[x] and I negate Resolved: The United States should replace means-tested welfare programs with a universal basic income, or UBI.

According to the [International Monetary Fund.](https://www.cnbc.com/2019/06/27/free-cash-handouts-what-is-universal-basic-income-or-ubi.html) Universal basic income refers to regular cash payments made to a given population (such as adult U.S. citizens, for example) with minimal or no requirements for receiving the money, in order to increase people’s income.

## Sole Contention is Igniting Inequality (x:xx)

#### UBI creates a more unequal society in 4 ways

### First is through a flawed redistribution (:55)

#### Contrary to popular misconceptions, American welfare programs are highly effective

#### **Worstall 16 of Forbes explains.** (Time Worstall, June 8th 2016, “America's Surprisingly Efficient And Effective Welfare Benefits System” Forbes, I'm a Fellow at the Adam Smith Institute in London, a writer here and there on this and that and strangely, one of the global experts on the metal scandium, one of the rare earths. An odd thing to be but someone does have to be such and in this flavour of our universe I am. I have written for The Times, Daily Telegraph, Express, Independent, City AM, Wall Street Journal, Philadelphia Inquirer and online for the ASI, IEA, Social Affairs Unit, Spectator, The Guardian, The Register and Techcentralstation. I've also ghosted pieces for several UK politicians in many of the UK papers, including the Daily Sport. https://www.forbes.com/sites/timworstall/2016/06/08/americas-surprisingly-efficient-and-effective-welfare-benefits-system/#117ea8154cb5)/RL

The Republicans look like turning to that perennial interest, reforming the welfare benefits system. And there's no doubt that it could be reformed to all our benefit. In particular, we could make the poor better off without spending any more money: or we could make them as well off as they are now and spend less. That's not quite what is being suggested as yet of course but we can all hope. However, when considering such reform we do need to think rather more than just a little bit about how good the current system is at alleviating poverty: that being the goal of a welfare benefits system of course, the alleviation of poverty. The truth here is that **the American [welfare] system is** really rather good at that job. And more than that, it's almost **excellent at** the aim of **reducing child poverty**. So, therefore, we've got both left and the progressives coming out in support of the current system. Which is great, why not? But their arguments then run smack into the face of their own more normal rhetoric, which we'll get to in a moment: “For years, decades now, Washington has spent billions of dollars on dozens of programs to fight poverty, but we have barely moved the needle,” Ryan says. “The War on Poverty is a stalemate, at best.” This is a favorite claim of Paul Ryan’s, and it’s completely wrong. Ryan and others who makes this claim that War on Poverty, launched in the mid-60s, has been ineffective usually point to the official poverty rate, which stands roughly equal to where it was in 1965. But as Vox’s Dylan Matthews wrote in 2015, the official poverty rate is a “travesty of a statistic” that doesn’t take into account “[**through] in-kind transfers like Medicaid, food stamps, and housing vouchers**, as well as tax-based programs like the [Earned Income Tax Credit].” So when Ryan complains that billions of dollars have been uselessly spent on anti-poverty programs, he’s citing a statistic that doesn’t account for much of that spending. Quite so, quite so, it's a point I have made many a time around here. In fact, in my native UK, I've made the point so many times that some now call it Worstall's Fallacy. We can't measure anything before whatever it is that we do to alleviate that problem. We must measure afterwards, to see how much we've alleviated. This is taken further by the CBPP: Workers in poverty typically have a greater incentive to work more hours or at higher wages than other workers do. A recent Congressional Budget Office (CBO) analysis found workers with earnings below the poverty line face “marginal tax rates” — i.e., the reduction in benefits or increase in taxes for each additional dollar earned — that are typically well below those that other workers face. The median or typical worker with earnings below half of the poverty line has a marginal tax rate of 14 percent, according to CBO’s analysis, meaning that he or she loses 14 cents in higher taxes and/or lower benefits for each additional dollar earned. Workers with earnings between 50 and 100 percent of the poverty line typically face marginal tax rates of 24 percent. In contrast, the groups of earners with somewhat higher incomes that CBO examined typically have marginal tax rates of about 33 or 34 percent. What we want in a welfare system is that it alleviates poverty, of course. But also that it doesn't destroy the incentives to kill off poverty through work rather than redistribution. This is something the American system does rather well. Rather better than most of the European systems in fact which almost all suffer from very high (millions above 60% in Britain alone) marginal tax rates as above. By the American measure of child poverty for example that **welfare system reduces [child poverty]**it **from** the **20%** or so that we see before welfare **down to** about 2 or **3%** after welfare. That's a pretty good performance for a government system and it manages it without those fearsome marginal tax rates. It's a good performance. But of course this defence of the system runs smack into the problem of the more usual political rhetoric. We are continually told that the poverty rate is still 15% or whatever: we must do more! Child poverty is 20%, we must do more! But when we defend the current system we point out that actually, after welfare those rates are nothing like that. All of which means that we really ought to move to the correct defence of the American system. The low tax and low redistribution system in general means that Americans are, in general, better off than Europeans. Then in kicks the various welfare systems, more generous in Europe than in the US. This leads to the average for the bottom 10% in say the US, Sweden and Finland as being about the same. Yes, including food prices, health care, education and so on. The richer economy in general in the US makes up for the lesser redistribution. For the bottom 5% on average it's a bit gloomier in the US. That's because the place deals rather badly with significant mental health and addiction problems rather than anything specifically to do with poverty itself. Thus any debate about the welfare system really does have to include two things which either side very rarely mention. Firstly, that the US system as a whole does its job pretty well. Secondly, that there's nowhere near as much poverty floating around as we generally get told there is. Because the claims are usually of the numbers before that rather good performance is taken into account.

#### This is because

Michael D. **Tanner**, 8-22-2013, "Why get off welfare?**," LA Times,** https://www.latimes.com/opinion/la-xpm-2013-aug-22-la-oe-tanner-welfare-work-pay-20130822-story.html

**The [average] value of the package in a medium-level welfare [benefits] state is $28,[000] 500.** In Washington, D.C., **and [in] 10** particularly generous **states** — Hawaii, Vermont, Connecticut, Massachusetts, New York, New Jersey, Rhode Island, Maryland, New Hampshire and California — these seven programs provide a mother with two young children an annual benefit **[can be] worth more than $35,000 a year.**

#### Unfortunately, implementing a UBI would cause these programs to get cut

#### Unfortunately, implementing a UBI would cause welfare to get cut–that outweighs since these programs are better than a UBI for several reasons.

Robert **Greenstein**, 6-13-**2019**, **CBPP**"Commentary: Universal Basic Income May Sound Attractive But, If It Occurred, Would Likelier Increase Poverty Than Reduce It," Center on Budget and Policy Priorities, <https://www.cbpp.org/poverty-and-opportunity/commentary-universal-basic-income-may-sound-attractive-but-if-it-occurred>

UBI’s daunting financing challenges raise fundamental questions about its political feasibility, both now and in coming decades. Proponents often speak of an emerging left-right coalition to support it. But consider what UBI’s supporters on the right advocate. They generally propose UBI as a replacement for the current “welfare state.” That is, they would **financ[ing] UBI [would] eliminat[e]]ing all or most [welfare] programs for people with low or modest incomes**. Consider what that would mean.  **[This would,] If you take the dollars targeted on people in the bottom fifth or two-fifths of the population and convert them to universal payments to people all the way up the income scale, you’re redistribut[e]ing income upward. That would increas[ing] poverty and inequality rather than reduce them.** Yet that’s the platform on which the (limited) support for UBI on the right largely rests. It entails abolishing **programs from SNAP (food stamps)** — which largely eliminated the severe child malnutrition found in parts of the Southern “black belt” and Appalachia in the late 1960s — **to the Earned Income Tax Credit (EITC), Section 8 rental vouchers, Medicaid, Head Start, child care assistance, and many others.  These programs lift tens of millions of people, including millions of children, out of poverty each year and make tens of millions more less poor.** Some UBI proponents may argue that by ending current programs, we’d reap large administrative savings that we could convert into UBI payments. But that’s mistaken. For the major means-tested programs — SNAP, Medicaid, the EITC, housing vouchers, Supplemental Security Income (SSI), and school meals — administrative costs consume only 1 to 9 percent of program resources, as a CBPP analysis explains.[1] Their funding goes overwhelmingly to boost the incomes and purchasing power of low-income families.

**Moreover, he finds that**

Moreover, as the Roosevelt Institute’s Mike Konczal has noted, **eliminating [welfare] Medicaid**, SNAP, the EITC, housing vouchers, **and the like would still leave you far short of what’s needed to finance a meaningful UBI.**[2] Would we also end Pell Grants that help low-income students afford college? Would we terminate support for children in foster care, for mental health services, and for job training? Ed Dolan, who favors UBI, has calculated that we could finance it by using the proceeds from eliminating all means-tested programs outside health care — including Pell Grants, job training, Head Start, free school lunches, and the like, as well as refundable tax credits, SNAP, SSI, low-income housing programs, etc.  **The result,** Dolan found, **would be an annual UBI of $1600 $1,582 per person, well below the level of support most low-income families** (especially working-poor families with children) **now receive. The increase in poverty and hardship would be very large**.[3] That’s why the risk is high that under any UBI that could conceivably gain traction politically**, tens of millions of poor people would likely end up worse off.**

### Second is through eliminating medicaid (:47)

**Rutgers** **University**

<http://raw.rutgers.edu/docs/Big%20Data/The%20Six%20Major%20U.pdf>

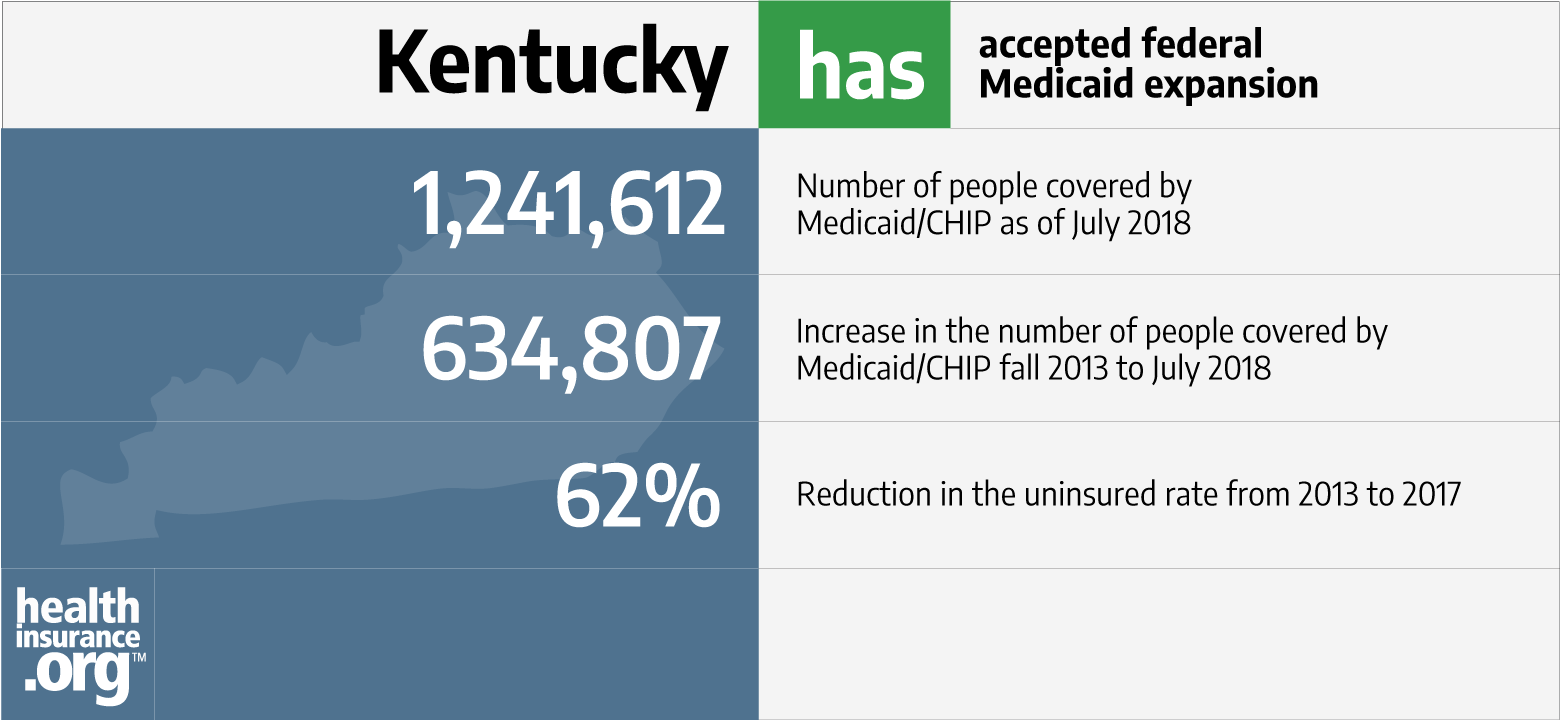
“**Medicaid paid for the health care of 75.1 million low-income adults in 2017. The largest share, of this cost (40 percent) went to 30.0 million children.** In 2014, Medicaid also paid health expenses for 9.8 million blind and disabled people. The smallest category of beneficiary was 5.4 million low-income seniors. Medicaid pays for any health costs that Medicare does not cover. The Affordable Care Act increased Medicaid coverage by 28 percent. The act also raised the qualification income level and allowed single adults to qualify.”

#### Recent Medicaid expansion programs have been especially effective

Louise **Norris**, 12-16-**2019**, "Kentucky and the ACA’s Medicaid expansion: eligibility, enrollment and benefits," healthinsurance.org, <https://www.healthinsurance.org/kentucky-medicaid/>

Kentucky has been one of the most successful states in reducing its uninsured rate through the Affordable Care Act (ACA) — both by **[after] expanding Medicaid** and adopting a state-run health insurance marketplace (Kentucky still technically has a state-run marketplace, but they began using HealthCare.gov’s enrollment platform in 2017). The Centers for Medicare and Medicaid report that **Kentucky’s Medicaid**/CHIP **enrollment increased by 99 percent** from 2013 to mid-2019 — by far the largest percentage increase of any state, and more than three times as much as the national average increase of 28 percent (although the state’s increase in net enrollment had been even larger — 111 percent — as of March 2018). And according to US Census data, Kentucky’s uninsured rate dropped 9.2 percentage points from 2013 to 2016, reaching a low of 5.1 percent. But it increased slightly in 2017, to 5.4 percent, and increased again in 2018, to 5.6 percent (nationwide, there has been an uptick in the uninsured rate under the Trump administration).

**While the number of its uninsured citizens fell by 62%.**



#### 

#### Without medicaid, low-income americans won’t be able to afford insurance on the private market with just a UBI

John **Tozzi**, 9-25-**2019**,**bloomberg**  "Health Insurance Costs Surpass&nbsp;$20,000 Per Year, Hitting a Record," Bloomberg, https://www**.**bloomberg.com/news/articles/2019-09-25/why-is-health-insurance-so-expensive-20-000-a-year-for-coverage

**The cost of family health coverage in the U.S. now tops $20,000**, an annual survey of employers found, **a record high that has pushed an increasing number of American workers into plans that** cover less or **cost more, or force them out of the insurance market entirely.**

**This would be devastating**

Cecere of [Harvard](https://news.harvard.edu/gazette/story/2009/09/new-study-finds-45000-deaths-annually-linked-to-lack-of-health-coverage/) University finds that

**Nearly 45,000 annual deaths are associated with lack of health insurance,** according to a new study published online today by the American Journal of Public Health. That figure is about two and a half times higher than an estimate from the Institute of Medicine (IOM) in 2002.

The study, conducted at Harvard Medical School and Cambridge Health Alliance, found that **uninsured, working-age Americans have a 40 percent higher risk of death than their privately insured counterparts,** up from a 25 percent excess death rate found in 1993.

#### When people are sick, they can’t work

**NILC**, 8-1-**2017,** "Increasing Access Benefits Everyone: Economic Impacts," https://www.nilc.org/issues/health-care/economic-impacts-of-increasing-access/

**Workers who have access to insurance are more productive.** People without insurance are often in poor health due to deferred treatment and uncontrolled chronic conditions. **Poor health** results in multiple dimensions of lost productivity: adults whose health status **[can] prevents [the uninsured] them from working**, **[and] workers** who **miss time from their jobs** because of health problems, and workers who are working but less productive because of their health conditions.[7] One study found that **workers who were uninsured missed [an additional] almost five more days of work each year than those who had insurance.[8** Health-related productivity losses are estimated to **reduc[ing] U.S. economic output by $260 billion per year.[9]** These productivity losses are due to a combination of work days missed due to illness, workers’ inability to concentrate because of their own or a family member’s health condition, and reduced labor force participation among people whose health status prevents them from working.[10]

#### **~~Without medicaid, a single emergency can financially ruin patients~~**

~~Kj~~ **~~Mcelrath~~**~~, 7-25~~**~~-2019,~~** ~~"Surprise Emergency Room Bills Legislation Withdrawn in California," Top Class Actions, https://topclassactions.com/lawsuit-settlements/money/surprise-bills/surprise-emergency-room-bills-legislation-withdrawn-in-california~~

~~Under industry pressure, California lawmakers withdrew new legislation that would have strengthened patient protections against~~ **~~surprise emergency room bills.~~**~~Assemblyman David Chiu of San Francisco, who authored the bill, has promised to re-introduce it next year. Nonetheless, failure of the bill means that for now, consumers will continue to face surprise medical bills in the tens of thousands of dollars simply because someone who treated them was “out of network.” The problem of unexpected medical bills is that can they~~ **~~can add tens of thousands of dollars for even relatively minor treatments or procedures~~**~~. Also known as “balance billing,” these invoices are sent to patients when they have been treated by a physician who is not part of a hospital’s “network” – even after this attending physician has billed or even received payment from an insurer.~~

### Third is neglecting people with disabilities (:52)

#### Millions of people with disabilities rely on crucial welfare programs which will be cut

**MACPAC Commission 19** <https://www.macpac.gov/subtopic/people-with-disabilities/>

**Over 10 million people qualify for Medicaid based on a disability.** Although many are dually eligible for Medicare and Medicaid, most (6.2 million) do not have Medicare coverage. People under age 65 who qualify for Medicaid on the basis of a disability include adults and children with disabilities that they have had since birth and others who have disabling conditions acquired through illness, injury, or trauma. Medicaid beneficiaries enrolled through disability pathways include those with physical conditions (such as quadriplegia, traumatic brain injuries); intellectual or developmental disabilities (for example, cerebral palsy, autism, Down syndrome); and serious behavioral disorders or mental illness (such as schizophrenia or bipolar disorder)**.Over one-third of Medicaid beneficiaries who qualify on the basis of a disability do so through receipt of [the] Supplemental Security Income (or SSI), the federal cash assistance program for the elderly and people with disabilities who have low levels of income and assets.**

#### Without this assistance, they will have no other option to turn to, as

Erica L. **Reaves** and Marybeth Musumeci, 12-15-**2015**, "Medicaid and Long-Term Services and Supports: A Primer," Henry J. **Kaiser Family Foundation**, <https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>

**These programs**

**Medicaid is the nation’s major publicly-financed health insurance program, covering the acute and long-term services and supports (LTSS) needs of millions of low-income Americans of all ages.** With limited coverage under Medicare and few affordable options in the private insurance market, **Medicaid will continue to be the primary payer for a range of institutional and community-based LTSS for people needing assistance with daily self-care tasks. Advances in assistive and medical technology that allow people with disabilities to be more independent and to live longer, together with the aging of the baby boomers, will likely result in increased need for LTSS over the coming decades. T**o reduce unmet need and curb public health care spending growth, state and federal policymakers will be challenged to find more efficient ways to provide high quality, person-centered LTSS across service settings. This primer describes LTSS delivery and financing in the U.S., highlighting covered services and supports, types of care providers and care settings, beneficiary subpopulations, costs and financing models, quality improvement efforts, and recent LTSS reform initiatives. “Long-term services and supports” encompasses the broad range of paid and unpaid medical and personal care assistance that people may need – for several weeks, months, or years – when they experience difficulty completing self-care tasks as a result of aging, chronic illness, or disability. **Long-term services and supports provid[ing] assistance with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals [and], managing medication, and housekeeping).** Long-term services and supports include, but are not limited to, nursing facility care, adult daycare programs, home health aide services, personal care services, transportation, and supported employment as well as assistance provided by a family caregiver. Care planning and care coordination services help beneficiaries and families navigate the health system and ensure that the proper providers and services are in place to meet beneficiaries’ needs and preferences; these services can be essential for LTSS beneficiaries who often have substantial acute care needs as well. Beyond unpaid care provided by relatives**, [but these care] LTSS costs often exceed what individuals and families can afford given other personal and household expenses.** Institutional settings such as nursing facilities and residential care facilities are the most costly. In 2015, the median annual cost for nursing facility care was $91,250.9 Generally, HCBS are less expensive than institution-based LTSS, but may still represent a major financial burden for individuals and their families. **In 2015, the median cost for one year of home health aide services [is]** (at $20/hour, 44 hours/week) **was [often costing] almost $45,800** and adult day care (at $69/day, 5 days/week) totaled almost $18,000 (Figure 2).10

#### **For the disabled, this is a matter of life or death**

**Sarris 17** (Sarris, Simon. Author @ Medium. "After universal basic income, the flood". <https://medium.com/@simon.sarris/after-universal-basic-income-the-flood-217db9889c07.> 22 Oct 2017. Accessed 26 Feb 2018 SM)

**Many of the funding ideas for basic income involve replacing all social safety programs: Disability (SSDI), SSI1, Social Security, food stamps, medicaid, etc. The money saved eliminating all these programs (and their overhead) can be used to give everyone a modest basic income,** many proponents suggest. On the face of it this makes the numbers come close to acceptable, but **it also means that Basic Income [UBI] schemes essentially takes money out of the pot currently reserved for the needy and disabled, and distribute it to able-bodied people plus the needy and disabled.** Such a scheme may have good effects, like encouraging people to enter the workforce by removing the welfare traps that can make people who switch from benefits to paid work worse off. But if that’s the main plus, why not just restructure the existing benefits so that these traps don’t exist, instead of blindly re-allocating money from the for-sure needy to wealthy hipsters who don’t feel like working? This is the same problem structurally that rent-eating-the-world, college-costs-eating-the-world, healthcare-costs-eating-the-world (okay, USA) have. **Providing the funds as a fix is not adequate, and may make the problem worse.** We must make sure that our optimism for UBI is not really masking very real and hard problems in society. (Nothing against wealthy hipsters who don’t want to work, they’re just a socially agreeable punching bag. You can insert your own personal despised out-group and the point is still true.) If you want a less inflammatory fairness example: **Removing all welfare to create UBI to give everyone the same amount it [for whom UBI] is a de facto pay decrease to anyone with needs outside their control, such as diabetics, who need all the things you do, plus insulin, to live. So after cost-to-stay-alive is factored in, they get less money than [people without disabilities.] you do from UBI. In this way, giving everyone the same amount results in its own kind of inequality starting from the very first check.**

### **Fourth is energy assistance (lifeline moved to bottom)**

**Department of Health and human services in 2019**

No Author, xx-xx-xxxx, "Welcome to Benefits.gov," No Publication, <https://www.benefits.gov/benefit/623>

**The Low Income Home Energy Assistance Program (LIHEAP) assists eligible low-income households with their heating and cooling energy costs,** bill payment assistance, energy crisis assistance, weatherization and energy-related home repairs. In order to qualify for this benefit program, you must need financial assistance for home energy costs. **In order to qualify, you must have an annual household income [below a federal threshold]** (before taxes) that is less than or equal to the following amounts:

#### **The HHS continues that**

<https://liheapch.acf.hhs.gov/news/feb19/vortex.htm>

**There are** 14 million homes in the United States who are propane-reliant and **23 million homes who depend on LIHEAP to keep their homes safely heated.**Timothy Smeeding, who researches poverty at the University of Wisconsin – Madison, said, “If your furnace goes out and it’s well below zero, it’s an extreme emergency.”

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#### **Eliminating LIHEAP would be devastating**

Washington Post, 3-17-2017, "Analysis," https://www.washingtonpost.com/news/wonk/wp/2017/03/17/program-that-keeps-families-from-freezing-is-only-lower-impact-if-you-ignore-all-the-families-who-didnt-freeze/

The authors also ran some economic simulations and found that "**eliminating LIHEAP decreases the number of energy-secure households by 17%**, significantly changing the size and composition of the energy secure population within the United States."

#### **The heating and cooling that LIHEAP enables saves lives and keep families in their homes**

NCLC 18 “The Low Income Home Energy Assistance Program (LIHEAP): A Safety Net that Saves Lives.” National Consumer Law Center. <https://www.nclc.org/issues/energy-utilities-a-communications/liheap-safety-net-saves-lives.html>

The federal[Low Income Home Energy Assistance Program (LIHEAP)](https://liheapch.acf.hhs.gov/)provides life-saving assistance for low-income households with young children, frail elderly, and individuals with disabilities, by helping to pay electricity, gas, and oil bills. Payments are generally made to the utility or fuel vendor directly to help ensure that utility service is not terminated and that fuel tanks don’t run dry. States and localities that deliver the assistance have leveraged substantial, additional funding from private sector programs and funds to help more families. Without LIHEAP, households experience disconnection of utility service, leading to lack of heat in the winter or cooling in the summer. This creates dangerous situations, especially for elders and young children. Households sometimes resort to unsafe heating methods resulting in serious property damage and even loss of life. Many more families experience homelessness simply because their houses are not livable. Unaffordable energy bills lead to dire choices. Research has documented that families with young children put less food on the table when they don’t get LIHEAP. The lack of adequate nutrition results in underweight babies and school-age children who aren’t able to get to school, or under-preform. A Cost-Effective, Life-Saving Program In recent years, LIHEAP has helped an estimated 7 million families annually by paying a portion of their heating or cooling bills. And yet the program is chronically underfunded:[currently only 20 percent of eligible households receive assistance.](https://www.washingtonpost.com/news/wonk/wp/2017/03/17/program-that-keeps-families-from-freezing-is-only-lower-impact-if-you-ignore-all-the-families-who-didnt-freeze/?utm_term=.5ecbda6cd4d3)Every year, LIHEAP provides grants to each state and territory. These governmental grantees have broad discretion in how they structure their energy assistance program. States have flexibility in setting the income-eligibility criteria and benefit amounts to target assistance so that the most vulnerable receive the most help. LIHEAP is a targeted energy assistance program that has enjoyed strong bipartisan support over its 35 years of existence. The federal government has imposed much stricter reporting requirements on the state LIHEAP programs. In response, states have demonstrated that LIHEAP is an effective program for reducing “energy burdens” – a key program measure showing the percent of out-of-pocket household income needed to pay energy bills. As LIHEAP help is provided to a vulnerable household, it makes energy bills more affordable. This means that households can avoid having the heating oil or propane tank run dry in the middle of a frigid winter or a shut-off of electricity in the middle of a sweltering summer. LIHEAP therefore frees up limited household income that can be spent on food, rent, or prescription medicine.

[National studies](http://neada.org/communications-events/surveys/neada-releases-2009-national-energy-assistance-survey/)have documented the dire choices low-income households face when energy bills are unaffordable. Because adequate heating and cooling are tied to the habitability of the home, low-income families will go to great lengths to pay their energy bills. Low-income **households faced with unaffordable energy bills cut back on life-sustaining necessities, including food**, medicine **and medical care.**

Low-income households experience very low food security during heating and cooling seasons when energy bills are high.[A pediatric study in Boston](http://pediatrics.aappublications.org/content/118/5/e1293?download=true)documented an increase in the number of extremely low weight children, age 6 to 24 months, in the three months following the coldest months, when compared to the rest of the year. Clearly, families are going without food during the winter to pay their heating bills, and their children fail to thrive and grow. A[Colorado study](http://www.ucdenver.edu/academics/colleges/SPA/researchandoutreach/Buechner%20Institute%20for%20Governance/Centers/CEPA/Publications/Documents/HomelessExecutive%20Summary-FINAL-2-27-07.pdf)found that **the second leading cause of homelessness for families with children is the inability to pay for home energy, [which can lead to evictions].**

When people are unable to afford paying their home energy bills, dangerous and even fatal results occur. **In** the **winter, families resort to** using **unsafe heating sources, such as** space heaters, ovens and burners, all of which are fire hazards. **Space heaters, [which] pose** 3 to **4 times more risk for fire and** 18 to **25 times more risk for death** than central heating.

In the summer, the inability to keep the home cool can be lethal. Older adults, young children, and persons with chronic medical conditions are particularly susceptible to heat-related illness and are at a high risk of heat-related death. Air conditioning is the number one protective factor against heat-related illness and death, especially in the South and Southwest. LIHEAP assistance helps these vulnerable people keep their homes at safe temperatures during the winter and summer. Simply put, **LIHEAP saves lives.**

#### **Without having a home, becoming employed becomes nearly impossible**

C E **Clark**, 2-27-20**19,** "Why Don't Homeless People Just Get Jobs?," Soapboxie, https://soapboxie.com/social-issues/why-homeless-people-dont-just-get-a-job

Why Can't **Homeless People [can’t] Get Jobs? [since] They don't have addresses, and most employers require addresses [for their employees].** This is a lose-lose situation: They can't get a place to live until they get a job, but can't get a job until they get a place to live. Many employers won't consider unemployed job applicants (not even those with homes). Many homeless people don't have reliable phones, and this becomes an obstacle to employment. Even if they have a phone, they might not always have a way to charge it.

#### **THUS WE NEGATE.**

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### LIFELINE DA: Fourth is cutting a lifeline

Christian Science Monitor, 2-3-2016, "Why many low-income families have Internet access, but remain 'under-connected'," https://www.csmonitor.com/Technology/2016/0203/Why-many-low-income-families-have-Internet-access-but-remain-under-connected

**In the US, low and moderate-income families are also increasingly purchasing technology** such as smartphones in order to enhance their children’s education and stay in touch with family and friends, a new national study released on Wednesday finds.

**But many families remain “under-connected,” with a stable home Internet connection often out of reach because of high costs**, particularly among immigrant Hispanic families, says the study, conducted by researchers at Rutgers University and the Joan Ganz Cooney Center.

[https://www.**nclc**.org/images/pdf/take-action/lifeline/lifeline-breakdown-fact-sheet.pdf](https://www.nclc.org/images/pdf/take-action/lifeline/lifeline-breakdown-fact-sheet.pdf)

Communication

**The federal Lifeline program,**created in 1985,**helps low-income consumers afford voice, wireless, and broadband internet service.Nearly 13 million** eligible older **Americans,** veterans, families with children, and other consumers in every state and territory **have access to affordable voice and broadband service to keep them connected with employers, schools, and healthcare providers**. With a focus on education and awareness,Lifeline Cloudreach many more eligible low-income families;just 1/3 of Lifeline eligible households are currently enrolled.

**This allows for future-proofing**

**Bloomberg**, 8-14-**2019,** "Employers Can’t Retrain the U.S. by Themselves," Bloomberg, https://www.bloomberg.com/opinion/articles/2019-08-14/employers-can-t-retrain-the-u-s-workforce-by-themselves

**As more workplace tasks become automated**, this deficit threatens to leave **millions****of** less-educated **workers** behind. According to a McKinsey report, low and middle-wage workers **are at greatest risk of seeing their jobs become obsolete [and]** by 2030. **Nearly two-thirds of the U.S. labor force will require additional training just to hold on to the[ir current] jobs they currently have**. High-wage jobs are expected to grow as a share of overall employment, but the country’s education system isn’t producing candidates with the skills required.

<https://www.nclc.org/images/pdf/take-action/lifeline/lifeline-breakdown-fact-sheet.pdf>

•Broadband access contributes to the continuing success of the American economy**.Tomorrow’s jobs are in the[STEM] fields of science, technology, engineering, and medicine–career paths where computer literacy is essential. Connecting Lifeline eligible households with children to affordable broadband services is an investment in their future and the future of the American labor force.**  •Affordable communications help to reduce unemployment. **With** access to **affordable broadband** and voice services**, jobless Americans can conduct employment searches, connect with employers, and complete online career development courses**. Once employed, Lifeline subscribers can receive real-time updates from their employers.

### Econ Impact

#### **UBI massively increases inflation**

Paul Boyce, 5-5-2019, "Universal Basic Income Is a Pandora’s Box," No Publication, <https://fee.org/articles/universal-basic-income-is-a-pandora-s-box/>

A UBI would essentially transfer wealth away from higher earners toward low earners. This spurs higher consumption because those with lower incomes have a higher propensity to consume. On a macro basis, this may not necessarily create any inflation, as there is no new money entering the economy. However, it will create inflation on a micro basis. Rather than money going toward investment, it is going toward consumer goods. Instead of inflation occurring through a wide variety of areas, it is being concentrated. Yang says this is just using the existing money in the economy. In part, he is right. However, he fails to consider the velocity of money. One of the reasons the US did not experience significant inflation after quantitative easing was due to a slowing of consumption growth. If we put $12,000 into everyone's hands, consumer demand will rise, and so, too, will velocity. When velocity increases, the same $1 exchanges hands at a quicker rate. For example, A may buy a television from B for $100. B will then buy a used iPhone from C for $100. C will then buy a used sofa from D for $100. The initial $100 has circulated around the economy at a value of $300. This sends demand signals to the relevant parties, who then respond with higher prices.

**Selig 20 of Stanford University citing Boyce** (if called show the small text card above ^^)

Increased inflation. **Although the total number of dollars in the economy would not increase with a UBI,** Boyce of the Foundation for Economic Education in 2019 gives a couple warrants for why **inflation would go up. First, by transferring more wealth to lower earners, the economy would see more consumption spending as opposed to investment spending. Second, the velocity of money [or] (the rate at which money is exchanged) would increase. The increased circulation increases demand signals, resulting in higher prices.**

#### **While the economy is stable now, short-term fiscal boosts like UBI would cause the Fed to impose devastating interest rate hikes.**

Michael **Cembalest,** 1-1-**20,** “Eye on the Market Outlook 2020” **JP Morgan,** https://am.jpmorgan.com/blob-gim/1383654367092/83456/PB-19-DE-755%20EOTM%20Outlook%202020\_AM%20INSTITUTIONAL\_DIGITAL\_r4.pdf

Just gonna flex his credentials: MICHAEL CEMBALEST is the Chairman of Market and Investment Strategy for J.P. Morgan Asset & Wealth Management, a global leader in investment management and private banking with $2.2 trillion of client assets under management worldwide (as of September 30, 2019). He is responsible for leading the strategic market and investment insights across the firm’s Institutional, Funds and Private Banking businesses. Mr. Cembalest is also a member of the J.P. Morgan Asset & Wealth Management Investment Committee and previously served on the Investment Committee for the J.P. Morgan Retirement Plan for the firm’s more than 256,000 employees. Mr. Cembalest was most recently Chief Investment Officer for the firm’s Global Private Bank, a role he held for eight years. He was previously head of a fixed income division of Investment Management, with responsibility for high grade, high yield, emerging markets and municipal bonds.

Ghosts of Christmas Past. After a very positive year for investors in 2019, we expect lower positive returns on financial assets **in 2020** as some Ghosts of Christmas Past reappear. **We don’t expect a global or US recession,** and anticipate a modest growth and profits rebound now that worst case trade outcomes may be avoided. **Even so,** high valuations, reduced effectiveness of monetary easing, the repricing of unprofitable companies and rising corporate cost pressures will likely constrain the equity market’s advance. **The two big risks that could cause problems for investors**: (a**)[is] a spike in inflation that [would] forces the Fed to make a U-turn on policy rates ,** and (b) a comprehensive progressive restructuring of the US economy after the 2020 election. The big risks for 2020 . Based on what we’ve discussed so far, we believe that 2020 should offer investors another year of global expansion and 7%-10% returns in equity markets. But like Odysseus crossing the Strait of Messina, investors in 2020 face two substantial risks. For investors, one 2020 peril is a pickup in US wage or price inflation **that indicat[ing] that the Fed has made a serious mistake in cutting real rates to zero** (again). The Fed’s thinking on policy rates has undergone a massive shift since 2007, with current estimates of the natural real rate of interest at less than 1% (actual real policy rates are even below this level). **Most recessions occur due to Fed tightening in response to rising** wage/price **inflation,** or due to a shock to financial conditions (debt/banking crisis, oil shock, global trade war, etc). On inflation, conditions outlined on pages 17-18 are likely to keep Fed tightening at bay for another year. After adjusting for structural changes in the US economy, the latest recession models now include business surveys like the PMI/ISM, core inflation, the shape of the yield curve out to 18 months, credit spreads and the private sector financial balance. Using this approach, **US recession probabilities** out 12-24 months **are ~25%.**

#### This would result in disaster

Pat **Garofalo**, 8-21-**2019**, "The Next Recession Will Be Harder Than It Needs to Be. Here’s Why.," Talk Poverty, https://talkpoverty.org/2019/08/21/next-recession-will-harder-needs-heres/

**The Next Recession Will Be Harder Than It Needs to Be.** Here’s Why.

**Take the Great Recession, the economic plunge that followed the 2008 financial crisis. It cost those in the poorest 10 percent of Americans more than 20 percent of their incomes**, which was more than twice the drop experienced by the richest 10 percent. It was black and Hispanic workers, as well as workers who didn’t have a college degree, who saw higher rates of unemployment and longer durations without a job than other workers**. Overall, the recession exacerbated already existing inequalities in wealth and income, with black and Hispanic families, as well as women, falling further behind their white, male counterparts in terms of asset building. And the next recession could be even [worse] harder.**

### The impact is closing the health-poverty trap

**A UBI would only serve to widen wealth and income inequalities,**

**Bor and Galea 17** (Jacob Bor – ScD, SM, is Assistant Professor and Peter T. Paul Career Development Professor in the Department of Global Health, Harvard School of Public Health, SD Harvard College, AB Harvard School of Public Health, SM/ScM, Sandro Galea – physician and an epidemiologist. He is the Robert A. Knox Professor and Dean at the Boston University School of Public Health Education University of Toronto, MD Harvard School of Public Health, MPH Columbia University School of Public Health, DPH; Article; 4/25/17; “The cost of economic inequality to the nation’s physical health”;<https://www.bostonglobe.com/opinion/2017/04/25/the-cost-economic-inequality-nation-physical-health/JTsEP3XkNx3425ypbw4KRI/story.html>;

After its unsuccessful push to reconfigure the US health care system, the **Trump administration has signaled that it will turn its attention to tax reform**. While the details of the administration’s plan are still unclear, President **Trump has indicated in the past a willingness to embrace measures that would greatly favor the wealthy**, including **tax cuts for the rich and a repeal of the estate tax**. This **could not come at a worse time for lower-income Americans**. According to the Center on Budget and Policy Priorities, the estate-tax repeal would increase the concentration of wealth at the top of the US economy. Due to the tax’s up-to $5.49 million gift exemption, repeal would benefit only the wealthiest o.2 percent of Americans who are in a position to leave such a sum to their heirs. This move would add to the already substantial wealth and income inequalities in this country, which have increased significantly since the late 1970s, and would do **nothing to address the country’s real earnings crisis: the large reduction in incomes** since 2000 for low- and middle-income Americans. In concert with tax cuts for the wealthy, **Trump has proposed large cuts to safety-net programs that protect the health of lower-income Americans**. In doing so, Trump’s tax plan and budget blueprint **will deepen gaps in health and longevity between those who are thriving in our economy and those who are not**. In a paper published recently in The Lancet, we reviewed the literature assessing changes in survival gaps between rich and poor Americans since 1980 and found that health gaps widened between 1980 and 2014. Characteristic of this trend, middle-income and high-income Americans have seen an increase of over two years of additional life expectancy since 2001, while the poorest 5 percent of Americans have seen no gains in survival. In some cases, such as among white women with low income or educational attainment, life expectancy even fell. The longevity gap is stark, with the richest 1 percent of Americans now living 10 to 15 years longer than the poorest 1 percent. **Poverty has** deepened, and it **has** also **become a stronger risk factor for early death**.If current trends continue, **the life expectancy gap between the poorest and wealthiest 20 percent of Americans will grow by nearly a decade in a single generation** — from 77 vs. 82 years for Americans born in 1930, to 76 vs. 89 years for those born in 1960. Two key trends may account for the widening gap in survival across income groups in this century: Poverty has deepened, and it has also become a stronger risk factor for early death. Since 2001, household earnings have decreased for Americans in the lower two-thirds of the income distribution, with the largest losses affecting those at the bottom — earnings decreased by 17 percent for men and women in households at the 25th income percentile. Americans at the top of the distribution had to contend with fewer losses or, in some cases, none at all. Compounding the challenge for low-income Americans is the steepening income-survival gradient. Simply put: The poor and non-college educated have been left out from the health gains enjoyed by middle- and upper-income Americans. On a number of health measures, conditions for the poor are deteriorating. Although as a society we have never had better information about causes of disease, better availability of healthy food, or better medical technologies, access to these and other health inputs is increasingly determined by ability to pay. Public subsidies have not kept pace, leading to widening differentials in access. Education, historically a door to economic opportunity and better health, is increasingly out of financial reach for many Americans. Rising economic insecurity has also contributed to an array of stress-related adverse coping behaviors that are harmful for health, including the persistence of smoking and the resurgence of opioid use. Poor health can also limit economic productivity, deplete household income, and create a negative feedback loop. The growing link between income and health may signal the emergence of a 21st century health-poverty trap.

# Framing

We turn the aff:

1. Poverty controls the IL to gendered violence
2. Poverty is the worst form of SV - cant afford necessities needed to survive

Poverty outweighs-

Healthcare outweighs-

Disabled lives outweighs-

Recession outweighs-

#### **CX: How much is UBI? How do we pay?**

# Lay Rhetoric

Cheese Frontline strats: We account, directionality, no warrant, not a turn

# SEE <https://docs.google.com/document/d/1YhyxsFmVuBTHaFoAVavpKAEhE5ShbxRBAtE3KmhJYEk/edit#heading=h.ehqhmxdurr1d>

# Frontlines

## Sub a: Welfare (generics)

### Extension/Weighing

Worstall and greenstein - welfare is effective and decreased child poverty from 20% to 3%. UBI means redist income upward which puts 10s of mil into poverty. Also only $1600 UBI - conceded.

Welfare o/w automation on timeframe: Loss of healthcare and lifeline happens immediately, autiomation takes at least a decade - means we win the prereq debate - also empirics prove (europe has tons of populism b/c ppl cant get healthcare or jobs)

Redist means money goes from the poor to the wealthy - concede tanner and greenstein - the value of benefits falls from 28k to 1.5k

1. Turns their consumer spending args - lower with a UBI
2. Magnitude filter -caps impacts -Prob not enough to start a company

### Frontlines

#### FL: everything

1. Our ev accounts/its just mitigation - Sheffield 16 finds that among low-income families with children, Medicaid, Food Stamps, and EITC have near 100% takeup rates - almost everyone who qualifies for these programs are able to access it

#### FL: Still high poverty rate

1. Worstall - poverty measure bad, doesnt account for in kind transfers programs like food stamps - our ev uses the better metric and finds actually 20% to 3% poverty

#### FL: Most ppl dont get it

1. (FL Caputo specifically 20% EITC)- His study is
   1. only talking about one program, EITC
   2. Literally from 1999–2005 according to the title of the paper
   3. Postdated by the IRS in 2016 that finds participation is closer to 78%
2. Math doesnt add up - 75 mil people get medicaid - if u multiplied by x it would be more than the total population of the US - ur ev is specific to a specific program (or all americans and not just the poor)

#### FL: Benefit Cliffs

1. adolphson/ less than 1 percent of people are within 10% of the cliff for snap
2. adolphson/ welfares have off ramps now
3. NCSL/ states have transitional benefits now

#### FL: Asset Caps

1. Rosenbaum 19 - More than 40 states use “broad-based categorical eligibility” (BBCE) to relax the restrictions so they can build assets
2. Ingram 18 - mostly eliminated through state laws and exemptions

#### NEED FL: stigma (jan), block grants

### FL Cards

Ingram, 12-20-2018, "Work:  What Welfare Is Missing," Heritage Foundation, https://www.heritage.org/insider/winter-2019-insider/work-what-welfare-missing

At least, that’s how it’s supposed to work. **But regulatory loopholes have all but eliminated the asset test in most of the country. Food stamp enrollees are automatically exempt from the commonsense asset test if they receive a “benefit” funded by states’ TANF cash welfare programs.** But “benefit” is not defined in the law. So states like Minnesota use TANF dollars to print welfare brochures and then claim that the brochure itself is a “benefit.” That means anyone eligible to receive the brochure is categorically eligible for food stamps, no matter how many millions of dollars they have in the bank.

Dottie Rosenbaum, 7-30-2019, "SNAP’s “Broad-Based Categorical Eligibility” Supports Working Families and Those Saving for the Future," Center on Budget and Policy Priorities, https://www.cbpp.org/research/food-assistance/snaps-broad-based-categorical-eligibility-supports-working-families-and

The Supplemental Nutrition Assistance Program (SNAP), the nation’s largest food assistance program, generally operates under a consistent set of federal eligibility rules. But one policy area that results in differences in income and eligibility rules across states is **“broad-based categorical eligibility” (BBCE),** which enables states to raise SNAP income eligibility limits somewhat so that many low-income working families that have difficulty making ends meet, such as because they face costly housing or child care expenses that consume a sizeable share of their income, can receive help affording adequate food. **This policy also lets states adopt less restrictive asset tests so that families, seniors, and people with a disability can have modest savings without losing SNAP**.[1 THE TRUMP ADMINISTRATION ON JULY 23 ISSUED A PROPOSED REGULATION TO ESSENTIALLY ELIMINATE THE POLICY THROUGH EXECUTIVE **ACTION.As a result of this two-decade old policy, more than 40 states effectively use less restrictive income and asset tests in SNAP, which allows them to better support low-income working families, promote asset-building among those households, and improve state administration while lowering administrative costs.** (See Figure 1.) Nonetheless, the Trump Administration on July 23 issued a proposed regulation to essentially eliminate the policy through executive action.[2]

Rachel Sheffield, 12-20-2016, "Five Myths About Welfare and Child Poverty," Heritage Foundation, https://www.heritage.org/welfare/report/five-myths-about-welfare-and-child-poverty

Do Low-Wage Families Actually Access Basic Benefits? Critics on the left might argue that the fact that the mother was eligible for these benefits does not necessarily mean she would apply for and receive them, but among families with children, the take-up rate of benefits is extremely high. (The take-up rate measures the ratio of the number of persons who receive benefits to the number who are theoretically eligible.) For example: The actual take-up rate of the **EITC** for adults claiming children appears to be over 100 percent. There appear to be more adults claiming the credit than there are families eligible for it. The **food stamp** take-up rate among single parents with children appears to be around 130 percent: The number of beneficiaries greatly exceeds the number of eligible families. The **Medicaid** take-up rate for low-income children is around 90 percent. There is a single enrollment process for Medicaid: If the children in a family are enrolled, the parent, if eligible, would be automatically enrolled as well. The take-up rate for free school lunches is also over 100 percent. On the other hand, only half of schools operate the school breakfast program; the benefits in the charts in this paper and the text have been prorated to reflect that fact.[16]

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#### Caputo

RICHARD CAPUTO 10 of the Journal of Social Services (2010, "Prevalence and Patterns of Earned Income Tax Credit Use Among Eligible Tax-Filing Families: A Panel Study, 1999–2005", doa 1-27-2020, https://sci-hub.tw/10.1606/1044-3894.3950) NY

*Findings of the study suggest that nt, while EITC participation is low among prime-age persons and their families.* Over the 7-year study period about one third of those in their prime working years are likely to be classified as working poor. This finding is consistent with Caputo (2007), who studied EITC use among EITC-eligible persons in 2001 and who contended that given its prevalence, working versus nonworking poverty had become the major social problem facing social policymakers. The EITC-eligibility finding of the present study represents an *almost fourfold increase in the prevalence of working poor households in the 1980s*, as reported in an earlier study by Caputo (1991), and equals the prevalence of poverty over the working life span in the United States, as reported by Rank and Hirschl (1995). *Findings in regard to the take-up rate of EITC (< 20% of those eligible) over the 7-year study period suggest that prime-age workers and their families underutilize the program*, although among EITC users, about half are likely to be repeat users. Any combination of three factors may plausibly account for the relatively lower EITC take-up rate, by about half, than those found elsewhere in the literature (see Caputo, 2006; Mammen & Lawrence, 2006; Paulson, 2008; Phillips, 2001): (a) the average prime working-age years of subjects between survey years 2000 (about 39 years old) and 2006 (about 44 years old); (b) an overestimation of EITC eligibility, which as previously noted was mechanically determined; or (c) ignorance about the program. Determining which of the three reasons is the most important contributing factor was beyond the scope of the present study and warrants future research. The low take-up rate is cause for concern, given that all ethnic/racial groups are affected, as are women and men, whether married or not. Millions of low-income working persons and their families are losing out by not filing for the EITC. Those in their prime working years may appear less vulnerable, to the extent more employment opportunities are available, but in economic downturns they too are vulnerable. Given the non-stigmatizing aspect of the EITC, low-income workers in their prime working years should nonetheless be the beneficiaries of extended outreach efforts and encouraged to claim the credit when filing tax returns. Social workers and other helping professionals would do well by their working-poor clientele to be knowledgeable about the EITC program, inquire about tax-filing status as part of a routine data collection, and encourage those EITC-eligible non-filers to file accordingly.

NCSL

The work group conducted a nationwide environmental scan to identify administrative policy changes and legislation that have been enacted to address benefits cliffs. **Short-term solutions primarily fell into three categories: 1) phasing out benefits slowly, extending certification periods or using sliding fee scales, 2) raising eligibility limits or changing exit/loss of eligibility standards to enable a longer stay on benefits while working, and 3) providing monetary incentives for continued employment or allowing more earned income to be retained.**

**Long-term strategies aim to revitalize employment opportunities by: 1) increasing educational and work supports through job-training and skill-development initiatives, 2) expanding educational funding, and 3) asking employers to increase investment in early stage workers**

## Sub b: Medicaid

### Extension/Weighing

Rutgers- 75 mil covered squo

Tozzi - cant afford insurance without medicaid since it costs over 20k - these people have no hc coverage in the aff world

-> cecere says that increases their risk of death by 40%, and NILC finds that they’re out of work once they get sick

**O/W mag- healthcare is the only link into life and death**

**Prereq to jobs - sick cant work**

### 

### Frontlines

#### FL: Group their responses

1. Terminal mitigation - brooks 18 finds that the vast majority of ppl who qualify for medicaid get it, including almost 94% of children who are eligible. That means [stigma/etc.] account for at most 6%.

#### FL: Medicaid aint do shit

1. Totally nonsensical
2. (AT: worse than no insurance) Carroll 17 NYT - correlation not causation - studies concede flawed
3. Cecere - 40% mort. Less
4. Rudowitz 19- much better care than wo insurance emp. Dec mortality, teens, women,

#### FL: Doctors dont accept it

1. Holgash 19- 70% of docs do because of ACA medicaid expansion over the last few years

#### FL: Docs inc premiums

1. Comparatively better - middle/upper class can afford the inc premiums, poor will go without care
2. Try to mitigate

#### FL: Trump cutting Medicaid

1. (Maybe dated if they talking abt new proposal) Diamond Politico 20 - Trump is concerned about perception of cutting healthcare during election year. Not going to do it bc Medicaid is bipartisan support
2. Carney Hill 20 - Democrats control the House which controls the budget. They’ll never pass it

#### FL: Medicaid is block grants now

1. Huberfield Health Affairs 19 - Block grants violate the Medicaid Statute because 1. Health Human Services cannot cap Medicaid funds. Fed gov is required to “match” spending and 2. Only way you can do block grants is waiving a legal statute but block grants don’t “furnish medical assistance”
2. Duffin NPR 20 - Would take months to complete applications to implement

#### FL: UBI solves better

1. Tozzi - cant afford insurance since it costs 20k which is more than UBI

#### FL: Insurance premiums increase

1. Russo 17 - Empirically it actually decreased premiums and out of pocket spending

#### FL: Medicaid is insolvent

1. The cards talking about medicaid??
2. Van De Water 19 -studies are wrong and misleading, still will be able to pay for 89% of it for the foreseeable future

#### FL: Medicaid shafts rural hospitals

1. Bolin 19- Rural hospitals close for other reasons too: declining populations, health professionals moving away, more sickly patients with complex diseases

#### FL: can buy insurance/not that expensive

1. Tozzi/20k
2. (AT: 300/400) EHI - after accounting for premiums and deductibles its 11.6k
   1. also it’s doubled since 2013 so rapidly becoming unaffordable
3. Individual mandate repealed so won't get since ppl r dumb

#### FL: Asset Test

1. Medicaid.gov - they are not allowed for medicaid

#### FL: Charity Care

1. NUQ - exists either world
2. Bannow - Just 1.4% of spending goes to charity care - it’s totally unsustainable since nobody at the hospital gets paid - also we turn somehow

### FL Cards

#### **Just 1.4% of spending goes to charity care - it’s totally unsustainable since you can’t pay doctors - turn somehow**

Tara Bannow, 1-6-2018, "Charity care spending flat among top hospitals," Modern Healthcare, https://www.modernhealthcare.com/article/20180106/NEWS/180109941/charity-care-spending-flat-among-top-hospitals

The yearslong decline in free or discounted care that hospitals provide to patients may have reached its floor.

**The 20 largest U.S. health systems dedicated 1.4% of their collective operating revenue in fiscal 2016** to charity care—about the same as the previous year, a Modern Healthcare analysis of financial data shows. That's noteworthy considering the significant declines in charity care spending that followed the 2014 implementation of the Affordable Care Act, a law credited with insuring nearly 24 million people through expanded Medicaid eligibility and subsidized commercial plans. **Total uncompensated care fell to a 25-year low in** 2015 and held steady in **2016**, according to the American Hospital Association.

"We're in an environment now where uncompensated care, which had been going down, is likely to be going up," said Steve Burrill, U.S. healthcare providers leader and vice chairman for Deloitte Consulting.

All that has some experts wondering whether not-for-profit health systems are finding ways to inflate their charity care levels, given that charity care spending stopped falling so abruptly between 2015 and 2016.

**"I'm sure there is a lot of playing around with the numbers,"** said Cynthia Woodcock, executive director of the Hilltop Institute, a nonpartisan health research organization at the University of Maryland.

EHI, 11-6-2019, "How Much Does Health Insurance Cost Without a Subsidy?," No Publication, https://www.ehealthinsurance.com/resources/affordable-care-act/much-health-insurance-cost-without-subsidy

According to eHealth, average premiums for individual plans were $374 with an average deductible of $7,148 in 2017. For family plans, the average premium was $903 with an average deductible of $12,044 in 2017.

eHealth Insurance Newsroom, 1-23-2017, "Average Individual Health Insurance Premiums Increased 99% Since 2013, the Year Before Obamacare, &amp; Family Premiums Increased 140%, According to eHealth.com Shopping Data," <https://news.ehealthinsurance.com/news/average-individual-health-insurance-premiums-increased-99-since-2013-the-year-before-obamacare-family-premiums-increased-140-according-to-ehealth-com-shopping-data>

The website eHealthInsurance.com estimated that premiums for subsidized Obamacare policies averaged $393 a month in 2017 for individuals, a 99% increase since 2013. And they came with an average annual deductible of $4,328. Costs for family policies skyrocketed 140% during the same period, with premiums hitting $1,021 a month in 2018 with an annual deductible topping $8,350

Medicaid.gov - https://www.medicaid.gov/medicaid/eligibility/index.html

MAGI is the basis for determining Medicaid income eligibility for most children, pregnant women, parents, and adults. The MAGI-based methodology considers taxable income and tax filing relationships to determine financial eligibility for Medicaid. MAGI replaced the former process for calculating Medicaid eligibility, which was based on the methodologies of the Aid to Families with Dependent Children program that ended in 1996. The MAGI-based methodology does not allow for income disregards that vary by state or by eligibility group and **does not allow for an asset or resource test.**

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#### Brooks 18

Tricia Brooks, 8-29-2018, "Growth in Medicaid Participation Rates of Uninsured Children Slows, while Parent Participation Rates Stall," Center For Children and Families, https://ccf.georgetown.edu/2018/08/29/growth-in-medicaid-participation-rates-of-uninsured-children-slows-while-parent-participation-rates-stall/

**In 2016, the percent of eligible, uninsured children enrolled in Medicaid and CHIP inched up from 93.1 percent to 93.7 percent,** according to a new report in Health Affairs from researchers at the Urban Institute. The six-tenths of a percent increase between 2015 and 2016 follows two years of annual gains of greater than two percentage points from 88.7 percent in 2013 to 91 percent in 2014 to 93.1 percent in 2015. More concerning is that growth in participation rate of eligible, uninsured parents dropped significantly in 2016 after a 10.9 percent gain between 2013 and 2015. In 2016, overall parent participation rates rose only slightly from 78.5 percent in 2015 to 79.9 percent.

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##### Van De Water 19

Paul N. Van De Water, 5-1-2019, "Medicare Is Not “Bankrupt”," Center on Budget and Policy Priorities, <https://www.cbpp.org/research/health/medicare-is-not-bankrupt>

**Claims by some policymakers that the Medicare program is nearing “bankruptcy” are highly misleading. Although Medicare faces financing challenges, the program is not on the verge of bankruptcy or ceasing to operate**. Such charges represent misunderstanding (or misrepresentation) of Medicare’s finances.

The 2019 report of Medicare’s trustees finds that Medicare’s Hospital Insurance (HI) trust fund will remain solvent — that is, able to pay 100 percent of the costs of the hospital insurance coverage that Medicare provides — through 2026. **Even in 2026, when the HI trust fund is projected to be depleted, incoming payroll taxes and other revenue will still be sufficient to pay 89 percent of Medicare hospital insurance costs.[1]** The share of costs covered by dedicated revenues will decline slowly to 78 percent in 2043 and **then rise gradually to 83 percent by 2093.** This shortfall will need to be closed through raising revenues, slowing the growth in costs, or most likely both. But **the Medicare hospital insurance program will not run out of all financial resources and cease to operate after 2026, as the “bankruptcy” term may suggest.**

**The 2026 date does not apply to Medicare coverage for physician and outpatient costs or to the Medicare prescription drug benefit; these parts of Medicare do not face insolvency and cannot run short of funds**. These parts of Medicare are financed through the program’s Supplementary Medical Insurance (SMI) trust fund, which consists of two separate accounts — one for Medicare Part B, which pays for physician and other outpatient health services, and one for Part D, which pays for outpatient prescription drugs. Premiums for Part B and Part D are set each year at levels that cover about 25 percent of costs; general revenues pay the remaining 75 percent of costs.[2] The trustees’ report does not project that these parts of Medicare will become insolvent at any point — because they can’t. The SMI trust fund always has sufficient financing to cover Part B and Part D costs, because the beneficiary premiums and general revenue contributions are specifically set at levels to assure this is the case. SMI cannot go “bankrupt.”

#### Russo 17

Therese Russo, 8-22-2017, "How Medicaid Expansion Affected Out-of-Pocket Health Care Spending for Low-Income Families," No Publication, <https://www.commonwealthfund.org/publications/issue-briefs/2017/aug/how-medicaid-expansion-affected-out-pocket-health-care-spending>

**Low-income families in Medicaid expansion states are less likely to have any out-of-pocket health costs. Out-of-pocket premium and cost-sharing expenses are lower for low-income families in states that expanded Medicaid.** Key Findings and Conclusions: Compared to families in nonexpansion states, low-income families in states that did expand Medicaid saved an average of $382 in annual spending on health care. In these states, low-income families were less like to report any out-of-pocket spending on insurance premiums or medical care than were similar families in nonexpansion states. For families that did have some out-of-pocket spending, spending levels were lower in states that expanded Medicaid. Low-income families in Medicaid expansion states were also much less likely to have catastrophically high spending levels. The form of coverage expansion — conventional Medicaid or waiver rules — did not have a statistically significant effect on these outcomes.

#### IRS

<https://www.eitc.irs.gov/eitc-central/participation-rate/eitc-participation-rate-by-states>

1The national EITC participation rate range is approximately 78% (TY2016), estimated in cooperation with the Census Bureau. The TY2016 estimates based on the Current Population Survey (CPS) is 78%, while the TY 2016 estimate based on the American Community Survey (ACS) is 78.6%. A major break-through in the study of EITC Participation Rate was accomplished with the estimation of state level participation rates based on the American Community Survey (ACS). While the ACS data does not allow for as precise a determination of EITC eligibility as the Current Population Survey (CPS) data, the state estimates allow interested parties to observe differences in state level taxpayer participation rates. The official estimate is based on the CPS, with the ACS estimated as supplementary source of information.

#### Caroll

Aaron E. Carroll and Austin Frakt, 7-3-2017, "Medicaid Worsens Your Health? That’s a Classic Misinterpretation of Research," No NYT, <https://www.nytimes.com/2017/07/03/upshot/medicaid-worsens-your-health-thats-a-classic-misinterpretation-of-research.html>

But that is not a proper interpretation of such studies. There are many other, more plausible explanations for the findings. Medicaid enrollees are of lower socioeconomic status — even lower than the uninsured as a group — and so may have fewer community and family resources that promote good health. They also tend to be sicker than other patients. In fact, some health care providers help the sickest and the neediest to enroll in Medicaid when they have no other option for coverage. Because people can sign up for Medicaid retroactively, becoming ill often leads to Medicaid enrollment, not the opposite.

Some of these differences can be measured and are controlled for in statistical analyses, including the Virginia study. But many other unmeasured differences can skew results, even in studies with such statistical controls. The authors of the U.V.A. surgical study and of studies like it know this, and say as much right in their papers. They practically shout that the correlations they find are not evidence of causation.

#### CBPP

<https://www.cbpp.org/research/social-security/chart-book-social-security-disability-insurance#Section_four>

Social Security’s administrative funding is inadequate. The Social Security Administration’s administrative funding (which, unlike Social Security benefits, is subject to annual appropriation) has declined in real terms since 2010, even as enrollment has climbed. That has impaired customer service by increasing wait times at field offices and on the phone. Staff cutbacks have also led to growing delays in processing applications or changing benefits when a beneficiary’s circumstances change. Another consequence of the cuts is that about 700,000 people await a final decision on their application for SSDI — after paying into Social Security their entire career — or their application for disability benefits from the Supplemental Security Income program. They wait an average of about a year and a half for decisions on their appeals.

#### Motley Fool

<https://www.fool.com/retirement/social-security-disability-what-you-need-to-know.aspx>

The specific number of work credits you need to qualify for SSDI will vary depending how old you are when you become disabled. As a general rule, you can potentially qualify if you've earned at least 20 credits in the 10 years prior to becoming disabled and if you've earned a total of 40 credits or more.

#### Rudowitz

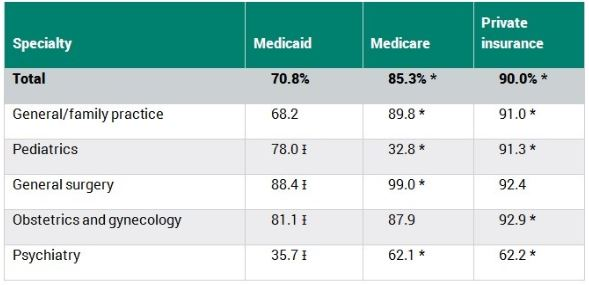
Robin Rudowitz, 3-6-2019, "10 Things to Know about Medicaid: Setting the Facts Straight," Henry J. Kaiser Family Foundation, <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>

A large body of research shows that Medicaid beneficiaries have far better access to care than the uninsured and are less likely to postpone or go without needed care due to cost. Moreover, rates of access to care and satisfaction with care among Medicaid enrollees are comparable to rates for people with private insurance (Figure 7). Medicaid coverage of low-income pregnant women and children has contributed to dramatic declines in infant and child mortality in the U.S. A growing body of research indicates that Medicaid eligibility during childhood is associated with reduced teen mortality, improved long-run educational attainment, reduced disability, and lower rates of hospitalization and emergency department visits in later life. Benefits also include second-order fiscal effects such as increased tax collections due to higher earnings in adulthood. Research findings show that state Medicaid expansions to adults are associated with increased access to care, improved self-reported health, and reduced mortality among adults.

#### Holgash

Kayla Holgash, 4-10-2019, "Physician Acceptance Of New Medicaid Patients: What Matters And What Doesn’t," No Publication, https://www.healthaffairs.org/do/10.1377/hblog20190401.678690/full/

Prior research has documented a number of factors affecting physician decisions to participate in Medicaid, including payment levels, Medicaid expansion, and use of managed care. Among these, low fees—relative to those of other payers—have been consistently shown to be most important to providers. Given the many policy changes affecting Medicaid programs in recent years, including growth in use of managed care and expansion of the program in many states to non-disabled adults, we were interested in determining whether these findings remained true. Once the Affordable Care Act extended coverage to millions more people, did more physicians accept new Medicaid patients? Has the trend toward providing care via comprehensive Medicaid managed care plans increased physician acceptance rates? Do payment rates still affect provider willingness to accept patients?



#### Braus

Without healthcare programs, UBI makes no impact on health costs

**Braus ’18** (Braus, Jan 20 2018. Braus Blog “A Universal Basic Income Requires Universal Healthcare” <https://medium.com/braus-blog/a-universal-basic-income-requires-universal-healthcare-ab0a78950d86> Accessed 1.26.2020 CB19QLC)

Now let’s imagine that Douglas lives in a society with a Universal Basic Income or Universal Social Security — a system that replaces means-tested welfare programs like food stamps, housing support, and university grants, with a direct cash deposit to all citizens ages 16 and above. Like Social Security for the elderly, but for everyone. Now we have to decide, should a society that adopts a UBI/USS, must it also have universal health insurance? Let’s imagine that there is no public health insurance and 20% of people are uninsured, and Douglas is one of those uninsured people when his diagnosis comes down. **Although Douglas receives ~$1,400 per month, the cost of his cancer treatment is in the hundreds of thousands of dollars. Even with the basic income, the same negative outcomes of lack of insurance would still plague him. He could go personally bankrupt, he might have avoided paying out of pocket for regular checkups which could have caught his cancer sooner, he might become a financial burden to his family leading to strains and risks to his children’s college fund, his wife’s work, their marriage, etc.**

#### Commonwealth Fund

Medicaid coverage is better than no insurance, even with a basic income

**Commonwealth Fund ’17** (Apr 27 2017, The Commonwealth Fund “New Report: Medicaid Provides Equal- or Better-Quality Health Insurance Coverage Than Private Plans as Well as More Financial Protection” <https://www.commonwealthfund.org/press-release/2017/new-report-medicaid-provides-equal-or-better-quality-health-insurance-coverage> Accessed 1.26.2020 CB19QLC)

New York, New York, April 27, 2017—**Having Medicaid is not only substantially better than being uninsured, but it provides enrollees with health insurance that on most measures is as good as or, in some cases, better than private coverage**, according to new a Commonwealth Fund report. **Medicaid is currently the nation’s largest health insurer, covering more than 70 million people**, about 12 million of whom enrolled when 31 states and the District of Columbia expanded eligibility for the program under the Affordable Care Act (ACA). The report finds that **the large majority of people who have Medicaid for the full year are able to get the health care they need. Based on survey results, 91 percent have a regular source of care, compared to 93 percent of privately insured people with continuous coverage and 77 percent of people uninsured for at least part of the year.** Medicaid enrollees are also happy with their care—57 percent rated it as very good or excellent, compared with 52 percent of the privately insured and 40 percent of the uninsured.

Those on Medicaid are more likely to get preventative care

**Commonwealth Fund ’17** (Apr 27 2017, The Commonwealth Fund “New Report: Medicaid Provides Equal- or Better-Quality Health Insurance Coverage Than Private Plans as Well as More Financial Protection” <https://www.commonwealthfund.org/press-release/2017/new-report-medicaid-provides-equal-or-better-quality-health-insurance-coverage> Accessed 1.26.2020 CB19QLC)

Medicaid Coverage Translates into Care

The Commonwealth Fund report finds that **Medicaid enrollees were much more likely than the uninsured to get preventive care such as blood pressure checks, cholesterol screenings, and flu shots. They were also more likely to have received cancer screenings such as mammograms and colonoscopies.**

#### [Diamond](https://www.politico.com/news/2020/01/23/trump-targeting-obamacare-102887) 20

- Trump doesn’t want to cut hc during election year

President **Donald Trump**, who last week lashed out as HHS Secretary Alex Azar over negative health care polling, **recently voiced concerns about fueling perceptions that he's cutting Medicaid and other health care services during an election year,** said two officials with knowledge of the president's comments. Trump's remarks Wednesday about his willingness to look at entitlement cuts quickly became fodder for Democrats, as they accused him of violating a campaign pledge to leave those programs alone.

alt card [Duffin](https://www.npr.org/sections/health-shots/2020/01/30/800841612/trump-administration-offers-states-a-way-to-block-grant-medicaid) 20 - Medicaid popular and cutting it is risky

It's a political risk for the Trump administration as well. P**olling suggests that Medicaid is very popular and that capping federal spending in the program is not.** "Medicaid is more popular than it has ever been because people understand that if it's not their immediate family, their kids, it's their parents, it's neighbors and others who rely on the program," Park adds.

#### [Huberfield](https://www.healthaffairs.org/do/10.1377/hblog20190722.62519/full/) HA 19

- Block grants not legal; will be challenged and held in court

First, Medicaid spells out federal payment within Section 1903, which states that the HHS secretary “shall pay to each State…the [federal match] of the total amount expended…as medical assistance under the State plan....” This language is not waivable under Section 1115, which explicitly permits waivers of Section 1902 but not Section 1903. As a result, **HHS cannot cap the Medicaid funds it disburses to states, either per person or programmatically, because it must pay the federal match for the “total amount” of a state’s spending.** Even if a state wanted to cap its own Medicaid spending, that would necessitate disenrollment and require waiver of many other Medicaid Act requirements such as sufficient state Medicaid funding, equal coverage of beneficiaries across the state, and adequate payment to providers. Second, **block grants are not “likely to assist in promoting the objectives” of Medicaid, the legal standard for HHS to authorize states’ proposals for demonstration waivers. Medicaid’s statutory purpose is to “furnish medical assistance”** to eligible beneficiaries, a phrase that recently has been dissected in the context of HHS’s authorization of several 1115 waivers for Medicaid work requirements. The federal court hearing challenges to the legality of work requirements has interpreted “furnish medical assistance” to mean that Medicaid must pay for care, not simply promote a generalized idea of “health” or decrease cost. **Spending caps would certainly decrease enrollment (like work requirements already have in Arkansas) and limit care across all kinds of Medicaid coverage, the opposite of furnishing medical assistance.**

#### [Duffin](https://www.npr.org/sections/health-shots/2020/01/30/800841612/trump-administration-offers-states-a-way-to-block-grant-medicaid) 20

Block grant implementation will take a while

Whether Thursday's announcement will upend that system depends on what states do with the new guidance. States will have to ask CMS for a waiver and wait for approval. It's usually a lengthy process, although on Thursday, Verma indicated the agency would be attempting to streamline things by creating a template application. Most likely, it will be months before this plan could go into effect in a state.

#### [Bolin 19](https://undark.org/2019/10/08/hospital-closures-rural-america-crisis-point/)

There are also cross-cutting rural community challenges such as:

Declining reimbursement levels

Shrinking rural populations

Health professionals moving to bigger cities for higher compensation

Increasing percentage of uninsured leading to rising uncompensated care

Increasing operating costs

Older and sicker rural dwellers with complex multi-system chronic diseases

The result is that rural hospitals often lack a dependable economic base to operate. In addition, changing processes, payment strategies and regulations coming from state and federal regulators place the small rural facility at particular risk because keeping up with changing payment or reporting rules often requires a full-time person.

#### [Carney 20 Hill](https://thehill.com/policy/finance/482356-democrats-pan-trumps-budget-proposal-dead-on-arrival)

**Democrats quickly panned President Trump's fiscal 2021 budget proposal on Monday, pledging that it is "dead on arrival"** on Capitol Hill. The $4.8 trillion plan includes cuts that would break with a two-year budget deal agreed to by both the White House and congressional leadership. Senate Minority Leader Charles Schumer (D-N.Y.) called Trump's proposal a "double-cross" of the Americans Trump promised to help during last week's State of the Union speech. "As typical, President Trump’s budget shows his State of the Union address was lie upon lie to the American people," Schumer said in a statement. Sen. Sheldon Whitehouse (D-R.I.), who is pitching reforms to Congress's budget process, called the White House proposal "dead on arrival." "It’s merely a political stunt to gratify extremists in his party," he added. Democrats are taking aim, in particular, at efforts in the proposal to eliminate the deficit over a 15-year period by cutting domestic spending and reining in how much funding goes to Medicaid and Medicare. That includes capping or block-granting Medicare benefits, adding work requirements to medical and anti-poverty programs or implementing changes that lower the costs of Medicare and Medicaid.

## 

## Sub c: Disabilities

### Extension/Weighing

Medpac and reaves - MTWPs like medicaid and SSI are crucial to helping disabled people supply from day to day - from bathing to preparing food and medicine. They can’t afford care under a UBI since it costs $45k, putting their lives at risk

Helping the disabled comes first

1. Policymakers traditionally neglect them when making policy decisions -(for example, the americans with disabilities act wasnt passed until 1990)-means we need to prioritize them since they are most vulnerable in society or they will always be ignored - comes before mag/all other mechs
2. Scope and Mag - 10 mil ppls lives at risk - only link to life and death
3. Discourse key to social movements

### 

### Frontlines

#### FL: SSDI Solves

1. SSA- you need work history and paid SS taxes (eg. people who never worked dont qual)
2. CBPP - SSDI average wait times are a year and a half; that’s fatal for people who need benefits immediately. Also 700,000 people are waiting for benefits because administration sucks
3. Motley Fool - SSDI has tough work requirements that make chronically disabled people uneligible.

#### FL: Work requirements stop benefits

1. Garfield 19 - Disabled people are exempt from work requirements
2. Garfield - also blocked in appeal courts

#### FL: 20% access it

1. yeah it’s the ppl who are most vulnerable, can’t live independently
2. Without it 10m people are at risk of death - o/w their turns

### FL Cards

Rachel Garfield, 8-8-2019, "Understanding the Intersection of Medicaid and Work: What Does the Data Say?," Henry J. Kaiser Family Foundation, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/

As of July, 2019, an appeal was underway in the DC Circuit after a federal trial court stopped implementation of Arkansas’s work and reporting requirements in March 2019 and prohibited Kentucky’s waiver from going into effect in April as planned. On July 29, 2019, the court set aside the Granite Advantage Health Care Program demonstration, approved by CMS on Nov. 30, 2018. Implementation of the work requirement and the elimination of retroactive eligibility is stopped unless and until HHS issues a new approval that passes legal muster or prevails on appeal. Previously, on July 8, 2019, NH enacted legislation that allowed for the suspension of the work requirement’s implementation up to but not after July 1, 2021, and suspended the work requirement through Sept. 30, 2019.

#### 

#### SSA

<https://www.ssa.gov/disability/>

Social Security Disability Insurance pays benefits to you and certain members of your family if you are "insured," meaning that you worked long enough and paid Social Security taxes.

Rachel Garfield, 8-8-2019, "Understanding the Intersection of Medicaid and Work: What Does the Data Say?," Henry J. Kaiser Family Foundation, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/

Most Medicaid adults are already working; among those who are not working, most report potential barriers to work (Figure 1). Overall, more than six in ten (63%) non-dual, non-SSI, nonelderly adults with Medicaid (referred to hereafter as Medicaid adults) are working either full or part-time. Even though individuals qualifying for Medicaid on the basis of a disability (e.g., by receiving SSI) and those dually eligible for Medicare are not subject to work requirements under CMS policy and therefore were excluded from this analysis, illness or disability was a primary reason for not working among the remaining Medicaid adults. Caregiving responsibilities or school attendance were other leading reasons reported for not working. The remaining seven percent of Medicaid adults report that they are retired, unable to find work, or not working for another reason. This small group of Medicaid adult enrollees could be the primary group targeted under Medicaid work requirement policies.

<https://www.ssa.gov/planners/disability/>

If you have not worked enough to qualify for Social Security Disability Insurance (SSDI), you may qualify for Supplemental Security Income (SSI), a federal program to assist those who are disabled, blind or aged and who are not working and have not worked for a long time.

The major differences between SSDI and SSI are:

SSI is a need-based program for people with limited income and resources. SSDI is a program based on your work history.

The monthly benefit for SSI is based on need and tops out at $710. SSDI monthly benefits are based on how much you worked and how much money you made.

#### [Scott](https://www.vox.com/policy-and-politics/2019/1/17/18186676/government-shutdown-medicaid-block-grants) 19

Disabled exempt from work requirements

About 50 million of the program’s 75 million enrollees are children, elderly, disabled, or pregnant. Those populations are usually exempt from work requirements and these other restrictions, like time limits, and states are required to cover them under federal law.

## Sub d: LIHEAP

### Case Extension/Weighing

Extend HHS - 23 million families depend on LIHEAP to heat their homes in the winter. Without it, 17% of households become energy-insecure since they can’t pay their heating bills which

1. Cause them to switch to unsafe heating practices which increases their risk of fires and death by 25x
2. Leads to evictions - inability to pay for home energy is the 2nd leading cause of homelessness - prereq to the aff since clark finds its almost impossible to get a job without a house

They say jobs pay for housing

1. We o/w timeframe -Only link to jobs is through automation which they a) are losing badly b) concede will take decades
2. We o/w mag -idk how many actually get retrained - 23m ppl have to pick between freezing to death, starving, or losing their house, all of which are prerequisites

### Frontlines

Amy Livingston, xx-xx-xxxx, "How to Get Help With Heating Costs Through LIHEAP," No Publication, <https://www.moneycrashers.com/help-heating-costs-liheap-eligibility-benefits/>

Even though millions of families now receive aid through LIHEAP, many millions more are turned away due to lack of funding. According to Inside Energy, only 22% of the families who qualify for LIHEAP aid actually get it. Under the rules of the LIHEAP program, s**tates with limited money to spend must focus on getting aid to the families that need it most. This includes the families that are paying the highest share of their income for energy costs and the ones who are at highest risk for health problems.**

<https://www.tdhca.state.tx.us/community-affairs/ceap/docs/19-LIHEAP-State-Plan.pdf>

The amount of benefit/assistance that an applicant is eligible for is based on their level of household

income. Households with incomes 0-50% of Federal Poverty Income Guidelines (FPIG) have a

maximum of $1,200 for the Utility Payment Assistance Component and the Household Crisis

Component, incomes at 51%-75% FPIG up to $1,100 per Component; incomes 76%-150% FPIG up to

$1,000 per Component; and up to $3,000 for Service and Repair of heating and cooling units. **The**

**maximum total eligible assistance $5,400.**

## Sub e: Lifeline

### Case Extension

csn/ low income americans lack internet access

NCLC/ lifeline gives phones and broadband internet to 13 mil - key to jobs since internets required for applying to jobs over the internet and retraining to learn technology skills - key since 2/3 of american workers to keep their jobs so the neg solves best

### Weighing

lifeline is a prereq to retraining

### Frontlines

### FL Cards

# Extra Cards

<https://www.nytimes.com/2019/09/25/health/employer-health-insurance-cost.html>

Employers remain the main source of health insurance in the United States, covering about 153 million people. But premiums and deductibles are pushing employer-based coverage increasingly out of reach, according to a new analysis released Wednesday by the Kaiser Family Foundation, which conducts a survey of employers every year.

The average premium paid by the employer and the employee for a family plan now tops $20,000 a year, with the worker contributing about $6,000, according to the survey. More than a quarter of all covered workers and nearly half of those working for small businesses face an annual deductible of $2,000 or more.

Paul **Krugman**, 6-24-2019, "Opinion," No Publication, https://www.**nytimes.com/2019**/06/24/opinion/republican-states-health-care.html

Over the weekend The Washington Post published a heart-rending description of a pop-up medical clinic in Cleveland, Tenn. — a temporary installation providing free care for two days on a first-come-first-served basis. Hundreds of people showed up many hours before the clinic opened, because rural America is suffering from a severe crisis of health care availability, with hospitals closing and doctors leaving. Since the focus of the report was on personal experience, not policy, it’s understandable that the article mentioned only in passing the fact that **Tennessee is one of the 14 states that still refuse to expand Medicaid under the Affordable Care Act.** So I’m not sure how many readers grasped the reality that **America’s rural health care crisis is largely — not entirely, but largely — a direct result of political decisions.** The simple fact is that the Republicans who run Tennessee and other “non-expansion” states have chosen to inflict misery on many of their constituents, rural residents in particular. And it’s not even about money: The federal government would have paid for Medicaid expansion. So if rural America is suffering, a large part of the explanation is gratuitous political cruelty. **This cruelty has denied health insurance to millions** who could have had it with a stroke of the pen. **And rural hospitals are closing**, rural doctors leaving, in large part **because people can’t afford to pay for care.** To see what I mean, just **compare Tennessee with its neighbor Kentucky**. **As recently as 2013**, just before the Affordable Care Act went into full effect**, the two states looked similar in terms of health care: In both states, about 20 percent of nonelderly adults lacked insurance. But unlike Tennessee, Kentucky did expand Medicaid**, and it also did its best to make Obamacare work. **The result was a two-thirds drop in the uninsurance rate**. At the same time, progress in Tennessee was far more limited. A**t this point, adults in Tennessee are twice as likely as their neighbors to lack health insurance.** And the divergence in destinies was even greater for rural residents. According to a Georgetown University study that covered a seven-year period spanning the introduction of the A.C.A., the percentage of low-income rural adults without health insurance fell 27 points in Kentucky, only six points in Tennessee. Of course, if the U.S. were like every other wealthy nation, and provided some kind of universal health care, there would be no uninsured at all. Those heart-rending scenes in Cleveland would be inconceivable anywhere else in the advanced world. But the A.C.A. isn’t a future aspiration, it’s an already-existing program — and a lot of rural America’s medical misery could be avoided if states like Tennessee were willing to take advantage of that program. And we’re not just talking about having insurance; we’re talking about whether there are doctors and hospitals available to provide care. True, rural hospitals have been closing in many states as the nonmetropolitan population declines. But **a project that tracks rural hospital closings since 2010 finds** that a great majority have taken place in states that didn’t expand Medicaid. Four rural hospitals have closed in California, but 17 have closed in Texas. **Tennessee has had three times as many [rural hospital] closings as Kentucky.**

<https://www.nytimes.com/2018/01/16/business/economy/work-medicaid.html>

It is well known by now that health insurance saves lives. A [review of recent research](http://annals.org/aim/fullarticle/2635326/relationship-health-insurance-mortality-lack-insurance-deadly) in the Annals of Internal Medicine concluded that the odds of dying for non-elderly adults are between 3 and 41 percent higher for the uninsured than for the insured.

Work by Katherine Baicker, now at the University of Chicago, with Benjamin Sommers and Arnold Epstein at Harvard found that Medicaid expansions in the past significantly reduced mortality. Their research, they concluded, “suggests that 176 additional adults would need to be covered by Medicaid in order to prevent one death per year.”

One common response to this question is that the welfare state is large and poverty is high because federal and state bureaucracies absorb most welfare spending, and very little reaches the poor. This is untrue. On average, administrative costs are less than 10 percent of means-tested cash, food, housing, and medical spending.23

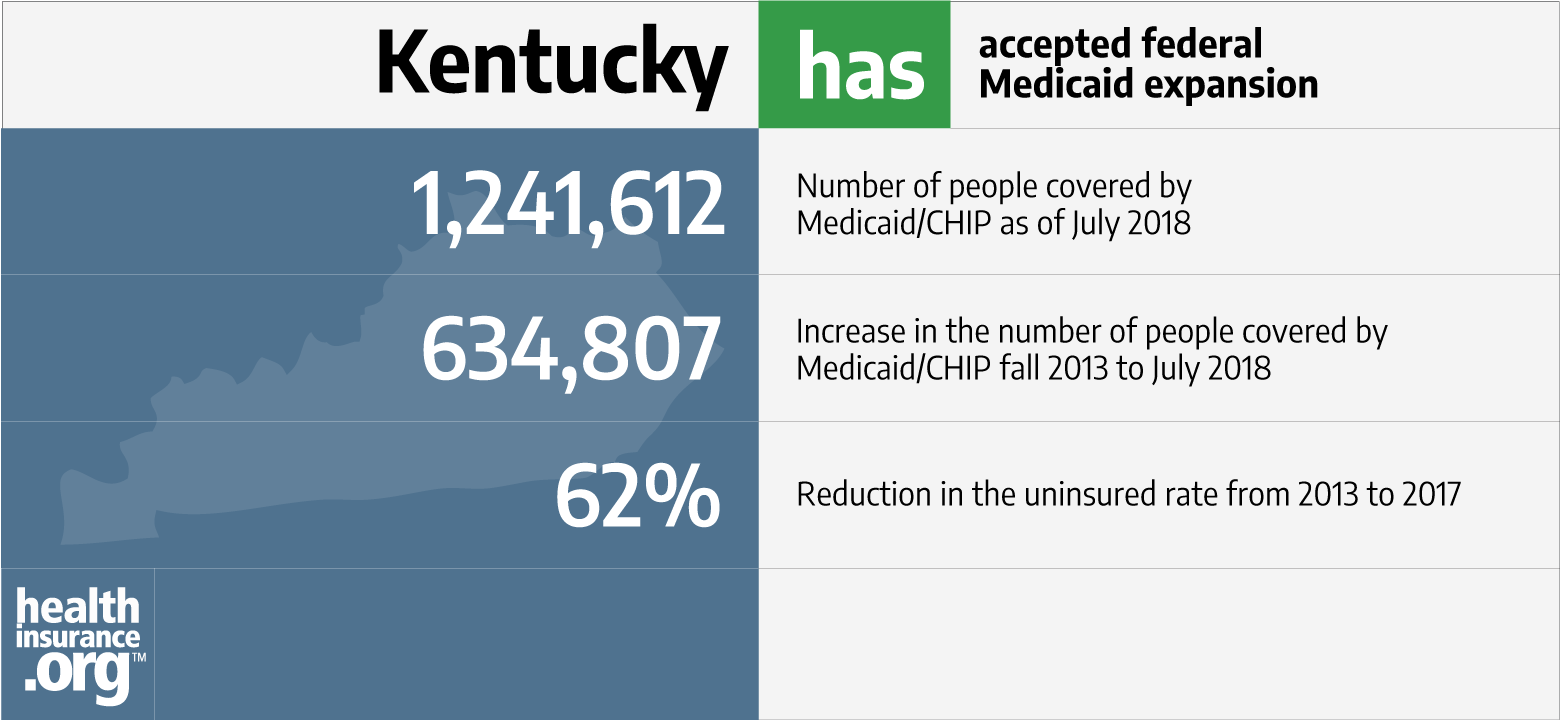
This estimation is based on the following programs: Administrative costs equal about 1 percent of total program costs in the EITC and ACTC programs; about 10 percent of total program costs in the food stamp program; about 5 percent of total program costs in Medicaid; about 9 percent of total program costs in CHIP; about 8 percent of total program costs in the national school lunch program; about 30 percent of total program costs in the Women, Infants and Children (WIC) program; about 6 percent of total program costs in HUD Section 8 and Public Housing programs; and about 6 percent of total program costs in the Supplemental Security Income (SSI) program. These programs make up about 80 percent of total means-tested welfare spending. Sources available upon request.

More than 90 percent of this spending reaches low-income families as benefits.

#### In contrast Kentucky proves medicaid expansion is good stuff

Louise Norris, 12-16-2019, "Kentucky and the ACA’s Medicaid expansion: eligibility, enrollment and benefits," healthinsurance.org, <https://www.healthinsurance.org/kentucky-medicaid/>

**Kentucky has been one of the most successful states in reducing its uninsured rate** through the Affordable Care Act (ACA) — **both by expanding Medicaid** and adopting a state-run health insurance marketplace (Kentucky still technically has a state-run marketplace, but they began using HealthCare.gov’s enrollment platform in 2017). **The Centers for Medicare and Medicaid report that Kentucky’s Medicaid/CHIP enrollment increased by 99 percent from 2013 to mid-2019 — by far the largest percentage increase of any state, and more than three times as much as the national average** increase of 28 percent (although the state’s increase in net enrollment had been even larger — 111 percent — as of March 2018). And according to US Census data, **Kentucky’s uninsured rate [fell by 62%]** [SEE IMAGE]dropped 9.2 percentage points from 2013 to 2016, reaching a low of 5.1 percent. But it increased slightly in 2017, to 5.4 percent, and increased again in 2018, to 5.6 percent (nationwide, there has been an uptick in the uninsured rate under the Trump administration). **As of** the third quarter of **2016, there were 650,867 adults enrolled in Kentucky’s Medicaid program, and three-quarters of them were eligible due to the ACA’s expansion of Medicaid**. As of September 2017, there were 479,567 adults enrolled in Kentucky’s expanded Medicaid program. Total Medicaid enrollment in Kentucky, including children and the elderly, stood at more than 1.2 million as of mid-2019, and expansion of Medicaid has helped to support rural hospitals that would otherwise have faced unsustainable financial prospects



#### UBI reverses social progress - it decreases public appetite and political will for future welfare reform and expansion

Daniel Sage, 2-1-2017, "(PDF) The Case Against Universal Basic Income," ResearchGate, https://www.researchgate.net/publication/314401252\_The\_Case\_Against\_Universal\_Basic\_Income

Even if UBI failed to lead to the marketization of existing public services, **there is the further risk that its introduction would make it more difficult to introduce new policies and expand on existing ones. UBI would be an extremely costly policy, limiting the funding available for other policy areas, while the necessity of raising taxes may dampen public appetite for further increases in public spending.** to expand services. This weakened potential for social policy expansion is especially problematic in countries where gaping holes in provision exist, such as in childcare, elderly care, disability support and housing provision. As long as such holes remain, it is unclear whether UBI would be the best use of the spoils in a hypothetical victory around the desirability of raising taxes to improve services. **UBI thus leads to three social policy risks: first, existing social programmes and benefits are rolled back to finance basic income; second, services are marketized under the logic that UBI should and could be used to purchase them; third, the political will and public feasibility for more expansive, generous and new social policies, arguably better placed to tackle social problems, is weakened.** While supporters of basic income may warn against such scenarios, it is unclear how existing social policies and potential future ones could be protected in the hands of governments intent on rolling them back.

#### Rural Healthcare impact - i feel like we had cards from the pharma topic on this

CDC, 11-20-2019, "CDC Press Releases," <https://www.cdc.gov/media/releases/2017/p0112-rural-death-risk.html> - 70k is just adding the numbers up

A new CDC study demonstrates that **Americans living in rural areas are more likely to die from five leading causes than their urban counterparts. In 2014, [over 70k] deaths among rural Americans were potentially preventable,** including 25,000 from heart disease, 19,000 from cancer, 12,000 from unintentional injuries, 11,000 from chronic lower respiratory disease, and 4,000 from stroke. The percentages of deaths that were potentially preventable were higher in rural areas than in urban areas. The report and a companion commentary are part of a new rural health series in CDC’s Morbidity and Mortality Weekly Report. “This new study **shows there is a striking gap in health between rural and urban Americans,**” said CDC Director Tom Frieden, M.D., M.P.H. “To close this gap, we are working to better understand and address the health threats that put rural Americans at increased risk of early death.” **Some 46 million Americans — 15 percent of the U.S. population — currently live in rural areas. Several** demographic, environmental, economic, and social **factors might put rural residents at higher risk of death from these public health conditions.** **Residents of rural areas in the United States tend to be older and sicker than their urban counterparts.** They have higher rates of cigarette smoking, high blood pressure, and obesity. Rural residents report less leisure-time physical activity and lower seatbelt use than their urban counterparts. **They also have higher rates of poverty, less access to healthcare**, and are less likely to have health insurance.