawbacks. With momentum gathering behind the idea, but formidable political obstacles obstructing its realization for at least the next two years, now would be a perfect time for the debate community to revisit the too-long neglected topic of how to best provide insurance to all Americans.

Single-payer advocates see many advantages to moving away from our current system of employer-provided or privately-provided healthcare. Single-payer healthcare would theoretically eliminate the problem of a chronically underinsured population in the world’s wealthiest nation, while allowing the government to deliver healthcare at a more affordable price than the profit-driven private sector. Critics worry about the expansion of government such a program would entail, while highlighting its massive and possibly disruptive economic effects. In the interest of not going overboard talking about single-payer – a self-evidently huge and controversial area worthy of debating. Single payer affirmatives will be able to access a variety of advantages premised upon the flaws of an employer-provided insurance – economy, competitiveness, democracy and others.

Negative debaters can argue, as many critics do, that a single-payer system would crush the U.S. economy and decrease the quality of care received by patients. Consider the testimony of Sally Pipes, president of the Pacific Research Institute, writing in a January 21, 2016 article:

Sanders promises a healthcare utopia – a future of "no more co-pays, no more deductibles and no more fighting with insurance companies." During Sunday’s debate, the candidate claimed that his health care plan would "save the average middle-class family thousands of dollars a year." This is complete nonsense. Every other single-payer system
around the world delivers subpar care at astronomical cost. Worse still, the multitrillion-dollar tax hikes – that's "trillion," with a "t" – that Sanders has proposed to finance his single-payer monstrosity would decimate the American economy. (Pipes, 2016).

Another common objection is that single-payer would suppress medical innovation. Peter Pitts, president of the Center for Medicine in the Public Interest, emphasizes this shortcoming: “The real problem with a single-payer system, however, is much simpler: The approach has failed everywhere it has been tried - from Europe to Canada to Sanders' own state of Vermont. In almost every instance, government-run health care has suppressed medical innovation and made it harder for patients to get the treatment they need at a price they can afford” (Pitts, 2016).

Public Option

Helen A. Halpin and Peter Harbage in their article, “The Origins and Demise of the Public Option,” provide a succinct overview of the history and debate over the public option. They write that when the debate over President Obama’s health care plan started in 2009, “the proposal to offer Americans the choice of a so-called public option became one of the most hotly contested issues” (Halpin & Harbage, 2010). The idea of a public option is to offer a government-backed insurance plan that competes directly with private insurance plans. During the 2008 presidential election, Senator John Edwards became the first candidate to propose a public option. After doing so, he was joined by then Senators Hillary Clinton and Barack Obama in developing health care plans that included a public option, although implementation details, such as who would administer the plan and who would be eligible to buy into it, varied amongst the candidates. It came as no surprise then when the first health care proposals of 2009 included a public option. Ultimately, due to a filibuster threat from Senator Joe Lieberman, the Affordable Care Act was passed without a public insurance market.

This is where the idea of a public option stood until 2015, when Senator Bernie Sanders advocated for a single-payer health care system. In response, his opponent, former Senator and Secretary of State, Hillary Clinton proposed Democrats should focus on adding a public option to the Affordable Care Act. The debate over single-payer versus public option animates Democratic Party politics and could be a rich source of controversy if this topic is chosen by the debate community. However, this paper will focus now on the public option itself as a potential area of controversy. Thanks to Secretary Clinton’s support for the public option, the literature on this area is once again recent, broad, and extensive.

In general, those who support a public option argue that it would create a more competitive marketplace, resulting in lower prices and an incentive for private insurers to change current behaviors. Additionally, proponents of a public option, argue that a public option would increase access/coverage over the Affordable Care Act, as it would provide a competitive option to consumers who reside in states with few insurance options. Opponents of the public option contend that it will eventually lead to a single-payer system, increase the national debt, and threaten the future viability of other government insurance programs, such as Medicare. In the opinion of the authors, a better debate over a public option though is not whether it is good or bad, but over how it would be designed.

One way to implement a public option would be for it to function similar to Medicare or for it to be a Medicare buy-in plan. There is a debate about whether such a program should be open to everyone or limited to those between 55-64, who do not have access to private plans. Proponents of a Medicare
style health care plan contend that it would lower costs and increase access. However, opponents argue that it could decrease access, as more providers would become unwilling to accept Medicare payments.

Another implementation question is whether a public option should be implemented nationally, regionally, or by individual states. Linda Blumberg and John Holahan, in their article “Designing a Medicare Buy-In and a Public Plan Marketplace Option,” write, “A public option might be more politically palatable if it were not offered in all markets nationally but instead in select areas where insurer or provider competition is low” (Blumberg & Holahan, 2016). In other words, instead of offering a national plan, the role of government could be limited to only offering a plan if there are not sufficient private options in a given area. The question would be whether a more limited option could increase coverage and lowers costs as well or better than a national plan, which would have more strength, due to its size, to negotiate prices.

This implementation debate invites us to consider our old friend, federalism. Who should implement and design a public option? How much flexibility should a state or region be given to meet the insurance needs of its constituents? The bottom line is that on most topics we have nebulous debates about politics and federalism. In regards to the public option, these are core questions that animate debates. Debates about the public option provide the debate community a unique opportunity to have debates about the proper role of federal and state governments. But negative arguments will not be limited to federalism. Megan McArdle, a Bloomberg staff writer, discusses the unintended consequences that will likely accompany the expansion of a public option:

In short, while a public option might appear to fix one problem, that's a mirage: The "problem" it would fix does not exist, and worse yet, it would create new problems. Health care regulation often has this problem, which is why much-heralded reforms so often fail to live up to their promise. Keeping costs down turns into a giant game of whack-a-mole: You knock them down in one area, and they just show up somewhere else. Or they show up as politically toxic shortages that have to be fixed by … spending more money. There are two unavoidable realities of making the American health-care system less costly: Americans must use less care, and our nation’s legion of well-paying, stable jobs in the health-care sector need to be both less numerous and less well paid. What no one can figure out is how to generate the political will to make this happen. The public option doesn’t fix that political problem. The public option was best sold as a way to keep insurers from taking excess profits off of a customer base that was required to buy their product. But as it turns out, that’s the exact opposite of the problem we actually have. Which makes it a little mystifying that the public option is still seen as the solution. Somehow in supporters' minds, it has become a harmless homeopathic remedy that will cure any disease that ails you. In medicine, when we see such claims, most of us know that we’re looking at a useless quack nostrum. In policy, we should be similarly skeptical of miracle cures. (McArdle, 2016)

Medicare and/or Medicaid Expansion

In 1965, Lyndon Johnson signed into law the Medicare and Medicaid health care programs, with the goal of providing insurance to vulnerable populations. According to the Congressional Budget Office, in 2016 the U.S. federal government spent $588 billion on Medicare and $368 billion on Medicaid; nearly a trillion dollars, and about 5.2% of total U.S. GDP. How to best maintain the solvency of these programs
which provide valuable benefits for the elderly, poor, and disabled – is a huge and controversial debate in the literature.

Progressives have proposed lowering the eligibility requirements of Medicare and Medicaid. Expanded access to Medicare and Medicaid has been proposed as an incremental step to increase coverage. Scott Lemieux, professor of political science at the College of Saint Rose, offers such a proposal in The American Prospect of August 214, 2016:

Full nationalization remains very difficult politically, but there are less-sweeping reform models that could work just as well as single-payer and would be easier to pass. But step one for Democrats should be to expand Medicare and Medicaid, while also strengthening existing private markets. Perhaps this will move the nation towards a single-payer system, or perhaps it will produce something more akin to a hybrid, public-private system. Either way, the goal of reform should be to provide truly universal and affordable health coverage to all Americans. (Lemieux, 2016)

Against affirmatives like this, the negative could either defend the current eligibility requirements or propose alternative standards. Some argue that the age for Medicare eligibility should actually be higher. Raising the Medicare age puts the program on a sustainable trajectory, reduces the deficit, and accelerates economic growth, as advocated by the Committee for a Responsible Federal Budget:

Criticisms of raising the Medicare age are not only off base, but they obscure the two major benefits of such a policy. First, as suggested above, raising the age will lead to much better targeting of limited government resources. Currently, pretty much everyone over age 65 receives the same effective insurance subsidy from the government -- regardless of age or income. But Medicare's costs are rising to unaffordable levels, and will have to be cut. Rather than reducing benefits across-the-board, raising the Medicare age does so in a very targeted way. For one, all reductions are targeted at the youngest of the Medicare population -- those who tend to be in the best health and are most able to work. And as we explain above, it is not as if they would be thrown to the dogs. The lowest income individuals would continue to receive free health care through Medicaid. Those of more moderate income would continue to receive subsidized health care in the health exchanges, with subsidies linked directly to income. And even those of higher incomes would still benefit from many of the coverage provisions under health reform. In addition, increasing the age would have positive labor market effects. Many people make their retirement decisions based upon the Medicare eligibility age, and increasing it would likely encourage longer working lives. As we've explained in the past, longer working lives would accelerate economic growth, increase revenue collection, and improve overall retirement security. It's time to consider raising the Medicare age. (Committee for a Responsible Federal Budget, 2011).

Community Clinics

Another possible affirmative is expanding primary health care infrastructure, particularly community clinics. There is a wealth of evidence that even with increased coverage, the lack of availability of services, especially in rural areas, is a substantial barrier to access. “Community clinics” would intersect
VI. Unique Educational Opportunity

The healthcare controversy provides a unique educational opportunity for our students. The high school debate topic in 2009 was a poverty topic that included some healthcare elements, but this was (mostly) prior to the ACA being signed into law and totally prior to its implementation. A healthcare topic would (1) improve students’ health insurance literacy, (2) provide unique opportunities for novice recruitment and retention, and (3) is not sufficiently addressed by other topics up for consideration. Choosing a “health insurance” topic will not turn all students and coaches into experts. But that’s not the point. Improving students’ tools and resources in making informed health insurance decisions is more important now than ever. This is important because health insurance literacy improves how effective people are at using health care services and buying / choosing insurance plans.

VII. Dictionary and Contextual Definitions

Access

*Access*. An individual's or group's ability to obtain medical care. Access has geographic, financial, social, ethnic and psychic components and is thus very difficult to define and measure operationally. Many government health programs have as their goal improving access to care for specific groups or equity of access in the whole population. Access is also a function of the availability of health services, and their acceptability.

Jean-Frederic Levesque, et. al. “Patient-Centred Access to Health Care: Conceptualising Access at the Interface of Health Systems and Populations,” *International Journal for Equity in Health*, Mar. 11, 2013. [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3610159/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3610159/). Etymologically, access is defined as a way of approaching, reaching or entering a place, as the right or opportunity to reach, use or visit. Within health care, access is always defined as access to a service, a provider or an institution, thus defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs.

Agency for Health Care Research and Quality, *National Healthcare Quality Report*, 2011, [https://www.ahrq.gov/research/findings/nhqrdr/nhqr11/chap9.html](https://www.ahrq.gov/research/findings/nhqrdr/nhqr11/chap9.html). Access to health care means having "the timely use of personal health services to achieve the best health outcomes." Attaining good access to care requires three discrete steps: Gaining entry into the health care system. Getting access to sites of care where patients can receive needed services. Finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust. Health care access is measured in several ways, including: Structural measures of the presence or absence of specific resources that facilitate health care, such as having health insurance or a usual source of care. Assessments by patients of how easily they can gain access to health care. Utilization measures of the ultimate outcome of good access to care (i.e., the successful receipt of needed services). Facilitators and Barriers to Health Care Facilitators and barriers to health care discussed in this section include health insurance, usual source of care.
(including having a usual source of ongoing care and a usual primary care provider), and patient perceptions of need.

**Coverage**

*A Discursive Dictionary of Health Care*, Prepared by the staff of the U.S. House Subcommittee on Health and Environment, Feb. 1976. [https://archive.org/stream/discuro00unit/discuro00unit_djvu.txt](https://archive.org/stream/discuro00unit/discuro00unit_djvu.txt). Coverage: The guarantee against specific losses provided under the terms of an insurance policy. Frequently used interchangeably with benefits or protection. The extent of the insurance afforded by a policy. Often used to mean insurance or an insurance contract.


**Expand**


- You can qualify for Medicaid based on income, household size, disability, family status, and other factors. Eligibility rules differ between states. In states that have expanded Medicaid coverage:
  - You can qualify based on your income alone. If your household income is below 133% of the federal poverty level, you qualify. (Because of the way this is calculated, it turns out to be 138% of the federal poverty level. A few states use a different income limit.)

**Health Care**

*Arcadia, The Final Word*, June 30, 2014, [http://www.arcadiasolutions.com/final-word-healthcare-vs-health-care/](http://www.arcadiasolutions.com/final-word-healthcare-vs-health-care/). To put it more simply, Dr. Waldman writes: “Health care—two words—refers to provider actions. Healthcare—one word—is a system. We need the second in order to have the first.” While this is a thorough and terribly useful set of conventions, the fact remains that in the US the most commonly accepted form in professional writing is “health care” (the Associated Press feels pretty strongly about it), regardless of the word’s part of speech and the concepts to which the author means to refer. My problem with this heavy-handed approach is that it flattens the language and allows the speaker and audience to discuss h/h/h with little specificity, leading to generalities made about h/h/h that are not valid for the other forms of the word/phrase/concept. As such, I think that Dr. Waldman’s model, which judiciously incorporates both forms, should supplant all of, in my opinion, the half-formed and barely-enforced rules on how to write h/h/h. You may be wondering why I (and others) care so much about this issue. The short answer is that “healthcare” has taken on more meaning as a closed compound word to describe the system/industry/field than is captured in the two separate words “health” and “care.” “Health care”
does not sufficiently capture the increasing demand for nuance and specificity in referring to topics surrounding the practice and facilitation of services to maintain or improve health. Healthcare represents the political, financial, historical, sociological, and social implications of a system that provides health care to the masses. As professionals in a fast-paced and demanding field, we should hold ourselves to a high standard of precision and accuracy in our language. More than a few (by that, I mean literally 100%) of the professionals in healthcare have found themselves at some point wondering whether they are writing this word/phrase properly. I say the time has come to end the Great Healthcare/Health Care Vacillation. It is understandable for many to feel they have neither the time nor resources to dedicate themselves to the pursuit of grammatical perfection. However, our issue here is not simply a lack of differentiation between two words in some obscure intellectual niche. Our issue is that our entire profession, industry, and field lacks a single, unifying convention for how to portray itself to the world. There is no excuse for confusion coupled with a lack of conviction for the need and method to address the problem.

Jeffrey D. Mamorsky, Member of the New York and DC Bar, Law Journal Press, "Health Care Benefits Law", 2005, p. 9. The current regulation defines health care as follows: [H]ealth care has the same meaning as medical care under §213(d) [of the Internal Revenue Code]. Thus, health care generally includes the diagnosis, cure, mitigation, treatment, or prevention of disease and any other undertaking for the purpose of affecting any structure or function of the body. Health care also includes transportation primarily for and essential to health care as described in the preceding sentence. However, health care does not include anything that is merely beneficial to the general health of an individual, such as a vacation.

Kleward Consulting Pvt. Ltd, 2014, “Difference between Healthcare and Medical care”, http://www.kleward.com/articles/difference-between-healthcare-and-medical-care/. Healthcare and Medical care are two terminologies that are often used interchangeably. To an ordinary person, the two terms are different sides of the same coin but are hardly able to differentiate. Medical care is not concerned with health but deals with illnesses & cure for illnesses. Physicians’ job is to cure diseases. They know they can hardly control anything once the patients are out of their reach. People have their own lifestyles and habits which they are not ready to change. Patients know well what their lifestyle has contributed in falling to the present state. How many of us are not aware that walking is a must for a healthy lifestyle? But when a number of issues arise out of our unhealthy lifestyle, most of us prefer to go for medication rather than taking a preventive approach and take out time for a 15min daily walk. Now-a-days, people tend to fall victim to chronic health conditions. Most of the chronic medical diseases are persistent and last for a life time. Such infirmities need specialists to alleviate pain or symptoms occurring out of them. For example, cardiologist deals with heart diseases. Dermatologist deals with skin cancer. Gastroenterologist deals with disorders related to stomach while nephrologist deals with disorders of kidney and so on and so forth. Sometimes, chronic disorders reach a stage that they need a team of specialists to deal with them. For example, a heart surgery would require a surgical team that involves surgeon, anesthesiologist, cardiologist, nurse, assistants etc. Healthcare, however, has a broader prospective. Healthcare emphasizes that care should be offered outside the province of physician. For that, people should follow a health care regime and visit a doctor for a health check-up regularly rather than wait for some trouble or sickness to show up. So, while medical care is taken care of by doctor for you, healthcare is taken care of by you for you. Healthy diet and a regular exercise is what defines healthcare. This can only be controlled by you and you alone. Healthcare should start at an early age but the fact is that we are not able to anticipate such medical conditions
so early. It is always shocking for all of us to hear a young one passing away by reason of heart attack or kidney failure since we associate such chronic diseases to age, in fact, old age. However, disease knows no age. So, health care should start as soon as we are wise enough to understand terminologies like health, exercise, fitness, diet etc.

Public Health Policy

Demetrius James Porche, "Public and Community Health Nursing Practice: A Population-Based Approach," *SAGE*, 2004, p. 318. Public health policy intersects the definitions of health, policy, and public policy into one comprehensive definition. Therefore, for the purposes of this book, public health policy is defined as the administrative decisions made by the legislative, executive, or judicial branches of government that define courses of action affecting the health of a population through influencing actions, behaviors, or resources.

National Health Insurance

*Business Dictionary*, 2002. [http://www.businessdictionary.com/definition/national-health-insurance.html](http://www.businessdictionary.com/definition/national-health-insurance.html). National Health Insurance: A system of insurance benefits established by a federal government to cover all or almost all of the citizens of the country. These systems are entirely or partially funded with tax money.


Single-Payer National Health Insurance


Physicians for a National Health Program, *Single-Payer National Health Insurance*, 2016. [http://www.pnhp.org/facts/single-payer-resources](http://www.pnhp.org/facts/single-payer-resources). Under a single-payer system, all Americans would be covered for all medically necessary services, including: doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug and medical supply costs. Patients would no longer face financial barriers to care such as co-pays and deductibles, and would regain free choice of doctor and hospital. Doctors would regain autonomy over patient care.

VIII. NFHS Criteria for Debate Topics

Resolutions

Proposed resolutions are listed at the end of this topic proposal paper. The seven resolutions considered in the intercollegiate topic selection process for the 2017-18 academic year are listed first, followed by another three potential resolutions for the 2018-19 interscholastic debate year.
**Timeliness**

At the time of this writing (July of 2017) it seems unlikely that the Republican-controlled 115th Congress will agree upon a health care proposal. This policy of inaction will leave in place the Affordable Care Act. The ACA made significant strides in banning private insurance plans that restricted coverage for pre-existing conditions. Yet the ACA continues to be plagued by soaring premiums and limited insurance options for persons not covered through employment-based plans. Whether the ACA is repealed or modified by the Republican Congress or whether it remains unchanged, health care will remain at or near the top of the domestic political agenda.

**Scope**

Health care controversies impact all 50 states equally. Most students will engage with the health insurance industry at some point in their lives. Most students are presently unequipped to weigh the costs and benefits of different health insurance options and to make informed, researched decisions. While the content of the debate round may not make our students “experts” in health insurance plans, encouraging students to research and read on this topic will greatly increase their health insurance literacy, which plays a vital role in an extremely important real-world decision making process.

**Range**

Another advantage to the health care controversy is the appeal to all debaters. Health care reform effects everyone, and most people have a pre-existing (pun kind of intended) opinion. Ideally, the opinion will evolve after doing research, particularly switch-side research, but because the topic is well known, recruiting students to engage with the topic could be easier than on some other topics. The research at its highest level can be challenging for advanced students, but also is accessible for students just learning how to research.

**Quality**

There are enough advantage areas, solvency mechanisms, critical arguments, and negative arguments to sustain an entire season of debates. Health care reform is more nuanced than “single payer,” and the debate community would benefit from devoting an entire season to exploring its intricacies.

**Material**

The bibliography at the end of this paper demonstrates the availability of material. Health care access and coverage will likely continue to dominate the news over the season, ensuring the literature stays fresh and updated. While it is important that the literature evolves, controversies that are at risk of changing mid-season can be frustrating. We think that while debates over repealing the ACA and limiting coverage will continue to grab national headlines, the status quo on health care coverage is rather firm for less government intervention, ensuring the affirmatives will be significant departure from the status quo.

**Interest**
Health care debates are not “all about” economy and disease. The advantage areas are numerous and the terminal impacts range from systemic to existential. Many groups, particularly persons who identify as LGBTQ, immigrants, prisoners, people in rural communities, women, and African Americans have demanded expanded health care access and coverage. There is a legitimate debate regarding the extent of health care as a right and what that would mean for quality of care. This topic allows debaters to be creative, while preserving a thematic controversy.

Balance

Core Affirmative Ground

The heart of the controversy is whether we should expand the role of government in providing health-care coverage for its population. Included in that is a debate over what extent health care is a right, the role of private and employer coverage, the role of the states, economics, quality of access and care. A healthcare topic would allow debaters to discuss solutions to some of the timeliest and pressing challenges currently facing the nation in ways that are likely only to be debated with a healthcare controversy, like opioid addiction and mental health care. Additionally, traditional advantages, like disease, bioterror, hegemony, and economy, are accessible but with internal links that are very topical in the literature, like competitiveness of our industries, worker health, lack of coverage, and budget deficits. Finally, many “social issue” based advantages are accessible on a healthcare topic, including healthcare as a “right” social justice, and inequality.

Core Negative Ground

As a controversy area, health care supplies negative teams with a variety of diverse and well-evidenced objections to affirmatives. Elsewhere in the paper you can find specific arguments that can be read against single-payer, public option, etc., but in this section, we’ll outline core, generic negative ground. To expand coverage requires spending money – guaranteeing meaty links to economy, tradeoff, budget, federalism, and politics DAs. There are also a variety of disadvantages based on the plan’s effect on healthcare markets, particular industries, and quality of patient care.

Disadvantages Related to the Doctor-Patient Relationship

Healthcare is a topic that will allow debaters to explore effect of various policies on international relations, while also encouraging debates about the interpersonal relationships between everyday people and their physicians. Opponents of government coverage programs claim that an expansion of government’s role in healthcare would hurt the doctor-patient relationship. Consider the following testimony of Paul Hsieh, physician and co-founder of Freedom and Individual Rights in Medicine:

The New York Times recently reported on a growing debate within the medical profession as to whether doctors should make treatment decisions in the best interests of their individual patients — or if they should limit care to save money for “society.” This would represent a seismic shift in standard medical ethics. Traditionally, a doctor’s primary ethical duty is to the patient. Patients literally put their lives in our hands, trusting that their
physician will always act as their advocate. But with health care costs currently consuming 18% of the US economy (and an enlarging share of government budgets), some doctors are openly calling for fellow physicians to limit their use of more expensive tests and therapies to save money for “the larger society.” As Dr. Martin Samuels (chairman of neurology at Brigham and Women’s Hospital in Boston) warned in the Times piece, doctors risk losing patients’ trust if they say, “I’m not going to do what I think is best for you because I think it’s bad for the health care budget in Massachusetts.” We don’t expect our lawyer to balance our legal interests against saving money for “the court system” or our real estate agent to balance our housing preferences against what’s best for “the regional housing market.” Shouldn’t our doctors adhere to the same code of ethics? This problem is worsened by the increasing role of government in financing health care. Government accounts for over 60% of total medical spending, and this will continue to increase under ObamaCare. To the extent that government pays for our medical care, it will demand a say in how that money is spent. Doctors will be increasingly expected to simultaneously answer to two masters — the patient and the government. The logical extreme of this trend can be seen in Canada. In a recent Slate article Adam Goldenberg argued that, “Canada Has Death Panels — And that’s a good thing.” Goldenberg notes that Canadian taxpayers cannot be expected to sign a blank check for unlimited expensive care for the sickest patients in the government health system. Hence, the government must necessarily limit what care patients can receive, even if the patients (or their families) disagree. (Hsieh, 2014)

According to Thomas Glass, professor of epidemiology at Johns Hopkins School of Public Health, a trusted doctor-patient relationship is essential to stopping pandemics:

The public will not take the pill if it does not trust the doctor. Stopping a disease outbreak will require that public health professionals and government leaders carefully nurture the general population's trust and confidence in the institutions of public health and government and their actions, especially if large-scale disease containment measures are necessary. After a bioterrorist attack, public trust could be a fragile asset, yet it is essential. The issue of trust bears significantly on 2 critical aspects of the medical and public health response to bioterrorism: (1) the choice of strategies for effective communication with the public, and (2) the processes for debating, as a society, some of the more ethically complex dimensions of disease containment. Although there is a tendency to view the media as an impediment to emergency response, a bioterrorist attack would necessitate a close working relationship between the media, decision-makers, and those involved in response operations. Given the speed with which news reports circulate today, and given the importance of the media in shaping public responses, health departments and hospitals would need to be responsive to media requests for information. An important
step toward maintaining an effective, nonadversarial relationship with the press is to have more routine interactions with reporters, producers, and editorial boards before periods of crisis. During an emergency, health professionals could then build on their relationship with the media to effectively disseminate an accurate account of events, provide vital disease control information, and communicate the rationale and justification for the necessary medical and public health responses. Mass media outlets can get vital information to the largest numbers of people the most quickly. However, the mass media and the Internet are not sufficient. Additional communication strategies would be critical to enlisting the public as partners in implementing epidemic controls. Multilingual materials and culturally relevant messages that are endorsed and delivered by persons who have local respect and authority can help ensure that control measures are successfully disseminated to all sectors of a diverse community. Direct personal contact has the most significant effect on a person's willingness to trust and act on health-related information. (Glass, 2002).

Economic Disadvantages

The ACA proves that there is no such thing as a free lunch. Increased spending on healthcare would likely require tax increases. Bernie Sanders proposed raising taxes on the rich to pay for Medicare-for-all; but to put money into expanded coverage means you’ve got to take money from somewhere else, a reality that guarantees broad links to economy-based disadvantages. Noam Levy, staff writer with the Seattle Times, discusses this economic reality:

Nothing is free, alas. Obamacare’s architects cobbled together a mix of taxes to offset the cost of subsidizing insurance for tens of millions of low- and moderate-income Americans. That has meant some new taxes on insurance companies and medical-device makers (both of which, it was reasoned, were benefiting from getting new customers through the law). Wealthy Americans are paying a bit more, too. Families making more than $250,000 a year have seen their Medicare payroll taxes increase slightly, thanks to Obamacare.

Disadvantages to Decreased Innovation

Innovation and healthcare policy go together. Many opponents of government-led healthcare programs allege that these plans harm medical innovation, by removing incentives for private companies to compete in finding the next-big-medical-advancement. Kathryn Nix, a policy analyst for the Heritage Foundation’s Center for Health Policy Studies, describes this impact to increased government control of health care:

As is often the case, government is just now catching on to what the private sector has already begun to accomplish. The problem is, whenever government tries to replicate a successful private model, it almost always fails. That’s
because bureaucratic operations simply cannot keep up with the speed of innovation. Ultimately, it becomes an outmoded relic that actually serves as a brake on further progress and delays the attainment of the goals it was meant to achieve. . . . Smart technology has paved the way for mobile apps to help patients manage their health, and tele-health enables caregivers to monitor and care for patients remotely. And advances in medical research will continue to revolutionize the practice of medicine. But government doesn’t drive innovation in the health-care system — the private sector does. To keep the kind of successes outlined above coming, Washington must ditch the big-government approach to health-care reform represented by Obamacare. Congress should pass reform that encourages even more experimentation and innovation to benefit patients, rather than try to impose uniformity by copying yesterday’s successes and locking them in place under a government-run system. (Nix, 2012)

Politics Disadvantages

Healthcare is also the timeliest controversy the debate community could choose to discuss – which guarantees high quality links to disadvantages about the plan’s political effects. Increasing the availability of healthcare would represent a golden opportunity for Trump to burnish his populist credentials – negative teams could claim that the plan would give Trump the popularity and leverage he needs to enact his agenda. Affirmative plans would represent a big political win for Trump and would boost his approval ratings. The political effects of healthcare policy go beyond Trump’s approval ratings or political capital—a compromise on healthcare might sound the death knell for the Tea Party (or House Freedom Caucus), which could save Trump’s presidency and have other dramatic effects on our political system.

Counterplans

Although the status quo is always an option, a healthcare topic would encourage nuanced and technical counterplan debates about the optimal ways to expand coverage based on the following questions: Should coverage be increased via government mandates or incentives? Via the states or the federal government or some other actor? Which populations should be targeted and at what cost? Here’s just a taste of some of the countless proposals available to the negative that stop short of expanding the government’s role: Allowing consumers to purchase healthcare across state lines combined with tort care reform is a proposal that proponents of small-government frequently forward in healthcare debates.


SELECTED HEALTH CARE BIBLIOGRAPHY


Hamel, M. G. (2017). Resistance to mandated healthcare change: Using psychological reactance to predict responses to the patient protection and Affordable Care Act insurance coverage requirement. ProQuest Information & Learning, US.


HEALTH CARE RESOLUTIONS

The Following Wordings Are Listed on the College Topic Ballot for 2017-18; the winner in this voting process is to be announced on July 21, 2017, meaning that it will be known to us by the time of our Topic Selection meeting.

A. Resolved: The United States Federal Government should establish national health insurance in the United States.

B. Resolved: The United States Federal Government should establish a universal health care policy, including at least comprehensive health insurance coverage, in the United States.

C. Resolved: The United States Federal Government should establish a national health care policy, including at least one or more of the following, in the United States: comprehensive and transgender-inclusive universal health care; comprehensive and universal health care for sexual and reproductive health; public health insurance option; single-payer national health insurance; substantially expanding Medicaid eligibility for incarcerated people and/or undocumented immigrants.

D. Resolved: The United States Federal Government should establish a national health care policy, including at least one or more of the following, in the United States: lowering the Medicare eligibility age to at least 55 or younger; price cap regulation of pharmaceuticals; public health insurance option; single-payer national health insurance; universal all-payer rate setting.

E. Resolved: The United States Federal Government should establish a national health care policy, including at least one or more of the following, in the United States: lowering the Medicare eligibility age to at least 55 or younger; national health insurance; price cap regulation of pharmaceuticals; universal all-payer rate setting.

F. The United States Federal Government should establish a national health care policy, including at least one or more of the following, in the United States: comprehensive and universal health insurance coverage; lowering the Medicare eligibility age to at least 55 or younger; price cap regulation of pharmaceuticals; universal all-payer rate setting.

G. Resolved: The United States Federal Government should establish a national health care policy, including at least substantially expanding financial access to health care services in the United States.

Proposed Resolutions for the 2018-19 Interscholastic Debate Year:

1. Resolved: The United States federal government should substantially expand eligibility for its Medicare and/or Medicaid programs.

2. Resolved: The United States federal government should establish a program of national health insurance in the United States.

3. Resolved: The United States federal government should establish a program of single-payer national health insurance in the United States.
Proposed Topic Paragraph for Health Care:

Health care is currently at the top of the domestic political agenda in the United States. The economic impacts of the health care system are significant, given that it encompasses approximately one-sixth of the American economy. On a per capita basis, residents of the United States spend almost $9,000 per year on health care – more than double the average in other developed countries. Yet controversies exist over whether health care dollars are well-spent, since the life expectancy of the American population, on average, is significantly less than other countries that spend far less on medical care. Critics charge that U.S. taxpayers are being ripped off by pharmaceutical companies and insurance companies in a poorly regulated marketplace. Affirmative teams can argue that the expansion of single-payer systems can reduce costs by dealing directly with health care providers rather than involving the intermediary roles of private insurance companies. Other affirmative arguments will involve the expansion of coverage to include groups or types of care now excluded and the question of whether access to health care should be a basic human right. Arguments against an expanded government role in the health care system include the inefficiency of the federal bureaucracy, the explosion of costs involved in the creation of new entitlement spending, allowing government to make life-and-death decisions for patients, and the many political implications of expanding access or coverage in the health care system.