Health Insurance Topic Paper

Will Katz, Carrollton School of the Sacred Heart

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Introduction and Summary

Health care is a life and death issue that affects every single person in the United States. For those that are insured, technical terminology and a confusing layout make the American health care system immensely difficult to navigate.[1] But for the millions of uninsured people in the United States, affording unexpected medical costs becomes an insurmountable goal that puts people at risk of worse health outcomes and high medical debt.[2] Despite the fact that health care is a politically "dominant" issue in political campaigns and the lives of most Americans,[3] people across the country lack "health literacy," especially as it relates to public policy and specific insurance terminology.[4] It is particularly important for young people, especially those who have lived through a global pandemic, to understand not only the technical intricacies of health care terminology, but the public policy implications of particular health care systems, as they enter into adulthood. I propose **health insurance reform** as the topic area for 2026-2027 to best facilitate debates over important domestic policy issues.

Under this proposed topic, affirmative teams would argue for increased government provision of health insurance. Depending on the specific wording, affirmative plans could range from various single payer mechanisms, to providing a public option, to mandating individuals acquire health insurance, to expanding Medicare or Medicaid, or providing universal catastrophic coverage. Affirmative teams could argue that such proposals would improve health outcomes, eliminate racialized, gendered, and classist health disparities, improve our economic well-being, improve the United States's international reputation, and improve response to chemical and biological terrorism. Negative teams would have a wide arsenal of arguments at their disposal. They could introduce disadvantages that increased government provision of health insurance would cause longer wait times, more rationing of care, disrupt the private health care industry, undermine pharmaceutical innovation, undercut military recruiting advantages, or fracture doctor-patient trust. Negative teams could introduce several other courses of action, such as moving toward a more privatized health care system, subsidizing access to private insurance, or having states implement their own health insurance schemes. The negative could also challenge critical assumptions about national health insurance by pointing out the biopolitical surveillance necessary to implement the plan, the racialized nature of medical care, the border-drawing required to demarcate health insurance as "national", or the Western conception of "medicine".

Debating about health insurance reform would be an excellent entry point for students to learn the details of very technical policies in an approachable way. Considering that the United States is the only major developed country that lacks universal health care,[5] there is a robust debate about whether and how the U.S. should change its health care system. Students at all levels will find something for them. Younger, less experienced students will find a clear entry point for broad discussions of cost, access, fairness, and innovation. More experienced students can dive deeper into public policy concepts of efficacy, efficiency, and administrative tradeoffs, as well as compare different models of national health insurance and national health services.

Given the wealth of literature and the variety of angles to approach this topic, it is time for the high school debate community to debate national health insurance. The last time there was a dedicated health insurance reform topic was the 1993-1994 topic (Resolved: That the federal government should guarantee comprehensive national health insurance to all United States citizens).[6] Since 1994, only 2 topics have had a more than minimal degree of overlap with this proposed resolution: the 2002-2003 mental health topic (Resolved: That the United States

federal government should substantially increase public health services for mental health care in the United States) and the 2009-2010 persons in poverty topic (The United States federal government should substantially increase social services for persons living in poverty in the United States). Considering that it has been over a decade and a half since a topic has involved health care, and that the American health insurance system has completely changed since then with the passage of the Affordable Care Act in 2010[7], it is time for students to debate national health insurance in 2026-2027.

Potential Resolutions and Justification of Terms

All resolutions proposed in this paper are aimed at achieving more government-provided healthcare. There is a relatively well-defined term that is used in most of the proposed resolutions: "national health insurance." At the end of this paper, there will be an appendix that includes some definitions of core terms. Some resolutions include some additional words (such as "comprehensive" or "universal") to make clear that the purpose of these resolutions is to make the affirmative do more than simply cover a particular procedure or subsidize a particular medical practice. Topical affirmatives should have to make a broad change to the structure of US health insurance.

Below is a list of potential resolutions, with resolution #1 preferred because of its elegance and simplicity. I believe the strongest definitions of "national health insurance" will push the affirmative to defend some version of publicly provided, universal, and comprehensive insurance. There are, however, broader definitions that affirmative teams may use to argue for more affirmative flexibility. Resolutions toward the bottom that use verbs of "expand coverage" or "expand access" are not preferred, and those verbs need to be vetted significantly more before those resolutions are endorsed.

Resolution 1- NHI

The United States federal government should establish national health insurance in the United States.

Resolution 2-Universal and comprehensive health insurance

Resolved: The United States federal government should provide universal and comprehensive health insurance in the United States.

Resolution 3- Universal national health insurance

The United States federal government should provide universal national health insurance in the United States.

Resolution 4- Expand coverage

Resolved: The United States federal government should expand coverage of public health insurance in the United States.

Resolution 5- List

Resolved: The United States federal government should expand healthcare access in the United States by one or more of the following: establishing single-payer health insurance, providing a public option for health insurance, expanding access to Medicare, expanding access to Medicaid.

Timeliness and Material

Ideal debate topics need to balance two competing elements of timeliness. First, topics need to be timely enough for debaters to use recent sources to construct and innovate arguments during the season. A health care topic fits this very well, considering that the challenges facing the U.S. health industry persist every year. At the end of 2024, public outrage at privatized health insurance gained a lot of media attention following the murder of the United Healthcare CEO.[8] Inequities in access to health insurance coverage, a perception that profit motive in health care is worsening health outcomes, rising health care costs, increased government spending, and lower health care outcomes are all present in our current health care landscape.[9] The COVID-19 pandemic has fundamentally given new attention to the old problems in our health care system[10], ensuring there is recent, high-quality scholarship written about it.

On the other hand, it is important that debate topics not be so timely as to create uniqueness or inherency problems. A good debate topic is one in which the status quo is entrenched enough to ensure the problems facing us now will exist throughout the entirety of the topic. Unfortunately, health care appears to meet that criteria as well. As a "highly political and controversial" issue, national health insurance seems unlikely to gain any major traction.[11] This is especially true since Republicans, who control the presidency and both chambers of Congress, are proposing health care policies that would decrease public health insurance coverage.[12]

Scope

The scope of health care as a topic is potentially extremely broad. To make this topic more manageable, this paper is proposing a resolution that attempts to thread the needle by allowing the affirmative to talk about a multitude of aspects of the U.S. health care system, while forcing them to defend a plan of action that reforms the structure of our health insurance system itself, rather than individual procedures. The goal of this topic would be to get debates over how health care procedures are paid for in the United States, not simply what procedures are valuable. That does not mean the types of procedures will be completely irrelevant in debates, quite the opposite. Affirmative teams can still read advantages about their insurance scheme creating more access to important procedures, and negative teams can read disadvantages about there being more rationing or longer wait times for those procedures.

By debating about national health insurance, students will not only learn how our health care system works, but they will gain an understanding of the political and social forces that explain *why* we administer health care so much differently than every other developed country.[13] By arguing over the benefits and drawbacks of enhanced public health insurance coverage, debaters will have the ability to evaluate multiple social, political, economic, and public policy perspectives around one of the most salient political issues in America.

Range and Interest

This is a topic that will be accessible to all types of debaters while offering everyone an opportunity to learn about an important and salient topic. Debaters of all experience levels can gain familiarity with terminology like deductibles, premiums, copays, pre-existing conditions, coinsurance, Medicare, and Medicaid. Similarly, students of all levels can engage in foundational debates over equity vs. efficiency, public vs. private goods, rights vs. privileges, and access vs. cost. Despite its complicated language, health care is easy to research. Because of its prevalence and importance in peoples' everyday lives, there are numerous resources that attempt to explain the U.S. health care system to laypeople.[14] These resources substantially lower the barriers to entry that exist for similarly complex topics.

For students that are looking to engage in more complicated public policy research, this topic has a lot to offer. Students will find ample literature comparing different models of national health insurance[15]. There are a plethora of advocates for different ways to expand health care coverage and lower health care cost, each of which comes with its own specific advantages and drawbacks.[16] Students who are more interested in socio-economic issues will find a vast literature base writing about race[17], gender[18], and class[19] in the context of health care coverage.

It is easy to see why this topic could generate substantial interest from students. Not only is it an excellently balanced debate, but it is one that could impact many aspects of students lives. Everyone will have some sort of interaction with the US health care system in some capacity or another. But beyond that, many students are interested in working in health care related fields, and starting that education in high school is important.[20]

Balanced Affirmative and Negative Ground

Perhaps the largest benefit of this topic is the extremely high quality of ground that both the affirmative and negative have access to. Because the affirmative must fundamentally restructure the way that the health care industry is financed in the United States, there are very strong advocates and opponents of such a change. That means that both sides will have detailed, high-quality scholarship defending their position.

Affirmative ground

The largest affirmative on any of the proposed resolutions would be the single payer health insurance affirmative. This aff would completely replace the private health insurance system that we have with the government as the single payer. There are several strong proponents who exist in the context of the United States and tie single payer healthcare to the advantage areas listed below.[21] While there are certain core features that are shared among all single payer health care systems, affs could specify a particular type or model. For example, Canada, Israel, Taiwan, and Australia all have a single payer model, but they each have their differences between them.[22]

There are other affirmative plans that would increase public coverage as well. For example, offering a "public option" would create a government-provided plan that competes with existing private health insurance plans to keep costs lower and increase access.[23] Such an affirmative plan would arguably get to the same affirmative advantages, potentially without creating as large of a shake-up with the private insurance industry.

Additionally, there are entire categories of affirmatives that seek to increase health insurance access via Medicare and Medicaid expansion.[24] These affirmatives would take existing programs targeted at elderly or financially insecure populations and make them easier to access.

Other affirmative plans could strengthen enforcement of the Affordable Care Act's individual mandate[25], provide universal catastrophic coverage[26], universal drug insurance[27], or create federal waivers for states to implement universal coverage.[28]

Affirmatives could claim a wide array of advantages to expanding public health insurance coverage. For example, they could claim economy advantages premised on lowering healthcare costs,[29] administrative costs,[30] lower medical debt,[31] or lower "job lock."[32] Affirmatives would also have access to a large array of advantages premised on medical care, such as the ability to prevent deadly pandemics,[33] increasing detection of diseases,[34] enhancing public trust in the medical system,[35] and preventing bioterrorism.[36] Teams interested in arguing for expanded health coverage on equity and social justice grounds would have ample room to do so as well.[37] Other affirmative advantages could center around rural communities,[38] international human rights law,[39] data collection[40] or the opioid crisis.[41]

Negative Ground

Negative teams would have several angles of attack against each affirmative. For example, they could introduce disadvantages based on the affirmative disrupting the economy,[42] undermining innovation in the pharmaceutical industry,[43] causing long wait times to receive care,[44] eroding public trust in doctors,[45] harming military recruitment,[46] raising taxes,[47] or inciting political controversy.[48]

Negative teams would also have the ability to challenge the affirmative by offering competing policy options. For instance, the negative could argue that the states, rather the federal government, should be responsible for increasing health care access.[49] On many domestic topics, the states counterplan can be too powerful of a tool. Although it is certainly a weapon in the negative's arsenal for this topic, the affirmative will have a wide variety of quality responses. For example, the affirmative could argue that federal laws like ERISA would preempt state action[50], states would be unable to afford the plan without ruining their economies[51], states can't effectively integrate data[52], or states are legally not allowed to negotiate drug prices based on social health value.[53]

Alternatively, the negative could introduce various proposals to eliminate federal intervention in health care, resulting in a stronger free market system.[54] Other counterplans could include subsidizing health care expenses without using insurance as a mechanism[55], nationalizing the health system entirely[56], or create health savings bonds to help pay for medical procedures.[57]

Finally, negative teams looking to criticize core assumptions of the resolution will also have plenty of literature. Many scholars suggest that increasing public health insurance would simply be a tool of expanded surveillance under a biopolitical state.[58] Similarly, there are articles that criticize universal health care as furthering the medicalization of race and racial surveillance[59]. There is also literature that challenges the notion of "medicalization" as an inherently Western, limited principle.[60] Finally, there are criticisms of national health insurance as requiring a particular, harmful form of citizenship or bordering.[61]

Ultimately, both the affirmative and negative teams will have high quality, well-evidenced arguments at their disposal to engage with a topic about expanding national health insurance.

Pre-evidence conclusion

National health insurance holds great potential as a debate topic. Students will need to learn the technical language of health care at some point in their lives, and high school debate is an excellent time for them to do that before they must confront it in the real world. This topic will give students the opportunity to engage in that technical learning as well as provide a plethora of well-evidenced perspectives on what the goals of our health care system are and what they ought to be.

This paper has thus far been written as a topic paper, not as a debate brief. Admittedly, it has been reliant on footnoted research. For definitions of core topic terms, however, I felt it was necessary to present briefed evidence in order to aid the topic committee.

Definition—Establish—Create

Establish means create

Words and Phrases 5 (v. 15, p. 180)

Ill. 1937. **The word "create" is equivalent to the word "establish." The words "establish" and "maintain" signify two distinct separate purposes**. "Establish" if given the commonly understood meaning of word "create" is not synonymous with "maintain" and the words denote independent purposes.—People ex rel. Gill v. Devine Realty Trust, 9 N.E.2d 251, 366 Ill.418.

This is the ordinary meaning of the term

Madigan 4 – Lisa, Attorney General for the State of Illinois (Opinion title "GOVERNMENTAL ETHICS AND CONFLICT OF INTEREST", 3/30, http://www.ag.state.il.us/opinions/2004/04-002.pdf)

Ms. Burke's letter notes that section 1A-1 of the Election Code uses the word "established" with respect to the origins of the State Board of Elections and not the term "created." The term "establish" ordinarily means "[t]o originate, to create; to found and set up; to put or fix on a firm basis; to put in a settled or efficient state or condition." Ballentine's Law Dictionary 417 (3rd ed. 1969); see also Webster's Third New International Dictionary of the English Language Unabridged 778 (1993). Applying the commonly understood meaning of the term "establish," it is my opinion that in enacting the language of section 1A-1 of the Election Code, the General Assembly has "created" the State Board of Elections "by State law."

It's not to acquire something already in existence

SC of Nebraska 53 (Adams v. Adams, 156 Neb. 778)

The words set up and establish are substantially **synonymous and the ordinary meaning of them is to bring into being, to create, to originate, or to set up**. They do not usually refer to something that already exists. **The word establish**, in its primary sense, **is defined as meaning to bring into being, create, or originate; to set up; but not to acquire something which has already been brought into existence**.

It's also distinct from 'change' or 'alter'

Maryland Court of Appeals 66 (Dixon v. Board of Supervisors of Elections, 244 Md. 48)

Appellee contended that since the lines for the Fourth Legislative District of Baltimore were set forth in House Bill No. 28, which was to be effective as of June 1, 1964, and there was no "change" in those lines under Senate Bill No. 5, that therefore the Fourth District was "established" as of June 1, 1964, more than one year prior to the 1966 election, and hence the exception in Section 9 of Article III of the Constitution, should not apply. This contention ignores the history of apportionment litigation and the decision of the Supreme Court in Maryland Committee v. Tawes, supra, decided on June 15, 1964, subsequent to the effective date of the act. It is clear from a reading of Senate Bill No. 5 that the Legislature did not consider the district lines of Baltimore City to be established since changes were made in other districts in Baltimore City. Moreover, appellee's arguments would require the conclusion that Senate Bill No. 5, insofar as it does set forth the district lines for the Fourth District, contains mere surplusage and that the June 1, 1966 effective date had no significance as it relates to the Fourth District. **Article III, Section 9, expressly uses the word "establish" rather than "change" or "altered". Hence**, merely showing that there had been no "**change" or** "**alteration**" in the Fourth District lines by House Bill No. 28, or by the later Senate Bill No. 5, **does not satisfy the larger definition implied in "establish**."

Establish means to create

McGarity 3 – Chair of trial and appellate advocacy @ UT (Thomas, "SCIENCE IN THE REGULATORY PROCESS: ON THE PROSPECT OF "DAUBERTIZING" JUDICIAL REVIEW OF RISK ASSESSMENT, 66 Law & Contemp. Prob. 155)

The court found that EPA had erred procedurally, however, when, instead of assembling a separate advisory committee under the Radon Act, it had allowed a special committee of its existing Scientific Advisory Board ("SAB") to perform the advisory role the Act envisioned. 413 The court found two problems with EPA's procedural shortcut. First, the Radon Act required EPA to establish a representative advisory committee. **The use of the word "establish" suggested that Congress meant for EPA to create** a **new committee, not borrow an existing standing committee**. The second problem was that the Radon Act also provided a role for the existing SAB in reviewing EPA's broad indoor-air research plan. Had Congress intended for a committee of the SAB to double as the statutory advisory committee, it presumably would have said so in the Radon Act. 414 Although perhaps insufficiently deferential to the agency's interpretation of its own statute, the court's statutory analysis was by no means unreasonable.

Definition—Establish—Create, Strengthen, or Secure

Establish means to create or alter, ordain and establish means only to create---Constitution

Calabresi and Lawson 7 - Professor of Law, Northwestern University School of Law; Professor of Law, Boston University School of Law. (Steven and Gary, "THE UNITARY EXECUTIVE, JURISDICTION STRIPPING, AND THE HAMDAN OPINIONS: A TEXTUALIST RESPONSE TO JUSTICE SCALIA", Columbia Law Review Vol. 107:1002, Hein Online)

As a matter of pure linguistic usage, one can "establish" a body such as a court either by creating it from scratch or by designating an existing body. Samuel Johnson's Dictionary contains definitions of "establish" that could support either reading.' 1 5 Indeed, a similar dispute over the meaning of "establish" in another part of the Constitution consumed **a great deal of attention in the nation's first fifty years. The Constitution authorizes Congress "[t]o establish Post Offices and post Roads."**116 Many founding era figures, including Thomas Jefferson and James Monroe, staunchly maintained that this only gave Congress the power to designate existing state roads as postal routes and did not include the power to construct a new road. Others, including Joseph Story, strongly disagreed. The issue divided the Supreme Court as late as 1845.117 **The intratextual evidence**, however, **strongly favors those who supported the congressional power to create and construct new roads as well as the power to designate existing roads**. A mere three clauses before the Postal Roads Clause **in Article I, Section 8, the Constitution gives Congress power "[t]o establish an uniform Rule of Naturalization, and uniform Laws on the subject of Bankruptcies throughout the United States**."" 8 This obviously grants the power to create rules of naturalization and bankruptcy rather than merely the power to designate preexisting rules as binding. There is no good reason to think that Article I, Section 8 uses the same term in two different senses in such close proximity. **This means that the term "establish" as used in the Constitution can mean either the creation or the designation of an institution**; surely the Postal Roads Clause at least permits Congress to designate existing state roads as postal roads (and by the same token the Bankruptcy Clause would surely permit Congress to pick an existing state bankruptcy law and give it uniform nationwide effect). The same would presumptively be true of the Article III Vesting Clause. Does Article III therefore refer either to courts created by Congress or to state courts designated by Congress as federal tribunals, with all of the startling consequences for the tenure and salary of state court judges that we have described? This might well be the case if Article III, paralleling the Bankruptcy Clause and the Postal Roads Clause, referred simply to courts that Congress might "establish." **But the Article III Vesting Clause uses a formulation subtly but importantly different from the uses of "establish" elsewhere in the Constitution: Article III speaks of inferior courts that Congress may from time to time "ordain and establish." This formulation is striking and significant**. **As a matter of common usage, the word "ordain" would seem to mean to confer a status** upon something, or at most to replicate the word "establish." Samuel Johnson's Dictionary is consistent with this intuition: The word "ordain" is defined as "1. To appoint; to decree. 2. To establish, to settle; to institute. 3. To set in an office. 4. To invest with ministerial function, or sacerdotal power."" 9 **So understood, there would be little or no difference between the word "establish" and the phrase "ordain and establish." The Constitution, however, uses the precise phrase "ordain and establish" in one other place, and in context the phrase has significant meaning and effect that goes beyond its ordinary usage**. The Preamble declares that "We the People ... do ordain and establish this Constitution for the United States of America." 120 **Since the Constitution obviously was not a preexisting legal institution that could be designated as having status in some fashion, the usage of the phrase in the Preamble clearly refers to bringing something into existence that did not previously exist**. **This is highlighted by comparison to and contrast with the ratification provision** in Article VII, which states that "[t]he Ratification of the Conventions of nine States, shall be sufficient for the Establishment of this Constitution between the States so ratifying the Same." 121 **To "establish" the Constitution through ratification is to "make firm**; to ratify " 122 **a document that already exists**. **By contrast, to "ordain and establish" the Constitution must be to bring it into existence so that it may subsequently be "establish [ed],"** or given the designated status of supreme law, through ratification. **As the Constitution uses the terms, to**

"ordain and establish" an institution is a markedly different act than to "establish" it: The latter can mean either to create or to designate a status for, while the former can only mean to create. 123

Establish means to fix OR create

McKenna 1900 – Supreme Court Justice, presenting the majority opinion of the court (Joseph, "Cases Argued and Decided in the Supreme Court of the United States", Vol 178, 5/14/1900, Hein Online)

The word "establish" means "to make stable, firm, or sure; appoint; ordain; settle or fix unalterably."

Stabilization is a process of creation that establishes---context of health care

Bagley and Jones 15 - Nicholas Bagley is an Assistant Professor of Law at the University of Michigan Law School. David K. Jones is an Assistant Professor at the Boston University School of Public Health ("No Good Options: Picking Up the Pieces After King v. Burwell", 4/29/15, Yale Law Journal, Hein Online)

Could the regular performance of essential and substantial exchange functions, over time, constitute the establishment of an exchange? **As relevant here, the term "establish" means "[t]o make or form; to bring about or into existence. '** 8 Arguably, that act of creation need not be intentional or formal. **In common usage, a consistent practice can be said to constitute the establishment of whatever that practice entails. "Establish" simply connotes making something "stable or firm."**2 9 **Just as habits, routes, and norms can be established over time through a regular course of conduct, so too might states establish exchanges.**

Establish includes creation and/or upkeep

Story 1833 – Supreme Court Justice, Professor of Law at Harvard (Joseph, "Consittution of the United States", Hein Online)

§ 1125. The grounds, upon which the other opinion is maintained, are as follows: This is not a question of implied power; but of express power. We are not now looking to what are properly incidents, or means to carry into effect given powers; but are to construe the terms of an express power. **The words of the constitution are, "Congress shall have power to "establish post-offices and post-roads."** What is the true meaning of these words? **There is no such known sense of the word "establish," as to "direct," ' designate," or "point out." And if there were, it does not follow, that a special or peculiar sense is to be given to the words, not conformable to their general meaning**, unless that sense be required by the context, or, at least, better harmonizes with the subject matter, and objects of the power, than any other sense. That cannot be pretended in the present case. **The received general meanings, if not the only meanings of the word "establish," are, to settle firmly, to confirm, to fix, to form or modify, to found, to build firmly, to erect permanently.'** And it is no small objection to any construction, that it requires the word to be deflected from its received and usual meaning; and gives it a meaning unknown to, and unacknowledged by lexicographers. Especially is it objectionable and inadmissible, where the received and common meaning harmonizes with the subject matter; and if the very end were required, no more exact expression could ordinarily be used. **In legislative acts, in state papers, and in the constitution itself, the word is found with the same general sense now insisted on**; that is, in the sense of, to create, to form, to make, to construct, to settle, to build up with a view to permanence. Thus, our treaties speak of establishing regulations of trade. Our laws speak of establishing navy hospitals, where land is to be purchased, work done, and buildings erected; of establishing trading-houses with the Indians, where houses are to be erected and other things done. The word is constantly used.in a like sense in the articles of confederation. The authority is therein given to congress of establishing rules in cases of captures; of establishing courts of appeal in cases of capture; and, what is directly in point, of establishing and regulating post-offices. **Now, if the meaning of the word here was simply to point out, or designate post-offices, there would have been an end of all further authority, except of regulating the post offices, so designated and pointed out**. Under such circumstances, how could it have been possible under that instrument (which declares, that every power not expressly delegated shall be retained by the states) to find any authority to carry the mail, or to make

contracts for this purpose? much more to prohibit any other persons under penalties from conveying letters, dispatches, or other packets from one place to another of the United States? The very first act of the continental congress on this subject was, "for establishing a post," (not a post office;) and it directed, "that a line of posts be appointed under the direction of the postmaster general, from Falmouth, in New-England, to Savannah, in Georgia, with as many cross-posts, as he shall think fit;" and it directs the necessary expenses of the "establishment " beyond the revenue to be paid out by the United Colonies.1 Under this, and other supplementary acts, the establishment continued until October, 1782, when, under the articles of confederation, the establishment was re-organized, and, instead of a mere appointment and designation of post-offices, provision was made, "that a continued communication of posts throughout the United States shall be established and maintained," &c.; and many other regulations were made wholly incompatible with the narrow construction of the words now contended for.1 § 1126. **The constitution itself also uniformly uses the word "establish" in the general sense, and never in this peculiar and narrow sense. It speaks in the preamble of one motive being, "to establish justice," and that the people do ordain and establish this constitution**. It gives power to establish an uniform rule of naturalization and uniform laws on the subject of bankruptcies. Does not this authorize congress to make, create, form, and construct laws on these subjects? It declares, that the judicial power shall be vested in one supreme court and in such inferior courts, as congress may, from time to time, ordain and establish. Is not a power to establish courts a power to create, and make, and regulate them? It declares, that the ratification of nine states shall be sufficient for the establishment of this constitution between the states so ratifying the same.' And in one of the amendments, it provides, that congress shall make no law respecting an establishment of religion. **It is plain, that to construe the word in any of these cases, as equivalent to designate, or point out, would be absolutely absurd**. **The clear import of the word is, to create, and form, and fix in a settled manner**. Referring it to the subject matter, the sense, in no instance, can be mistaken. To establish courts is to create, and form, and regulate them. To establish rules of naturalization is to frame and confirm such rules. To establish laws on the subject of bankruptcies is to frame, fix, and pass them. To establish the constitution is to make, and fix, and erect it, as a permanent form of government. In the same manner, to establish post-offices and post-roads is to frame and pass laws, to erect, make, form, regulate, and preserve them. Whatever is necessary, whatever is appropriate to this purpose, is within the power.

Establish can mean maintain or secure

Marlyand Ct of Appeals 1914 (Novak v. Trustees of Orphans' Home, 123 Md. 161)

While the word "establish" most commonly means to found or to bring into being, **it may also be used to mean to place upon a secure foundation or basis and to strengthen that which is already in being**.

Establish means create or maintain---can make something existing uniform

Calabresi 7 - Professor of Law, Northwestern University School of Law (Steven, THE UNITARY EXECUTIVE, JURISDICTION STRIPPING, AND THE HAMDAN OPINIONS: A TEXTUALIST RESPONSE TO JUSTICE SCALIA, 107 Colum. L. Rev. 1002)

This means that **the term "establish**" as used in the **Constitution can mean either the creation or the designation of an institution**; surely the Postal Roads Clause at least permits Congress to designate existing state roads as postal roads (and by the same token **the Bankruptcy Clause would surely permit Congress to pick an existing state** bankruptcy **law and give it uniform nationwide effect**). The same would presumptively be true of the Article III Vesting Clause. Does Article III therefore refer either to courts created by Congress or to state courts designated by Congress as federal tribunals, with all of the startling consequences for the tenure and salary of state court judges that we have described?

This might well be the case if Article III, paralleling **the Bankruptcy Clause** and the Postal Roads Clause, **referred simply to courts that Congress might "establish."** But the Article III Vesting Clause uses a formulation subtly but importantly different from the uses of "establish" elsewhere in the Constitution: Article III speaks of inferior courts that Congress may from time to time "ordain and establish." This formulation is striking and significant.

As a matter of common usage, **the word "ordain" would seem to mean to confer a status upon something, or at most** to **replicate the word "establish."** Samuel Johnson's Dictionary is consistent with this intuition: The word "ordain" is defined as "1. To appoint; to decree. 2. To establish, to settle; to institute. 3. To set in an office. 4. To invest with ministerial function, or sacerdotal power." 119 So understood, there would be little or no difference between the word "establish" and the phrase "ordain and establish."

Making an existing program 'federal'

Collins 95 – Professor of Law (Michael, "ARTICLE III CASES, STATE COURT DUTIES, AND THE MADISONIAN COMPROMISE," 1995 Wis. L. Rev. 39)

Interestingly, the language of Article I eschews the obvious word "**establish**" when it **gives Congress the power to "constitute" lower federal courts**. See U.S. Const. art. I, section 8, cl. 9. The latter is somewhat more reminiscent of earlier wording of Article III at the time of the Convention, even though Article III eventually opted for "establish," and even though elsewhere in article I, section 8, **the verb "establish" is used** (e.g**., to establish post-offices; to establish a uniform rule** of naturalization). Cf. Lawson & Granger, supra note 4, at 267 n.3 (observing that **the word "establish" might include notion of designation of existing facilities as federal**).

Definition—NHI—Universal & Comprehensive

NHI means universal enrollment and the government insures the 'vast majority' of services

Myers 71 - F.S.A., Chief Actuary, Social Security Administration, in a speech to Congress (Robert, "THE SPECTRUM OF GOVERNMENTAL HEALTHCARE PROPOSALS", Congressional Record 10/21/71, Hein Online)

Many governmental health care proposals at the Federal level have been put forward since this session of Congress began in January. **The financial involvement of the Federal Government would vary widely** under these proposals. In some, the Government would meet the entire cost (out of general revenues), while in others it would collect part of the cost through payroll taxes, and the remainder would come from general-revenue financing. In still other plans, the entire cost would be met from payroll taxes. The following discussion will refer to the most important proposals without describing them, in the belief that the reader is already reasonably familiar with them. **The term "national health insurance" is often used to describe or refer to these varied proposals**. In my opinion, **this is a misuse of the term**, **because national health insurance** really **only means a program under which the financing of the vast majority of health-care costs of virtually the entire population is under governmental auspices**. (Socialized medicine is one form of national health insurance, but it goes further than other forms by having the Government also supply the medical services through its own employees and facilities.) For example, **if Medicare were extended to all** Social Security beneficiaries and to all covered workers and their dependents, **it could truly be referred to as national health insurance**.

NHI must be universal coverage with a comprehensive package

Roberts 15 – MD, MBA, Director, University of the West Indies School of Clinical medicine & Research (Robin, "Sparking the Debate: The Introduction of National Health Insurance in the Bahamas," p. 17)

At the onset, **there is a need to clarify** the relevant and related **health care terminologies** typically used interchangeably: national health, national health insurance, and universal health coverage. A national health system or plan is where the government mandates comprehensive and essential health care services to which all residents/citizens have access and availability as needed, without the barrier of affordability, at the point of delivery of the service. This is normally funded from the consolidated fund or general tax revenues appropriated for health services, not collected specifically for health care. The term **national health insurance** system or plan, theoretically **defines a list of comprehensive and essential services** which are covered by a mandatory insurance premium or plan which the government mandates **to cover all residents and to which everyone must contribute**; thus all are entitled to access care as needed without the barrier of affordability, at the point of delivery of the service. Universal health coverage, universal health or universal coverage extends the financial affordability and guarantee of a national health or national health insurance plan. It aims at securing access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost that secures financial protection with no fear of financial hardship or impairment. Nerdwallet, the USA consumer based financial analysts and advisors illuminated quite clearly the limitations of health insurance coverage and financial risk. Nerdwallet s research in 2013, determined that health care is the biggest cause of bankruptcy in America: Almost two million people will file for bankruptcy protection (from health care bills). Outside of bankruptcy, 56 million adults, more than 20% of the population between the ages of 19 to 64 years, will have major financial impediments because of health care costs. Fifteen million people have depleted their savings to cover medical bills and another 10 million will be unable to pay for necessities such as rent, food and utilities more than 25 million people are skipping doses, taking fewer medications or delaying refilling prescriptions to save money. 17

Topical affirmatives must provide insurance for all medical needs for the entire population

Myers 70 - F.S.A., Chief Actuary, Social Security Administration (Robert, "Universal Health Insurance", 5/16/1970, a speech to the Annual Convention of the Oklahoma State Medical Association, Congressional Record June 18 1970 Hein Online)

Before going any further, **let me define what** I believe **the term "national health insurance" means**, since nowadays many people are using it with quite different meanings. In my opinion, national health insurance means **a program under which the entire population of the country, or virtually the entire population, would be provided all their medical care needs either directly by the Government through** salaried physicians and other staff and through government-owned hospitals (**socialized medicine**), **or** else **through private providers** of service most of **whose remuneration would come from government insurance programs** (the **Medicare or social insurance** approach). Other types of proposals are currently being made that are called national health insurance plans, but, in my opinion, they should be categorized differently. Some proposals would completely change-or it might be said, scrap-present methods of providing medical care. It would seem to many people that these would be catastrophic in effect if put into operation in the near future, and I think that many of the advocates realize this but are merely using the proposals for talking purposes. Other proposals would instead be harmonious with the present medical-care system, which, despite strident charges from some quarters, has not been remaining static but rather, in the desirable pattern of American democracy, has been gradually and steadily developing better and more efficient procedures as experience has indicated feasible.

NHI means the universal coverage where the government eliminates hardship of medical bills

Meilton 79 (Sandra, award winning attorney, "Cost Containment in the Health Care Industry: An Analysis of Physician Reimbursement Under Medicare and the Implication for Future Regulation in the Health Care Field", Dickinson Law Review, 1979 Fall; 84(1): 51-74, Hein Online)

6. **National Health Insurance is defined as a comprehensive national plan for the provision of and payment for health care**. **The primary goals include insuring that all persons have access to medical care, eliminating the financial hardship of medical bills, and limiting the rise in health care costs**. See K. DAVIS, NATIONAL HEALTH INSURANCE: BENEFITS, COSTS, AND CONSEQUENCES (1975).

Definition—NHI—Universal

NHI requires universal coverage

Kooijman 99 – Associate Professor @ U Amsterdam (Jaap, "…and the Pursuit of National Health: The incremental strategy toward National Health Insurance in the United States of America," p. 125)

In summary, "staging" is not necessary, it is not desirable, and it carries great dangers. It may be the original intention that partial benefits should rapidly become comprehensive; but if the change should be delayed, limited scope of benefits would gravely distort the proper content and organization of medical care. Merely announcing the intention of "staging" the benefits may strengthen the proposals for "contracting out" to voluntary plans; Blue Cross and Blue Shield provide limited and categorical benefits of the scopes contemplated in some of the advocated "staging" patterns. "Staging" may threaten to sacrifice the objectives of care early in the course of disease or illness, and the objectives of strengthening preventive services, it would weaken the status and the future opportunities of the general practitioners, especially those with limited or no hospital connections; and it would make more difficult the subsequent solution of administrative problems in paying for comprehensive services. 26 Moreover, Falk feared that any **compromise on the scope of national health insurance would undermine the** most important **objective** "**National health insurance is national because it undertakes to draw on the economic recourses of the whole nation in order to meet the health needs of people everywhere — whether** they live in **rich or poor** areas, **and whether they are urban or rural**.

Experts agree

Fritz 93 - award-winning journalist, covered politics on Capitol Hill for more than three decades (Sara, "'HMO, HIPC, Pay or Play . . . ' Learning Lingo of the Debate," LA Times, http://articles.latimes.com/1993-02-23/news/mn-463_1_health-care)

NATIONAL HEALTH INSURANCE: Does not always mean a federally funded and regulated system, such as the one in Canada, even though it is frequently used to refer to such a program. Many **experts**, such as Starr, **use this term to describe any system that would provide all Americans access to** an agreed-upon standard of **health care**.

Requires coverage for all

Coylewright 7 – M.D. Candidate, 2009, Johns Hopkins School of Medicine, Baltimore, Maryland; J.D., 2005, University of Maryland School of Law, Baltimore, Maryland; B.S., 1998, University of Wisconsin, Madison, Wisconsin (Jeremey, "No Fault, No Worries Combining a No-Fault Medical Malpractice Act with a National Single-Payer Health Insurance Plan, *4 Ind. Health L. Rev. 29*, Lexis)

National single-payer health insurance could foster greater health equity in other ways as well. A national single-payer health insurance plan would eliminate the problematic practice of risk avoidance through adverse patient selection demonstrated by private insurance companies. 118 Private health insurers have the incentive to avoid high risk patients or those with preexisting health conditions that have high health care utilization patterns. Thus sicker patients find it difficult to obtain adequate and affordable health coverage in the present system, or any health insurance coverage at all. 119 As **national health insurance would provide adequate coverage for all citizens**, adverse selection would cease.

'National' means coverage everyone

Shuster 13 - M.S. in Jewish Philosophy from Yeshiva University, a J.D. from New York Law School, and an LL.M. from NYU School of Law (Kenneth, "Because of History, Philosophy, the Constitution, Fairness & Need: Why Americans Have a Right to National Health Care, *10 Ind. Health L. Rev. 7*5, Lexis)

There are three ways to fund national health care plans. All of them involve using taxpayers' dollars. The only difference between them is the degree of direct taxpayer involvement and whether the government will be exclusively or partially responsible for the costs of such care. **For example, a national health care system can be realized by Americans paying government health care premiums out of pocket**. The amount of such premiums would depend on income. Those who earn more would pay more and naturally, those who earn less would pay less. Americans whose income is below a certain level would be exempt from such premiums; their care would be paid for entirely by the government. 115 **Other ways national health care can be paid for are deducting the cost of one's annual health care from her paycheck**, paying upfront for services and being reimbursed by the government, 116 and permitting health consumers to deduct the value of all their health expenditures on their tax returns. 117 The self-employed would pay government subsidized premiums, and low-income individuals would be covered completely and upfront by the government. Finally, as we have seen, **a government sponsored national health care plan** can be funded by taxpayer contributions and delivered by the government via a single- payer system without any upfront expenditures and reimbursements or payroll deductions. This **is the most cogent manner national health care should be implemented** for at least three reasons. First, it **would be truly "national" inasmuch as it would cover all Americans without regard to income**. Second, it would exponentially cut down on administrative costs and bureaucratic involvement because, unlike the German and French systems, there would not be as much of a need to keep track of what or when residents have paid for health care or deal with the extra paperwork involved to repay nationals for their lay-outs in a timely fashion. However, under a single-payer system there will still be a need for paperwork or record keeping, as some governmental patient health care tracking would be required. 118 Also, record keeping promotes four important values. First, to ensure that patients are not over treated. Second, it combats fraud. Third, it ensures that doctors, hospitals, and other health care workers are appropriately compensated. Fourth, it helps to protect doctors from illegitimate malpractice suits. Third, any health care program that allows the government to pay health costs without out-of-pocket, upfront payments, will psychologically reinforce the idea that government health care is something all Americans are entitled to by right. 119

NHI is benefits for everyone

Wagner 92 – Washington Bureau Chief (Lynn, "Forces dig in on reform strategies, boosting likelihood of a stalemate," *Modern Healthcare*, 22.8)

The plan behind door No. 1 **would be national health insurance, a tax-financed government program providing** a minimum package of **benefits for everyone** and setting annual limits on healthcare spending. Behind door **No. 2 would be the "play-or-pay**" plan that would force employers to offer insurance to their workers or pay a tax to bankroll a fund that would pay for care for the uninsured. Door **No. 3 would reveal a market-oriented strategy** that relies largely on tax credits and deductions to enhance access to healthcare and on competition to control costs. With those choices arrayed, the contestant would make a selection, the door would open and the healthcare reform debate would immediately be resolved. But national policy isn't made on television, and solving the complex problem of the healthcare system isn't as simple as choosing the grand prize. However, **the options for overhauling the healthcare system are** that **simple to define**. All of the major reform proposals that have been offered, including the one recently unveiled by President Bush, can be placed in one of the three aforementioned categories.

NHI covers everyone---there's a right to benefit, even without payment

Doron 7 – PhD, lecturer, w/ Tal Golan is Assistant to the Haifa Civil District Attorney at the Israeli Ministry of Justice and a doctoral student in the Faculty of Law at Tel-Aviv University in Tel-Aviv, Israel (Israel, "AGING, GLOBALIZATION, AND THE LEGAL CONSTRUCTION OF "RESIDENCE": THE CASE OF OLD-AGE PENSIONS IN ISRAEL, *15 Elder L.J. 1*, Lexis)

The committee's report notes that the main claim it received from the public comments was that the citizens who left Israel had for many years been Israeli residents who had respected all of their civil duties and paid insurance fees to the Institute, and they had, therefore, acquired the "right" to receive a pension. 173 Rejecting this argument, the committee stated that, as a general rule, **National Insurance is not a regular commercial insurance**, and **there is no** direct **connection between** the **payment of** insurance **fees and the right to a benefit**. 174 The

committee determined that a pension is a mutual insurance that is not established on an actuary basis; as a result, there is no correlation between the insurance fees paid by or on behalf of the eligible person and the pension that person is entitled to receive. 175 The committee further noted that the state contributes to the cost of the pension by applying taxes paid solely by the state's current residents. 176 Because the resources available to the National Insurance are limited, [*31] the report explained, any extension of eligibility to persons other than residents of Israel could impair the amount of benefits paid to insured residents of Israel or prevent the increase thereof. 177

Previous US legislation concurs

Kucskar 8 – JD @ Maryland School of Law (Jonathan, "LABORATORIES OF DEMOCRACY: WHY STATE HEALTH CARE EXPERIMENTATION OFFERS THE BEST CHANCE TO ENACT EFFECTIVE FEDERAL HEALTH CARE REFORM," *11 J. Health Care L. & Pol'y 377*, Lexis)

Numerous legislators endorse a single payer system as the solution to America's health care crisis. 84 Longtime Congressman John **Conyers** (D-MI) **sponsored the United States National Health Insurance Act** (USNHI) **to provide health coverage to all individuals** residing in the United States. 85 First introduced in February 2003, 86 USNHI now has eighty-eight cosponsors in the U.S. House of Representatives. 87 **USNHI contains the traditional elements of a single payer health care system. The bill guarantees every United States resident "a universal, best quality standard of care**." 88 Coverage must include inpatient and outpatient care, prescription drugs, long-term care and various other types of treatment. 89 This proposal would prohibit for-profit health providers from participating in the single payer system, and private health insurers would be barred from providing benefits that duplicate coverage provided by USNHI. 90 Thus, as a result of USNHI, traditional private health insurance would be virtually eliminated throughout the United States.

NHI distinct from piecemeal targeting of particular groups

Starr 13 – PhD, Professor of Sociology (Paul, "LAW AND THE FOG OF HEALTHCARE: COMPLEXITY AND UNCERTAINTY IN THE STRUGGLE OVER HEALTH POLICY," 6 St. Louis U. J. Health L. & Pol'y 213)

Just as Americans have gotten used to the fog in the healthcare market as if it were normal for producers and consumers not to know the price of services, so they have gotten used to the fog that hangs over public programs for healthcare. **The history of healthcare policy in the twentieth century is a story first of failure and then of piecemeal reform** -- **the failure of** general proposals for **national health insurance, and the passage of piecemeal efforts to deal with the problems of groups** that benefit from public sympathy and effective organization. The passage of these programs has often involved compromises of a particular kind. Compromise does not inherently lead to greater organizational complexity; for example, members of Congress may split the difference on the budget for an agency without complicating the agency's structure. The adoption of major health programs, however, has involved ideological compromises between left and right that have resulted in complex structures with hybrid operating principles. The passage of Medicare and Medicaid in 1965 and the [*219] adoption of the State Children's Health Insurance Program in 1997 illustrate these patterns. 17

NHI requires 'everyone in and no one out' --- it's distinct from incremental approaches

Wolfe 9 – MD, Acting President, Public Citizen and Director, Health Research Group at Public Citizen (Sidney, "Dr. Sidney Wolfe's Congressional Testimony in Support of a Single-Payer System," *Subcommittee on Health House Committee on Energy and Commerce Hearing on Health Insurance*, Lexis)

The real question is **why should we tolerate the fragmented**, highly profitable, administratively wasting private **health insurance** industry any longer? In this regard, the public is way ahead of either President Obama or the Congress in its distrust of the health insurance industry.

A recent national Harris Poll (October, 2008) asked the following question: "Which of these industries do you think are generally honest and trustworthy - so that you normally believe a statement by a company in that industry?"Only one out of 14 people (7%) thought that the health insurance industry is honest and trustworthy. The only industries in the survey that were even more distrusted than the health insurance industry were HMO's (7%), oil (4%) and tobacco (3%).

The Congress, on the other hand, trusts the health insurance industry and feels compelled to come up with a "solution" that avoids a big fight with them, not only writing them into the legislation but assuring further growth of that industry. The Congress wants to believe that the health insurance and pharmaceutical industries will be good citizens and voluntarily lower their prices to save some of the money that is necessary to fund health insurance. Several weeks ago, the collective forces of the health industry promised that they could voluntarily save two trillion dollars over the next 10 years.

But the amount that can be saved over the next ten years by just eliminating the health insurance industry and the $400 billion of excessive administrative costs it causes each year is $4 trillion, in one fell swoop. This would be enough to finance health care for all without the additional revenues the Congress and the Administration is desperately seeking.

As an example of administrative waste, over the last 30 plus years there have been maybe two and a half, three times more doctors and nurses, in proportion with the growth in population. But over the same interval, there are 30 times more health administrators. These people are not doctors. They're not nurses. They're not pharmacists. They're not providing care. Many of them are being paid to deny care. So, they are fighting with the doctors, with the hospitals to see how few bills can be paid. That's how the insurance industry thrives by denying care, paying as little out as it can, getting the healthiest patients.

There is no question that we have a fragmented health insurance industry. And it thrives on being fragmented, avoiding any kind of serious centralized examination or control. The drug companies make much more money with this insurance fragmentation, because there's no price control. The insurance companies make much more money because they can push away people who aren't going to be profitable, let public programs take care of these patients who are "unprofitable".

What the President and the Congress are really, realistically **advocating** - since there is absolutely no possibility of having enough money to cover all people in this country as long as the private, for-profit health insurance industry is allowed to exist - **is** more **incremental reform, not National Health Insurance**. It is now 44 years since Medicare and Medicaid came into existence. In the interim, there have been many experiments in this country and abroad to try to provide universal health coverage.

Other countries have uniformly **rejected the private for-profit insurance industry and have adopted National Health Insurance**. Is everyone else wrong and only the US is right?

A recent study by the international OECD (Organisation for Economic Co-operation and Development)[1] provided health insurance data from its 30 member countries (Europe, Korea, Japan, Mexico, Canada, the U.S. and others including Australia, New Zealand and Iceland). The latest data from those countries showed that 27 of the 30 had health insurance coverage for more than 96% of the population, with only Germany having any non-public coverage (10.3%). The other three were Mexico with 60.4% covered - all with public coverage, Turkey, with 67.2% covered, also with public coverage and the U.S. with 84.9% covered 57.5% with private and 27.4% with public coverage.

In Canada, back in 1970, they were spending the same percentage of their gross national product as we were on health. They also had millions of uninsured people and many of the same insurance companies such as Blue Cross, Blue Shield. They decided to just get rid of the health insurance industry. They had experimented with it in Saskatchewan ten years earlier and it had worked so well, they couldn't wait to do it nationally. So, where there's a will, there's a way. There is no way we are ever going to get to having good health insurance for everyone, as long as there's a health insurance industry, in the way, obstructing care.

Other more recent experiments abroad include Taiwan. In 1995, Taiwan had said, we don't like the fact that 40 percent of our people are uninsured. They passed, essentially, single-payer plan and within a few years 90-95 percent of the people were covered.

In the U.S. we have had experiments as well with seven states having instituted various versions of the public/private combination that this legislation seeks to provide. In none of these states has this worked, once several years had elapsed, despite initial enthusiasm and short-lived decreases in the uninsured.

So as we consider what to do, which experiments do we follow? The ones that were successful, all of which, for all practical purposes, eliminated the private for-profit insurance industry, or the failed U.S. state examples, all of which were built on this industry?

If instead of saying that **a single payer program is** not politically possible, the President and the Congress need to say, "It is not only politically possible, politically feasible, but it's **the only** practical **way national health insurance will** ever **happen**." Anything short of that is essentially throwing tens of billions of dollars at the insurance industry. And if you're afraid of the insurance industry, than you're afraid of doing the right thing: **Having everybody in, and nobody out of having health insurance**.

Insurance for part of the population is not 'national insurance'---Congressional debates over S-CHIP prove

Casey 7 – JD, Senator from Pennsylvania (Robert, "CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2007," *Congressional Record*, Lexis)

Thirdly, fiscal responsibility. We heard people talk about that issue today. No one on this side of the aisle needs a lecture from that side of the aisle or anywhere else about fiscal responsibility. This administration is the administration that brought us to a $9 trillion debt level and huge deficits. I think that is disingenuous. I want to read a quotation from a recognized expert from MIT, Professor Jonathan Gruber, on private versus public: I have undertaken a number of analyses to compare public sector costs of public sector expansions such as SCHIP to alternatives such as tax credits. I find that the public sector provides much more insurance coverage at a much lower cost under SCHIP than these alternatives. Tax subsidies mostly operate to ``buy out the base'' of insured without providing much new coverage. That quote is from a recognized expert. We heard discussions about the cost over 5 years. This is a 5-year reauthorization. The cost is not, as it was alleged before, some lie. The cost over 5 years is very simple: $25 billion is in the program now. We want to add $35 billion, so it is a $60 billion cost over 5 years. It makes all the sense in the world to spend $12 billion a year on health insurance when billionaires get $100 million in 1 year, or I should say over $200,000 of income. They get $100 million a year if they make that kind of money. My last point is, he and **others talked about this being a debate about national health insurance. We can have that debate**. We agreed on that. That is one thing we all agree on, both sides of the aisle. We should have a debate about health insurance. **This is not national health insurance**. This is not the debate about health insurance generally. **This is a very focused debate about** whether the President of the United States is in favor of providing **health care for 10 million** children and whether he is going to make that commitment. It is very simple. If you are supporting the President, then you are supporting a policy which will lead to the failure of this country to provide health care for 10 million children, and that would be a terrible mistake for those kids, for their communities, but especially, over the long term, for our economic future. We can't compete around the world unless our kids are healthy and they learn more now and earn more in the future. Mr. AKAKA. Mr. President, I support **the Children's Health Insurance Program** Reauthorization Act of 2007.

Medicare and Medicaid are incremental steps towards NHI

Procino 96 – JD, Elder law attorney (Michele, "NOTE: THE DEATH OF HEALTH CARE REFORM IN 1994: ANOTHER EXAMPLE OF CONGRESS' INABILITY TO ENACT MAJOR REFORM, *1 Wid. L. Symp. J. 547*, Lexis)

During his 1912 presidential campaign, Theodore Roosevelt called for national health insurance. 199 **In 1932**, President **F**ranklin **D**. **R**oosevelt **also promoted** a form of comprehensive **national health insurance**. 200 During the Post-World War II era, President Truman made a serious effort toward national health insurance with universal access. 201 Presidents **Kennedy and Johnson also confronted the health care issue**, 202 and **their efforts led to the enactment of Medicare and Medicaid** in the mid-1960s. **These presidential initiatives represent only incremental changes. Proponents of national health insurance viewed Medicare and Medicaid as "a beginning and not a culmination" of over fifty years of effort**. 203 **These programs represented "a first step toward** a strategic phase-in of broader comprehensive **national health insurance** coverage." 204 During the 1970's, both Democrats and Republicans wanted some type of national health insurance. Due to the problems with his economic recovery program, however, President Carter made health care a fairly low priority. 205 Almost a century has passed since Theodore Roosevelt began the push to reform health care, yet despite his efforts and those of his many successors, **national health**

insurance remains an elusive goal. Today the United States health care system is both inequitable and inefficient, but Congress has refused to enact any form of a National Health Security program.

Anything short of universal is distinctly categorized as incremental

Himmelstein 8 – MD, distinguished professor of public health and health policy in the CUNY School of Public Health at Hunter College (David and Steffie Woolhandler, "**National Health Insurance or Incremental Reform**: Aim High, or at Our Feet?," *American Journal of Public Health*, 93.1)

WE ADVOCATE SINGLE-PAYER **national health insurance** (NHI) (Table 1 ►) **because it would work and lesser reforms would not**. The policy establishment often portrays NHI as an impossible dream: an ultra-left, utopian vision. Yet, most other wealthy capitalist nations have implemented NHI, and it enjoys wide, even majority, public support in the United States.

Most would agree that our health care system is deeply troubled. At least 41 million people residing in the United States have no health insurance, and millions more have inadequate coverage. Medical care costs are soaring, and job-based coverage is eroding. Public resources of enormous worth—hospitals, visiting nurse agencies, even hospices—built over decades by taxes, charity, and devoted volunteers, are being taken over by companies attentive to profits but indifferent to suffering.

Since the defeat of the Clintons' Rube Goldberg scheme for universal coverage, reform debate has been muted. But the fast developing medical care crisis—business grappling with soaring premiums, workers and unions fighting cutbacks in coverage, governments confronting deficits, and a sharp upturn in the number of individuals who are unemployed and uninsured—ensures a reopening of health policy debate.

Since the passage of Medicare and Medicaid, a welter of **incremental reforms have been attempted**—and have failed. Health maintenance organizations (**HMOs**) and **diagnosis-related groups** promised to contain costs and free up funds to expand coverage. Billions have been allocated to expanding **Medicaid**, **the State Children's Health Insurance Program**, and similar state-based insurance programs for poor and near-poor citizens. **Medicare and Medicaid** have pushed managed care. Oregon essayed rationing; Massachusetts and Hawaii passed laws requiring all employers to cover their workers; Tennessee promised nearly universal coverage; and several states implemented risk pools to insure high-cost individuals and insurance regulations to protect consumers.1 Senators Kennedy and Kassebaum lent their names to **insurance market reform** legislation. And for-profit firms pledged that market discipline and businesslike efficiency would fix health care.

Fans of incrementalism dismiss NHI as a hopeless home run swing when a bunt—small steps toward universal coverage—would do. **Despite incrementalists' claims of pragmatism, however, they have proven unable to shepherd meaningful reform through our political system**. Over the past quarter century, incrementalists have trumpeted victories such as those detailed above. Meanwhile, the number of uninsured individuals has increased by 18 million, health care's share of the gross domestic product has risen from 7.9% to 13.2%, and more and more seniors have been forced to choose between food and medicine. How many more strikes before incrementalism is out?

Definition—NHI—Only Single Payer

NHI is exclusively single payer with private care providers

Liu 16 – PhD @ RAND graduate school (Jodi, "Exploring Single-Payer Alternatives for Health Care Reform," DOI: 10.7249/RGSD375)

Health care systems vary country by country but generally follow similar models. Reid classifies health care systems in **four basic models: Beveridge, Bismarck, National Health Insurance, and Out-of-Pocket** (Reid, 2009). Other classifications describe three main models that include National Health Insurance as a Beveridge model (Kulesher and Forrestal, 2014; Lameire, Joffe and Wiedemann, 1999). In the Beveridge model, health care is financed through taxes and is provided by the government as the single payer. **An example of the Beveridge model is the United Kingdom's National Health Service, in which most hospitals are government facilities and health care providers are government employees. The National Health Insurance model also has the government as the single payer with financing from** residents generally through **taxes**. **However**, one distinction from the National Health Service is that the **National Health Insurance model relies on mostly private providers to deliver care**. The health system in **Canada is an example** of the National Health Insurance model. **The Bismarck model has employer-sponsored insurance and coverage provided through non-profit, private insurers**. For example, Germany's sickness funds are compulsory (high-income individuals may opt out) and financed through payroll taxes (premium contributions for the unemployed are made by federal and local governments), and care is delivered through private providers. Last**, the Out-of-Pocket model is a system in which most people pay for services directly without a widespread insurance system; this model exists mostly in developing countries**.

NHI is only single payer---that's different from an NHS or social or out of pocket

PNHP 8 (Physicians for a National Health Program, http://www.pnhp.org/single_payer_resources/health_care_systems_four_basic_models.php)

Health Care Systems - Four Basic Models An excerpt from correspondent T.R. Reid's upcoming book on international health care, titled "We're Number 37!," referring to the U.S.'s ranking in the World Health Organization 2000 World Health Report. The book is scheduled to be published by Penguin Press in early 2009. There are about 200 countries on our planet, and each country devises its own set of arrangements for meeting the three basic goals of a health care system: keeping people healthy, treating the sick, and protecting families against financial ruin from medical bills. **But we don't have to study 200 different systems to get a picture of how other countries manage health care. For all the local variations, health care systems tend to follow general patterns. There are four basic systems: The Beveridge Model** Named after William Beveridge, the daring social reformer who designed Britain's National Health Service. **In this system, health care is provided and financed by the government through tax payments**, just like the police force or the public library. Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government. In Britain, you never get a doctor bill. These systems tend to have low costs per capita, because the government, as the sole payer, controls what doctors can do and what they can charge. Countries using the Beveridge plan or variations on it include its birthplace Great Britain, Spain, most of Scandinavia and New Zealand. Hong Kong still has its own Beveridge-style health care, because the populace simply refused to give it up when the Chinese took over that former British colony in 1997. Cuba represents the extreme application of the Beveridge approach; it is probably the world's purest example of total government control. **The Bismarck Model** Named for the Prussian Chancellor Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the 19th century. Despite its European heritage, this system of providing health care would look fairly familiar to Americans. **It uses an insurance system** — the insurers are called "sickness funds" — **usually financed jointly by employers and employees through payroll deduction.** Unlike the U.S. insurance industry, though, Bismarck-type health insurance plans have to cover everybody, and they don't make a profit. Doctors and hospitals tend to be private in Bismarck countries; Japan has more private hospitals than the U.S. Although this is a multi-payer model — Germany has about 240 different funds — tight regulation gives government much of the cost-control clout that the

single-payer Beveridge Model provides. The Bismarck model is found in Germany, of course, and France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America. **The National Health Insurance Model** This system has elements of both Beveridge and Bismarck. **It uses private-sector providers, but payment comes from a government-run insurance program that every citizen pays into.** Since there's no need for marketing, no financial motive to deny claims and no profit, these universal insurance programs tend to be cheaper and much simpler administratively than American-style for-profit insurance. **The single payer** tends to have considerable market power to negotiate for lower prices; Canada's system, for example, has negotiated such low prices from pharmaceutical companies that Americans have spurned their own drug stores to buy pills north of the border. National Health Insurance plans also control costs by limiting the medical services they will pay for, or by making patients wait to be treated. **The classic NHI system is found in Canada**, but some newly industrialized countries — Taiwan and South Korea, for example — have also adopted the NHI model. **The Out-of-Pocket Model** Only the developed, industrialized countries — perhaps 40 of the world's 200 countries — have established health care systems. Most of the nations on the planet are too poor and too disorganized to provide any kind of mass medical care. The basic rule in such countries is that the rich get medical care; the poor stay sick or die. In rural regions of Africa, India, China and South America, hundreds of millions of people go their whole lives without ever seeing a doctor. They may have access, though, to a village healer using home-brewed remedies that may or not be effective against disease. In the poor world, patients can sometimes **scratch together** enough **money to pay a doctor bill**; otherwise, they pay in potatoes or goat's milk or child care or whatever else they may have to give. If they have nothing, they don't get medical care. These four models should be fairly easy for Americans to understand because we have elements of all of them in our fragmented national health care apparatus. When it comes to treating veterans, we're Britain or Cuba. For Americans over the age of 65 on Medicare, we're Canada. For working Americans who get insurance on the job, we're Germany. For the 15 percent of the population who have no health insurance, the United States is Cambodia or Burkina Faso or rural India, with access to a doctor available if you can pay the bill out-of-pocket at the time of treatment or if you're sick enough to be admitted to the emergency ward at the public hospital. **The United States is unlike every other country because it maintains so many separate systems for separate classes of people. All the other countries have settled on one model for everybody**. This is much simpler than the U.S. system; it's fairer and cheaper, too.

Note - Reid's "**Beveridge**" model **corresponds to** what PNHP would call a single payer **national health service** (UK); "**Bismark**" model **refers to** countries that PNHP would say use non-profit "sickness funds" or **a "social insurance model"** (Germany); **and** "**National health insurance**" **corresponds to single payer national health insurance** (Canada, Taiwan). Reid's "**out-of-pocket**" model **is** what PNHP would call "**market driven**" health care. Some countries have mixed models (e.g. Sweden has some features of a national health service such as hospitals run by county government; but other features of national health insurance such as physicians being paid on a FFS basis). This explains why Reid might classify the Scandinavian systems as "Beveridge" while PNHP classifies them as "single payer national health insurance."

Definition—NHI—Not Universal

Can be universal or catastrophic

Levmore 96 – JD, Professor of Corporate Law and the Albert Clart Tate, Jr. Professor at the University of Virginia School of Law (Saul, "Coalitions and Quakes: Disaster Relief and its Prevention," *3 U Chi L Sch Roundtable 1*, Lexis)

The comparison is more interesting when we force the affordability issue by thinking of the problem of uninsured patients who cannot afford critical care. One way to think about the apparent move toward national health insurance is to see that we have a post-disaster relief scheme currently in effect in the form of public and private subsidies to maintain emergency rooms and other hospital facilities used rather intensively by uninsured patients. 68 This form of disaster relief seems akin to what we would expect in the event of famine; it is difficult to imagine an affluent democracy (or perhaps any society) denying emergency medical care, 69 so that public sympathy generates relief even for a group with little political power. Given the reality of this post-disaster relief scheme, 70 taxpayers may sensibly prefer pre-disaster relief in the form of subsidized insurance over the post-disaster relief currently taking place in emergency rooms. The analogy is to the disaster mitigation features of subsidized flood (and perhaps earthquake) insurance. Just as taxpayers and potential victims may both benefit by a move from post-disaster to pre-disaster relief when the latter is in the form of subsidized insurance contingent on disaster-mitigating steps (such as flood planning and conformity to building codes), so too everyone may benefit if subsidized heath insurance leads to preventive rather than emergency care. The move can be beneficial in both financial and mortality terms. Put somewhat differently, there is also the possibility of evolution toward catastrophic health insurance (or health care), but the expenditures necessary to support more routine (but emergency room) care bring about the possibility of pre-"disaster" relief for all health problems. But **either kind of national health insurance (universal or catastrophic) is an example of pre-disaster relief succeeding post- disaster relief so long as substantial redistribution is involved**.

Medicare, Medicaid, Veterans and Military

McFadden 1 - PhD, CRNA. A practicing CRNA MSP @ Barry's (John, "Employee Benefits," 6th Edition, google books)

Don't We Already Have National Health Insurance?

The answer is "**yes**," for many Americans. Unlike most other industrialized countries, however, the United States does not have a system of national health insurance that covers everyone. Although **national health insurance does exist in the form of Medicare, Medicaid,** certain **veterans' benefits, and coverage of military personnel and their families**, each of these programs at- tempts to address the issue of health insurance for a specific group and each takes a different approach.

Only some NHI seek universal coverage

McFadden 1 - PhD, CRNA. A practicing CRNA MSP @ Barry's (John, "Employee Benefits," 6th Edition, google books)

Is the Goal Universal Coverage or Universal Access?

Some national health insurance programs call for universal coverage, which means that all Americans would be covered. Unfortunately the cost of universal coverage would be very expensive, and it is questionable whether such a program could be accomplished voluntarily. As long as some people are in a position of voluntarily electing coverage, there are those who would be un- willing to pay the price, even if it was subsidized. Therefore, universal cover- age probably requires a program similar to Medicare and accompanying tax revenue to support the program. With the majority of the public wanting a nongovernment program of health insurance, **many** other **national health in- surance proposals** focus on universal access and **realize that a goal of** slightly **less than universal coverage is** all that is realistically **attainable**. But even this goal will require subsidies for some segments of the population.

There's no 'universal scheme'

Mashaw 95 – Professor of Law @ Yale (Jerry, with Theo Marmor, "THE CASE FOR FEDERALISM AND HEALTH CARE REFORM," 28 Conn. L. Rev. 115, Lexis)

B. "**Universal**" Coverage

Does this mean that states really have no choice but to mandate coverage for 100% of their legal residents? Not at all. First, no nation's "universal" scheme is, in practice, truly universal. The Swiss are 98% covered in a radically decentralized federal system with no mandates, as are the Dutch. **Germany has more than 95% coverage in a "mandatory" system that exempts 20-25% of the populace from the mandate**.

Definition—NHI—Not Comprehensive

Not comprehensive

Smith 87 – JD (Steven, "Law, Behavior, and Mental Health: Policy and Practice," p. 158)

National health insurance would not necessarily be comprehensive in terms of providing complete mental health coverage. In fact, **some** recent major legislative proposals **have provided for very limited mental health coverage within a national health insurance program**. The reasons for this exclusion are the same as those for limited coverage: **it is difficult to define what conditions should be covered** by the insurance **or to determine when the patient is "cured**" or no longer needs treatment; there traditionally has been relatively limited con- sumer demand for mental health coverage and thus mental health may appear to be optional or elective rather than essential; some mental health care is aimed at personal growth or education rather than "real" health care; and mental health care is commonly provided outside the hospital and therefore does not fit neatly within hospital- based insurance plans.

Can be basic or comprehensive

McFadden 1 - PhD, CRNA. A practicing CRNA MSP @ Barry's (John, "Employee Benefits," 6th Edition, google books)

What Benefits Should Be Available?

One of the major debates in designing a national health insurance program involves the scope of the benefits that will be included. At one extreme in the debate **are those who feel the government should guarantee only a minimum level of health care**. Private medical expense insurance or personal resources would be necessary to obtain broader benefits. **At the other extreme are those who feel that a comprehensive level of health care should be available to all** Americans. This group views complete health care protection as a basic right that belongs to everyone regardless of income.

NHI is not comprehensive

Cunningham 95 – Associate Professor of Law, Benjamin N. Cardozo School of Law (Laura, "NATIONAL HEALTH INSURANCE AND THE MEDICAL DEDUCTION, *50 Tax L. Rev. 237*, Lexis)

As a matter of health care policy and fiscal policy, no national health insurance program would cover all health care expenses, so it is inevitable that any such program must grapple with the problem of distinguishing expenses covered by the mandatory insurance program and those not. It is therefore safe to assume that **if a program of national health insurance were adopted, it would provide for the mandatory purchase** 90 **of a baseline level of health insurance, that is, a "standard benefit package**," 91 **and would permit the private purchase of insurance for expenses not within the baseline** ("**excess medical expenses**") **as well as permitting the purchase of uncovered services directly from the provider**. 92

NHI can go disease-by-disease---renal dialysis proves

Annas 8 - Professor Annas is the Edward R. Utley Professor and Chair of the Department of Health Law, Bioethics & Human Rights at Boston University School of Public Health and a professor at the Boston University School of Medicine and School of Law (George, "Health Care Reform in America: Beyond Ideology Recipient of the McDonald-Merrill-Ketcham Memorial Award for Excellence in Law and Medicine March 19, 2008," *5 Ind. Health L. Rev. 441*, Lexis)

There are really two ways to think about this, and this takes me back to my beginning days in this field, in the1970s. We think about two ways to **get to national health insurance. One is by age**, by just lowering the age of Medicare every few years and increasing it at the other end. Cover children and then cover people to twenty-one, then to twenty-four. So one way to change things is by age, **being more and more inclusive. The other one is to go "disease by disease" to national health insurance**.

I don't know if you remember the end stage renal disease program. **In 1970, we decided we were going to cover everybody who needs renal dialysis, because it was so expensive and it was a lifesaver. We decided that we were just going to have national health insurance for renal dialysis. We still do**, by the way. **It's the only thing we have national health insurance for**, because it turned out to be more than twenty times more expensive than imagined. So we didn't go disease by disease, and we don't cover children although we could still go age by age, but neither one looks like a likely path.

[62]Definition—Comprehensive

Comprehensive means these services

US Code 14 (42 U.S. Code § 300gg–6 - Comprehensive health insurance coverage, https://www.law.cornell.edu/uscode/text/42/300gg%E2%80%936---this card includes the text from a hyperlink to US code 18022 a)

42 U.S. Code § 300gg–6 - **Comprehensive health insurance** coverage

(a) **Coverage for essential** health **benefits** package

A health insurance issuer that offers health insurance coverage in the individual or small group market **shall ensure** that such **coverage includes the essential health benefits package required under section 18022(a) of this title**.

18022(a) is hyperlinked to this section of US code

Essential health benefits packageIn this title,[1] the term "essential health benefits package" means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) Essential health benefits

(1) In general Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) **Ambulatory patient services**.

(B) **Emergency services**.

(C) **Hospitalization**.

(D) **Maternity and newborn care**.

(E) **Mental health and substance use disorder services**, including behavioral health treatment.

(F) **Prescription drugs**.

(G) **Rehabilitative and habilitative services and devices**.

(H) **Laboratory services**.

(I) **Preventive and wellness services and chronic disease management.**

(J) **Pediatric services, including oral and vision care**.

(2) Limitation

(A) In general

The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) Certification

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) Notice and hearing

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) Required elements for considerationIn defining the essential health benefits under paragraph (1), the Secretary shall—

(A) ensure that each essential health benefits reflect an appropriate balance among the categories described in each subsection,[2] so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 1601(b)(2)(B)(ii)(I) of this title (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and [4]

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) Rule of construction

Nothing in this title 1 shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) Requirements relating to cost-sharing

(1) Annual limitation on cost-sharing

(A) 2014

The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of title 26 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 and later

In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year, and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(2) Repealed. Pub. L. 113–93, title II, § 213(a)(1), Apr. 1, 2014, 128 Stat. 1047

(3) Cost-sharingIn this title—1

(A) In generalThe term "cost-sharing" includes—

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditures required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of title 26) with respect to essential health benefits covered under the plan.

(B) Exceptions

Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) Premium adjustment percentage

For purposes of paragraph (1)(B)(ii), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) Levels of coverage

(1) Levels of coverage definedThe levels of coverage described in this subsection are as follows:

(A) Bronze level

A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) Silver level

A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) Gold level

A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) Platinum level

A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) Actuarial value

(A) In general

Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) Employer contributions

The Secretary shall issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of title 26) may be taken into account in determining the level of coverage for a plan of the employer.

(C) Application

In determining under this title,1 the Public Health Service Act [42 U.S.C. 201 et seq.], or title 26 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) Allowable variance

The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) Plan reference

In this title,1 any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) Catastrophic plan

(1) In generalA health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if—

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides—

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 271(f) 1 and

(ii) coverage for at least three primary care visits.

(2) Individuals eligible for enrollmentAn individual is described in this paragraph for any plan year if the individual—

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title 1 that the individual is exempt from the requirement under section 5000A of title 26 by reason of—

(i) section 5000A(e)(1) of such title (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such title (relating to individuals with hardships).

(3) Restriction to individual market

If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) Child-only plans

If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

(g) Payments to Federally-qualified health centers

If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1396d(l)(2)(B) of this title) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1396a(bb) of this title) for such item or service.

(Pub. L. 111–148, title I, § 1302, title X, § 10104(h), Mar. 23, 2010, 124 Stat. 163, 896; Pub. L. 113–93, title II, § 213(a), Apr. 1, 2014, 128 Stat. 1047.

(b) Cost-sharing under group health plans

A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraph (1) of section 1302(c)(1) of this title.

(c) Child-only plans

If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of this title, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

(d) Dental only

This section shall not apply to a plan described in section 1301(b)(2)(B)(ii) 1 of this title.

(July 1, 1944, ch. 373, title XXVII, § 2707, as added Pub. L. 111–148, title I, § 1201(4), Mar. 23, 2010, 124 Stat. 161; amended Pub. L. 113–93, title II, § 213(b), Apr. 1, 2014, 128 Stat. 1047.)

It's a wide variety of services, but not unlimited

HCY 17 (Health Care and You, What does Comprehensive Health Insurance cover?, http://www.healthcareandyou.co.uk/content/what-does-comprehensive-health-insurance-cover)

What does Comprehensive Health Insurance cover?

Comprehensive Health Insurance

Comprehensive health insurance covers all the medical needs of you and your family. Unlike basic plans it covers outpatient as well as inpatient treatments. This includes consultations, scans and tests as well as hospital stays.

Comprehensive medical insurance also offers limited cover for physiotherapy, acupuncture, homeopathy and osteopathy. Certain plans also include oral surgery, the use of a private ambulance and home nursing. You can also add routine dental and optical cover to a plan for extra cost.

Treatments Included in Comprehensive Health Insurance Plans

Treatment	Included?
Outpatient cover	Included
Specialist Consultants	Included
MRI, PET and CAT scans	Included
Cancer treatments, chemotherapy and radiography	Included
Private Hospital Rooms	Included
Latest drugs and treatments	Included
Flexible appointments	Included
Physiotherapy	Some plans
Psychiatric Care	Some plans
Osteopathy	Occasionally
Homeopathy	Occasionally
Acupuncture	Occasionally

Comprehensive means not limited to a particular disease

GA SB 509 (Health Insurance Competition and Rate Relief Act of 2006., 2005 Bill Text GA S.B. 509, Lexis)

(b) Upon the Commissioner making a determination that the market is not functioning in a competitive manner and giving the notice as provided in subsection (a) of this Code section, every initial filing of an individual, guaranteed renewable comprehensive accident and sickness policy by insurers authorized to transact individual accident and sickness insurance under any chapter of this title shall be accompanied by a rate filing, with supporting actuarial certification and demonstration by a qualified actuary. Any subsequent addition to or change in rates applicable to the policy, rider, or endorsement shall also be required to be filed with the Commissioner for prior approval of any increase in premium rate. As used in this Code section, **the term 'comprehensive' means** coverage that qualifies as creditable coverage under the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, because it is **not of limited benefit or limited duration, is not for specified disease,** is not for long-term care, and is not a medicare supplement.

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