## 1NCs

### 1NC Public Option

#### Instead of <<<PLAN>>> the United States federal government should spend the funds allocated by the aff to pursue a public option.

#### The plan trades off with a public option in terms of economics AND political capital

Annie **Lowrey 18**. Staff writer at The Atlantic. “A Promise So Big, Democrats Aren’t Sure How to Keep It,” The Atlantic. May 11, 2018. <https://www.theatlantic.com/ideas/archive/2018/05/the-democratic-party-wants-to-end-unemployment/560153/>,

For some Democratic policy wonks, the trade-offs in both economic and political capital seem the most salient. What do you give up by implementing a jobs guarantee? What comes first: a public option for health insurance, or a major jobs plan, or an expansion of the Earned Income Tax Credit, or a universal child allowance, or a major educational debt-relief plan, or postal banking—all of which are ideas being pushed by Democratic presidential aspirants right now?

#### The plan costs over 500 billion dollars.

Mark Paul 18. Postdoctoral Associate at the Samuel DuBois Cook Center on Social Equity at Duke University. “The Federal Job Guarantee – A Policy to Achieve Permanent Full Employment,” Center on Budget and Policy Priorities. March 9, 2018. https://www.cbpp.org/research/full-employment/the-federal-job-guarantee-a-policy-to-achieve-permanent-full-employment

Program uptake and costs are challenging to estimate for a program that will have profound implications for the economy. Make no mistake, this is a policy to transform the U.S. labor market. For instance, a recent Economic Policy Institute report analyzing the effect of a $15 minimum wage phased in by 2024 found that 41 million workers, roughly 29 percent of the wage-earning workforce, would see a raise. While the wage rate in the NIEC is lower than this, taking benefits into account may result in a comparable change within the labor market—leading to the direct employment of millions and raises for tens of millions. In this section, we provide estimates for program uptake and costs under a job guarantee program in the United States. Table 1 provides estimates for program uptake and gross cost under the NIEC given the most recent labor market statistics. Using January 2018 data from the Bureau of Labor Statistics, we estimate a total annual program cost of $543 billion, or just under 3 percent of GDP. While headline economic numbers commonly cite the official unemployment measure, we generate the estimate using a broader notion of unemployment and underemployment, known as U-6. We assume U-6 would be brought down to 1.5 percent—what we believe to be a reasonable estimate for frictional unemployment in the U.S. economy—by the uptake of employment through the NIEC and the elimination of involuntary unemployment. This would result in the employment of 10.7 million workers, or 9.7 million full-time equivalent positions.

#### So does the public option.

**PNHP n.d.** Physicians for a National Health Program, “The ‘Public Plan Option’: Myths and facts,” PNHP. <http://www.pnhp.org/change/Public_Option_Myths_and_Facts.pdf>

Myth: A public option will provide everyone with the security that quality, affordable coverage will always be there. Fact: Our health care system is unsustainable. Health care reform that includes a public plan option will add hundreds of billions of additional dollars annually on top of 2.5 trillion dollars, (twice what any nation spends per person). We have vast domestic and international experience with public option schemes, and in no case have they resulted in universal coverage. This is because private insurance companies seek to enhance their profits by screening out sick and unprofitable patients, ultimately relegating most of the sick and costly to the public system, which quickly comes unraveled due to rising costs. Absent effective cost control, any increase in coverage or benefits will quickly be erased by rising costs. In conclusion, a public plan option does not lead toward single payer, but toward the segregation of patients, with profitable ones in private plans and unprofitable ones in the public plan.

### --Impact – Monopolies

#### Insurer and provider consolidation undermines care and jacks-up costs.

Brent D. Fulton 17. Assistant Adjunct Professor in the School of Public Health at Berkeley. “Health Care Market Concentration Trends In The United States: Evidence And Policy Responses.” *Health Affairs*. 36(9): 1530-8. Emory Libraries.

The US health care system relies on competition in the provider and health insurer markets to lower costs and improve quality. However, the market concentration of hospitals and insurers has been a matter of concern for several decades.1⇓⇓⇓⇓–6 More recently, Martin Gaynor and colleagues reviewed studies of the competitive landscape of hospitals, health insurers, and physician services and found that hospital and health insurer markets have become more concentrated since the 1990s.7

To measure market concentration, the Antitrust Division of the Department of Justice (DOJ) and Federal Trade Commission (FTC) often use the Herfindahl-Hirschman Index (HHI), which is calculated by squaring the market shares of each firm competing in a market and summing those values across all firms, resulting in a range from 0 to 10,000.8 Gaynor and colleagues reported that 65 percent of Metropolitan Statistical Areas (MSAs) had highly concentrated hospital markets (those with HHIs greater than 2,500) in 1990, and that share had increased to 77 percent by 2006.7 By way of example, an HHI of 2,500 could result from each of four firms in a given market having a 25 percent market share. There is less historical information on concentration in physician markets, but Gaynor and colleagues reported that those markets were generally unconcentrated (with HHIs less than 1,500), particularly for primary care physicians.

Although provider concentration could produce efficiencies that benefit purchasers of health care services, the evidence does not point in that direction. For example, reviews of studies of hospital markets have found that concentrated markets are associated with higher hospital prices, with price increases often exceeding 20 percent when mergers occur in such markets.7,9 Of even greater concern, the reviews found that these price increases did not appear to improve quality: In some cases, higher hospital concentration was associated with higher mortality rates.

In comparison to the number of hospital market studies, a relatively small number of studies has examined the impact of physician organization concentration. Overall, these studies found that higher concentration was associated with higher physician prices across a range of services, including three types of commonly billed office visits,10 office visits across ten prominent specialties,11 orthopedics,12 cardiology and orthopedics,13 and common outpatient procedures.14

A significant share of health care services in the United States is purchased by health insurers via employer-sponsored insurance and the individual market, including the Affordable Care Act Marketplaces. Increased health insurer concentration could result in lower premiums to employers and consumers along two pathways: having efficiencies from economies of scale and insurers’ negotiating lower prices with hospitals and physician organizations that are attempting to charge prices above the competitive level. To some extent, research shows that this is happening, with higher health insurer concentration being associated with lower hospital15⇓–17 and physician prices.10,17 However, the evidence shows that these price reductions are not passed on to consumers. A number of studies have found that higher health insurer concentration leads to higher premiums,7,18 including for employers19⇓–21 and for individuals purchasing Marketplace plans.22 (This effect was moderated in Covered California, the Marketplace in an active-purchaser state that selectively contracts and negotiates premiums with insurers.)23

#### The public option solves---it injects competition through a government plan.

Ethan Kaplan & Melissa A. Rodgers 9. \*PhD, Columbia University and Fellow at the Institute for International Economic Studies. \*\*JD, Professor at the Berkeley Center on Health, Economic, & Family Security. “The Costs and Benefits of a Public Option in Health Care Reform: An Economic Analysis.” *Berkeley Law*. October. <https://www.law.berkeley.edu/files/chefs/Public_Option_Economic_Analysis.pdf>.

Each of the health care bills under serious consideration dramatically expands health insurance coverage, leaving open the question of how to best reduce costs without compromising access or quality. The purpose of the public option is largely to inject greater competition in the health insurance market and thus reduce costs, both of total health expenditures as well as public sector costs of subsidizing health care. The status quo involves:¶ Š Health care expenditures of $2.2 trillion in 2007. The United States GDP in 2006 was $13,195 trillion. This means that 16 cents of every dollar spent was spent on health care.1¶ Š The federal government subsidizing health care by allowing firms to purchase health insurance for their employees with pre-tax dollars, at a cost of $246 billion in the year 2007.2¶ Overall reductions in health care costs, therefore, will not only affect individual and employer spending, but also dramatically increase tax revenues to the government. This in turn will improve fiscal balance in our economy.¶ Whether health care reform will reduce the growth in health care spending depends on what elements of the House, Senate HELP, and Senate Finance Committee bills survive the legislative process. Congressional proposals contemplate that with health care reform tens of thousands of uninsured Americans will gain access to health insurance. In addition to Medicaid expansions for the lowest-income Americans, current legislative proposals include subsidies for Americans between 133%3 and 400% of the federal poverty level who buy health insurance through a marketplace known as a health insurance “exchange.” Insurers who offer products in the exchange will then compete for the greatest market share of these new customers. Robust competition in the exchange is necessary to control costs. The two main visions for how to inject meaningful competition into the exchange are (1) through health insurance cooperatives as proposed by the Senate Finance Committee and (2) through an additional public option as set forth in the Senate HELP Committee bill and most clearly in the House bill.¶ Existing cost estimates from the Congressional Budget Office, the Lewin Group and the Urban Institute all agree that a public option would reduce overall health care costs in the United States and save the federal government money.¶ Debates about the merits of including a public option in health care reform have thus far focused on ideological policy preferences. This brief is designed to clarify the underlying assumptions behind existing cost estimates and make the models more accessible to policy makers. This brief analyzes existing models of health insurance markets in general and the public option in particular. It points to flaws in modeling of the health insurance market presented in the existing models, which most likely lead to an overestimate of the costs and an underestimate of the benefits of the public option. The projections considered in this brief come from the Congressional Budget Office (CBO), the Lewin Group, Price Waterhouse Cooper, and the Urban Institute, all of which have developed economic models that have been used to estimate the net cost of implementing the various health care proposals being debated in Congress (see Figure 1). It is important to note that only the Urban Institute has explicitly looked at the costs and savings of the public option. It estimates that a public option would generate $788 billion of savings over a ten year period, $400 billion of which would accrue to the government. The Lewin group has modeled the additional savings that a widely-available public option would generate and finds similar fiscal savings levels of approximately $48 billion per year or $500 billion over ten years.

**We’re heading towards fiscal Armageddon---try or die to reduce healthcare costs**

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Both **private and public payers** have experienced a **persistent rise in health care spending** that has **exceeded income growth**. The issue now transcends the health care system because **health care spending growth threatens the fiscal health of the nation**. This paper examines the causes and consequences of health care spending growth. It notes that the determinants of spending growth may differ from the determinants of high spending at a point in time. Specifically, the evidence overwhelmingly suggests that the primary driver of inflation-adjusted, per capita spending growth over the past decades (and thus premium growth) has been the diffusion of new medical technology. The paper argues that while new technology has provided significant clinical benefit, we can **no longer afford** the **persistent gap** between health spending and income growth. In simple terms, **if the economy is growing 2%, we cannot afford persistent health care spending growth of 4%.** Growth in public spending is particularly important. **If not abated**, high public spending will require either **substantially higher** taxes or **debt**, both of which could lead to **fiscal Armageddon**. Growth in **private spending** also threatens **economic well-being** by forcing **more resources toward health care** and **away from other sectors**. For example, since the cost of employer-based coverage is always borne by employees (directly or indirectly), **salary increases** and health care cost increases **cannot continue on together**. **To avoid economic disaster**, payers will be forced to have a **greater resolve** in the future. Specifically, because **neither public nor private payers will be able to finance growing health care spending**, the coming decade will likely experience significant changes in health care financing. Consumers may be asked to pay more out of pocket when they seek care and both public and private payers will put increasing pressure on payment rates. Furthermore, payment rates to providers are likely to rise more slowly than in the past, likely by less than inflation, and a new form of payment that bundles reimbursement across providers and services will be implemented. All stakeholders, particularly health care providers, will need to adapt to the pressure. Ideally, this will lead to more efficient care delivery that will require a partnership among major stakeholders to develop systems of managing population health in ways that promote affordable, high-quality outcomes. In the United States, inflation-adjusted national health expenditures have increased from approximately $150.6 billion in 1960 to $2,156.1 billion in 2008 (Centers for Medicare and Medicaid Services [CMS] 2010a). This represents an average annual growth rate of approximately 5.7%. These numbers are not simply a result of increases in the size of the population. Annual real per capita national health expenditures have increased dramatically too, at an annual rate of 4.7%, from an average of $796 per person in 1960 to $7,080 in 2008 (CMS 2010a). Nominal spending growth (not adjusted for inflation) was even more dramatic. Moreover, the increase in health care spending relative to income has been **persistent**. Health care spending growth in the United States has exceeded gross domestic product (GDP) growth for every 10-year period since World War II. On average, the annual gap between real per capita health spending growth and real per capita GDP growth from 1970 to 2008 has been about 2.2 percentage points (CMS 2010a). Projections (prior to health reform) suggested that total health care spending would consume 26% of GDP by 2035 (Congressional Budget Office [CBO] 2010b). **Under even favorable assumptions**, the coming several decades will see health care **absorb** about **twice the share of income growth** as in past decades (Chernew, Hirth, and Cutler 2009). **The Specter of Fiscal Armageddon** Given the growing share of national income devoted to health care, its large share of the federal budget (19% in 2009), and new commitments to public financing of care contained in recent health reform legislation (the Patient Protection and Affordable Care Act or PPACA), the consequences of health care spending growth transcend health care (The White House 2010). Peter Orszag, former director of the Congressional Budget Office and Office of Management and Budget, has testified before Congress and written that ‘‘the **nation’s long-term fiscal balance** will be determined **primarily by the future rate of health care cost growth’’** (Orszag 2007). Specifically, in 2010 the Medicare Trustees Report forecast that under the reasonable ‘‘alternative scenario,’’ which assumes draconian payment cuts will not occur, Medicare alone will represent 11% of GDP by 2084 (CMS 2010b). This spending can **only be financed by higher debt** or higher taxes. It is unlikely that the electorate would be willing to accept taxes of the magnitude necessary to finance growing health care expenditures. Historically, the share of the economy devoted to federal taxes has been consistently around 20%. Continued health care spending growth, relative to income, would necessitate taxing well outside of that range (CBO 2007). For example, analysis in 2007 by the CBO suggested that financing even a 1% gap between income and health spending growth without cutting other public programs would require an increase in taxes of more than 70% by 2050, which would bring the highest tax rate to 60% and have broad adverse economic ramifications. An alternative financing strategy would be to finance health spending with increased debt. Economists often measure the size of the debt relative to the overall economy, or the debt-to-GDP ratio. To finance this debt, the government issues interest-bearing bonds. In the United States, **interest payments** increasingly are consuming more of the federal budget ($684 billion in 2009 or 1.2% of GDP) (CBO 2009), thus **reducing the monies** available for either **public programs** or tax reductions. **Growing debt** can also lead to **higher interest rates** for all borrowers (government, businesses, and individuals), thus **slowing economic growth** and improvements in standards of living. **High debt** also reduces our capacity to **respond to sudden economic shocks**, **such as those created by economic downturns**, and **magnifies the detrimental effects of any deficit**. National economies can bear **substantial debt** for many years with relatively few adverse consequences. Most economists agree that there is some level of debt that is more than economies can bear, but do not agree on where this threshold lies. The European Union has set the maximum debt-to-GDP ratio at 60% for member countries (which is often exceeded), but some economic research suggests that **percentages under 90%** are manageable without **significant overall harm to the economy**, and in fact many countries exceed this threshold. In 2009, the U.S. debtto-GDP ratio was 55%, which is moderate relative to that of other countries. **While this suggests some short-term flexibility**, **reasonable projections** suggest that our large and **rising structural deficits**, largely **driven by health care**, will shoot us to the **90% of GDP threshold** in about **2020**, **110% of GDP by 2025, and to an unimaginable 180% of GDP by 2035,** assuming tax cuts are extended, the alternative minimum tax is indexed to inflation, and payment for health care services follow past history (CBO 2010). **Such a trajectory would result in economic Armageddon**. Interest rates **would likely** soar, GDP would **contract significantly** leaving many **out of work**, and the government would **have few levers to respond**. Policymakers will be forced to respond to prevent this scenario well before 2025. This implies some combination of tax increases and spending cuts (relative to the projections) and those cuts will likely include health care. **In addition** to the **broad fiscal consequences** associated with greater public spending in health care, there are **significant adverse consequences** of private sector spending as well. In the private sector, higher health care spending **crowds out spending on other goods and services** either **directly**, as is the case of out-of-pocket spending, or **indirectly** through **lower wages** when premiums are subsidized by employers. Despite new penalties if employers fail to offer coverage, as health care consumes a higher share of income, individuals, and their employers, will increasingly substitute away from care and coverage. In fact, empirically, most research finds that individuals (or firms) are less likely to purchase coverage when health spending (and thus premiums) rises (Fronstin and Snider 1996/1997; Kronick and Gilmer 1999; Cutler 2002; Glied and Jack 2003; Chernew, Cutler, and Keenan 2005a, 2005b; Keenan, Cutler, and Chernew 2006). Over time, with **rapid health spending growth**, the burden of the mandate in the private sector will fall on **individuals** and significantly reduce well-being and **distort demand** for other goods and services. Given the potential dramatic consequences of a continued increase in health care spending growth, it is important to understand the issues related to more rapid spending growth and how spending growth might be addressed.

#### Goes nuclear

Tønnesson 15 - Stein Tønnesson 15, Research Professor, Peace Research Institute Oslo; Leader of East Asia Peace program, Uppsala University, 2015, “Deterrence, interdependence and Sino–US peace,” International Area Studies Review, Vol. 18, No. 3, p. 297-311

Several recent works on China and Sino–US relations have made substantial contributions to the current understanding of how and under what circumstances a combination of nuclear deterrence and economic interdependence may reduce the risk of war between major powers. At least four conclusions can be drawn from the review above: first, those who say that interdependence may **both inhibit and drive conflict** are right. Interdependence raises the cost of conflict for all sides but asymmetrical or unbalanced dependencies and **negative trade expectations** may generate tensions leading to trade wars among inter-dependent states that in turn increase the risk of military conflict (Copeland, 2015: 1, 14, 437; Roach, 2014). The risk may increase if one of the interdependent countries is governed by an inward-looking socio-economic coalition (Solingen, 2015); second, the risk of war between China and the US should not just be analysed bilaterally but include their allies and partners. Third party countries could drag China or the US into confrontation; third, in this context it is of some comfort that the three main economic powers in Northeast Asia (China, Japan and South Korea) are all deeply integrated economically through production networks within a global system of trade and finance (Ravenhill, 2014; Yoshimatsu, 2014: 576); and fourth, decisions for war and peace are taken by very few people, who act on the basis of their future expectations. International relations theory must be supplemented by foreign policy analysis in order to assess the value attributed by national decision-makers to economic development and their assessments of risks and opportunities. If leaders on either side of the Atlantic begin to seriously **fear or anticipate their own nation’s decline** then they may blame this on external dependence, appeal to anti-foreign sentiments, contemplate the use of force to gain respect or credibility, adopt protectionist policies, and ultimately **refuse to be deterred by** either **nuclear arms** or prospects of socioeconomic calamities. Such a dangerous shift could happen **abruptly**, i.e. under the instigation of actions by a third party – or against a third party. Yet as long as there is both nuclear deterrence and interdependence, the tensions in East Asia are unlikely to escalate to war. As Chan (2013) says, all states in the region are aware that they cannot count on support from either China or the US if they make provocative moves. The greatest risk is **not** that **a territorial dispute** leads to war under present circumstances but that **changes in the world economy** alter those circumstances in ways that render inter-state peace more precarious. If China and the US fail to rebalance their financial and trading relations (Roach, 2014) then a trade war could result, interrupting transnational production networks, provoking social distress, and exacerbating nationalist emotions. This could have unforeseen consequences in the field of security, with nuclear deterrence remaining the only factor to **protect the world from Armageddon**, and **unreliably so**. Deterrence could **lose its credibility**: one of the two great powers might gamble that the other yield in a cyber-war or conventional limited war, or third party countries might engage in conflict with each other, with a view to obliging Washington or Beijing to intervene.

### --Impact – Bioterror

#### The aff is key to disease surveillance --- each person without insurance undermines early identification and mitigation.

Kimberly A. Petersen 14. Captain, MA student in Security Studies at the Naval Postgraduate School, BA from Stanford. “The Affordable Care Act: A Prescription for Homeland Security Preparedness?” Doctoral Dissertation. Naval Postgraduate School. 53-8. http://tinyurl.com/ybpvolb4.

The fact that millions of U.S. residents do not possess health insurance negatively affects our collective safety and homeland security preparedness level. The consequences of uninsurance and its relation to homeland security are discussed here. Implementation of the Affordable Care Act will expand health insurance to millions of U.S. residents not currently covered. This expansion has significant potential to positively impact homeland security preparedness in a variety of ways. These potential impacts are explored in this chapter, both from the health perspective and the economic perspective.¶ According to a report by the Institute of Medicine, 43 percent of working-age adults who did not have health insurance reported that they chose not to see a doctor for a medical problem in a one-year time period; in contrast, only 10 percent of working-age adults who did have coverage for the entire year reported not seeing a physician for a medical issue.157 Jack Hadley’s comprehensive analysis of 51 studies in Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income finds “the uninsured receive fewer preventive and diagnostic services, tend to be more severely ill when diagnosed, and received less therapeutic care.”158 Numerous studies over the long-term have shown that uninsured Americans are less likely to obtain preventive health care, care for chronic conditions and more likely to suffer from undiagnosed medical conditions. As a result, uninsurance is associated with a higher rate of mortality159 and decreased access to health care.160¶ In the National Strategic Narrative, authors Captain Wayne Porter and Colonel Mark Mykleby promote the idea that security means more than physical safety, “for Americans, security is very closely related to freedom, because security represents freedom from anxiety and external threat, freedom from disease and poverty… [emphasis added].” 161 They urge us to focus on, among other things, “quality health care and education”162 and the prioritization of “a sustainable infrastructure of education, health and social services to provide for the continuing development and growth of America’s youth.”163 While Porter and Mykleby do not advocate for any particular type of health care system or structure, they point out that health care is an integral part of a secure and prosperous society. Griffen Trotter echoes the idea that basic health care provides a foundation for a physical infrastructure that promotes “a social and physical that enhances the quality and security of ordinary lives…”164 Health, in and of itself, contributes to one’s sense of security, and health care is a component of maintaining one’s health.¶ The Congressional Budget Office estimates that the ACA will bring down the proportion of uninsured, nonelderly adults in the U.S. from 20 percent to 11 percent.165 Some early proof that implementation of the ACA will equate to health insurance coverage gains can already be found. As noted earlier in this paper, the ACA goes into effect in stages. One of the earliest prongs of the law went into effect on September 23, 2010. This aspect of the ACA allowed young adults to remain on their parents’ insurance plans up to age 26.166 This is a gain of seven years beyond when children “aged-out” of coverage prior to the ACA.¶ A study published in Health Affairs journal in January of 2013 studied the early effects of the ACA on health insurance coverage and access to care for young adults. The study by Benjamin Sommers et al. notes that between September of 2010 and December of 2011, approximately three million uninsured adults between the ages of 19–25 gained health insurance coverage as a result of the ACA.167¶ This particular study demonstrated that not only did more young adults enjoy coverage gains, but also enjoyed increased access to care, which is ultimately one of the primary goals of the law.168 As Shane Green noted in 2004, “A nation’s greatest defense against bioterrorism, both in preparations for and in response to an attack, is a population in which an introduced biological agent cannot get a foothold, i.e., healthy people with easy access to care.”169¶ By expanding health insurance to 33 million more people through the implementation of the ACA, the results of these studies support the likelihood that this newly insured population will overall seek medical care earlier on, be in a better state of health when seen, and have better health outcomes. This will have positive ripple effects for homeland security in dealing with emerging disease, bioterror, flu pandemic, mental illnesses, and potentially economic security.¶ B. HEALTH SURVEILLANCE SYSTEM¶ An effective health surveillance system requires that those stricken by illness or disease—whether accidentally contracted or intentionally afflicted—seek treatment from a health care professional. The health care professional works to diagnose the problem, prescribe care, mitigate further spread, and report the illness as necessary to the health care community and possibly the government. This process is critical to our nation’s security in the event of a bioterror attack, such as with an Ebola virus or anthrax attack. The same holds true in managing contagious diseases such as influenza or newly emerging diseases. The sooner an illness or disease is correctly diagnosed, the more options remain available to help mitigate the spread or effect. Delays in diagnoses and therefore the development of appropriate treatments can have a limiting effect on both the health care community’s and the homeland security community’s choices and options in managing the spread and effect of the affliction.¶ Jack Hadley’s analysis showed statistically significant and positive support for the hypothesis that having health insurance or greater medical care use improves health: seven of the 10 natural experiments analyzed, six of the seven longitudinal studies, 29 of 35 of the observational studies showed “statistically significant results consistent with a positive relationship between health insurance or medical care use and health.”170¶ According to author G. Kenny, the uninsured received only 55 percent of the medical services received by the insured.171 Increased health insurance coverage correlates with an increased use of health care services,172 which is likely to increase the chance of earlier identification and mitigation of disease. This is good news for homeland security. The uninsured are more than four times more likely than the insured to delay needed medical care or forego it altogether due to cost concerns.173 By increasing the number of insured Americans, we also increase the likelihood that those with contagious diseases will seek treatment earlier on, allowing health professionals to identify, treat and mitigate disease spread more successfully. This would include diseases of concern to the homeland security community such as influenza virus, or any disease that has the ability to spread from person-to-person.

#### A bioterror attack is likely and existential.

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Recent developments in biotechnology may, however, give people the capability to design pathogens which overcome this trade-off. Some gain-of-function research has demonstrated the feasibility of altering pathogens to create strains with dangerous new features, such as vaccine-resistant smallpox40 and human-transmissible avian flu,41 with the potential to kill millions or even billions of people. For an engineered pathogen to derail humanity’s long-term future, it would probably have to have extremely high fatality rates or destroy reproductive capability (so that it killed or prevented reproduction by all or nearly all of its victims), be extremely infectious (so that it had global reach), and have delayed onset of symptoms (so that we would fail to notice the problem and mount a response in time).42 Making such a pathogen would be close to impossible at present. However, the cost of the technology is falling rapidly,43 and adequate expertise and modern laboratories are becoming more available. Consequently, states and perhaps even terrorist groups could eventually gain the capacity to create pathogens which could deliberately or accidentally cause an existential catastrophe.

## 2NR – Perm/Competition

### AT: Perm - Fund Both

#### 1. Intrinsic – neither the plan nor the CP takes funding from this second source. Voting issue – it allows the 2AC to add unpredictable planks and gain advantages and avoid disads, making neg strategy impossible.

#### 2. Opportunity cost – the plan trades off with the public option, and other liberal poicy priorities---there isn’t enough money for both. That’s 1NC Lowrey AND…

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**JGP = Job Guarantee Program**

A second macroeconomic issue concerns financing and policy trade-offs. If government is financially constrained, policy must operate in a realm of trade-offs. Consequently, adopting a JGP may require giving up other desirable policy proposals such as increased public infrastructure investment, expanded subsidized healthcare, covering the shortfall in Social Security via general revenues, free tertiary education at public universities, elimination of student debt, or a universal basic income (UBI).

#### Judging policy desirability requires opportunity cost analysis – ignoring it leads to government failure – the aff’s attempt to artificially limit discussion to one use of resources distorts decision-making

Lucas, Jr., Professor of Law, Texas A&M University School of Law, 2014

(Gary M., OUT OF SIGHT, OUT OF MIND: HOW OPPORTUNITY COST NEGLECT UNDERMINES DEMOCRACY, NYU Journal of Law & Liberty, static1.squarespace.com/static/514e1ca0e4b04c6ad1834313/t/553e658ee4b035aa6f1c7d22/1430152590269/Lucas.12.pdf

This Article contributes to the behavioral public choice literature by explaining for the first time how opportunity cost neglect, which is a particular failure of rationality, leads to government failure. The rational actor model assumes that prior to choosing an option, decision makers consider its opportunity cost, which is the highest valued alternative that the decision maker must forgo to pursue the option.7 A rational consumer choosing between a $1,000 stereo and a $700 stereo would consider the best alternative use of the $300 that she could save by purchasing the cheaper stereo. If the best alternative is downloading $300 worth of music from iTunes, then the consumer would buy the more expensive stereo only if its enhanced features make it more desirable than the cheaper stereo plus the music downloads. This approach to decision making has considerable normative appeal. But several recent studies of consumer behavior suggest that people often fail to think this way.8 Instead of focusing on forgone alternatives, people frequently restrict their attention to the focal option. They do not think about opportunity costs unless those costs are obvious from the context in which the decision is made. As a result, altering the context of a given decision by making opportunity costs more salient can change the outcome. Specifically, increasing the salience of opportunity costs generally makes particular purchase opportunities appear less desirable. This reduces the likelihood that consumers will spend money and increases the likelihood that when they do spend money, they will favor cheaper products over more expensive ones.

Although the existing literature focuses on consumers, opportunity cost neglect has important consequences for democracy. Systematic neglect of opportunity costs causes government policy to deviate from what it would be if voters were rational.

#### 3. There *actually* isn’t enough money to do both – there has to be *some* realistic bound on fiat. You can’t fiat the impossible, including GDP-sized outlays:

#### 4. Polcap tradeoff is dropped. Both the plan and counterplan are massive legislative pushes, and both can’t have sufficient momentum to pass concurrently.

### AT: PDCP – General

#### Nonsense – the counterplan is the opposite of the plan! It takes the funding for the plan and uses it for something else. Severance = vi

### AT: PDCP – Plan Includes PO/Healthcare

#### [Integrate T cards]

#### 1] The plan doesn’t include a public option---that’s distinct.

Pavlina **Tcherneva 18**. Chair of the economics department at New York’s Bard College, “The Job Guarantee: Design, Jobs, and Implementation,”Levy Economics Institute of Bard College. April 2018. http://www.levyinstitute.org/pubs/wp\_902.pdf

The JG is first and foremost a program that provides decent jobs at decent pay, but it resides within a broader policy agenda. A comprehensive policy reform that aims to address income insecurity must incorporate other forms of nonwage income support. These would include expanding Social Security and Disability benefits, reducing the retirement age and working week, and instituting a federal-level paid family leave. Furthermore, while the JG will go a long way to reducing individual and household poverty, an anti-poverty agenda ought to also include a universal child allowance policy, universal childcare, free school lunches, and a public healthcare option, to name a few.

#### 2] The plan isn’t universal, and continues reliance on the employment-model of healthcare.

Pavlina **Tcherneva 18**. Chair of the economics department at New York’s Bard College, “The Job Guarantee: Design, Jobs, and Implementation,”Levy Economics Institute of Bard College. April 2018. http://www.levyinstitute.org/pubs/wp\_902.pdf

There is an important argument to be made in support of providing universal healthcare (and other benefits), irrespective of one’s employment status. But in the absence of such a policy, incorporating health benefits into the JG wage-benefit packages is an expedient way of achieving near-universal coverage. Whatever wages and benefits the JG provides will be the minimum standard for the pay conditions throughout the economy.

#### The plan and perm give people coverage through their jobs. Reliance on the employer-model fails to solve the net benefit---

#### A] Inequality. Reliance on employer-based health insurance creates inequality---those with lower salaries pay more

Ed **Dolan 18**. Senior Fellow, Fiscal and Monetary Policy at Niskanen Center, “What’s Wrong with Employer Sponsored Health Insurance,” Niskanen Center. November 6, 2018. https://www.niskanencenter.org/whats-wrong-with-employer-sponsored-health-insurance/

**ESHI = Employer Sponsored Health Insurance**

A second criticism of ESHI is its inequity. Workers with high paid jobs get most of the benefits, while those with lower pay or part-time jobs get little help. Differences in tax rates are one source of that inequity. Consider how differences in tax rates would affect the value of a typical ESHI policy. According to data from the [Kaiser Family Foundation](https://www.kff.org/report-section/2018-employer-health-benefits-survey-summary-of-findings/#figurea) (KFF), such a policy has a total cost of just under $20,000 as of 2018, of which employers pay about $14,000 on average. Suppose you are a head of household earning $60,000 a year, putting you in a 25 percent federal tax bracket. In that case, having your employer pay $14,000 of your insurance premium, rather than getting that much extra in cash and paying the premium yourself, saves you $3,500 in taxes. If you are a top executive in a 40 percent tax bracket, the tax deductibility of the insurance is worth $5,600. However, according to the [Tax Policy Center](https://www.taxpolicycenter.org/taxvox/closer-look-those-who-pay-no-income-or-payroll-taxes), some 44 percent of Americans will pay no income tax at all in 2018. Sixty percent of the nonpayers work. Even if they get ESHI, it gives them no tax benefit at all. They would be no worse off if health benefits were not deductible and if employers added the cost of their insurance to their cash pay instead. A second factor adding to the inequity of ESHI is that low-wage workers, by and large, are not even offered the option of health benefits. The following chart, provided by the [Social Security Administration](https://www.ssa.gov/policy/docs/ssb/v73n1/v73n1p83.html), shows that only about a third of workers in the lowest fifth of the wage distribution are offered health benefits and that fewer than 20 percent accept those offers. In contrast, more than 80 percent of those in the top fifth of the wage distribution are offered health benefits and accept them. [Robert Kaestner and Darren Lubotsky](https://www.aeaweb.org/articles?id=10.1257/jep.30.2.53), economists at the University of Illinois, Chicago, provide an estimate of the overall inequality of ESHI based on the combined effects of differences in tax rates and differences in offer and acceptance rates. As shown in the next chart, taken from their study, workers in the bottom fifth of the family income distribution get annual benefits of less than $500 from ESHI, while those in the top fifth get benefits averaging $4,500. What is more, the value of health benefits to well-paid workers grew substantially over the period shown in the chart, while the value for the lowest paid workers decreased slightly.

#### B] Bargaining. Reliance on employer-based healthcare can’t solve fragmentation or bargaining power. Only the public option can---that’s the 1NC scenario.

Ed **Dolan 18**. Senior Fellow, Fiscal and Monetary Policy at Niskanen Center, “What’s Wrong with Employer Sponsored Health Insurance,” Niskanen Center. November 6, 2018. https://www.niskanencenter.org/whats-wrong-with-employer-sponsored-health-insurance/

A third problem to which ESHI contributes is fragmentation of health care finance. As a Policy Brief from [Brandeis University](http://www.niatx.net/pdf/ARC/Delivery_System_Redesign.pdf) put it, The US health care delivery system is expensive, fragmented, highly decentralized, and poorly organized . . . made up of a fragmented network of public and private financing, health care delivery, and quality assurance structures. There is no single national entity or set of policies guiding the health care system. States divide their responsibilities among multiple agencies, and providers who practice in the same community and care for the same patients often work independently from one another. The US health system is the most expensive system in the world and yet health outcomes and quality are no better and often worse than in most developed nations. Fragmentation is a problem for small employers, who have little bargaining power in purchasing group policies from insurers, but also for larger employers. Many larger employers try to save on health benefit costs by self-insuring. According to [Collective Health](https://blog.collectivehealth.com/employer-driven-healthcare-270bfb7ee8c7), a company that advises employers on their ESHI programs, 79 percent of companies with 200 or more employees self-insured as of 2017, up from 60 percent in 1999.  The problem is, companies that self-insure don’t always do a good job of it. Ali Diab, CEO and founder of Collective Health, puts it this way in a post on the company’s blog: Contrasted with other areas of concentrated employer spending, like payroll, or sales and marketing, the distinct absence of a modern, technology-driven approach to managing this effort [ESHI] stands out. To understand why employers depend on these complex arrangements, we need look no further than the antiquated, error-prone administration systems that power the “back office” of today’s healthcare industry.Recently three corporate giants, Amazon, JPMorgan Chase and Berkshire Hathaway, have joined forces to form a combined health care enterprise to manage benefits for their hundreds of thousands of employees. The stock prices of traditional insurers fell when news of the consortium was announced, but many analysts are skeptical of how well it will work. Leemore Dafny, a professor at Harvard Business School, told reporters from the [New York Times](https://www.nytimes.com/2018/01/30/upshot/can-amazon-and-friends-handle-health-care-theres-reason-for-doubt.html?module=inline), “Just because you know an industry is underperforming and you have a lot of money doesn’t mean you have a successful strategy.” Dafny said she was excited to see such serious players take on the problems of ESHI, but noted there were numerous examples of outsiders trying, and failing, to succeed in the health care system. When it comes down to hard bargaining, health care providers, including big insurers, hospitals, and drug companies, are less fragmented than employers. Furthermore, health care is what they know best. For employers, whose main expertise lies in manufacturing, customer service, finance or other areas, health care is only a sideline. Given the structure of the system, providers will always come out ahead, driving up costs for workers and their families, who are the ultimate health care consumers.

### --Job Lock DA to Perm

#### Reliance on employer-sponsored insurance creates job lock, which the counterplan avoids---that creates widespread entrepreneurship and innovation

David Sterret 14. Principal at the Health Care Policy Group, et al., 2014, “A Business Case for Universal Healthcare: Improving Economic Growth and Reducing Unemployment by Providing Access for All,” Health Law & Policy Brief 8, No. 2, p. 41-55

A. ‘Job Lock’ Reduces Economic Growth

Unlike people who live in other industrialized countries, most Americans rely on employer-sponsored health insurance for access to medical services.16 Our system is a historical accident that resulted from World War II economic controls.17 To dodge government-imposed wage controls, businesses began offering health insurance and other fringe benefits to attract workers.18 The federal government made this system permanent in 1943 by making employer-sponsored healthcare a tax-free benefit.19

Fifty-five percent of all Americans, and more than sixty-eight percent of working-age Americans—those ages eighteen to sixty-five—rely on employer-based insurance for access to healthcare.20 Although the United States has health insurance programs for the very poor (Medicaid) and those sixty-five and older (Medicare), there is no reliable, reasonably affordable means for Americans who lack access to government programs or employer-based insurance to obtain access to healthcare. Some would argue that the health insurance exchanges being created under the ACA will meet this need, but costs to obtain insurance through the new exchanges, especially for older people, will likely put this solution out of reach for many.21

Our employer-reliant system has caused health insurance to become an overriding consideration in Americans’ career decisions.22 This phenomenon has resulted in lower “employment dynamics,” which are “the rate at which workers and businesses exchange jobs.”23 An employee’s unwillingness to change jobs for fear of losing health insurance benefits is known as “job lock.”24 Job lock inhibits workers from gravitating to the jobs most suited to them or pursuing entrepreneurial endeavors. Likewise, it frustrates employers’ ability to find and hire the best potential employees.25 Studies have found that job lock reduces mobility by 22.5 percent,26 makes employees sixty percent less likely to leave their jobs,27 and decreases the rate of self-employment by two-to-four percent.28

A system that provides universal access to health coverage, on the other hand, is “far more likely to promote entrepreneurship than one in which would-be innovators remain tied to corporate cubicles for fear of losing their family’s access to affordable healthcare,” wrote Jonathan Gruber, who was one of the chief architects of the healthcare reform law passed in Massachusetts in 2005 and whose work greatly influenced the structure of the ACA.29 It is estimated that 1.6 million small business workers suffer from job lock and that providing universal healthcare coverage would bring that number close to zero.30 In addition, instituting a system to ensure universal coverage would add 1.5 million entrepreneurs,31 which would significantly increase our gross domestic product (GDP), according to a study by the Kauffman Foundation.32

The Kauffman Foundation study goes further to explain how eliminating job lock benefits the economy on a micro-level. Through the process of new and expanding businesses replacing the market share of established companies and the ongoing efforts of businesses and workers seeking their most productive matches, entrepreneurs create new products, which allows employees to accomplish more tasks in less time and ultimately creates more jobs.33 This increased activity is associated with higher economic growth.34 By enabling workers to do the type of work that they do best and enjoy the most, eliminating job lock increases the GDP.

B. ‘Job Lock’ Drives Up Unemployment, Reducing the Number of Potential Customers for Businesses

A 2009 study by researchers at the Rand Corporation shows a link between the healthcare system in the United States and unemployment levels.35 The study examined the effects of “excess healthcare costs,” which the study defined as the difference between the inflation rate for healthcare services and the increase of the GDP of the United States.36 For example, if the rate of medical inflation were five percent and the rate of GDP growth were three percent, “excess healthcare costs” would be calculated as equaling two percent.

By looking at the experience of close to seventy million workers in thirty-eight industries over nineteen years, the researchers measured the impact of rates of growth of healthcare costs in certain industries and extrapolated that data across the United States economy.37 The average excess healthcare costs over the period in which the Rand study was conducted (1986-2005) were 2.2 percent.38 Meanwhile, the Rand study found that an excess healthcare cost of just 0.2 percent—one-tenth the actual experience for the period—would exact a toll of 120,803 lost jobs.39 Taken together, Rand study findings yield the conclusion that excess healthcare costs led to the loss of more than a million jobs over a twenty-year period.40 This means that businesses were left with about a million fewer employed potential customers.41

Instituting a system that provides care to all Americans would end the problem of nonportable healthcare benefits, freeing the United States economy from a long-standing burden and create jobs.

#### Continued innovation’s key to all aspects of U.S. hard and soft power---and it solves cyber attacks on infrastructure and bio-terror

Cody Knipfer 17. MA Candidate in Space Policy at George Washington University’s Space Policy Institute, 3/7/17, “On the Nature of Science and Technology Power,” http://www.reallycoolblog.com/on-the-nature-of-science-and-technology-power/

Indeed, the United States’ leadership in science and technology has been a historical cornerstone of its capacity for “hard power” force application and projection and economic and societal “soft power.” It buttresses the country’s economic might, enables the modern standards of living of our citizenry, and expands our global cultural and normative reach.[ii] Equally so, the power of science and technology has been decisive in the context of national security. As President Truman noted in 1945, while urging Congress to create a Department of National Defense, “no aspect of military preparedness is more important than scientific research.”[iii] Through discoveries, technological innovation, and the capacity to develop ideas into deployable weapons, systems, and concepts, the United States has arrived at its modern-day military advantage and superiority.[iv]

To that end, science and technology may be considered key elements of the United States’ comprehensive national power – fundamentals of the country’s strength vis-à-vis competitors. Yet science and technology alone cannot ensure any country’s continued security, prosperity, or hegemony; far from operating in a vacuum, science and technology are constantly evolving to address changing domestic and international circumstances and threats. To reap advantage from science and technology, especially in their national security application, a country must continually innovate to tackle contemporary developments and anticipate future ones. This poses a considerable challenge, the solution to which extends beyond advanced engineering and research.

To explore these notions, this essay, particularly interested in the application of science and technology toward national security ends, examines the United States’ recent employment of security-related technologies. From this, it explores the attributes of science and technology power and the similarities and differences between science and technology power and other forms of national power such as the economic and diplomatic. Looking at the relative importance of science and technology in the United States today and likely significance in the coming future, it lays out a series of policy recommendations that may guide policymakers as they make decisions that impact the direction of the country’s scientific and technological course.

Employment of – and Challenges Facing – National Security-Related Technolog

Recognizing the vital role that technology played in winning World War Two, along with the emerging threat of Soviet technological competitiveness, the United States established in the war’s wake an extensive infrastructure to support national security science and technology efforts. This provided foundation and catalyst for the development of military capabilities and tools needed to meet the challenges of the Cold War and the modern day: the nuclear triad, intelligence-gathering and cyber infrastructure, space-based radar and communications systems, advanced precision-guided munitions, and integrated command and control, along with myriad other assets.[v]

These technologies have seen extensive use in contemporary military conflicts. The wars in the Balkans and the Gulf saw the ever-increasing use of position, navigation, and timing assets such as GPS to provide precise and reliable information to the warfighter and direct precision-guided weaponry.[vi] Targeted airstrikes and weapons such as the long-range cruise missile have allowed for far more rapid, responsive, and accurate strikes than those of the past while substantially reducing collateral damage. Combat drones and unmanned aerial vehicles, innovations emblematic of the “War on Terror,” enable the warfighter to engage adversaries and conduct reconnaissance while safely remaining away from the front lines of the battlefield. Stealth aircraft, using a range of advanced technologies that reduce reflections and emissions, have helped pilots conduct sorties while evading detection.[vii]

Technology abets the United States’ security beyond warfighting. Advanced cyber capabilities – encryption, for example – seek to defend the networks which control the country’s power, transit, and water infrastructure from malicious hacks and crippling denial of service.[viii] Technologies capable of detecting harmful biological and chemical agents guard the country against potentially devastating attack by non-state actors.[ix] Increasingly sophisticated monitoring and surveillance technology enables the government to globally track and work to counter criminal activity, terrorist organizations, and other developments which threaten the country’s safety.[x]

Crucially, though, the United States’ contemporary application of national security systems has also demonstrated the inherent challenges of innovation and the limitations of technology. Despite advanced military hardware, principally designed to fight large-scale conventional wars against Cold War-era foes, the United States military had to “catch up” and react to unconventional tactics, such as roadside bombs and sniper attacks, employed against it in the Iraq and Afghanistan wars. Though decidedly outnumbered and outgunned, enemy combatants effectively countered the United States’ asymmetric technological advantage through guerilla warfare, propaganda, and exploiting collateral damage that advanced weapons systems created – doctrines which the United States’ technology did not anticipate and was unprepared or unsuited to counter.[xi] Likewise, despite the sophistication of the United States’ homeland security technologies, the government has struggled to prevent incidents of domestic terrorism such as mass shootings, often characterized by the use of simple, off-the-shelf equipment.[xii]

Meanwhile, in reaction to the United States’ present-day technological superiority, competitive foreign powers such as Russia and China are heavily investing in hardware and capabilities in the cyber and military realms specifically designed to counter the United States’ technological strengths and exploit its demonstrated vulnerabilities. The technological capabilities underlying the United States’ comparative military advantage are now proliferating to an increasing number of state and non-state actors, including potential adversaries, leveling the military “playing field.”[xiii]

The Attributes of National Security Science and Technology Power

From this, several key attributes and characteristics of science and technology as a form of national power can be identified. Foremost is the capacity for technology and science to be a significant, occasionally decisive, enhancer of a country’s military strength against enemies. Countries which develop innovative military technologies which effectively counter an adversary’s offenses or defensives, or against which an adversary has no means to protect itself, find themselves disproportionately advantaged on the battlefield. Indeed, technologies which upend dominant “status quo” warfighting paradigms – such as, historically, the introduction of the chariot, the tank, or nuclear weapons – are poised to significantly disrupt and reorder the geopolitical and military balance of power.[xiv]

To that end, science and technology power, particularly in the national security sphere, is developed and sustained through the adaption to, and more so through the anticipation of, revolutionary changes in military affairs, doctrine, and hardware. As Lieutenant Colonel Scott Stephenson noted in the influential “The Revolution in Military Affairs,” “those slow to adapt to military revolutions… are likely to suffer painful results. When the pace of change accelerates, the militaries that anticipate and adapt are likely to gain a massive advantage over potential enemies who are less agile.”[xv] That agility is, in large part, borne from innovations in science and the development of new technologies which lead to unanticipated, and therefore difficult to counter, doctrines.

A defining characteristic of science and technology power, then, is the continual quest for states to match, counter, and out-compete the technology of their adversaries. This continuing interplay between technology and national power, characterized by the sustained technological evolution and described often as an “offset,” has been a key focus for national security-related research and development throughout the Cold War and into the present. The United States’ deployment of nuclear weapons, for example, offset the numerical advantage held by the Soviet Union’s land forces in the early Cold War. Soviet parity in nuclear weapons catalyzed the development of guided weapon and integrated command and control as a counter, focusing on accuracy of targeted weapons systems independent of range.[xvi] The United States’ capacity to offset Soviet technology through innovative developments – and the Soviet bankruptcy borne from military expenditure that came as a corollary – was an important factor in maintaining a generally peaceful stable of power along with the country’s ultimate triumph in the Cold War. In the present-day, China and Russia’s focus on countering the systems and technologies which currently provide the United States’ military asymmetry is emblematic of this “offset” approach to science and technology power.

Paradoxically, however, national security-related technology in the present day has become as great an equalizer as it has historically been a separator of actors’ strengths. Technological superiority in the present may provide the United States’ unrivaled military strength, especially against foes (historically, state actors with large conventional forces) for which its national security technologies anticipated countering. Yet as the example of the Iraq and Afghani insurgencies amply demonstrated, technological superiority coupled with innovation focused on addressing hypothetical future battlefields may not be adequate to oppose or defeat all actors or all forms of warfare, regardless of the level of their sophistication.

Indeed, advanced technologies may be entirely vulnerable to actors utilizing doctrines with simple technologies that nonetheless exploit their weaknesses, as was the case with sophisticated – and expensive – American vehicles being destroyed by crude, homemade IEDs. Technology itself also creates weaknesses; the United States’ progressing economic and social reliance upon interconnected networks, for example, makes the country more vulnerable to potentially crippling attack. Despite advanced American cybersecurity technologies and techniques, non-state actors have still proven themselves capable of infiltrating, attacking, and even denying use of American cyber capabilities; considering recent trends, this vulnerable seems likely to continue, if not worsen.[xvii]

It may be that an attribute of science and technology power, borne more from the focus and perceptions of the technologists, theorists, and military leadership that employ it than from science and technology itself, is that it obscures other factors which equally dictate important developments in military, international, and geopolitical affairs. Political upheaval, social change, and economic development can change warfare dramatically, for example – and have nothing to do with “offset” strategies or war-room predictions of possible enemies’ future high-tech military hardware. As a product of the military-industrial complex that emerged in the Cold War United States to sustain continued technological development, Americans tend to be acutely – perhaps overly – sensitive to technological innovation among competitors and potential rivals. Fears during the Cold War and contemporary discussions of the “Third Offset” paint pictures of emerging, potential, and fanciful enemy weapon systems – which military planning and technology development was and is oriented toward countering.[xviii] This fixation on solutions entailing engineering and technological complexity blinds the national security technology apparatus to external trends that could definitively impact the future course of war – such as the collapse of the Soviet Union leaving the United States with a high-tech military and warfighting doctrine unsuited for the military pressures and asymmetric nature of counterinsurgency; the rise of radical terrorism with ideological underpinnings that condone unconventional guerilla tactics such as suicide bombings, which had great effect against high-tech targets; or the continuing crisis where lone-wolf gunmen using off-the-shelf rifles can commit massacres despite the government’s highly complex and pervasive surveillance and monitoring technology.

Similarities and Differences to Other Forms of National Power

With these attributes in mind, a comparison can be drawn between science and technology power and other forms of power which constitute a country’s comprehensive strength, such as the economic and diplomatic. Regarding the economic, science and technology power is similar in that the development of science and technology is driven by the same forces as economic growth. Like new economic products, services, and methods of operation, science and technology power relies upon the ingenuity of human actors predicting and anticipating future trends, possibilities, and human behavior. Innovation, iteration, and competitiveness are fundamental catalysts for the continued evolution and growth of both. The rapid proliferation and subsequent use of innovative technologies across the world quickly equalizes both the national security advantage and the economic advantage they provided their inventor.

Economic power, like national security technology, is a key element of a country’s warfighting capability – industrial might, strength in quality production, and capable infrastructure are crucial facets of a country’s ability to mobilize and project force. A fundamental difference between economic power and science and technology power, however, is competition. While economies naturally compete, there is incentive for states to specialize in the economic product or service most suited for it – their comparative advantage. Competing economies are not actively incentivized to counter the economic specialization of their rivals. With science and technology power for national security use, however, states decidedly hope to actively and explicitly counter the relative advantage of their adversaries.

Like diplomatic power, science and technology has a “soft power” element; other states and their societies may be influenced or compelled to action by the might, prestige, or cultural and technological hegemony of a country in possession of highly advanced and capable technologies.[xix] Diplomatic power occasionally experiences the same issue of science and technology policy in being blinded to unpredicted or external trends in the social, cultural, and economic spheres. The power of diplomacy, for example, did not anticipate and struggled to deal with the cultural, social, and political circumstances that led to a breakdown of order in post-invasion Iraq; just as national security technology was unprepared for the guerilla warfare of the Iraqi insurgency. Diplomatic power and science and technology power differ, though, in the fields of innovation and evolution. Whereas the military regime is constantly evolving and occasionally being upended by revolutions in security technology and associated doctrine, the Westphalian diplomatic order has remained largely similar through centuries – even as it has grown gradually more complex and interconnected. States do not tend seek to outcompete each other in the diplomatic sphere through revolutionary new approaches to diplomacy; negotiations, sanctions, deals, bi- and multilateral agreements, and the like have remained consistent “doctrines” employed by states in their dealings with international friends and foes.

Science and Technology Power’s Present and Future Importance

To return to Vannevar Bush’s assertion over half a century ago, science and technology is crucially important for a states’ economic growth and prosperity, the wellbeing of its citizens, and national security. This remains absolutely the case today. Despite the challenges facing innovation in the face of unanticipated adversaries and the proliferation of advanced, equalizing technologies among adversarial states and non-state actors, science and technology provides the United States’ unrivaled levels of security and military hegemony.

With the appearance of significant global challenges – refugee crises, environmental degradation, the possible emergence of a bi- or multi-polar world characterized by states with rough or equal technological parity, to name a few – the future importance of science and technology power cutting across all aspects of national security will undoubtedly redouble. Science and technology and its application as an element of the United States’ national power will need to be directed to address these challenges. While the exact characteristics that will define domestic and foreign national security technologies of the future – not to mention the economic and social – remain uncertain, the United States cannot afford to permit its current technological advantage to slip. Indeed, as revision states such as China continue to develop their technologies to directly counter the United States’ capabilities, it will likely become an imperative for the country to more actively engage in and support the development of innovative new security technologies and doctrines – lest, as history would suggest, the international order again be upended.

### AT: Plan Costs Little

#### Including benefits and other services makes it cost over 600 billion.

Mark **Paul 18**. Postdoctoral Associate at the Samuel DuBois Cook Center on Social Equity at Duke University. “A Path to Ending Poverty by Way of Ending Unemployment: A Federal Job Guarantee,” RSF: The Russell Sage Foundation Journal of the Social Sciences, February 2018, Vol. 4, No. 3, Anti-Poverty Policy Initiatives for the United States (February 2018)

Next, we also estimate two scenarios under recent economic conditions using July 2016 employment data. The first scenario assumes modest uptake under the FJG, on the assump- tion that all workers currently counted in U6 engage in employment through the National Investment Employment Corps (NEIC). In this case, 13.2 million workers may seek employ- ment, demanding 11.9 million full-time equivalent jobs. The gross cost of the program, in-cluding benefits and materials, would be $654.6 billion.

#### That’s a conservative estimate – it might be way higher

Mark **Paul 18**. Postdoctoral Associate at the Samuel DuBois Cook Center on Social Equity at Duke University. “A Path to Ending Poverty by Way of Ending Unemployment: A Federal Job Guarantee,” RSF: The Russell Sage Foundation Journal of the Social Sciences, February 2018, Vol. 4, No. 3, Anti-Poverty Policy Initiatives for the United States (February 2018)

The second case based on recent labor market conditions estimates program uptake and expenditures assuming workers earning wages below the minimum offered by the NEIC also would partake in the FJG. Although we believe U6 provides a reasonable approximation of pro- gram uptake, we recognize that the establish- ment of a FJG will transform much of the labor market. In turn, we analyze a third estimate that represents an upper bound for uptake and cost under a FJG. This estimate assumes that all workers currently earning below the base wage offered by the NEIC (about one-quarter of all employed workers according to Bureau of Labor Statistics data), plus workers counted under U5, will seek employment with the NEIC. Under this scenario, program costs would increase sizably.

#### Multiple studies prove---the range is 400 to 600 billion.

Peter C. **Earle 18**. Research Fellow at the [American Institute for Economic Research](https://www.aier.org/). “'Federal Jobs Guarantee' Idea Is Costly, Misguided, And Increasingly Popular With Democrats,” Investor’s Business Daily. November 19, 2018. <https://www.investors.com/politics/commentary/federal-jobs-guarantee-democrats/>

The costs, too, are daunting. Both the CBPP and LEI reports project costs ranging from $450 billion to more than $600 billion, which put the proposed programs in the same league with the Pentagon in terms of discretionary spending.

### AT: Cost Savings Offset It

#### Integrate from econ file

#### Any spending offset is incomplete---it doesn’t include administrative costs.

Peter C. **Earle 18**. Research Fellow at the [American Institute for Economic Research](https://www.aier.org/). “'Federal Jobs Guarantee' Idea Is Costly, Misguided, And Increasingly Popular With Democrats,” Investor’s Business Daily. November 19, 2018. https://www.investors.com/politics/commentary/federal-jobs-guarantee-democrats/

And while it is true that the cost of any of the federal jobs guarantee programs would be offset by savings in current unemployment insurance and poverty mitigation programs, neither of the estimates include costs of designing, staffing, and managing the proposed agency.

### AT: Plan Doesn’t Cover P/O

#### The public option costs hundreds of billions.

Emily **Rappleye 19**. Writer for Becker’s Hospital Review; cites a study by the Urban Institute. “Single-payer vs. public option: Comparing cost, coverage,” Becker’s Hospital Review. October 21, 2019. https://www.beckershospitalreview.com/hospital-management-administration/single-payer-vs-public-option-comparing-cost-coverage.html

1. Public option. This plan would make premium and cost-sharing subsidies more generous for people enrolled in marketplace plans, create a reinsurance program for insurers, prohibit short-term plans, add a public option and autoenroll legal residents in coverage.

This would reduce the number of uninsured Americans by 25.6 million, achieving near-universal coverage. It leaves 6.6 million undocumented residents uninsured.

Federal government spending would increase $122.1 billion in 2020.

National health spending, which incorporates government spending, employer spending and household spending, would decrease by $22.6 billion in 2020.

## 2NR – Econ NB

### 2NR – P/O Solves Competition

#### That breaks the provider and insurer monopolies which reduces costs.

Ethan Kaplan & Melissa A. Rodgers 9. \*PhD, Columbia University and Fellow at the Institute for International Economic Studies. \*\*JD, Professor at the Berkeley Center on Health, Economic, & Family Security. “The Costs and Benefits of a Public Option in Health Care Reform: An Economic Analysis.” *Berkeley Law*. October. <https://www.law.berkeley.edu/files/chefs/Public_Option_Economic_Analysis.pdf>.

The Lewin Group and the Urban Institute models correctly predict that a public option will save the government money and reduce total health care costs. However, their quantitative cost estimates likely underestimate the benefits and overestimate the costs of a public option. This brief discusses some of the modeling flaws evident in existing estimates and their relevance to overall cost and benefit estimates for the public option. Existing models of the health insurance market exhibit two flaws, both of which lead to substantial underestimates of the cost savings a public option would generate:¶ 1. Existing models do not fully model the competitiveness of health insurance markets; and¶ 2. Some models (the Lewin Group and especially the Price Waterhouse Cooper model, in particular) incorrectly assume that reduced profits through the effect of a public option in the exchange will show up as higher premiums in other insurance markets.¶ The Competitive Effect of a Public Option¶ The main problem with the existing studies is the way in which they model competition among providers and the prices that providers set with insurance companies. All studies assume that the public option will pay providers at or near the Medicare reimbursement rate and will charge enrollees premiums to cover costs. But existing studies do not model the monopoly power that hospitals have to set high prices.7 Private insurers pay hospitals on average 30 [percent] % more than Medicare. A public option that exerts pressure on hospitals to lower the prices they charge private insurers would lead to overall price declines. The Lewin Group and the CBO models do not account for these savings, and the Urban Institute model does so only to a limited extent.8 In existing models, the main benefit of the public option is therefore its lower administrative costs, which for private payers amount to at most 10 [percent] % of health care costs on average, although effective administrative costs in the individual market are most likely substantially higher. Administrative savings from having a public option are projected at around 5%, which translates into significant savings, but less than the models would predict if they correctly accounted for the counter-effect of the public option on the price-setting power of hospitals.¶ Cost Shifting¶ In the Lewin Group and Price Waterhouse Cooper models, as the public option becomes more widely available, private insurance premiums rise. These cost estimates assume that the public option will cause “cost shifting.” In essence, the argument is that hospitals lose money on Medicare and will therefore lose money on the public option. Moreover, as the argument goes, hospitals make up their losses by charging private insurers higher prices, which in turn are passed on in the form of higher premiums. In fact, the Price Waterhouse Cooper report assumes such an extreme form of cost shifting that every dollar of decreased revenue from the public option shows up as increased premiums for private insurers. Both the Lewin Group and Price Waterhouse Cooper conclude that government savings from lower premium prices for those who purchase the public option are partially offset by increases in private insurance premiums.¶ The cost shifting argument has some very problematic implications and little to no empirical support. Hospitals and insurance companies both set prices to maximize profits; hospitals charge private insurers the maximum amount possible, regardless of whether they also receive payments from Medicare. Lower prices from one payment source may affect a hospital’s profit margin, but should not cause the hospital to increase the already profit-maximizing price it charges private insurers. The one exception to this would be if hospitals are operating near bankruptcy in order to keep prices as low as possible, in which case a decrease in one customer’s payments would lead to an increase for another customer because the hospital had not been charging the second customer a profit maximizing price in the first place. Whereas this is theoretically possible, there has been no good empirical work documenting that it happens. In fact, the best research done on the behavior of non-profit hospitals suggests that non-profits behave identically to for-profit hospitals.9 There is, in sum, no good empirical evidence that the type of cost shifting modeled by the Lewin Group, in which 40% of the lost revenues are shifted into private insurance premiums, actually occurs. In other words, the Lewin Group model dramatically reduces the estimated fiscal savings from a public option, thereby underestimating its fiscal benefit. Adding back in the 40 [percent] % cost shift, savings from the expansive public option would increase by $37.8 billion in the year 2011 alone.

### 2NR – HC Costs K2 Econ

#### Reducing cost inflation is necessary and sufficient to avert fiscal catastrophe – escalating debt makes long-term growth impossible

Horowitz 18 (Evan Horowitz, Director of Communications and Technology at Massachusetts Budget and Policy Center, fellow at the Radcliffe Institute for Advanced Study at Harvard University, PhD. from Princeton, policy writer for the Boston Globe, January 11, 2018. “To Cut The Debt, The GOP Should Focus On Health Care Costs.” https://fivethirtyeight.com/features/to-cut-the-debt-the-gop-should-focus-on-health-care-costs/)

Energized by the successful passage of tax cuts, some Republicans are eying a new target: entitlement programs like Social Security and Medicare. House Speaker Paul Ryan is [leading the charge](https://www.washingtonpost.com/news/wonk/wp/2017/12/01/gop-eyes-post-tax-cut-changes-to-welfare-medicare-and-social-security/), arguing that the only way to break the cycle of rising deficits and surging debt is to reduce entitlement spending. Political resistance is likely to be fierce, not only because these programs are [massively popular](http://www.pewresearch.org/fact-tank/2017/05/26/few-americans-support-cuts-to-most-government-programs-including-medicaid/), but also because President Trump opposed any such cuts [during his campaign](http://www.politifact.com/truth-o-meter/promises/trumpometer/promise/1347/make-no-cuts-medicare/). Even if the political hurdles can be cleared, though, the bigger problem is that this push for entitlement reform attacks the wrong target. There is no wide-reaching entitlement funding crisis, no deep-rooted connection between runaway debts and the broad suite of pension and social welfare programs that usually get called entitlements. The problem is linked to entitlements, but it’s much narrower: If the U.S. budget collapses after hemorrhaging too much red ink, the main culprit will be rising health care costs. Aside from health care, entitlement spending actually looks relatively manageable. Social Security will get a little more expensive over the next 30 years; welfare and anti-poverty programs will get a little cheaper. But costs for programs like Medicare and Medicaid are expected to climb from the merely unaffordable to truly catastrophic. Part of that has to do with our aging population, but age isn’t the biggest issue. In a hypothetical world where the population of seniors citizens didn’t increase, entitlement-related health spending would still soar to unprecedented heights — thanks to the relentlessly accelerating cost of medical treatments for people of all ages.[1](https://fivethirtyeight.com/features/to-cut-the-debt-the-gop-should-focus-on-health-care-costs/#fn-1) What’s needed, then, is something far more focused than entitlement reform: an aggressive effort to slow the growth of per-person health care costs. Or — if that’s not possible — some way to ensure that the economy grows at least as fast as the cost of health care does. Diagnosing the debt: It’s not about demographics America’s long-term budget problem is very real. Already, the federal government has a pile of publicly held debts amounting to around $15 trillion, or about 75 percent of the country’s entire gross domestic product. That’s the highest level since the 1940s, yet the debt burden is expected to double by 2047 and reach 150 percent of the GDP, according to the Congressional Budget Office.[2](https://fivethirtyeight.com/features/to-cut-the-debt-the-gop-should-focus-on-health-care-costs/#fn-2) It makes sense to list entitlement spending among the culprits for the growing national debt, given that these programs have grown from costing less than 10 percent of the GDP in 2000 to a projected 18 percent in 2047. Part of this is simple demographics: As America ages, more of us become eligible for Social Security and Medicare, thus driving up expenses.[3](https://fivethirtyeight.com/features/to-cut-the-debt-the-gop-should-focus-on-health-care-costs/#fn-3) But there’s a crack in this demographic explanation: It only makes sense for the next 10 to 15 years. That’s the period of rapid transition when graying baby boomers will boost the population of seniors from around 50 million to more than 70 million. A change like that should indeed produce a surge in entitlement spending as those millions submit their enrollment forms. By 2030, however, this wave will start to ebb, leaving the elderly share of the population at a roughly stable 20 to 21 percent all the way through 2060, based on the size of the population following the boomers and slower-moving forces like lengthening lifespans. But think what this should mean for entitlement spending. As the population of seniors levels out in those later years, costs should naturally stabilize — at least, if demographics were really the driving factor. This is exactly what you see for Social Security. The CBO expects total Social Security spending to leap up over the next decade but then settle at just over 6 percent of the GDP, at which point it will cease to be a major contributor to rising entitlement spending or growing debts. Social Security is thus a minor player in our long-term budget drama; if you cut the program to the bone, shrinking future payouts so that they won’t add a penny to the deficit, the federal debt would still reach 111 percent of the GDP in 2047.[4](https://fivethirtyeight.com/features/to-cut-the-debt-the-gop-should-focus-on-health-care-costs/#fn-4) Likewise, cuts to [welfare and poverty-related entitlements](https://www.washingtonpost.com/news/wonk/wp/2017/12/06/congressional-republicans-are-laying-the-groundwork-to-overhaul-welfare-programs-for-the-poor/) like food stamps and unemployment insurance are unlikely to improve the debt forecast. In fact, spending on these entitlements has been dropping since the high-need years around the Great Recession and is expected to shrink further in the decades ahead — partly because payouts aren’t adjusted to keep up with economic growth, and partly because the birth rate [has been falling](https://www.cdc.gov/nchs/data/vsrr/report002.pdf) and several programs are geared to families with children.[5](https://fivethirtyeight.com/features/to-cut-the-debt-the-gop-should-focus-on-health-care-costs/#fn-5) But the scale of the problem is totally different when you turn to health care. Spending on entitlement-related health programs — including Medicare, Medicaid and subsidies required by the Affordable Care Act — will never shrink or stabilize, according to projections. The CBO predicts these costs will grow over 65 percent between now and 2047 — and then go right on growing after that, heedless of the fact that the percentage of the population that’s over 65 should no longer be increasing. Why is health care eating the budget? Per-person costs Demographics aren’t responsible for the projected explosion in health care costs. More important than the growing number of elderly Americans is the growing cost per patient — the rising expense of treating each individual The CBO found that the lion’s share — 60 percent — of the projected increase in health spending comes from costs that would continue to increase even if our population weren’t getting older. The reasons for this are many, including the [rising cost of prescription drugs](https://khn.org/news/pace-of-u-s-health-spending-slows-in-2016/) and the fact that hospital mergers have [reduced competition](https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html). But since 2000, per capita health costs in the U.S. have, on average, grown [faster than the GDP](https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/). And while these costs rose more slowly after the Great Recession and the implementation of the Affordable Care Act, analysis from the Centers for Medicare and Medicaid Services suggests [this slower growth rate won’t last](https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html). Which is bad news for these programs, because if the problem were demographic, it’d be easier to solve. By mixing the kind of program cuts Republicans generally support with targeted tax increases [favored by some Democrats](https://www.npr.org/2013/12/05/249068448/to-fix-social-security-some-democrats-want-to-lift-wage-cap), you could meet the short-term challenge posed by retiring baby boomers and raise enough money to cover the larger — but stabilizing — population of eligible seniors. But with ever-rising costs, there is no stable future to prepare for. To keep these programs funded, you’d need a wholly different approach — indeed a whole new perspective on mounting federal debt and the role of entitlements. The future is a race between rising health care costs and economic growth, a race that the economy is losing. Each time health costs outpace the GDP, it creates what the CBO calls “excess cost growth,” which feeds the federal debt. If the government could close this gap, the long-term budget outlook would be a lot rosier. There are two ways to solve this issue: Either contain health care costs — say through price regulation or more competitive markets — or boost economic growth enough to pay for this expensive health care. Success on either front would make health care spending look more manageable over future decades and lighten the debt load. Entitlement reform needs health care reform to work Few of [the proposals](https://www.politico.com/story/2017/12/11/trump-welfare-reform-safety-net-288623) that commonly fall under the heading of entitlement reform target the health care cost problem, which limits their ability to reduce the long-term debt. Even when they do address health care, often the result is to shift — rather than solve — the problem. Say lawmakers decide to dramatically cut Medicare. That would indeed ease the government’s debt problem. But the underlying dynamic — the race between health costs and the GDP — wouldn’t really change. Seniors would still need health care, and per-person costs would likely still grow (maybe even faster, since Medicare is a [relatively efficient program](http://www.politifact.com/truth-o-meter/statements/2017/sep/20/bernie-s/comparing-administrative-costs-private-insurance-a/)). On top of all this, there’s also a deep-seated political barrier: It’s no good if one party picks its favored solution only to watch the other party dismantle it when they next take over. You need political consensus to make changes stick, and America is notably short on consensus right now. In the end, though, it won’t do to just throw up our hands. Absent some workable solution, spending on health care will sink the federal budget, generating levels of debt that would [hold back the economy](https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/workingpaper/45140-NSPDI_workingPaper_1.pdf) and potentially spark a [global crisis of confidence](https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/60xx/doc6094/02-16-cbo_testimony.pdf) in the United States’ ability to borrow. If Republicans are serious about addressing this challenge and reducing America’s debt, they need to find an approach to entitlement reform that can both reduce out-of-control health costs and also survive under Democratic governance.