SUSTAINABLE DEVELOPMENT
YOUTH CONVENTION 2019

UNITED STATES SENATE

HEALTHCARE REFORM

TOPIC GUIDE

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ABOUT THE CHAIRS

Deepak S/O Alagusubramanian - Head Chairperson

Deepak Alagu is a 18 year old student with a keen interest in geopolitics and dance. He loved Infocomm Club and now loves a certain talented idol group. He has a memorable face and personality which has earned him plenty of friends but no girlfriend (yet). He is delighted to be given the opportunity to finally chair the council of his dreams, the United States Senate, and hopes that all participants will have a fruitful and enjoyable three days at SDYC 2019 :)

Joshua Chin Zhi Yi - Vice Chairperson

To Joshua Chin, sleep is pretty much a foreign subject, as seen from his 3am sleeping time and zombie-like disposition, so don't be shocked should you see him return PP feedback at these hours. Interestingly enough, despite the academic rigor of MUNs, Joshua can hardly be found dozing off in such conferences. Is it due to the camaraderie in council? Is it due to his enthusiasm towards debate? Or is it due to his persistent efforts to type out his script, only to have a blank screen on his computer when speaking? Whatever the answer is, he proudly admits that MUNs have a really special place in his life.

Srihari Rangan - Vice Chairperson

Srihari Rangan considers himself to have an IQ of duality nature. At some times, he would feel like he has an IQ of 500, yet sometimes he would feel like he has an IQ of 5. He is also a big fan of cricket and sometimes, albeit unfortunately, you may see him shadow batting. He is always open to a friendly conversation of global politics and would really like to hear others' opinions on various issues around the world. This is his first time chairing and is really looking forward to SDYC 2019. He hopes all the participants in this council have a fun and meaningful time this year and leave with long lasting memories!

COMMITTEE INTRODUCTION

The United States Senate is a highly regarded legislative institution throughout the globe and is often dubbed the "world's greatest deliberative body". It is an exemplary demonstration of the spirit of bipartisanship, that is, forging working compromises in spite of differing partisan ideologies to advance the interests of the country. Founded in 1787 at the Constitutional Convention, the Senate is the upper chamber of the bicameral national legislature. It plays a key role not just in passing laws, but also in confirming the President's executive and judicial nominees. Each of the 50 states in the Union elects two Senators to serve six-year terms, which are staggered so that one-third of all the seats are up for election biennially. The current makeup of the Senate is as depicted in Figure 1.

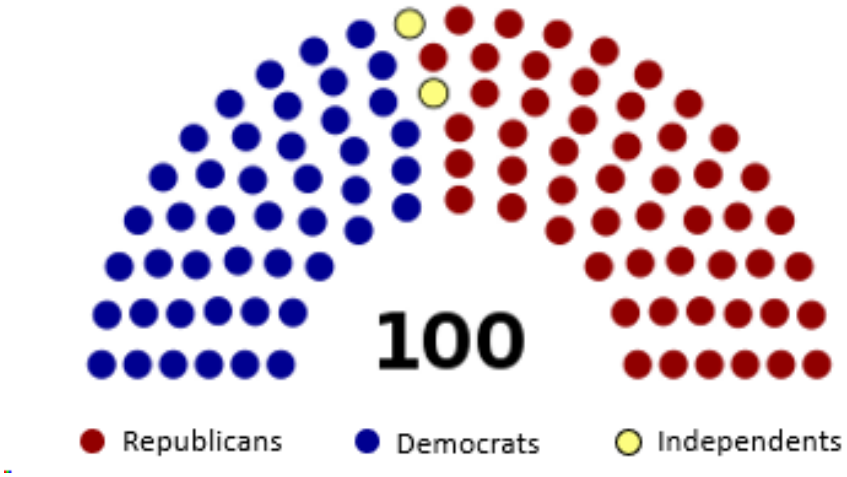

Figure 1. Partisan Makeup of Senate, as of June 2019

SPECIAL PROCEDURES

In council, delegates may be referred to as Senators and draft resolutions may be referred to as Bills. Bills must follow the stipulated format which will be released during the first council session.

The positions and votes of Senators are heavily influenced by their external environment, including poll numbers, news stories and Presidential tweets. To simulate this environment, we will feature real-time updates on these factors to push Senators to stick to their ideological stances. An example of an update can be "Activists slam Senator Graham for abandoning conservative principles for cap-and-trade".

Moreover, to better simulate the actual workings of the United States Senate, we will be adopting special voting procedures and motions. Any Bill will need a simple majority to pass under normal circumstances. Note that standard Rules of Procedure still apply unless otherwise stated.

1. Special Circumstances

1.1 Special Circumstance 1

Any single Senator may raise a "Filibuster Motion" anytime after the Bill is introduced but before entering voting procedures. This motion does not have to be voted on by the Senate but is subject to the chairs' discretion after a brief justification is provided by the Senator. If approved, the Senator is given 45 seconds to explain the reason for the filibuster. Then, all formal debate on the Bill in question is halted and the Senate enters an unmoderated caucus for three minutes. Immediately after this, any Senator may raise a "Cloture Motion" and if it passes with a three-fifths majority, formal debate on the Bill may resume. Otherwise, if no such motion is raised or the motion fails the three-fifths vote threshold, the Bill is automatically tabled.

1.1.1 Exception to Special Circumstance 1 - "Reconciliation Bills"

A "Reconciliation Bill" makes use of budget reconciliation procedures to avoid a filibuster under Senate rules. A "Reconciliation Bill" must be clearly titled as such (eg. "Better Healthcare Reconciliation Bill") and must meet the following stipulated criteria stated below. The chairs will have the final say whether a Bill meets the required criteria to be considered a "Reconciliation Bill". After a "Reconciliation Bill" has been introduced, any individual Senator can challenge provisions of the Bill by corresponding with the chairs via notepaper. The chairs reserve the right to accept any such challenge and strike provisions even after the "Reconciliation Bill" has been formally introduced.

1.1.2 Criteria for "Reconciliation Bills" - The Byrd Rule[1]

1. The Bill must change federal spending or revenue.
2. The Bill's effect on spending or revenues must be more than incidental to its policy impact. In other words, the Bill must be largely centred around budgetary matters and minimise provisions that do not explicitly affect spending and revenue.
3. The Bill cannot increase the federal deficit after a ten-year period.
4. The Bill cannot change Social Security.

[1] Scott, Dylan. "The Senate's rules will make it really hard to pass Medicare-for-all." Vox, March 8, 2019. https://www.vox.com/policy-and-politics/2019/3/8/18251707/medicare-for-all-bill-senate-filibuster-budget-reconciliation-byrd-rule

1.2 Special Circumstance 2

The President may issue a tweet threatening a veto if the Bill is not to his liking. In such a scenario, the Bill will need a two-thirds majority to pass and override the veto. Alternatively, Senators may use floor speeches to try and convince the President to retract his veto threat.
See the flowcharts below for a visual summary of the special procedures.

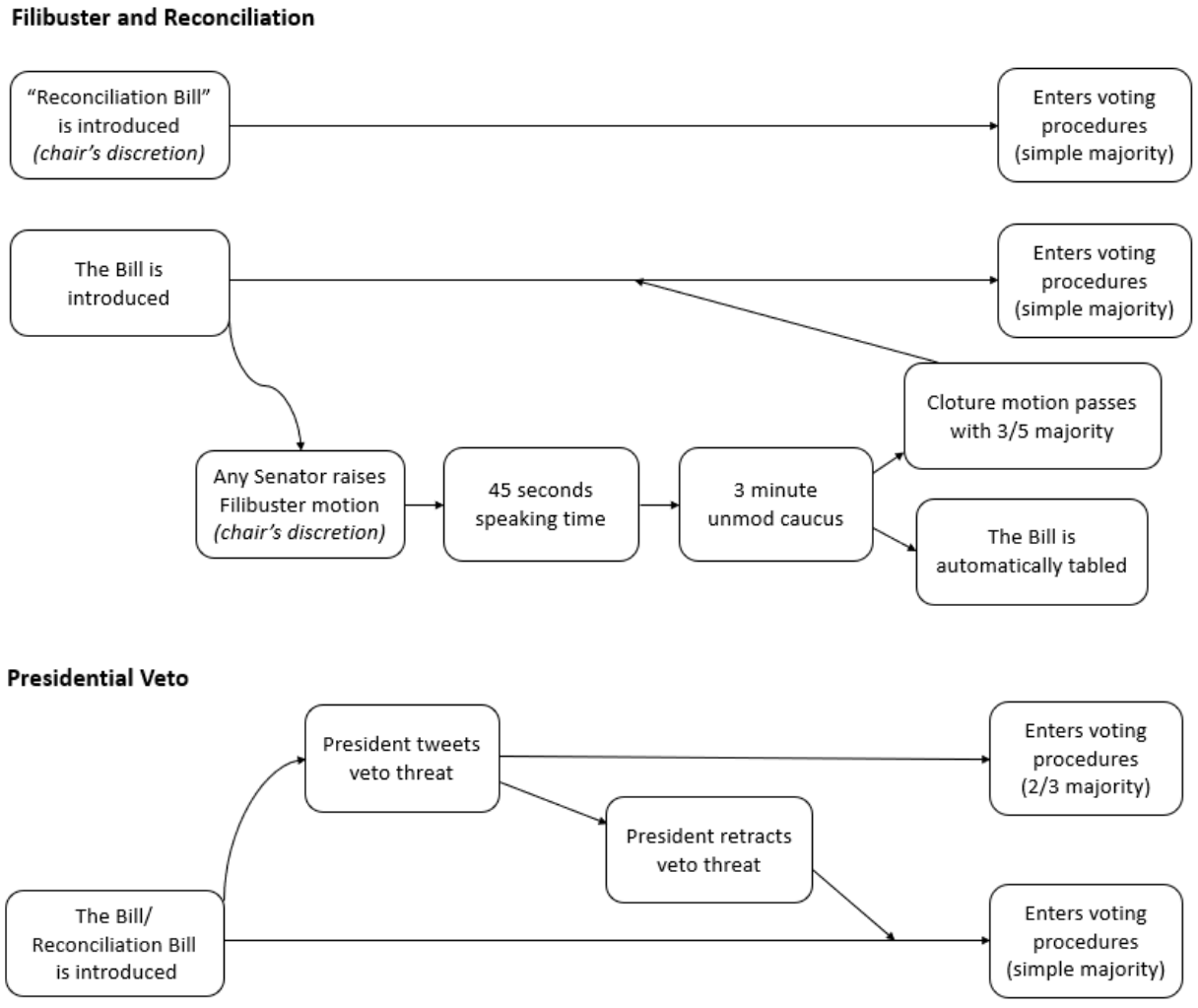

Figure 2. Visual Summary of the Special Procedures

INTRODUCTION TO TOPIC

Healthcare reform has long been a contentious issue in modern American political discourse. In the early 1990s, President Bill Clinton pushed heavily for a comprehensive plan to offer universal healthcare to all Americans. Amid stiff opposition from conservative groups and the health insurance industry, his efforts ended up unsuccessful. The next major initiative came when President Barack Obama took office in 2009, and his healthcare agenda sparked heated debates and raucous rallies all across the country. Ever since the passage of the Affordable Care Act (dubbed ObamaCare) in 2010 on a party-line vote, the Republican Party has adopted a mantra of "repealing and replacing" the law while the Democratic Party has upheld its merits while pledging to fix the issues associated with it. In today's polarized political climate, however, leading Democrats have called for a complete overhaul of the healthcare system that guarantees every American the right to healthcare coverage, while Republicans have increasingly called for individual states to be given the flexibility to decide how they want to provide healthcare coverage for their citizens with minimal federal involvement. This stark difference of opinion has contributed to gridlock and dysfunction in Congress and culminated in the failed Republican-led healthcare reform effort in 2017.

Why does the United States healthcare system need reform in the first place? The issue is that although healthcare services tend to be of high quality, they are also expensive, having totalled a whopping $3.3 trillion in 2016. As per statistics from the Organization for Economic Cooperation and Development, the United States spent 17.9% of Gross Domestic Product on healthcare in 2016, a significantly higher proportion than any other nation[2]. Yet, more than 12% of Americans lack health insurance[3], in contrast to other developed nations like Canada and the United Kingdom which provide universal healthcare access with lower expenditure.

Before delving into healthcare policy, it will be helpful to have an understanding of how the United States funds its healthcare. Rather than a uniform health system, the United States has a hybrid system. Healthcare providers such as doctors and hospitals are paid in three broad ways as depicted in Figure 3.

[2] Schreck, Roger I. "Overview of Health Care Financing." Accessed March 2, 2019. https://www.msdmanuals.com/home/fundamentals/financial-issues-in-health-care/overview-of-health-care-financing
[3] Sarlin, Benjy. "3.2 million more Americans were uninsured in 2017." NBC News, January 17, 2018. https://www.nbcnews.com/politics/white-house/3-2-million-more-americans-were-uninsured-2017-n837986

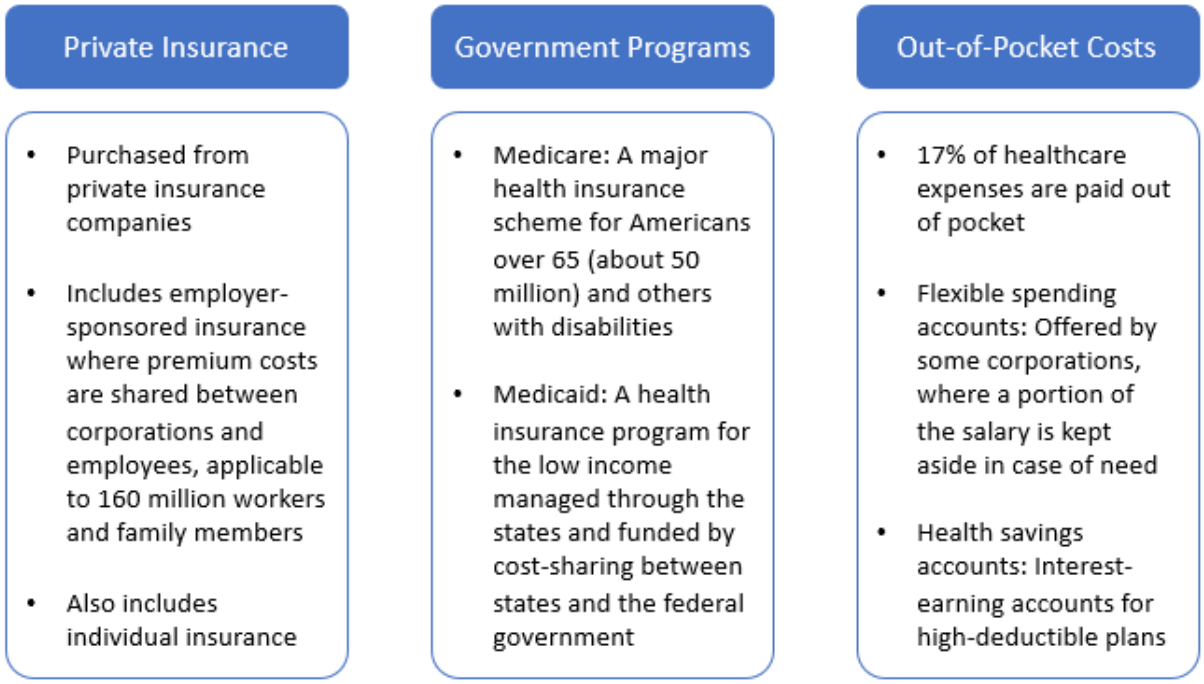

Figure 3. How the United States Funds its Healthcare

In 2014, private sources accounted for 48% of healthcare expenditure, with households making up 28% and private corporations making up 20%. 28% of healthcare spending came from the federal government while state and local governments contributed 17%. Nevertheless, it is to be noted that most publicly-financed healthcare is still delivered privately.

[4] DPE Research Department. "The U.S. Health Care System: An International Perspective." Accessed March 2, 2019. https://dpeafl-cio.org/programs-publications/issue-fact-sheets/the-u-s-health-care-system-an-international-perspective/

KEY QUESTION

Can the Senate reach a compromise on healthcare reform to uplift the lives of struggling citizens?

KEY DEFINITIONS

Coinsurance:
The percentage of costs paid by the consumer for healthcare services after a deductible is paid. A 50/50 coinsurance plan implies the consumer bears half the expenses while the insurance provider bears the other half. On a general note, plans with lower coinsurance tend to have higher monthly premiums.[5]

Copayment:
A copayment (also termed "copay") refers to the fixed amount paid by the consumer for healthcare services after a deductible is paid. For example, if the copayment for a doctor's visit is $50, the consumer only pays $50 at the time of the visit rather than the full amount. On a general note, plans with lower copayments tend to have higher monthly premiums.[6]

Deductible:
A deductible refers to the amount that has to be first paid by the consumer before any money starts to be paid by the health insurance provider. A $500 deductible means that the consumers pay the first $500 of covered services themselves, and after that, they share the cost with their health insurance plan by through coinsurance or copayments. On a general note, plans with lower deductibles tend to have higher monthly premiums.[7]

High Risk Pool:
A high risk pool, which was widespread among states prior to the implementation of the Affordable Care Act, is a program reserved for residents who had been denied insurance coverage due to health-related problems. These pools were established to ensure that individuals can get covered regardless of their health status. They typically charged premiums that were 125 per cent to 200 per cent the cost of a comparable plan in the private insurance market.[8]

[5] United States Government. "Coinsurance." Accessed May 7, 2019. https://www.healthcare.gov/glossary/co-insurance/
[6] United States Government. "Copayment." Accessed May 7, 2019. https://www.healthcare.gov/glossary/co-payment/
[7] United States Government. "Deductible." Accessed May 7, 2019. https://www.healthcare.gov/glossary/deductible/
[8] Bihari, Michael. "Health Insurance: Understanding High Risk Pools." verywell. Accessed May 9, 2019. https://www.verywellhealth.com/high-risk-pools-1738930

Medicaid:

Medicaid is a federal and state program for certain groups of disadvantaged people, including some low-income families, the elderly and the disabled. Medicaid offers benefits such as nursing home care and personal care services that are not typically covered by Medicare.[9] In 2014, it covered 78 million Americans and made up 16 per cent of all healthcare spending nationally.[10]

Medicare:

Medicare is a federal health insurance program for seniors 65 and older, younger individuals with some disability status, as well as those suffering from End-Stage Renal Disease.[11] It is the second largest program in the budget, costing $582 billion in 2018 and benefitting 18 percent of the United States population.[12]

Premium:

A premium is the amount paid to the health insurance provider on a monthly basis. The cost of premiums may be lowered with the premium tax credits offered under the Affordable Care Act.[13]

Single Payer Healthcare:

In a single payer healthcare system, a sole public agency finances healthcare for all residents in the country. Everyone is covered under one health insurance plan and has access to services such as doctors, hospitals and prescription drugs. However, individuals are given the freedom to choose the facility they receive care in.[14] Though on a larger scale, a single payer healthcare system would operate similarly to the existing Medicare program and is thus often dubbed as 'Medicare for All'.

A note of caution: 'Medicare for All' has different interpretations by different political entities, but single payer is the most commonly accepted definition.

Universal Healthcare:

A universal healthcare system provides healthcare services, for free or at a cost, to all legal citizens in the population. There are many models of such a healthcare system, such as a single payer healthcare system, a socialised medicine system and an insurance-mandate system.[15]

[9] United States Government. "Medicaid." Accessed May 8, 2019. https://www.healthcare.gov/glossary/medicaid/
[10] Peter G. Peterson Foundation. "Budget Basics: Medicaid." Accessed May 8, 2019. https://www.pgpf.org/budget-basics/budget-explainer-medicaid
[11] United States Government. "Medicare." Accessed May 8, 2019. https://www.healthcare.gov/glossary/medicare/
[12] Peter G. Peterson Foundation. "Budget Basics: Medicare." Accessed May 8, 2019. https://www.pgpf.org/budget-basics/medicare
[13] United States Government. "Premium." Accessed May 7, 2019. https://www.healthcare.gov/glossary/premium/
[14] Christopher, Andrea S. "Single payer healthcare: Pluses, minuses, and what it means for you." Harvard Health Publishing, 27 June, 2016.
https://www.health.harvard.edu/blog/single-payer-healthcare-pluses-minuses-means-201606279835
[15] Kenton, Will. "Universal Health Care Coverage." Investopedia, 21 November, 2017.
https://www.investopedia.com/terms/u/universal-coverage.asp

PAST INITIATIVES

ObamaCare, one the most major shakeups to the healthcare system in recent years, came into effect in 2014. It was established with the goal of improving access to quality healthcare, primarily through the expansion of the private insurance market. The law creates incentives for employers to provide health insurance and for uncovered individuals to purchase private health insurance. The key elements[16] of this landmark legislation are depicted in Figure 4.

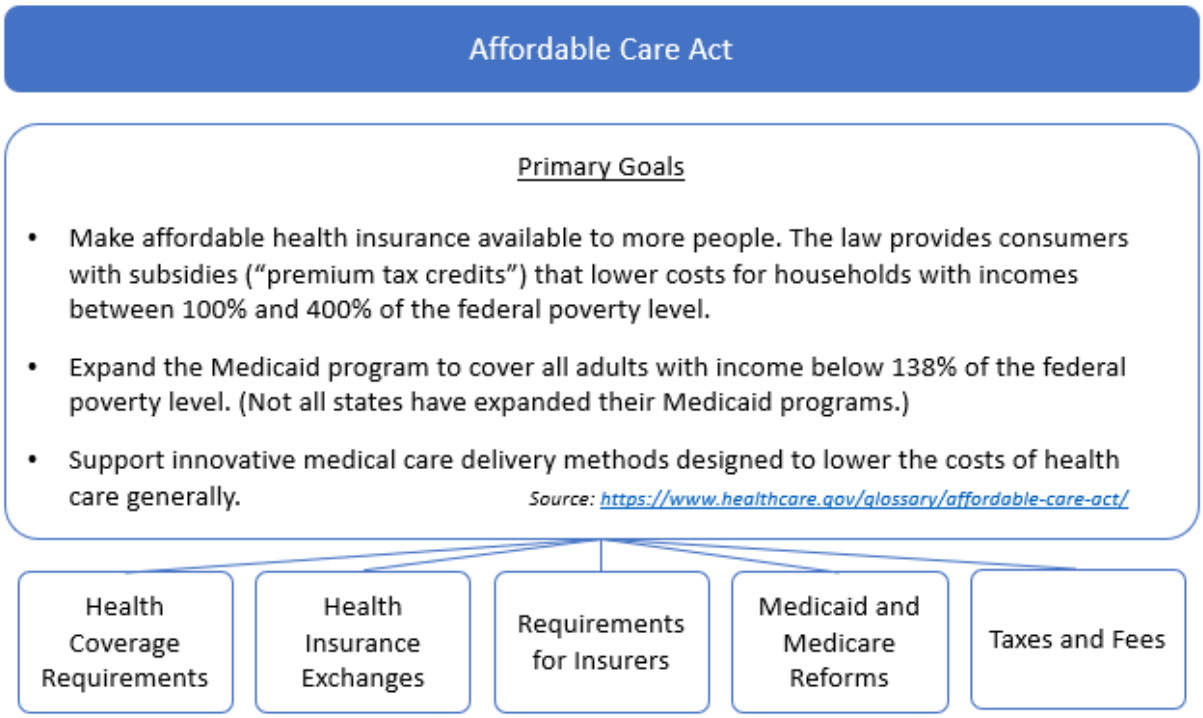

Figure 4. Overview of the Affordable Care Act

[16] Ballotpedia - "Obamacare overview." Accessed May 5, 2019. https://ballotpedia.org/Obamacare_overview#Summary_of_the_law

CURRENT INITIATIVES AND STATUS

1. Health Coverage Requirements

1.1 Individual Mandate

The Affordable Care Act requires all individuals to obtain health insurance by levying a fine on those who do not. The individual mandate was calculated based on the number of months an individual went without health insurance in a given year and included hardship exemptions for the homeless and bankrupt. This soon became one of the most unpopular provisions in the law, and under the Trump administration, the mandate was lowered to zero.

The rationale for the mandate was to ensure it is not just the sick who are buying health insurance. Expanding the insurance risk pools to include a mixture of healthy and sick consumers lowers insurance costs as individuals are deterred from signing up for insurance when they are sick only to cancel it when they recover.[17]

1.2 Employer Mandate

The Act also charges medium-sized and large businesses with the responsibility of providing their employees with affordable health coverage. Employers with at least 50 employees are subject to the requirement of covering at least 95 per cent of their workforce. Errant companies have to fork out a fine based on the number of employees who were not covered. Critics decried the dampening effect of this mandate on businesses' economic activity.

[17] Mukherjee, SY. "The GOP Tax Bill Repeals Obamacare's Individual Mandate. Here's What That Means for You." Fortune, 20 December, 2017
http://fortune.com/2017/12/20/tax-bill-individual-mandate-obamacare/

2. Health Insurance Exchanges

The Affordable Care Act set out the establishment of health insurance exchanges, which are readily accessible marketplaces for individual consumers to browse and purchase insurance plans. State governments were given the choice of establishing their own state-based exchanges, partnering with the federal government to jointly manage state-federal partnership exchanges, or simply allowing the federal government to operate federally-facilitated exchanges on the healthcare.gov platform. States that opted for the first approach were awarded a total of $5 billion in grants for the early administration of their exchanges.

Health insurance plans on the exchanges fall under one of the four categories as per Figure 5. Cheaper plans that charge lower monthly premiums correspondingly offer lower payouts in events of illness. In other words, consumers have to fork out higher deductibles for his/ her medical expenses.

Plan type	Plan pays	Consumer pays
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

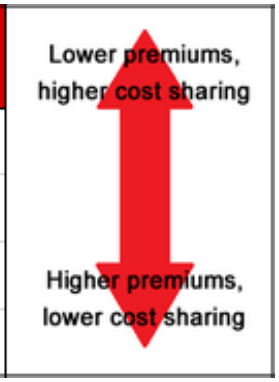

Figure 5. Types of Health Insurance Plans on the Exchanges

To ease the financial burden of health insurance premiums for low-income families, subsidies are offered in the form of premium tax credits for those earning between 100 per cent and 400 per cent of the federal poverty level. However, individuals with incomes below the poverty level do not qualify for these subsidies, because when the law was originally drafted, it was expected that they would be eligible for Medicaid. However, some states have not expanded Medicaid coverage, which will be covered in greater depth in the Medicaid section. Consequently, there is a coverage gap for individuals with incomes below the poverty level in these states.[18]

[18] Norris, Louise. "Will you receive an Obamacare premium subsidy?" December 27, 2018. https://www.healthinsurance.org/obamacare/will-you-receive-an-obamacare-premium-subsidy/

Some of those who qualify for the premium tax credits are also eligible for cost-sharing reductions (CSRs) that reduce out-of-pocket charges such as deductibles and copayments. Specifically, those who earn between 100 per cent and 250 per cent of the federal poverty level and purchase a Silver Plan in the exchanges automatically receive a cheaper version of the plan with lower out-of-pocket costs.[19] The federal government used to reimburse health insurers for offering these low-cost plans, but the Trump administration abruptly scrapped the payments in 2017, contributing to a rise in premiums as insurers attempted to maintain their bottom line.

3. Requirements for Insurers

One of the widely-heralded provisions of the Affordable Care Act is the prohibition on denying health insurance coverage to consumers with pre-existing conditions. Young adults are given the ability to stay on their parents' health insurance plans until they turn 26. Moreover, insurers are obliged to allow consumers to renew their plans annually unless their premiums were unpaid.

The law also mandated that all individual and small group-health insurance plans cover services that fall into ten broad categories of "essential health benefits": as listed in Figure 6. States are given the freedom to select specific services according to their citizens' needs, as long as the services fall into these categories. All plans also have to cover the full cost of screenings, contraception and breastfeeding-related services. Critics argue that these onerous requirements merely drive up the cost of health insurance.

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Rehabilitative and habilitative services and devices
6. Prescription drugs
7. Mental health and substance use disorder services
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Paediatric services, including oral and vision care

Figure 6. List of "Essential Health Benefits"

[19] Health Reform: Beyond the Basics. "Key Facts: Cost-Sharing Reductions." Updated September 6, 2018. https://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-part-2/

Furthermore, premium pricing restrictions are put in place to ensure fairness across age and gender. Insurers are required to seek approval for proposed rate increases of ten per cent or more from either state or federal regulators. Large insurers serving at least 1,000 customers are also made to use at least 80 percent of revenue from premiums to pay customer claims and support enhancements in health quality, such as wellness promotion programs. In essence, the amount that can go towards marketing, employee salaries and profits are capped, and this percentage is termed the minimum medical loss ratio.

4. Medicare and Medicaid Reforms

4.1 Medicare

The Affordable Care Act slashed reimbursements to privately administered Medicare Advantage plans, saving $132 billion between 2010 and 2020. Payments to healthcare providers were also decreased. Critically, the "doughnut hole" loophole in Medicare prescription drug coverage (Part D) was closed. Medicare beneficiaries used to have to fork out 100 percent of prescription drug costs that come within the range of $2,250 and $5,100 in a single year, but Medicare now covers a portion of these costs.

4.2 Medicaid

Under the Affordable Care Act, the Medicaid program is expanded significantly. Medicaid originally served two key groups: disabled people, older children, and parents with household incomes below the federal poverty level, as well as pregnant mothers and young children with household incomes around the federal poverty level. The law allowed for Medicaid to be expanded to cover adults with incomes below 138 percent of the federal poverty level. The federal government shouldered 100 per cent of the cost of covering new enrollees until 2016, then cutting this funding to 95 per cent in 2017 and to 90 per cent by 2020. Although all states were meant to adopt this expansion, a 2012 Supreme Court decision granted individual states the choice of expanding Medicaid. Consequently, more than a quarter of states have not expanded Medicaid for their citizens, as can be seen from Figure 7.

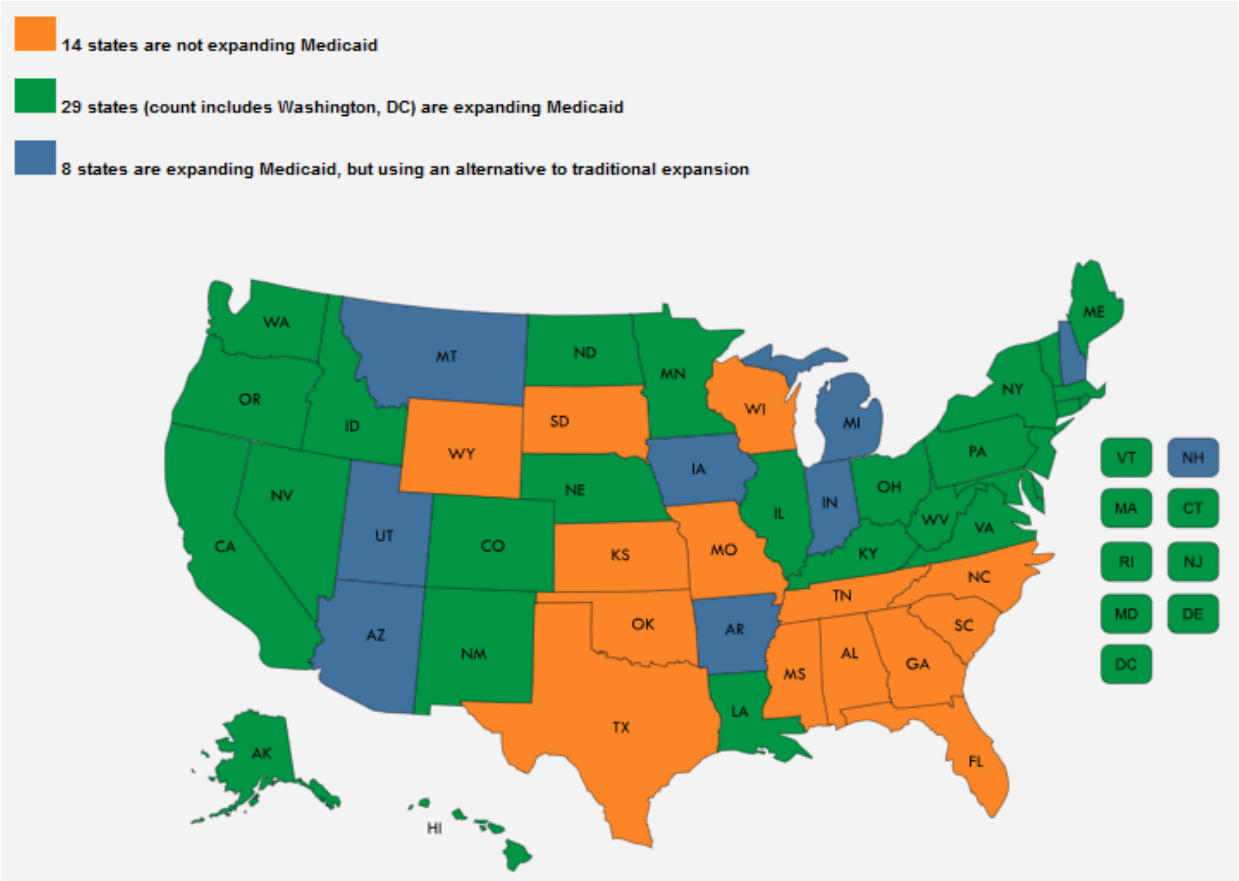

Figure 7. Implementation of ObamaCare's Medicaid Expansion[20]

The implementation of the Affordable Care Act saw an array of new taxes and fees to recoup some revenue for the federal government. These taxes were largely skewed towards the wealthy, and include a 3.8 percent tax on investment returns above a certain threshold as well as a 0.9 percent Medicare tax hike on high-income earners.

[20] National Academy for State Health Policy - "Where States Stand on Medicaid Expansion." Accessed May 5, 2019. https://nashp.org/states-stand-medicaid-expansion-decisions/

SCOPE OF DEBATE

1. Key Issue - Single Payer Healthcare

Brief Description

Some say that a single payer system would address[21] several issues in the U.S. system. A single payer healthcare system would be a major step towards guaranteeing universal healthcare for Americans. Overall expenses would be better regulated through cost control and lower administrative costs, as evidenced in other single payer healthcare systems in countries like Sweden or Australia.

At the same time, one must also recognize the potential tradeoffs of transitioning to a single payer system. Experts have warned that there could be longer waiting times and certain controversial healthcare services such as sex reassignment surgeries or cosmetic procedures may not be covered under the single payer healthcare system. However, the main concern is the economic sustainability of this system. As will be mentioned later in the case study of Vermont, a proposed single payer system could not be enacted due to insufficient funds to maintain the programme. The single payer system also puts a big strain on the taxpayers as countries who adopt the single payer system generally have relatively higher taxes than the rest.

In conclusion, a single payer healthcare system has the capability to address issues such as accessibility and affordability plaguing the current healthcare system. In fact, a similar system called Medicare is in place, but it is only available to the elderly and other disadvantaged groups. Nearly half of American voters have indicated an interest in adopting a single payer healthcare system and protests are common for the nation to adopt this system with the slogan 'Medicare for all' being used frequently. As the meaning of the phrase suggests, all Americans want to experience the benefits of Medicare and do not want to restrict it for certain demographics.

Given single payer's fiscal strain on the state and federal governments, as well as the taxpayers, is this system sustainable in the long run? Moreover, should controversial medical operations be insured under this scheme? While there are also sizable benefits to a single payer healthcare system, these are some of the significant drawbacks which delegates have to consider as well.

[21] Christopher, Andrea S. "Single payer healthcare: Pluses, minuses, and what it means for you." Harvard Health Publishing, Accessed March 2, 2019.
https://www.health.harvard.edu/blog/single-payer-healthcare-pluses-minuses-means-20160627983

2. Case Studies

2.1 Vermont

In 2011, the northeastern state of Vermont implemented a single payer healthcare system, which was spearheaded by the efforts of then-Governor Peter Shumlin. The state legislature passed Act 128, which compelled the state government to design a new healthcare model for Vermont and allocated $300,000 to the Health Care Reform Commission to hire consultants to design three plans for achieving universal coverage, which was named Green Mountain Care. This programme was a reformation to the already established Affordable Care Act. The three consultants chosen were led by Harvard health economist[22] William Hsiao, a well-known expert on health system reform who had advised Taiwan during her transition to a single payer system.

Green Mountain Care[23] had to gain approval from the federal government to use federal health finances to fund the state program, along with the state of Vermont itself too preparing $2 billion. However, by April 2014, Vermont had yet to prepare the $2 billion in extra funding required for the creation of Green Mountain Care. Funds were severely deficient to establish this programme. To run the programme, the report by Hsien and his team of consultants revealed that an 11.5 percent payroll tax on businesses and a new income tax of up to 9.5 percent was needed, but this was considered simply infeasible to pass. Shumlin ultimately decided to drop this Act as it would cost Vermont $4.3 billion per year, which is almost the size of the state's annual budget of $4.9 billion. As such, the single payer model was scrapped as it was simply not economically sustainable for the Vermont state government.

Politically, Shumlin suffered at the ballot box when he ran for reelection, only winning the popular vote by a percentage point in a heavily Democratic state. His poor performance is largely attributed to voters' dissatisfaction with his efforts on the healthcare front.

[22] VerValin, Joe. "The Rise and Fall of Vermont's Single Payer Plan." Cornell Policy Review, Posted July 13, 2017 http://www.cornellpolicyreview.com/rise-fall-vermonts-single-payer-plan/
[23] Kertscher, Tom. "Vermont single-payer was scrapped because it was going bankrupt? No, it was never implemented." Politifact, Published 20 September, 2017 https://www.politifact.com/wisconsin/statements/2017/sep/20/sean-duffy/vermont-single-payer-was-scrapped-because-it-was-g/

2.2 California

In 2012, the California State Senate failed a Bill to introduce a single payer healthcare system in the state. Although this period was under the Obama administration, one where there were major prospects for significant healthcare reform, this Bill did not come to fruition for various reasons. These included a US$16 billion[24] budget deficit faced by California at that point in time and fears by Democrats that the bill was too expensive and too dramatic of an overhaul.[25] Unsurprisingly, not a single Republican California State Senator voted for this bill, and amongst the Democratic California State Senators, six failed to vote for this bill, of which two voted no and four abstained.

At that point in time, five of the six State Senators who failed to vote for the Bill received money from Big Pharma and other insurance companies, with each of them receiving in excess of US$100,000. Support for a single payer healthcare system in California was quite prominent at that point in time, with unions such as the California School Employees, California Nurses supporting such a system. A poll conducted 3 years prior, in 2009, showed that 65 percent of Americans support such a system.[26]

Costs aside, given the relatively large support for single payer healthcare, why would this Bill fail? Inherently, healthcare providers also have a large say in this as well. As stated earlier, Big Pharma, as well as other insurance companies, have given large handouts of money to the senators to try to influence their votes. Such actions are a component of a bigger phenomenon known as lobbying. Due to the sheer size and immense power of these healthcare corporations and providers, lobbying is a serious issue in the United States.

Why do lobbyists disapprove of a single payer healthcare system then? Big Pharma, as well as insurance companies, are concerned that such a system would decrease their bargaining power in the healthcare sector, lowering their potential profits. While California is currently considering implementing statewide universal healthcare, it is not only met with intense criticism from the Trump administration but also intense opposition from these lobbyists, which seek to maintain the high costs of treatment and medication, and the prevalence of private insurance in the United States.

[24] Reuters. "California budget hole deepens to $16 billion: governor." Accessed May 26, 2019. https://www.reuters.com/article/us-california-deficit-idUSBRE84C00D20120513
[25] Potash, Lenny. "Why Did Single-Payer Health Care Fail in California?" Healthcare-Now! Accessed May 26, 2019. https://www.healthcare-now.org/blog/why-did-single-payer-health-care-fail-in-california/
[26] Potash, Lenny. "Why Did Single-Payer Health Care Fail in California?" Healthcare-Now! Accessed May 26, 2019. https://www.healthcare-now.org/blog/why-did-single-payer-health-care-fail-in-california/

As it stands, a majority of American healthcare is centred around private insurance plans. Single payer is deemed by many lobbyists as a threat to their operations. As many American hospitals rely on private insurance reimbursement rates as a source of income, there is major opposition amongst private hospitals when it comes to single payer healthcare.

Lobbying groups such as the American Medical Association (AMA), Pharmaceutical Research and Manufacturers of America (PhRMA) and the Federation of American Hospitals (FAH) have all come out to oppose Medicare for All, spending about US$143m in 2018 alone to achieve this goal.[27] Furthermore, leading insurance, medical, hospital and pharmaceutical lobbyists have formed the Partnership for America's Health Care Future, to curb the expansion of Medicare and Universal Healthcare legislature to be introduced and passed. For instance, this group has been documented to sway candidates in the midterms from discussing single payer reform to discussing possible Affordable Care Act expansions and developments.[28]

Other than lobbyists, lots of medical professionals were against this system, fearing that a single payer healthcare system would decrease their wages and rendering more advanced healthcare procedures more difficult. Transitioning to a single insurance provider eliminates the competition between healthcare providers, and gives a single provider the leverage over the healthcare market which might place their pays at higher risk. Dr. Paul Orloff, a physician who is president of the New York County Medical Society, who has participated with Oxford since 1985, faces the same problems. As Oxford was the only provider at that point in time, they had the right to change the doctors' pays as and when they wanted, and medical professionals had to accept the new rates.

As it stands, some private exchange plans are offering medical professionals 60 to 70 percent of what Medicare offers for the same product. In California currently, a number of private plans offer rates that are significantly lower than the rates offered by Medicare.[29]

Thus, although a single payer system might seem perfect for the United States of America, it is fraught with many disagreements and objections from lobbyists and medical professionals. Given that California, one of the most liberal states in the United States, has failed to pass a single payer healthcare bill, there is great scepticism that such a bill would pass in the United States.

[27] Evers-Hillstrom, Karl. "Big Pharma, Insurers and Hospitals Team Up to Kill Medicare for All." truthout, Published March 9, 2019. https://truthout.org/articles/big-pharma-insurers-and-hospitals-team-up-to-kill-medicare-for-all/
[28] Fang, Lee et al. "Lobbyist Documents Reveal Health Care Industry Battle Plan Against 'Medicare for All'.", The Intercept_, Published November 21, 2018.
https://theintercept.com/2018/11/20/medicare-for-all-healthcare-industry/
[29] Rabin, Roni C. "Doctors Fear Pay Cuts Under Obamacare Coverage." The Fiscal Times, Accessed June 9, 2019.
https://www.thefiscaltimes.com/Articles/2013/11/21/Doctors-Fear-Pay-Cuts-Under-Obamacare-Coverage

2.3 Nordic Countries

As compared to the United States, which spends approximately 17.9 per cent of its GDP on healthcare, several Nordic countries - such as Sweden and Norway, spend around half of that amount - at around 9 per cent of their GDP. Furthermore, the effectiveness of the Nordic countries' healthcare system is much higher than that of the United States, with the rates of death amenable to healthcare, rates of premature death and disease burden being much lower for the Nordic countries than the United States. For instance, Norway's rate of death amenable to healthcare, in terms of deaths per 100,000 of the population, is 64, while that of the United States is 112.[30] This suggests that there are certain areas in the healthcare system that the United States can learn from such countries.

Firstly, there is a relationship between the reliance of private insurance in a country's healthcare system and the country's total healthcare costs; in which there is a positive relationship, as shown in Figure 8 below.

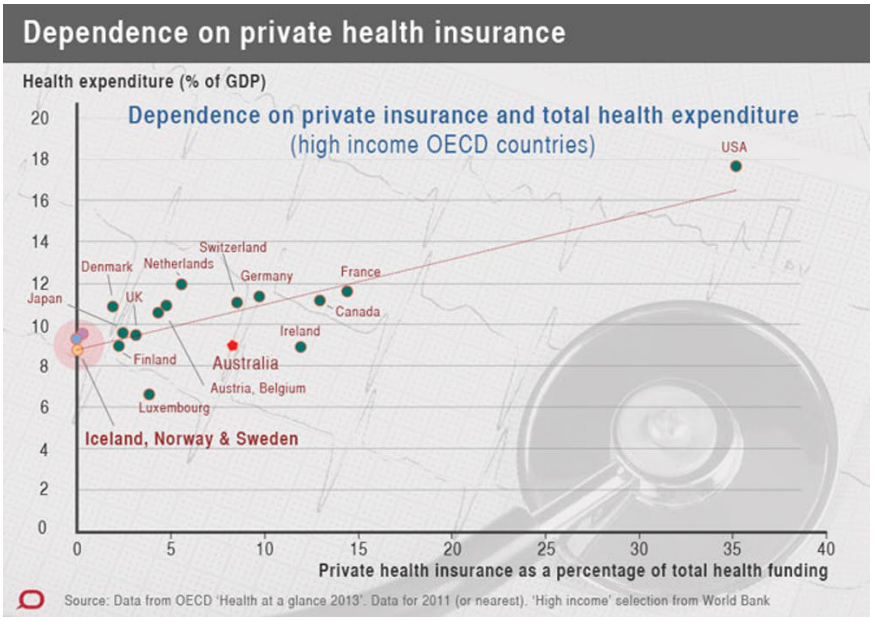

Figure 8. A graph on the relationship between the overall health expenditure (% of GDP) and the reliance on private health insurance in the healthcare system.

Referring to the graph above, there is a positive correlation between private health insurance spending and health expenditure as a percentage of GDP. On the end of the spectrum, Iceland, Norway and Sweden have extremely low levels of private health insurance as total health funding, which suggests that these countries have minimal involvement in private healthcare.

[30] "Mortality Amenable to Health Care (Deaths per 100,000 Population), 2013." International Health Care System Profiles. Accessed May 26, 2019.
https://international.commonwealthfund.org/stats/mortality_amendable/

In both Norway and Sweden however, some forms of healthcare are being provided by private doctors. Private hospitals do exist but are not as prevalent as it is in the United States. Furthermore, in these two nations, there is substantial devolution of policy-making to state and local authorities. For instance, in Sweden, healthcare policy-making is devolved to its 21 county authorities, and in Norway, its 428 municipalities are responsible for such policy-making. The role of tax collection and funding of healthcare services falls on the individual states while standards of care, pricing of drugs and negotiation with large pharmaceutical companies fall on the national government. Owing to demographic differences and disparities between the various regions of countries, devolving the burden and responsibility of decision-making to local authorities would enable a more efficient healthcare system, which would also remove several administrative inefficiencies and unnecessary costs.

Furthermore, these Nordic countries favour a more regulated healthcare system, as seen in how the government controls drug prices as well as the standards of drugs and treatment. This is in contrast to the United States, which as it stands, favours a free-market approach that is centred on competition.

As seen, there is certainly a lot in which the United States can learn from the Nordic countries when it comes to healthcare systems, especially when it comes to the areas of removing administrative inefficiencies and cost reductions.

[34] "A report of the CSIS freeman chair in China studies and the CSIS health policy centre.", Charles W Freeman III. Last Accessed 8 July 2019 https://csis-prod.s3.amazonaws.com/s3fs-public/legacy_files/files/publication/111122_Freeman_ChinaEmergingGlobal-Health_Web.pdf

3. Analysis

3.1 Pros of a Single Payer System

3.1.1 Reduction in Paperwork and Administrative Costs

In the United States, at least 25 percent of healthcare spending goes towards administrative costs. In Canada, this figure is at 12 per cent, less than half of what the United States spends on administration. If the figures were extrapolated, each American worker would spend about $5700 towards administrative costs in healthcare.[31] These administrative costs generate copious amounts of waste, when in fact such funds could go towards increasing the quality and accessibility of healthcare. By having a single payer healthcare system, administrative costs are greatly reduced as it is mainly the government and relevant authorities collating health data. This increases the efficiency of administration and reduces such costs, similar to what is seen in countries with Universal Healthcare systems.

3.1.2 Increased Healthcare Coverage

Roughly 13.7 percent of Americans are uninsured as of end 2018.[32] This figure is expected to increase following the successful repeal of ACA's individual mandate requirement last year. This means that an increasing amount of Americans are left without healthcare coverage. By having a Universal Healthcare System, the number of Americans with basic healthcare coverage would increase. A universal healthcare system would also serve as a basic framework of protection for Americans who do not qualify for Medicaid but are unable to afford insurance.

[31] Frakt, Austin. "The Astonishingly High Administrative Costs of U.S. Health Care." Accessed April 14, 2019. https://www.nytimes.com/2018/07/16/upshot/costs-health-care-us.html
[32] Kliff, Sarah. "Under Trump, the number of uninsured Americans has gone up by 7 million." Vox, Accessed April 14, 2019. https://www.vox.com/2019/1/23/18194228/trump-uninsured-rate-obamacare-medicaid

3.1.3 Increase in the Life Expectancy and Standard of Living of Americans

When compared to other developed countries, the United States' life expectancy of 79.25 years is low. This is coupled with the fact that there is an increasing disparity in life expectancies along wealth lines, with the richest 1 percent of Americans living approximately 15 years longer than the poorest 1 percent of Americans.[33] Part of this could be attributed to the lack of a proper healthcare system for the poorest citizens and their inability to secure proper treatment. A Universal Healthcare system would, at the very least, secure basic medical and healthcare benefits for the poorest citizens and ensure that they get basic treatment, which will improve the general standard of living and life expectancy of Americans.

3.1.4 Lower Long-term Costs

By transferring US healthcare spending from the private sector to the public sector, this would decrease long-term costs. Healthcare schemes such as Bernie Sanders' "Medicare for All" proposal is projected to save the United States around US$2 trillion by 2031.[34] By transferring healthcare spending to the public sector, the government would have a greater say over the prices in the healthcare system. This is greatly beneficial as the prices of private healthcare are significantly more expensive than the prices of healthcare systems in other nations with single payer systems. Referring to the case study on Nordic countries above, the United States spends 17.9 per cent of her GDP on healthcare while Norway and Sweden spend approximately 9 per cent of her GDP on healthcare respectively. Furthermore, the high costs of healthcare in the United States can also be attributed to the relatively higher wages of doctors compared to European countries. In particular, specialists in the United States earn an average of more than $250,000 a year, and it is not uncommon for family practitioners in the United States to clock in more than $200,000 annually.[35] In a country where roughly two-thirds of doctors are specialists, this further exacerbates the high costs in the United States. Whereas specialists in European countries earn much less on average, with the average German specialist clocking in 80,000 euros a year, or just under US$90,000 a year.[36] It is thus hoped that transitioning towards a single payer system would decrease the proportion of medical professionals and specialists in the United States, decreasing healthcare expenditure.

[33] Belluz, Julia. "What the dip in US life expectancy is really about: inequality." Vox, Accessed April 14, 2019. https://www.vox.com/science-and-health/2018/1/9/16860994/life-expectancy-us-income-inequality
[34] Stein, Jeff. "Does Bernie Sanders's health plan cost $33 trillion - or save $2 trillion?" The Washington Post, Accessed May 26, 2019. https://www.washingtonpost.com/business/economy/does-bernie-sanderss-health-plan-cost-33-trillion--or-save-2-trillion/2018/07/31/d178b14e-9432-11e8-a679-b09212fb69c2_story.html?noredirect=on&utm_term=.3f9eb50c05b6
[35] Baker, Dean. "The problem of doctors' salaries." Politico, Accessed May 26, 2019. https://www.politico.com/agenda/story/2017/10/25/doctors-salaries-pay-disparities-000557
[36] "Foreign Doctors in Germany." How to Germany, Accessed 26 May, 2019. https://www.howtogermany.com/pages/international-doctors.html

3.2 Cons of a Single Payer System

3.2.1 High Initial Cost

Following Senator Sanders' (I-VT) plan to introduce universal healthcare for American citizens, an additional US$2.8 trillion would be spent each year, amounting to a total of $33 trillion by 2031.[37] For comparison, healthcare spending in the United States was US$3.5 trillion, or US$10,739 per citizen in 2017. The additional initial costs that a single payer healthcare system would create is inherently large. Correspondingly, the additional amount of taxpayer money which needs to be collected and diverted towards this cause is immense. In addition, this would dwarf the other areas in which the federal government spends its money on, which could have economic ramifications for the United States. Steep income tax hikes would also be projected should a single payer system be enacted, which might place an unfair burden on the American middle-class.

3.2.2 Dramatic Change from the Status Quo

As of 2016, around 155 million Americans aged under 65 have employer-sponsored insurance. This represents around three-quarters of working Americans.[38] Implementing a single payer system might seem counterproductive then, seeing as how most Americans rely on private corporations for healthcare treatment. This is especially so in the context of Bernie Sanders' new "Medicare-for-All" plan, which aims to transition Americans from private insurance to government-sponsored and funded insurance schemes. Considering that employer-sponsored insurance is a key incentive for employment in the United States, this leaves much room for free-market competition between various companies. There is a lot of competition between companies to offer the most attractive insurance scheme, and this manifests in the quality of healthcare schemes offered by them, with several companies even offering coverage for autism, and relevant insurance companies offering speech and music therapy.[39]

[37] Stein, Jeff. "Does Bernie Sanders's health plan cost $33 trillion - or save $2 trillion?" The Washington Post, Accessed May 26, 2019.
https://www.washingtonpost.com/business/economy/does-bernie-sanderss-health-plan-cost-33-trillion--or-save-2-trillion/2018/07/31/d178b14e-9432-11e8-a679-b09212fb69c2_story.html?noredirect=on&utm_term=.3f9eb50c05b6
[38] Mangan, Dan. "Number of people with health insurance via jobs remained steady with Obamacare." CNBC, Accessed 14 April, 2019.
https://www.cnbc.com/2016/07/13/number-of-people-with-health-insurance-via-jobs-remained-steady-with-obamacare.html
[39] Delbanco, Suzanne. "What can tech companies teach us about health care benefits?" Linkedin, Accessed 14 April, 2019.
https://www.linkedin.com/pulse/what-can-tech-companies-teach-us-health-care-benefits-delbanco

3.2.3 Ineffective at Treating Complicated Illnesses

Barring the terms and conditions of a particular insurer, private healthcare insurers are generally more able to provide treatment of better quality, especially when it comes to the treatment of complicated illnesses which public clinics are generally less able to do. This is because private healthcare firms do not have to suffer from the high bureaucratic costs that public sector firms face, and that private sector companies have more incentives to be efficient. As seen in the United States, the general quality of specialised healthcare is very high, especially when compared to many nations which practice a single payer healthcare system. To back this claim, USA has a 64.7 percent survival rate for patients diagnosed with colorectal cancer, as compared to Norway, Singapore and the United Kingdom, which have rates of 62.9 per cent, 59.2 percent and 54.5 percent respectively.[40] It is noted that the latter 3 countries have healthcare systems with a heavy state presence. This could be attributed to the higher quality of health treatment received by Americans as compared to citizens from other countries.

3.2.4 Longer Waiting Times

According to data from the Commonwealth Fund, 42 percent of Canadians waited for 2 hours or more in emergency rooms, as compared to 29 percent in the United States; 57 percent of Canadians waited for 4 weeks or more to consult a specialist, as compared to 23 percent in the United States.[41] In a 2009 survey, the average waiting time for an orthopaedic surgeon across the United States is just 17 days, which is very low when compared to other nations with universal healthcare schemes.[42] It is now apparent that having a more personalised and privatised healthcare system allows for shorter waiting times, especially in the context of emergency and critical medical treatment.

[40] Organisation for Economic Co-operation and Development "Health Status." Accessed 14 April, 2019. https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#
[41] Schoenbaum, Stephen C. et al. "Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care." The Commonwealth Fund, Accessed 14 April, 2019. https://www.commonwealthfund.org/publications/fund-reports/2007/may/mirror-mirror-wall-international-update-comparative-performance
[42] http://www.merritthawkins.com/pdf/mha2009waittimesurvey.pdf Accessed 14 April, 2019.

3.2.5 Healthcare Rationing

Healthcare rationing means restricting the availability of healthcare for certain people. It is widely thought that in order to transition towards a single payer system with increased governmental control and oversight, the government or relevant agencies would have to restrict access to healthcare for some people in favour of others, through longer wait times and prioritisation of certain treatments.[43] Currently, a different type of healthcare rationing is present in the United States, that is, rationing by income. A prime example is how then-Governor Jan Brewer and Arizona Republicans opted to ration care in 2010, effectively cutting off payments for organ transplants and restricting access to healthcare for over 300,000 low-income adults.[44] Because prices cannot be used to ration and discern who receives or does not receive healthcare in a single payer system, there have to be some other method of rationing procedures in place instead of money.[45] This is a popular Republican attack against government intervention in the healthcare free market, popularised by former Alaska Governor and Vice-Presidential candidate Sarah Palin.

3.2.6 Stifles Innovation

It is a well-known fact that the United States champions medical research and engineering, and that most of her ability to do so can be attributed to the structure of her healthcare system. Around 40 per cent of medical breakthroughs and medical research papers stems from the United States.[46] It is also claimed that 5 American hospitals alone contribute more clinical research than the rest of the hospitals in the O.E.C.D. combined.[47] Due to the American healthcare system being able to conduct more challenging medical procedures, it follows that there would be more room for innovation and development of medical techniques to be employed in clinics and hospitals. It is highly unlikely that there would be such funds for innovation under a universal healthcare system due to a lack of profit margins and a need to treat more patients with commonplace medical conditions.

[43] healthinsurance.org "rationing." Glossary, Accessed 26 May, 2019.
https://www.healthinsurance.org/glossary/rationing/
[44] Emanuel, Ezekiel J. et al. "How Republicans Plan to Ration Health Care." The New York Times, Accessed 26 May, 2019.
https://www.nytimes.com/2017/03/07/opinion/how-republicans-plan-to-ration-health-care.html
[45] Miller, Tracy. "To be Sustainable, Universal Health Care Requires Rationing." Accessed 26 May, 2019.
https://www.faithandfreedom.com/universal-health-care-requires-rationing/
[46] Herper, Matthew. "The Most Innovative Countries In Biology And Medicine." Forbes, Accessed April 14, 2019.
https://www.forbes.com/sites/matthewherper/2011/03/23/the-most-innovative-countries-in-biology-and-medicine/#1fc-0c2661a71
[47] Kristof, Nicholas. "Franklin Delano Obama." The New York Times, Accessed April 14, 2019.
https://www.nytimes.com/2009/03/01/opinion/01Kristof.html

4. Other Proposals and Initiatives - The Graham Cassidy Bill

The Graham Cassidy Bill was a proposed Republican healthcare reform package after the failure of the repeal efforts in July 2017. This Bill, crafted by Senators Bill Cassidy (R-La.), Lindsey Graham (R-S.C.), Dean Heller (R-Nev.) and Ron Johnson (R-Wisc.), makes some key changes to the healthcare system. Instead of funding Medicaid and the affiliated subsidies directly, the money would instead be put into a block grant that the state could use to develop the healthcare system of its choice. It also allows states to opt out of Affordable Care Act regulations. "If you like Obamacare, you can keep it," Graham has said, but "if you want to replace it, you can."[48]

Democrats refute this claim, arguing that with federal funding for the block grants projected to be abolished by the year 2027, it is impractical for states to continue implementing Obamacare. Both the states of New York and California, home to large and important American cities, are expected to be the hardest hit by this cut in funding. Republicans, on the other hand, have maintained that by cutting the funding, it would force states to be more efficient with their respective healthcare structures. Ultimately, under this Bill, state governments get authority over their respective healthcare markets with minimal federal involvement. Some key details regarding this Bill are on the next page.

[48] Soffen, Kim. "There's one Obamacare repeal bill left standing. Here's what's in it." The Washington Times, Accessed April 4, 2019. https://www.washingtonpost.com/graphics/2017/politics/cassidy-graham-explainer/?utm_term=.3c49269f9b38

Affordable Care Act	**Amendments in the Graham Cassidy Bill**
Employer mandate requires larger companies to offer affordable coverage to their employees.	Mandate would be eliminated.
The individual mandate requires citizens earning above 133 percent of the federal poverty line to obtain private healthcare insurance else face a tax penalty.	The tax penalty and mandate would be scrapped.
Insurers can charge older customers up to three times as much as they charge younger customers.	Insurers would be able to charge older customers up to five times as much as they charge younger customers. However, individual states can overrule this.
Insurers are required to cover certain categories of essential health benefits, such as hospital visits and mental-health care.	Various health benefits would be removed, and each state would have greater autonomy over which health benefits constitutes as 'essential'.
Individual states can expand Medicaid to cover people making up to 138 percent of the poverty line, and the federal government will cover an outsized portion of their costs.	For states that expand Medicaid, the federal government would pay a smaller portion of the cost starting in 2020.
Medicaid is an open-ended welfare program and federal funds were matched for anyone who qualified.	Medicaid would be funded by giving states a block grant beginning in 2020.

The Graham Cassidy Bill demonstrates conservative principles such as a smaller federal government with greater autonomy for states, as well as a reduction in expenditure on welfare schemes to promote efficiency and balanced budgets. The Bill was initially perceived to be easily passe, but ultimately failed due to its rushed timeframe and ambivalence amongst moderate Republican Senators like Lisa Murkowski (R-Alaska) and John McCain (R-Ariz.) which eroded support for a dramatic overhaul of the system with little to no hearings.[49]

An important point to note is that with the attempt to pass the Bill through the reconciliation process, which would only require 50 votes in favour, it is likely that certain provisions would violate the Byrd Rule for their "non-budgetary" nature. A post by Medium is attached below for your perusal to have a better understanding of the provisions that could have potentially been struck if the Bill had been brought up to a vote:
https://medium.com/whatever-source-derived/graham-cassidy-is-on-a-collision-course-with-the-byrd-rule-50a760f09419

[49] Haberkorn, Jennifer. "Inside the life and death of Graham-Cassidy." Politico, Accessed 15 June, 2019. https://www.politico.com/story/2017/09/27/obamacare-repeal-graham-cassidy-243178

LINK TO SUSTAINABLE DEVELOPMENT

Four years ago, the United Nations established a set of seventeen Sustainable Development Goals to ensure that countries meet the needs of the present without compromising the ability of future generations to meet their own needs. Of these goals, "Good Health and Well-Being" is most applicable to the issue at hand. It is imperative for the United States not just for economic reasons, but also moral reasons, to design a sustainable system that ensures its citizens can receive quality and affordable healthcare services. A healthy population will give rise to increased productivity and happiness, spurring a virtuous cycle of economic activity and prosperity. Affordable healthcare coverage will also save lives and better support those on the lower rungs of the socioeconomic ladder.

Furthermore, the United Nations General Assembly has adopted the goal of universal health coverage by 2030. This highlights the amount of pressure the international community places and the extent to which it values universal healthcare.

KEY SENATORS

Republican Party (majority)	Democratic Party (minority)
Mitch McConnell Senate Majority Leader (KY)	Chuck Schumer Senate Minority Leader (NY)
Lamar Alexander Chairman of the Health, Education, Labor and Pensions Committee (TN)	Patty Murray Ranking Member of the Health, Education, Labor and Pensions Committee (WA)
Ted Cruz Junior Senator (TX)	Bernie Sanders Junior Senator (VT)
Lisa Murkowski Senior Senator (AK)	Kamala Harris Junior Senator (CA)
Rand Paul Junior Senator (KY)	Amy Klobuchar Senior Senator (MN)
Lindsey Graham Senior Senator (SC)	Joe Manchin Senior Senator (WV)
Mitt Romney Junior Senator (UT)	Cory Booker Junior Senator (NJ)
Chuck Grassley Senior Senator (IA)	Tim Kaine Junior Senator (VA)
Steve Daines Junior Senator (MT)	Chris Murphy Junior Senator (CT)
Thom Tillis Junior Senator (NC)	

There are three broad blocs encompassing the general positions taken on the healthcare debate, but do note that each Senator's individual stance is more nuanced.

Conservative Bloc

The conservative group consists of Senators like Ted Cruz and Mitch McConnell, who have strongly denounced ObamaCare and repeatedly pledged to "repeal and replace" the law. A conservative vision for healthcare can be found in the American Health Care Act, which eliminated the individual mandate, employer mandate and most of the taxes under the Affordable Care Act. It also gave states more leeway in determining "essential health benefits" (refer to Figure 6), rolled back the Medicaid expansion and did away with the minimum medical loss ratio.

Moderate Bloc

The moderate wing includes Senators Lamar Alexander and Patty Murray, the leaders of the Health, Education, Labor and Pensions Committee. Their most notable attempt was the ultimately unsuccessful Bipartisan Health Care Stabilisation Act, which aimed to shore up insurance markets by restoring cost-sharing reduction payments to insurance companies for an interim period of two years. These payments reimbursed insurers for holding down out-of-pocket costs for low-income ObamaCare consumers, but had been nixed by the Trump administration in 2017 which prompted premium spikes.[50]

Liberal Bloc

The liberal bloc includes Senators like Bernie Sanders and Kamala Harris who have endorsed a sweeping single payer plan that would overhaul the system in place presently. Senator Harris is co-sponsoring Senator Sanders' Medicare for All Act which would establish a universal Medicare program covering every American resident in a government-run system. Under this scheme, consumers are not subjected to any out-of-pocket health-related expenditures except for prescription drugs, and employers are prevented from offering competing healthcare plans.[51]

[50] Kilgore, Ed. "Alexander and Murray's Bipartisan Obamacare Alliance Disintegrates." New York Intelligencer, Accessed May 9, 2019.
http://nymag.com/intelligencer/2018/03/the-bipartisan-obamacare-alliance-disintegrates.html
[51] Kliff, Sarah. "Bernie Sanders's Medicare-for-all plan, explained." Vox, Accessed May 9, 2019.
https://www.vox.com/2019/4/10/18304448/bernie-sanders-medicare-for-all

QUESTIONS A BILL MUST ANSWER

1. **Is access to quality and affordable healthcare an inherent right or a privilege?**

2. **Is healthcare a business or a public good? To what extent should the government be involved in the provision and regulation of healthcare?**

3. **Would it be more efficient to modify the existing framework of the Affordable Care Act, or to repeal it and move on to a different system?**

4. **How do we balance the competing interests of the different stakeholders, which include patients, physicians, employers, insurance companies and pharmaceutical firms? Whose interests are given the highest priority?**

5. **How do we build a sustainable healthcare system that will not require any further reforms in the foreseeable future?**

APPENDIX

How to Effectively Role-Play as a Senator

In this council, sticking to stance is extremely important to model the workings of the United States Senate and foster productive debate. Therefore, delegates should do adequate research to be well-versed on their Senator's stance on the issue of healthcare reform. Some resources to help you are provided below, but you are expected to read beyond these to better immerse yourself in your Senator's role.

- http://www.ontheissues.org/Senate/Senate.htm gives a brief summary of each Senator's position and key quotes relevant to the issue of healthcare.

- https://votesmart.org/ gives a detailed voting record on legislation related to healthcare.

- https://www.washingtonpost.com/graphics/2017/politics/health-care-senate-amendment-votes/?noredirect=on&utm_term=.8ebb07cab0cc#skinny-repeal gives Senators' positions on the specific proposal Senate Republican leadership rolled out to repeal and replace the Affordable Care Act in July 2017.

- You may find more specific information on individual Senators' websites.