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Universal Healthcare: Solution or Delusion? Comparing Medicare for All, Public Option, and Business-As-Usual Models Among U.S. Democratic Presidential Candidates

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Universal Healthcare: Solution or Delusion? Comparing Medicare for All, Public Option, and Business-As-Usual Models Among U.S. Democratic Presidential Candidates

By

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Abstract

How much longer can the United States remain the only developed country without universal health insurance? While the U.S. leads the world in healthcare costs per capita, it trails behind in access and quality measures. Many Americans live in fear of medical bankruptcy, especially the twenty-six million people who remain uninsured. The Democratic presidential candidates vying for the nomination in 2020 have released plans to resolve these problems and bring the nation closer to universal coverage.

Through the analysis of proposed actions, plan feasibility, and expected impact, the candidates' suggestions have been evaluated within the context of the United States. This study will show that all of the Democratic candidates with internally coherent platforms fit into one of three categories: 1) Medicare for All enthusiasts, who advocate for a single-payer system, 2) Affordable Care Act defenders, who favor a new public insurance option, and 3) business-as-usual believers, who do not make health insurance their reform target.

This study will also demonstrate the need for universal healthcare. It will show that inequities in healthcare delivery—denying some Americans access on the basis of socioeconomic status—is the reason why the current healthcare system is able to function. Furthermore, it will submit that the gold standard to remedy this problem is a single-payer system. A single-payer system such as the one proposed in by the Medicare for All Act will remove cost-sharing measures, allowing all Americans to access important preventative health

services and seek treatment when needed. It also will alleviate overhead insurance costs which result from the nuances of filing insurance claims with a mixture of private and public programs.

However, the current U.S. healthcare industry is not ready for Medicare for All. There already exists a shortage of physicians in the United States; if everyone could access healthcare, the U.S. would need about 95,900 additional physicians.[1] For this reason, the U.S. must prepare for a single-payer system by maintaining its current healthcare workforce and by expanding education and training programs for future healthcare workers.

Despite increased public support for universal healthcare, even a single-payer system, several prohibitive factors exist. Lobbying organizations from the healthcare industry and the private insurance industry, both of which tend to dislike the expansion of government programs, have been influencing the legislative process. These organizations also release attack advertisements which can mislead the public on the intentions of healthcare insurance reform plans. Finally, Congressional support for universal coverage remains low, even for more moderate options such as the addition of a buy-in public insurance program. These factors make the potential for fast, sweeping reform unlikely.

The U.S., however, must soon incorporate changes to its health insurance. It currently lags behind the rest of the world in both access and quality measures, despite spending more on healthcare per capita than any other nation. As healthcare premiums rise faster than wages, a greater proportion of American incomes will need to go towards healthcare spending. Leaving insurance the same will prolong, and potentially aggravate, the cost burden Americans face when they become sick.

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[1] Dall, et al,. "The Complexities of Physician Supply and Demand: Projections from 2017 to 2032." *Association of American Medical Colleges by IHS Markit Ltd.* 2019, 41

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Chapter 1: Introduction

In the nation with the highest gross domestic product per capita in the world, fifteen million people skip medical care each year because they fear the cost. Twenty-six million people remain uninsured—making a treatable illness a potential death sentence, as Americans struggle to afford treatments and prescriptions. Due to high out-of-pocket expenses and inadequate incomes to pay them, some Americans cannot to find enough money to repay their debts. Often, take-home pay becomes even lower, as people take time from work to recover. In 2009, President Barack Obama claimed that every thirty seconds, a person in the United States becomes bankrupt from medical bills.[2] Unsurprisingly, 45% of Americans are concerned that a serious medical incident will result in bankruptcy.[3]

Furthermore, the United States is the global leader in prescription pharmaceutical costs. Avastin, a drug used to treat certain types of cancers, will run an American patient $3,930. In the United Kingdom, the same drug may be purchased for $470. A thirty-day supply of a multiple

[2] Dobkin et al. "Myth and Measurement - The Case of Medical Bankruptcies." *The New England Journal of Medicine* vol. 378,12 (2018): 1076
[3] West Health and Gallup. *The U.S. Healthcare Cost Crisis*. 2019.

sclerosis treatment costs $5,089 in the United States, a staggering amount when juxtaposed with the $663 fee in the United Kingdom.[4] As expected, a recent Kaiser Family Foundation poll found that one in four Americans have trouble affording their prescriptions. Most of these people belong to vulnerable population groups: the aging, poor, and ill.[5]

The United States spends $3.5 trillion each year on healthcare, one-fifth of its GDP. Furthermore, the U.S. is the world leader in healthcare costs per capita, with expenditures more than double those of many other developed nations.

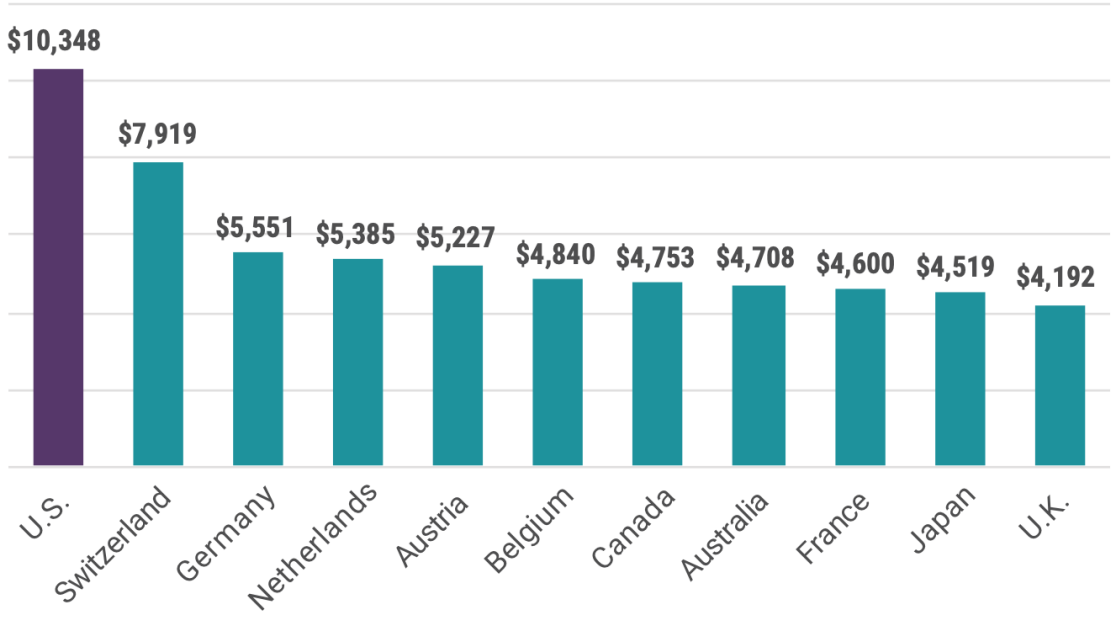

Figure 1.1: 2016 Healthcare expenditures per capita of ten developed nations compared to those of the United States. Values are reported in U.S. dollars and are purchasing power parity (PPP) adjusted to account for relative prices between countries (SOURCE: West Health and Gallup 2019).

[4] Gooch, K. "Prescription drug costs around the globe." Beckers Hospital Review, 2016.
[5] "Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say It's Difficult to Afford Their Medicines, including Larger Shares Among Those with Health Issues, with Low Incomes and Nearing Medicare Age." *Kaiser Family Foundation*, 2019.

Despite having the highest overall healthcare spending and healthcare spending per capita, the United States continues to fail in guaranteeing affordable, accessible care. Out of the 36 Organisation for Economic Co-operation and Development (OECD) countries, the U.S. ranks 16th in heart attack mortality, 28th in life expectancy, and 31st in infant mortality.[6]

Even though the U.S. spends more money per person than any other country, it trails behind the rest of the developed world in access and quality. A Kaiser Family Foundation study used data from 2016 to calculate Healthcare Access and Quality (HAQ) indices for 195 countries. The calculations were based on 32 mortality factors, controlled for behavioral and environmental risks by using the average joint risk exposure. The United States received its lowest component scores in lower respiratory infections (LRIs), hypertensive heart disease, and chronic kidney disease. Table 1.1 shows 27 nations ahead of the United States (tied with the Czech Republic) in healthcare quality and access. All of the countries in Figure 1.1, which spend much less than the U.S., have higher HAQ ranks.

HAQ Rank	Country	HAQ Score
1	Iceland	97
2	Norway	97
3	Netherlands	96
4	Luxembourg	96
5	Australia	96
6	Finland	96
7	Switzerland	96
8	Sweden	95
9	Italy	95
10	Andorra	95
11	Ireland	95
12	Japan	94
13	Austria	94

[6] West Health and Gallup, 2019

14	Canada	94
15	Belgium	93
16	New Zealand	92
17	Denmark	92
18	Germany	92
19	Spain	92
20	France	92
21	Slovenia	91
22	Singapore	91
23	UK	90
24	Greece	90
25	South Korea	90
26	Cyprus	90
27	Malta	90
28	Czech Republic	89
29	United States	89

Table 1.1: A table of Healthcare Access and Quality (HAQ) indices for the United States and the nations scoring above the United States. HAQ was calculated based on the Global Burden of Diseases, Injuries, and Risk Factors Study 2016 (Adapted from the Kaiser Family Foundation analysis from the Global Burden of Disease Study, 2018).

Evaluating the Future of Healthcare

Currently, debate exists regarding the next step in reshaping the future healthcare system. In the 2020 Presidential Election cycle, several Democratic candidates have suggested strategies for reforming health insurance in the United States. Six top candidates have outlined their plans for reform: Joseph Biden, Pete Buttigieg, Amy Klobuchar, Bernie Sanders, Elizabeth Warren, and Andrew Yang. While former Vice President Biden, former Mayor Buttigieg, and Senator Klobuchar want to take a more moderate approach and build upon the Affordable Care Act, other democratic candidates have pushed for more radical reforms. Senators Sanders and Warren have embraced Medicare for All, the expansion of the Medicare program to all Americans. Political outsider Andrew Yang has implied bypassing major insurance reform altogether in favor of an

approach which targets the underlying causes of medical waste and American poverty. Ultimately, he would take a business-as-usual approach in health insurance, as he agrees with "the spirit of Medicare for All" but believes it is impractical.[7]

On the Republican front, incumbent Republican president Donald Trump has different ideas for the future of healthcare. Throughout his presidency, he has taken a stance to "repeal and replace" sections of the Affordable Care Act (ACA) with varying degrees of success. Part of this plan involved the elimination of Cost-Sharing Reduction (CSR) payments, the federal subsidization of insurance to reduce premiums, co-payments, and deductibles for the public. In 2017, the Trump Administration also repealed the ACA's individual mandate in favor of Short-Term Limited Duration (STLD) plans and Association Health Plans (AHPs). While these can be more affordable options for the healthy population, they are generally unavailable for people with pre-existing conditions and omit certain services. A study of insurance premiums found an average 6% increase in 2019 premiums, due to the expansion and loose regulation of non-ACA compliant plans, and the removal of CSR payments, by the Trump Administration.[8] Trump's official plan for the future of healthcare remains unclear; however, based on his first term of presidency, his plan will likely reduce restrictions on insurance companies and decentralize policy decisions.

With such of wide variety of ideas in discussion throughout this election cycle, how is it possible to determine which reforms could fit into American society and bring beneficial change to the American public? This study will use a combination of frameworks for healthcare system analysis which will provide the guidelines to answer this question. From existing literature, a

[7] Yang 2020, "Medicare for All," Paragraph 4
[8] Kamal et al. "How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums". *Kaiser Family Foundation*, 2018.

new framework considers the proposed actions, impact, and feasibility of a healthcare plan within the context of society.

In 2016, the Directorate-General for Health and Food Safety (European Commission) published a framework for evaluating healthcare reform effects. It included four steps: 1) an explanation of the reform in the context of the society, 2) a description of the reform's actions, 3) the feasibility of the implementation process, and 4) the impact.[9] The language in these steps can be adjusted to gauge the efficacy of reform proposals prior to their implementation. Figure 1.2 shows the organization of these factors and the questions that must be addressed when evaluating a healthcare plan.

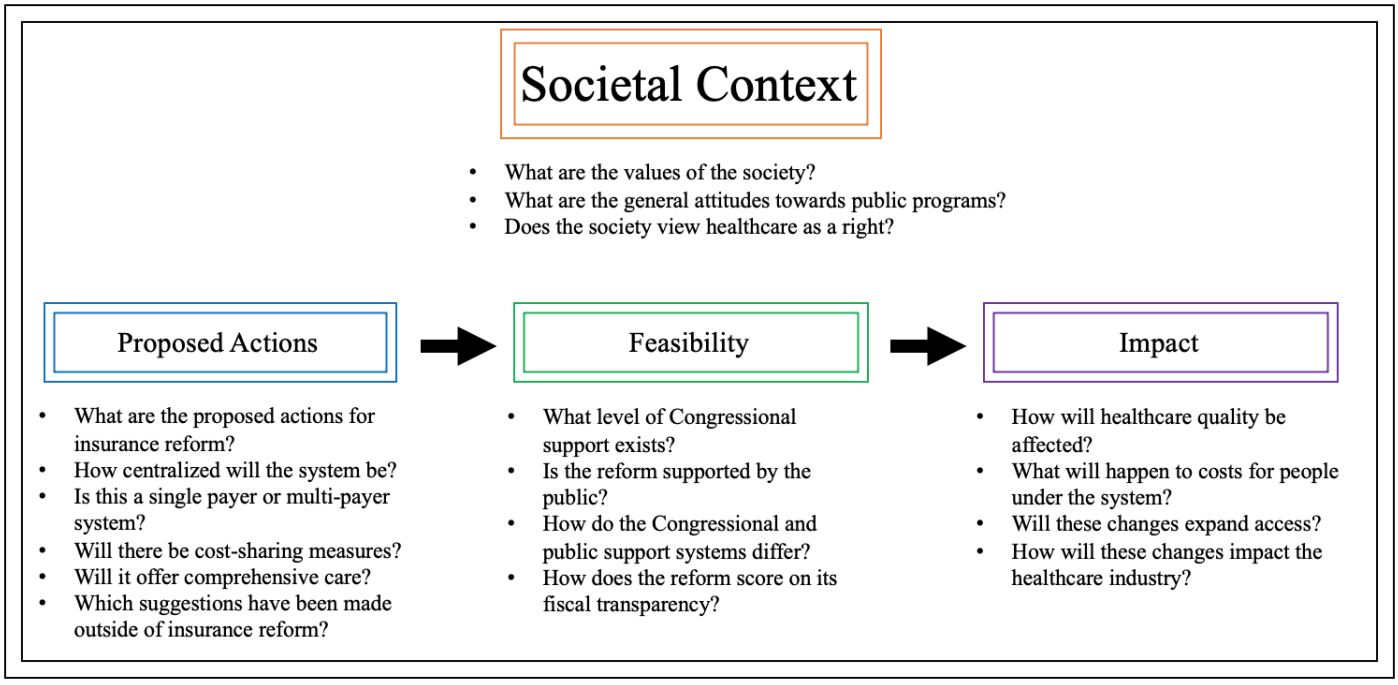

Figure 1.2: The four main considerations in the analysis framework for healthcare system reform strategies. The proposed actions, feasibility, and expected impact of a healthcare reform plan will be evaluated based on the context of American society.

[9]Directorate-General for Health and Food Safety (European Commission). *Typology of Health Policy Reforms and Framework for Evaluating Reform Effects*. [Publications Office], 2016, 11

To understand the societal context, a historical background of the United States and its development of health insurance is necessary. This will be provided in Chapter 2, along with current public opinion data which will provide an understanding of general attitudes toward public programs in the United States. Chapter 3 will review the proposed actions in each candidate's platform. It will also compare the level of centralization, insurance program structures, and cost-sharing measures across plans. Additionally, it will highlight similarities to healthcare system structures in other countries around the world.

Evaluations of the support and fiscal transparency for the platforms will estimate the feasibility of each plan in Chapter 4. First, support can come from three key players: Congress, the public, and the healthcare industry. Congressional support for the healthcare plans will be assessed through the examination of recent bills, their sponsorship, and their likelihood of ratification. Recent polls will help assess American readiness to embrace universal healthcare. Finally, patterns of healthcare payments and lobbying will bring the sentiments of the healthcare industry to light.

Secondly, fiscal transparency helps the plan appear more complete. The plan may have weak internal cohesion if it does not include a clear path to its execution. Criticism also tends to center on the finances of a public-program expansion plan. For this reason, it is important to consider which of the six candidates has the most transparent platform in terms of financing. Based on expert analyses, platform websites, and self-reported data, each candidate has been assigned a rating of either high, medium, or low transparency. They have been compared relative to each other to understand which explanations are missing among the platforms.

Chapter 5 will forecast the expected impact of each candidate's proposal if hypothetically implemented exactly as the candidate intends. This will include the effects on the access, costs,

and quality of healthcare services in the United States. Additionally, it will suggest how the overall healthcare system will change and how healthcare workers will be affected.

In actuality, every bill undergoes major revisions and compromises before becoming a law. This project does not aim to predict the amendments to the proposed reform plans. Instead, it seeks to assess raw ideas for restructuring American healthcare, regardless of their viability in Congress. It aims to uncover unique elements suggested by the presidential candidates and understand how they will affect the United States. The analysis of healthcare reform plans will help understand which discussions are occurring, as well as which ones have been overlooked.

Each chapter will also include dialogue from presidential debates, conventions, and rallies, revealing the discussion and controversies of each proposal. The goal is to draw comparisons between candidate proposals to create an argument for the best healthcare reform strategy in the United States. Suggestions will be made for establishing healthcare coverage for vulnerable populations, building the infrastructure necessary for universal healthcare, and improving healthcare outcomes.

This analysis of the current healthcare state in the United States points to several key questions:

1. How can we make evaluate healthcare reform proposals made by presidential candidates?
2. What is the best approach to achieve universal coverage in the United States?
3. What must be done to prepare the country for these changes?

Existing Systems

Across the world, people wonder why the United States remains one of the last developed nations to adopt a universal coverage program. The answer stems from several root

causes. For one, unlike in other developed countries, healthcare is not perceived as a right in the United States. Rather, Americans consider it a privilege that must be earned through honest labor. American culture consists of self-reliance and antipathy to government interference. The threat of taxation elicits outrage and dismissal. This is partially because of the country's original virtues— liberty, independence, and freedom.[10] The history behind the origin of these individualistic principles will be clarified in the next chapter.

Most developed nations have already created systems of universal access to healthcare services. Whether there exists a single payer (Australia, Canada, Denmark, the United Kingdom, and Sweden) or multi payer (Germany, Netherlands, and Switzerland) system, all citizens are entitled to vital healthcare services. While almost all of these systems incorporate private insurance, its significance varies by country.

Francesco Paolucci, an internationally renowned health policy expert, states that there are two essential dimensions to consider in defining a plan for healthcare coverage: 1) the types of services and 2) the type of coverage provided. This means that services can be basic (essential, physical healthcare) or supplementary (additional services such as vision, dental, and psychiatric). The coverage for services may either be mandatory or voluntary, suggesting that nations must decide to either require the coverage of its citizens or allow them to choose to pay for insurance.[11] His dimensions are illustrated in Figure 1.3.

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[10] Johnson, James A., Carleen H. Stoskopf, and Leiyu Shi. *Comparative Health Systems : a Global Perspective.* Second edition. Burlington, MA: Jones Bartlett Learning LCC, 2018, 79

[11] Paolucci, Francesco. *Health Care Financing and Insurance Options for Design*. 1st ed. 2011., Springer Berlin Heidelberg, 2011

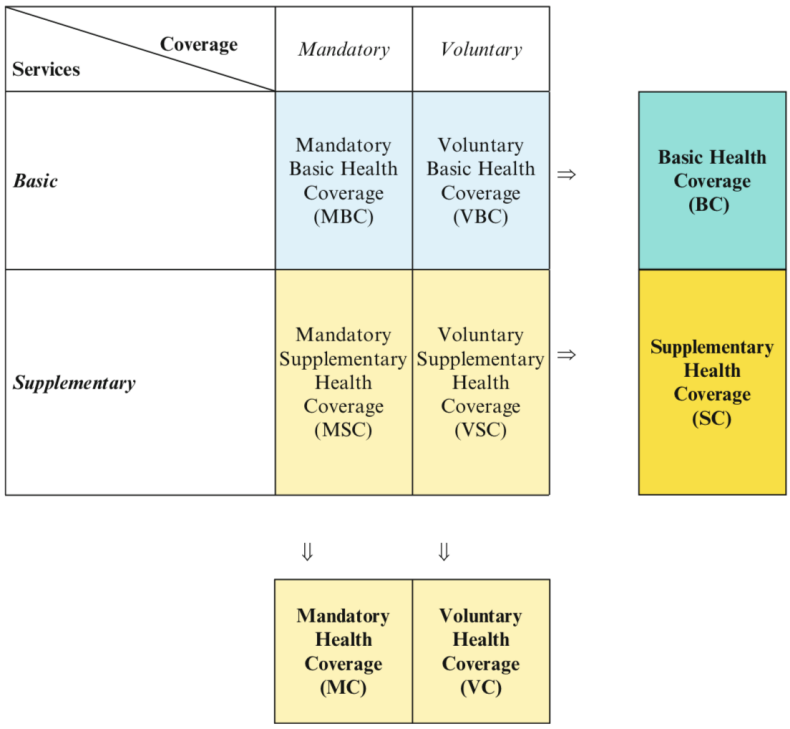

Figure 1.3: An outline of basic and supplementary coverage crossed with mandatory and voluntary coverage, showing the options considered by nations in designing a health plan (SOURCE: Paulucci 2011)

Paolucci's dimensions can be applied to existing global healthcare systems. For example, Canada covers basic health services for all of its citizens and offers voluntary supplemental insurance for additional services. Conversely, Australia, France, and Norway mandate coverage of both, although they have higher copays and deductibles.[12] At the federal level, the United States falls into the category of voluntary health coverage. Health insurance has not been mandated since 2017 and neither basic nor supplementary coverage is required. However, individual states may have their own individual mandates. Currently, five states and the District of Columbia require citizens who can afford health insurance to purchase it or risk facing a fine.[13]

[12] Alonso-Zaldivar, Ricardo. "'Medicare for All' proposed benefits leapfrog other nations." *Associated Press*, 2019.
[13] Tolbert, Jennifer, Maria Diaz, Cornelia Hall, and Salem Mengistu. "State Actions to Improve the Affordability of Health Insurance in the Individual Market." *Kaiser Family Foundation*, 2019

Another difference between healthcare systems is the degree of cost-sharing. The term "cost-sharing" refers to the out-of-pocket payments for which patients are responsible. Some argue that incentives for responsible consumption, such as these out-of-pocket costs, are necessary to prevent a "moral hazard." The moral hazard is the theory that people are more likely to act recklessly when they have cost-free resolutions. For instance, people with plans which give them a new phone for free every time they lose or break the one they currently have may be less inclined to protect it. Of course, human health has the added element of pain, which people tend to avoid, making this a weak argument in favor of cost-sharing.

However, additional arguments have been made that cost-sharing prevents healthcare overutilization and waste. When consumers have no constraints on the resources they may use, they burden the system through unnecessary consumption. Adding cost-sharing elements prevent this by making people reconsider whether they require medical attention. On the other hand, introducing excessive cost-sharing measures may select for wealthier patients and neglect the riskier and poorer population groups. When truly sick people need medical attention but cannot afford it, they are left to fend for themselves.[14]

There exist several strategies to address healthcare cost-sharing across the world. Canada, for one, has no cost-sharing for public services. The United Kingdom, Denmark, and Germany also offer a wider variety of services with limited cost-sharing, focused primarily on prescription pharmaceuticals. These countries align with the ideal system proposed in most United States single-payer bills—one with broad coverage and limited out-of-pocket pay. Another category of countries utilizes moderate cost-sharing strategies to help pay for broad public services. Australia charges a co-payment for visits to specialists and adjusts drug costs based on income. Singapore,

[14] Gingrich, Jane R. *Making Markets in the Welfare State the Politics of Varying Market Reforms* Cambridge: Cambridge University Press, 2011, 10

Switzerland, and the Netherlands use deductibles, and Taiwan charges up to $1,200 per inpatient episode.[15] These strategies could help the United States develop a more moderate universal coverage plan; however, they tend to lead to more out-of-pocket expenses. Figure 1.4 displays each country's out-of-pocket expenditures as a percentage of total national health expenditures. Unsurprisingly, more cost-sharing leads to more patient payments.

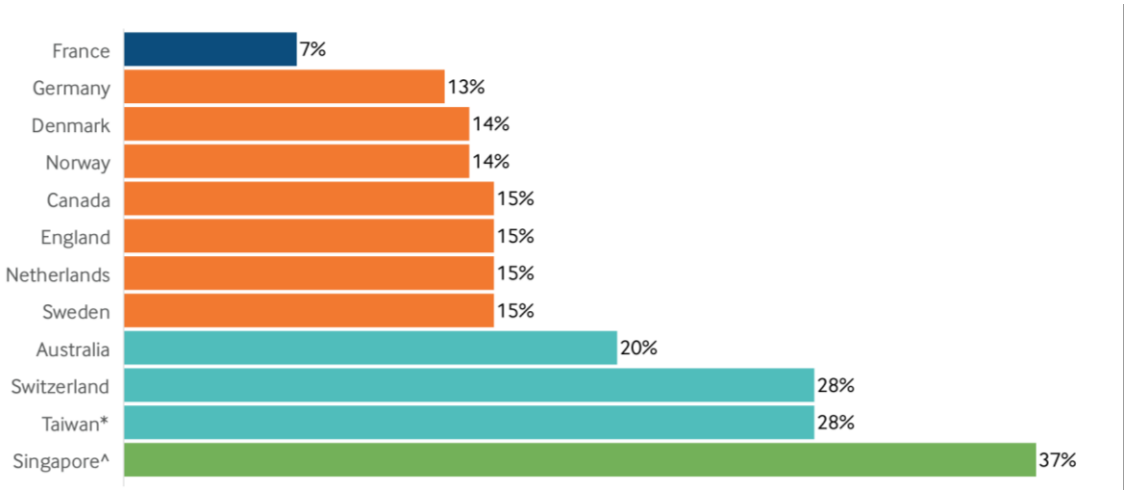

Figure 1.4: Patient out-of-pocket expenditures as percentages of total national health expenditures (SOURCE: Glied et al. 2019)

Finally, the extent of centralization in healthcare is another consideration in the development of a system. Many United States legislators wrongly assume that all universal systems are highly centralized, with power concentrated in the federal government. However, several nations have crafted systems which are more decentralized, divvying power between federal, regional, and local governments.[16] Furthermore, variations healthcare system financing exist. Table 1.2 shows how different nations with universal healthcare programs finance them.

[15] Glied, Sherry A., Stephanie Ma, and Anais Borja. "Effect of the Affordable Care Act on Health Care Access." *Commonwealth Fund*, 2017.
[16] Glied, Ma, and Borja, 2019

Structure	Country	National Financing	Regional/Local Financing
Federal	France	X	
	Netherlands	X	
	Singapore	X	
	Taiwan	X	
Central with regional flexibility	Australia	X	X
	Denmark	Block Grants	X
	England	X	
	Norway	X	X
Regional control under broad federal policy	Canada	Block Grants	X
	Germany	X	X
	Sweden		X
	Switzerland	X	X

Table 1.2: A summary of twelve nations' healthcare financing structures, highlighting variations in centralization (Adapted from Glied et al. 2019).

Note how federal management, as proposed in most United States universal healthcare bills, is common among small, wealthy countries.[17] Australia and Canada, which are much closer to the size and structure of the United States, incorporate some elements of regional financing and policy decentralization. While Australia allows regional governments some choice in the allocation of resources, Canada has an entirely decentralized system. Provincial governments fulfill healthcare policy responsibilities. In exchange for federal block grants, Canadian

[17] Glied, Ma, and Borja, 2019

provinces agree to provide broad coverage for all citizens and never implement cost-sharing measures.[18]

In the United States, arguments for universal healthcare, particularly for a system similar to Canada's, have been on the rise. The 38th vice president of the U.S., Hubert Humphrey, was a force in 20th century politics. He believed that the way a society treats its weakest members is the direct reflection of its government. If members of American society are left to fend for themselves when they fall ill, then the government has failed to protect them. Building on these principles, the United States has an obligation to ensure its population with accessible, affordable healthcare and reverse the current crisis of medical debt. The need for universal healthcare access is evident; can we break through its appearance of delusion?

[18] Glied, Ma, and Borja, 2019

> "the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life; the sick, the needy and the handicapped."
>
> -Hubert Humphrey

Chapter 2: The Context of United States Healthcare

In the quote above, Hubert Humphrey argued that the treatment of vulnerable groups is a government's true moral test. As of today, the United States is failing. Partisan politics coupled with *traditional* American values place challenges upon the politicians who try to expand government healthcare programs. The decent treatment of the aging, poor, and ill becomes seen as delusional, as Americans cling to values of self-sufficiency and hard work.

Hubert Humphrey died after a five-year battle with bladder cancer. At the time of his passing, Republican Senator Rudy Boschwitz said that Humphrey "…represented to me the fact that we must look for the good in people if our society is to have a chance for success".[19] Our currently fragmented country bequeaths us to remember a time when a Republican Senator said these words about his Democratic colleague. Yet his words speak beyond the partisan politics of

[19] Boschwitz qtd. in Kneeland, Douglas E. "Hubert H. Humphrey is Dead At 66 After 32 Years of Public Service." *New York Times*, 1978.

today, delving deeper into trusting vulnerable populations and helping those in need. Looking for the good in people even if they cannot work, have made mistakes, or have made few contributions *will* make our society stronger. This constitutes an argument for universal health coverage.

Why do American values reject that healthcare is a human right? How have government programs been structured to evoke resentment toward those who benefit? Separate from insurance, which other flaws of the healthcare system obstruct healthcare access?

Chapter 2 will answer these questions, offering a context for the existing culture and healthcare system structure in the United States. Furthermore, it will show differences in the perception of Medicare and Medicaid—existing public programs—due to funding and trends in American culture. Americans value, and even romanticize, ideas of hard work, self-sufficiency, and initiative. These principles make it difficult to accept the funding of public programs to assist people who do not pay for their benefits. However, American attitudes have been shifting over time in favor of government-sponsored universal healthcare coverage. In 2016, a national survey discovered that half of Americans would favor a single-payer, universal system operated by the federal government; it was the first time since 1998 that the majority did not oppose it.[20]

Despite recent efforts, gaps in healthcare coverage remain. Besides cultural barriers, structural flaws also barricade the path to universal coverage. A doctor shortage, especially in primary care, sets up the system for failure. In particular, rural areas struggle to keep up with growing demand and shrinking supply, as doctors prefer to live in metropolitan areas.

Without the proper resources, the healthcare industry would face excessive pressure. We would need an estimated 95,900 more physicians to confidently implement a healthcare program

[20] "Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage." *Kaiser Family Foundation*, 2020, Figure 2

which provides equity across all socioeconomic and health insurance statuses.[21] Before universal coverage can be implemented, the healthcare industry will need to be prepared by training more staff to avoid system collapse. In other terms, our current system works because some people cannot access it.

Insurance Programs in the United States

Health insurance has a complicated history in the United States. First emerging as a worker compensation plan for injury-related wage loss, it developed into a nationwide strategy to spread health risks across an entire population. As labor unions grew powerful, health insurance became an important negotiation feature between unions and employers. Consequentially, employment-based private insurance grew to be an $8.7 billion industry by 1965. The elderly, unemployed, and poor needed to find other methods of covering their healthcare bills or avoid medical care entirely. And so, in 1965, Congress decided to add Medicare and Medicaid programs to cover two vulnerable population groups: the elderly and the poor, respectively.[22]

Medicare serves the 65 and older community and certain younger, chronically ill patients. It receives funding from members of the working class, who pay taxes out of their incomes. They essentially pay for the services they will use through the Medicare program once they become older and no longer employed. Medicare is managed by the Centers for Medicare and Medicaid services under the federal government. As a federal program, its eligibility and function remains consistent throughout the United States. Patients covered by Medicare still have to pay monthly premiums for out-of-hospital care and meet a certain deductible.[23]

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[21] Dall, et al., 2019, 41
[22] Johnson Stoskopf, and Shi, 2018, 85
[23] "What is the Difference Between Medicare and Medicaid?" *United States Department of Health and Human Services*, 2015.

Medicaid is quite different from Medicare in several ways. First and foremost, it exists to serve low-income people of any age. As a federal-state program, it operates according to federal guidelines executed by individual states and local governments. For this reason, Medicaid varies from state to state and lacks the nationwide consistency of Medicare. One who qualifies for Medicaid in a state with sufficient funding may not qualify in another state. Moreover, most people under Medicaid do not have the responsibility of cost-sharing measures, other than an occasional, small co-payment. Medicaid, for those enrolled, is essentially cost-free.[24]

The Myth of the Bootstraps

Medicaid is much more divisive than Medicare in the United States. Unlike Medicare, not everyone who benefits from Medicaid has contributed to it. Atul Gawande—an American surgeon, renowned author, and researcher—gathered American opinions on whether or not healthcare is a human right. In the Appalachian foothills, one family recounted filing for bankruptcy due to medical debt as "shameful."[25] They viewed bankruptcy as the consequence of their personal failures, not the government's. Even after undergoing such hardships, they were bothered by the idea of the government sponsoring healthcare for the poor. Why should the burden fall on able-bodied, working taxpayers?[26] Why are these people incapable of pulling themselves up by their bootstraps?

The attitude that those who *work hard* deserve *more* persists in American society due to the collective principles by which Americans tend to live. L. Robert Kohls, a cultural patterns researcher, developed a list of thirteen common values in the United States to explain American

[24] "What is the Difference…", 2015
[25] Joe Dutton qtd. in Gawande, Atul. "Is Healthcare a Right?" *The New Yorker,* 2017, 2
[26] Gawande, 2017, 2

behavior. His first principle, "Personal Control Over the Environment" submits that Americans believe their lives are not controlled by fate. Instead of accepting an unhappy life as the product of *bad luck*, people are urged to find the motivation to pursue a better life. When one becomes compliant with unhappiness, sickness, and poverty, it is perceived as laziness.[27] Kohl's principle nine, "Action/Work Orientation," outlines a similar phenomenon. Americans are workaholics, scheduling each day to avoid idleness. In fact, Americans tend to integrate their jobs with their identities; one of the first questions asked when two Americans meet for the first time is "what do you do for a living?" Idleness, joblessness, and inaction are shameful, much less dignified than hard work.[28]

And so, those who work are honorable and those who do not are burdens. The ones who are unable to work become reduced to *lazy* and less-deserving of cost-free healthcare. This context of American society is a crucial consideration in the feasibility and public support of any healthcare cost-reduction program. Who will be taxed and why do some not need to contribute? Why do *I* have to pay for someone else? A tax raise becomes personal, an attack on hard-earned wages for someone else's benefit.

Cultural Changes

There is evidence of change in American values. A 2017 Kaiser Family Foundation survey found that most Americans, about 74%, view Medicaid favorably. This includes 84% of Democrats, 76% of independents, and 61% of Republicans, showing consistent approval across political affiliations.[29] Furthermore, a study of public opinion changes from 1998 to 2016 show a

[27] Kohls, L. Robert. *Values Americans Live By.* Meridian House International. Washington, D.C., 1984, 2

[28] Kohls, 1984, 4-5

[29] "Data Note: 10 Charts About Public Opinion on Medicaid." *Kaiser Family Foundation*, 2017, 1

growing trend in support for national healthcare programs to cover all Americans. This trend is evident in Figure 2.1, with a 10% increase in support from 1998 to 2016.

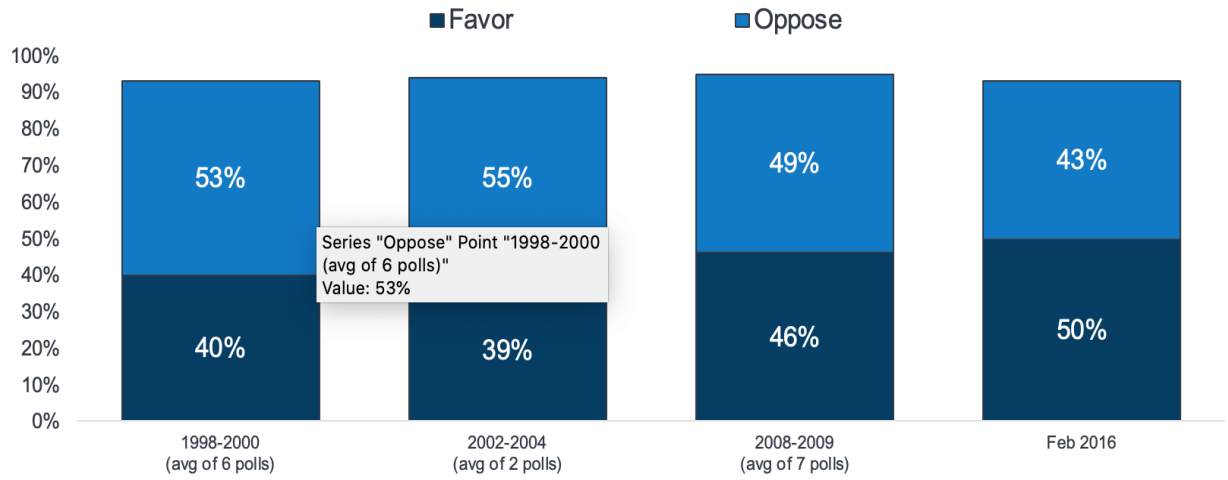

Figure 2.1: The percentage of Americans who favor and oppose a single-payer, universal coverage health insurance plan run by the government. (SOURCE: Kaiser Family Foundation "Public Opinion…" 2020, Figure 2)

Using Gallup data, another study found that in 2018, 60% of Americans believe the government has an obligation to provide all Americans with healthcare coverage. This increased from 51% in 2016. Only 4% of Americans agreed that the government should not be involved in healthcare at all.[30]

With the majority of Americans in apparent agreement over the government's role, we again wonder why the United States remains the last developed nation to adopt universal coverage. One explanation comes from the drawn-out legislative process. A bill must go through a bicameral legislature while numerous interest groups attempt to influence the vote. Even if the

[30] Kiley, Jocelyn. "Most continue to say ensuring health care coverage is government's responsibility." *Pew Research Center*, 2018, 1

bill passes, the president has the power to veto it. In the instance of a veto, the bill again goes to a vote and must be supported by at least two-thirds of Congress. If a bill becomes a law after this process, it must still be interpreted and enforced, which requires even more time.[31]

The Canadian Parliamentary system, for example, looks quite different. While still bicameral, with the House of Commons and the Senate, it is less prone to stalemate in the creation of new legislature. In Canada, the leader of the party with the most seats in the House of Commons becomes the Prime Minister, who advises appointees in the Senate. Therefore, both houses of legislature tend to hold the majority of one party, making it easier for new laws to pass. Unlike the United States, which may face conflict from political divides between the president, House of Representatives, and Senate, Canada and other parliamentary countries can progress legislature more quickly.[32] Consequently, the United States is less likely to pass sweeping changes in healthcare.

Our Current Shortfalls

The lack of reform has serious consequences, since the combination of public and private insurance programs fails to cover all Americans. The beginning of the 21st century was still marked with plenty of uninsured working-aged adults and their children. The unemployed lacked healthcare coverage unless it was paid for out of pocket, and even for those who had jobs, not all employers were required to provide health insurance benefits. Furthermore, private insurance companies could drop subscribers who developed costly illnesses such as cancer. They could also raise premium rates for people with complicated illnesses or expensive health incidents.

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[31] Johnson, Stoskopf, and Shi, 2018, 82

[32] Forsey, Eugene. *How Canadians Govern Themselves*. Public Information Office, Library of Parliament, 1997, Chapter 4

Prior to 2010, few safeguards had been placed by legislature to prevent insurance companies from taking advantage of the American people, who generally value life and will pay top dollar to preserve their health.[33]

In the spring of 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA). Finally, a law placed new restrictions onto health insurance companies, no longer allowing them to deny coverage based on pre-existing conditions. Twenty six million more people acquired health insurance coverage through the bill's facilitation of Medicaid expansion and subsidized employer insurance. Additionally, it permitted young Americans to stay on their parents' health insurance plans until the age of twenty-six, expanding coverage to 2.3 million young adults.[34]

While the Affordable Care Act helped insure more people, it was met with protest and failed to remedy the underlying societal issues obstructing universal coverage. Years after Obama left office, these concerns remained in the American healthcare system. While Obama advanced the United States toward universal coverage, the remaining uninsured continue to pose a challenge to population health. In addition, a focus on innovative technology causes a neglect in the matter of access. High drug prices and the fear of cost-sharing measures force Americans to skip healthcare altogether, even if they have insurance. Many never receive the opportunity to take advantage of the vast facilities, modern equipment, and the high-quality medical education system due to prohibitive costs. Furthermore, the fragmented billing system appears vulnerable to billing abuses, and excessive overhead costs spike prices for services and prescriptions.[35]

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[33] Jacobs, Lawrence R. and Theda Skocpol. *Health Reform and American Politics: What Everyone Needs to Know.* Third edition. New York, NY: Oxford University, 2016, 2
[34] Jacobs and Skocpol, 2016, 5
[35] Jacobs and Skocpol, 2016, 5

All of these factors lead to system inefficiency. Besides insurance, the current healthcare system falls short in other ways. For one, there exists a disconnect between the supply of services and population demand. The United States has some of the most advanced medical technology in the world. A large focus is placed on specialized medicine, considering that surgeons earn a 40 to 80% higher salary than physicians in family practice.[36] Higher salaries incentivize medical students to specialize. As a result, the supply of medical specialists outweighs the supply of primary care physicians; the focus shifts onto treatment instead of prevention. Noncommunicable diseases, which are preventable over a lifetime, result in over five times more deaths than both injuries and communicable diseases combined.[37] When the priority for preventative care trails behind medical technology, noncommunicable diseases may manifest even further among a population.

Additionally, rural areas across the United States struggle to recruit enough physicians. Doctors prefer to stay in metropolitan locations. As a result, while 17% of people live in rural areas, only 9% of physicians choose to practice there. Most rural Americans need to commute far to receive the healthcare they need. The delay in medical care which results from travel time can lead to poorer health outcomes and costlier interventions.[38] Additionally, rural hospitals face challenges in remaining in operation due to low staff numbers. 166 rural hospitals have closed since 2005, including four in 2020 as of February.[39] This number does not include mergers or acquisitions in which the facility continues to provide inpatient care.

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[36] Johnson, Stoskopf, and Shi, 2018, 85
[37] Johnson, Stoskopf, and Shi, 2018, 77
[38] Johnson, Stoskopf, and Shi, 2018, 85
[39] "166 Rural Hospital Closures: January 2005 – Present (124 since 2010)." *Cecil G. Sheps Center at The University of North Carolina at Chapel Hill.* Updated 2020

While rural areas experience the healthcare shortage more intensely, its effects are felt nationwide. The healthcare industry and medical education simply cannot keep up with the population demand. By 2050, the U.S. population is projected to reach 89 million, more than double the 40.5 million in 2010.[40] As modern medicine raises the national life expectancy, the geriatric population continues to grow. Hospital inpatient days are projected to increase by 19% in 2025 from their 2013 frequencies, reflecting the rising complex cases seen in older populations.[41] This contributes to the projected physician shortage described in Figure 2.2, which estimates a range of 46,900 to 121,900 too few physicians in 2032 to meet the population demand.

[40] Dall et al. "An Aging Population And Growing Disease Burden Will Require A Large And Specialized Health Care Workforce By 2025." *Health Affairs,* 2013 32:11, 2013
[41] Dall et al. 2013, 2016

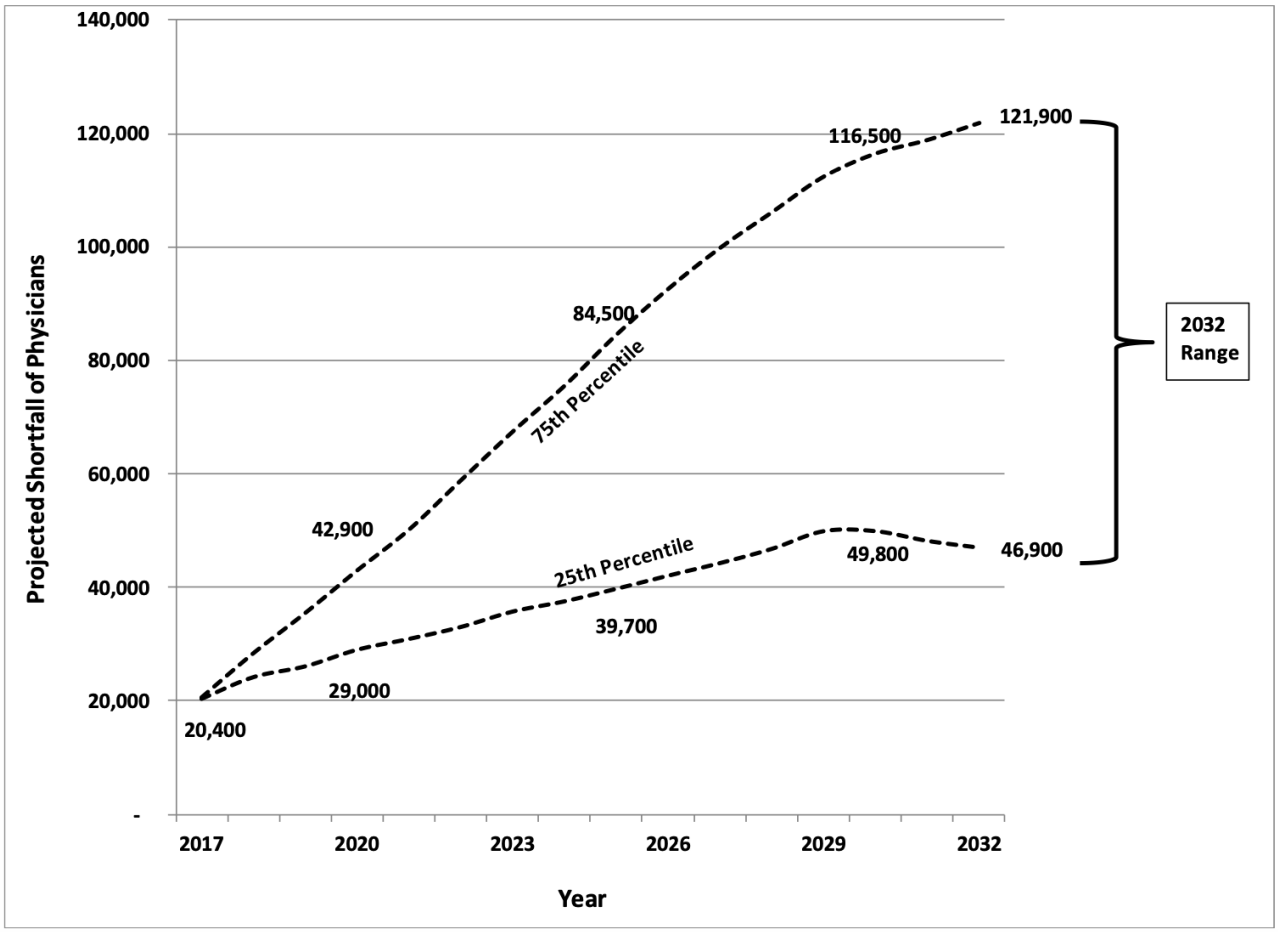

Figure 2.2: Physician shortage predictions through 2032 (SOURCE: Dall et al. 2019, 5)

However, these shortage projections only account for our current, capitalist system. An even more disturbing finding comes from the estimation of additional physicians necessary to execute healthcare equity. If healthcare delivery was equalized across race, socioeconomic status, and insurance status, we would need 95,900 more physicians than we have currently, bringing the system to potential collapse.[42] This implies that if universal healthcare were to be implemented confidently in the United States, the supply of physicians would need to increase dramatically.

[42] Dall et al. 2019, 41

If the physician supply remains unaddressed, the problem will worsen. Many healthcare workers already face burnout, a stress reaction which results from incongruencies between workplace demand and resource capacity.[43] Burnout has harmful effects, including physician mental wellness deterioration, poor patient care, and difficulties maintaining a workforce due to early retirement and high turnover.[44] This puts the system into a continuous feedback loop in which the system overburdens healthcare workers, which causes more of them to leave the workforce, which leads to greater overburdening. If more people were to access healthcare services, the workforce must be adequately equipped. Therefore, the first and foremost priority in healthcare equity should therefore be the expansion of medical education, hospital residency training programs, and physician retention efforts.

What to Look for in a Healthcare Reform Platform

Healthcare reform efforts should be comprehensive, addressing access, quality, and cost issues. An emphasis on reducing costs is crucial, since healthcare and prescription medication expenses deter Americans from getting the treatments they need. An aspect of the plan should focus on the expansion of insurance coverage to all Americans to take care of our vulnerable populations. However, the plan must also work to build a more efficient system, reduce waste, and prevent the overburdening of healthcare workers. Without efforts to reform the healthcare industry and prepare it for wide-sweeping changes, the system will suffer with the American people alongside it.

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[43] Gregory, Sean T., Terri Menser, and Brian T. Gregory. "An Organizational Intervention to Reduce Physician Burnout." *Journal of Healthcare Management*, 63(5), 2018, 339

[44] Gregory, Menser, and Gregory, 2018, 340

Chapter 3: Proposed Actions

At the core of each presidential candidate's platform exists a blueprint for restructuring the healthcare system. Each candidate has a vision of his or her ideal access, quality, and cost balance in healthcare, as well as a path to achieving it. Chapter 3 will examine the visions of six candidates: Bernie Sanders, Elizabeth Warren, Joe Biden, Amy Klobuchar, Pete Buttigieg, and Andrew Yang. It will answer six key questions for each platform based on primary data from each candidate:

What are the proposed actions to restructure health insurance?
How centralized will the system be?
Is this a single payer or multi-payer system?
Will there be cost sharing measures?
Will the system offer comprehensive care or make certain services supplemental?
What actions, outside of insurance reform, are also proposed?

Although there exist many types of candidates with unique platforms, this chapter will explain why only three types of plans exist among Democrats in the 2020 election cycle. These

types are grouped into: 1) the Medicare for All enthusiasts, 2) the Affordable Care Act defenders, and 3) the business-as-usual believers. Group 1 consists of Bernie Sanders and Elizabeth Warren, who have cosponsored the Medicare For All Act of 2019. They believe that restructuring healthcare entirely and eliminating private insurance will heal the United States system. Joe Biden, Pete Buttigieg, and Amy Klobuchar disagree; they all favor the defense and expansion of the Affordable Care Act, which places them into Group 2. Distinct from the other candidates, Andrew Yang lies in Group 3, prioritizing the prevention of waste and investment in technology over health insurance reform.

Additionally, Chapter 3 will compare and contrast the proposals of the candidates, highlighting both common themes and absent considerations. It will show which healthcare policies exist within various European models but not in the policies proposed in the United States. Among them are reduced cost-sharing options and tiered health insurance structures. Finally, this chapter will suggest that detecting omissions of information in platforms may indicate subtleties in a candidate's preferences. It will show how the absence of an explicit statement can signal a weakness in the platform or a potentially unfavorable opposition.

Group 1: Medicare For All Enthusiasts

> "As somebody who wrote the damn bill, as I said, let's be clear. Under the Medicare for all bill that I wrote, premiums are gone. Co-payments are gone. Deductibles are gone. All out-of-pocket expenses are gone. We're going to do better than the Canadians do, and that is what they have managed to do."
>
> -Bernie Sanders at the Democratic Debate on October 15th, 2019

Bernie Sanders and Elizabeth Warren have subscribed to the idea of Medicare for All. That is, all Americans would be covered under the public insurance program which currently serves the 65 and older community. Sanders wrote the Medicare for All Act and introduced it to

the Senate in April of 2019. He found fourteen co-sponsors, all of whom are Democrats. [45] The bill was moved to the Senate Committee on Finance and no further action has been taken since.

Upon first glance, Bernie Sanders has minimal information regarding his healthcare policy on his campaign website, with one summary page at just 475 words. However, Sanders has disclosed his plan in his bill, providing one of the most specific proposals for healthcare reform and the transition to a single-payer system. Oddly, Sanders does not include a link to his bill on his healthcare platform website page. He does not even specify that he wrote the bill on his platform; this seems unusual because he mentions it in many public appearances, including the debate mentioned above.

The absence of the bill on his website may be a strategy of simplicity—not to overwhelm the public with political jargon. Medicare for All calls for the most system upheaval out of all three groups, necessitating the lengthy, detailed nature of the document. Elizabeth Warren was one of the original cosponsors of the bill and has expressed enthusiasm to implement it upon her election.[46] For this analysis, we will first look at Medicare for All as introduced by Sanders and then highlight the features of Warren's platform which add to or conflict with the bill.

The Medicare for All Act provides universal coverage through a single-payer system, which enrolls people automatically upon birth in the United States or immigration to the United States. It replaces private insurance with the Medicare public healthcare plan. More specifically, it eliminates all private insurance and insurance through employment, unless it provides services not covered by Medicare for All.[47]

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[45] U.S. Congress, Senate. *Medicare for All Act of 2019*. S 1129, 116th Cong., 1st sess., introduced in Senate April 10, 2019

[46] Warren 2020, "Ending the Stranglehold of Health Care Costs on American Families", Page 4

[47] U.S. Congress, Senate. *Medicare for All Act of 2019*. S 1129, Section 107

Which exact services would not be covered by Medicare? This is unclear in the bill, as it appears to embody the idea of comprehensive care. Medicare for All aims to expand Medicare coverage to include everything mentioned in Table 3.1. Thereby, in addition to the usual supplementary services such as auditory, dental, and vision, this bill proposes coverage for long-term care and even transportation to and from the doctor. It would create mandatory supplementary health coverage, as described under the Paolucci framework.[48]

1.	Hospital services, including inpatient and outpatient hospital care, including 24-hour-a-day emergency services and inpatient prescription drugs.
2.	Ambulatory patient services.
3.	Primary and preventive services, including chronic disease management.
4.	Prescription drugs, medical devices, biological products, including outpatient prescription drugs, medical devices, and biological products.
5.	Mental health and substance abuse treatment services, including inpatient care.
6.	Laboratory and diagnostic services.
7.	Comprehensive reproductive, maternity, and newborn care.
8.	Pediatrics, including early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r) of the Social Security Act (42 U.S.C. 1396d(r))).
9.	Oral health, audiology, and vision services.
10.	Short-term rehabilitative and habilitative services and devices.
11.	Emergency services and transportation.
12.	Necessary transportation to receive health care services for individuals with disabilities and low-income individuals.

[48] Paolucci 2011

13.	Home and community-based long-term services and supports (to be provided in accordance with the requirements for home and community-based settings under sections 441.530 and 441.710 of title 42, Code of Federal Regulations)

Table 3.1: A list of services covered under the Medicare for All bill (SOURCE: U.S. Congress, Senate. *Medicare for All Act of 2019*. S 1129, Section 201)

In addition, Sanders's bill calls for the establishment of regional offices with regional and state directors appointed by the Secretary of Health and Human Services. These offices will provide reports and assure quality.

Regional offices shall be responsible for—	
1.	providing an annual State health care needs assessment report to the Secretary, after a thorough examination of health needs, in consultation with public health officials, clinicians, patients, and patient advocates;
2.	recommending changes in provider reimbursement or payment for delivery of health services in the States within the region; and
3.	establishing a quality assurance mechanism in the State in order to minimize both under-utilization and over-utilization and to ensure that all providers meet high-quality standards.

Table 3.2: A list of regional office responsibilities as stipulated by Medicare for All (SOURCE: U.S. Congress, Senate. *Medicare for All Act of 2019*. S 1129, Section 403)

The responsibilities outlined in the bill do not indicate resource allocation or policy decision-making duties. Medicare for All may be the most centralized proposal, as state self-determination of important regional healthcare choices is not explicitly specified as a right.

A central aspect to the Medicare for All plan is the elimination of cost-sharing burdens. There will be no cost sharing above $200 in a calendar year—adjusted annually for inflation—

for any individual. This cost-sharing will be limited to prescription pharmaceuticals. Additionally, drug cost-sharing will exclude preventative medications and not collect payments from families living at 200% or below the poverty line. Otherwise, there will be no deductible, premium, or copayments collected from anyone.[49]

Outside of insurance reform, both candidates have proposed actions to reform the healthcare and pharmaceutical industries. Senator Sanders intends to focus on reducing pharmaceutical costs and waste. He plans to encourage the use of "best-practice prescribing" through evidence-based medicine, believing it promotes generic medications in order to reduce expenses. He also wants to allow Medicare to negotiate with pharmaceutical companies and make drug prices the median of five international standards: Canada, the United Kingdom, France, Germany, and Japan. Additionally, he would allow Americans to purchase their drugs internationally if they can find high quality products at cheaper prices.[50]

Elizabeth Warren has her own proposal to tackle pharmaceutical costs, frustrated that "36 million people last year couldn't afford to get a prescription filled."[51] She would also remove the ban on Medicare negotiations with drug manufacturers and hold prices to an international standard, with no drug costing more than 110% of its standard. Additionally, she plans to use compulsory licensing and public manufacturing if negotiations fail—meaning large pharmaceutical companies would need to compete with cheaper, public drug manufacturers.[52]

Warren also encourages research to improve the field of medicine, pledging to raise the National Institutes of Health (NIH) budget by $100 billion over ten years for mandatory research. She would also create a new National Institute for Drug Development (NIDD) to take

[49] U.S. Congress, Senate. *Medicare for All Act of 2019*. S 1129, Section 202
[50] Sanders 2020, "Health Care as a Human Right – Medicare for All"
[51] Elizabeth Warren at the Democratic Debate on January 14th, 2020
[52] Warren 2020, "Ending the Stranglehold of Health Care Costs on American Families," Page 12

NIH research and use it to build new pharmaceuticals. Warren believes that the NIDD—in contrast to profit-motivated pharmaceutical companies—would prioritize drugs that could potentially help the most patients.[53]

Group 2: Affordable Care Act Defenders

> "We should build on Obamacare…I trust the American people to make the decision, not force them to get public insurance."
>
> -Joe Biden, at the Democratic Debate on November 20th, 2019

Joe Biden, Pete Buttigieg, and Amy Klobuchar have pledged to defend and expand the Affordable Care Act. As Vice President under the Obama Administration, Biden gives the impression of pride in this legislature and considers it a milestone. He vows to push back against any effort, whether Republican or Democratic, to repeal the Affordable Care Act.[54] Pete Buttigieg plans to contribute to the existing legislature, passing new measure to pursue more affordable and universal coverage (Buttigieg 2020). Similarly, "Klobuchar believes that the Affordable Care Act is a beginning, not an end" and it should be built upon to reduce costs for the average consumer.[55]

A common thread between the three candidates is the proposal of a new public buy-in option. The public option would offer a plan for those who cannot receive insurance through an employer. It would allow Americans to purchase access to a program similar to Medicare at a lower rate than private companies offer. Therefore, the public option addition would maintain the current multi-payer system with private insurance companies.

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[53] Warren 2020, "My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All," Page 21
[54] Biden 2020, "Health Care," Introduction Paragraph 5
[55] Klobuchar 2020, "Senator Klobuchar on Health Care and Prescription Drugs," Paragraph 1

> "We take a version of Medicare, we make it available for the American people, and if we're right, as progressives, that that public alternative is better, then the American people will figure that out for themselves."
>
> -Pete Buttigieg at the Democratic Debate on September 13th, 2019

Rather than require all Americans to have Medicare insurance, Group 2, as Buttigieg says above, would allow Americans to choose. Private insurers would ideally need to compete with the low-cost public option, ultimately resulting in lower prices. Joe Biden and Pete Buttigieg plan to cover the uninsured in states that have not expanded Medicaid by automatically enrolling them in the public option, premium-free.[56] Amy Klobuchar has not stated a plan for access expansion in these states.[57]

Furthermore, the "Biden Plan" will automatically enroll those below 138% of the poverty line when they interact with other government assistance programs or public schools.[58] Similarly, Buttigieg's "Medicare For All Who Want It" will retroactively enroll those who have no coverage and cannot afford it, shielding them from burdensome medical bills after sudden visits to the hospital.[59] Again, Klobuchar does not mention this type of plan. Instead, she intends to expand cost-sharing reductions and premium subsidies to lower costs for families when they purchase health insurance.[60]

All three candidates plan to incorporate cost-sharing measures but have plans to reduce existing healthcare insurance costs. They plan to offer income-based subsidies for premiums. However, Joe Biden is the only candidate in this group who laid out a specific plan to do so. Biden would increase the value of tax credits for families with income levels between 100%-

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[56] Biden 2020, "Health Care," Section I and Buttigieg 2020, "Medicare for All Who Want It," Paragraph 5
[57] Klobuchar 2020, "Senator Klobuchar on Health Care and Prescription Drugs"
[58] Biden 2020, "Health Care," Section I
[59] Buttigieg 2020, "Medicare for All Who Want It," Paragraph 7
[60] Klobuchar 2020, "Senator Klobuchar on Health Care and Prescription Drugs," Page 2

400% of the poverty line, which would help pay for the cost of premiums. He would also raise that 400% tax credit cap to include more families that do not currently qualify for premium subsidies.[61]

Biden and Buttigieg would also lower the cap on premiums from 9.86% to 8.5% of a family's total income. As a result, a family making $100,000 a year could save $1,360 a year on insurance premiums through this provision.[62] Buttigieg would also introduce a cap on out-of-pocket spending for Medicare patients, although it has yet to be determined what this amount will be. He also plans to prohibit providers from charging more than twice what Medicare would for the same services.[63] Biden and Klobuchar do not have the similar clauses written into their healthcare agendas to reduce out-of-pocket spending. Their cost-sharing reductions appear to only affect healthcare premiums.[64]

None of the three candidates have explicitly stated whether policy decisions will be made at the federal level or decentralized to regional governments. The level of centralization is an area that should be clarified by the candidates in Group 2, as Group 1 was more specific in its intent to establish regional offices for quality control. Additionally, under these plans it is unclear whether financing will occur at the federal level or incorporate state financing. While the absence of information may indicate no drastic changes on the existing system, it could also mean that the candidates have not fully considered the aspects of centralization and financing.

Some ambiguity exists in Group 2 on behalf of care comprehension as well. Pete Buttigieg states that he plans to make coverage under the public option as comprehensive as it is

[61] Biden 2020, "Health Care," Section I
[62] Biden 2020, "Health Care," Section I and Buttigieg 2020, "Medicare for All Who Want It," Paragraph 10
[63] Buttigieg 2020, "Medicare for All Who Want It," Paragraph 13
[64] Biden 2020, "Health Care" and Klobuchar 2020, "Senator Klobuchar on Health Care and Prescription Drugs"

under private insurers.[65] However, most private insurance currently is not comprehensive. Vision and dental care, for instance, may require the purchase of a separate plan. It is unclear whether Buttigieg intends to expand coverage under private insurance or match the public option to the current system. For this reason, there remains uncertainty regarding whether supplementary services will be mandatory or voluntary under the Paolucci framework.[66]

Biden also leaves a degree of uncertainty regarding the expansion of supplementary service coverage. He does not target the construction of comprehensive care for all Americans as part of his healthcare plan. As a matter of fact, he neglects to address it entirely, with no details on which services would be considered essential and which would be supplementary.[67] In contrast, Klobuchar stated her intent to expand coverage for dental, vision, and hearing under Medicare.[68] It would create a mandatory supplementary services system, similar to the candidates in Group 1, as described by the Paolucci framework.[69]

In addition to insurance reform**,** all three candidates have announced plans to tackle the pharmaceutical industry, beginning with repealing the law that prohibits Medicare from negotiating drug prices. They believe that when the federal government becomes able to reach deals with pharmaceutical companies, prescription drug costs will go down for the consumer.[70] Biden and Klobuchar mention giving Americans the right to purchase quality medications abroad, forcing the domestic industry to compete with foreign manufacturers. They also aim to increase the supply of lower cost generic drugs, which would help drive down prices.[71]

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[65] Buttigieg 2020, "Medicare for All Who Want It," Paragraph 2
[66] Paolucci 2011
[67] Biden 2020, "Health Care"
[68] Klobuchar 2020, "Senator Klobuchar on Health Care and Prescription Drugs," Page 2
[69] Paolucci 2011
[70] Biden 2020, "Health Care," Section III; Buttigieg 2020, "Affordable Medicine for All," Paragraph 7; and Klobuchar 2020, "Senator Klobuchar on Health Care and Prescription Drugs," Pages 2-3
[71] Biden 2020, "Health Care," Section III and Klobuchar 2020, "Senator Klobuchar on Health Care and Prescription Drugs," Page 3

Buttigieg declares no such provisions in his "Affordable Medicine for All" plan. He, however, is the only candidate in Group 2 who vows to tax pharmaceutical companies as part of his plan to fund access to prescriptions. He is also the only candidate in this group who openly stated that he would take away rights to patents for companies that refuse to make life-saving medications affordable.[72] To the pharmaceutical companies, this would be the ultimate threat—to no longer be allowed to produce more of their products.

Biden also has unique suggestions for reducing prescription pharmaceutical costs. First, he suggests limiting launch prices for newly approved drugs that have no competition on the market. This prevents one drug from monopolizing the treatment and setting unreachably high prices. Second, Biden would stop offering tax breaks for pharmaceutical company advertising.[73] From 1997 to 2016, the pharmaceutical industry has over quadrupled its advertisement spending, from $1.3 billion to $6 billion. As they spend money on direct-to-consumer marketing, they claim tax deductions from the federal governments. Biden is planning to modify a plan from New Hampshire Senator Jeanne Shaheen to cease these deductions and the promotion of direct-to-consumer marketing of pharmaceuticals.[74]

In additional to reshaping the pharmaceutical industry, common themes among the three candidates were broadening access to women's healthcare services, contraception, and mental health services. Buttigieg and Biden would like to enforce mental parity, the notion that mental illness should be treated "on par" with physical illness.[75] Buttigieg plans to penalize insurers who do not comply with parity and charge more for mental health services. Ideally, he would create a

[72] Buttigieg 2020, "Affordable Medicine for All," Section on "Confronting Pharmaceutical Companies"
[73] Biden 2020, "Health Care," Section III
[74] Shaheen referenced in Biden 2020, "Health Care," Section III
[75] Biden 2020, "Health Care," Section IV and Buttigieg 2020, "Improving Mental Health and Combating Addiction"

more comprehensive care system via this method by mandating the coverage of mental health services.[76]

Buttigieg also wrote about the reduction of waste as an integral part of his healthcare plan. He proposes a central clearinghouse for all medical bills to simplify the billing process. Additionally, he would integrate the electronic health record, billing, and reporting systems, which could reduce the time medical providers spend on paperwork. Ideally, this measure would open up more time for doctors to see their patients and simultaneously reduce administrative costs.[77]

On several occasions, Klobuchar has inserted the idea of expanding long term care coverage.

> "We need to make easier to get long-term care insurance and strengthen Medicaid."
>
> -Amy Klobuchar at the Democratic Debate on October 15th, 2019

> "…what should we do about long-term care? The elephant that doesn't even fit in this room. We need to make it easier for people to get long-term care insurance. We need to make it easier for them to pay for their premiums."
>
> -Amy Klobuchar at the Democratic Debate on January 14th, 2020

She proposes the creation of a refundable tax credit to lower costs of long-term care insurance. However, her platform does not indicate how this tax credit would be determined or who would be eligible.[78] Buttigieg specifically suggests a $90 per day credit—for those eligible—in order to pay for long-term care. Again, what "eligibility" entails is unstipulated in his plan.[79] Biden

[76] Buttigieg 2020, "Improving Mental Health and Combating Addiction," Section titled "Heal"
[77] Buttigieg 2020, "Medicare for All Who Want It," Paragraph 14
[78] Klobuchar 2020, "Senator Klobuchar on Health Care and Prescription Drugs," Page 2
[79] Buttigieg 2020, "Long-Term Care," Section titled "Make Long-Term Care More Affordable"

suggests a different approach, offering a $5,000 tax credit for informal caregivers and provide tax credits for older Americans who choose to purchase long-term care insurance. Additionally, he would protect Medicaid funding so that beneficiaries can continue to use it to fund their long-term care programs.[80]

Group 3: Business As Usual

> "…I know a lot of doctors, and they tell me that they spend a lot of time on paperwork, avoiding being sued, and navigating the insurance bureaucracy. We have to change the incentives so instead of revenue and activity, people are focused on our health in the health care system."
>
> -Andrew Yang at the Democratic Debate on September 13th, 2019

Andrew Yang is a fascinating candidate because of his stark contrast to the others in the presidential race. While he never explicitly states an intent to reform insurance in the United States, he has copious ideas on how to change the actual system, focusing on technological innovation and industry reorganization. As described in Chapter 2, the healthcare system must be adequately prepared for open access to services. Yang's plan focuses on reducing waste and building a stronger provider network so that doctors can spend more time with their patients and less on bureaucratic work, as suggested by his statement above. However, in regards to health insurance, he believes it is most practical to maintain business as usual.

Andrew Yang never states an intention to change our current health insurance structure. While he agrees with "the spirit of Medicare for All," he does not believe Sanders's bill is realistic.[81] He also never addresses the expansion of insurance coverage, which could be an

[80] Biden 2020, "The Biden Plan for Older Americans," Section II
[81] Yang 2020, "Medicare for All," Paragraph 4

indication that it is not his objective. From the information lacking in his platform, it may be deduced that he does not plan to eliminate private insurance or create any new insurance options. It would keep the multi-payer system we currently have, with a combination of private insurers, Medicare, and Medicaid. The power distribution of Yang's system would likely remain the same as it is today, with states reserving the same rights in healthcare decision-making. Likewise, the cost-sharing measures we have today will either remain the same or will be addressed by Yang's campaign in the future.

Yang's definition of comprehensive care specifically includes services for people with disabilities, mental healthcare, sexual health needs, maternal health needs, dental care, vision care, and HIV/AIDS treatment.[82] He believes that including these services will build a stronger workforce and a healthier patient population, overall raising our nation's productivity while reducing health expenditures.

> "Comprehensive care is not just a moral imperative—it makes economic sense. A robust healthcare system where everyone, including people with disabilities, has accessible and affordable coverage will build a healthier population and reduce our expenditure on long-term medical costs."
>
> -Andrew Yang's platform on Care for People with Disabilities[83]

This description falls in the category of mandatory comprehensive services under the Paolucci framework.[84] However, Yang shares this sentiment without offering clarity in his path to changing the existing system in favor of mandatory comprehensive care. It does not appear that his platform would even require Americans to have basic healthcare coverage and therefore a comprehensive care plan seems even more unlikely.

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[82] Yang 2020, "Medicare for All," Paragraph 7
[83] Yang 2020, "Care for People with Disabilities," 2
[84] Paolucci 2011

Most of Yang's ideas are independent of insurance reform. Similar to all the other candidates in the 2020 election cycle, he places a high priority on controlling the cost of prescription drugs. Similar to other candidates, he also would give federal authority to negotiate drug prices and use international standards to cap drug prices in the United States. He also devises a plan to hold pharmaceutical companies accountable for false advertising, poor testing, and overall safety risks to the American public. Yang claims he would strictly enforce clinical research laws and work with the Food and Drug Administration and United States Department of Justice to initiate more criminal cases against pharmaceutical companies that break these laws.[85]

Unlike the other candidates, Yang suggests investing in technology as a potential solution to the problems within the healthcare industry. He specifically recommends a telehealth expansion—the use of phone and video communication—to give rural areas more access to providers and mental health services. To make this possible, he would implement federal medical licensing so doctors would be able to practice telemedicine across state lines, making more providers available to underserved populations.[86]

Yang also believes that a reduction in medical waste can streamline the healthcare system, maximizing access and quality while minimizing costs. His first suggestion is to modernize the electronic health record (EHR) to be more user-friendly and less cumbersome. Ideally, a new EHR would allow providers to spend more time with their patients and less time doing paperwork. Yang also wants to incentivize hospitals to pay doctors on a salary basis instead of using the fee-for-service model. Fee-for-service reimburses providers based on every test and procedure they order, promoting the overuse of resources and the practice of defensive medicine. Salaried physicians and physicians who are paid a fixed amount per patient, according

[85] Yang 2020, "Hold Pharmaceutical Companies Accountable," Paragraph 4
[86] Yang 2020, "Medicare for All," Section titled "As President I Will…"

to Yang, are less likely to use more resources than they need.[87] From Group 2, Amy Klobuchar briefly mentions changing reimbursement models to value-based instead of fee-for-service in her platform.[88] Value-based payments are based on performance measures, incentivizing hospitals and providers to maintain high quality and patient satisfaction.

Another aspect of Yang's overall healthcare system reform plan is to make changes to medical school education. He wants to shift the focus onto preventative care by expanding loan forgiveness programs for physicians entering primary care and placing an emphasis on primary care in medical schools. This provision could help reallocate resources back into preventative medicine and improve the over-specialization problem described in Chapter 2. Furthermore, Yang believes that mental health checkups should be integrated into primary care and that physicians should be trained to administer them during annual physicals.[89] While he does not use the term "mental parity," as Biden and Buttigieg have, his ideas echo the sentiment that mental illnesses should be treated as seriously as physical ones.

Organization, Omission, and Opposition

How can one make sense of the long platforms of such a wide array of candidates? The nuances within these platforms obstruct the fact that *only three types of healthcare plans have been discussed* by the Democratic candidates in the election cycle of 2020. I argue that the only options among the Democratic candidates are: 1) the single-payer Medicare for All, 2) the addition of a public option to the Affordable Care Act, and 3) changes to the healthcare delivery

[87] Yang 2020, "A New Way Forward for Healthcare in America," Page 9
[88] Klobuchar 2020
[89] Yang 2020, "A New Way Forward for Healthcare in America," Page 19

system rather than the insurance system. Table 3.3 has summarized the shared characteristics among the candidates within each group, as well as the criteria upon which the groups were based.

	Group 1	Group 2	Group 3
Reform idea	Medicare for All Act	"Public option"	Leave insurance as-is
Number of payers	Single-payer system	Multi-payer system	Multi-payer system
Cost-sharing?	No cost-sharing	Premium reductions	No specified cost-sharing reduction

Table 3.3: A summary of the three healthcare plan groups and the shared characteristics among the candidates within each group.

Even less popular candidates, or those who have dropped out of the race, fall into one of the three groups discussed above. The only candidate who could not be placed was Tulsi Gabbard, who claims to support a single-payer system through Medicare for All while still allowing Americans to choose private insurance.[90] Based on this condition, her plan lacks the internal cohesion necessary for categorization. Table 3.4 classifies the other Democratic candidates into the three groups. Groups 1 and 2 clearly dominate Group 3, especially with both Andrew Yang and Marianne Williamson out of the race at this time. The overwhelming majority of Democratic candidates favor insurance reform and the divisive issue becomes whether or not Medicare for All will be favored in the primary.

[90] Gabbard 2020, "Healthcare for All," Paragraph 4

Group 1	Group 2	Group 3
• Bernie Sanders • Elizabeth Warren • Kamala Harris[91] • Corey Booker[92] • Kirsten Gillibrand[93] • Julian Castro[94]	• Joe Biden • Pete Buttigieg • Amy Klobuchar • John Delaney[95] • Mike Bloomberg[96] • Tom Steyer[97] • Michael Bennet[98]	• Andrew Yang • Marianne Williamson[99]

Table 3.4: The categorization of Democratic candidates for president in the 2020 election cycle, past and present.

Which ideas are present in international health systems but missing from current United States presidential campaign platforms? For one, all the single-payer Medicare for All advocates in this election cycle aspire to remove cost-sharing in the form of premiums, deductibles, and co-payments. The Medicare for All Act stipulates that no cost sharing will exist outside of a $200 cap for prescription medications.[100] And yet, under many international government plans, cost-sharing has a stronger presence.

Germany, Sweden, and France all have universal systems that incorporate more cost-sharing than Medicare for All proposes. Germany's system provides comprehensive coverage to all citizens, yet it still uses small co-payments for inpatient days, outpatient prescriptions, and medical devices. However, it caps out-of-pocket healthcare spending to 2% of the household income.[101] Similarly, the Swedish system sets up copayments for primary care physician visits,

[91] S.1129 2019 and Harris 2020, "Kamala's Medicare for All Plan"
[92] S.1129 2019
[93] S.1129 2019
[94] Castro 2020, "Health Care"
[95] Delaney 2020, "BetterCare," Paragraph 3
[96] Bloomberg 2020, "Health Coverage"
[97] Steyer 2020, "The Right to Health"
[98] Bennet 2020, "Medicare-X"
[99] Williamson 2020, "The Whole Health Plan"
[100] S.1129 2019, Section 202
[101] Brumel, Miriam and Reinhard Busse. The German Healthcare System. *The Commonwealth Fund*, 2016. , Paragraph 10

hospital consultations, and days of hospitalization. It also caps annual out-of-pocket spending equal to $123 for health services and $246 for prescription drugs.[102] Unlike Germany and Sweden, France has no cap on out-of-pocket spending. The French system uses copayments as well, with an annual ceiling equivalent to $60 for doctor appointments and hospital stays.[103] However, there exists no cap on additional services, such as dental and vision care.[104]

The takeaway is that the United States does not need to eliminate all forms of cost-sharing, it simply needs to reduce them. In 2016, the cost-sharing cap in the U.S. was $13,700 for families and $6,850 for individuals on private insurance plans.[105] The cap on premiums alone stands at 9.86% of an American family's annual income.[106] This percentage does not include copayments upon the use of services or annual deductibles. Compared to the aforementioned 2% cap on all cost-sharing in Germany, healthcare spending pressure remains much higher in the United States.

A tiered healthcare system, similar to France's or Denmark's, is another missing idea from the campaign trail. [107] These systems include mandatory basic coverage but have voluntary private insurance, through nonprofit companies, for supplementary services such as dental care. In both countries, private insurance complements—not replaces—the mandatory basic public health plan. The additional insurance helps cover copayments when subscribers use services not fully covered by the state.[108]

Most candidates—with the exceptions of Biden and Buttigieg—have openly stated their intent to cover more services and broaden insurance comprehension. Andrew Yang even

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[102] Glenngård, Anna H. "The Swedish Health Care System." *The Commonwealth Fund*, 2016, "Benefit Design"
[103] Durand-Zaleski. "The French Healthcare System." *The Commonwealth Fund*, 2016, Paragraph 17
[104] Durand-Zaleski, 2016, Paragraph 15
[105] "The U.S. Health Care System." *The Commonwealth Fund*, 2016., Paragraph 11
[106] Biden 2020, "Health Care," Section I and Buttigieg 2020, "Medicare for All Who Want It," Paragraph 10
[107] Durand-Zaleski, 2016 and Vrangbaek, Karsten. "The Danish Health Care System." *The Commonwealth Fund*
[108] Durand-Zaleski, 2016, Paragraph 8 and Vrangbaek, 2016, Paragraph 6

believed that mandatory health coverage creates a more robust workforce and could stimulate the economy. Recall the Paolucci framework from Chapter 1, as shown in Figure 3.1, and how it depicts the decision of mandating health coverage based on definitions of basic or supplementary services. None of the six candidates have suggested a tiered system, in which certain services would require additional insurance.

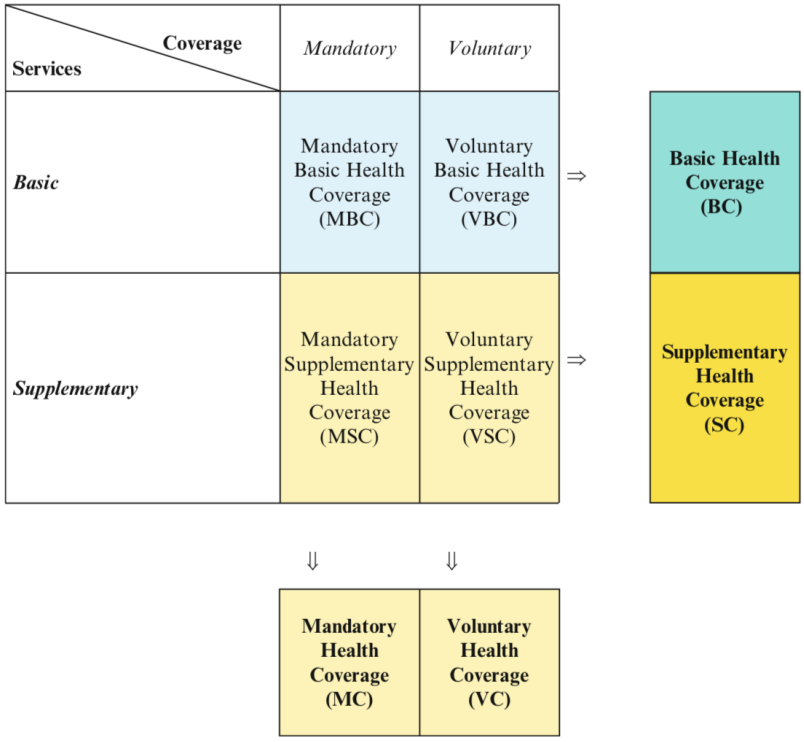

Figure 3.1: An outline of basic and supplementary coverage crossed with mandatory and voluntary coverage, showing the options considered by nations in designing a health plan (SOURCE: Paulucci 2011)

Perhaps the most lasting impression from reading several presidential candidate health care proposals is the significance of ambiguity. Words left unsaid are as important as words said. Candidates neglecting to *explicitly* state their stances on a policy can imply one of two possibilities: 1) They have failed to consider it or 2) They do not support it. For example, Biden and Buttigieg may have forgotten to consider their stances on insurance comprehension or

simply have not decided on a final opinion. Otherwise, their missing statements may indicate an opposition to service expansion. Similarly, Amy Klobuchar may disagree with automatically enrolling those who cannot afford insurance and waiving their premiums. She also does not mention lowering the income cap on premiums, as Biden and Buttigieg do. Again, these gaps infer either her dislike of these policies or her failure to consider them.

Openly aiming below the absolute best would meet resistance and consequently hurt a candidate's campaign. Recall L. Robert Kohl's thirteen common American values, as mentioned in Chapter 2. His second value *change* refers to an insatiable desire for improvement. Kohls argued that Americans believe "each individual has a responsibility to do the best he or she can do to have helped Americans achieve some great accomplishments."[109] The platforms of the current presidential campaigns fall into this logic. It explains why candidates aim high, refuse to settle, and choose to omit rather than admit certain attitudes.

[109] Kohls, 1984, 2

> "The ACA was the best that we could get through the American political system. The fact that we failed in every previous instance in the past 100 years reflects the reality that there hadn't been a reform designed to deal with the realities of American politics, and there hadn't been a broad-based movement built effectively for the country to pass this reform."
>
> -Richard Kirsch[110]

Chapter 4: Feasibility

Richard Kirsch was the former chief executive for Health Care for America Now (HCAN), an organization which helped shape and ratify the Affordable Care Act (ACA). He asserted that regardless of the candidate elected in 2008—whether the Democrats chose Barack Obama, Hillary Clinton, or John Edwards—the result would have been the same. As he says in the above quote, the ACA was the best law that could have passed, despite its significant compromises. Any of the Democrats would have "faced a similar political climate, with a very hostile opposition," as Obama experienced upon his election.[111]

A similar situation applies today, as anyone attempting to pass legislature through Congress must endure partisan politics and their polarization. This can have effects on the

[110] Kirsch qtd. in Pollack, Harold. "The group that got health reform passed is declaring victory and going home." *The Washington Post*, 2014.
[111] Kirsch qtd. in Pollack, 2014

feasibility of a policy, as ideas are scrutinized, prodded, and conceded throughout the legislative process. The term *feasibility* may represent several matters of policy implementation. It can refer to the political practicality or fiscal feasibility of a policy. For the purpose of defining feasibility in this project, there will be two primary factors under consideration: 1) platform support and 2) financial transparency.

First, platform support is essential in the ratification and execution of policy. It includes both government and public support, which can differ. Congressional support for the healthcare platforms of the six candidates will be assessed through examination of recent bills, their sponsorship, and their likelihood of ratification. An evaluation of American readiness to embrace universal healthcare, as discussed in Chapter 2, will be also expanded to show public support. Recent surveys will argue that the American public tends to favor universal healthcare, even though the current Congress is unlikely to enable its implementation. Furthermore, Americans have a slight preference for a public health insurance addition over Medicare for All in reaching universal coverage, potentially leading to a preference of more moderate candidates on the political spectrum.

Second, without transparency, the public views the plan as incomplete, containing weaknesses or loopholes. Fiscal feasibility may be difficult to convey in a platform, yet it a common criticism of social program expansion. The plan may also have weak internal cohesion if it does not include a clear path to its execution. For this reason, it is important to consider which of the six candidates has the most transparent platform in terms of financing. Each candidate has been assigned a rating of either high, medium, or low to evaluate their transparency. They have been compared relative to each other to understand which explanations are missing among the platforms. Elizabeth Warren was the only candidate to score “high,”

based on her release of an expert analysis on financing Medicare for All and her acknowledgment of the estimate variations among sources.

Support

A common criticism of the Group 1 candidates, Bernie Sanders and Elizabeth Warren, pertains to their ability to enact the Medicare for All Act. Amy Klobuchar has said "…the difference between a plan and a pipe dream is something that you can actually get done. And we can get this public option done."[112] She defended the addition of a buy-in public plan as more practical than a single-payer system under Medicare for All. "Two-thirds of the Democratic senators are not even on that bill," she said, suggesting it would never pass through Congress.[113]

Bernie Sanders and fourteen cosponsors introduced the Medicare for All Act in April of 2019. Since then, it was moved to the Committee on Finance and no action has been taken. GovTrack and Skopos Labs use software to compile information on proposed legislation in Congress. According to Skopos Labs data, Medicare for All has only a 3% chance of being enacted.[114]

Also in April of 2019, Senator Sheldon Whitehouse and eight cosponsors introduced the Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act.[115] This bill intends to establish a public health option, similar to the one proposed in Klobuchar, Buttigieg, and Biden's campaign platforms. After its introduction, the bill was referred to the Senate Committee on Health, Education, Labor, and Pensions, and no further action has been taken

[112] Amy Klobuchar at the Democratic Debate on October 15th, 2020
[113] Amy Klobuchar at the Democratic Debate on February 19th, 2020
[114] Skopos Labs referenced in "S. 1129 — 116th Congress: Medicare for All Act of 2019." www.GovTrack.us. 2019. February 26, 2020
[115] S U.S. Congress, Senate. *Consumer Health Option and Insurance Competition Enhancement Act*. S 1033, 116th Cong., 1st sess., introduced in Senate April 4, 2019

since. Skopos Labs also generated a calculation for this bill—and also estimates a 3% chance of its ratification.[116]

A couple of important lessons may be taken away from the comparison of the two bills. First, Amy Klobuchar, the only remaining Senator candidate in the presidential election, did not cosponsor the CHOICE Act. In 2009, she openly stated her concerns about adding a public insurance option, refusing to vote in favor of it. Instead she favored private insurance competition to incentivize lower costs.[117] Considering her missed opportunity to join the CHOICE Act as a cosponsor in early 2019, as former candidates Kamala Harris and Cory Booker have done, it is possible that Klobuchar has only changed her stance recently. It also may be possible that she simply joined the other moderate candidates in supporting public option additions, to cater to the more liberal voter population.

Second, although the public insurance option appears to be more sensible than the *pipe dream* of Medicare for All, the bill with the public option currently has just as much a chance of passing as Medicare for All. Especially with a Republican majority in the Senate, the odds of a Democratic healthcare reform bill passing are bleak. Therefore, support for any universal coverage bill must come from the public, in the election of more representatives to endorse health insurance reform.

Unlike the current Congress, the public appears ready to see universal healthcare in the United States. As mentioned in Chapter 2, a national survey in 2016 discovered that half of Americans would favor a single-payer, universal system operated by the federal government. It happened to be the first time since 1998 that the majority did not oppose it.[118] The proportion of

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[116] Skopos Labs referenced in GovTrack, "S. 1033 — 116th Congress: Consumer Health Options and Insurance Competition Enhancement Act." www.GovTrack.us. 2019. February 26, 2020
[117] Dizikes, Cynthia. "Klobuchar, Franken outline specifics on their health-care views." *Minnpost*, 2009, Page 4
[118] "Public Opinion…" 2020, Figure 2

Americans in support of universal healthcare has grown since then. By January of 2020, the same study found that 55% of surveyed Americans would be in favor of Medicare for All, as illustrated in Figure 4.1.[119]

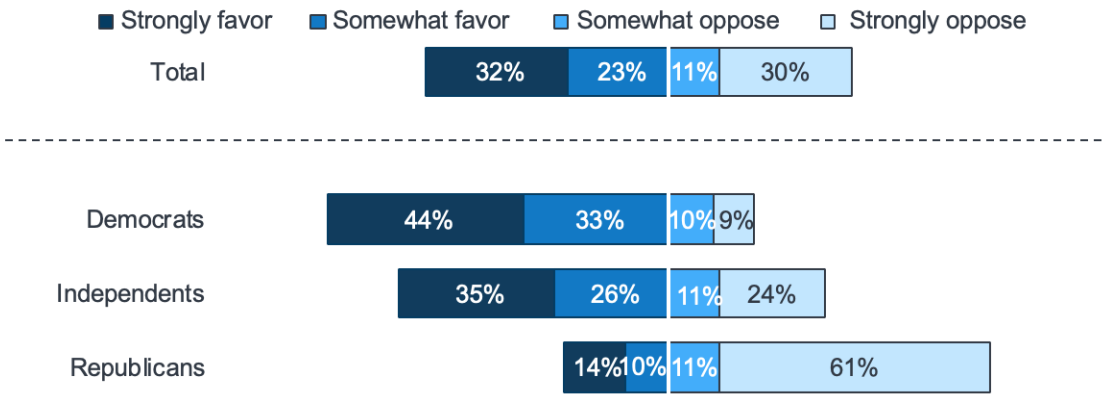

Figure 4.1: How Americans of different political affiliations responded to this question: "Do you favor or oppose having a national health plan, sometimes called Medicare-for-all, in which all Americans would get their insurance from a single government plan?" (SOURCE: KFF Health Tracking Poll (January 16-22, 2020)).

Additionally, Figure 4.2 shows that only 22% would oppose both Medicare for All and a public option. This affirms that the majority of Americans, 71%, are ready for some type of health insurance reform. Furthermore, 65% of Americans stated they would favor a public option and 55% support Medicare for All in 2020.[120] The public option therefore holds more approval than a single-payer, national system.

[119] "Public Opinion…" 2020, Figure 3
[120] "Public Opinion…" 2020, Figure 16

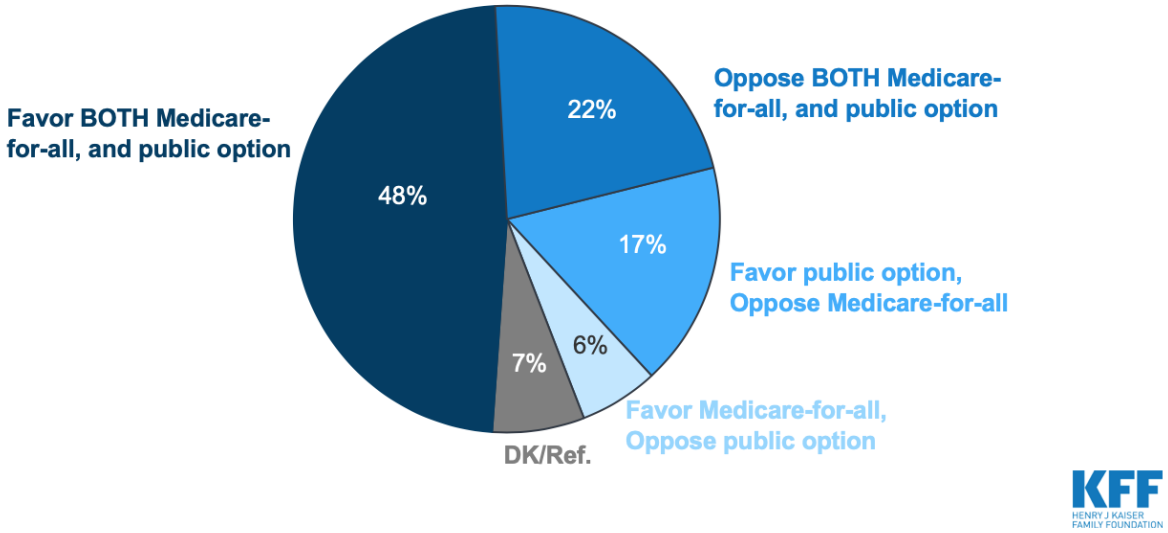

Figure 4.2: A comparison of public support for Medicare for All and the addition of a public health insurance option. SOURCE: KFF Health Tracking Poll (conducted January 16-22, 2020).

If this truly reflects public opinion, then voters in 2020 must focus on backing candidates who support a path to universal healthcare coverage. More importantly, they should make sure to cast a vote. In 2016, the United States ranked 26th out of 32 countries in voter turnout, at only 55.7% of the voter-eligible-population.[121] When only about half of the population decides who to elect into office, the election may misrepresent public opinion. For the 2020 presidential election, it will be important for Democrats to increase voter turnout in order to find support for policies such as universal health coverage.

Even if the public elects more universal-healthcare-supporting representatives, the healthcare industry also has influence over the legislative process. John McDonough, a professor at the Harvard T.H. Chan School of Public Health helped write the Affordable Care Act. He has

[121] Desilver, Drew. "U.S. trails most developed countries in voter turnout." *Pew Research Center*, 2018, Paragraph 3

since said that he heard from insurance lobbyists on each day of the process. The final bill included many concessions to please their demands.[122]

Hospitals will likely oppose the expansion of public insurance programs. Currently, Medicare reimburses hospitals at much lower rates than their operating costs, making them lose money on Medicare patients. To remain in business, hospitals are able to negotiate higher reimbursement rates with private insurers. In 2019, Medicare reimbursed at 88.1% of operating costs while Medicaid offered only 86.8%. Conversely, private payers average 144.8%.[123] In a shift to more public insurance subscribers, hospital systems have concerns about revenue decline. If reimbursement rates remain the same, hospitals could lose $151 billion in revenue.[124] A potential resolution could be to raise reimbursement rates to equal operating costs. However, this would do little to encourage hospitals to improve their productivity rates and reduce waste.

Ultimately, Congress can expect lobbying from hospitals against any bill suggesting a public insurance expansion and especially a Medicare for All effort.[125] Arguments have been made claiming that if reimbursement rates rise to 100% to please hospitals and medical providers, federal spending would increase by $66.3 billion. In the Fiscal Transparency section, it will become clear that this number may be a low estimate, or may appear insignificant, when compared to estimates of additional federal spending in trillions of dollars.

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[122] John McDonough in "Strong opposition to Medicare for All from insurance industry." The Harvard T.H. Chan School of Public Health. n.d.
[123] Schulman, Kevin A. and Arnold Milstein. "The Implications of 'Medicare for All' for US Hospitals." *JAMA* 321, no. 17 (2019), 1661
[124] Schulman and Milstein, 2019, 1661
[125] Schulman and Milstein, 2019, 1662

Fiscal Transparency

Fiscal transparency is a crucial aspect of evaluating plan feasibility. It refers to a clear and candid conveyance of program costs, as well as a straightforward, descriptive plan for financing. After examining the platforms of the six Democratic candidates, Table 4.1 was created to show differing levels of financial transparency.

High	Medium	Low
• Elizabeth Warren	• Pete Buttigieg • Joe Biden • Bernie Sanders	• Amy Klobuchar • Andrew Yang

Table 4.1: High, Medium, and Low groupings for the candidates based on each platform's transparency in healthcare plan financing.

Medicare for All has received plenty of criticism on its projected expenditure. "I don't think it is realistic," said Joe Biden.[126] He confronted Sanders on the cost of his plan and the fiscal burden it could create. "It costs $30 trillion. Let's get that straight, $30 trillion over 10 years."[127] Pete Buttigieg took a similar approach, calling attention to the financing of Medicare for All. "If you add up all [Sanders's] policies altogether, they come to $50 trillion. He's only explained $25 trillion worth of revenue, which means that the hole in there is bigger than the size of the entire economy of the United States."[128]

[126] Joe Biden at the Democratic Debate on December 19th, 2020
[127] Joe Biden at the Democratic Debate on December 19th, 2020
[128] Pete Buttigieg at the Democratic Debate on February 19th, 2020

Indeed, the last recorded gross domestic product (GDP) of the United States was $20.5 trillion in 2018.[129] Medicare for all could result in additional federal spending of $3 trillion per year, or approximately an additional 15% of the current annual GDP. Figure 4.3 compares the estimated costs over ten years of health care plans proposed by the six candidates. It appears that the Group 2 proposals—the public option—would require much less additional spending than those of Group 1. This is the reason that the aforementioned $66.3 billion, if public insurance reimbursement rates rise to 100%, appears small in the context of all additional federal spending projections for a universal healthcare system.

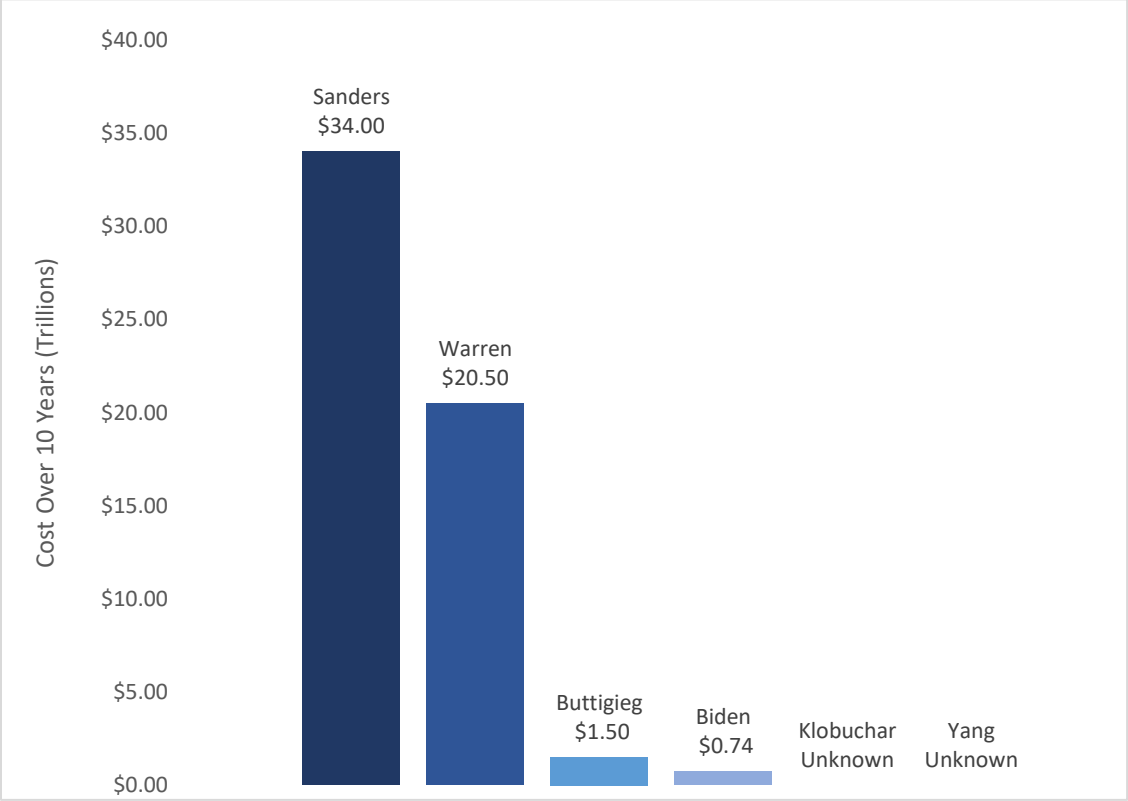

Figure 4.3: Estimates of new federal spending based on health care programs suggested by each of the six candidates.[130]

[129] The World Bank, GDP (current US$) - United States, 2018

[130] Source for Sanders: Blumberg et al. "From Incremental to Comprehensive Health Reform: How Various Reform Options Compare on Coverage and Costs." *The Urban Institute*, 2019, page 47 (not on candidate's website).

However, several considerations are important to note in these data. For one, Buttigieg and Biden's cost projections are self-reported. There appears to be no published expert cost projection for either candidate. Buttigieg states his value on his website while Biden has only mentioned it in a debate: "My plan for health care costs a lot of money. It costs $740 billion. It doesn't cost $30 trillion."[131] Both of them fail to clearly convey a source of their approximation and whether they worked with experts to calculate those numbers. While Biden and Buttigieg continuously attack the Group 1 candidates on the cost of their plans, they have yet to publish publicly accessible cost-analyses for their own platforms. For this reason, both Biden and Buttigieg have been assigned scores of "medium" in table 4.1.

Secondly, it is possible that Warren and Sanders's varying estimations result from two different groups of economic analysts evaluating the costs of Medicare for All. Warren reports her estimate of $20.5 trillion on her website; Sanders does not report his. As Warren states on her platform, she "asked top experts to consider the long-term cost" of her healthcare plan.[132] Bernie Sanders appears to not have *asked* Linda Blumberg and her team of analysts at the Urban Institute to create a cost projection for his plan, nor does he mention her study on his platform.

Sanders does, however, mention a study from Yale researchers who found that his plan would actually save $5 trillion over the next ten years.[133] He then claims that if the nation remains the same as it exists today, it would need $52 trillion over the next decade to finance

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Source for Warren: Berwick, Donald and Simon Johnson. "Expert letter on cost estimate of Medicare for All." 2019, Page 1 (expert report featured on candidate's website)
Source for Buttigieg: Buttigieg, 2020, "Medicare for All Who Want It," Paragraph 3 (Self-reported on candidate's website).
Source for Biden: Democratic Debate on September 12th, 2019 (Self-reported by candidate)
[131] Joe Biden at the Democratic Debate on September 12th, 2019
[132] Warren, "Ending the Stranglehold of Health Care Costs on American Families," 2020, Page 7
[133] Galvani et al. "Improving the prognosis of health care in the USA." *Health Policy* vol. 395, 10223, P524-533, 2020, 524

healthcare. According to the Yale study, Medicare for All would need $47 trillion. Based on national health expenditure projections from the Centers for Medicare & Medicaid Services (CMS), Sanders states that government spending will already total $30 trillion over the next ten years.[134] He has released a "menu of financing options" to pay for the additional $17 trillion needed for his Medicare for All legislation.[135] Sanders claims that his options for additional financing will provide at least an additional $17.5 trillion, the breakdown of which can be seen in Table 4.2.

Plan	Revenue Claimed (Over 10 Years)
1. Creating a 4% income-based premium paid by employees, exempting the first $29,000 in income for a family of four	$4 Trillion
2. Imposing a 7.5% income-based premium paid by employers, exempting the first $1 million in payroll to protect small businesses.	$5.2 Trillion
3. Eliminating health tax expenditures, which would no longer be needed under Medicare for All.	$3 Trillion
4. Raising the top marginal income tax rate to 52% on income over $10 million.	$700 Billion
5. Replacing the cap on the state and local tax deduction with an overall dollar cap of $50,000 for a married couple on all itemized deductions.	$400 Billion
6. Taxing capital gains at the same rates as income from wages and cracking down on gaming through derivatives, like-kind exchanges, and the zero tax rate on capital gains passed on through bequests.	$2.5 Trillion
7. Enacting the For the 99.8% Act, which returns the estate tax exemption to the 2009	$336 Billion

[134] Sanders 2020, "How Does Bernie Pay for His Major Plans?," Subsection "Medicare for All"
[135] Sanders 2020, "How Does Bernie Pay for His Major Plans?," Subsection "Medicare for All"

level of $3.5 million, closes loopholes, and increases rates progressively. It would also add a top tax rate of 77% on estate values in excess of $1 billion.	
8. Enacting corporate tax reform including restoring the top federal corporate income tax rate to 35 percent.	$3 Trillion

Table 4.2: Bernie Sanders's ideas for financing Medicare for All, as well as the revenue he predicts to acquire from each source. (SOURCE: Sanders 2020, How Does Bernie Pay for His Major Plans?, Subsection "Medicare for All")

The income-based premium suggestion in the first line of Table 4.2 may be surprising. Recall that in Chapter 3, Sanders pledged in the Medicare for All Act to remove all premiums, copayments, and deductibles.[136] Here, he is replacing a payment to a private health insurance company with a premium in the form of a tax. Sanders uses the example of a four-person family with an annual income of $60,000. With Sanders's 4% tax—excluding the first $29,000—the family would pay $1,240 per year on Medicare for All. In comparison, as Sanders stated on his website, families paid an average of $6,015 towards the cost of insurance premiums in 2018.[137] This number was likely taken from the Kaiser Family Foundation's Benchmark Employer Survey.[138] From these numbers, Sanders's plan will ideally allow overall costs to go down, while still generating new revenue through a tax instead of a premium.

However, the revenue expected from each of the eight provisions in Table 4.2 does not seem to be cited, or backed by existing literature. It appears as though these values are self-reported by Sanders. The lack of transparency in financing values, as well as the jargon and untraceable sources in Sanders's platform, land him a score of "medium" in fiscal transparency.

[136] U.S. Congress, Senate. *Medicare for All Act of 2019*. S 1129, Section 202
[137] Sanders 2020, "How Does Bernie Pay for His Major Plans?," Subsection "Medicare for All"
[138] Claxton et al. "Employer Health Benefits 2019 Annual Survey." *Kaiser Family Foundation*, 2019, 101

While he puts out a detailed plan to drive new revenue to fund Medicare for All, he should have worked with, or cited, a team of professionals to solidify his calculations. Sanders also opted to include the most optimistic study regarding the costs of his plan without mentioning any other studies, such as Linda Blumberg's estimate of $34 trillion in additional spending.[139]

No data, whether self-reported or expert, exists for Klobuchar and Yang's healthcare plans. This could result from a lack of detail in their proposals. They may have not considered the magnitude to which each of their provisions would be implemented. This is especially true in Yang's policy, which enthusiastically describes the application of various new technologies with no clear prioritization. Additionally, he provides no specifics on the cost breakdown for his plan to restructure healthcare in the U.S. For this reason, Yang is considered "low" in the fiscal transparency ratings of Table 4.1.

Klobuchar's healthcare plan, while not the "Post-It note" described by Elizabeth Warren, is relatively ambiguous.[140] In particular, her idea to pay for the implementation of a universal system lacks specifics:

> To pay for these investments Senator Klobuchar will increase the income tax rates for the top two brackets to the rates that were in place before the 2017 Republican tax law, further raise the income tax rate for the highest tax bracket and implement prescription drug reforms.[141]

Without values for the estimated revenue Klobuchar expects to accrue from this tax plan, and without a cost-analysis of the program itself, her plan lacks a certain depth. Compared to the other candidates, it was the least detailed, bringing her to a "low" score in Table 4.1.

Elizabeth Warren is the only candidate out of the six with an expert analysis on financing embedded into her website. Specifically, she asked Dr. Donald Berwick, who ran the CMS under

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[139] Blumberg et al., 2019
[140] Elizabeth Warren at the Democratic Debate on February 19th, 2019
[141] Klobuchar 2020, "Senator Klobuchar on Health Care and Prescription Drugs," Paragraph 26

the Obama Administration, and Simon Johnson, former Chief Economist at the International Monetary Fund and professor at the Massachusetts Institute of Technology.[142]

Donald Berwick has also practiced as a pediatrician, served as president for the Institute for Healthcare Improvement, taught at the Harvard Medical School and School of Public Health. He has written several books and received numerous awards, including "Honorary Knight Commander of the British Empire" for his work on the British National Health Service.[143] He undoubtedly has the credentials to be considered an expert in the healthcare field, yet he has clear affiliations with the Democratic Party, which could be a source of potential bias. Under the Obama Administration, Berwick was a controversial appointee to the CMS. Some Republicans accused him of rationing healthcare, a claim which Democrats dismissed as absurd.[144]

Simon Johnson, the other analyst who worked with Warren, can be considered an expert in the field of economics. Outside of the positions Warren mentioned on her website, Johnson is a published author of ten books, a Senior Fellow at the Peterson Institute for International Economics, and a regular columnist for several media outlets.[145] Unlike Berwick, he does not openly state his political affiliation as a Democrat or Republican. However, he appears to agree with Elizabeth Warren on her healthcare proposal. In an opinion piece he wrote for the *Wall Street Journal*, he claims Warren has the solution to high healthcare costs in a streamlined financing plan that reduces inefficiency and helps small business.[146]

Together, Berwick and Johnson form a strong healthcare economic analysis team. While it would have been intriguing for Warren to pursue an analysis from a more moderate or

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[142] Warren 2020, Ending the Stranglehold of Health Care Costs on American Families, Page 7
[143] Fero, Allison. "Dr. Donald Berwick – A Resource Guide." *Kaiser Health News*, 2010, Page 2
[144] Fero, 2010, Page 1
[145] Johnson, Simon. CV. Accessed 2/26/2020, Page 1
[146] Johnson, "Warren Has the Remedy for Health Costs," 2019, Paragraph 9

conservative group—dissimilar from her own political affiliations—her healthcare plan has a distinctly higher transparency for publishing a detailed, easily visible expert report. Warren also is the only candidate to provide a range of additional spending values based on other expert analyses not included on her website. Her range is $13.5 to $34 trillion, which is consistent with current literature.[147] For these reasons, she has the highest ranking in Table 4.1.

Takeaways

A few main takeaways result from the investigation of platform support and fiscal transparency. In regards to support, Americans are ready for change and universal healthcare may be more feasible than it has been in the past. A study published in 2020 discovered that only 22% of Americans would disapprove of any Democratic insurance reform ideas suggested in this election cycle in order establish universal coverage.[148] Furthermore, it showed that 65% would support a public option, while 55% support Medicare for All. This could indicate that more Americans would support moderate Democratic candidates, such as Biden, Buttigieg, or Klobuchar, over those who push Medicare for All.

The new willingness to accept reforms may come from America's acceptance of needing change. As costs continue to rise and put families at risk of bankruptcy, the situation becomes dire. Healthcare premium costs have burdened Americans by rising at a pace which overtakes annual wage increases. The average family has experienced a 5% increase in premiums over the past year, while workers' wages grew only about 3.4%.[149] As a greater and greater portion of

[147] Warren 2020, Ending the Stranglehold of Health Care Costs on American Families, Page 7
The $34 trillion value is consistent with Blumberg et al. 2019, Page 47
[148] "Public Opinion…", 2020, Figure 16
[149] Claxton et al. 2019, 101

income becomes removed each year, more Americans will likely realize that the situation must change.

Additionally, after all the candidates have been ranked on the clarity and integrity of their platforms, Elizabeth Warren prevailed. Warren's platform is the easiest to understand, has the clearest citations for facts and values, and is backed by published expert analyses. When juxtaposed with her platform, those of other candidates seem incomplete. Biden and Buttigieg lack sources for the estimates of their program costs. Yang and Klobuchar appear to be missing so many details that they have no cost estimates and no precise method to fund their programs. Furthermore, Klobuchar may be the most likely to maintain the status quo in healthcare upon election. Her history of supporting private insurance competition instead of a public insurance option, coupled with her lack of sponsorship of a bill that aligns directly with her campaign policy, may indicate inexperience or hesitance.

Finally, although there are only two groups of healthcare insurance reform ideas in this election—the Medicare for All enthusiasts and the Affordable Care Act defenders—there may exist even fewer possibilities within the scope of Congressional approval. Recall Richard Kirsch, as he described the concessions that had to be made to pass the ACA. Harvard professor John McDonough discussed the constant pressure from healthcare industry lobbyists, leading to even more concessions. Medicare for All, in particular, would receive unyielding opposition from hospitals nationwide. Inevitably, not all of the ideas postulated by each candidate will receive approval. An unfortunate reality may rise again if a Democrat is elected into the presidential office. Meaning, only one possibility for healthcare legislature may succeed through Congress and its lobbyists, and it will matter neither who pushes for it nor his or her original ideas.

Chapter 5: Impact

During the Obama Administration, the Affordable Care Act (ACA) expanded health insurance coverage to millions of Americans. However, the Act faced aggressive criticism and wide speculation over its impact. Upon the addition of more people to the health marketplace, people voiced their fears of potential wait time surges and quality deterioration. “If Obamacare had been fully implemented when I caught cancer, I’d be dead,” said Republican presidential candidate Herman Cain in 2011.[150] Others disapproved of removing American freedom to choose not to buy insurance. Justice Antonin Scalia declared: “Everybody has to buy food sooner or later, so you define the market as food. Therefore, everybody is in the market. Therefore, you can make people buy broccoli.”[151] Like many others in the United States, he believed the government should never tell Americans to purchase health insurance or suffer a penalty. Echoes of socialism, a derogatory term in the context of American society, surrounded the ACA.

A similar situation has occurred in 2020, with most of the Democratic candidates pushing to either expand the ACA or create a national, single-payer health system. The speculation of

[150] Cain qtd. by Politico Pro Health Staff. “25 unforgettable Obamacare quotes.” *Politico*, 2013.
[151] Scalia qtd. by Politico Pro Health Staff, 2013

universal healthcare's potential effects on America has been extensive. When asked about his potential presidential campaign in an interview for Yahoo Finance, Starbucks CEO Howard Schultz had comments on Medicare for All, arguing that it is "unamerican" and will "wipe out the insurance industry."[152] President Donald Trump, during his State of the Union Address in February of 2020, exclaimed "We will never let socialism destroy American health care."[153]

What would be the true impact of the proposals by the candidates of Group 1, Group 2, and Group 3? How would Medicare for All, a public insurance option, and a business-as-usual approach, respectively, affect the United States? A compilation of healthcare system data, expert analyses, and candidate dialogue will predict what would happen if each idea could be hypothetically implemented as intended.

Of course, no platform will ever be implemented as-is, with all of its ideas incorporated. As shown in Chapter 4, the political process will lead to many concessions to partisan politics and healthcare industry lobbyists. The courts also may potentially sway the impact, as they did for the Affordable Care Act in 2012. The case *National Federation of Independent Business v. Sebelius* decided that Congress exceeded its power in threatening states with the loss of federal funding if they refuse to expand Medicaid.[154] Without this expansion, variations exist among income levels below which people qualify for Medicaid. Not all states followed Obama's intention of coverage expansion for the poor.

Chapter 5 will show that certain clarifications have yet to be made in Medicare for All. If changes are made, Medicare for All is most likely to reduce administrative waste and create a true universal coverage system. However, without preparing the healthcare industry and

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[152] Schultz qtd. in La Roche, Julia. "Howard Schultz: Medicare for all is 'not realistic'." *Yahoo Finance*, 2019.
[153] Donald Trump at the State of the Union Address on February 4th, 2020
[154] "National Federation of Independent Business v. Sebelius." *Oyez*, 2012 Accessed March 4th, 2020

specifying a plan for people currently working for private insurance companies, who would risk losing their jobs, several consequences could result. These include unemployment for up to 1.6 million people, longer wait times for health services, and intensification of the healthcare worker shortage.

Group 2's public option addition could provide a fluid transition into a single-payer system. If the public option can out-compete private insurance, the industry would eventually shut down. This explains why even the more moderate Democratic proposal have been attacked by private insurance lobbying organizations. However, unless a transition to a single-payer happens, the public option will address neither address administrative waste nor high, deterring costs in the U.S.

This chapter will also warn of the dangers of taking a Group 3 approach and leaving the insurance structure the same. It will include Donald Trump in Group 3 based on his actions as president, which indicate support for private insurance. This includes his a reversal of specific ACA stipulations that promoted health coverage expansion. If the current system remains unchanged, rising insurance costs will take more and more out of an individual's take-home pay. Additionally, leaving people uninsured will continue to put the U.S. behind other developed countries in health outcomes, as the uninsured are significantly less likely to seek preventative care and more likely to skip necessary medical treatment.

Group 1: Medicare for All

The Group 1 candidates intend to achieve universal coverage as soon as possible, offering access to services for people who previously had to weigh *how badly* they needed treatment and

decide if it was worth the expense. Medicare for All would eliminate most cost-sharing, altering the U.S. system to be much more like Canada. It would also ideally reduce administrative costs by no longer needing private insurance companies and therefore simplifying the billing process. If implemented effectively, this could save $238.7 billion per year.[155]

Unsurprisingly, Medicare for All has already received brash opposition from the private health insurance industry. The Partnership for America's Health Care Future (PAHCF) comprises of pharmaceutical, insurance, and hospital lobbyists. In February of 2020, the PAHCF launched a series of advertisements to attack Medicare for All and the candidates who support it.[156] They claimed that Medicare for All would cost $32 trillion in taxes and raise premiums, based on a post from the Committee for a Responsible Federal Budget on February 27th, 2019. However, the post actually says that the overall federal cost of Medicare for All is projected to be $32 trillion and that Sanders's tax proposal would raise $11 trillion. The PAHCF has spread misinformation, claiming the entire $32 trillion will come from taxes instead of only $11 trillion. It also claimed Medicare for All would raise premiums instead of replacing them with a 4% income tax which would contribute towards the $11 trillion.[157]

Many Americans employed in the health insurance industry have expressed concern for their jobs under Medicare for All. What will the 870,600 people currently working for private health insurance companies do, once their jobs no longer exist?[158] This question was asked during the Democratic debate in January of 2020. Bernie Sanders responded: "We build into our Medicare for all program a transition fund of many, many billions of dollars that will provide for

[155] Woolhandler and Himmelstein 2019, using NHE projection data from the CMS
[156] "Press Release on 02/25/2020." *Partnership for America's Health Care Future*, 2020.
[157] "How Much Will Medicare for All Cost?," *Committee for a Responsible Federal Budget*, 2019
[158] National Insurance Association of Insurance Commissioners data, sourced from S&P Global Market Intelligence, Insurance Information Institute. 2018.

up to five years income and healthcare and job training for those people."[159] This transition period can be found under Title VI of the act:

> TEMPORARY WORKER ASSISTANCE.—For up to 5 years following the date on which benefits first become available as described in section 106(a), up to 1 percent of the budget may be allocated to programs providing assistance to workers who perform functions in the administration of the health insurance system and who may experience economic dislocation as a result of the implementation of this Act.[160]

The "budget" referred to above is a "national health budget, which specifies the total expenditures to be made for covered health care services under this Act."[161] It would be established each year by the Secretary of Health and Human Services. Therefore, a 1% allocation of this amount would be subject to the budget total. This section also does not stipulate that some of the funds would be used for job training, as Sanders described in the debate. It does not specify whether the five-year fund would match the individual's previous income or how the budget would be distributed among all of the people who need it.

A study published by economists at the University of Massachusetts estimates that the bill could actually reduce 1.6 million jobs within the healthcare industry.[162] It recommends that these individuals be compensated with at least one year of full pay in addition to job retraining.[163] Currently, the Medicare for All Act does not guarantee meeting these suggestions. It also does not communicate whether any of the people who lose their jobs would be absorbed into employment for the new public insurance program, leaving the "job retraining component" ambiguous.

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[159] Bernie Sanders at the Democratic Debate on January 14th, 2020.
[160] U.S. Congress, Senate. *Medicare for All Act of 2019*. S 1129, Title VI Sec. 601 (4), 2019
[161] U.S. Congress, Senate. *Medicare for All Act of 2019*. S 1129, Title VI Sec. 601 (1), 2019
[162] Pollin et al. "Economic Analysis of Medicare for All." *Political Economy Research Institute*, 2018, 155
[163] Pollin et al. 2018, 109

Sanders, Warren, and other politicians who support Medicare for All should have an explanation for people who would lose their jobs under a single-payer system. Without one, they could lose the support of those with a connection to an insurance company employee. As seen in Chapter 4, transparency with voters regarding the intentions of a plan—especially one which could displace so many members of the working class—is crucial for its feasibility. People should understand what to expect in the future when supporting a candidate who calls for a reorganization of a current system.

Additionally, many who oppose a national healthcare system mention poor quality, long wait times, and unkempt facilities.[164] However, recall from Chapter 1 that the United States currently ranks 29th in the world for healthcare access and quality indices.[165] Many single-payer nations, including Canada, rank higher than the U.S. on mortality factors. When looking at wait times, the United States also appears to lag behind. Figure 5.1 shows that the United States falls below average when compared to eight other countries on the percentage of adults who could make a same-day or next-day appointment when needed. Australia and the United Kingdom—both single-payer systems—score considerably higher than the U.S. Furthermore, all of these countries, except for the U.S, cover 100% of their citizens. When the uninsured need medical care in the U.S., they must receive it at the emergency department and therefore have not even been factored into this study. The percentages for universal systems reflect everyone within that country, while the U.S. percentage represents only the insured. At least five other countries have been able to provide *all* of their citizens with healthcare and make appointments more accessible than the U.S.

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[164] Gingrich 2011, 80

[165] "Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016." *Lancet*. 2018 Jun 2;391(10136):2236-2271

Figure 5.1: The percentage of adults who made a same-day or next day appointment when they needed care, displayed by country. (SOURCE: Peterson Center on Healthcare with data from the KFF analysis of Commonwealth Fund International Health Policy Survey of Eleven Countries, 2016)

However, at 43%, Canada scored even lower than the U.S. on the ability to make same-day or next-day appointments. Canada also has longer wait times for elective surgery, according to a Commonwealth Fund study in 2016. Figure 5.2 shows that only 34.8% of Canadian respondents received their operation within a month, compared to 61.0% of American respondents. Again, the U.S. is not universal. While all Canadians have access to elective surgery services, most of the uninsured in the U.S. cannot afford it. Therefore, the insured American population does not have to compete with *everyone*, which likely results in the higher proportion of respondents who received an operation within a month. As mentioned in Chapter 2, our current system works for some because others cannot access it.

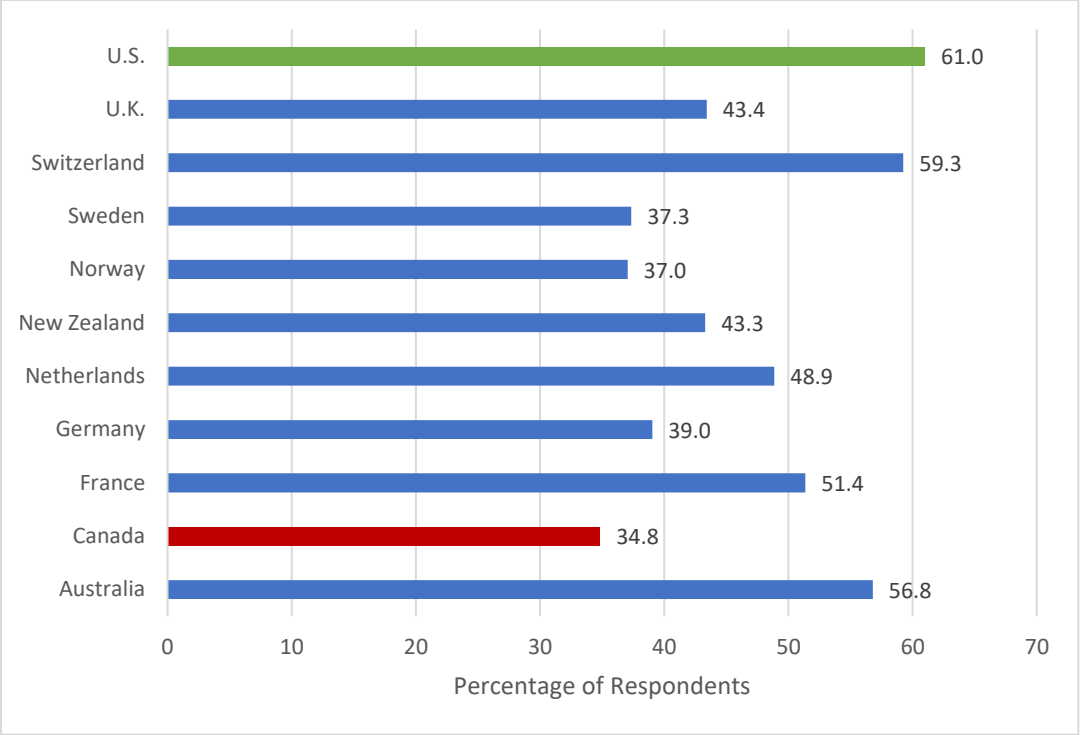

Figure 5.2: The percentage of respondents who waited less than a month to receive elective surgery by country. (Data adapted from the 2016 Commonwealth Fund's International Health Policy Survey of Adults).

Doctors, mid-level providers, and nurses may have concerns for the future of healthcare, the burdening of hospitals, and decreases in their take-home pay. During a speech at the University of Toronto, Sanders exclaimed, "we will take back…what we learned about the Canadian healthcare system to the United States Congress and to the American people," after visiting Canadian hospitals.[166] Yet healthcare workers in Canada are paid about 24% less than those in the United States, according to the National Bureau of Economic Research (NBER).[167] This number is in part due to the higher proportion of primary care providers in Canada, whereas the United States has more high-salaried specialists. It also results from the fact that skilled

[166] Sanders, Bernard. "Bernie Sanders on what the U.S. can learn from Canadian health care." *CBC News.* The University of Toronto, 2017.
[167] Chown et al. "The Opportunities and Limitations of Monopsony Power in Healthcare: Evidence from the United States and Canada." *The National Bureau of Economic Research.* Working Paper No. 26122. 2019, 17

American labor across all fields tends to be compensated at about 26% higher than Canadian counterparts.[168] If Medicare for All decreases the pay of physicians to Canadian levels, the profession would shift to the eighth-highest paid in the U.S. The NBER warns that this could draw talent away from medicine and into other fields, or away from clinical practice, at a time when a physician shortage already exists.[169]

Modeling on the Canadian system, Medicare for All may have several effects on the U.S. healthcare system. It may result in longer wait times, especially for elective surgery. In Chapter 2, one study showed that universal access in the U.S. would result in an additional shortage of 95,900 physicians.[170] Without making up for this shortage, wait times would inevitably increase. Physicians could experience more burnout, leading to earlier retirement, high turnover, and poor patient care.[171] It also remains uncertain whether healthcare worker salaries would be cut to fit closer to Canadian salaries. If so, the nation could risk losing even more physicians and amplify the shortage.

Furthermore, up to 1.6 million people may become unemployed upon the elimination of private insurance companies. Currently, there exists no specific plan to handle the future of employment for these people. The existing clause in Medicare for All is vague and does not meet expert recommendations. In the future, the sponsors of the bill must revise this clause to offer more details for the people who have their jobs at stake under a single-payer system.

[168] Chown et al., 2019, 5
[169] Chown et al., 2019, 25
[170] Dall et al., 2019, 41
[171] Gregory, Menser, and Gregory, 2018, 340

Group 2: Affordable Care Act and the Public Option

In adding a public insurance option, Group 2 would also have its merits and weaknesses. The public option did not make it into the final Affordable Care Act, as the Senate removed it in 2009. It was, however, under discussion since 2001—criticized by conservatives for giving the government too much control and praised by progressives for offering a transition to a single-payer system.[172] A public option would allow people to buy into a subsidized government insurance program, similar to Medicare, without going through a private company. Ideally, it would create more competition for private insurance companies, help bring the nation closer to a universal system, and partially cut costs for American families.

The time and staffing requirements to process billing for private insurance companies creates lots of waste. When hospitals must work with each company to negotiate a contract, file claims, and wait for companies to process them, it creates redundancy and inefficiency.[173] One criticism of the public option plan is its inability to curb these overhead insurance costs. Overhead costs in the United States equal approximately 34.2% of the national health expenditure, compared to 17% in Canada.[174] Furthermore, insurance overhead uses about 12% of premiums in the U.S., compared with only 1.6% in Canada. If the U.S. adopts Medicare for All, overhead costs would drop to 2.2%, saving approximately $238.7 billion per year.[175] The simple addition of a public option would not resolve the administrative waste problem and would fail to save this money, which could be spent on patient care instead.

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[172] Halpin, Helen A. and Peter Harbage. "The Origins and Demise of the Public Option." *Health Affairs* Vol 29 No. 6. 2010. https://doi.org/10.1377/hlthaff.2010.0363

[173] Kahn, James G. "Excess Administrative Costs," in Pierre L. Young, Robert S. Saunders, and LeighAnne Olsen, eds., *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary* (Washington: National Academies Press, 2010), 141

[174] Himmelstein, David U., Terry Campbell, and Steffie Woolhandler. "Health Care Administrative Costs in the United States and Canada, 2017." *Ann Intern Med*. 2020, 134

[175] Woolhandler and Himmelstein 2019, using NHE projection data from the CMS

There also exist concerns that a low-cost, public option would create an adverse selection for sicker patients. It would need to draw a stable risk pool; if private insurers are allowed to select for patients without pre-existing conditions, the viability of the public option could be in danger.[176] However, since the Affordable Care Act has passed in 2010, insurers have been forbidden by law to discriminate based on pre-existing conditions.[177] As long as this provision—and other restrictions on insurance companies—continue to exist, the creation of a high risk pool among the subscribers of the public option will be much less of a concern.

An issue which could pose more of a concern is the execution of universal coverage through the public option. With remaining premiums, deductibles, and co-payments, costs still may deter some Americans from seeking healthcare. In Chapter 1, cost-sharing was presented as a balance of preventing system overutilization without preventing access to healthcare services for those who need them. As Elizabeth Warren mentioned during a Democratic debate, the Group 2 candidates only offer subsidies for premiums, leaving families to contribute the rest out-of-pocket. It would make families continue to be responsible for deductibles, copayments, and unexpected costs.[178] As mentioned in Chapter 2, even for those who have insurance, high drug prices and the fear of cost-sharing measures force some Americans to skip healthcare altogether. The idea that providing all Americans with some form of insurance will solve healthcare disparities turns out to not be so straightforward, as many would likely continue to skip services under Group 2's plan.

Sanders has even called out the Group 2 candidates on "a continuation of the status quo," to which Buttigieg responded: "He said my plan is the status quo, and that's false. Look, if my

[176] Halpin and Harbage, 2010
[177] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001, 2010
[178] Elizabeth Warren at the Democratic debate on February 19th, 2020

plan is the status quo, why was it attacked by the insurance industry the moment it came out?"[179] Indeed, PAHCF—the same organization which released attack advertisements on Medicare for All—also released a statement denouncing a public buy-in option, specifically naming Buttigieg's Medicare for All Who Want It.

> "The fact is, a new government-controlled health insurance system – whether it's called the public option, Medicare buy-in, or 'Medicare for all who want it' – would ultimately lead to a one-size-fits-all system that would cause Americans to pay more and wait longer for worse care."
>
> -Lauren Crawford Shaver, executive director of the PAHCF[180]

The PAHCF press statement in which Lauren Crawford Shaver criticized Buttigieg's plan came right after he released it. Buttigieg was correct in saying that he also has faced criticism from the health insurance industry. Besides expanding health care access, the public option intends to create more competition for private insurance companies, which explains why candidates who support it have faced this type of criticism from healthcare insurance lobbyists. However, unlike Group 1, Group 2 would not remove private insurance entirely, and therefore not displace potentially 1.6 million workers.

The Group 2 candidates, in implementing a public insurance option, should consider adding details on adjustments to cost-sharing outside of premiums. While cost-sharing does not need to be eliminated entirely, its current influence puts a burden on Americans who become sick. As shown in Chapter 3, international examples help suggest ways to make cost-sharing more reasonable in the U.S. For instance, there could be a cap on total out-of-pocket

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[179] Bernie Sanders and Pete Buttigieg at the Democratic debate on February 19th, 2020
[180] Lauren Crawford Shaver in "Press Release on 09/19/2019." *Partnership for America's Health Care Future,* 2019.

spending—not just premiums—based on household income. Additionally, a public option will not eliminate the administrative waste from the current private insurance industry. The U.S. will continue paying approximately $238.7 billion per year on these services instead of patient care. These effects indicate that the public option may be a decent start, not end, to addressing the insurance problem in the U.S.

Group 3: No Insurance Reform

If business continues as usual, and the government makes no changes to healthcare insurance, what would be the result? This is not only Andrew Yang's approach but also incumbent Republican Donald Trump's. While Trump has not yet released a healthcare plan for his 2020 reelection campaign, his actions as president show support of private insurance and no effort towards universal coverage. Since his inauguration he has repealed the ACA individual mandate, which required most Americans to enroll in health insurance.[181] The repeal led to as many as 13 million enrollees dropping their insurance.[182] He has also eliminated Cost-Sharing Reduction (CSR) payments, the federal subsidization of insurance to reduce premiums, co-payments, and deductibles for the public. As a result, the cost-sharing protections under the Obama Administration were reversed for some Americans.[183] These measures have moved the U.S. further away from universal coverage and aim to perpetuate the existing system.

There are certain consequences for a business-as-usual approach in regards to health insurance. The uninsured population remains at a greater risk of facing unaffordable medical bills. One in five uninsured individuals will forgo necessary treatment and are less likely to seek

[181] Trump 2020, "Healthcare," *Promises Kept*
[182] Eibner, Christine and Sarah Nowak. "The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors." *The Commonwealth Fund*, 2018
[183] Kamal et al. 2018

preventative health services.[184] The uninsured also have a significantly higher inpatient mortality, when controlling for race, age, and gender.[185] And so, insurance status constructs the health outcomes and quality of life for many Americans who cannot afford to access the services they need.

Additionally, the widening gap between a rise in premiums and a rise in wages was mentioned in Chapter 4. As time passes, a greater and greater proportion of one's income must go towards paying these premiums. Workers who make $8 or less per hour are particularly vulnerable to employers dropping their health insurance coverage as premiums rise.[186] Without addressing this problem, America risks losing even more enrollees in insurance plans. It also risks increasing the proportion of people who have insurance but still feel burdened by healthcare costs. Starting on the next page, a few finals thoughts on the state of healthcare in the United States will be offered in reflection of the findings of this study.

[184] Tolbert et al., "Key…", 2019
[185] Usher et al., "Insurance Coverage Predicts Mortality in Patients Transferred Between Hospitals: a Cross-Sectional Study." *Journal of general internal medicine*, 33(12), 2018, 2078
[186] Claxton et al. 2019, 101

Conclusion

In a seemingly complex election cycle with rich Democratic debate over healthcare reform, only three types of plans have been proposed. Chapter 3 described the candidates within these groups to be either 1) Medicare for All enthusiasts, 2) Affordable Care Act defenders, and 3) the business-as-usual believers, who suggest that insurance reform should not take priority. All of the candidates with internally coherent platforms could be placed into one of these three groups. Within each group, the candidates agreed on the type of insurance reform, whether it would be a single or multi-payer system, and the type of cost-sharing reductions.

Overall, the proposal most likely to improve health outcomes in the United States is Group 1's Medicare for All, supported by candidates such as Sanders and Warren, as it frees Americans from the worry of steep medical bills. It is the only plan which removes premiums, deductibles, and copayments, expanding access to everyone regardless of socioeconomic background. Americans would have better access to primary care as well, which is important in the prevention of chronic disease. Medicare for All also remains the only single-payer plan under discussion, meaning it is the only plan that would remove private insurance companies and the bureaucratic waste they create. This plan is the dream—the gold standard—for American healthcare access.

Unfortunately, the current infrastructure, Congressional support, and external pressure from lobbying organizations will make a U.S. single-payer system impractical and unlikely. Instead of saying "we need Medicare for All," we should be saying "we need to prepare for Medicare for All." Chapter 2 showed that our system would need an estimated 95,900 additional physicians to support a system in which healthcare delivery was equalized across race, socioeconomic status, and insurance status.[187] Incorporating a single-payer system could nearly double the already projected shortage of up to 121,900 physicians by 2032.[188]

And so, what can be done, to ensure that we achieve a system which no longer discriminates based on socioeconomic status? For one, instead of denying access to everyone due to the fear of increased demand, the system must change to meet that demand. Education and training programs must be expanded for healthcare workers. Even further, hospitals must create more graduate medical education (GME) residency program spots for physicians out of medical school, to make it possible for them to become board certified and begin practicing medicine.[189] There are currently fewer GME spots than graduating medical students each year. Without each medical school graduate in a residency program, the potential workforce becomes underutilized.[190]

Congressional support and lobbying pressure can also hinder the likelihood of a universal coverage program. Chapter 4 showed that Congressional disapproval and lobbying influence from the healthcare industry will make it more difficult to implement changes to the healthcare system. In the current Congress, both the Medicare for All Act and the CHOICE Act, which

[187] Dall et al. 2019, 41
[188] Dall et al. 2019, 5
[189] Kirch, Darrell G., Mackenzie K. Henderson, and Michael J. Dill. "Physician Workforce Projections in an Era of Health Care Reform." *Annual Review of Medicine*, (2012) 63:1, 438
[190] Kirch, Henderson, and Dill, 2012, 440

stipulates a public option addition, have an estimated 3% chance of ratification.[191] Furthermore, as Congress debates and amends the bill it faces daily pressure from industry lobbying groups, which have a particular interest in opposing the expansion of public healthcare programs. Based on the outcome of the Affordable Care Act, if a reform bill can pass through both legislative chambers, it will include many concessions which will ultimately reduce its scale.

Currently, the Medicare for All Act has some weaknesses. For one, it has yet to specify the fate of those who would lose their jobs when private insurance companies are eliminated. Whether some of these people could be incorporated into working for the public insurance system remains unknown. The Act also does not specify what type of job retraining, if any, will be provided. Furthermore, as mentioned in Chapter 3, the Act may go further than most countries in its cost-sharing elimination methods. However, the 4% income tax proposed by Sanders to replace premiums arguably is a form of cost-sharing, just not one that would prevent the overutilization of services. While too much cost sharing prohibits Americans from receiving necessary healthcare, too little could result in unnecessary spending and place burden on the system. Finally, this type of system could be less satisfactory among the healthy population, who may opt for cheaper premiums and a higher deductible plan. Although generally healthy, these people could still face expensive medical bills for a sudden medical event and would remain unprotected against high out-of-pocket spending.

The public option proposed by candidates such as Biden, Buttigieg, and Klobuchar could provide a transition to Medicare for All. It would offer a public program to compete with private insurance companies, pushing them to lower their prices. It would not, however, eliminate the

[191] Skopos Labs referenced in "S. 1129 — 116th Congress: Medicare for All Act of 2019." And Skopos Labs referenced in GovTrack, "S. 1033 — 116th Congress: Consumer Health Options and Insurance Competition Enhancement Act."

cost burdens of deductibles, copayments, and other unexpected bills. It also would not reduce bureaucratic spending, which takes an estimated $238.7 billion per year.[192] However, if enough of the public chooses public insurance, it may out-compete private insurance companies and pull the U.S. into a single-payer system over time. If this is the case, it would lead to a system similar to the one described by the Medicare for All Act.

Chapter 4 showed that among the candidates, Elizabeth Warren had the most transparent plan. The other five candidates who were studied lacked the depth of detail she had in her financing method, which was reviewed by experts and published for public access. Chapter 3 remarked on the importance of ambiguity; it can signify that a candidate has either failed to consider an aspect of policy or recognized that his or her stance would look unfavorable. An example of this could be Klobuchar not stating she would lower the cap on insurance premiums, which most other candidates have done.

Ultimately, the U.S. must take a step towards either Medicare for All or the public option to begin catching up to the rest of the developed world. Leaving the insurance structure the same would be a mistake and would preserve the current healthcare system disfunction. 45% of Americans will continue to fear bankruptcy due to a serious medical incident.[193] The U.S. will continue to spend a fifth of its GDP on healthcare, the highest amount per capita in the world, and continue to have some of the worst health outcomes among developed nations.

We have seen how past attempts to establish universal coverage have been met with outcries against socialism. There have been sentiments against increasing government involvement, claiming it obstructs liberties and is inherently "unamerican."[194] President Trump

[192] Woolhandler and Himmelstein 2019, using NHE projection data from the CMS
[193] West Health and Gallup 2019
[194] Schultz qtd. in La Roche, 2019

has vowed to "never let socialism destroy American health care."[195] The "socialism" implies a sort of delusion—one in which American values are rejected. In reality, most Americans would accept universal healthcare, even a single-payer system.[196] The rugged individualism described in Chapter 2 may be losing its importance with Americans as they begin to support more government intervention in their healthcare.

At a time when the United States has failed its moral test, and has neglected its vulnerable populations, accusations of socialism work to perpetuate the idea that socioeconomic status determines one's right to healthcare. Hubert Humphry has said "Compassion is not weakness, and the concern for the unfortunate is not socialism." In the U.S., concern for the unfortunate, especially in healthcare, needs to manifest. Universal healthcare is the solution—not delusion—that the U.S. needs to take care of its people.

[195] Donald Trump at the State of the Union Address on February 4th, 2020
[196] "Public Opinion…" 2020, Figure 16

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