

H.R. 1384, MEDICARE FOR ALL ACT OF 2019

HEARING BEFORE THE COMMITTEE ON RULES HOUSE OF REPRESENTATIVES ONE HUNDRED SIXTEENTH CONGRESS FIRST SESSION

—
TUESDAY, APRIL 30, 2019
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Printed for the use of the Committee on Rules

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U.S. GOVERNMENT PUBLISHING OFFICE

36-400

WASHINGTON : 2019

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ORIGINAL JURISDICTION HEARING ON H.R. 1384, MEDICARE FOR ALL ACT OF 2019

TUESDAY, APRIL 30, 2019

HOUSE OF REPRESENTATIVES,
COMMITTEE ON RULES,
Washington, DC.

The committee met, pursuant to call, at 10:05 a.m., in Room H-313, The Capitol, Hon. James P. McGovern [chairman of the committee] presiding.

Present: Representatives McGovern, Perlmutter, Raskin, Scanlon, Morelle, Shalala, DeSaulnier, Cole, Woodall, Burgess, and Lesko.

OPENING STATEMENTS

The CHAIRMAN. The Rules Committee will come to order. Good morning, everybody. And I want to welcome our witnesses to the Rules Committee. Thank you so much for being here. Before I give my opening statement, I would like to outline the time agreements that we reached between the majority and minority on this committee for the purposes of this hearing. In the Rules Committee, we have no rules, but we are going to have rules today, at least a little bit.

So, you know, while the rules of our committee provide members with 5 minutes to ask questions of the witnesses, that rule has not been followed for as long as I can remember. I believe we have reached a fair agreement with our minority that respects the time of our expert witnesses and provides members of this committee with ample time to ask questions.

Under the agreement, the chair and ranking member will provide an opening statement around 5 minutes. If other members of the committee have opening remarks, we ask that you submit those statements for the record. Each witness will then have 5 minutes to provide an opening statement. If you go over a little bit, fine. But if you see that red light on, that means try to wind it up.

After the committee receives testimony from our witnesses, each member of the committee will have about 15 minutes to ask questions of the witnesses. And if a member has a question for Mr. Barkan, please ask him your question at the beginning of your time and then proceed with your questions for the other witnesses to give Mr. Barkan some time to type his responses. Please be sure to leave some time at the end of your questioning for his responses.

The chair and ranking member will have an additional 15 minutes to provide comments throughout the hearing or to provide additional time to members during questioning. The minority's addi-

tional time must be used before the majority's last member begins his or her questioning. The chair and ranking member will have about 5 minutes to close, and the chair will close after the ranking member offers his very, I am sure, eloquent closing remarks.

I want to thank Ranking Member Cole for his assistance in reaching this agreement, and I thank all of our members, both Democratic and Republican, for participation in this hearing. And before I begin, I just want to acknowledge some people here in the audience. You saw Speaker Pelosi was here a little bit earlier. We appreciate her coming by. And Congresswoman Katie Porter is here from California. We are grateful that she is here in the audience. In addition, we have Amirah Sequeira from National Nurses United, Jean Ross from National Nurses United, Nicole Jorwic from the Consortium of Citizens with Disabilities, Kristy Fogle with the Maryland Progressive Healthcare Coalition, Robert Kraig with People's Action, and Savanna Lyons with People's Action. Rebecca Wood and her daughter, Charlie, are here. Charlie was born prematurely, and before the age of 3, she had suffered through more therapies and injections than most experience in a lifetime. And as the expenses piled up, Rebecca and her family faced tough choices regarding Charlie's treatment, which highlight the need for adequate long-term care in this country.

Jennifer Epps-Addison is sitting behind Ady from the Center for Popular Democracy; Nate Smith, Ady's lifelong friend and caretaker; Liz Jaff, president of Be a Hero, which is Ady's organization; and Elazar Barkan, Ady's father, is here. I am sure you are very proud of your son today, as we all are. Yochai Benkler, Ady's uncle, is here; and Ari Benkler, Ady's cousin. And the incredible Pramila Jayapal is here. When I get to my opening statement, I want to thank her again because it is her legislation that is why we are all here today.

STATEMENT OF THE HONORABLE JAMES P. MCGOVERN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS AND CHAIR OF THE COMMITTEE ON RULES

Let me begin with my opening statement. I believe this is a historic day. Today the Rules Committee is holding a hearing on the Medicare for All Act, and this marks the first time Congress has ever held a hearing on Medicare for All. And I want to thank again Congresswoman Pramila Jayapal and Congresswoman Debbie Dingell and their staffs, Senator Sanders and his staff as well, for leading this effort and for all their help with this hearing. But I particularly want to thank Congresswoman Jayapal for her commitment and her dedication to this issue, and we are all grateful to her.

We have a talented witness panel with us today, and I have a sneaking suspicion that we will have a lively debate. And that is a good thing. After nearly a decade of Republicans talking only about how to rip healthcare away from people when they were in charge, this majority is here to discuss how to expand coverage and how to lower costs and improve outcomes in the process.

I have long believed that healthcare is a right for all, not a privilege for the lucky few. That is why I voted for the Affordable Care Act, a law that gave 20 million more people access to health cov-

erage. It banned insurance companies from discriminating against cancer patients and women and made sure that health plans actually covered essential benefits.

The ACA changed lives. It saved lives. But we knew then that it was never going to be the last stop in healthcare reform, that we were always going to have to come back and build upon those core values. And that is what today is all about, because the work of reform isn't done. Twenty-nine million Americans are still without coverage. Forty-four million people have coverage that isn't there for them when they need it. And all of us deserve healthcare that we can afford without health insurance middlemen unnecessarily jacking up costs or deciding who gets care. Because it is still true today that for too many in America, you can go broke if you get cancer; you can lose your home if your kids get sick. That is not healthcare being delivered as a basic human right; that is healthcare that remains out of reach for too many.

The Medicare for All Act would change that. The 29 million uninsured Americans in our country today would get healthcare. The 44 million underinsured people would have the peace of mind of finally knowing that their healthcare will be there for them when they need it. And all of us—workers, seniors, students—all of us will be free from crushing out-of-pocket costs.

Importantly, this bill would also guarantee for the first time that people living with disabilities have access to services they need to live with dignity. The Medicare for All Act is a serious proposal. That is why more than 100 Members of Congress are cosponsors. That includes me, and it includes some others on this panel. Not only does it deserve to be part of the discussion as we consider ways to expand and strengthen coverage, it deserves to move forward. I hope today is just the start.

Congress should be a place where we tackle big things, where we are not afraid to have hearings and real debates. I know we won't pass this bill overnight, but we won't pass it unless we start the dialogue.

This Democratic majority was built by Americans tired of political leaders who tried to sabotage their healthcare and who looked after the wealthy and well-connected at the expense of everyone else. The American people in the last election spoke loudly and clearly. They wanted a Congress that works to expand coverage. They are sick and tired of the problems that are fundamental in our system today.

So, if my Republican friends want to use a lot of scary words like "government takeover" and "socialism" today, have at it. They tried that during the passage of Medicare. They tried that during the passage of Social Security. They tried that during the passage of the Affordable Care Act. And every time, the American people saw through it and supported those programs. This would be no different.

And by now, we all know that the Republican plan for healthcare can be summed up in one word: repeal, no replacement. To the extent that they had a healthcare plan, I think it could probably be summarized as take two tax breaks and call me in the morning. They didn't hold a single hearing on the repeal plan last Congress, not one. Well, this majority is taking a different route. We have

fantastic witnesses who will talk about this bill today. Some are for; some are somewhere in the middle; and some are against.

But I want to focus on one witness. With us today is Ady Barkan. Ady is a father and a husband and, out of circumstance, a healthcare advocate. I think we all have a picture of Ady's beautiful family here today. And I am sure your son is incredibly proud of you being here at the first ever Medicare for All hearing. We are so honored that you are here.

If you recognize Ady's name, it is because he has been fighting like hell for his life and for all of ours. Ady was diagnosed with ALS in the fall of 2016. Since then, he has battled insurance companies, drug companies, medical device companies. You name it, Ady has battled it just to get the care that he needs.

And I say "battle" because that is exactly what he has had to do. Battle to get care, battle to get services, battle to get life-sustaining medical equipment. But no one should have to fight a healthcare company while they are fighting for their lives.

I can't do Ady's story justice. I will let him tell it. But I will leave my colleagues with this: If you think healthcare in America is just fine today, if you think we only need to nibble at the edges of reform, look at Ady after what he has gone through and try to tell him that.

Of course, Ady, you are welcome to stay here as long as you want and take any breaks that you want. We are just honored that you are here. You literally put your life on the line to travel here from California, and we are fortunate to be able to hear your story.

Let me just close with this: You know, in Washington, we talk a lot about national security. That is everybody's favorite topic. And I believe we need to expand the definition of national security to include more than just the number of bombs we have. National security should also mean things like quality healthcare for every person in this country. You know, we expect the Federal Government to defend us against enemies abroad. I don't think it is too much to expect the Federal Government to protect us against illnesses here at home.

We are going to have a spirited debate here. I am looking forward to it, but before I get started I want to first recognize our distinguished ranking member from Oklahoma, my good friend Mr. Cole.

STATEMENT OF THE HONORABLE TOM COLE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA AND RANKING MEMBER OF THE COMMITTEE ON RULES

Mr. COLE. Thank you very much, Mr. Chairman. And I too want to thank you for holding the hearing.

And I want to thank all of our witnesses for coming and participating. I had the opportunity to read all of your testimony. And, frankly, I found it very informative in all cases and quite moving, obviously, in a number.

And it is interesting to me to note, Mr. Chairman, that while, as you pointed out, there is a variety of perspectives, as there should be, amongst our witnesses today, each and every one of them is interested in the best possible healthcare for the American people. And they may disagree over how they get there, but it is a noble

and worthy goal that you all share and, frankly, you have all dedicated a lifetime in pursuit of. So I am very grateful for that, as I know every member of this panel is.

Today's hearing, Mr. Chairman, is quite extraordinary. We are here today to consider H.R. 1384, the Medicare for All Act of 2019. Unlike our usual weekly hearings, today's hearing is an original jurisdiction legislative hearing, covering a bill over which the Rules Committee has some original jurisdiction. I say "some" because out of the 120 pages of bill text, the Rules Committee has jurisdiction over precisely one of those pages. That is it, just one page. Yet we are about to hold our first original jurisdiction legislative hearing in nearly 3 years on this bill. That is what makes this hearing extraordinary.

I also think it is worth noting that Speaker Pelosi's personal committee is the one to take the first swing at this ball when three other committees in the House can claim wider jurisdiction than Rules. Energy and Commerce, Ways and Means, and Education and Labor could, and should, all conduct multiple hearings on this legislation as well. And, frankly, I am sure ranking Republican members of those committees will be requesting their chairs to take up this legislation in the relevant committees. And I hope that happens.

Of course, there is a reason it is coming to Rules first, and that is because this bill too is an extraordinary bill. What Democrats are proposing today would completely change America's healthcare system and not, in my view, for the better. Medicare for All would require all Americans to pay more in taxes, wait longer for care, and receive potentially worse care. Even worse, it would put our current Medicare recipients at risk.

As Medicare is structured now, current Medicare recipients and Medicare Advantage plan holders are, by and large, satisfied with the healthcare they receive. In particular, Medicare Advantage plans are extremely popular. However, this radical bill puts Medicare itself at risk by enrolling millions of new recipients who have not paid into the program in the same way current recipients have. It would reduce the quality of services, enforce longer wait times, and ban Medicare Advantage entirely. For current Medicare recipients, Medicare for All really means Medicare for none.

Indeed, this bill is a socialist proposal that threatens freedom of choice and would allow Washington to impose one-size-fits-all plans on the American people. Private health insurance would be completely banned. Everyone, every man, woman, and child in America with private employer-based or union-based health insurance, would lose their plan. Even if you like your plan, you really can't keep it.

More than 150 million people will lose health plans they like, plans that they bargained for, and, in many cases, plans that they have earned through years of hard work. Medicare for All throws it all out the window in favor of a one-size-fits-all government-run health plan.

We will hear from one of our witnesses, Ms. Grace-Marie Turner, on the impact this will have on employer-sponsored insurance and the method by which roughly half of Americans receive their healthcare.

In the midst of all this, I think the majority needs to be honest about the phenomenal cost of this new program. We are going to hear from Dr. Charles Blahous, a former public trustee for Social Security and Medicare. He reviewed Medicare for All for the Mercatus Center and authored a very telling study on the topic. Dr. Blahous' work showed the previous more basic version of Medicare for All would cost at least \$32 trillion over the next 10 years, and, frankly, the version in front of us would cost more than that.

The majority has not told us how much this massive new program will cost, how they will raise the money to pay for it, or whose taxes will have to go up to pay for it. On the last concern, I can assure you that the answer is everyone. Everyone's taxes will have to more than double to pay for this program. The majority needs to be honest with us and with the American people about the cost.

Beyond this, I would like to point out one of the most egregious provisions of the Democratic healthcare bill is that it relates to the Federal funding of abortion. As many know, the Federal funding of abortion has been limited for well over three decades by several legislative provisions: The Hyde amendment limits taxpayer public funding of abortion; the Weldon amendment prohibits States from discriminating against providers that do not support abortions; the Church amendments protects the conscience rights of health practitioners; and even ObamaCare maintained limited conscience protections.

However, this bill contains none of them. It requires coverage of comprehensive reproductive care, quote/unquote, which includes elective abortions paid for with taxpayer dollars. Section 701 of the bill explicitly states that this bill must ignore these Federal laws dating back 33 years.

Mr. Chairman, I would hope that you are encouraging your leadership to pursue hearings and markups within the committees that have primary jurisdiction over the majority of healthcare issues—Energy and Commerce and Ways and Means—so that we can ensure that longstanding life protections are included as you move Medicare for All to the floor for a vote.

Mr. Chairman, I am looking forward to today's hearing, hope our witnesses can shed some light on these and other questions as we review this proposal that, if passed into law, would dramatically change the American healthcare system for absolutely everyone and, in my opinion, not for the better.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Cole, for your statement. And let me just assure you that I hope all of the committees of jurisdiction will do hearings on this bill because I think that would be, as I mentioned in my opening statement, a big contrast to the way my friends on the other side of the aisle conducted themselves when they tried to repeal the Affordable Care Act. There were no hearings. Hearings are a good thing. And as far as why Rules is beginning, I would like to think it is because it is an enlightened chairman.

We are ready to begin. Our first witness is Ady Barkan. Ady is a lawyer and an organizer with the Center for Popular Democracy and the founder of the Be a Hero PAC. He helped design and draft

policy proposals to enhance the quality of low-wage jobs in New York City, including the right to paid sick days, regulation of major retailers, and unionization of the car wash industry. He graduated from Yale Law School and Columbia College cum laude. And as I said in my opening statement, we are deeply honored to have you here, Mr. Barkan, and the floor is yours.

STATEMENT OF ADY BARKAN, FOUNDER, BE A HERO ORGANIZATION

Mr. BARKAN. Chairman McGovern and members of the committee, thank you for inviting me to testify today. My name is Ady Barkan. I am 35 years old, and I live in Santa Barbara, California, with my brilliant wife Rachel and our beautiful toddler Carl. She is an English professor at the University of California-Santa Barbara, and I am an organizer at the Center for Popular Democracy and the Be a Hero project.

I earned my bachelor's degree from Columbia University with a major in economics and my law degree from Yale Law School. For 20 years, since I was a freshman on my high school debate team, I have been giving speeches and presentations on topics like healthcare reform and the Federal budget, but never before have I given a speech without my natural voice. Never before have I had to rely on a synthetic voice to lay out my arguments, convey my most passionately held beliefs, tell the details of my personal story.

Three years ago, Rachel and I felt like we had reached the mountaintop. We had fulfilling careers, a wonderful community of friends and family, and a smiling chubby infant boy. We could see decades of happiness stretching out before us. The sun was shining, and there was not a cloud in sight. And then, out of the clear blue sky, we were struck by lightning: ALS, a mysterious neurological disease with no cure and no good treatment, a life expectation of 3 to 4 years. Most of its victims are in their fifties and sixties. I was 32.

Every month since my diagnosis, my motor neurons have died out, my muscles have disintegrated, and I have become increasingly paralyzed. I am speaking to you through this computer because my diaphragm and tongue are simply not up to the task.

Although my story is tragic, it is not unique. Indeed, in many ways, it is not so rare. Jennifer Epps-Addison, the president of my organization, is sitting next to me. Like me, her husband was struck at a young age by a neurological disease, multiple sclerosis. Ten percent of Americans have a serious disability. Every family is eventually confronted with serious illness or accidents. On the day we are born and on the day we die and on so many days in between, all of us need medical care. And yet in this country, the wealthiest in the history of human civilization, we do not have an effective or fair or rational system for delivering that care. I will not belabor the point because you and your constituents are well aware of the problems: high costs, bad outcomes, mind-boggling bureaucracy, racial disparities, bankruptcies, geographic inequities, and obscene profiteering.

The ugly truth is this: Healthcare is not treated as a human right in the United States of America. This fact is outrageous, and it is far past time that we change it. Say it loud for the people in

the back: Healthcare is a human right. For my family, although we have comparatively good private health insurance, ALS now means paying out of pocket for almost 24-hour home care. This costs us \$9,000 every month. The alternative is for me to go on Medicare and move into a nursing home away from my wife and my son. So we are cobbling together the money from friends and family and supporters all over the country, but this is an absurd way to run a healthcare system. GoFundMe is a terrible substitute for smart congressional action.

Like so many others, Rachel and I have had to fight with our insurer, which has issued outrageous denials instead of covering the benefits we pay for. We have so little time left together and yet our system forces us to waste it dealing with bills and bureaucracy.

That is why I am here today urging you to build a more rational, fair, efficient, and effective system. I am here today to urge you to enact Medicare for All. There are three simple reasons why Medicare for All is the right solution, the only solution to what ails the American healthcare system. I will summarize them here, but I urge you to read the fantastic testimony submitted by the National Nurses United for more details.

First, Medicare for All will deliver to everyone living in America the high-quality care that we deserve. The law will provide comprehensive care, including primary and hospital care, dental, vision, reproductive, and mental healthcare. We will all be allowed to see the doctors and specialists we want. And crucially, the program will provide for long-term services and supports that will allow people like me to stay in our homes and communities with the people we love. This will dramatically improve life for the tens of millions of people whose families include older or disabled people.

Second, Medicare for All will save the American people enormous sums of money. Under the program, there will be no premiums, no deductibles, and no copays. That means that we will no longer need to choose between paying the rent and filling a prescription. It means we will no longer delay necessary care until it is tragically late and tragically expensive. It means that we won't have to worry every year when our employer announces the new rates. It means that we can finally start to eliminate the atrocious racial and economic disparities that destroy so many lives, that rob our communities of so much dignity, that strip us all of our common humanity.

Any proposal that maintains financial barriers to care, any proposal that continues to charge patients exorbitant copays, deductibles, and premiums will necessarily leave people out. Any proposal that maintains the for-profit health insurance system will require that some people don't get the healthcare they need. Without the generous support of my family and friends, this would include me.

Crucially, Medicare for All is the only way to make our healthcare system more efficient. Over the past 3 years, I have seen firsthand how the current system creates absurdly wasteful cost-shifting, delays, billing disputes, rationing, and worry. Administrative waste is costing us hundreds of billions of dollars every year.

Medicare for All will streamline the entire system, letting doctors and nurses focus on delivering care instead of on paperwork. As a single-payer program, Medicare for All will be able to eliminate immoral price gouging by pharmaceutical and device companies. The fundamental truth is that too many corporations make too much money off of our illnesses, and they are spending zillions of dollars lobbying and campaigning and fighting to stop us from building something better.

It is very important to emphasize the following point: These cost savings are only possible through a genuine Medicare for All system; other proposals to increase health insurance coverage, such as those that would make Medicare compete with private insurance, would not facilitate administrative and billing savings. There are many other major benefits to Medicare for All detailed in the written testimony submitted by the nurses and others.

But my time to deliver this testimony is running out. And in a much more profound sense, my time to deliver this message to the American people is running out as well. So I want to end on this third and final note: Our time on this Earth is the most precious resource we have. A Medicare for All system will save all of us tremendous time. For doctors and nurses and providers, it will mean more time giving high-quality care, and for patients and our families, it will mean less time dealing with a broken healthcare system and more time doing the things we love together.

Some people argue that, although Medicare for All is a great idea, we need to move slowly to get there, but I needed Medicare for All yesterday. Millions of people need it today. The time to pass this law is now. Winning this reform will not be easy. The monied interests will do everything in their power to stop us, and yet, despite these obstacles and despite the personal challenges that I face, I sit before you today a hopeful man, a hopeful husband, and a hopeful father. I am hopeful because right now there is a mass movement of people from all over this country rising up. Nurses, doctors, patients, caregivers, family members, we are all insisting that there is a better way to structure our society, a better way to care for one another, a better way to use our precious time together.

And so my closing message is not for the members of this committee; it is for the American people. Join us in this struggle. Be a hero for your family, your communities, your country. Come give your passion and your energy and your precious time to this movement. It is a battle worth waging and a battle worth winning. For my son, Carl, for your children, and for our children's children, we have a once-in-a-generation opportunity to win what we really deserve. No more half measures, no more healthcare for some. We can win Medicare for All. This is our Congress. This is our democracy, and this is our future for the making.

[The statement of Mr. Barkan follows:]

**Testimony of Ady Barkan
House of Representatives
Committee on Rules
April 30, 2018**

Chairman McGovern and members of the committee, thank you for inviting me to testify today. My name is Ady Barkan. I am thirty-five years old and I live in Santa Barbara, California with my brilliant wife Rachael and our beautiful toddler Carl. She is an English professor at the University of California Santa Barbara and I am an organizer at the Center for Popular Democracy and the Be A Hero project.

I earned my bachelor's degree from Columbia University with a major in economics and my law degree from Yale Law School. For twenty years, since I was a freshman on my high school debate team, I have been giving speeches and presentations on topics like health care reform and the Federal budget.

But never before have I given a speech without my natural voice. Never before have I had to rely on a synthetic voice to lay out my arguments, convey my most passionately held beliefs, tell the details of my personal story.

Three years ago, Rachael and I felt like we had reached the mountaintop. We had fulfilling careers, a wonderful community of friends and family, and a smiling, chubby infant boy. We could see decades of happiness stretching out before us. The sun was shining and there was not a cloud in sight. And then, out of the clear blue sky, we were struck by lighting.

ALS. A mysterious neurological disease with no cure and no good treatment. A life expectancy of three to four years. Most of its victims are in their fifties and sixties. I was thirty two.

Every month since my diagnosis, my motor neurons have died out, my muscles have disintegrated, and I have become increasingly paralyzed. I am speaking to you through this computer because my diaphragm and tongue are simply not up to the task.

Although my story is tragic, it is not unique. Indeed, in many ways, it is not so rare. Jennifer Epps Addison, the president of my organization, is sitting next to me. Like me, her husband was struck at a young age by a neurological disease. Multiple sclerosis.

Ten percent of Americans have a serious disability. Every family is eventually confronted with serious illness or accidents. On the day we are born and on the day we die, and on so many days in between, all of us need medical care.

And yet in this country, the wealthiest in the history of human civilization, we do not have an effective or fair or rational system for delivering that care. I will not belabor the point, because you and your constituents are well aware of the problems: high costs, bad outcomes, mind-boggling bureaucracy, racial disparities, bankruptcies, geographic inequities, and obscene profiteering.

The ugly truth is this: health care is not treated as a human right in the United States of America. This fact is outrageous. And it is far past time that we change it. Say it loud for the people in the back: health care is a human right.

For my family, although we have comparatively good private health insurance, ALS now means paying out of pocket for almost 24-hour home care. This costs us nine thousand dollars, every month. The alternative is for me to go on Medicare and move into a nursing home, away from my wife and my son. So we are cobbling together the money, from friends and family and supporters all over the country. But this is an absurd way to run a healthcare system. GoFundMe is a terrible substitute for smart Congressional action.

Like so many others, Rachael and I have had to fight with our insurer, which has issued outrageous denials instead of covering the benefits we've paid for. We have so little time left together, and yet our system forces us to waste it dealing with bills and bureaucracy.

That is why I am here today, urging you to build a more rational, fair, efficient, and effective system. I am here today to urge you to enact Medicare For All.

There are three simple reasons why Medicare For All is the right solution, the only solution, to what ails the American healthcare system. I will summarize them here, but I urge you to read the fantastic testimony submitted by the National Nurses United for more details.

First, Medicare For All will deliver to everyone living in America the high quality care that we deserve. The law will provide comprehensive care, including primary and hospital care, dental, vision, reproductive, and mental health care. We will all be allowed to see the doctors and specialists we want. And, crucially, the program will provide for long-term services and supports that will allow people like me to stay in our homes and

communities, with the people we love. This will dramatically improve life for the tens of millions of people whose families include older or disabled people.

Second, Medicare For All will save the American people enormous sums of money. Under the program, there will be no premiums, no deductibles, and no copays. That means that we will no longer need to choose between paying the rent and filling a prescription. It means we will no longer delay necessary care until it is tragically late and tragically expensive. It means that we won't have to worry every year when our employer announces the new rates. It means that we can finally start to eliminate the atrocious racial and economic disparities that destroy so many lives, that rob our communities of so much dignity, that strip us all of our common humanity.

Any proposal that maintains financial barriers to care -- any proposal that continues to charge patients exorbitant copays, deductibles, and premiums -- will necessarily leave people out. Any proposal that maintains the for-profit health insurance system will require that some people don't get the healthcare they need. Without the generous support of my family and friends, this would include me.

Crucially, Medicare For All is the only way to make our healthcare system more efficient. Over the past three years, I have seen first hand how the current system creates absurdly wasteful cost-shifting, delays, billing disputes, rationing, and worry. Administrative waste is costing us hundreds of billions of dollars every year. Medicare For All will streamline the entire system, letting doctors and nurses focus on delivering care instead of on paperwork. As a single payer program, Medicare For All will be able to eliminate immoral price gouging by pharmaceutical and device companies. The fundamental truth is that too many corporations make too much money off of our illnesses, and they are spending gazillions of dollars lobbying and campaigning and fighting to stop us from building something better.

It is very important to emphasize the following point: these cost savings are only possible through a genuine Medicare For All system. Other proposals to increase health insurance coverage, such as those that would make Medicare compete with private insurance, would not facilitate administrative and billing savings.

There are many other major benefits to Medicare For All, and these are detailed in the written testimony submitted by the nurses and others.

But my time to deliver this testimony is running out. And, in a much more profound sense, my time to deliver this message to the American people is running out as well. So I want to end on this third and final note.

Our time on this earth is the most precious resource we have. A Medicare For All system will save all of us tremendous time. For doctors and nurses and providers, it will mean more time giving high quality care. And for patients and our families, it will mean less time dealing with a broken health care system and more time doing the things we love, together.

Some people argue that although Medicare for All is a great idea, we need to move slowly to get there. But I needed Medicare for All yesterday. Millions of people need it today. The time to pass this law is now. .

Winning this reform will not be easy. The monied interests will do everything in their power to stop us. And yet despite these obstacles and despite the personal challenges that I face, I sit before you today a hopeful man, a hopeful husband, and a hopeful father.

I am hopeful because right now, there is a mass movement of people from all over this country, rising up. Nurses, doctors, patients, caregivers, family members -- we are all insisting that there is a better way to structure our society, a better way to care for one another, a better way to use our precious time together.

And so my closing message is not for the members of this committee. It is for the American people.

Join us in this struggle. Be a hero for your family, your communities, your country. Come give your passion and your energy and your precious time to this movement. It is a battle worth waging, and a battle worth winning. For my son Carl, for your children, and for our children's children.

We have a once in a generation opportunity to win what we really deserve. No more half measures. No more healthcare for some. We can win Medicare for All.

This is our Congress. This is our democracy. And this is our future for the making.

The CHAIRMAN. Thank you very much, Mr. Barkan.

I appreciate it. I think this entire committee is grateful for your testimony, and we are honored to have you here.

Let me yield to my colleague, Mr. Cole.

Mr. COLE. I simply want to echo your remarks. It is a great privilege to have you here and at considerable sacrifice and risk to yourself, which is a testament to your courage. We are very happy and honored to have you in this debate, in this hearing today. Thank you.

We will go next to Dr. Charles Blahous, who is the J. Fish and Lillian F. Smith Chair and Senior Research Strategist at the Mercatus Center at George Mason University as well as a visiting fellow at Stanford University's Hoover Institution, previously served as a public trustee for the Social Security and Medicare programs, and was deputy director of the National Economic Council under President George W. Bush.

STATEMENT OF CHARLES BLAHOUS, J. FISH AND LILLIAN F. SMITH CHAIR AND SENIOR RESEARCH STRATEGIST, MERCATUS CENTER

Mr. BLAHOUS. Thank you very much. Chairman McGovern, Ranking Member Cole, all the members of the committee, I greatly appreciate this opportunity to appear before you to discuss the estimated Federal budget costs of Medicare for All.

Before I proceed to the estimates, just a few caveats. This is not an analysis of whether Medicare for All is good policy or bad policy. It is purely a cost projection. And as I discuss the factors that play into the estimates, it is purely by way of explaining how they affect the numbers.

The second caveat is that my testimony is based on an analysis of the Medicare for All Act of 2017, introduced by Senator Sanders in the last Congress. Obviously, there are more recent bills introduced by Representative Jayapal and by Senator Sanders himself. These would be expected to cost somewhat more because they have added long-term care benefits, but I have had not had an opportunity to analyze these bills.

Medicare for All would add somewhere between \$32.6 trillion and \$38.8 trillion in new Federal budget costs over the first 10 years. The \$32.6 trillion estimate is a lower bound estimate. It essentially assumes every cost containment provision in the bill saves as much as possible. If, instead, things play out more consistently with historical trends, the new Federal costs would be closer to \$38.8 trillion. And I will say more about the specific assumptions later.

Now, obviously, such enormous numbers are very difficult to grasp. We are talking about 11 to 13 percent of our GDP in 2022 rising to 13 to 15 percent of GDP in 2031 being added to the Federal ledger. And we simply do not have historical experience with permanent government expansions of this size. So, to provide a sense of the magnitude, the study notes that doubling all currently projected Federal individual and corporate income taxes would be insufficient to finance even the lower bound estimate of \$32.6 trillion.

Now, to be clear, these would not be the total costs of Medicare for All. These would be the Federal Government's net new costs above and beyond currently projected Federal health obligations. Total Federal spending on Medicare for All over the first 10 years would be somewhere between \$54.6 trillion and \$60.7 trillion.

Now, the vast majority of these costs would arise simply from the Federal Government's assuming responsibility for health spending that is now done by others, by State and local governments, by private insurance, and by individuals in their payments out of pocket. Other aspects of Medicare for All would add to that existing health spending. Still others are intended to bring costs down.

The biggest factor increasing health spending under Medicare for All would be its expansion and increased generosity of health insurance coverage. Spending on behalf of the currently uninsured would rise, as one would expect and presumably intend. Additional benefits would be provided that Medicare currently doesn't, such as dental, vision, and hearing services.

Perhaps most importantly, as has been noted here, Medicare for All would provide first dollar coverage of all Americans' health expenses, meaning no deductibles, no copays, no other cost-sharing. And this would considerably increase the demand for health services for the well-documented fact that the more of people's healthcare that is financed by their insurance, the more they tend to consume. So, under Medicare for All, the Federal Government would not only take on responsibility for funding currently projected health services but a significantly increased demand.

Now, other provisions of Medicare for All are expected or hoped to reduce costs. The study assumes substantial administrative cost savings from eliminating private health insurance and it brackets a range of possible outcomes of efforts to negotiate lower drug prices.

Now, the big variable here is payment rates for health providers. The bill indicates that providers will be paid at Medicare payment rates, and these are much lower than those that are paid by private insurance. For hospitals, the payment reductions would be more than 40 percent for treatments now covered by private insurance; and for doctors, the reductions from private insurance rates would start out around 30 percent, on average. They would grow even steeper over time, reaching 42 percent within 10 years.

Now, importantly, these reduced payment rates would be substantially below providers' reported costs of providing services. We do not know what would happen to the supply, timeliness, or quality of healthcare services if we were to impose sudden provider payment cuts of this magnitude while simultaneously increasing the demand for services. And because of this, several other studies performed prior to the bill's introduction assumed higher payment rates than Medicare's would be needed.

Now, my study did not take sides on whether these provider payment cuts would be desirable. But purely from an analytical standpoint, you have to recognize that they are much larger and more sudden than lawmakers have historically been willing to implement. If historical patterns continued and such payment reductions did not occur, Medicare for All would further increase national health spending even above current projections.

My written testimony provides comparisons showing that these estimates are generally similar to those of other experts when you adjust for the years being estimated as well as for alternative assumptions regarding the administrative costs, prescription drug costs, and provider payment rates.

I hope this information is useful, and I thank the committee again for the opportunity to discuss these important aspects of Medicare for All.

[The statement of Mr. Blahous follows:]

Statement of Charles P. Blahous¹
Before the U.S. House of Representatives Committee on Rules
April 30, 2019

Thank you, Chairman McGovern, Ranking Member Cole, and all of the members of the committee. I appreciate this opportunity to appear before you to discuss the estimated federal budget costs of enacting Medicare for All (M4A).

My testimony is based on research performed last year to estimate the cost of a specific bill from the 115th Congress, the Medicare for All Act of 2017 introduced by Senator Bernie Sanders (I-VT). Let me begin with a few caveats before summarizing these estimates and the assumptions that underlie them. The first caveat is that while there are strong similarities between Representative Jayapal's bill that is the subject of this hearing, and the Sanders bill that I analyzed, I have not developed estimates for the Jayapal bill, nor have I analyzed the revised Medicare for All bill introduced by Senator Sanders in the current Congress. Cost estimates for these current bills are expected to be somewhat higher due to their additions of long-term care benefits, but I can only provide quantitative estimates for the previous Sanders bill that I analyzed.

Second, the narrow purpose of this research was to estimate the federal budget costs of enacting M4A. The study does not offer opinions on whether such legislation would be good or bad policy, nor does it engage various important value judgments or difficult health policy calls that must be made in the course of any comprehensive health care legislation. While the study (as well as this testimony) does describe possible effects of various policy decisions associated with implementing M4A, it does so only to illuminate how the numerical estimates might be affected by them.

Third, although various incarnations of these proposals have titles that include the phrase "Medicare for All," the federal health care systems they would establish differ from current Medicare in fundamental ways. Instead of extending the current Medicare program to the population as a whole, these bills would move all Americans, including seniors currently on Medicare, into a new system offering different (generally more generous) benefits, while doing away with many of Medicare's current financing mechanisms such as patient deductibles and copays. Accordingly, while these estimates pertain to a specific bill known as M4A, I have not attempted to analyze an actual expansion of eligibility for traditional Medicare. Nor have I analyzed any of various proposals to allow other individuals to buy into the current Medicare program.

¹ Charles P. Blahous holds the J. Fish and Lillian F. Smith Chair at the Mercatus Center at George Mason University, where he is also Senior Research Strategist. He is also a Visiting Fellow with the Hoover Institution at Stanford University.

Cost Estimates

The additional federal costs of enacting the Medicare for All Act of 2017 would likely be somewhere within the range of \$32.6-\$38.8 trillion over its first ten years of full implementation, which at the time the study was conducted would be 2022-2031. The \$32.6 trillion projection was presented in the paper as a lower-bound estimate, representing an unlikely scenario in which the provisions of M4A that are intended to lower costs all produce the full amount of their potential savings, without regard for any accompanying adverse effects this might have on health care access, timeliness or quality. Alternatively, if after M4A's enactment, historical patterns of federal government behavior remained more consistent with past practice, the new federal costs would be closer to \$38.8 trillion over the first ten years.

Such enormous numbers are difficult to grasp, and these particular numbers also appear especially large because they extend out to 2031. To provide context, the study also translates them into a share of GDP. The \$32.6 trillion estimate equates to an addition to federal budget costs of roughly 10.7% of GDP in 2022, gradually increasing to 12.7% of GDP in 2031, and growing further afterward. If instead, new federal costs were \$38.8 trillion over ten years, federal obligations would be increased by 12.6% in 2022 and by 15.1% in 2031, also growing larger over subsequent time. We have no experience with enacting federal cost assumptions of this magnitude, which renders these numbers especially difficult for many to conceptualize. To illustrate the general size of the cost increase, the study notes that even under the lower-bound estimate of \$32.6 trillion, a doubling of all currently projected federal individual and corporate income taxes would be insufficient to finance the added federal costs of enacting M4A.

Table 1: Projected Federal Cost Increases under M4A

Scenario	New Federal Costs, 2022-31 (\$T)	New Federal Costs, 2022 (% of GDP)	New Federal Costs, 2031 (% of GDP)
Lower-bound estimate	\$32.6 T	10.7%	12.7%
Estimate assuming continuity in provider + drug payments	\$38.8 T	12.6%	15.1%

It is especially important to understand that these estimates do not reflect the total federal costs of M4A, but rather just its addition to federal costs above and beyond currently projected federal health care outlays and tax subsidies, which include Medicare, Medicaid, the tax subsidy for employer-sponsored health insurance, Affordable Care Act exchange subsidies, and other health programs. The total projected federal costs under M4A would be substantially higher than the net cost increases shown in Table 1, with federal obligations for M4A being somewhere within the range of \$54.6 trillion and \$60.7 trillion over the first ten years. Under the lower-bound estimate, federal spending on M4A alone would be 20.8% of GDP by 2031. 20.8% of GDP also equals the total amount of all current federal spending projected for 2019 by the Congressional Budget Office. Further, these figures do not account for all national health-related spending under the M4A bill, as

for example they exclude long-term care spending that would remain the responsibilities of individuals and state governments.

Factors Affecting the Cost Estimates

The vast majority of new federal costs under M4A would result from the federal government's assuming responsibility for most national health spending currently financed by other entities, including private insurance, state and local governments, and individuals. By itself, and before considering possible offsetting savings, M4A's expansion of coverage while shifting from privately-financed to federally-financed insurance would not only cause federal budget obligations to increase, but national health expenditures as well. This is partially because of increased expenditures on health services for the currently uninsured, and partially because of M4A's coverage of some services not now covered by traditional Medicare, such as dental, vision and hearing benefits. Additional expenditure increases would also occur because M4A would offer complete first-dollar coverage of all individuals' health services, unlike traditional Medicare and most current private insurance. It is well established in the economics literature that the more of an individual's health services that are covered by insurance, the more they tend to consume, irrespective of the services' efficacy or value. M4A's first-dollar coverage of health services would therefore fuel substantial additional demand. As the study explains in greater detail:

“Finally, the plan's requirement that “no cost-sharing, including deductibles, coinsurance, copayments, or similar charges, be imposed on an individual” would also significantly increase healthcare utilization. As a general rule, the greater the percentage of an individual's healthcare that is paid by insurance (i.e., the insurance's actuarial value, or AV), the more healthcare services an individual tends to buy. There is an extensive literature devoted to estimating how much individuals increase their use of healthcare as the AV of their insurance increases—which, in the case of M4A, would be to an AV of essentially 100 percent. Providing this first-dollar coverage is estimated to induce 11 percent additional demand for those currently covered by private insurance and 16 percent for those now in traditional Medicare without supplemental coverage.”

The M4A bill seeks to offset these additional costs through various means. One is through the replacement of private health insurance by a federally-administered system that sponsors intend to have lower administrative costs. The study makes an aggressive assumption that over half of the administrative costs currently borne by private insurance would be eliminated. These assumed administrative cost savings would offset roughly 4% of the additional federal costs arising from the federal government's becoming the financier of nearly all US health care. For another comparison, these assumed administrative cost savings would offset roughly 28% of the additional national health spending expected to arise from increased health service demand under M4A. In other words, health insurance administrative costs would be lowered, but this would offset only a fraction of the additional national health expenditures projected as a result of M4A's expanded and enhanced coverage.

Another means by which M4A would attempt to contain costs is by having the Secretary of Health and Human Services negotiate drug prices with a particular emphasis on replacing brand-name medications with less expensive generics. To understand the cost projections, it is important to distinguish between potential savings and likely savings. There are hard limits on the potential savings that can arise from such a provision because prescription drugs account for just 10 percent of total national health expenditures, and generics already make up 85 percent of all prescription drugs sold. Nevertheless, the lower-bound estimates employ aggressive assumptions for prescription drug cost savings, specifically an immediate 12 percent reduction in prescription drug expenditures, without attempting to model potential adverse effects of this reduction on the pharmaceutical industry or the pace of innovation.

History provides reason for skepticism that this level of savings would actually be achieved. Historically the federal government has tended to prioritize health benefits for those dependent on federal programs over the interests of taxpayers in restraining cost growth. Though it is theoretically possible that under M4A the federal government would switch its emphasis from allowing patients full access to the fruits of pharmaceutical and other health care innovation, to protecting the interests of taxpayers through cost containment, the political economy incentives under M4A make this unlikely. Under M4A, the lack of deductibles, copayments and cost-sharing would largely eliminate consumer (and thus voter) sensitivity to health care prices, including drug prices. Dramatic drug price savings under M4A should therefore be considered an aspirational goal rather than the basis for an intermediate cost projection. This is one of multiple reasons why actual costs under M4A would likely exceed the study's lower-bound projection scenario.

The most significant variable affecting M4A cost projections is that of provider payment rates. The study's lower-bound projection assumes that all provider payment rates would immediately be set to Medicare rates, which are roughly 40% lower than private insurance rates over the time window in the study, with the exact percentage reduction varying by year and by type of provider. Other studies performed before the introduction of the Sanders bill assumed that higher payment rates than this would be required, because Medicare payment rates are substantially below providers' reported costs of providing services. The CMS Medicare actuary, for example, projected at the time of the study that 80% of hospitals would experience negative margins in 2019 when treating Medicare patients, a situation M4A would extend to the population as a whole. See Figures 1 and 2, reproduced from a memorandum from the CMS Medicare actuary's office.²

² The figures shown here are reproduced from CMS Office of the Actuary, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2018TRAlternativeScenario.pdf>. These figures from the 2018 memorandum were chosen for inclusion here because they illustrate data cited in the study. CMS has recently published a 2019 update of these figures that is broadly similar.

Figure 1: CMS Medicare Actuary Comparisons of Hospital Payment Rates

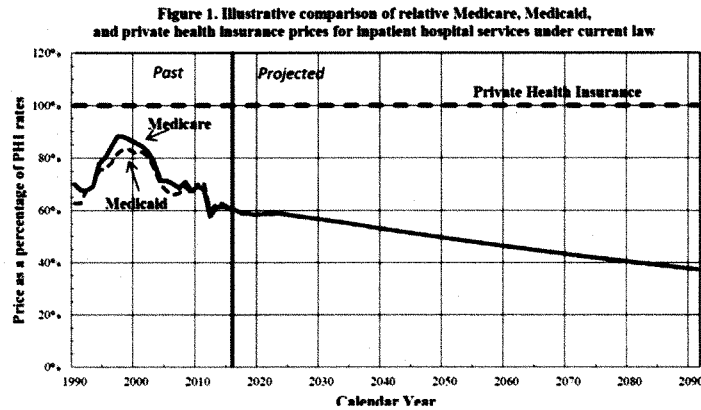
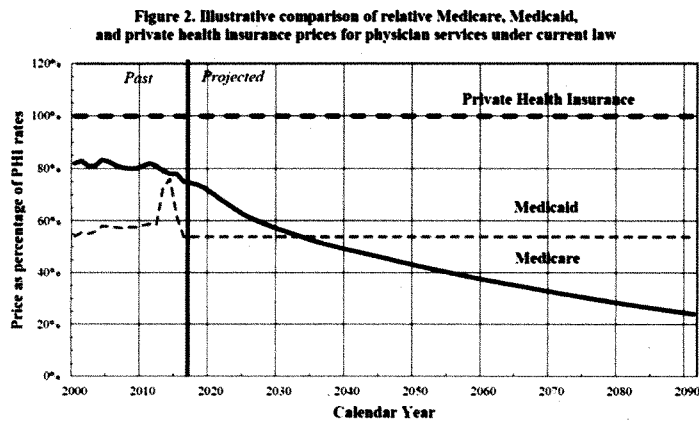


Figure 2: CMS Medicare Actuary Comparisons of Physician Payment Rates



We do not know how providers would respond to payment reductions of this magnitude for treatments now covered by private insurance, concurrent with a simultaneous increase in patient demand for health services under M4A. It is likely that there would be some disruptions in the availability, timeliness and quality of health care services, but no one can say what they would be. The study does not attempt to model the extent to which the supply of health care services may be

insufficient to meet expanded demand under M4A. In a scenario of insufficient supply, the amount of services would be lower than projected, but prices per service would increase.

For the purpose of producing accurate cost estimates, the relevant question is whether Medicare payment rates or higher payment rates are more likely to be implemented. The study's lower-bound estimates assume the universal application of Medicare payment rates as indicated in the Sanders bill. It should be noted, however, that lawmakers have repeatedly balked at applying payment reductions that are far smaller, less sudden, and applicable to a lesser number of payments, than is called for in the Sanders bill. For example, lawmakers began annual overrides of the Medicare physician payment Sustainable Growth Rate formula when the pending cuts were only 4-5% and pertained only to Medicare treatments. By contrast, hospital payment cuts under M4A would start at over 40% and apply to the larger number of treatments now covered by private insurance. The study does not attempt to predict what would happen in legislative practice; it simply quantifies the magnitude of the provider payment cuts called for under the M4A bill, as well as how the overall cost estimates would change in a (possibly more likely) scenario in which they are not applied.

Table 2 summarizes how the M4A cost estimates are affected by these various assumptions.

Table 2: Effect of Various Assumptions upon M4A Cost Projections

Scenario	Additional Federal Costs, 2022-2031 (\$T)
= Added federal costs from coverage increase	= \$40.368 T
- Administrative cost savings	- \$1.572 T
= Estimate assuming administrative savings	= \$38.797 T
- Potential drug cost savings	- \$0.846 T
= Estimate assuming drug and admin. savings	= \$37.950 T
- Lowering provider payments to Medicare rates	- \$5.307 T
= Lower-bound estimate	= \$32.644 T

Other Perspectives on Estimated Costs

An occasional question about such estimates is whether they reflect a particular policy viewpoint or instead reflect broader agreement among experts as to the likely costs of M4A. The answer is that cost estimates produced by experts from a wide range of policy perspectives and institutional affiliations arrive at roughly the same place, after adjusting for different years estimated, as well as assumptions regarding provider payment rates, drug prices, and whether long-term services and supports (LTSS) are included. The following table translates my estimates into what they would have been for M4A's implementation during 2017-2026, as assumed in studies published by the Urban Institute, the Center for Health and Economy, and Emory University professor Ken Thorpe.

Table 3: Alternative Estimates for Added Federal Costs under M4A, if Effective 2017-2026

Estimate	New Federal Costs over 2017-2026 (\$T)
Center for Health and Economy, Alternative Estimate	\$40.2
Blahous (w/o provider cuts or drug savings)	\$29.5
Urban Institute (w/o LTSS benefit)	\$29.1
Blahous (w/drug savings, w/o provider cuts)	\$28.9
Center for Health and Economy, Primary Estimate	\$27.3
Blahous (w/provider cuts & drug savings)	\$25.2
Thorpe	\$24.7

As Table 3 shows, my estimates are generally within the range of those produced by other experts, the differences between them largely attributable to differences in key assumptions. The Urban Institute study produced an estimate of \$32.0 trillion, which included LTSS coverage based on information available during the 2016 Sanders presidential campaign. Adjusting for the fact that the 2017 Sanders M4A bill did not include this coverage brings the Urban Institute's estimate down within the range of my own. My lower-bound estimate is generally smaller than those of other experts because it assumes (per the language of the Sanders bill) the application of Medicare provider payment rates, which are lower than the payment rates the Urban Institute, CHE and Thorpe studies all assumed would be the minimum necessary, prior to the bill's introduction. The Thorpe study estimates higher total national health spending than mine, but mine assumes the federal government would pay for a higher percentage of the whole. In general, however, the estimates are qualitatively similar regardless of who makes them, and provide the same general picture of the scale of federal government expansion M4A would bring about.

My study focused on federal cost projections under M4A, in part because such cost estimates play a key role in Congress's legislative procedures and are thus critical information for lawmakers. Many have correctly noted, as also described earlier in this testimony, that the vast majority of these projected costs are not new to the US economy as a whole, are currently being shouldered by others, and would be shifted to the federal government under M4A. Lawmakers should be cognizant that just as with other major national expenditures such as what Americans spend on food or housing, the fact that we are already bearing most of these costs does not necessarily imply that the federal government would find it easy or even practicable to assume them, nor does it necessarily suggest that the federal government can readily provide these goods and services free of charge to every American while satisfying their diverse needs and preferences. While total national health spending under M4A is an important piece of policy information, federal lawmakers would not be able to avoid the central question of how to finance its costs to the federal budget.

I hope this information is useful to committee members as Congress considers the various implications of enacting M4A legislation.

The CHAIRMAN. Thank you very, very much. I appreciate it.

Dean Baker is a macroeconomist and cofounder of the Center for Economic and Policy Research, CEPR, in Washington, D.C. His areas of research include housing and macroeconomics, intellectual property, Social Security, Medicare, and European labor markets. He is the author of several books, and his piece “‘Medicare for All’ is not a fantasy” was recently published on CNN’s website. He received his B.A. from Swarthmore College and his Ph.D. in economics from the University of Michigan.

Mr. Baker, we are very honored to have you here.

STATEMENT OF DEAN BAKER, SENIOR ECONOMIST, CENTER FOR ECONOMIC AND POLICY RESEARCH

Mr. BAKER. Thank you, Chairman McGovern and Ranking Member Cole. I have to say it is a great honor to be next to Ady again. I knew Ady from prior days when we were in the Fed Up coalition to pressure the Fed to allow more full employment, and that was an amazing effort that Ady deserves enormous credit for in addition to his great subsequent work. And I appreciate being here.

I want to make three main points and then say a little bit about the transition. First off, I want to say that Medicare for All is affordable, that the bulk of the payments should be coming from shifting employer premiums to government basically to taxes. So it is not additional money out of workers’ pockets.

Secondly, that the amount of additional revenue that will be needed depends hugely on the extent to which we can reduce input costs. And here what we have to keep in mind front and center is that we pay twice as much for everything as everyone else in the world, and that doesn’t make sense. And the third point is that lower costs can be associated with better care, not just for the obvious reason that it will increase access but for other reasons, that we should expect better outcomes.

On the first point, in terms of the overall affordability, taking a look at Dr. Blahous’ numbers, my basic story is very comparable, that you are looking at incorporating somewhere on the order—I was looking at 2021 to 2030; I think those might be slightly different years—but incorporating the private payments under the government budget. It is about \$33.4 trillion, by my calculations, using CMS numbers.

First off, though, we know that there will be a lot of administrative savings. There was an analysis done back in 2003 by Stephanie Woolhandler and David Himmelstein that compared our administrative costs with Canadian administrative costs. Most obviously, you have the huge difference in what we actually pay upfront for insurance; but in addition to that, we have huge administrative costs in providers: hospitals, doctors’ offices, nursing homes. They all have to have large numbers of staff to deal with different billing from different insurers. So, using their figures, I calculate that we would get that tab down to \$25 trillion. Still considerable. That is shown in table 1 of my written testimony.

The second point, second adjustment, we will see more utilization. I think that with the amount of utilization, we are somewhat shooting in the dark here because we don’t know what happens when we, in essence, make more healthcare free or cheap for peo-

ple, but the important point to keep in mind that 70 percent of our healthcare costs come from roughly 10 percent of the population.

The point about that is those 10 percent, they are either on Medicaid or they have hit their out-of-pocket limits. In other words, they are not already constrained. So we are looking at 30 percent of total costs. So how much more will that go up? We don't know. I assume 10 percent of the total bill in the calculations. We need more research on this.

Also, there will be some out of pocket again. That will be debated, how much you have. I assume 1 percent of GDP. That leaves us, after we account for the \$11.6 trillion in employer payments, we are left with \$13.6 trillion, still a substantial bill over a decade.

But then I go, okay, well what about input costs? And I won't go into these in great detail; it is in my written testimony. But if we look at our input costs, as I say, if we look through medical equipment, prescription drugs, physicians' payments, dentists' payments, we pay twice as much as everyone else in the world. Now, will we get down to others' levels? That is an open question, but there is no obvious reason we should be paying twice as much for our drugs, for our medical equipment as people in France and Germany. We don't pay our auto workers twice as much. We don't pay twice as much for cars. It is not clear why we should pay twice as much for healthcare.

And let me just focus quickly on prescription drugs. CMS projects we will spend roughly \$6.6 trillion on prescription drugs. Now, the assumption in the bill, and by most people who have analyzed it, we can get that down a lot. One of the points I like to make is we are not talking about making prescription drugs cheap. The problem is we make prescription drugs expensive. Drugs would be cheap if we didn't give government-granted patent monopolies. I understand there is a rationale for that, but the point is we can fund the research in alternative ways, and they would be cheap.

So, just to come quickly to the last points, we could expect better care. People shouldn't have to deal with the stress. Ady and his family shouldn't have to deal with the stress of paying for their bills. That has to be a negative in terms of care for someone, a cancer victim, someone else suffering from a serious disease that they have to deal with bills. Also, in the case of prescription drugs, our opioid problem, at least it is alleged, is in large part the result of our patent monopolies. Purdue Pharma would not have done as they are alleged to have, pushed their drug, insisting that it wasn't addictive, when they had evidence it was. We helped create that problem by granting patent monopolies.

Lastly, some points on the transition; I would be cautious on how you do it. First off, fix Medicare. It is absurd that we don't have an out-of-pocket limit on traditional Medicare. We need that. Secondly, not incorporating the drug benefit. We don't have standalone drug plans in the private sector. Why do we have that with Medicare? It just raises costs. That is utterly pointless. And we overpay the Medicare Advantage plans. A recent analysis found we overpay them by roughly 13 percent, \$20 billion a year. No reason for that.

Secondly, in the transition, I would say allow a buy-in, have a competitive Medicare plan.

The third point, reduce input prices. I can give you lots of ways in which we can get input prices down. In addition, as I said, to public funding of research for prescription drugs.

And, lastly, as just a very, very simple first step, how about lowering the Medicare age of eligibility to 64? That is very affordable in the scheme of things. A lot of 64-year-olds are already on Medicare through disability, or they are on Medicaid. A great downpayment, in my view.

So, long and short, I think it is affordable, but we have to be careful in how we get there. Thank you.

[The statement of Mr. Baker follows:]



Testimony by Dr. Dean Baker, Senior Economist, Center for Economic and Policy Research

April 30, 2019

US House of Representatives Rules Committee

Re: HR 1384 — Medicare for All Act of 2019

I want to thank Chairperson McGovern and Ranking Member Cole for inviting me to address the committee on issues related to Medicare for All. I will make three main points in my testimony.

1. The bulk of the cost of implementing a universal Medicare program will come from shifting payments for employer-provided health insurance to the government;
2. The amount of additional revenue required for a universal Medicare program will depend on the extent to which the cost of health care inputs (e.g. prescription drugs, medical equipment, physicians) can be brought in line with other wealthy countries;
3. Reduced costs can be associated with better care.

I will also make a few comments on the transition to a universal Medicare program, arguing that it is important that it not be done too quickly.

The Cost of a Universal Medicare Program

At the most basic level, proposals for Medicare for All, such as the Jayapal bill, involve making the government responsible for costs now paid by private insurers or as out-of-pocket payments by individuals. If we just project out these costs for the years 2021 to 2030, it would come to \$33.4 trillion or 11.5 percent of GDP over this period.¹

¹ These calculations are taken from the Centers for Medicare and Medicaid Services (CMS). 2019. "National Health Expenditures Projections, 2018–2027." Baltimore, MD: CMS. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2018Tables.zip>, Table 1. Spending levels for 2028–2030 assume the same rate of growth projected for 2024–2027. All subsequent calculations make projections for these years in the same manner.



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While this is very substantial by any measure, it becomes considerably more manageable on closer examination. Most immediately, the Centers for Medicare and Medicaid Services (CMS) projects that we will spend \$3.9 trillion on insurers' administrative costs and profits over this period. This comes to 27.9 percent of projected payments for services by insurers.² If we assume that a universal Medicare system would have administrative costs comparable to the current Medicare system, or the Medicare-type systems in Canada, the United Kingdom and elsewhere, administrative costs would be closer to 3.0 percent of payments to providers. This would save roughly \$3.5 trillion over the course of the decade.

In addition to the direct administrative costs associated with our private insurance system, it also imposes substantial costs on hospitals, doctors' offices, and other providers. They need people on staff to deal with a variety of different forms and billing practices. They also need staff to assist patients in dealing with insurers and their own billing. In addition, employers who provide health care benefits need to devote staff time and/or hire consultants both to select and administer plans and to assist workers in making claims and choosing plans.

These costs can be substantial. A 2003 study comparing administrative costs in Canada and the United States found that hospitals in the United States devoted 24.3 percent of spending to administrative costs compared to just 12.9 percent in Canada.³ If we apply this difference of 11.4 percentage points to projected hospital spending for the decade, it comes to \$2.1 trillion. **Table 1** shows the impact of savings on administrative costs on the additional revenue needed to pay for a universal Medicare program.

² *Ibid.*, Table 2 and Table 3.

³ Woolhandler, Steffie et al. 2003. "Costs of Health Care Administration in the United States and Canada." *N Engl J Med*, 349:768–775. <https://www.ncbi.nlm.nih.gov/doi/full/10.1056/NEJMsa022033>.



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TABLE 1

Projected Costs and Savings: 2021–2030

(trillions of dollars)

Costs

Projected private health care spending \$33.4

Savings

Savings on administrative costs of insurers \$3.5

Savings on administrative costs of hospitals \$2.1

Savings on administrative costs of physicians' offices \$1.8

Savings on administrative costs of nursing homes \$0.2

Savings on administrative costs of home health care \$0.3

Savings on employers' administrative costs \$0.5

Projected cost net of savings

\$25.0

Source and notes: Calculations are based on the percentage of spending going to administrative costs in the United States compared to Canada, as estimated in Woolhandler et al. (2003). The projection for employers' savings assume that spending is the same as the share of GDP calculated for 1999 (0.17 percent).

The total projected administrative savings comes to \$8.4 trillion over the decade, leaving a net increase in spending of \$25 trillion or 8.6 percent of projected GDP. While these estimates of potential administrative savings are necessarily inexact, there is good reason to believe they might on the low side. The calculations are all done in percentage terms. Since our per person health care costs are roughly twice as high as Canada's, these calculations would still imply that US providers under a universal Medicare system would still spend twice as much on administrative costs as their counterparts in Canada.

The next adjustment to the additional spending needed is for increased utilization. A main goal of a universal Medicare system is to ensure that people have access to the care they need, regardless of their income. With almost 30 million people currently uninsured and tens of millions more underinsured, there are undoubtedly many people now who are not getting the care they need due to the cost.

While there is some research on the sensitivity of health care usage to price, it is difficult to assess the impact of such a large change. It is also important to note that because of the enormous skewing of health care costs, most health care spending now is attributable to people who have already reached



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deductible limits on private insurance or are under Medicaid, which picks up most of patients bills.⁴ For these people, cost is not a constraint on usage.

To get a ballpark number on increased utilization, we can assume that people will increase their usage by roughly 10 percent if a universal Medicare system eliminated most cost constraints.⁵ This implies an additional \$2.5 trillion in spending over the decade.

Even under a universal Medicare system, people will still have some out-of-pocket expenditures for health care. At the least, we would still expect people to pay for items like Band-Aids, some non-prescription drugs, like aspirin, as well as optional items like non-essential cosmetic surgery. In Canada and the United Kingdom, out-of-pocket spending comes to an average of 1.3 percent of GDP. If we assume that a universal Medicare system in the United States is somewhat more generous, we can assume patients will pay an amount equal to roughly 1.0 percent of GDP, or \$2.9 trillion over the course of the decade for out-of-pocket expenses or supplemental insurance.

Table 2 nets out these costs and compares them to projected employer payments for employer-provided insurance.

TABLE 2

Projected Additional Cost of Universal Medicare: 2021–2030

(trillions of dollars)

Costs

Additional spending net of administrative costs	\$25.0
Additional utilization	\$2.5
Out-of-pocket spending	\$2.9

Revenue

Projected revenue needed by the government	\$24.6
Projected employer payments for insurance	\$11.6

Additional revenue beyond payments for employer insurance \$13.0

Source and notes: Calculations are explained in text, spending on employer provided insurance is taken from CMS (2019), Table 16.

⁴ In 2016, 5.0 percent of the population accounted for half of health care expenditures and the top 10 percent accounted for more than 70 percent of spending. See Agency for Healthcare Research and Quality. 2019. "Concentration of Health Expenditures and Selected Characteristics of High Spenders, U.S. Civilian Noninstitutionalized Population, 2016." Rockville, MD: Agency for Healthcare Research and Quality. https://mcps.ahrq.gov/data_files/publications/st521/stat521.pdf.

⁵ For a discussion of the evidence on utilization and cost, see Pollin, Robert et al. 2018. "Economic Analysis of Medicare for All." Amherst, MA: PERI. <https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>, pp 22–32.



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As can be seen, after adding in the expense for additional utilization and subtracting out a projection of out-of-pocket spending equal to 1.0 percent of GDP over the decade, the net amount of revenue needed is \$24.6 billion over the decade or 8.5 percent of projected GDP. Projected employer payments for insurance come to \$11.6 billion, or nearly half of this sum. While there are undoubtedly political issues associated with having these payments go to the government rather than private insurers, from the standpoint of workers, it likely makes little difference who their employer mails a check to.⁶

This leaves \$13.0 trillion, an amount equal to 4.8 percent of GDP as the additional revenue that would be needed to cover the cost of a universal health care system. This is still a substantial amount of money, a bit less than the current size of the Social Security program, but this is before considering the cost side of the picture.

Lowering the Costs of Health Care Inputs

Just as we pay roughly twice as much per person for our health care as people in other wealthy countries, we also pay twice as much for most of our inputs, such as prescription drugs, medical equipment, and physicians' services. By bringing these costs in line with costs in other wealthy countries, we can substantially reduce health care spending and the amount of additional revenue that would be needed to cover a universal Medicare program.

CMS projects that we will spend more than \$6.6 trillion on prescription drugs over the course of the decade.⁷ Other wealthy countries spend roughly half as much per person for prescription drugs as the United States.⁸ In the United Kingdom, per person spending is less than 40 percent as much as in the

⁶ There is an important point that employer-provided insurance is an important benefit that employers give workers. If workers got the same insurance regardless of where they worked, employers could not use the quality of their insurance as a way of attracting workers.

⁷ The CMS projections (Table 11) only count retail spending on prescription drugs. The Bureau of Economic Analysis (Bureau of Economic Analysis (BEA). 2019. "National Income and Product Accounts." Suitland, MD: BEA. <https://apps.bea.gov/iTable/iTable.cfm?reqid=19&step=2#reqid=19&step=2&isuri=1&1921=survey>) has data on total spending on prescription drugs (Table 2.4.5U, Line 121). For this calculation, the projection for spending on prescription drugs over the decade was multiplied by the ratio of BEA's estimate of spending on all prescription drugs to CMS's estimate of retail spending (1.24).

⁸ OECD. 2019. "Pharmaceutical spending." Paris, France: OECD. <https://data.oecd.org/healthres/pharmaceutical-spending.htm>.



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United States. If the United States adopted similar rules on negotiations or price controls, presumably it would be able to pay a comparable amount for prescription drugs. This would imply savings of \$3.3 trillion over the course of the decade.

It is worth noting that it is government policy that makes drugs expensive, specifically government-granted patent monopolies and related forms of protection. Without these monopolies, prescription drugs would almost invariably be cheap. It is rare that drugs are expensive to manufacture. In most cases, free market drugs would sell for less than 10 percent of their patent-protected price and often for less than 1 percent.⁹

The pharmaceutical industry undertakes roughly \$70 billion in research annually, which must be paid for in some manner.¹⁰ If we assume that the prescription drugs we bought in 2018 would have cost us roughly \$80 billion if they sold in a free market without patents or related protections, we effectively paid \$350 billion in higher drug prices for \$70 billion in research by the industry. This suggests even greater opportunities for savings if, rather than giving patent monopolies, the government directly paid for prescription drug research with all new drugs being sold as generics. In addition to the savings on drugs prices, this route would also have the advantage that all research findings would be fully public, which could be made a condition of receiving the funding.

CMS also projects that we will spend more than \$1 trillion on non-prescription drugs and non-durable medical products over the decade.¹¹ If these prices can also be brought down by 50 percent, that would save another \$0.5 trillion over the course of the decade.

The projections assume that the country will spend \$2.6 trillion on durable medical equipment over the decade.¹² These are items like MRIs and dialysis machines that cost far more to buy and use in the

9 Collins, Simon. 2016. "1,000-Fold Mark-Up for Drug Prices in High Income Countries Blocks Access to HIV, HCV and Cancer Drugs." *The Body Pro*, October 24. <http://www.thebodypro.com/content/78658/1000-fold-mark-up-for-drug-prices-in-high-income-c.html>.

10 This figure is obtained by taking the National Science Foundation's estimate for 2012 and increasing it in proportion to GDP growth between 2012 and 2018. National Science Foundation. 2012. "Business Research and Development and Innovation: 2012." Arlington, VA: National Science Foundation. <http://www.nsf.gov/statistics/2016/nsf16301/#chp2>, Chapter 2.

11 This comes from CMS (2019), Table 12.

12 CMS (2018), Table 15.



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United States than elsewhere. This is also a situation comparable to that of prescription drugs, where the equipment would be relatively cheap in a free market, but the government makes it expensive with patent monopolies. If we assume prices can be reduced by 50 percent with negotiations and/or controls, it would save \$1.3 trillion over the course of the decade.

Our doctors and dentists also get paid roughly twice as much as their counterparts in other wealthy countries.¹³ With 900,000 doctors getting an average pay of close \$300,000 annually, this comes to roughly \$270 billion in 2018.¹⁴ With 150,000 dentists earning average pay of \$200,000 annually, this comes to \$30 billion, for a total \$300 billion for the two professions.¹⁵ Adjusting for projected growth in spending in these areas, the ten year total is \$4.5 trillion.¹⁶ If US doctors and dentists were paid in line with their counterparts in other wealthy countries, the savings would \$2.3 trillion over the course of the decade.

There are both political and practical reasons why it may not be desirable to push doctors' and dentists' salaries down to international levels. For example, many have incurred large debt in the course of their education. Presumably, if these professionals were to receive lower pay going forward, the government would also want to pay for much or all of the cost of their education. However, this would be a limited additional expense. If the federal government were to pay an additional \$100,000 a year for the education of 60,000 medical and dental school students, it would come to just \$6 billion annually or 0.03 percent of GDP.

Table 3 sums the potential savings in the categories discussed above.

13 Laugesen, Miriam J. and Sherry A. Glied. 2008. "Higher Fees Paid To US Physicians Drive Higher Spending for Physician Services Compared to Other Countries." *Health Affairs*, Vol. 30, No. 9, pp. 1647–56.
<http://content.healthaffairs.org/content/30/9/1647.full.html>.

14 Kane, Leslie. 2018. "Medscape Physician Compensation Report 2018." Medscape, April 11.
<https://www.medscape.com/slideshow/2018-compensation-overview-6009667?faf=1#2>.

15 American Dental Association (ADA). 2015. "Income, Gross Billings, and Expenses: Selected 2014 Results From the Survey of Dental Practice." Chicago, Ill.: ADA.

http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIData_SDPI_2014.ashx.

16 CMS (2019), Table 7.



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TABLE 3
Projected Potential Savings from Universal Medicare: 2021–2030
(trillions of dollars)

Savings	
Prescription drugs	\$3.3
Non-durable medical equipment	\$0.5
Durable medical equipment	\$1.3
Salaries of doctors and dentists	\$2.3
Total savings	\$7.4

Source and notes: Calculations are explained in text.

The net additional revenue needed in this case is \$5.6 trillion over the course of the decade or roughly 1.9 percent of projected GDP. This roughly equal to the projected increase in Social Security spending as a share of GDP over the years 2000 to 2030, as shown in **Table 4**.

TABLE 4
Projected Additional Cost of Universal Medicare, Net of Savings on Health Care Inputs: 2021–2030
(trillions of dollars)

Revenue	
Projected revenue needed by the government net of savings on administrative costs	\$24.6
Projected employer payments for insurance	\$11.6
Additional revenue beyond payments for employer insurance	\$13.0
Savings	
Savings on health care inputs	\$7.4
Total revenue needed in addition to insurance payments	\$5.6

Source and notes: Calculations are explained in text.

This is not to argue that the additional revenue needed or the projected costs savings would be easy to accomplish either practically or politically. However, it is important to recognize that these are plausible numbers, if we could get costs more in line with is paid in other wealthy countries, a universal Medicare system is certainly affordable. It would require substantial, but not unprecedented, tax increases. It is worth noting in this respect that if we look at low-cost health care systems, such as the one in the United Kingdom, we already spend enough on a per person basis in the public sector to fully cover the cost of its system.



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Lower Costs Can Be Associated with Better Quality Care

In spite of the large gap between what people in the United States pay for health care and what people pay in other countries, we do not get better quality care.¹⁷ Not only do we have shorter life expectancies and higher infant mortality rates than people in other countries, we also don't do better by measures of disease treatment, such as care for people with heart conditions or survival rates from cancer. We pay a huge amount more to get outcomes in these areas that are not systematically better than in other wealthy countries. If we looked to go the route of a universal Medicare system, in addition to increasing access, there are also reasons for thinking that even people who already have insurance would get better care.

The first reason is an obvious one, patients and their families would have to spend many fewer hours dealing with bills and insurers. While I am not aware of any studies that measure the amount of time that people must spend dealing with bills and insurers, there is the obvious point that people are most likely to face this ordeal when they are in bad health. It is not good policy to make someone struggling with cancer to also have to contend with bills from a hospital and/or an insurance company that does not want to pay them.

However, as much we might want to believe the goodwill of insurers, it is a simple fact that they make more money by paying out less in claims. If they can find a way to avoid paying a claim, they will. We should not be forcing people in bad health, or their families, to contend with insurers who are trying to avoid paying claims.

In the same vein, the goal to persuade patients to shop around to better “consumers” of health care seems hopelessly wrongheaded. People do not want to shop around for the best insurance plan, which in most cases are quite hard to understand even for those who try.¹⁸ They also are not generally well-prepared to shop around for the lowest priced procedures. A fascinating study of patients' decisions

17 The Commonwealth Fund. 2017. “International Profiles of Health Care Systems.” New York, NY: The Commonwealth Fund. <https://www.commonwealthfund.org/publications/fund-reports/2017/may/international-profiles-health-care-systems>.

18 Remember, the lists of in-network doctors are constantly changing, so even if a person tries to make a careful choice based on the available information, they may find that their doctor(s) are no longer in-network after they select a plan.



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on lower-body MRIs supports the notion that patients are not generally inclined to do comparative shopping when it comes to health care.¹⁹

Lower-body MRIs are a relatively standardized item, as compared to something like hip replacement surgery. Yet, the study found that patients typically choose a provider recommended by their doctor rather than a lower-cost alternative that was as close or closer to their home. If people are not prepared to do comparative pricing on lower-body MRIs, it seems unlikely that they will do comparative pricing on more complex procedures. We need to design policies based on the way people actually behave, not on how we might like them to behave.

The lower prices for prescription drugs and medical equipment, discussed in the last section, may actually lead to better outcomes in many cases. There is a very basic economic principle at stake here. When government intervention raises a price above the market price, it alters the incentive structure. Economists often make this point in terms of tariffs, such as the ones the Trump administration has recently put in place. These tariffs give consumers of items subject to the tariff incentives to misrepresent items in order to avoid paying the tariff. For example, The New York Times recently ran an article on how a shoe manufacturer is able to circumvent a 12.5 percent tariff on imported rubber soles.²⁰ The companies that benefit from a tariff will also use their political and legal power to extend and increase the tariff as much as possible.

This is the story of patent protection for prescription drugs, except instead of raising the price by 10 or 25 percent, the patent-protected price is typically several thousand percent above the free market price. In addition to the incentive this gives companies to use legal and political power to push for ever longer and stronger patents and related protections, it also gives them an incentive to promote their drugs as widely as possible, even in circumstances where it may not be helpful or could even be harmful.

19 Chennaw, Michael, et al. 2019. "Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans." Cambridge, MA: NBER. <https://www.nber.org/papers/w24869>.

20 Tankersley, Jim. 2018. "A Winter-Coat Heavyweight Gives Trump's Trade War the Cold Shoulder." The New York Times, November 13. <https://www.nytimes.com/2018/11/23/business/economy/columbia-sportswear-trump-trade-war.html>.



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The most famous incidence of the latter is the efforts by Purdue Pharma to promote OxyContin. It allegedly promoted it to doctors with the claim that it was not addictive. Needless to say, it would not have had the same incentive to push this opioid if it was selling at generic prices. This a major source of abuse in our medical system which would be eliminated if drugs were not granted patent monopolies and related protections.²¹

The Transition to Universal Medicare

A Medicare for All system of the type envisioned in the Jayapal bill is a huge step from our current system, which relies largely on private insurers. The list of transition problems that would arise is too long to address here. However, I would argue that it is essential that any move to such a system be done piecemeal since a quick changeover would virtually guarantee confusion and quite possibly lead to some people going without care.

Just to take an obvious point, there will almost certainly be some doctors who opt to remain outside the system. While the intention is to make this decision rare, the administrative and legal ability to prevent physicians from practicing outside the system is likely to be limited. If the claim is that people will be able to keep their doctors, in many cases this may prove not to be true if their doctors stay outside the system.

Raising taxes and/or lowering prices are also steps that are probably best done through time. If the government were to quickly assume the costs of more than half the health care system, and only raise the taxes to offset this spending over a period of years, we are likely to see a serious problem of inflation, as the government will be injecting more than \$1 trillion a year of additional spending in the economy.

These and other issues will make the transition difficult. On the plus side, there are a wide range of policies that can be pursued that are both steps toward universal Medicare and offer immediate

21 Katari, Ravi and Dean Baker. 2015. "Patent Monopolies and the Costs of Mismarketing Drugs." Washington, DC: Center for Economic and Policy Research. <http://cepr.net/publications/reports/patent-monopolies-and-the-costs-of-mismarketing-drugs>.



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benefits in the short-term. For example, a wide range of policies that would lower the cost of prescription drugs would both provide immediate savings and make an eventual transition easier. In addition, if the government were to set aside funding for the development of new drugs to be sold as generics in certain areas (e.g. cancer and heart disease) it could begin to set us on a path toward publicly funded research and free market drugs and medical equipment.

We can also look to gradually add people to the Medicare program and improving it. For example, allowing people to voluntarily buy into the program would be a big step. We can also try gradually lowering the age of eligibility. If dropping it to age 55 or even 60 is too big a leap, a reduction to age 64 would be a great first step. This move would be made easier by the fact that many 64-year-olds are already on Medicare through Social Security disability, or alternatively receive Medicaid. This small step would both be appealing to people approaching Medicare age, while also calling attention to any problem incurred in adding more people to the program.

There are many ways to get from the current system to a universal Medicare system. The risk of trying to do it quickly are enormous, taking advantage of openings where they exist seems a much better route.

The CHAIRMAN. Thank you very much.

Mr. Cole.

Mr. COLE. Thank you very much, Mr. Chairman. Ms. Grace-Marie Turner is president of the Galen Institute, a public policy research organization that she founded in 1995 to promote an informed debate over free-market ideas for health reform. She has been instrumental in developing and promoting ideas for reform to transfer power over healthcare decisions to doctors and patients.

She speaks and writes extensively about incentives to promote a more competitive patient-centered marketplace in the health sector.

STATEMENT OF GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE

Ms. TURNER. Thank you, Ranking Member Cole. Thank you, Chairman McGovern, members of the committee, for the opportunity to testify today.

Let me begin by saying that I believe there are important shared goals for health reform. Everyone should be able to get health coverage to access the care they need. It should be affordable. People should be able to see the doctors they choose. We must guard the quality of care, and we must protect the most vulnerable with a strong safety net.

Millions of Americans are frustrated with the current system. Health care costs too much, and many are simply priced out of the market. Those with insurance say premiums and deductibles are so high they might as well be uninsured. Those on public programs like Medicaid struggle to find physicians, especially specialists, who can afford to take the program's low payment rates. People are hurting, and they feel powerless, like cogs in the \$3.6 trillion health sector with little power to impact choices or costs.

But it is hard to see how consumers would be more empowered when dealing with a single government payer. In a country that values diversity, will one massive program with one list of benefits and one set of rules work for everyone?

I was in the gallery the night that the House passed the Affordable Care Act in March of 2010 and heard Member after Member talk about the importance of passing the bill in order to finally achieve universal coverage and to lower cost. Nine years later, with millions still uninsured and costs doubling in the individual market, our Nation is still struggling to achieve those goals.

In calling this hearing today, you acknowledge the growing interest in this bold proposal. But when people learn that Medicare for All would mean much higher taxes and losing the coverage they have now, support plummets. What happened recently in Colorado and Vermont when they tried and failed to create their own single-payer systems I think is important to study.

I believe the growing presence of government in the health sector is a significant contributor to its dysfunction. Government officials, not consumers, increasingly determine what services can or must be covered, how much will be paid, and who is eligible to both deliver and receive these services. Third-party payment systems lead to significant disruptions, and insurers and others must respond to

government rules and regulation, shoving consumers to the bottom of the healthcare totem pole.

Rather than dramatically expand the role of government, I believe we need to look more carefully at these problems and target appropriate solutions that empower consumers and build on what works.

Medicare for all's promise of unrestricted access to benefits is virtually unprecedented, and it is difficult to anticipate the impact of this new system. Representative Jayapal's bill implies a recognition of cost by imposing global budgets to contain spending. Paying doctors and hospitals at Medicare rates would force many to close or significantly cut back on services and would worsen the existing physician shortage.

We do know from the experience of other countries that global budgets and centrally-determined benefit structures lead to rationing, waiting lines, and lower quality of care, as I describe in my testimony. Tragically, it is often the most vulnerable who are left behind when the demand for services outpaces resources.

Many Americans would see it as severely disruptive to lose their current coverage when public programs as well as job-based health insurance would be shut down under Medicare for All. 173 million Americans get health coverage through the workplace, a highly valued benefit.

My colleague Doug Badger explains that the employment-based health system is really a central pillar in our health sector. It produces a nearly 3-to-1 ratio in value-to-tax expenditures. Employer plans also pay doctors and hospitals more than Medicare and Medicaid do and provide the margins that most providers need to maintain quality and even keep their doors open.

Employers also have more flexibility to tailor insurance to the needs of their workforce, to advocate for them and to provide education and incentives about good health.

I describe in my testimony targeted solutions already underway to give individuals and workers more, not fewer, choices and to provide States with more resources and flexibility to help their health insurance markets recover. I describe work by the Health Policy Consensus Group, which I facilitate, in developing a plan to reduce the cost of health insurance while protecting the poor and sick, including those with preexisting conditions.

Finally, Americans want more, not fewer, choices in health coverage, yet Medicare for All would put them on a single government program. When government officials are making decisions about what services will be covered, as the legislation explicitly says, how much providers will be paid, how much citizens must pay in mandatory Federal taxes, then consumers will have even fewer choices than they do today. It will reduce access to new technologies, stifle innovation, and result in a near doubling of the tax burden.

I would welcome the opportunity to work with you to achieve the goals of better access to more affordable coverage and better protection for the vulnerable. Thank you for the opportunity to testify.

[The statement of Ms. Turner follows:]



A not-for-profit health and tax policy research organization

**Hearing before the
Committee on Rules
U.S. House of Representatives**

April 30, 2019

"H.R. 1384: The Medicare For All Act of 2019"

**Chairman Jim McGovern
Ranking Member Tom Cole**

**Testimony by Grace-Marie Turner
President
Galen Institute**

H.R. 1384: The Medicare for All Act of 2019

Hearing before the Committee on Rules Jim McGovern, Chairman

Testimony by Grace-Marie Turner, President, Galen Institute

April 30, 2019

Chairman McGovern, Ranking Member Cole, and members of the committee, thank you for the opportunity to testify today.

My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization focusing on patient-centered health policy. We focus on ways to ensure access to affordable health coverage and care for all Americans, especially the most vulnerable. I also have served as a member of the Advisory Board of the Agency for Healthcare Research and Quality, as an appointee to the Medicaid Commission, and as a congressional appointee to the Long Term Care Commission.

Mr. Chairman, in calling this hearing today about the Medicare for All national health insurance bill introduced by Congresswomen Pramila Jayapal and Debbie Dingell with 107 co-sponsors, you acknowledge the growing interest in a bold proposal to achieve universal coverage in the United States.

Let me begin by saying I believe there are important shared goals for health reform:

- Everyone should be able to get health coverage to access the health care they need
- Coverage and care should be affordable
- We must guard the quality of care
- People should be able to see the physicians and other providers of their choice
- We must work to protect the most vulnerable

There is no question that many millions of Americans are frustrated with our current health care system. Care costs too much, and many are simply priced out of the market for health insurance. Many who are not eligible for subsidies say the premiums are unaffordable, especially for exchange policies with such high deductibles and ultra-narrow provider networks.

Millions remain uninsured and even those with insurance can face thousands of dollars in “surprise billings.” Patients without generous cost-sharing subsidies can face out-of-pocket costs so high they say they might as well be uninsured.

Those on public programs are often frustrated as well. Many Medicaid recipients struggle to find physicians who can afford to take the program's low payment rates and can find it especially difficult to get appointments with specialists for more serious health problems.

People are hurting, and they feel powerless against this system.

Health care has become a very big and even lucrative business. Many patients feel they are simply cogs in the \$3.6 trillion health sector with little power to impact choices of care or coverage—or even find out before they get care what it is going to cost them. Independent physicians are selling their practices to hospitals, and some hospital systems have become virtual oligopolies, setting prices and giving plans and purchasers little choice but to pay.

These and other frustrations, I believe, are generating interest in a bold plan that promises universal coverage for everyone, with no premiums, copayments, or deductibles, and the ability to choose any provider or hospital participating in the new system.

But it is hard to see how consumers would be more empowered when dealing with a single government payer. In a country that values diversity, will one program with one list of benefits and set of rules work for everyone?

STRUGGLING TO ACHIEVE PROMISED GOALS

I was in the gallery the night the House passed the Affordable Care Act in March of 2010 and heard member after member talk about the importance of passing the bill in order to “finally achieve universal coverage” and guarantee that everyone will be able to access quality, affordable care. Former President Obama promised repeatedly that people would be able to keep their doctors and their plans and that the typical American family's premiums would drop by \$2,500 a year.

Many Americans are frustrated that, nine years later, our nation still is struggling to achieve these goals of access and affordability. They are understandably skeptical of new promises. When informed that Medicare for All would mean higher taxes and losing the coverage they have now, support plummets.¹

Colorado and Vermont recently failed in their attempts to implement statewide single-payer systems. Colorado voters rejected a single-payer initiative in 2016 by a four to one margin, with residents especially concerned about the high taxes that would be required to finance it and about losing the coverage they have now to the uncertainties of the new system. Vermont officials worked feverishly to design a single-payer system but found that the costs of the program would be prohibitive and that the higher taxes required would seriously damage the economy.

¹ Robert E. Moffit, “No Choice, No Exit: The Truth About ‘Medicare for all’,” February 1, 2019. *The Sacramento Bee*. <https://www.heritage.org/medicare/commentary/no-choice-no-exit-the-truth-about-medicare-all-proposals>

TOO MUCH GOVERNMENT

The high cost of health care in the United States compared to other developed countries and the number of Americans who remain uninsured are real and serious concerns that deserve attention.

The United States does not have a properly functioning market in the health sector. It does not respond to the needs of consumers and their demands for lower costs and more choices which they experience in other sectors of the economy.

But I would argue that the growing presence of government is a significant contributor to these problems. In the health sector, government officials, not consumers, increasingly determine what services can or must be covered, how much will be paid, and who is eligible to both deliver and receive these services. Third-party payment systems and the resulting lack of price and benefit transparency lead to significant disruptions in the market. Consumers are at the bottom of the health care totem pole.

Today, people in the individual and small group markets have few choices—they can either buy an expensive ACA-compliant plan or go uninsured. The Affordable Care Act rewrote the rules for health insurance policies, including mandating a rich benefits package. California spent \$100 million last fall trying to boost enrollment in its exchange, yet it saw the number of new enrollees shrink by nearly 24%.

The problem is cost. The costs of premiums and deductibles can be prohibitive, especially for those who don't get subsidies.

But rather than dramatically expanding the role of government in the health sector, I believe we need to look more carefully at these problems and target appropriate solutions that empower consumers and build on what works.

THE MEDICARE MODEL

Today's Medicare is seen as a model for reform at least partly because it allows seniors in traditional fee-for-service Medicare to get care from the doctors of their choice. The Medicare for All bill, H.R. 1384, before the committee would:

- allow patients to choose the doctors, hospitals, and other providers they wish to see.
- provide a much more comprehensive list of covered benefits than seniors have today. It would cover all primary care, hospital and outpatient services, dental, vision, audiology, women's reproductive health services, maternity and newborn care, long-term services and supports, prescription drugs, mental health and substance abuse treatment, laboratory and diagnostic services, dietary therapies, transport, and more.

- guarantee that everyone would be able to access care without facing any private insurance premiums or deductibles. Upon receiving care, patients would not be charged any co-payments or other out-of-pocket costs.
- outlaw private health insurance, including employer-sponsored health insurance and Medicare Advantage or supplements, for any of the benefits covered under Medicare for All.
- eliminate Medicare, Medicaid, TriCare, the State Children's Health Insurance Program, the Federal Employee Health Benefits Program, and ACA exchange coverage
- require the HHS secretary to determine policies and procedures to implement the new program, including determining benefit eligibility, enrollment, benefits provided, levels of funding, methods of determining payments to providers, appeal processes, planning for capital expenditures and health professional education, and set up a new system of "uniform reporting standards" to a national database.
- require the HHS secretary to "establish a national health budget, which specifies a budget for the total expenditures to be made for covered health care items and services" under the new program. Spending would be based upon "government negotiated prices."
- require providers to provide information and allow examination of records that document items and services furnished to patients.
- begin the Medicare for All program two years after enactment of the bill.

Proponents of a single-payer health care system argue that if all the money flowing through the health sector today were put into one program, the U.S. could more than afford the new program. But unrestricted access to benefits is virtually unprecedented, and it is difficult to anticipate the impact of this new system.

Rep. Jayapal's bill implies a recognition of the cost risk by imposing global budgets to cap Medicare for All spending for institutional providers. The relatively few providers who are expected to work in non-institutional settings would be paid on a national fee schedule. In addition, the bill assigns to Washington the task of determining on an annual basis adjustments to the list of covered benefits.

WHAT GLOBAL BUDGETS WOULD MEAN

As Dr. Blahous likely will explain, if current Medicare rates are applied, assigning Medicare rates to hospitals would entail payment rates that are roughly 40% lower than commercial rates, while physicians would see 30% cuts. These payment reductions would gradually grow larger over time for both. Such dramatic payment reductions would mean many physician practices

would be operating in the red, and hospitals would be forced to close or significantly cut back on services. Some anticipate the new program would look more like mandatory Medicaid as a result.

A new report from the Association of American Medical Colleges finds that, even under our current health system, the U.S. will see a shortage of up to nearly 122,000 physicians by 2032. The demand for physicians is expected to grow faster than the supply, and rural areas will be hit especially hard, according to the report.² The payment cuts envisioned in H.R. 1384 are likely to exacerbate this trend as more physicians close their practices or otherwise withdraw because of the payment reductions.

THE HIGH PRICE OF FREE CARE

We do know from the experience of other countries that global budgets, such as would be implemented under H.R. 1384, and associated centrally-determined benefit structures lead to rationing, waiting lines, and lower quality of care. These and other forms of rationing seriously compromise access to care.

While patients in countries with nationalized health systems say they value their access to free care, many pay a very high price in other ways. Tragically, it is often the most vulnerable who are left behind when demand for services outpaces resources.

The Fraser Institute in Canada devotes considerable time and resources to tracking waiting lists for Canadians seeking care.³ In “Waiting Your Turn: Wait Times for Health Care in Canada, 2018,” it finds that the median wait time for medically necessary treatment in Canada was 19.8 weeks.

We regularly see articles in UK papers about patients stuck in ambulances for hours in London waiting for an opening to a hospital emergency room.⁴ And once patients are admitted, they can be warehoused in hallways for days, with some dying before a hospital bed becomes available.⁵

² Association of American Medical Colleges, “The Complexities of Physician Supply and Demand: Projections from 2017-2032,” April 2019. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf

³ <https://www.fraserinstitute.org/categories/health-care-wait-times>

⁴ *The Guardian*, “16,900 people in a week kept in NHS ambulances waiting for hospital care,” January 4, 2018. <https://www.theguardian.com/society/2018/jan/04/16900-people-in-a-week-kept-in-nhs-ambulances-waiting-for-hospital-care>

⁵ BBC, “Patients ‘dying in hospital corridors,’” January 11, 2018. <https://www.bbc.com/news/health-42572116>

Sally Pipes of the Pacific Research Institute, who was born and raised in Canada, writes that Britain's version of Medicare For All is struggling with long waits for care.⁶ "The [National Health Service] routinely denies patients access to treatment. More than half of NHS Clinical Commissioning Groups, which plan and commission health services within their local regions, are rationing cataract surgery. They call it a procedure of 'limited clinical value.' It's hard to see how a surgery that can prevent blindness is of limited clinical value," she writes.

Nearly a quarter of a million British patients have been waiting more than six months to receive planned medical treatment from the National Health Service, according to a recent report from the Royal College of Surgeons. More than 36,000 have been in treatment queues for nine months or more.

Access to new medicines and other medical technologies also is limited in these countries. In just one example, my colleague Doug Badger recently surveyed access to new drugs in a number of countries with government-dominated health systems.⁷ He found the French have access to only 48% of new drugs introduced between 2011 and 2018. Americans, by contrast, have access to 89% of those innovative medications. Nor is France an exception. The Swiss have access to only 48% of newly-developed drugs, the Belgians 43%, and the Dutch 56%.

Prescription drug prices are a key focus of members of Congress on both sides of the aisle and both sides of the Capitol. Doug Badger's analysis suggests that many of the distortions in drug pricing come from our own government programs: "The federal government requires manufacturers to pay rebates, grant discounts, and comply with various price-distorting directives across a range of programs. The Department of Veterans Affairs uses multiple contracting systems and a single national formulary that restricts access to pharmaceuticals to hold down prices. Medicare requires manufacturers to provide a 70 percent discount on drugs in the Part D 'coverage gap.' Medicaid requires them to pay the federal government a rebate of 23.1 percent, and nearly every state exacts additional rebates from manufacturers. The government also mandates that drugmakers provide similar rebates to qualifying clinics and hospitals under its 340B program."⁸ All put upward pressure on the prices consumers face.

Some pharmaceutical companies have voluntarily announced rollbacks of price increases, cuts in prices, price freezes, or other ways to improve affordability for patients. As one example,

⁶ Sally Pipes, "Britain's Version Of 'Medicare For All' Is Struggling With Long Waits For Care," *Forbes*, April 1, 2019. <https://www.forbes.com/sites/sallypipes/2019/04/01/britains-version-of-medicare-for-all-is-collapsing/#2c4418a536b8>

⁷ Doug Badger, "Examination of International Drug Pricing Policies in Selected Countries Shows Prevalent Government Control over Pricing and Restrictions on Access," Galen Institute, March 5, 2019. <https://galen.org/2019/examination-of-international-drug-pricing-policies-in-selected-countries-shows-prevalent-government-control-over-pricing-and-restrictions-on-access/>

⁸ Doug Badger, "Trump Blames the Wrong Government for High Drug Prices," *RealClearHealth*, March 22, 2019. https://www.realclearhealth.com/articles/2019/03/22/trump_blames_the_wrong_government_for_high_drug_prices_110887.html

Amgen, a leading biologics company, announced it was breaking through the complex and opaque drug pricing maze with a simpler pricing model that reduced the list price of its innovative biologic, Repatha, by 60%.⁹ This is a healthy response to market competition and political pressure.

Administrative costs: While H.R. 1384 does not specify funding mechanisms, Medicare for All advocates say the administrative savings would help fill the funding gap. But the new single-payer system still would require many of the same administrative functions as any insurance system. Physicians, hospitals, labs and other service providers would have to be approved and payment rates set. The government would need verification that approved services were actually provided, and there would need to be even greater need for safeguards against fraud and abuse.

Merrill Matthews, now with the Institute for Policy Innovation, analyzed Medicare administrative costs vs those of private insurers.¹⁰ He found that an apples to apples comparison showed little administrative savings between Medicare and private payers when, for example, services such as the costs that other agencies of government perform in collecting premium revenue are considered.

Value of innovation: The United States is a recognized leader in medical innovation. Over the past half century, the United States has been the birthplace of the majority of the world's biomedical innovations.¹¹ Our hospitals and physicians offer top quality care where Americans have access to the latest medical diagnostics. Generations of people in the UK have grown up knowing no system other than the National Health Service, but Americans are used to better quality and access and are unlikely to be satisfied with restrictions and rationing.

Losing current plans: I began my testimony talking about the very real problems and frustrations with health care in American, but any policy solution must also take into account what people value about the system and to assess the risks of such sweeping changes.

In addition to inevitable restrictions on access to medical technologies and newest treatments, seniors value their current Medicare coverage, and many believe their access would be undermined if 265 million more Americans were competing with them for services to the same underpaid providers.

Medicare and Medicaid recipients, federal employees, kids on the Children's Health Insurance Program, workers and retirees getting insurance through the workplace, and those receiving coverage through ACA exchanges all would all be moved into the new program within the short span of two years. Many would see this as severely disruptive.

⁹ <https://www.amgen.com/media/news-releases/2018/10/amgen-makes-repatha-evolocumab-available-in-the-us-at-a-60-percent-reduced-list-price/>

¹⁰ Merrill Matthews, "Medicare's Hidden Administrative Costs," Council for Affordable Health Insurance, January 10, 2006. http://mforall.net/files/CAHI_Medicare_Admin_Final_Publication.pdf

¹¹ <https://www.americanactionforum.org/weekly-checkup/new-drug-patents-country/>

Today, 60 million people, including 51 million older adults and 9 million younger adults with disabilities, rely on Medicare for their health insurance coverage. In 2018, two-thirds of Medicare beneficiaries were in traditional Medicare, and one-third had chosen to enroll in private Medicare Advantage plans.¹² Medicare For All would take away the private coverage that 22 million seniors have voluntarily chosen under the existing Medicare Advantage program.

The Medicare Trustees' Report issued April 22 presents warning signs about the sustainability of the Medicare program we have today.

Medicare is on track to bankruptcy in 2026. According to the report, Medicare had a cash shortfall in 2018 of \$363 billion. The program paid \$740 billion for medical goods and services for today's seniors but collected only \$377 billion in payroll taxes and seniors' monthly premiums.¹³ Medicare has accumulated a \$5.1 trillion cash shortfall since the program started in 1965, and covering this shortfall is responsible for one third of U.S. federal debt.

Just balancing the books for the program for today's seniors would mean increasing payroll taxes for working Americans by 15% and increasing Medicare premiums for seniors by 261%.

Instead of expanding Medicare, Congress could consider instead ways of securing Medicare's promise for future generations. The part of Medicare that is working best is Medicare Advantage, which deploys private insurers to provide better access and better-coordinated care to seniors. MA plans have lower premiums, broader benefits, and better health outcomes. The best way to reform Medicare is to enact reforms that will further improve the quality and affordability of Medicare Advantage plans, and to build on this model to improve coverage for working-age Americans.¹⁴

EMPLOYER-SPONSORED HEALTH INSURANCE: A CENTRAL PILLAR IN OUR HEALTH SECTOR

In our multi-payer health sector, employer-sponsored health insurance (ESI) is the single-largest conveyer of health coverage in America. As such, it is worth taking a deeper dive into this program and its central role in our health sector—including supporting the current Medicare program.

¹² <https://www.kff.org/medicare/issue-brief/sources-of-supplemental-coverage-among-medicare-beneficiaries-in-2016/>

¹³ Tara O'Neill Hayes and Gordon Gray, "The Future of America's Entitlements: What you need to know about the Medicare and Social Security Trustees Reports," American Action Forum, April 22, 2019. <https://www.americanactionforum.org/research/the-future-of-americas-entitlements-what-you-need-to-know-about-the-medicare-and-social-security-trustees-reports-2/>

¹⁴ Avik Roy, "Medicare Advantage: A Platform for Affordable Health Reform," FREEOP, April 18, 2019. <https://freopp.org/medicare-advantage-a-platform-for-affordable-health-reform-fbe31bf444f3>

In 2016, an estimated 173 million Americans received health coverage through the workplace, either as an employee, retiree, or dependent. The great majority highly value their coverage that would be eliminated under Medicare for All.

A survey by Luntz Global Partners shows the critical importance of employer-sponsored health coverage to American workers.¹⁵ It found 71% of Americans are satisfied with their current employer health coverage. Further, 56% indicated coverage remains a key factor in their decision to stay at their current job. In tight labor markets where companies are competing for workers, employers work hard to meet their employees' demands for quality coverage. Employers negotiate fiercely to keep costs as low as possible and continually adjust their plans to meet the needs of their workers for the benefits they value. Many employees say ESI is a prime reason for picking the employer they do.

Employers know that high quality health coverage leads to better health outcomes and a healthier workforce. Long before the ACA, they offered preventive and wellness services because they know that addressing health issues before they become a crisis can minimize costs and lead to better outcomes.

Employers and employees both have a vested interest in getting the best value for their health care dollars to obtain the highest quality care and coverage at the lowest cost.

My colleague Doug Badger provides a detailed history of how the employer-based health insurance system evolved in the United States and how central it is to the network of programs in our health sector today.¹⁶ He explains that "The vast majority of workers—89 percent according to the Kaiser survey¹⁷—worked for companies that sponsored health insurance coverage in 2016, and an estimated 79 percent of those employees were eligible to enroll in their firm's plan. In all, 62 percent of those working for employers that sponsor coverage enrolled in that coverage in 2016."¹⁸

Badger describes the cost in terms of tax preference for employer-sponsored health insurance (ESI) and how that is leveraged to produce a nearly 3-1 ratio in value to tax expenditures:

¹⁵ <https://www.ahip.org/majority-of-americans-satisfied-with-their-employers-health-plan-new-survey-shows/>

¹⁶ Doug Badger, "Replacing Employer-Sponsored Health Insurance with Government-Financed Coverage: Considerations for Policymakers," Galen Institute, December 2018. <https://galen.org/assets/Replacing-Employer-Sponsored-Health-Insurance-112618.pdf>

¹⁷ Kaiser Family Foundation/Health Research & Education Trust 2016 Employer Health Benefits Survey. Sep 14, 2016. <https://www.kff.org/report-section/ehbs-2016-summary-of-findings/>

¹⁸ Badger explains that some may have chosen to remain uninsured despite exposure to tax penalties on the uninsured. Others may have had other sources of coverage—through a working spouse, for example, a parent (in the case of those under 26), or through another public program such as Medicaid or Medicare.

ESI offers considerable benefits to the government. Premiums for those with ESI totaled nearly \$991.3 billion in 2016.¹⁹ Of that amount, 73 percent was contributed by employers and 27 percent by workers.²⁰ Government does not tax health benefits. If it treated ESI the same as it does wages, federal income and payroll tax revenues would increase.²¹ The Treasury Department estimates that, absent the tax exclusion, federal revenues would have been \$348 billion higher in fiscal year 2016.²²

By not taxing ESI, the government leveraged nearly \$1 trillion in private health insurance spending at a net cost to the federal budget of less than \$350 billion.²³ To finance that sum through payroll taxes in 2016 would have required raising the OASDI [Old-Age, Survivors, and Disability Insurance] tax by 9.6 percentage points, from 12.4 percent to 22.0 percent of taxable payroll.²⁴

... Instead of taxing workers and corporations and directly financing their medical care, the U.S. government exempts ESI from taxation, leveraging \$2.85 in health insurance spending for every \$1 in federal revenue losses.²⁵

¹⁹ CMS, National Health Expenditures, Table 24.

²⁰ CMS, National Health Expenditures, Table 24. It is generally accepted that the employer contribution is, in fact, a form of compensation or, to put it somewhat differently, a labor cost.

²¹ Firms do, of course, deduct their contribution to ESI from their corporate taxes but they also deduct the wages they pay. The difference between wage and non-wage compensation is the latter's exclusion from federal income and payroll taxes.

²² Department of Treasury, "Tax Expenditures," Table 1, line 128 and footnote 12. Line 128 estimates the FY 2016 federal income tax loss at \$216.1 billion. Footnote 12 estimates lost payroll tax revenue of \$131.6 billion.

²³ Badger's paper is concerned largely with federal expenditures and consequently makes no effort to estimate the effects of the exclusion on state tax revenues. A very rough estimate of the benefit to the government in 2016 can be derived by subtracting the amount of federal revenue lost to the exclusion (\$348 billion) from the total amount of ESI premiums (\$991.3 billion), yielding \$643.3 billion. That is a rough estimate of the net cost of supplanting ESI with direct government financing in 2016.

²⁴ Wages subject to OASDI taxes totaled \$6.7 trillion in 2016. 2017 SSA Trustees Report, Table VI.G6, p. 216. This is not to suggest that the government would finance health care through an increase in the OASDI payroll tax, but merely to provide perspective on the amount of private health spending government leverages through the exclusion.

²⁵ Others have arrived at a higher ratio. The American Benefits Institute has estimated that employers paid \$4.45 to finance health benefits for every \$1.00 in foregone federal revenue. (See *American Benefits Legacy: The Unique Value of Employer Sponsorship*, American Benefits Institute, October 2018, p. 31. <https://www.americanbenefitscouncil.org/pub/?id=b949f447-fl-ca-4dd0-817a-a7e96d8e3bfc>.) There are several reasons for the difference between this ratio and the one used in this paper. First, the American Benefits Institute (ABI) paper derives its employer payments for group health insurance from the Commerce Department's National Income and Products Accounts. This paper uses National Health Expenditures data compiled by the CMS Actuary. Second, ABI uses tax expenditure data compiled by the Joint Committee on Taxation. Badger's paper uses Treasury Department data. Most importantly, this paper takes into account both foregone income and payroll taxes that result from the tax treatment of ESI. That yields a denominator of \$348 billion in this paper, compared with \$155.3 billion in the ABI report.

ESI Supports Public Programs: Few recognize the significant cross-subsidization of today's Medicare that sustain access to care. Badger points out the important role that employer-sponsored health insurance plays by paying doctors and hospitals more than Medicare and Medicaid do, providing the margins many providers need to maintain quality and even keep their doors open.

It can be argued that the employer-sponsored health insurance system is a vital part of the reimbursement matrix supporting the U.S. health sector.²⁶

Reimbursement rates to physicians and hospitals are generally substantially less under Medicare and Medicaid than under private employer plans. Proposals to extend Medicare coverage to all Americans would extend these public reimbursement rates universally, with a detrimental effect on quality and access to medical care.

BETTER OPTIONS

Instead of supplanting ESI with a government-run system, Congress should build on ESI. The Trump administration is offering several options through its regulatory authority to help employers and employees get and keep more affordable coverage.

Association Health Plans: First, the administration has created new options for smaller and medium-sized firms through its new Association Health Plans rule.

The Washington Post reported that: "Chambers of commerce and trade associations have launched more than two dozen of these 'association health plans' in 13 states in the seven months since the Labor Department finalized new rules making it easier for small businesses to band together to buy health coverage in the same way large employers do. And there are initial signs the plans are offering generous benefits and premiums lower than can be found in the Obamacare marketplaces."²⁷

²⁶ The number of employers offering health coverage has remained steady over the last five years at 55%, even as firms are struggling to provide this valued benefit despite steadily rising health costs. But that number still is down from the 65% of firms that offered coverage in 2001. Badger argues that the employer mandate instituted by the ACA appears to have had very little effect on the percentage of workers enrolled in ESI. In general, it appears that larger firms, which are subject to the mandate, sponsored health insurance before the government required them to do so, while a fairly substantial percentage of smaller firms, which are generally exempt from the mandate, did not offer coverage to their employees.

²⁷ Paige Winfield Cunningham, "The Health 202: Association health plans expanded under Trump look promising so far," January 30, 2019, *The Washington Post*. https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/01/30/the-health-202-association-health-plans-expanded-under-trump-look-promising-so-far/5c50ba751b326b29c3778d05/?noredirect=on&utm_term=.6435676a70d4

There have been some criticisms that these plans might not be offering the same protections as ACA-compliant plans. But a new study shows that they are offering benefits comparable to most workplace plans, and they haven't tried to discriminate against patients with preexisting conditions, according to an analysis by Kev Coleman, a former analyst at the insurance information website HealthPocket.²⁸ "We're not seeing skinny plans," he said.

Health Reimbursement Arrangements: The administration also is finalizing a rule to enhance employer and employee options through Health Reimbursement Arrangements (HRAs), originally created by the Bush administration to give employers more options in their benefit offerings. Under those rules, HRAs, which are tax-preferred, notional accounts, can be integrated with group health coverage sponsored by the employer. They cannot be integrated with individual health insurance coverage. Many workers who are offered health coverage at work do not participate in their employer plans, often because of costs, and therefore are more likely to be uninsured.

In a 2017 executive order, President Trump directed administration officials to "increase the usability of HRAs, to expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage."²⁹

The proposed rule would allow HRAs to be integrated with individual health coverage. This would allow workers to use their accounts to fund both premiums and out-of-pocket costs associated with individual health insurance coverage.³⁰

The Galen Institute submitted public comments encouraging the administration to take the rule one step further by allowing spouses to integrate HRA funds to obtain a family plan.³¹ We argue that current law would allow the integration of HRAs with group health plans sponsored by the employer of a spouse.³²

As an example, consider that one spouse is offered health insurance at work. The employer may allow the plan to be extended to cover the family but only if the employee pays the full extra costs, which may be prohibitive for this lower-income worker.

²⁸ Kev Coleman, "First Phase of New Association Health Plans Reveal Promising Trends," Association Health Plan News, January 2019. <https://www.associationhealthplans.com/reports/new-ahp-study/>

²⁹ Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States, The White House, October 12, 2017. <https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/>

³⁰ <https://www.federalregister.gov/documents/2018/10/29/2018-23183/health-reimbursement-arrangements-and-other-account-based-group-health-plans>

³¹ <https://galen.org/2019/increasing-access-to-health-insurance-for-working-families/>

³² Doug Badger and Grace-Marie Turner, "Give Working Families A Break," *RealClearHealth*, January 7, 2019. https://www.realclearhealth.com/articles/2019/01/07/give_working_families_a_break_110856.html

If the other spouse's employer offers an HRA contribution, that employee could use the funds to buy into the first spouse's plan. This working couple could benefit from the ability to combine the HRA funds and obtain a family health insurance plan.

We believe the administration has the authority to include this change when it publishes the final rule. This would provide a new funding option and could expand insurance coverage, especially for those currently shut out of the market.

State Innovations: The solution is more, not fewer, choices. States have much more experience than the federal government in overseeing health insurance markets and greater flexibility to meet the needs of their residents.

One part of the ACA provides an option for State Innovation Waivers to allow states to reallocate existing resources to take better care of those with pre-existing conditions, for example.

States that have used early waiver authority to create risk-mitigation programs have seen in many cases dramatic results with no new federal spending.

Doug Badger and Heritage scholar Ed Haislmaier explain how early targeted waivers granted to states are helping them to better manage patients with chronic and pre-existing conditions.³³ "Several states have successfully used a waiver to change market conditions sufficiently that premiums fell for individual health insurance while still protecting the ability of people with high health care costs to access care," they write.

After the waiver reform in Alaska, premiums for the lowest-cost Bronze plans fell by 39 percent in 2018, they report. Oregon showed similar results in 2018, with premiums for the lowest-cost Bronze plans falling by 5 percent. Premiums for the highest-cost Bronze plans plunged by 20 percent. In Minnesota, the third state with an approved waiver, premiums dropped in both 2018 and 2019. Average premium for ACA coverage in 2019 will be lower for every Minnesota insurer than they were in 2017. Four other states have had waivers approved for 2019: Maryland, Maine, New Jersey, and Wisconsin.³⁴

According to the paper, "States repurpose a portion of federal money that would otherwise have been paid to insurers as premium subsidies, supplement this federal money with non-federal

³³ Doug Badger, Ed Haislmaier, "State Innovation: The Key to Affordable Health Care Choices," The Heritage Foundation, September 27, 2018. <https://www.heritage.org/health-care-reform/report/state-innovation-the-key-affordable-health-care-coverage-choices>

³⁴ Grace-Marie Turner, Doug Badger, "Several States Have Found Ways To Mitigate Obamacare's Damage To Their Health Insurance Markets," *Forbes*, October 3, 2018. <https://www.forbes.com/sites/gracemarieturner/2018/10/03/several-states-have-found-ways-to-mitigate-obamacares-damage-to-their-health-insurance-markets/#56d1b71730da>

sources, and then use the resulting pool of money to pay medical claims for policyholders who incur high medical bills. Since this process would reduce premiums, it also would reduce federal premium subsidies, making it budget neutral to the federal government.”

States are employing various risk mitigation strategies to finance coverage for those with high health costs, repurposing federal money to pay medical bills for residents in poor health. By separately subsidizing those with the highest health costs, they can lower premiums for individual health insurance, and the lower premiums also mean increased enrollment.

The administration is offering states additional flexibility through new Section 1332 guidance to tailor solutions to the needs of their residents.

OTHER OPTIONS TO SOLVE THE PROBLEMS IN OUR HEALTH SECTOR

A group of policy experts—the Health Policy Consensus Group³⁵—has developed a plan³⁶ to help the millions of people who are struggling to afford health insurance, particularly in the small group and individual markets, to have access to more choices of more affordable insurance while protecting the poor and the sick, including those with pre-existing conditions.

It is based upon formula grants to the states, using existing Obamacare resources, but with guidelines that incentivize states to provide people with more choices of more affordable coverage (and even provide an option for some people on Medicaid and CHIP to obtain private coverage, if that is their choice). It provides generous resources for those needing help in purchasing coverage and important protections for those with expensive and chronic illnesses. It is based upon a plan that came closer than is commonly believed to passage in the Senate in the fall of 2017.

Unlike the ACA, the Health Care Choices plan has money dedicated to creating guaranteed protection programs. Rather than forcing those participating in the ACA insurance pools to pay extra to support people with high medical expenses, we would stipulate that dedicated resources be devoted to providing extra financial support for their care.

By putting the sickest people in the same pool with others, premiums are higher, often much higher, for those not eligible for subsidized exchange coverage. Virginia State Sen. Bryce Reeves read in a recent speech³⁷ an email he received from one of his constituents in

³⁵ The Health Policy Consensus Group is comprised of state health policy experts, national think tank leaders, and members and leaders of grassroots organizations across the country. Participants are committed to market-based policy recommendations that give people access to the health plans and doctors they choose at a price they can afford so that they can get the care they need, with strong protections for the most vulnerable.

³⁶ www.healthcarechoices2020.org

³⁷ Grace-Marie Turner, “Health Care Choices Proposal: A New Generation of Health Reform,” *Forbes*, June 22, 2018. <https://www.forbes.com/sites/gracemarieturner/2018/06/22/health-care-choices-proposal-a-new-generation->

Fredericksburg. The constituent wrote he made a good living and tried to provide for his family. But his insurance premiums cost \$4,000 a month! "That's more than my mortgage," he told Sen. Reeves. There is only one carrier offering coverage in his area. "What am I supposed to do?"

An analysis by the Center for Health and Economy has shown the Health Care Choices Plan would reduce premiums by one third while keeping coverage numbers level.³⁸ By encouraging healthy people to remain covered, insurance pools are healthier, and resources can be directed to help those with greater health needs.

Americans want more, not fewer choices in health coverage, and Medicare for All would put them all on a single government program. When government officials are making decisions about what services will be covered, how much providers will be paid, and how much citizens must pay in mandatory federal taxes, consumers will have even fewer choices and less control than they do today. Medicare for All takes away coverage options, will pay providers less, reduce access to new technologies, stifle innovation, and result in a near-doubling of the tax burden.

Thank you for inviting me to offer this perspective. I look forward to your questions and would welcome the opportunity to work with you to achieve the goals of better access to more affordable coverage and better protection for the vulnerable.

[of:health-reform/#1106ce6664f1](#)

³⁸ <http://healthandeconomy.org/the-health-care-choices-proposal/>

The CHAIRMAN. Thank you very much.

Dr. Sarah Collins is vice president for healthcare coverage and access of the Commonwealth Fund. As an economist, she directs the fund's program on insurance coverage and access. Dr. Collins has led several multiyear national surveys on health insurance and authored numerous reports, issue briefs, and journal articles on health insurance coverage, health reform, and the Affordable Care Act. Early in her career, she was an associate editor at U.S. News and World Report, a senior economist at Health Economics Research and a senior health policy analyst in the New York City Office of the Public Advocate.

Dr. Collins holds an A.B. in economics from Washington University and a Ph.D. in economics from George Washington University. Thank you for being here.

STATEMENT OF SARA COLLINS, VICE PRESIDENT FOR HEALTHCARE COVERAGE AND ACCESS, COMMONWEALTH FUND

Ms. COLLINS. Thank you, Mr. Chairman and members of the committee, for this invitation to testify on proposals to reform the U.S. health system. My comments are going to focus on gains in health insurance since the passage of the Affordable Care Act, the problems people continue to report affording insurance and healthcare, and the potential of recent congressional bills to address these problems.

The ACA brought sweeping change to the health system in expanding comprehensive health insurance to millions of Americans and making it possible for anyone with health problems to get coverage by banning insurers from denying coverage or charging more because of preexisting conditions.

The number of uninsured people has fallen by nearly half since the ACA became law. There has also been a decline in the share of people reporting problems paying medical bills or not getting needed care because of cost. The large body of research on the ACA shows that the law's overall impact on people's ability to afford insurance and get healthcare has been positive.

However, three distinct yet interrelated problems remain: 29.7 million people remain uninsured; 44 million people with insurance have plans that are leaving them underinsured; and healthcare costs are growing faster than median income in most States. The stalled gains in coverage stem from five primary factors: 17 States have not yet expanded Medicaid; people with incomes just over the eligibility threshold for marketplace subsidies and many in employer plans have high premium costs; congressional and executive actions on the individual market and Medicaid have reduced potential enrollment in both; undocumented immigrants are ineligible for subsidized coverage; and cost-sharing is climbing in individual market and employer plans.

A major factor underlying trends in both uninsured and underinsured rates is growth in healthcare costs. Healthcare costs are the primary driver of premium and deductible growth in private insurance. There is growing evidence that a major cause of healthcare cost growth are prices paid to providers, especially hospitals. There is also evidence that these prices explain the wide

healthcare spending gap between the U.S. and other wealthy countries. And there is also evidence that the greatest provider price growth is occurring in private insurance.

Congressional Democrats have introduced several bills to address these problems. The bills all propose to expand the public dimensions of our private and public health system and may be grouped into three categories: bills that add more public plan features to private insurance, such as enhancing marketplace subsidies and reinsurance; bills that give people a choice of public plans alongside private plans, such as plans based on Medicare or Medicaid offered through the marketplaces; bills that make public plans the primary source of coverage, such as Medicare for All bills.

These bills are an amalgam of provisions that individually or collectively have the potential to make the following changes in the health system: improve the affordability, benefits, and cost protection of insurance; slow cost growth in hospital and physician services, prescription drugs, and administration; reduce the number of uninsured and underinsured people.

Some notable estimates of the effects of these bills' provisions include lifting the top income eligibility threshold for marketplace tax credits could insure nearly 2 million more people and lower silver plan premiums by nearly 3 percent at a net Federal cost of \$10 billion. Allowing HHS to negotiate prescription drug prices under a Medicare for All approach could lower drug prices by 4 percent to 40 percent. A Medicare for All approach could lower administrative costs from a current 14 percent of spending in commercial plans to anywhere from 6 percent to 3.5 percent of all spending. The estimated effects of a Medicare for All approach on U.S. health expenditures range from a decline of 10 percent to an increase of 17 percent.

What has captured the most attention in the debate about Medicare for All is the significant shift in how healthcare would be paid for. Most Medicare for All bills shift most financial responsibility to the Federal budget. This shift raises important questions about financing sources, in particular the incidence of taxation.

But what is notable about the range of national health expenditure estimates under a Medicare for All approach is that the increase in expenditures is often less than the increase in demand for health care induced by providing comprehensive coverage to everyone. These spending estimates vary widely because of assumptions about the degree of change in provider prices, prescription drug costs, and administrative costs. But the mechanisms for slowing cost growth in these proposals could be considered, refined, and applied not only in single-payer approaches but in other health reform approaches as well.

In the absence of congressional action on improving coverage, many States have stepped up and implemented policies such as reinsurance programs. But improving coverage for everyone will ultimately require Federal legislation. Expanding coverage, limiting families' costs, and slowing cost growth are achievable goals, and these bills provide mechanisms to move forward on each.

I look forward to your questions. Thank you.

[The statement of Ms. Collins follows:]



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**Status of U.S. Health Insurance Coverage and the Potential of Recent Congressional
Health Reform Bills to Expand Coverage and Lower Consumer Costs**

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Invited Testimony

U.S. House of Representatives Committee on Rules
Hearing on “Medicare for All Act of 2019”

April 30, 2019

The author thanks Herman Bhupal, David Radley, Munira Gunja, and Susan Hayes for data analysis and research support; Barry Scholl, Bethanne Fox, Don Moulds, Rachel Nuzum, and Kathy Regan for helpful comments; and Deborah Lorber for editorial support, all of the Commonwealth Fund.

The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund’s website and [register to receive email alerts](#).

Status of U.S. Health Insurance Coverage and the Potential of Recent Congressional Health Reform Bills to Expand Coverage and Lower Consumer Costs

Sara R. Collins, Ph.D.
The Commonwealth Fund

EXECUTIVE SUMMARY

Thank you, Mr. Chairman, members of the Committee, for this invitation to testify today on current proposals to reform the U.S. health care system. My comments will focus on the national gains in health insurance coverage since the passage of the Affordable Care Act (ACA), the problems people continue to report affording health insurance and health care, and the potential of recent Congressional health reform bills to address these problems.

The ACA brought sweeping change to the U.S. health system, expanding comprehensive and affordable health insurance to millions of lower-and middle- income Americans and making it possible for anyone with health problems to buy health insurance by banning insurers from denying people coverage or charging them more because of pre-existing conditions.

The number of uninsured people in the United States has fallen by nearly half since the ACA was signed into law, dropping from a historical peak of 48.6 million people in 2010 to 29.7 million in 2018. There was also a decline in the share of people who reported financial problems associated with medical bills or who had problems getting health care because of cost. A large body of research on the effects of the ACA shows conclusively that the overall impact of the legislation on people's ability to afford health insurance and get needed health care has been positive.

However, three distinct, yet interrelated, problems remain: millions of people remain uninsured, millions of people with insurance have plans that are leaving them underinsured, and health care costs are growing faster than median income in most states.

After dropping significantly through 2015, the national uninsured rate has held steady around 9 percent, with some ominous upticks in fourteen states in 2017. These stalled gains stem from four primary factors:

- Seventeen states have not yet expanded Medicaid, including the heavily populated states of Florida and Texas;
- People with incomes just over the marketplace subsidy threshold (about \$48,560 for an individual and \$100,000 for a family of four) and many in employer plans have high premium contributions relative to income;
- Congressional and executive actions regarding the individual market and Medicaid that have reduced potential enrollment in both;
- The ACA's exclusion of undocumented immigrants from eligibility for subsidies and Medicaid.

In addition to the 29.7 million people who lack insurance, an estimated 44 million working age adults with insurance are underinsured because they have high out-of-pocket costs and deductibles relative to their income. This is up from 29 million in 2010, according to Commonwealth Fund survey data. The greatest growth in the share of underinsured adults is occurring among those in employer health plans. However, people who buy plans on their own through the individual market—including the ACA marketplaces—are underinsured at the highest rates.

The growth in underinsurance is attributable to two primary factors:

- Growth in cost-sharing, particularly deductibles, in the individual market and employer plans;
- Sluggish growth in U.S. median income such that out-of-pocket health care costs and deductibles are comprising a growing share of income among low- and moderate-income families.

Leaving millions of people uninsured or underinsured has implications for families and the nation's general prosperity. Commonwealth Fund surveys have consistently found that

people who lack health insurance, even for short periods of time, or who are underinsured, avoid or delay needed health care and are at risk of accumulating medical debt. Many adults with medical bill or debt problems report serious financial problems including using up all their savings to pay their bills or receiving a lower credit rating as a result of their debt. Other research has demonstrated that people who don't have adequate health insurance all their lives have fundamentally different life experiences and less economic opportunity than those who are adequately insured. This includes lower educational attainment, lifetime earnings, and life expectancy.

A major factor underlying trends in both uninsured and underinsured rates, is the overall rate of growth in U.S. health care costs. Health care costs are the primary driver of premium growth in private insurance. To temper premium growth, insurers and employers have increased deductibles, exposing enrollees to growing out-of-pocket risk. This means that health care costs ultimately drive both consumer decisions to buy insurance (via premiums) and whether to get health care (via cost-sharing). Income-based subsidies and risk reduction strategies like reinsurance can lower premiums and consumer out-of-pocket costs, but they will not address the underlying driver. Moreover, the federal and state costs of those policies will also be affected by overall cost growth. It is therefore critical that such policies be paired with strategies to lower U.S. health care costs.

There is growing evidence that prices paid to providers, especially hospitals, rather than people's use of health care services, are the primary driver of health care cost growth. There is also considerable evidence that prices explain the wide health care spending gap between the United States and other wealthy countries.

Recent research also indicates that per capita costs in U.S. private insurance are rising faster than those in public insurance programs. Since Medicare sets prices for providers while prices in commercial plans are usually the result of negotiation between providers and insurers, or employers, much of this spending differential likely stems from price differences. Gerard Anderson and colleagues note that the difference between prices paid by public and private insurers ballooned from 10 percent in 2000 to 50 percent in 2017. The authors argue that in

order to lower the rate of growth in U.S. health care costs, there needs to be increased scrutiny of private insurer payments to providers.

Congressional Democrats have introduced several bills aimed at addressing these interrelated problems of uninsurance, underinsurance, and rising health care costs. These bills are similar in that they expand the public dimensions of our mixed private and public health care system. They can be characterized as falling along a continuum with single-payer or Medicare for all proposals at one end. The bills range from adding more public sector involvement into the system, to adding substantially more public sector involvement, and may be broadly grouped into three categories:

- **Adding public plan features to private insurance.** These bills include provisions to enhance the premium and cost-sharing subsidies for marketplace plans, fixing the so-called “family coverage glitch” in employer plans, adding reinsurance, and addressing the Medicaid coverage gap for low income people in non-expansion states.
- **Giving people a choice of public plans alongside private plans.** In addition to enhancing ACA subsidies and providing reinsurance, the bills in this category also give consumers a choice of a public plan, based on either Medicare or Medicaid, for people in the ACA marketplaces and employers. The bills also use the leverage of the federal government’s buying power in setting premiums for the public plan, establishing provider payment rates, and negotiating prescription drug prices. Some bills also improve benefits for people currently enrolled in Medicare.
- **Making public plans the primary source of coverage in the U.S.** Bills in this category are single-payer or Medicare-for-all bills in which all residents are eligible for a public plan that resembles the current Medicare program, but is not the same program we have today. The bills limit or end premiums and cost-sharing and end most current forms of insurance coverage including most private coverage, with the exception of HR 7337 which retains employer coverage as an option. Benefits are comprehensive and include services not currently covered by Medicare such as dental and vision and long-term care. The approach brings substantial federal leverage to bear in setting premiums, and lowering provider and prescription drug prices.

While details will matter in terms of the degree of change, the multitude of individual provisions proposed in these bills have the potential to make the following general directional changes in the U.S health care system:

- Improve the affordability, benefit coverage, and cost protection of insurance for many to all U.S. residents;
- Lower the rate of cost growth in hospital and physician services, prescription drugs, and health plan and provider administration;
- Reduce the number of uninsured people, in some bills to near zero;
- Reduce the number of underinsured people, in some bills to near zero.

Some notable empirical estimates of the potential effects of provisions include:

- Lifting the top income eligibility threshold for marketplace premium tax credits could insure 1.7 million more people and lower silver plan premiums by 2.7 percent, at a net federal cost of \$10 billion in 2020.¹
- Reinstating the ACA's reinsurance program could increase insurance coverage by up to 2 million people, lower silver plan marketplace premiums by as much as 10.7 percent and result in net deficit savings of as much \$8.8 billion in 2020.²
- Enhancing premium tax credits and lifting the income eligibility threshold could reduce annual marketplace premium contributions by enrollees from \$356 to as much as \$9,434.³
- Funding and extending the cost-sharing reduction payments and pegging premium tax credits to the gold plan could decrease marketplace deductibles by \$1,650 for people with incomes at 250 percent of poverty (\$30, 350 for an individual) and above.⁴

¹ Jodi Liu and Christine Eibner, *Expanding Enrollment Without the Individual Mandate: Options to Bring More People into the Individual Market* (Commonwealth Fund, Aug. 2018.)

² Jodi Liu and Christine Eibner, *Expanding Enrollment Without the Individual Mandate: Options to Bring More People into the Individual Market*.

³ Assumes individual mandate and funding for cost-sharing reductions are reinstated. Linda J. Blumberg, John Holahan, Matthew Buettgens, Robin Wang, *A Path to Incremental Health Care Reform: Improving Affordability, Expanding Coverage, and Containing Costs*, The Urban Institute, December 2018.

⁴ Assumes individual mandate and funding for cost-sharing reductions are reinstated. Linda J. Blumberg, John Holahan, Matthew Buettgens, Robin Wang, *A Path to Incremental Health Care Reform: Improving Affordability, Expanding Coverage, and Containing Costs*.

- Allowing HHS to negotiate prescription drug prices under a Medicare for all approach could lower drug prices from 4 percent to 40 percent.⁵
- Replacing most private insurance with public insurance under a Medicare for all approach could lower insurance and provider administrative costs from a current 13.9 percent of spending in commercial plans to 6 percent to 3.5 percent of all spending.⁶
- Setting provider prices at Medicare rates under a Medicare for all approach could reduce U.S. health spending in 2022 by \$384 billion in 2022, or \$5.3 trillion over ten years.⁷
- Recent estimates of the effects of a Medicare for all proposal on overall U.S. national health care expenditures range from: declines of 9.6 percent (Pollin) and 2.1 percent (Blahous) to increases of 1.8 percent (RAND), 9.8 percent (RAND), 12.6 percent (Thorpe) and 16.9 percent (Urban Institute).⁸

In the area of costs, what has captured the greatest attention in the emerging debate around Medicare for all, is the significant shift in the how national health spending would be financed. With the exception of HR 7339, which retains employer coverage as an option for employers and employees, the Medicare for all and single payer bills would shift most U.S. health care spending from households and employers and state and local governments to the federal budget.⁹ This shift raises important questions about financing sources, in particular the incidence of taxation.

⁵Jodi Liu and Christine Eibner, [National Health Spending Estimates Under Medicare for All](#), The RAND Corporation, April 2019; Robert Pollin, et al., [Economic Analysis of Medicare for All](#), Political Economy Research Institute, University of Massachusetts Amherst, November 2018; Charles Blahous, [The Costs of a National Single-Payer Healthcare System](#), Mercatus Working Paper, Mercatus Center at George Mason University, July 2018; John Holahan, et al., [The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending](#), Urban Institute, May 2016; Kenneth E. Thorpe, [An Analysis of Senator Sanders' Single Payer Plan](#), Unpublished paper, Emory University, January 2016.

⁶Jodi Liu and Christine Eibner, [National Health Spending Estimates Under Medicare for All](#); Charles Blahous, [The Costs of a National Single-Payer Healthcare System](#); John Holahan, et al., [The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending](#); Kenneth E. Thorpe, [An Analysis of Senator Sanders' Single Payer Plan](#).

⁷Charles Blahous, [The Costs of a National Single-Payer Healthcare System](#), Mercatus Working Paper, Mercatus Center at George Mason University, July 2018.

⁸None of these estimates include the potential effects of HR 1334's proposal to establish regional global budgets for institutional providers and separate budgets for capital projects.

⁹HR 7339 requires employers to meet the new coverage requirements of the public program and gives them and their employees the option to elect the public plan.

But in terms of policies that might lower the rate of growth in U.S. health care costs, what is notable about the range of national health spending estimates for the Medicare for all proposals is that the increase in health spending is often less than the increase in demand for health care from providing comprehensive coverage to most of the U.S. population. The range of estimates on spending is very wide. This is because the degree of potential savings and efficiencies are highly dependent on assumptions, particularly the ability of a single payer plan to lower provider payments, prescription drug costs and administrative costs. But the mechanisms for achieving slower health care cost growth in these proposals could be considered, refined and applied not only in single payer approaches but in other health reform approaches as well. For example, as part of a set of incremental ACA reforms, the Urban Institute estimated that capping provider payments at a level just above Medicare rates in the individual market could lower federal spending on the ACA's premium tax credits by \$11.8 billion and household spending on premiums by \$1.7 billion in 2020.¹⁰

Conclusion

Since the ACA was passed in 2010, Congress has not passed further legislation that would insure more people or make private plans more affordable or cost-protective. Many states have stepped into the void by promulgating regulations, passing legislation, and establishing programs like reinsurance to secure insurer participation, inform consumers of their coverage options, and lower consumer costs. But people living in states that did not embrace the coverage expansions, such as Medicaid expansion or operating a state-based marketplace, are lagging further and further behind those who live in more actively engaged or resourced states. Moreover, some states that have taken actions like establishing reinsurance programs are struggling to finance them long-term.

Improving coverage for all U.S. residents will require federal legislation. These recently introduced bills are an amalgam of provisions that individually or collectively have the potential to make small to large improvements in coverage and increase the ability of people to get the health care that they need. Lowering premiums, limiting out-of-pocket cost exposure, and

¹⁰ Assumes individual mandate and funding for cost-sharing reductions are reinstated. Linda J. Blumberg, John Holahan, Matthew Buettgens, Robin Wang, [A Path to Incremental Health Care Reform: Improving Affordability, Expanding Coverage, and Containing Costs](#), The Urban Institute, December 2018.

lowering the overall rate of health care cost growth are achievable goals and these bills provide mechanisms to move forward on each. Some ideas, like enhancing the ACA's subsidies, won't completely solve the U.S.'s significant affordability problem, but they provide a step in the right direction in providing targeted relief to several million people.

Many of these ideas can be implemented without a major reorganization of the health care system. For example, paying providers in commercial insurance plans at prices closer to those in Medicare or allowing the Secretary of Health and Human Services to negotiate prescription drug prices have potential to slow health care cost growth and would not require an immediate shift to a single payer system. The Medicare for all bills feature some of the proposed approaches in less sweeping bills as a way to transition into a single payer system. On the other hand, moving piecemeal also involves tradeoffs including the possibility, based on the experience of the ACA, that additional steps may take some time to achieve.

The committee is to be commended for taking on the issue of health reform. Hearings like these allow for fact-based consideration of policy options, their potential implications, and their trade-offs. I look forward to your questions.

Thank you.

Status of U.S. Health Insurance Coverage and the Potential of Recent Congressional Health Reform Bills to Expand Coverage and Lower Consumer Costs

**Sara R. Collins, Ph.D.
The Commonwealth Fund**

Thank you, Mr. Chairman, members of the Committee, for this invitation to testify today on current proposals to reform the U.S. health care system. My comments will focus on the national gains in health insurance coverage since the passage of the Affordable Care Act (ACA), the problems people continue to report affording health insurance and health care, and the potential of recent Congressional health reform bills to address these problems.

The ACA Brought Sweeping Change to the U.S. Health Care System

The ACA brought sweeping change to the U.S. health system, expanding comprehensive and affordable coverage options to lower-and middle- income Americans through a newly regulated and subsidized individual market and expanded eligibility for Medicaid. The law's provisions also made it possible for people with health problems at all income levels to buy health insurance on their own by banning insurers from denying people coverage or charging them more because of pre-existing conditions.

The number of uninsured people in the United States has fallen by nearly half since the ACA was signed into law, dropping from a historical peak of 48.6 million people in 2010 to 29.7 million in 2018 (Exhibit 1).¹¹ Cost-related problems gaining access to health care and financial problems associated with medical bills care also declined (Exhibits 2 and 3).¹² And while people still experience coverage gaps, those gaps have shortened considerably in duration (Exhibit 4). A large body of research on the effects of the ACA show conclusively that the overall impact of the legislation on people's ability to afford health insurance and get needed health care has been positive.¹³

¹¹ Emily P. Terlizzi, Robin A. Cohen, and Michael E. Martinez, Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2018 (National Center for Health Statistics, February 2019).

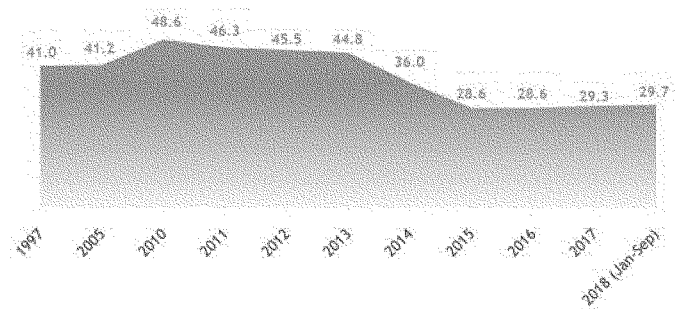
¹² Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured (Commonwealth Fund, Feb. 2019).

¹³ B. D. Sommers, B. Maylone, R. J. Blendon et al., "Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults," *Health Affairs* Web First, published online May 17, 2017;

EXHIBIT 1

The number of uninsured people in the United States fell by nearly half, from 48.6 million people in 2010 to 29.7 million in 2018

Number of people uninsured at the time of the survey (millions)



Note: Data is for all ages.

Source: Emily P. Bertozzi, Robin A. Cohen, and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2018* (Washington: Center for Health Statistics, February 2019).

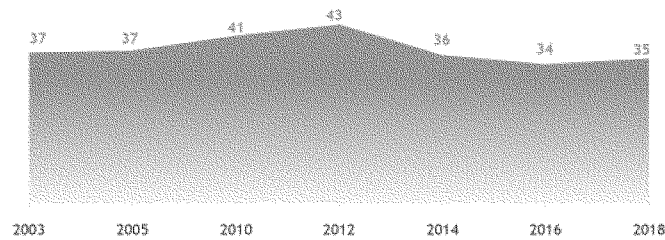
Olena Mazurenko, Casey P. Balio, Rajender Agarwal, Aaron E. Carroll, and Nir Menachami, *The Effects Of Medicaid Expansion Under The ACA: A Systematic Review*, Health Affairs, June 2018; M. Z. Gunja, S. R. Collins, and H. K. Bhupal, *Is the Affordable Care Act Helping Consumers Get Health Care?*, The Commonwealth Fund, December 2017; S.R. Collins, M.Z. Gunja, M.M. Doty, S. Beutel, *Americans' Experiences with the ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction*, The Commonwealth Fund, May 2016; S. R. Collins, P. W. Rasmussen, and M. M. Doty, *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period*, The Commonwealth Fund, July 2014.

EXHIBIT 2

Fewer Adults Report Not Getting Needed Care Because of Costs, but Gains Have Stalled in Recent Years

Percent of adults ages 19-64 who reported any of the following cost-related access problems in the past year:

- Had a medical problem but did not visit doctor or clinic
- Did not fill a prescription
- Skipped recommended test, treatment, or follow-up
- Did not get needed specialist care



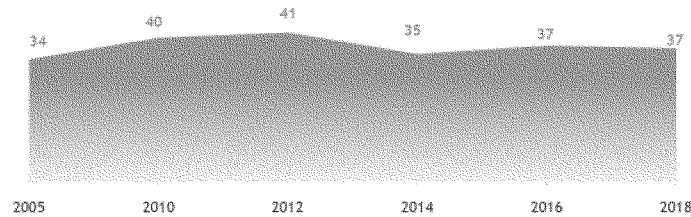
Data: Commonwealth Fund Biennial Health Insurance Surveys (2005, 2010, 2012, 2014, 2016, 2018).
Source: Sara R. Collins, Herman K. Bhopal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).

EXHIBIT 3

Fewer Adults Have Difficulty Paying Their Medical Bills, but the Improvement Has Stalled

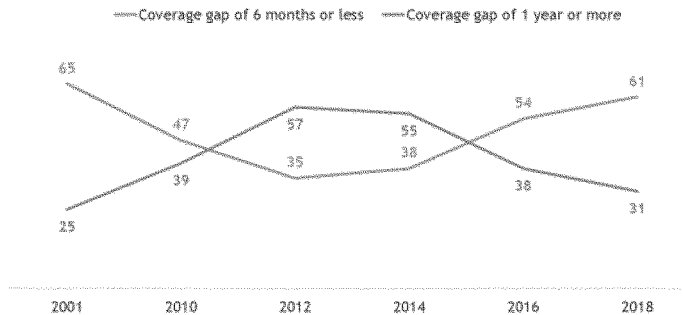
Percent of adults ages 19-64 who reported any of the following medical bill or debt problems in the past year:

- Had problems paying or unable to pay medical bills
- Contacted by a collection agency for unpaid medical bills
- Had to change way of life to pay bills
- Medical bills/debt being paid off over time



Data: Commonwealth Fund Biennial Health Insurance Surveys (2005, 2010, 2012, 2014, 2016, 2018).
Source: Sara R. Collins, Herman K. Bhopal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).

EXHIBIT 4

Since the ACA, Gaps in People's Coverage Have Been Shorter*Percent of adults ages 19-64 insured now but had a coverage gap in past year*

Data: Commonwealth Fund Biennial Health Insurance Surveys (2001, 2010, 2012, 2014, 2016, 2018).
 Source: Sara R. Collins, Herman K. Bhopal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured* — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018 (Commonwealth Fund, Feb. 2019).

Millions of People Remain Uninsured or are Underinsured

However, three distinct, yet interrelated, problems remain: millions of people remain uninsured, millions of people with insurance have plans that are leaving them underinsured, and growth in health care costs is outstripping that of median income in most states.

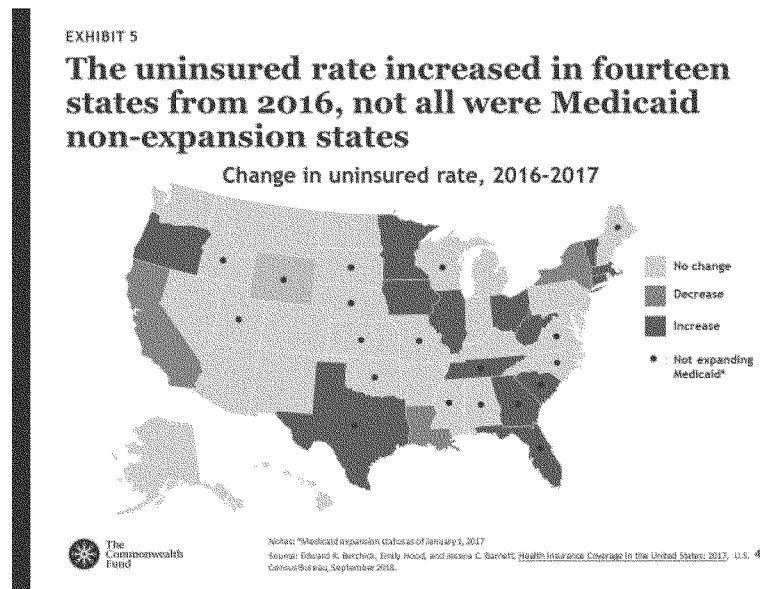
29.7 million people remain uninsured

After dropping significantly through 2015, the national uninsured rate has held steady at around 9 percent, with some ominous upticks in fourteen states in 2017 (Exhibit 5).¹⁴ The share

¹⁴ Emily P. Terlizzi, Robin A. Cohen, and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2018* (National Center for Health Statistics, February 2019); Edward R. Berchick, Emily Hood, and Jessica C. Barnett, *Health Insurance Coverage in the United States: 2017*, U.S. Census Bureau, September 2018.

of working age adults who are uninsured is about 13 percent; about 5 percent of children are uninsured. (Exhibit 6).¹⁵ These stalled gains stem from four primary factors:

- Seventeen states have not yet expanded Medicaid, including the heavily populated states of Florida and Texas (Exhibit 7);
- People with incomes just over the marketplace subsidy threshold (about \$48,560 for an individual and \$100,000 for a family of four) and many in employer plans have high premium contributions relative to income;
- Congressional and executive actions regarding the individual market and Medicaid that have reduced potential enrollment in both;
- The ACA's exclusion of undocumented immigrants from eligibility for subsidies and Medicaid.

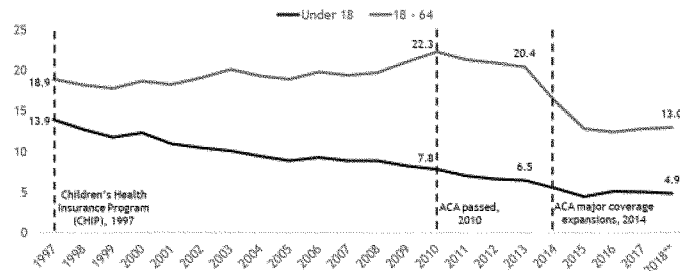


¹⁵ Emily P. Terlizzi, Robin A. Cohen, and Michael E. Martinez, Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2018 (National Center for Health Statistics, February 2019).

EXHIBIT 6

Uninsured Rates Have Fallen In Response to Coverage Expansions, but Gains Have Flattened

Percent of individuals without health insurance*, 1997-2018

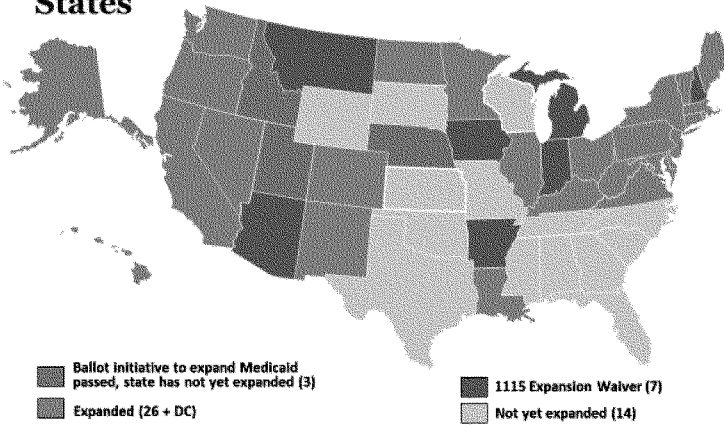


Notes: *At the time of interview. **2018 data is for January-September.

Source: Emily R. Terlizzi, Robin A. Cohen, and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-September 2018* (National Center for Health Statistics, February 2019).

EXHIBIT 7

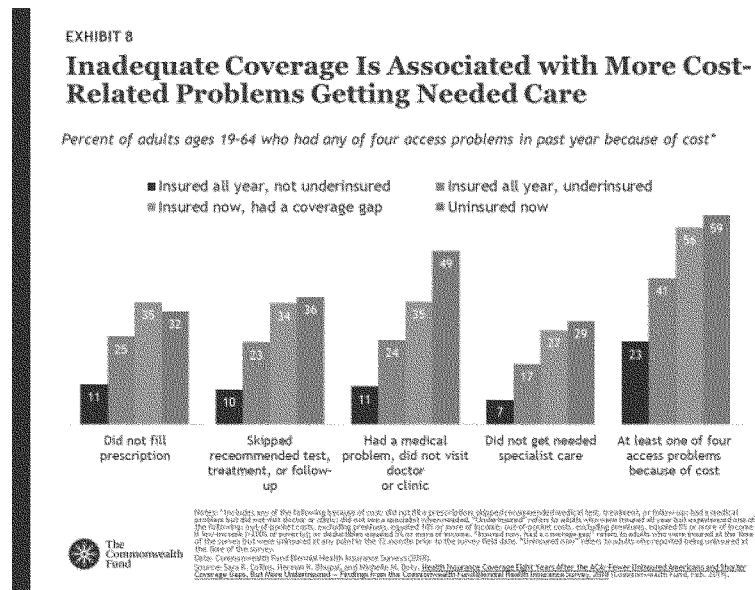
Status of Medicaid Expansion Across the States



Notes: Adults in Wisconsin and Utah are eligible for Medicaid up to 100% of federal poverty. Last updated: April 9, 2019.

6

Why it matters. Commonwealth Fund surveys have consistently found that people who lack health insurance, even for short periods of time, avoid or delay needed health care and are at risk of accumulating medical debt. In the 2018 Commonwealth Fund Biennial Health Insurance Survey, more than 55 percent of people who spent any time uninsured in the past year reported not getting needed health care including filling prescriptions, because of cost (Exhibit 8).¹⁶ More than half said that they had problems paying medical bills, including paying off medical debt over time (Exhibit 9). People who are uninsured are much less likely to report getting recommended preventive care like flu shots, and cancer screens like mammograms and colon cancer screens (Exhibits 10 and 11).

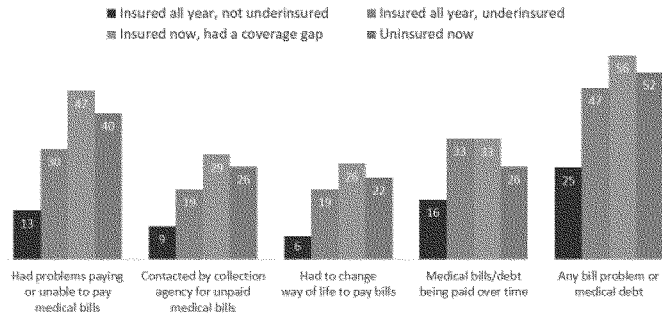


¹⁶ Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, [Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured](#) (Commonwealth Fund, Feb. 2019).

EXHIBIT 9

Inadequate Coverage Is Associated with More Problems Paying Medical Bills

Percent of adults ages 19-64 who had medical bill or debt problems in past year*



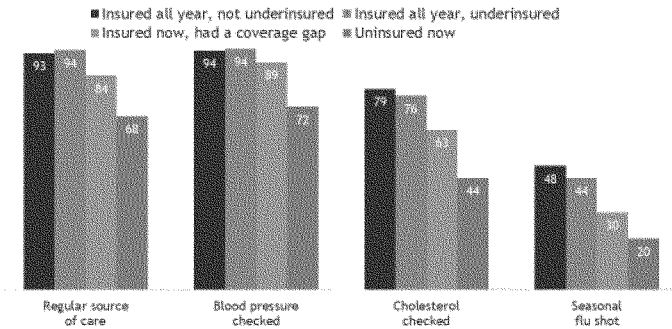
Notes: * Includes any of the following: had problems paying or unable to pay medical bills; contacted by collection agency for unpaid medical bills; had to change way of life to pay bills; medical bills/debt being paid over time. "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding co-insurance, exceeded 10% or more of income; out-of-pocket costs, excluding co-insurance, exceeded 10% or more of income; or deductibles exceeded 25% or more of income. "Coverage gap" refers to adults who were insured for the year but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey.

Data: Commonwealth Fund Biennial Health Insurance Survey (2018).
 Source: Mary E. Coffin, Rebecca S. Shapell, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured* – Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018 (The Commonwealth Fund, Feb. 2019).

EXHIBIT 10

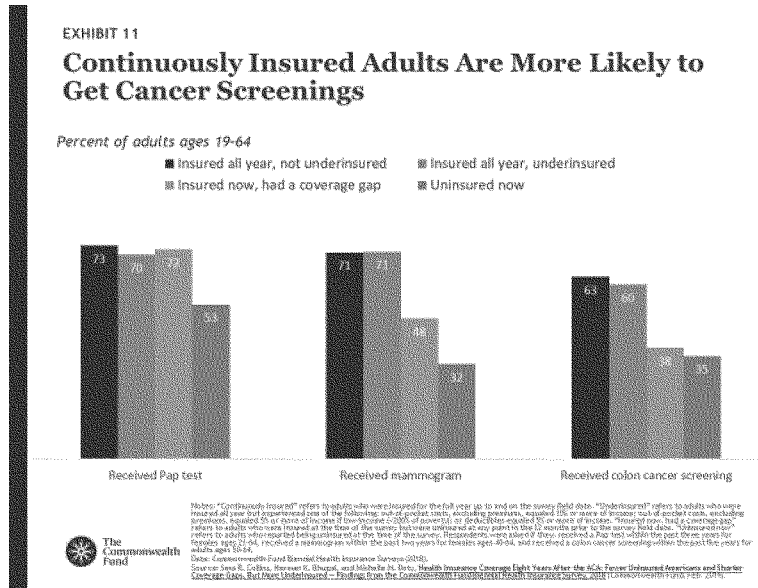
Continuously Insured Adults Are More Likely to Get Preventive Care

Percent of adults ages 19-64



Notes: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date. "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding co-insurance, exceeded 10% or more of income; out-of-pocket costs, excluding co-insurance, exceeded 10% or more of income; or deductibles exceeded 25% or more of income. "Coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who were uninsured at the time of the survey. Respondents were asked if they had their blood pressure checked within the past 12 months (in past year if has hypertension or high blood pressure), had their cholesterol checked in past 12 months (in past year if has hypertension, heart disease, or high cholesterol), and had their seasonal flu shot within the past 12 months.

Data: Commonwealth Fund Biennial Health Insurance Survey (2018).
 Source: Mary E. Coffin, Rebecca S. Shapell, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured* – Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018 (The Commonwealth Fund, Feb. 2019).



In its landmark 2003 study, the Institute of Medicine (IOM) concluded that people who lack adequate health insurance all their lives have fundamentally different life experiences and less economic opportunity than those who are adequately insured, including lower educational attainment, lifetime earnings, and life expectancy.¹⁷ At the time of the study, the IOM estimated that the aggregate, annualized cost of uninsured people's lost capital and earnings from poor health and shorter lifespans fell between \$65 billion and \$130 billion annually.

44 million people are underinsured

In addition to the 28 million people who lack insurance, an estimated 44 million working age adults with insurance, or 29 percent, are underinsured because they have high out-of-pocket costs

¹⁷ Institute of Medicine, Committee on the Consequences of Uninsurance, *Hidden Costs, Value Lost: Uninsurance in America*, Washington, DC: National Academies Press, 2003.

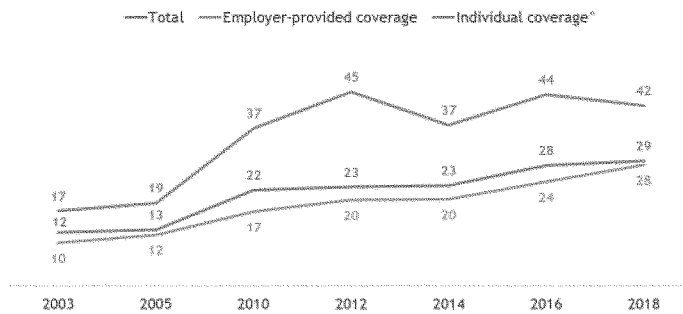
and deductibles relative to their income (Exhibit 12).¹⁸ This is up from an estimated 29 million, or 22 percent, in 2010. People who buy plans on their own through the individual market—including the ACA marketplaces—are underinsured at the highest rates. However, the greatest growth in the share of underinsured adults is occurring among those in employer health plans. The growth in underinsurance is attributable to two primary factors:

- Growth in cost-sharing, particularly deductibles, in private health plans.
- Little or no growth in U.S. median income such that out-of-pocket health care costs and deductibles are comprising a growing share of income among low- and moderate-income families.

EXHIBIT 12

More adults are underinsured, with the greatest growth occurring among those with employer coverage

Percent of adults ages 19-64 insured all year who were underinsured



Notes: "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, including premiums, equalled 10% or more of income; out-of-pocket costs, including premiums, equalled 5% or more of income if low-income (200% of poverty); or deductibles equalled 5% or more of income. Total includes adults with coverage through Medicaid and Medicare. Respondents may have had another type of coverage at some point during the year, but had coverage for the entire previous 12 months. ^a For 2014 and 2016, includes those who got their individual coverage through the marketplace and outside of the marketplace.
 Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).
 Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty. *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured* (Commonwealth Fund, Feb. 2019).

Greater cost-sharing, especially higher deductibles, has been the predominant tool of choice by private insurers and employers in their attempts to temper premium growth over the last several years. Deductibles have grown in both proliferation and size. In 2017, 87.5 percent of

¹⁸ Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured* (Commonwealth Fund, Feb. 2019).

single person health plans offered by employers had deductibles, compared to 70.7 percent in 2008.¹⁹ Over that period, average deductibles more than doubled in size, from \$869 to \$1,808.²⁰

Why it matters. Commonwealth Fund surveys consistently find that underinsured adults are much more likely to skip needed health care, like filling prescriptions or going to the doctor when they are sick, than are those who are not underinsured. In 2018, 41 percent of underinsured adults reported not getting needed health care because of the cost (see Exhibit 8).²¹

In addition, people who are underinsured are much more likely to report problems paying medical bills or say they are paying off medical debt over time. In 2018, 47 percent of underinsured adults reported problems paying medical bills, nearly twice the rate of adults who were insured all year but not underinsured. One-third reported that they were paying off medical debt over time, twice of the rate adults who were not underinsured (see Exhibit 9).

Many moderate- and low- income families simply do not have the assets or savings to pay for an unexpected medical bill—from an accident or acute illness and subsequent emergency room visit, for example—they may experience because of a high-deductible health plan. A recent Commonwealth Fund survey found that half of moderate- and low-income adults with employer coverage said they would not have the money to pay for an unexpected \$1,000 medical bill in a month’s time (Exhibit 13).²²

¹⁹ Commonwealth Fund analysis of the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), 2017.

²⁰ Sara R. Collins and David C. Radley, [The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families](#) (Commonwealth Fund, Dec. 2018).

²¹ Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, [Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured](#) (Commonwealth Fund, Feb. 2019).

²² Sara R. Collins, [The Growing Cost Burden of Employer Health Insurance for U.S. Families and Implications for Their Health and Economic Security](#), Invited Testimony, U.S. House of Representatives Committee on Ways and Means, Subcommittee on Select Revenue Measures, Hearing on “How Middle-Class Families Are Faring in Today’s Economy,” Feb. 13, 2019.

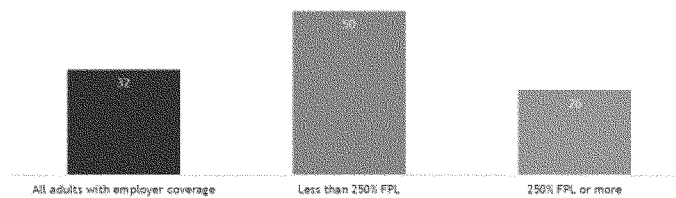
EXHIBIT 13

One of third of adults with employer coverage say they would not have the money to pay an unexpected \$1,000 medical bill within 30 days



If you were to experience an unexpected medical event in 2018 that left you with a bill for \$1,000, would you have the money to pay the bill within 30 days?

Percent of adults ages 19-64 with employer coverage who responded "no"



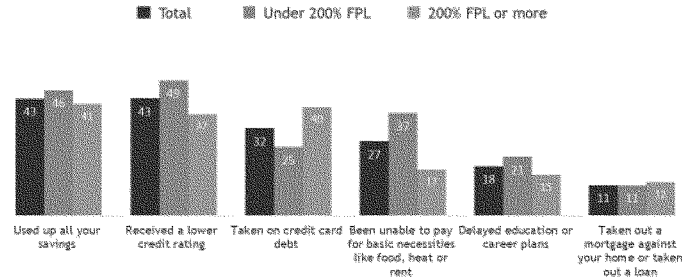
Data: Commonwealth Fund Affordable Care Act Tracking Survey, Feb.-Mar. 2016.

Paying off accumulated medical bills over time affects other aspects of people's lives. The Commonwealth Fund Biennial survey found that many adults with medical bill or debt problems reported serious financial problems: 43 percent had used up all their savings to pay their bills, 43 percent had received a lower credit rating as a result of their debt, 32 percent racked up debt on their credit cards, 18 percent said they had delayed education or career plans (Exhibit 14) People with lower incomes were particularly affected: 37 percent said they were unable to pay for basic necessities like food, heat or rent as a result of their bills.

EXHIBIT 14

Adults with medical bill problems had lingering financial problems

Percent adults ages 19-64 who reported the following happened in the past two years because of medical bill problems^a



^a Basic: Respondents who reported at least one of the following medical bill problems in the past 12 months: had problems paying medical bills, contacted by a collection agency for unpaid bills, had to change way of life in order to pay medical bills, or has outstanding medical debt.
 Data: Commonwealth Fund Biennial Health Insurance Survey (2016).

Health care cost growth is outpacing growth in U.S. median income

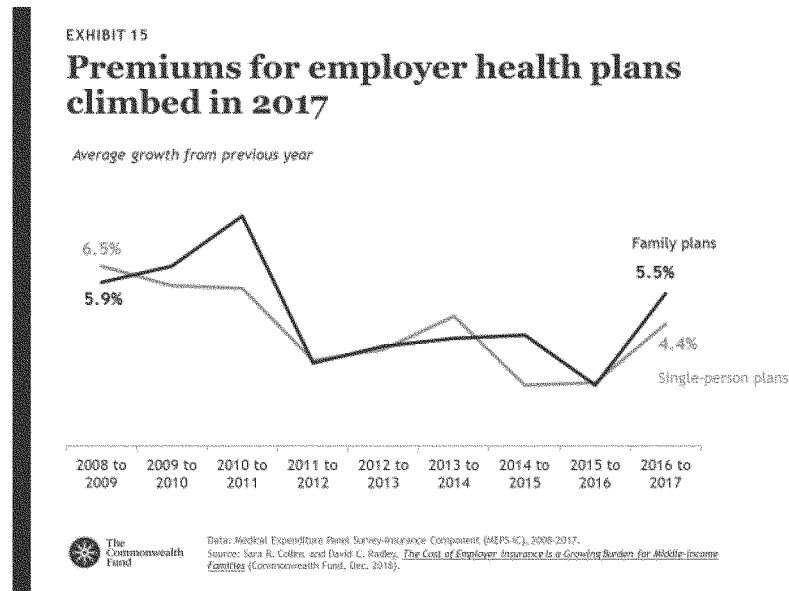
A major factor underlying trends in both uninsured and underinsured rates, is the overall rate of growth in U.S. health care costs, particularly relative to growth in median income. Health care costs are the primary driver of premium and deductible growth in private insurance. This means that health care costs ultimately drive both consumer decisions to buy insurance and whether to get health care.

Over 2014 to 2016, U.S. health care spending rose at an annual rate of 5.3 percent and is projected to grow by 5.5 percent per year over the next decade, to nearly \$6 trillion by 2027, or about 19.4 percent of GDP.²³ Median household income is growing at comparatively slower pace: 3.2 percent in 2016 and 1.8 percent in 2017.²⁴

²³ Andrea M. Sisko, et al. "National Health Expenditure Projections, 2018-27: Economic and Demographic Trends Drive Spending and Enrollment Growth," *Health Affairs*, March 2019.

²⁴ U.S. Census Bureau, Income and Poverty in the United States, 2016 and 2017.

Health care costs are the primary driver of premium growth in private plans comprising 80 to 85 percent of premiums. In 2017, the annual rate of growth in employer premiums ticked up by 4.4 percent for single person plans and 5.5 percent for family plans (Exhibit 15).²⁵



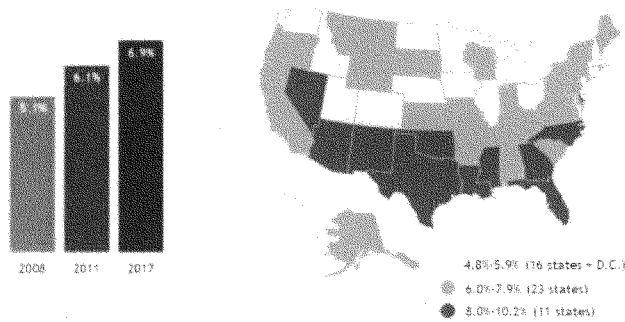
While the employee share of premium costs has stayed relatively constant over time, as employer premiums have grown, so has the dollar amount employees contribute to their premiums. Between 2016 and 2017, average annual employee premium contributions nationally rose by 6.8 percent to \$1,415 for single-person plans and by 5.3 percent to \$5,218 for family plans (Exhibit 16).²⁶ The average employee premium cost across single and family health plans amounted to nearly 7 percent of U.S. median income in 2017, up from 5.1 percent in 2008. In 11 states (Arizona, Delaware, Florida, Georgia, Louisiana, Mississippi, Nevada, New Mexico, North Carolina, Oklahoma, Texas), premium contributions were 8 percent of median income or more, with a high of 10.2 percent in Louisiana.

²⁵ Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families*, Commonwealth Fund, Dec. 2018.

²⁶ Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families*.

Worker payments for employer coverage are growing faster than median income

Average employee premium contribution as percent of median state income in 2017

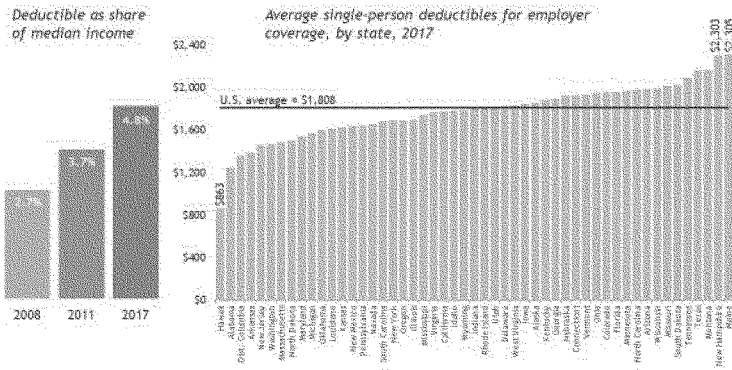


Grains: A review of studies on grain. Having access to the literature has, for the first time, been the current September 2007 JGIM, which included the following abstracts in 2007. The abstracts have been edited into 2007 JGIM, which has been published in the current issue of the journal. The abstracts have been edited into the current issue of the journal. The abstracts have been edited into the current issue of the journal.

²⁷ Not everyone with a deductible has enough medical expenses in a given year to meet the deductibles; some services are covered by plans before people meet deductibles. By law, preventive care services and many cancer screens must be covered pre-deductible without cost-sharing. And many plans also cover certain prescription drugs and other services before the deductible is met.

EXHIBIT 17

Average deductibles are also outpacing growth in median income

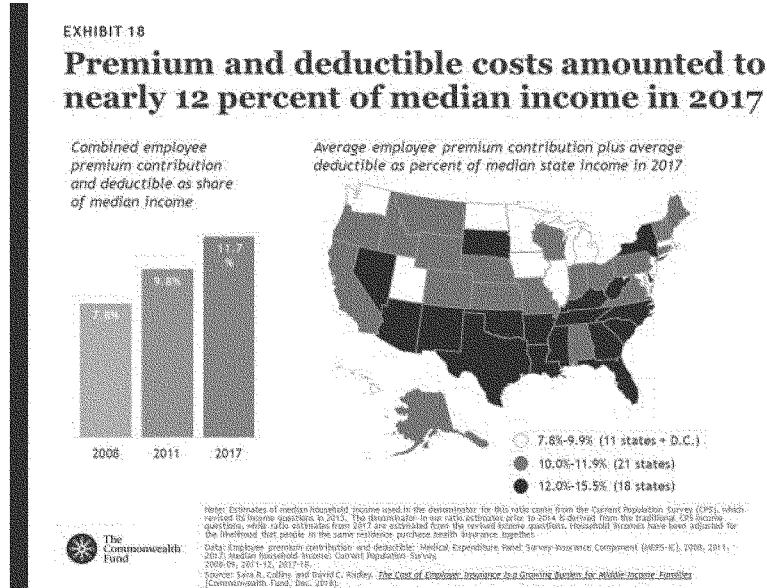


Note: Estimates of median household income used in the denominator for this ratio come from the Current Population Survey (CPS), which revised its income questions in 2013. The numerator is an out-of-pocket estimate prior to 2014 is derived from the traditional CPS income questions, while ratio estimates from 2017 are estimated from the revised income questions. Household incomes have been adjusted for the likelihood that people in the same residence purchase health insurance together.

Data: Deductibles: Medical Expenditure Panel Survey-Buyside (MEPS-BU), 2008, 2011, 2017; Median household income: Current Population Survey, 2008-09, 2013-15, 2017-18.

Source: Lisa M. Collins and David C. Reardon, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families* (Commonwealth Fund, Dec. 2018).

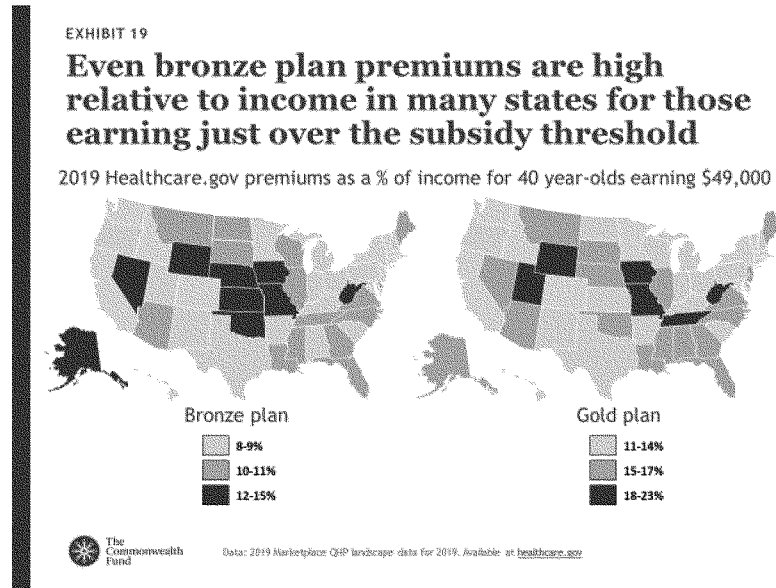
In employer plans in 2017, total spending on premiums and potential out-of-pocket costs amounted to 11.7 percent of median income in 2017 (Exhibit 18). This is up from 7.8 percent a decade earlier. Costs were 12 percent or more of median income in 18 states. In Louisiana and Mississippi, these combined costs rose to 15 percent or more of median income.



In the individual market, premium growth stabilized in 2019 as insurers adjusted to the ACA market regulations and gained knowledge of their enrollment risk pools. While premiums will continue to be affected by external factors such as uncertainty over Congressional, executive and judicial decisions regarding the ACA's parameters, health care cost growth will be the primary source of premium growth in this market as well. In contrast to the employer market, lower and moderate-income people eligible for premium tax credits in the marketplaces are largely protected from premium increases since the ACA capped their contributions as a share of income on a sliding scale. The premium tax credits have been the central stabilizer for the marketplace enrollment. Across the states, 80 to 90 percent of marketplace coverage is subsidized.

However, people whose incomes are just over the income eligibility threshold of 400 percent of poverty (\$100,400 for a family of four and \$48,560 for an individual) are fully exposed to their plan premiums and year-to-year increases (Exhibit 19). For people with incomes just above that level, premiums can comprise well over 10 percent of their income, even for

bronze level plans in many states. Ten percent is an important marker because that is the most people have to pay for their premiums if their income is below the subsidy eligibility threshold.



The potential of Congressional health reform bills to decrease the number of uninsured and underinsured people and lower health care cost growth

The U.S. health insurance system is comprised of both private (employer and individual market and marketplace plans) and public (Medicare and Medicaid) coverage sources, as the table below shows (Exhibit 20). In addition, both coverage sources are paid for by a mix of private and taxpayer financed public dollars.

EXHIBIT 20

U.S. Health Insurance System is Currently Both Private and Public

Source	People (millions)	Financing	Insurer Type	Regulation
Employer	138	Federal, Employers, Individuals	Private	Federal and state
Individual Market and Marketplaces	27	Federal, Individuals, Private Insurers	Private	Federal and state
Medicaid	44	Federal, State, Individuals	Public and Private	Federal
Medicare	62	Federal, Individuals	Public and Private	Federal
Uninsured	28	Federal, State, Individuals	—	—



Source: Analysis of the 2018 U.S. Current Population Survey by Ougni Chakraborty and Sherry Glied of New York University for the Commonwealth Fund.

Most Americans get their insurance through employers, who either provide coverage through private insurers or self-insure. Employers and employees share the cost through premiums and cost-sharing. But the federal government significantly subsidizes employer coverage by excluding employer premium contributions from employees' taxable income. In 2018 this subsidy amounted to \$280 billion, the largest single tax expenditure.²⁸

About 27 million people are covered through regulated private plans sold in the individual market, including the Affordable Care Act's marketplaces. This coverage is financed by premiums and cost-sharing paid by enrollees. The federal government subsidizes these costs for individuals with incomes under \$48,560.

For 44 million people, Medicaid or the Children's Health Insurance Program is their primary source of coverage. These public programs are financed by federal and state

²⁸ Tax Policy Center, [Key Elements of the U.S. Tax System](#), Urban Institute and Brookings Institution.

governments, and small individual premium payments and cost-sharing in some states. In most states, these benefits are provided through private insurers.

Medicare covers 62 million people over age 65 and people with disabilities. The coverage is financed by the federal government along with individual premiums and significant cost sharing. About 20 million people get their Medicare benefits through private Medicare Advantage plans and most beneficiaries either buy supplemental private insurance or qualify for additional coverage through Medicaid to help lower out-of-pocket costs and add long-term care benefits.²⁹

The “Medicare for All” Continuum

The recent set of proposals from House and Senate Democrats seek to address the current problems in the health care system — millions of people uninsured or underinsured, and high health care costs — by expanding the public dimensions of our health care system.³⁰ These bills can be characterized as falling along a continuum with Medicare for all proposals at one end.³¹ The bills range from adding somewhat more public sector involvement into the system, to adding substantially more public sector involvement. The bills may be broadly grouped into three categories:

- **Adding public plan features to private insurance**
 - HR 1884, Protecting Pre-Existing Conditions & Making Health Care More Affordable Act of 2019 (Rep. Pallone)
 - S 2582, Consumer Health Insurance Protection Act of 2018 (Sen. Warren)
- **Giving people a choice of public plans alongside private plans**
 - S 981, Medicare-X Choice Act of 2019 (Sens. Bennet, Kaine); HR 2000 (Rep. Delgado)
 - S 2708, Choose Medicare Act (Sen. Merkley); HR 6117 (Rep. Richmond)

²⁹ Gretchen Jacobson, Anthony Damico, Tricia Neuman, [A Dozen Facts about Medicare Advantage](#), Kaiser Family Foundation, Nov. 2018.

³⁰ Sherry A. Glied and Jeanne M. Lambrew, “How Democratic Candidates for the Presidency in 2020 Could Choose Among Public Plans,” *Health Affairs* 37, no. 12 (Dec. 2018): 2084–91.

³¹ Sara R. Collins and Roosa Tikkanen, [The Many Varieties of Universal Coverage](#), The Commonwealth Fund, March 6, 2019.

- HR 1346, Medicare Buy-In and Health Care Stabilization Act of 2019 (Rep. Higgins)
- S 470, Medicare at 50 Act (Sen. Stabenow)
- S 489 State Public Option Act (Sen. Schatz); HR 1277 (Rep. Lujan)

➤ **Making public plans the primary source of coverage in the U.S.**

- HR 7339, Medicare for America Act of 2018 (Rep. DeLauro)
- S 1129, Medicare for All Act of 2019 (Sen. Sanders)
- HR 1384, Medicare for All Act of 2019 (Rep. Jayapal)
- HR 676, Expanded and Improved Medicare for All Act (Rep. Ellison)

Summaries of the bills that fall within these categories are available in an interactive tool on the Commonwealth Fund website.³² I next discuss the general provisions and implications of each category of approaches.

Adding public plan features to private insurance

The bills in this category include provisions to enhance the premium and cost-sharing subsidies for marketplace plans, fixing the so-called “family coverage glitch” in employer plans, addressing the Medicaid coverage gap for low income people in non-expansion states, and increasing the regulation of private plans such as banning non-ACA compliant plans or requiring private insurers who participate in Medicare and Medicaid to offer health plans in the ACA marketplaces.

Potential Effects: Directional

While details matter in terms of degree, the bills as a group have the potential to make the following directional changes in the health system:

- Improve the affordability and cost-protection of individual market insurance;
- Increase health plan choice in some individual markets;
- Reduce the number of uninsured people; and
- Reduce the number of underinsured people.

³² Sara R. Collins, Roosa Tikkanen, The Many Varieties of Universal Coverage.

Potential Effects: Estimates from the Literature

Researchers have estimated the effects of several provisions in these bills. I next review some notable examples.

Enhancing premium tax credits. Lifting the income eligibility threshold for the premium tax credits (currently about \$48,560 for an individual and \$100,400 for family of four) would have the effect of capping the most anyone in the market would pay for premiums at 10 percent of income. This has a natural phase out — as people’s income rises, premiums take up a smaller and smaller share of their income, so fewer and fewer people are eligible for the tax credits.

Researchers Jodi Liu and Christine Eibner from the RAND Corporation estimated the coverage and federal budget effects of such a policy change.³³ They assumed current law: no individual mandate or federal reimbursement for cost-sharing reduction subsidies. They project that lifting the income threshold for the premium tax credits could insure 1.7 million more people and lower marketplace silver plan premiums by 2.7 percent at a net federal cost of \$10 billion in 2020 (Exhibit 21).

³³ Jodi Liu and Christine Eibner, *Expanding Enrollment Without the Individual Mandate: Options to Bring More People into the Individual Market* (Commonwealth Fund, Aug. 2018).

EXHIBIT 21

Options to Increase Coverage and Affordability of Individual Market Plans

	Lifting the 400% FPL cap	Standard reinsurance	Generous reinsurance
Change in coverage	1.7 m	0.3 m	2 m
Change in individual market premiums*	-2.7%	-2.4%	-10.7%
Net deficit impact	\$9.9 b	-\$2.3 b	-\$8.8 b



*Change in silver premiums for a 40-year-old nonsmoker.
 Source: Joel Liu and Christine Eibner, *Expanding Enrollment Without the Individual Mandate: Options to Bring More People into the Individual Market* (Commonwealth Fund, Aug. 2018).

Liu and Eibner also modeled the effects of lifting the threshold combined with reducing the maximum premium contribution as a share of income to a range of 1.79 percent at 100 percent of poverty to 8.5 percent of income at 300 percent of poverty and above. Under this scenario, 2.4 million more people are estimated to gain coverage and silver plan premiums would drop by 3.1 percent, at an annual net deficit impact of \$18.8 billion.

In addition to increasing coverage, enhancing marketplace premium and cost-sharing subsidies would significantly increase the affordability of premiums and health care. The Urban Institute, for example, modeled the effect of lifting the premium tax credit threshold combined with reducing the maximum premium contribution as a share of income to a range of 0 percent at 100 percent of poverty to 8.5 percent of income at 400 percent of poverty and above. They pegged premium tax credits to the gold plan, rather than the silver plan. The modeling assumes the individual mandate is in place, and the cost-sharing reductions are financed. Under these policy changes, average annual premiums for single person policies are estimated to decline by \$356 for adults earning 138 percent of poverty, by \$721 for those earning 250 percent of poverty, \$902 at 350 percent of poverty, and by \$9,434 for a 64-year old at 450 percent of poverty.

The Urban Institute researchers also modeled the combined effect on cost-sharing from pegging tax credits to the gold plan and enhancing and extending the cost-reduction subsidies to people up to 300 percent of poverty. The improved cost-protection from enrolling in gold plans combined with enhanced cost sharing decreases single policy deductibles by \$1,650 for adults earning 250 percent of poverty and above.

Reinsurance. Reinsurance has a proven track record in lowering marketplace premiums. The ACA's temporary reinsurance program resulted in premiums that were as much as 14 percent lower than they might otherwise have been. All seven states that have implemented reinsurance programs through the ACA's 1332 waiver program have experienced drops in premiums, some of them substantial.³⁴

Liu and Eibner estimated the effects of reinstating the ACA's reinsurance program which was wholly financed through insurer fees. They estimate that depending on the generosity of the program (ACA year one vs. ACA year three), reinsurance could increase insurance coverage from 300,000 to 2 million people, lower silver plan marketplace premiums by 2.4 percent to 10.7 percent and result in net deficit savings of \$2.3 billion to \$8.8 billion annually (see Exhibit 21).

Family coverage glitch fix. Urban Institute researchers estimated the effect of fixing the family coverage glitch by pegging unaffordable coverage in employer plans to family policies rather than single policies.³⁵ In 2016, the researchers estimated that more than 6 million people were affected by the glitch and were ineligible for marketplace subsidies because of it. They estimated that fixing the glitch would lower family spending on premiums from 12 percent of income on average to 6.3 percent, at a cost to the federal government of \$3.7 billion to \$6.5 billion in 2016. The fix was not estimated to significantly expand insurance coverage.

³⁴ Justin Giovannelli, *What Is Your State Doing to Affect Access to Adequate Health Insurance?* The Commonwealth Fund, last updated April 2, 2019; Rachel Schwab, Emily Curran, Sabrina Corlette, *Assessing the Effectiveness of State-Based Reinsurance: Case Studies of Three States' Efforts to Bolster Their Individual Markets*, Robert Wood Johnson Foundation, November 2018.

³⁵ Matthew Buettgens, Lisa Dubay, and Genevieve M. Kenney, "Marketplace Subsidies: Changing The 'Family Glitch' Reduces Family Health Spending But Increases Government Costs," *Health Affairs*, 35, 7, July 2016: 1167-75.

Comprehensive package of policy options. The Urban Institute also recently modeled a set of policy changes that build on one another, beginning with the reinstatement of the ACA's individual mandate and funding for the cost-sharing reduction subsidies.³⁶ The additional options include enhanced premium and cost-sharing subsidies (discussed above), expanded eligibility for Medicaid in all states, a \$10 billion federal investment in a reinsurance program, and capping what providers are paid in the individual market somewhat above Medicare rates. The combined effect of these policies is a drop in the number of uninsured by 12.2 million, or 7.3 percent of the under 65 population, at a total federal cost of \$119 billion in 2020.

Giving people a choice of public plans alongside private plans.

In addition to enhancing ACA subsidies and providing reinsurance, the bills in this category also give consumers a choice of a public plan, based on either Medicare or Medicaid, for people in the ACA marketplaces and employers. The bills also use the leverage of the federal government's buying power in setting premiums for the public plan, establishing provider payment rates, and negotiating prescription drug prices. Some bills also improve benefits for people currently enrolled in Medicare.

Potential Effects: Directional

Again, details matter in terms of degree, but the bills as a group have the potential to:

- Improve the affordability and cost-protection of individual market insurance and for people currently enrolled in employer plans;
- Increase health plan choice in the individual market and for people in employer plans;
- Lower rate of growth in the cost of health care and prescription drugs;
- Reduce the number of uninsured people;
- Reduce the number of underinsured people.

Potential Effects: Estimates from the Literature

Lowering health care cost growth. A major goal of introducing a public plan option to the marketplaces is to lower marketplace premiums through increased competition with a lower priced plan. The HHS secretary would set premiums. Presumably these premiums would be

³⁶Linda J. Blumberg, John Holahan, Matthew Buettgens, Robin Wang, [A Path to Incremental Health Care Reform: Improving Affordability, Expanding Coverage, and Containing Costs](#). The Urban Institute, December 2018.

lower than private plans as the secretary could pay participating providers closer to Medicare reimbursement rates and would have fewer administrative costs to cover. Lower premiums in all plans would also reflect the new power accorded the secretary in negotiating prescription drug prices. The potential effects of these cost-control mechanisms are reviewed in the next section.

Making public plans the primary source of coverage in the U.S.

Bills in this category are single-payer or Medicare for all bills in which all residents are eligible for a public plan that resembles the current Medicare program, but isn't the same Medicare program we have today. The bills limit or end premiums and cost-sharing and end most current forms of insurance coverage including most private coverage, with the exception of HR 7337 which retains employer coverage as an option. Benefits are comprehensive and include services not currently covered by Medicare such as dental and vision and long-term care. The approach harnesses substantial federal leverage in setting premiums and lowering provider and prescription drug prices.

Each bill includes provisions aimed at improving coverage during the transition period, some of which appear in bills in other categories. These include providing a public plan option through the marketplaces, addressing the Medicaid coverage gap, and improving benefits for the current Medicare program.

Potential Effects: Directional

Details matter, but the bills as a group have the potential to:

- Improve the affordability, benefit coverage, and cost protection of insurance for most of the U.S. population;
- Increase health plan choice for people in employer plans, for bills that retain employer coverage;
- Lower the rate of cost growth in hospital and physician services, prescription drugs, and health plan and provider administration;
- Lower the uninsured rate close to zero;
- Lower the underinsured rate close to zero.

Potential Effects: Estimates from the Literature

The single payer bills can achieve universal coverage and eliminate underinsurance, depending on whether undocumented immigrants are included. The approach also has the potential to significantly slow the rate of growth in health care costs, including those for hospital and physician services, prescription drugs, and health plan and provider administration. But there is uncertainty about the degree of savings that might be achieved. I briefly review current estimates of the effect of a single payer approach on national health spending in five areas: provider payment, prescription drugs, administration, and overall spending. I review estimates by researchers from RAND, the Mercatus Institute, the Urban Institute, Emory University, and the University of Massachusetts Amherst.

Provider payment. There is growing evidence that prices paid to providers, especially hospitals, rather than people's use of health care services, are the primary driver of health care cost and premium growth.³⁷ For example, the Health Care Cost Institute (HCCI) recently found that between 2013 and 2017, prices of inpatient services climbed by 16 percent while utilization fell by 5 percent (Exhibit 22).³⁸ HCCI found similar patterns in outpatient and professional services, and prescription drugs. There is also considerable evidence that prices explain the wide health care spending gap between the United States and other wealthy countries (Exhibits 23 and 24).³⁹ Other research has found that this greater spending in the U.S. does not result in better health outcomes compared to other countries.⁴⁰

³⁷ Z. Cooper, S. Craig, C. Gray, et al., "Variation in Health Spending Growth for the Privately Insured From 2007 to 2014," *Health Affairs* 38, no.2 (Feb. 2019): 230-236; Z. Cooper, S. Craig, M. Gaynor, et al., "Hospital Prices Grew Substantially Faster than Physician Prices for Hospital-Based Care in 2007-14," *Health Affairs* 38, no.2 (Feb. 2019): 184-189; A.M. Sisko, S.P. Keehan, J.A. Poisal, et al., "National Health Expenditure Projections, 2018-27: Economic and Demographic Trends Drive Spending and Enrollment Growth," *Health Affairs*, 38, no.3 (Feb. 2019):1-11.

³⁸ Health Care Cost Institute, *2017 Health Care Cost and Utilization Report*, February 2019.

³⁹ G. F. Anderson, P. Hussey, and V. Petrosyan, "It's Still the Prices Stupid: Why the U.S. Spends so Much On Health Care, and A Tribute to Uwe Reinhardt," *Health Affairs*, 38, no.1, (Jan. 2019):87-95.

⁴⁰ E. C. Schneider, D. O. Sarnak, D. Squires, A. Shah, and M. M. Doty, *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care* (The Commonwealth Fund, July 2017).

EXHIBIT 22

Prices, not utilization, are driving spending growth in private insurance

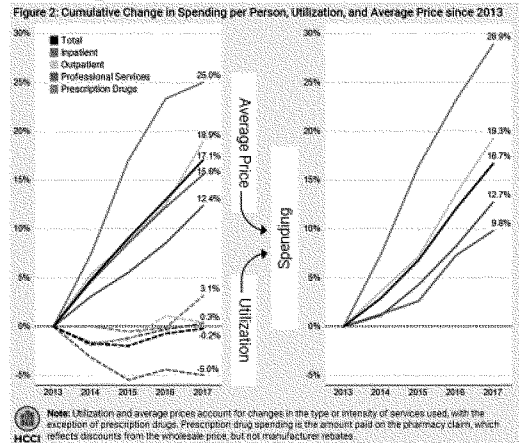
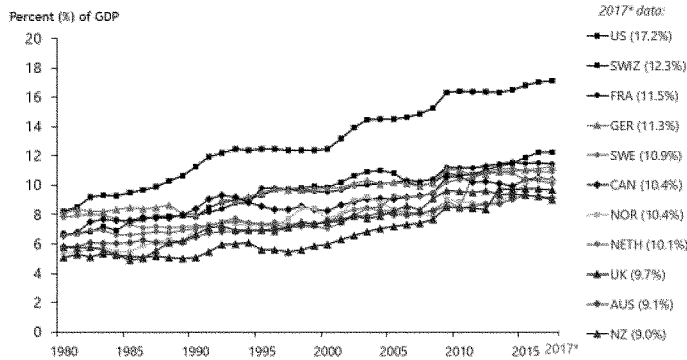


EXHIBIT 23

Health Care Spending as a Percent of GDP, 1980–2017

Adjusted for Differences in Cost of Living



Notes: Current expenditures on health per capita, adjusted for current US\$ purchasing power parities (PPPs). Based on System of Health Accounts methodology, with some differences between country methodologies (Data for Australia uses narrower definition for long-term care spending than other countries). *2017 data are provisional or estimated.

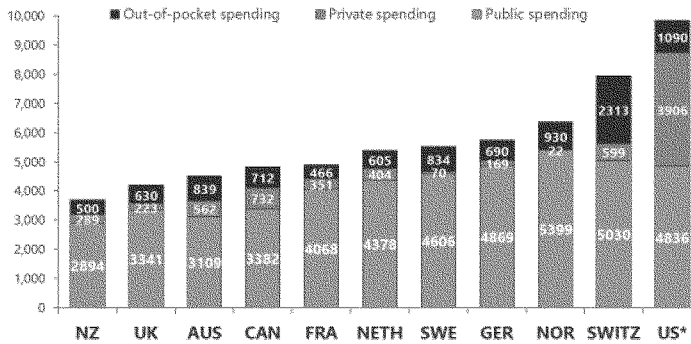
Source: OECD Health Data 2018.

EXHIBIT 24

Health Care Spending per Capita by Source of Funding, 2017

Adjusted for Differences in Cost of Living

Dollars (\$US)



Data from 2017 or most recent year: 2019 for FRA, SWITZ, UK and the US, and 2015 for AUS. Current expenditures on health, adjusted for US purchasing power parity (PPP). Members may not sum to total health care spending per capita due to excluding dental, long-term care, and non-ambulatory health care spending.
 *NOTE: For the US, spending in the "Compulsory private insurance scheme" (PFI12) category has been reclassified into the "Voluntary health insurance schemes" (PFI11) category, given that the individual mandate will end starting in 2019.
 Source: OECD Health Data 2018.

Recent research also indicates that per capita costs in U.S. private insurance are rising faster than those in public insurance programs and that prices are a likely culprit. Between 2007 and 2014, Cooper and colleagues found that private health spending per enrollee increased more rapidly and showed much more variability than that in Medicare. Since Medicare sets prices for providers while prices in commercial plans are usually the result of negotiation between providers and insurers, or employers, much of this spending differential likely stems from price differences. Anderson and colleagues note that the difference between prices paid by public and private insurers ballooned from 10 percent in 2000 to 50 percent in 2017.⁴¹ The authors argue that in order to slow the rate of growth in U.S. health care costs, increased attention needs to be given to private insurer payments to providers.

The Congressional Medicare for all bills, as well as those that give consumers a choice of enrolling in a Medicare-like public plan, do exactly that: they propose setting provider prices at

⁴¹ G.F. Anderson, P. Hussey, and V. Petrosyan, "It's Still the Prices Stupid: Why the U.S. Spends so Much On Health Care, and A Tribute to Uwe Reinhardt," *Health Affairs*, 38, no. 1, (Jan. 2019):87-95.

Medicare rates or somewhere between private and public rates. HR 1384 also proposes setting regional budgets for hospitals which has not been modeled as part of the research reviewed here. Paying providers in employer and other private insurance plans at or near Medicare rates could also be done without a public plan or single payer system.⁴²

Jodi Liu and Christine Eibner of RAND recently estimated the effect of a Medicare for all approach on national health spending.⁴³ They note that commercial insurers pay on average 167 percent of Medicare rates for hospital services and 125 percent of Medicare physician prices and that Medicaid pays about the same as Medicare for hospital prices and 72 percent of Medicare physician prices. They assume that a Medicare for all plan would pay hospitals about 124 percent of current Medicare rates and physicians 107 percent of Medicare rates, resulting in an overall blended rate of 109 percent.

The Urban Institute in their analysis assumed providers would be paid at Medicare rates, with an upward adjustment for hospitals, for an overall blended rate of 107 percent of Medicare rates.⁴⁴ Kenneth Thorpe of Emory University makes a similar assumption for an overall blended rate of 105 percent of Medicare rates.⁴⁵ In all these scenarios, payments would rise for services now covered by public plans and fall for those covered by private plans.

Charles Blahous from the Mercatus Center at George Mason University who also estimated the cost implications of a Medicare for all proposal assumed provider prices would be set at Medicare rates.⁴⁶ At those rates he estimates savings in 2022 of \$384 billion, or \$5.3 trillion over ten years. Robert Pollin and colleagues' analysis of a Medicare for all proposal also

⁴² Sherry A. Glied and Jeanne M. Lambrew, "How Democratic Candidates for the Presidency in 2020 Could Choose Among Public Plans," *Health Affairs* 37, no. 12 (Dec. 2018): 2084–91.

⁴³ Jodi Liu and Christine Eibner, *National Health Spending Estimates Under Medicare for All*, The RAND Corporation, April 2019.

⁴⁴ John Holahan, et al., *The Sanders Single-Payer Health Care Plan The Effect on National Health Expenditures and Federal and Private Spending*, Urban Institute, May 2016; Josh Katz, Kevin Quealy, Margot Sanger-Katz, "Would 'Medicare for All' Save Billions or Cost Billions?" *The New York Times*, April 10, 2019

<https://www.nytimes.com/interactive/2019/04/10/upshot/medicare-for-all-bernie-sanders-cost-estimates.html>

⁴⁵ Kenneth E. Thorpe, *An Analysis of Senator Sanders' Single Payer Plan*, Unpublished paper, Emory University, January 2016.

⁴⁶ Charles Blahous, *The Costs of a National Single-Payer Healthcare System*, Mercatus Working Paper, Mercatus Center at George Mason University, July 2018.

assumes prices would be set at Medicare rates leading to a reduction in U.S. health care expenditures of 2.8 percent.⁴⁷

None of these estimates include HR 1334's proposal to establish regional global budgets for institutional providers and separate budgets for capital projects. Such a provision could have very different implications for the cost of hospital and nursing home care than does setting payment rates at or near Medicare rates.

Prescription drugs. Most of the recent Congressional reform bills including Medicare for all and those that add a choice of public plan would allow HHS to negotiate drug prices. RAND assumes that this negotiation power would enable HHS to negotiate prices that are 10 percent lower than current levels. At that rate, RAND estimates savings of \$39.2 billion in 2019. Blahous projects prices would be 12 percent lower, and estimates savings of \$61 billion in 2022, or \$846 billion over ten years. Thorpe estimated that negotiation could lower drug prices by 4 percent.⁴⁸ Pollin assumes a reduction of 40 percent.

The Urban Institute assumed that negotiation would leave drug prices about halfway between Medicare and Medicaid prices, after rebates. This translates into a 30 percent reduction for prices in commercial plans, an 18 percent reduction in Medicare prices, and a 29 percent increase in Medicaid prices, or about a 20 percent overall decline.⁴⁹

Administrative costs. Administrative costs for private health plans exceed those of Medicare. RAND notes that administrative costs were 6.9 percent of personal health spending on Medicare in 2017, compared to 13.9 percent in commercial plans. RAND also estimates that administrative costs such as billing comprise 13 percent of physician expenditures, 8.5 percent of hospital costs, and 10 percent of other costs. RAND assumes that Medicare for all would lower health plan administrative costs to 5.3 percent of spending and provider administrative costs to 5.6 percent, for a combined savings of \$158.7 billion in 2019.

⁴⁷ Robert Pollin, et al., *Economic Analysis of Medicare for All*, Political Economy Research Institute, University of Massachusetts Amherst, November 2018.

⁴⁸ Josh Katz, Kevin Quealy, Margot Sanger-Katz, "Would 'Medicare for All' Save Billions or Cost Billions?" *The New York Times*, April 10, 2019.

⁴⁹ Author communication, April 24, 2019.

Blahous assumes health plan administrative costs would decline to 6 percent of spending for an overall savings of \$83 billion in 2022, or \$1.57 trillion over 10 years. The Urban Institute and Thorpe assume health plan administration of 6 percent and 4.7 percent of spending, respectively. Pollin assumes a larger decline to 3.5 percent of spending.

Demand for health care. Medicare for all would increase demand for health care because millions more people would have coverage and most people would face no cost sharing. Benefits would also include more services than many people, including those in Medicare, currently have. RAND assumes that demand for health care under Medicare for all would rise by 2.2 percent for people currently covered by Medicare, by 2.6 percent among those insured by private plans, and by 25 percent for those currently uninsured. In its estimates, RAND assumes that limits on provider capacity would leave 50 percent of the new demand either unmet, or delayed. Blahous assumes demand would increase by 11 percent for those with private coverage, 16 percent for people with Medicare who do not have supplemental coverage, and 89 percent for those currently uninsured. Thorpe assumes demand by those currently insured would climb by about 7 percent and by 60 percent for those currently uninsured, for an overall increase of about 15 percent.⁵⁰ Pollin assumes overall demand would increase by about 12 percent.

Overall spending. Based on the above assumptions, RAND estimates that national health spending under Medicare for All would increase by 1.8 percent in 2019, rising from \$3.823 trillion under current law to \$3.891 trillion. However, RAND estimates that if new demand for health care is fully met, overall spending would increase by 9.8 percent to \$4.2 trillion. Using slightly older national expenditure data, Blahous estimates that Medicare for all would lead to a 2 percent decrease in U.S health care spending, falling from an estimated \$4.562 trillion in 2022 to \$4.469 trillion. Pollin estimates that health spending in 2017 would have fallen from \$3.24 trillion to \$2.93 trillion, or a 9.6 percent decline. Thorpe estimates an increase of about 12.6 percent in 2019.⁵¹ The Urban Institute projects the greatest increase in national health expenditures, 16.9 percent in 2017.

⁵⁰ Author communication, April 25, 2019.

⁵¹ Author communication, April 25, 2019.

In the area of costs, what has captured the greatest attention in the emerging debate about Medicare for all, is the significant shift in the how national health spending would be financed. With the exception of HR 7339, which retains employer coverage as an option for employers and employees, all the bills in this category would shift most U.S. health care spending from households and employers and state and local governments to the federal budget. This shift raises important questions about financing sources, in particular the incidence of taxation which is discussed in some of the analyses reviewed here.

But in terms of policies that might lower the rate of growth in U.S. health care costs, what is notable about the range of national health spending estimates for the Medicare for all proposals is that the increase in health spending is often less than the overall increase in demand for health care from providing comprehensive coverage to most of the U.S. population. The range of estimates on spending is very wide. This is because the degree of potential savings and efficiencies are highly dependent on assumptions, particularly the ability of a single payer plan to lower provider payments, prescription drug costs and administrative costs. But the mechanisms for achieving slower health care cost growth in these proposals could be considered, refined and applied not only in single payer approaches but in other health reform approaches as well. For example, as part of a set of incremental ACA reforms, the Urban Institute estimated that capping provider payments at a level just above Medicare rates in the individual market could lower federal spending on the ACA's premium tax credits by \$11.8 billion and household spending on premiums by \$1.7 billion in 2020.⁵²

Conclusion

Since the passage of the ACA in 2010, Congress has not passed subsequent legislation that would insure more people or improve the affordability or cost-protection of private plans. Many states have stepped into the void by promulgating regulations, passing legislation, and establishing programs like reinsurance to secure insurer participation, inform consumers of their coverage options, and lower consumer costs. But people living in states that did not embrace the coverage expansions, such as Medicaid expansion or operating a state-based marketplace, are

⁵² Linda J. Blumberg, John Holahan, Matthew Buettgens, Robin Wang, [A Path to Incremental Health Care Reform: Improving Affordability, Expanding Coverage, and Containing Costs](#), The Urban Institute, December 2018.

lagging further and further behind those who live in more actively engaged or resourced states. Moreover, some states that have taken actions like establishing reinsurance programs are struggling to finance them long-term.

Improving coverage for all U.S. residents will require federal legislation. These recently introduced bills are an amalgam of provisions that, individually or collectively, have the potential to make significant improvements in coverage and increase the ability of people to get the health care that they need. Lowering premiums, limiting out-of-pocket cost exposure, and lowering the overall rate of health care cost growth are achievable goals and these bills provide mechanisms to move forward on each.

The selection of policy approach presents a host of tradeoffs and financing decisions that will require more microsimulation modeling, analysis and information gathering through hearings like these, and public vetting and discussion. But the set of policy options discussed in this testimony should be viewed as falling along a continuum. Some ideas, like enhancing the ACA's subsidies, won't completely solve the U.S.'s significant affordability problem, but they provide a step in the right direction in providing targeted relief to several million people.

Moreover, many of these ideas can be implemented without a major reorganization of the health care system. For example, paying providers in commercial insurance plans at prices closer to those in Medicare or allowing the Secretary of Health and Human Services to negotiate drug prices have the potential to slow health care cost growth and would not require an immediate shift to a single payer system. Even the Medicare for all bills feature some of the proposed approaches in less sweeping bills as a way to transition into a single payer system. On the other hand, moving piecemeal also involves tradeoffs including the possibility, based on the experience of the ACA, that additional steps may take some time to achieve.⁵³

The committee is to be commended for taking on the issue of health reform. Hearings like these allow for fact-based consideration of policy options and their trade-offs. I look forward to your questions.

⁵³ Sherry A. Glied and Jeanne M. Lambrew, "How Democratic Candidates for the Presidency in 2020 Could Choose Among Public Plans," *Health Affairs* 37, no. 12 (Dec. 2018): 2084–91.

Thank you.

The CHAIRMAN. Thank you very much.

Dr. Doris Browne is a retired colonel in the U.S. Army Medical Corps and the 118th president of the National Medical Association. Dr. Browne retired from the National Cancer Institute, where she managed the breast cancer chemo prevention portfolio. She was a Woodrow Wilson Public Policy Scholar in 2007 where her research focused on breast cancer health disparities. Her focus is on achieving health equity.

Dr. Browne now serves as the president and CEO of Browne and Associates, a small business specializing in improving health outcomes. Dr. Browne graduated with a B.S. from Tougaloo College, a historically black college in Mississippi; an M.P.H. from the University of California in Los Angeles; and an M.D. from Georgetown University. She is a medical oncologist by training. And we are thrilled to have you here.

STATEMENT OF DORIS BROWNE, IMMEDIATE PAST-PRESIDENT, NATIONAL MEDICAL ASSOCIATION

Dr. BROWNE. Thank you. Thank you, Chairman McGovern, Ranking Member Cole, and members of the committee. I thank you for the opportunity to appear before the committee to discuss universal health coverage for all Americans, particularly the vulnerable underserved population.

I am here as the retired military medical officer and the immediate past president of the National Medical Association, which is the largest and oldest national organization representing the interests of more than 30,000 African-American physicians and the patients we serve.

As the Nation's only healthcare organization still devoted to the needs of African-American physicians and their patients, we are disturbed by the vast health inequities of our vulnerable populations. With numerous and often insurmountable obstacles to receiving quality healthcare, people of color experience differences in access to care, the affordability of these services, implicit bias by some providers, and limited participation in clinical research, which has consequences around viable medical treatment. And the NMA has been responding to inequities in the healthcare system throughout our history. Most notably, we were the only organization to support the Medicare Act of 1965.

Research reveals that African Americans, of course, are more likely than other racial and ethnic groups to experience health inequities, and in my written testimony, I address some of those concerns. But given the disproportionate impact on chronic diseases in communities of color, Congress must find ways to make healthcare coverage affordable, accessible, and of high quality for all.

For the National Medical Association, healthcare is more than a provision of medical services. Healthcare is a multifocal, complex product which takes into account the critical determinants of health, including the socioeconomic conditions, housing, education, food and nutrition, environmental exposures, genetics and biological factors. And while the ACA was a step in the right direction and made substantial improvements in our healthcare system, it did not go far enough.

And in order to stem the high prevalence morbidity and mortality of chronic diseases, we must first develop a comprehensive agenda around health equity. And health equity is a state in which everyone has the opportunity to attain their full health potential, and no one is disadvantaged. It is imperative that healthcare be provisioned to surpass one's social position or socially defined circumstances. Health equity and opportunity are inextricably linked. When health equity is achieved, there is no health disparities.

Universal health coverage is a pathway to achieving that health equity. It has the potential to address poverty, inequality, and discrimination. It can also provide a more efficient and effective cost-saving healthcare system for everyone. Because health equity and opportunities are linked, the health equity as I have indicated, there will be no health disparities.

The government has maintained a track record for providing comprehensive healthcare throughout the military's TRICARE program, the Department of Veterans Affairs, and other sponsored programs, as you know, with Medicare and Medicaid and others. These programs have diligently worked to confirm affordable access to high-quality healthcare benefits for millions of citizens covered by these programs.

Under DOD's TRICARE, which is the second largest single-payer health system in the country and second only to the VA program, both of these high-caliber systems adhere to high-quality, evidence-based, accessible care for their beneficiaries. A patient should not have to decide between getting their full prescriptions filled and whether they should buy food. And, of course, that certainly is something that we have seen in the private sector, taking care of cancer patients, where they would decide maybe I should fill only a part of this prescription. Part care does not get you to remission in cancer.

Every patient should have the opportunity to receive first-class medical care rather than being considered second best because of a lack of insurance, provider's bias, and limitation of the Medicaid system. And we have seen this over and over where an individual may not get the approved drug for care in cancer but get the second best because their system did not have the drugs on the formulary.

The best framework for universal health coverage is through collaboration and engagement of diverse multisector partners, including the communities in which they serve. Some of the existing healthcare programs already have the infrastructure and provider network to serve our communities. But improvement is needed to target the excessive costs, service accessibility, while minimizing the duplicative services that we see in many cases.

I want to leave you with two points. First, we must adopt a system of universal coverage that minimize the administrative medical costs. It does not matter what label you use, whether it is Medicare for All, universal health coverage, single-payer, whatever. The coverage must be one that would allow the patient the ability to choose the provider for their care. And care should be the same, no matter whether you receive it in Mississippi or California, whether you are in rural America or urban America. And it should

not be restricted based upon language, age, gender, racial and ethnic areas.

And, secondly, we must continue to address the physician shortage and funding of our safety net hospitals.

Dr. BROWNE. Universal health coverage would allow for increased investment in educating more providers and allowing for additional residency slots. With consistent and predictable provider costs, we can end the two-tiered system of healthcare that has placed hospitals that serve low-income and minority communities at risk for closure.

Universal coverage would ensure that our safety net hospitals are sufficiently funded and resourced. The NMA will continue its long history of advocacy and education. We believe that all individuals in every community in the United States have a right to equal, quality, high-quality healthcare that is accessible, affordable, comprehensive, and coordinated. We begin by providing the comprehensive coverage benefits that we have under Medicare for All.

Thank you.

[The statement of Ms. Browne follows:]

Testimony of Doris Browne M.D., MPH
Physician and Retired Military Medical Officer
Immediate Past President of the National Medical Association (NMA)

House Rules Committee

April 30th, 2019

Good afternoon Chairman McGovern, Ranking Member Cole, and Members of the Committee. I thank you for the opportunity to appear before the committee to discuss universal health coverage for all Americans, particularly for underserved vulnerable populations.

I am here as a retired military medical officer and the Immediate Past President of the National Medical Association (NMA), which is the largest and oldest national organization representing the interests of more than 30,000 African-American physicians and the patients that they serve.

As the nation's only healthcare organization *still* devoted to the needs of African-American physicians and their patients, we are disturbed by the vast health inequities for vulnerable populations. With numerous and often insurmountable obstacles to receiving quality health care, people of color experience differences in access to health care, the affordability of these services, implicit biases by some providers, and limited participation in clinical research, which has consequences around viable medical treatments.

The NMA has been responding to inequities in health care systems throughout its history. One notable example of advocacy includes our association's contribution to the creation of Medicare in the early 1960s. It was not until the introduction of the Medicare Act of 1965—when hospitals faced the threat of losing Medicare reimbursement dollars -- that hospitals began to integrate. The NMA was the only medical association that supported the adoption of the Medicare Act of 1965, which played a huge part in expanding equity in our health care system.

Health disparities in African-American communities

Research reveals that African-Americans (AA) are more likely than other racial or ethnic group to experience health inequities. Black women are twice as likely to die from breast cancer compared to their white counterparts, especially young AA women who are diagnosed with triple negative breast cancer. African-American men are at increased risk for developing prostate cancer and 2.4 times more likely to die from the disease. Both AA men and women have a shorter survival after being diagnosed with cancer.

Maternal mortality rate for Black women is dismal as well. In fact, the rising maternal mortality rates in the U.S. is driven predominantly by the disproportionately high mortality rates seen in AA women who are three to four times more likely to die from pregnancy or maternal-related causes than white women. Maternal mortality is one of the greatest and most disconcerting racial inequities in public health. In D.C. 75% of maternal deaths between 2014 and 2016 were AA women.

Given the disproportionate impact of chronic diseases in communities of color, Congress must find ways to make health care coverage affordable, accessible, and of high quality for all. For the NMA, health care is more than the provision of medical services. Health care is a multifocal, complex product which takes into account the critical determinants of health, including socio-economic conditions, housing, education, food and nutrition, environmental exposures, genetics, and biological factors.

While the Patient Protection and Affordable Care Act was a step in the right direction and made substantial improvements to our health care system, it didn't go far enough.

The Importance of Health Equity and Universal Coverage

To stem the high prevalence, morbidity, and mortality of chronic diseases, we must first develop a comprehensive agenda around health equity. Health equity is the state in which everyone has the opportunity to attain their full health potential and no one is disadvantaged. It is imperative that health care be provisioned to surpass one's social position or socially-defined circumstances. Health equity and opportunity are inextricably linked. When health equity is achieved there will be no health disparities.

Universal coverage is a pathway to achieving health equity. It has the potential to address poverty, inequality, and discrimination. It can also provide a more efficient and effective, cost savings, healthcare system for everyone. Because health equity and opportunity are inextricably linked, when equity is achieved there will be no health disparities.

Whether you call it universal coverage, single payer, Medicare for all, or some other label, the label is not the most important point. What is important - is that the care must be of high quality, accessible, affordable, comprehensive and coordinated.

The Role of Government

The government has maintained a track record for providing comprehensive health care, through the military TRICARE program, the U.S. Department of Veterans Affairs and other sponsored health programs. These programs have diligently worked to confirm affordable access to high quality health care benefits for the millions of citizens covered by these programs. The Department of Defense TRICARE is the second largest single-payer, health system in this country, second only to the integrated VA health system. Both of these high-caliber systems adhere to high quality, evidence-based, accessible care for their beneficiaries.

A patient shouldn't have to decide between buying the full prescription as prescribed for cancer care or getting part of the prescription filled and buying food for a week. I practiced military medicine, which afforded me the opportunity to practice the best medicine in the world without worrying if my patients could afford the medication, procedure or services required.

Every patient should have the opportunity to receive "first class" medical care rather than being offered the "second best" because of a lack of insurance, provider bias, or limitation of a Medicaid system.

Frameworks for Health Care Coverage to Aid Communities of Color

The best framework for universal health coverage is through collaboration and engagement of diverse multisector partners, including the community in which they serve. Some of the existing health care programs already have the infrastructure and provider networks to serve our communities, but improvement is needed to target excessive costs, service accessibility, while minimizing duplicative services.

I want to leave you with two points:

First, we must adopt a system of universal coverage that minimize administrative medical costs, it does not matter what label is used. Such an undertaking must include preventive care, screening, early detection and treatment. The coverage would allow patients the ability to choose their provider (primary care or specialist). Care should be the same no matter where you live, rural or urban, California or Mississippi, and not restrictive based on language, age, gender, or race/ethnicity.

Second, we must continue to address the physician shortage and funding for our safety net hospitals. Universal health coverage would allow for increased investment in educating more providers and allowing for additional residency slots. With consistent and predictable provider rates, we can end our two-tiered system of health care that has placed hospitals that serve low-income and minority communities at risk for closure. Universal coverage would ensure that our safety net hospitals (whether rural or urban) are sufficiently funded and resourced.

NMA will continue its long history of advocacy and education. We believe all individuals in every community in the United States have a right to quality health care that is accessible, affordable, and coordinated. We can begin with providing comprehensive health care benefits in universal health care coverage program.

Thank you Mr. Chairman.

The CHAIRMAN. Thank you very, very much.

And before I go to Dr. Nahvi, I just want to acknowledge Congresswoman Debbie Dingell from Michigan who has arrived here. She is a coauthor of the Medicare for All Act, along with Congresswoman Jayapal, and we appreciate her leadership and her being here.

Last, but certainly not least, Dr. Farzon Nahvi is an emergency medicine physician and an assistant professor for emergency medicine in New York City. Dr. Nahvi completed his M.D. and residency at NYU School of Medicine and has been featured on *NowThis* discussing his patients' struggles with the current healthcare system, and he is on the board of directors of the New York Metro Chapter of Physicians for a National Health Program.

And I would urge my colleagues to Google Dr. Nahvi. He has some really interesting and compelling videos that highlight some of the inadequacies of the current system. We are happy to have you here.

STATEMENT OF DR. FARZON NAHVI, EMERGENCY ROOM PHYSICIAN

Dr. NAHVI. Thank you, Chairman McGovern, thank you, Ranking Member Cole, for inviting me to be here today. My name is Farzon Nahvi. I am an emergency medicine doctor in New York City, and I support Medicare for All.

As an ER doctor, I have the opportunity to help all sorts of people in all sorts of ways. I get to save investment bankers from heart attacks and strokes, and I get to help homeless veterans from hypothermia in the winter. And that is what I love about my job. The idea that I could help any person with any problem at any time is what attracted me to emergency medicine in the first place.

But over the years, I have learned that it becomes impossible to care for someone when our medical system forces them to fear things like bankruptcy and foreclosure when they decide to seek medical care.

Now, if you ask any ER doctor, any ER nurse, or even any ER janitor in this country, you are going to hear countless, countless stories of people who came into the hospital to seek medical care only to walk out in the middle of the treatment AMA. AMA stands for against medical advice. And people often walk out against medical advice often because they are concerned about the cost of their treatment.

The reality for many people in this country is that seeking medical care means weighing one's health against one's wallet. Now, everyone in this room is very smart. Everyone in this room already knows all the statistics. You already know that 41 percent of Americans have skipped a visit to the ER in the past 12 months because of cost concerns.

That is easy to gloss over, but we should let that sink in. That is 41 percent of Americans. Over two in five Americans have skipped a visit. They felt that they needed to go to the ER, but then they decided not to go seek medical care because they were concerned about the cost of that visit.

You also already know that 45 percent of Americans live in fear that a health event could lead to bankruptcy. But I see these num-

bers every day on the ground level. I have to look these patients in the eye, and I want to put some faces on those numbers that you all already know so well.

A few weeks ago, I took care of a patient who I was sure had appendicitis. I recommended a CAT scan. We discussed IV antibiotics and possibly a surgery. But a short while later, this patient flagged me down, she pulled me aside, she asked me to pull out her IV because she wanted to go home.

Now, she wasn't stupid. She wasn't crazy. She didn't distrust doctors or anything. The patient just was concerned about the cost of her treatment. She did some research on her phone. She learned that in some rare cases appendicitis can be treated with antibiotics alone. She asked me if I could give her a prescription so that she could go home.

Now, you don't need to be a doctor to know that this is far, far, far from the standard of care for appendicitis. All cases of appendicitis need a hospital admission, IV antibiotics, and probably a surgery. I told her that there were way too many things that could go wrong with her plan and I strongly advised against it.

Now, she asked about me about the risks and I told her the truth. I told her about the possibility of an abscess formation, perforation of her bowels, sepsis from infection, and even death. This is not an exaggeration. This is just the truth of what happens when you don't treat appendicitis.

She sat back. She asked me for some time. She thought about it for a long while, but eventually she flagged me back down. She decided to leave. In her own words, she said, thanks, Doc. I appreciate all you have done. I really do, but I just don't know if I am going to be able to afford this. I am going to go take my chances.

Now, in my line of work, I often have to give people really bad news. I often tell loved ones that their family members have died. I have had to tell parents that their child has died, children that their parent has died. I have had to tell spouses that their husband or wife has died. But I can tell you with complete sincerity that watching someone sick walk out of the door with something that is completely treatable right here in the richest country in the world is just as awful a feeling as any of those conversations.

About 1 year ago, I took care of a young lady who came in for an overdose on fish antibiotics. She had a fever. She couldn't afford an ER visit, so she decided to go to her local pet store to buy some fish antibiotics for her symptoms. She had had a job interview coming up, and she wanted to make sure she was better for that interview.

Now, of course, fish antibiotics come as a packet of powder. You put them in a fish tank so the fish can eat it. There are obviously no instructions for human consumption. She ended up overdosing by an order of magnitude. She had side effects that affected her brain and her central nervous system. She fell down a staircase while she was on that job interview actually and she had to be admitted to the ICU, all of that because she felt like she couldn't afford a simple visit to the ER for a simple fever.

Twenty-one years ago, when she was 10 years old, my fiancée, who is here right now, she lost her mother because her mother decided to delay medical care for her abdominal pain until only after

her stomach cancer had already spread beyond any hope for treatment. A housekeeper raising two daughters, my fiancée's mother was worried about the cost of her care, and she paid for it with her life.

I am here today because my patients and my fiancée deserve better than this. These stories and countless, countless, countless others are absolutely ridiculous to be taking place right here in the richest country in the world.

I am not asking for much. All I want to do is practice medicine in a world where I no longer have to watch a patient walk out of the ER without medical care that could save their life because they are worried about going bankrupt. And I never want to see another patient who thinks their best option for medical care is to go to their local pet store. To simply treat someone for a problem as simple as appendicitis in 2019 or to have my human patients take human antibiotics from a human pharmacy are absolutely not radical ideas.

From my perspective on the ground, the solution has to involve approaching medical care in just the same way we approach educating our children, maintaining our roads, or supporting our armed forces. All this means is treating healthcare like any other public good, creating a universal healthcare system like Medicare for All, so that when they are at their most vulnerable, my patients never have to make any consideration except simply to do what they need to do in order to get better.

Once again, thank you Chairman McGovern, Ranking Member Cole, and the Rules Committee for inviting me to be here. I am looking forward to any questions.

[The statement of Dr. Nahvi follows:]

Thank you Chairman McGovern and thank you Ranking Member Cole for inviting me to be here today. My name is Farzon Nahvi. I'm an emergency medicine doctor in New York City and I support Medicare for All.

As an ER doctor, I have the opportunity to help all sorts of people in all sorts of ways. I get to save investment bankers from heart attacks and homeless veterans from hypothermia.

That's what I love about my job – the idea that I can help anyone with any problem at any time is what attracted me to medicine in the first place.

But over the years, I've learned that it becomes impossible to care for someone when our medical system forces them to fear things like bankruptcy and foreclosure when they seek medical care.

If you ask any ER doctor, nurse, or janitor in this country, you will hear countless stories of patients who came to seek medical care only to walk out in the middle of their treatment "AMA," or against medical advice. They often walk out Against Medical Advice out of concern for the cost of their treatment.

The reality for many people in this country is that seeking medical care means weighing their health against their wallet.

You all already know all the statistics. You already know that 41% of Americans have skipped a visit to the ER in the past 12 months because of cost concerns. And you already know that 45% of Americans live in fear that a health event could lead to bankruptcy.

But I see this every day on the ground level, I have to look these people in the eye, and I want to put some faces on those numbers that you all already know so well.

A few weeks ago, I took care of a patient who I was sure had appendicitis. I recommended a CT scan and we discussed IV antibiotics and possibly an operation. But a short while later this patient pulled me aside and asked me to pull out her IV so she could go home.

Now, this patient wasn't stupid. She was not crazy. She did some research on her phone learned that in some rare cases appendicitis can be treated with antibiotics alone and without an operation, and she asked me if I could just discharge her with a prescription. You don't need to be a doctor to know that this is *far* from the standard of care for appendicitis and an incredibly risky idea. I told her that there were too many things that could go wrong and strongly recommended against it.

She asked me the risks of her plan and I told her the truth. I told her about the possibility of a perforation of her bowels, an abscess formation, sepsis from her infection, and even death. This wasn't an exaggeration, this was the truth. She sat back, asked for some time, thought about it

for a long while but she eventually did decide to leave. In her own words she said, "Thanks doc, I appreciate all you've done, but I just don't know if I'll be able to afford this -- I'm going to take my chances."

In my line of work I often have to tell people that their spouse, their parent, or their child has died -- but I can tell you that watching someone sick walk out the door with something that is completely treatable right here in the richest country in the world is just as awful of a feeling.

About one year ago I took care of a young lady who came in for an overdose on fish antibiotics. She had had a fever, could not afford an ER visit, so decided to go to a local pet store to buy fish antibiotics for her symptoms. The antibiotics came as a packet of powder and the directions were designed for a fish tank. There were no instructions for human consumption. She accidentally overdosed by an order of magnitude, the side effects ended up affecting her brain, she ended up falling down a staircase while on a job interview, and needed to be admitted to the ICU.

Twenty one years ago, when she was ten years old, my fiance lost her mother because her mother decided to delay medical care for her abdominal pain until only after her stomach cancer had already spread beyond any hope for treatment. A housekeeper raising two daughters, my fiance's mother was worried about the cost of her care and she paid for it with her life.

I'm here today because my patients and my fiance deserve better. These stories and countless others are absolutely ridiculous to be taking place here in the richest country in the world.

All I want is to practice medicine in a world where I no longer have to watch a patient walk out of the ER without medical care that could save their life because they are worried about going bankrupt. All I want is to never see another patient who thinks their best option for medical care is to go to their local pet store. To simply treat someone for a problem so simple as appendicitis and to have human patients take human antibiotics from a human pharmacy are not radical ideas.

From my perspective on the ground, the solution has to involve approaching medical care in just the same way we approach educating our children, maintaining our roads, and supporting our armed forces. This means treating healthcare like any other public good and creating a universal healthcare system like Medicare for All so that when they're at their most vulnerable, my patients never have to make any consideration except to simply do what they need to do in order to get better.

Once again, thank you Chairman McGovern, Ranking Member Cole, and the Rules Committee for allowing me to testify. I'm looking forward to any questions you may have.

The CHAIRMAN. Thank you all very much for testifying. Before I ask some questions, I have a few unanimous consent requests I want to add into the record.

You know, our healthcare system is built with checkpoints that more often than not prohibit a person from being able to access healthcare, including preauthorization requirements, lifetime limits, network restrictions, cost, and the inherent discrimination built into the system.

Without objection, I would like to submit a letter from the National Nurses United, an organization with 150,000 members. Their letter explains how gatekeeper obstacles would be eliminated with this bill.

And I would like to thank Jean Ross, president of the National Nurses United, who is with us here today, for her leadership and her work in ensuring that every American has access to affordable healthcare in this country. Jean is here in Washington, D.C., with the nurses from 28 different States advocating for Medicare for All. We want to thank you.

[The document is printed at page 187]

Without objection, I would like to submit in the record a letter from Diane Archer, the founder and past president of the Medicare Rights Center, which is a national nonprofit consumer service organization. In her letter she brings to light the serious concerns with Medicare Advantage and how Medicare for All, an improved and expanded Medicare system, can fix these problems.

And, you know, a child's access to healthcare is crucial. They are going through a time of rapid brain and body development, and it is important that their health coverage reflects their needs. Yet a recent survey by Georgetown Center for Children and Families found an increase in uninsured children for the first time in a decade.

[The document is printed at page 220]

Without objection, I would like to submit a letter from The Children's Partnership, a California-based nonprofit child advocacy organization working to ensure that every child has access to healthcare.

This letter outlines the critical components of health coverage and care for children that should be addressed in any policy Congress considers, including Medicare for All. And I would like to thank Mayra Alvarez, president of the Children's Partnership.

[The document is printed at page 227]

Hearing no objection, those documents will be added to the record.

The CHAIRMAN. Let me begin my question. Mr. Barkan, let me ask you a question and then I will come back to you in a minute for the answer. But you know a little bit about how health insurance companies deny claims. And you testified that your medical bills cost thousands and thousands and thousands of dollars a month. You also talked about the time commitment it takes to fight back against these denials.

My question is, what are some of the services or medical devices that were denied by your insurance company? And how is your life impacted by not having those services? And I will go to the next question then come back to you, Ady, in a minute.

Let me say to Drs. Baker, Blahous, and Collins, you are all economists. Tell me, are economists always right?

Mr. BLAHOUS. No.

The CHAIRMAN. I mean, no, right? Yeah. I mean, you should try being a Member of Congress. We are always right, right.

But seriously, though, let's look at the studies. You know, even looking at Dr. Blahous' study from the conservative Mercatus Center, it seems like the studies suggest that Medicare for All could cost a little more or a little less than we are currently paying now, right. Getting that right?

Mr. BLAHOUS. I think that is fair.

The CHAIRMAN. All right. So worst-case scenario, we could spend about what we are spending now nationally on healthcare and guarantee that another 29 million people get healthcare coverage, we could end crushing out-of-pocket costs for everyone, and we could include new services for seniors and the disabled. I mean, that sounds like a pretty good deal to me.

When we have all these warnings about the high cost, I mean, we are spending an awful lot on healthcare right now, and we are not getting the services and the effectiveness that we are all demanding. And so I just want to put that out there because I think that it is important for people to put all this in perspective. We are not talking about all new costs. We are talking about costs that were already built into the system.

Dr. Baker.

Mr. BAKER. If I could just throw a quick point in on your point about comments not being right. You know, I think the Affordable Care Act hasn't gotten as much credit as it should for reducing costs. And, again, one could argue how much it deserves credit for the slowdown in cost growth, but if you go to 2008, the projections from the Center for Medicare and Medicaid Services for 2017 compared with what we actually spent, we spent 1.5 percentage points of GDP less on healthcare than what they had projected. So that comes to \$300 billion that year.

Same thing if you look at the CBO projections. We are spending half a percentage point of GDP less on Medicare than what they had projected in 2010 before the bill passed.

Now, whether you want to say the Affordable Care Act was responsible for all that slowdown, that is a totally arguable point. But the point was we are actually doing pretty good in terms of slowing the course of healthcare cost growth with, even as we increased government involvement.

The CHAIRMAN. Dr. Collins.

Ms. COLLINS. I just wanted to—my testimony covers the range of estimates that are currently out here, including Dr. Blahous'. And what you do see is exactly what you said. Some estimates show a decline in national health expenditures, some show an increase in national health expenditures. It depends crucially on savings that we can potentially get from lower provider prices, from prescription drug costs, from administrative costs.

But I think what one of the major contributions of the Medicare for All bills is putting the issue out there on how much we are paying providers right now. I think that is a really critical issue. It is

why we do see some savings in some of the estimates that we have seen of the Medicare for All bills.

It is a conversation that the country needs to have right now, and the differences and the changes in expenditures under these approaches put a fine point on that issue.

The CHAIRMAN. Look, all of us here, as Members of Congress, we do casework too, right. And we get an inordinate amount of casework that is healthcare related, and it is always about fighting with insurance companies, right. It is always about crippling costs.

The point I am trying to make is that I would like to think we all believe we can do better. I am simply saying, when people push the panic buttons on cost, I mean, we are spending an awful lot right now and we are not getting the result we want.

And to me, Medicare for All offers a better way to go forward and it gives us more care. And by the way, for senior citizens, it gives them Medicare plus. Seniors get a lot more than they are getting right now.

I don't know, Ady, are you ready to—all right.

Mr. BARKAN. First of all, my plan doesn't cover long-term care, and so we have to pay for 24-hour care, which is incredibly expensive (sic). In addition, my insurance company, Health Net, denied me a breathing-assist machine. Health Net ruled that the ventilator and medicine provided by my neurologist was not necessary and that I would have to pay full price. The company also denied me a brand-new FDA-approved medicine to treat ALS.

The first time I had to complain publicly and generate an outcry for them to reverse their decision. The second time I had to organize a protest at their headquarters. But most people don't have the ability to do that, and nobody should have the obligation to do that. But this is a big part of how insurance companies make their money. They deny, delay, and wait for patients to give up.

I believe that approximately one-quarter of claims are denied. As a result, people get sick, get sicker, and die. Fundamentally, the priority for health insurance companies is to make a profit, but that is not in the public interest. By getting the profit motive out of the healthcare industry, we can refocus on the real priority: delivering high-quality healthcare.

The CHAIRMAN. Thank you.

Dr. Nahvi.

Dr. NAHVI. I just wanted to piggyback on that. I do think when health insurance companies deny claims, that it is not only unethical. I just want to share a couple of examples of when it is just financially stupid as well.

I have a couple cases I will share real quick. In my hospital recently there was a 28-year-old female, she came in with a regular, run-of-the-mill urinary tract infection—super easy to treat with a course of outpatient antibiotics. No problem.

She was denied that claim for the antibiotics. No good reason was given why but she was charged \$300 over the counter in cash. She couldn't afford that. She ended up going to the other side of the pharmacy, ended up buying some cranberry juice because she thought that might be her best option to treat her UTI.

She ended up coming into the hospital 2 days later, septic, with a fever, high heart rate, had to be admitted to the hospital and get

IV antibiotics. We denied her \$300, but now we are paying thousands of dollars for that.

There is another example I had. I had a patient that came in, he was having a heart attack. His cardiologist came down, recognized him, and started yelling at him and said, why did you stop taking the antiplatelet medication that I told you you cannot stop taking?

He said, 6 months ago, I was admitted to the hospital with complications from my diabetes medications. My endocrinologist told me I can't stop taking those. I had to make a decision. I couldn't afford both of them, so I stopped taking my antiplatelet medications. He ended up coming back in with a heart attack.

Because we insufficiently covered these patients' prescription medications, we ended up paying more in the long run.

Another example. There is a patient I had, she was 38 years old. She had a long history of depression. Her depression was controlled with some psych medications. She had been on these medications for many years. Out of nowhere, her medical insurance company started denying that medication. She stopped taking them. She couldn't get in to see her psychiatrist for another month or two. So she ended up coming in because she was feeling suicidal and had to be admitted to the hospital.

All three of these cases these patients had bad medical outcomes, and that is horrible in and of itself. But it is just—financially it doesn't make any sense. We ended up paying more for these bad outcomes, and that needs to be a part of this discussion as well.

And when we talk about all these estimates of cost, I imagine that the kind of cost savings we would see by making sure patients are covered and fully covered, we don't really see that in these numbers because there is no way to really account for what we are seeing on the ground level. This would save a lot of money.

The CHAIRMAN. Dr. Browne.

Dr. BROWNE. Yes. Well, certainly in the oncology area we see this, most particularly with people of color, because, one, they have a fear of going to the doctor to begin with, and so they will deny that that lump is there and think it is going to go away, in many cases will say I will pray it away. But when they finally come in after being denied several times, it is advanced disease and they require much more care that is much more costly, but the outcome is negative because they tend not to survive.

The CHAIRMAN. Mr. Barkan, let me ask you a question and then I will come back to you. You indicated, again, you are paying all these thousands of dollars worth of medical bills. And that you have turned to a GoFundMe page online, the online fundraising website to help you cover the cost.

If you didn't have GoFundMe, what other household costs or family bills might not get covered to cover your care? You know, you are a pretty popular guy. Even I have seen your Twitter feed and know all about your work. Relying on GoFundMe might be something that someone of your stature can do, but not everybody could do that.

What if you don't have the Twitter following you have? How would you afford the care? And do you think there is anything sane about our GoFundMe healthcare system?

While you think of that answer, let me go to Dr. Browne and Nahvi. Based on your testimonies, I am guessing that these stories of insurance companies denying care isn't surprising, right.

Dr. Browne, you are a cancer specialist. Can you tell the committee how a prepaid system like the military compares to a post-paid system like the one for the civilian population, and how it differs when it comes to patients getting the care that they need and actually following the doctor's best medical advice?

And, Dr. Nahvi, you testified about your patients who put costs before their healthcare out of necessity or fear, and you have told some really horrible stories here. Do you believe that you are free to practice the best medicine you can, that your patients are free to take your advice without fear, or do you think that there is something standing between you and your patients getting the care that they deserve?

Dr. BROWNE. Yes. Well, in the prepaid system in the military as a military provider, whether it is cancer or general internal medicine, it is an equal access system, and we do not have to be concerned with can that patient afford an MRI or should I just order an X-ray.

Again, I know that the best possible care is what I can provide for those patients, and so I order the MRI and get the best care for those individuals so they don't look at, do I have a copay? Is it some out of pocket? They go to that facility in the integrated system and they get the best care.

If you are outside, you weigh that. Maybe I should see if a CAT scan will suffice and I can still see the dimensions of this mass and its distinguishing features to whether I should order surgery.

If the patient cannot afford for even a CT scan, then I look at what are the other kinds of things that I can order to get that patient to the care that they need. And that is not the way I was trained to practice medicine. You go in to provide the best possible care for those patients. And it is not based upon costs, it is based upon need so that you can improve the health outcomes.

The CHAIRMAN. Dr. Nahvi.

Dr. NAHVI. I couldn't agree more. The answer to your question is, no, I don't think I am practicing the best medicine I can practice. I feel like I am practicing with one hand tied behind my back. I feel like every time I—not every time, but oftentimes when I recommend something to my patients, they sit down and they think, can I afford this? Should I do it? Before they decide whether to do it or not.

And these are lose-lose conversations. I feel like if I try to tell someone to do something and they say, no, I don't know if I can afford that CAT scan and they walk out, their health suffers.

But even if I convince them, I don't feel terribly good about myself. If I convince someone to get a CAT scan that they are not sure they could afford, we might be taking care of their health, but I walk away thinking, did I just kind of sentence this person to years of debt that they are not going to be able to pay off? So there is no winning a lot of these conversations, and I am not giving the best care.

The CHAIRMAN. Thank you.

Mr. Barkan.

Mr. BARKAN. If I couldn't use GoFundMe, I would probably start by asking my parents to start spending down their retirement savings. Then we would go hat-in-hand to friends. Nobody dealing with a serious illness should have to do either of these things. We should instead have a rational, fair, comprehensive social safety net that actually catches us when we fall.

The CHAIRMAN. Thank you.

Mr. Cole.

Mr. COLE. Thank you very much, Mr. Chairman.

And if I may, I am going to follow your lead here, and I want to submit a letter, without objection, from the American Hospital Association in opposition to the legislation.

The CHAIRMAN. Without objection.

[The document is printed at page 230]

Mr. COLE. Thank you very much, Mr. Chairman.

If I could, Ms. Turner, I will start with you. H.R. 1384 explicitly makes it illegal for private health insurers to provide for service that the government would provide under this legislation. How many people would lose their current health insurance that they have if we did something like that?

Ms. TURNER. Nearly everyone would lose the current health coverage they have, including the 173 million Americans with job-based health insurance. In addition, those with ACA coverage, seniors and others on Medicare, those on Medicaid and the Children's Health Insurance Program all would be reassigned to the new Medicare for All program.

Mr. COLE. So under this legislation, really, if you liked your plan, you liked what you had, you would have any option at all to keep it?

Ms. TURNER. Only if you are covered under the VA or the Indian Health Service, as I understand it.

Mr. COLE. Well, believe me, a lot of people in the Indian Health Service might want to make this change. That is another issue.

Ms. TURNER. Oklahoma is——

Mr. COLE. Yeah. That gets to what Congress does and doesn't do in that service.

But anyway, let me ask you this in followup to that. How would this impact both employers who provide the coverage and employees who are satisfied with what they are actually receiving?

Ms. TURNER. I think this is a significant issue. Colorado considered a ballot initiative in 2016 to create a single-payer system for the State. There was serious pushback from people who had not understood at first that it meant that they would lose their private coverage, including employer coverage.

The employer-based system is a central pillar in our health sector for a number of reasons. Employers are able to help their employees access care by offering them different health plan options. They listen to their employees, what benefits they need, and what matters to them. Employers are always trying to balance costs and benefits to get the best deal for their employees. Many also offer wellness programs. They know that a healthy workforce is beneficial. They invest a lot in their employees.

But I think there are two other points that are really crucially important. One is that employer plans pay higher rates to hos-

pitals, doctors, and other providers to make sure their employees have access to the care and the treatment they need.

Medicare—and Medicaid—underpay for health care, but because employer plans pay more, those on public programs still are able to access care. So part of the value of the employer-based health insurance system, covering 173 million people—half of the population of the country, including retirees, workers, dependents, et cetera—is helping to support the current Medicare system.

Also both employers and employees get a tax break: health insurance is part of the compensation package companies offer their employees and therefore is deductible, and for employees, the value of their health insurance is excluded from their income.

My colleague, Doug Badger, says that the value of employer-sponsored health insurance was about \$991 billion, almost \$1 trillion, in 2016, and the tax break is worth about \$350 billion to support employer-based health insurance. So that tax break supports 3 to 1—and some estimates are even higher—health insurance for half of the country.

Our robust employer-sponsored insurance system, which has evolved over 70 years in this country, is unique to America. We started on this path through some permutations of history, but it is something that people enormously value and has become a central pillar in our health sector.

Mr. COLE. Well, your answer actually anticipated a lot of my next question, but let me put it to you this way and get your response on this as well. If we, as this bill calls for, held the reimbursement rates for providers at Medicare and Medicaid levels, how would that impact the providers? What—how—what do you think the response would be?

Ms. TURNER. I am not an economist. I am a policy person. But the former actuary for CMS anticipated, when Congress was considering and actually enacted cuts to Medicare providers, that if hospitals and physicians were to see 40 percent payment cuts, many of them simply could not keep their doors open. They do not have that kind of a margin. They would either dramatically curtail services or they would wind up closing their doors, and you would have many fewer physicians in practice.

Mr. COLE. Well, fortunately, you are sitting right next to an economist, so I am going to ask Dr. Blahous for his response to the same question.

Mr. BLAHOUS. Well, I think the honest answer is that the effects are unpredictable. We do know the data. We know the data indicates that Medicare payment rates for hospitals over the time window, first 10 years of Medicare for All, Medicare payment rates are a little bit more than 40 percent below private insurance rates. For physicians, they are about 30 percent below at the beginning of that 10-year period. But those relative reductions under the MACRA law become even steeper, so they would be about 42 percent by the end of 10 years.

And the honest answer is we have no idea how providers would respond to this. We do know, roughly, that under the legislation the demand for health services would increase by probably about 11 percent. Other studies have made similar estimates.

And if we make simultaneous very dramatic reductions in payment rates to providers at the same time as this increase in demand, none of us can say for certain how they would respond. We do know from the Medicare Actuary's Office that Medicare payment rates—that the margins on treating Medicare patients are negative for about 80 percent of hospitals. And Medicare for All would extend that situation to the population as a whole. How providers would react to that, what sort of disruptions there might be in the timeliness or quality or supply of health services, we simply don't know.

Mr. COLE. Let me ask you this, because we all know that not all hospitals, you know, are equally profitable or serve populations that are equally affluent. Certainly, in my district we have lost a number of rural hospitals in recent years that have both—they are treating a population that is older, quite often sicker, and enjoys less private coverage, so they rely very heavily on Medicare and Medicaid and they are having a tough go.

Again, if we remove that, it suggests to me the impact wouldn't be equal all across the country. In other words, I think rural areas in particular would really take a pretty hard hit unless something was done to change the rates. Is that a fair—

Mr. BLAHOUS. I think that is fair. And I—just to add an additional perspective on this, from the vantage point of my study, my main reason for flagging this issue is primarily just to help with understanding of the numbers.

We have a set of cost estimates that would arise if you assume that these very dramatic payment reductions were implemented right from the get-go, right in the very first year. But if you look at the historical patterns of congressional behavior, you do not see a willingness to impose sudden cuts for providers or anything close to that magnitude.

And if you think those historical patterns of congressional behavior were to continue, the cost estimate for the legislation would be much, much higher. It would be more in the area of \$38 trillion rather than \$32.6 trillion.

Mr. COLE. Let me ask you this, and I am going to address this to all of you, if I may. We will just start actually down here and go across. This is an enormously complex undertaking that we are talking about to change the entire healthcare system. I lived through one of these things as many of my colleagues did, the discussion, debate, and then the implementation of ObamaCare, the ACA.

Is 2 years a sufficient period of time? Because that is what the legislation calls for, as I understand it. Within 2 years, we would make this entire transition. Is that a realistic—even for those of you that want to go in this direction, I worry about the timeframe, so—

Mr. BAKER. Well, I would just say that you would have to be cautious. Two years is certainly very ambitious.

I just want to add quickly, if you are referring to your hospitals as largely rural and they already have a large number of Medicare patients, if that is the case, they are less likely to be a danger because they are already getting reimbursed at Medicare rates.

Mr. COLE. Well, they also get private payments as well.

Mr. BAKER. Understood, but it is a smaller share.

Mr. COLE. But if every patient they treated was at Medicaid and Medicare levels, I promise you, most of them would close.

Mr. BAKER. Well, I can't comment on the specific providers in your district. That may well be true.

Ms. COLLINS. I think the transition issue, you can certainly decide to extend it, make it a longer period of time. The ACA was a 4-year transition period, so that certainly is something that you could consider.

I did want to address the cost shift argument in the Medicare payment area. The evidence really does not show that the reason that private provider prices are higher is because Medicare prices are so low. If that were the case, we would see consistently higher margins all the way across the country. Instead, we see a lot of variability across the country.

So the way this works is that private providers are negotiating with commercial carriers' prices that work the best for them. In concentrated markets, they get higher prices, and insurers want them in their network, so they concede to those higher prices. They then take that negotiated rate to employers. Employers then have to pay higher premiums. They reduce their workers' wages. They increase deductibles. So those costs get shifted ultimately to people.

So there is really not a lot of evidence that the cost shift argument is a reason for higher prices. It is really these non-transparent price negotiations that occur in the private market.

Mr. COLE. Dr. Browne.

Mr. BARKAN. Representative, may I please—

Mr. COLE. Oh, yes. Absolutely.

Mr. BARKAN [continuing]. Respond to the employer issue you asked earlier?

We don't expect employers to provide their workers with education for their children or with fire insurance. There is no reason to tie healthcare to employment. It just exacerbates the negative impact of job loss, and, frankly, it is a huge burden on employers.

Mr. COLE. Thank you.

Dr. Browne.

Dr. BROWNE. Yes. I just wanted to add, in terms of people of color, the Medicare and Medicaid reimbursement cost is not the same across the board, so our providers are already getting a lower rate. It is not likely that they are going to go out of business.

And in terms of employers and the amount that is being paid, many of the smaller businesses go to part-time individuals so that they do not have to carry that cost. And so, again, I think for providers that we are concerned about, they are not going to walk out on taking care of their patients even though they are getting a lower rate.

Mr. COLE. Dr. Nahvi.

Dr. NAHVI. Sure. I assume you are asking the question from an implementation perspective. But from a physician perspective, we are ready for this not in 2 years but 2 years ago. I am ready to stop seeing my patients not get good care because they can't afford things.

Mr. COLE. Thank you.

Mr. BLAHOUS. And I will answer the question, as I am answering every question, from the Federal cost perspective. When I did my study, I was dealing with a bill that had a 4-year transition and was not able—did not feel myself able to score the effects during that 4-year transition period because very unpredictable factors like transition costs, voluntary buy-in rates, things like that.

And so for simplicity's sake, I assumed that in that fourth year, everything just instantly sprang forth fully formed, that we instantly had administrative cost savings, we instantly had a level shift downward in prescription drug costs, that we instantly had the full implementation of these provider cuts.

So you could look at that and you could say, well, those might be reasons why the lower-bound estimate, even assuming a 4-year transition, would be an understatement. If you had a 2-year transition, obviously that increases the likelihood that the lower-bound estimate is a gross understatement, because there is probably very, very little chance that we would be able to attain those instant administrative cost savings, those instant drug cost savings that I am assuming in the lower-bound estimate.

Mr. COLE. Ms. Turner.

Mr. BARKAN. Representative, may I please weigh in on the transition issue?

Mr. COLE. Let me let Ms. Turner. I have very limited time left, and then I will come right back to you, if I may.

Ms. TURNER. Mr. Cole, there is an excellent article in today's Washington Post about Vermont's experience that is both relevant and instructive. Reporter Amy Goldstein took an in-depth look at Vermont's experience in trying to create a single-payer healthcare system for the state—Green Mountain Care. Leaders worked for 4 years and were unable to figure out, for the small State of Vermont, how to structure it, how providers would be paid, and how to collect enough taxes to pay for it.

The initial cost projections took what Goldstein calls "a 36,000-foot view" of what the costs were going to be. But when they got into the hardwiring of implementation, they found that the costs were going to be so high that it would be highly disruptive to the State's economy and so disruptive to the current structure of their healthcare delivery system that they had to pull the plug on it. She wrote that Vermont ultimately found it would be very difficult to dismantle one healthcare system and replace it with another.

Mr. COLE. May I—

The CHAIRMAN. Yeah, absolutely.

Mr. COLE. Okay. Mr. Barkan, please.

Mr. BARKAN. Here is what I know for sure: I needed Medicare for All to be in effect yesterday. If the richest nation in the history of the world really decided to, we could guarantee healthcare as a right and we could probably do it more quickly than people think. But the problem is that right now, we are not even trying. Too many people in the halls of this building are fine to accept the status quo that leaves people like me behind.

Mr. COLE. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

I want to yield myself a minute here to make a couple of points to amplify Ady's point. Employer-sponsored healthcare means the effects of job loss are amplified. It also puts a huge burden on employers. Imagine if we expected employers to provide for fire insurance, as was mentioned, police insurance, school funding for K-12, and the paperwork that is all part of that. It is insane.

And just one other point here, because I think some of us are looking at this whole initiative from a different perspective. People aren't going to lose their healthcare with Medicare for All. I mean, you would actually get to keep your doctors and go to your hospitals that you currently have. The only difference is you wouldn't have to deal with insurance companies. And I don't know about you, but that is not my favorite thing to do when I get sick.

I now yield to my good friend, Mr. Perlmutter.

Mr. PERLMUTTER. I just want to thank this panel, everybody. The professionalism in your testimony is very much appreciated by this Congressman and I know the Rules Committee generally.

Mr. Barkan, a couple questions for you. You know, you talk a lot about time. Another guy in a chair like you, Stephen Hawking, he wrote a number of essays on time, but time is really a key piece to all of this. And you talked about a number of things, you know, the effect of taking time and the waste of time on you personally. So I would like you to maybe expand on that a little bit.

And then you also said we could save enormous sums of money. I would like you to expand on that. And then you said we could avoid immoral price gouging. I think those were your words. So I am just putting those three things that you talked about, I would ask you to expand.

Now, to the economists, I would like to just talk a little bit more about the money that is in the system, in the healthcare system—it is the biggest part of our economy. In its own right, the healthcare system, 19, 20, 21 percent, 18 percent, whatever it is, it is far bigger than anything else.

So my first question, I guess, to you, Dr. Baker and Dr. Collins, is how does that percentage of our overall economy compare to the rest of the world, other countries, industrialized countries?

And, I guess, to all of you, and, Dr. Blahous, you as well, the overall savings that we might expect from something like this—and, you know, there was an economist, Bob Pollin, and sort of his approach to these things, because it is a massive change. And why do we want to undergo a massive change if we are not going to save some money and have better outcomes for patients? And I will get to you doctors, you medical doctors in a second to talk about the outcomes.

And then, Ms. Turner, just so you know, I am going to talk about Colorado, so I will tee that up for you.

Mr. BAKER. Okay. Well, we spend about 18 percent of our GDP on healthcare, and that is roughly twice the average from the OECD. You have a range. If you take a lower-cost system like the U.K., we could finance that whole system from what we spend now in the public sector. That is how much we are out of line with everyone else.

And, you know, the point that I think is striking, on the one hand, we have huge administrative cost, but the other point that

I was trying to emphasize in my both comments and my written testimony, we pay twice as much for all the inputs, so twice as much for the drugs, for the medical equipment, for our doctors, on down the list.

And, again, that is not true of our cars. It is not true of our auto workers. So you are sort of hard pressed to say why do we have to pay twice as much for drugs as everyone else? We don't pay twice as much for our—you know, our cups here and our cars, but we do. And that, I think, speaks to the enormous potential savings.

Again, I understand none of that is easy. You are the ones that have to fight with these people, because these excess payments—that is income for people. But if we just make the comparison, what does it look like, the U.S. compared to everyone else, we are paying twice as much on average.

Mr. PERLMUTTER. Dr. Collins.

Ms. COLLINS. I would just echo Dr. Baker's comments. And we have a—there is a chart in my testimony that shows all the detail on the countries that pay so much less than we do. And—but I would also make the point, that we also don't get commensurate outcomes for the spending that we are making. So we actually have worse outcomes in a number of areas than other countries that are spending far less. So the quality issue is a huge issue internationally as well.

Mr. PERLMUTTER. And, Dr. Blahous, and I appreciated your testimony when Mr. McGovern was asking you some questions about, you know, ultimately it is kind of a push, maybe it is a little bit of a loss, maybe a little bit of a gain. This Dr. Pollin, I guess, economist from University of Massachusetts, thinks that there is a big savings. Do you have any comments on that?

Mr. BLAHOUS. Well, sure, if I could try to unpack it a little bit.

Mr. PERLMUTTER. Sure.

Mr. BLAHOUS. And I want to build off some of the things that Dr. Baker and Dr. Collins have said. I think it was well stated by Dr. Baker that most of the costs from the Federal perspective are a shift. They are a shift from costs now being borne by the private sector to the Federal Government. I would add to that that the Federal Government would also be assuming costs that are currently borne by State and local governments. So it is not just the private sector, but it is all of that.

Mr. PERLMUTTER. Right.

Mr. BLAHOUS. It is primarily a shift. That is the biggest piece of the Federal cost.

Now, there are other things that would increase the cost beyond that. And I thought Dr. Collins said something earlier that I thought was very useful, where she said basically the total national cost increase would be less than the utilization increase. So in other words, the biggest part of this cost increase is an increase in service demand and utilization.

Now, maybe we can cut into some of that increase by savings on administrative costs, savings on drug prices, things like that. Now, we wouldn't be able to offset that cost completely with those measures, and that is where the cuts to provider payments come in. The question is, would we be able to cut provider payments enough to offset that additional cost?

Mr. PERLMUTTER. Well, and I think Dr. Nahvi mentioned this, and it is in somebody else's papers, you know, that two out of five people don't take advantage of healthcare, their need for healthcare because of fear of expense, that they walk back out. And he gave some dramatic examples. So in effect, you know, there is a lot of demand that is not being met because people are afraid of the cost.

So I was a bankruptcy lawyer for many, many years before I was elected to Congress, and obviously one of the biggest areas of bankruptcy is because of healthcare costs. So I do appreciate your comments, Dr. Nahvi, when you said, yeah, I may convince somebody to stay there, but now have I saddled them with some debt that could cause a bankruptcy or something else.

So there are all sorts of issues here, but I think to Dr. Browne and Dr. Nahvi, and then I would like to get back to Mr. Pollin's kind of estimates, if we were to go to this Medicare for All or universal healthcare system, do you agree that there would be more demand on the system? And can we—could we, from a provider standpoint, manage that?

Dr. BROWNE. Thank you. Yes. I think that there would not necessarily be a demand on the system. I think you would practice medicine in a more appropriate, better way. And the idea is that you are going to increase your educational components for your patients and practice prevention. And if you put prevention into practice, you are not going to have many of those hospitalization visits that will end up in the intensive care units, and so there is cost savings there.

We have not practiced prevention, and we have been talking about it for years and years, and it is just going to the wayside. If we get people to come in and to do their immunizations and get those standard tests of screening, so screening and early detection, find the diseases at an earlier stage and, again, you can then provide that care at a more cost effective—and so the demand is not going to increase. We are practicing care in a more efficient, effective way.

Mr. PERLMUTTER. Dr. Nahvi.

Dr. NAHVI. Yeah. I would like to echo that. So I gave you a couple examples of people that came in, didn't get the care they needed, then ended up having more expensive care. There will be some people that will be using more care, but we are going to be more efficient as well with primary care and other ways to utilize our healthcare system.

As an ER doctor, I see a lot of people come in with late-stage disease because they didn't get to go to their primary care doctor when they needed to and then we end up paying more for that. The reason for that is we have laws, a Reagan-era law called EMTALA in 1986, it is the Emergency Medicine Treatment and Active Labor Act. It makes it such that anyone insured, uninsured, documented, undocumented, whoever they are, they could come to the ER when they need to come to the ER and we treat them. And if they can't foot the bill, the taxpayers foot the bill or the hospital does.

I think if we expand coverage, we get these people utilizing care at the right places. They end up going to their primary care doctors to get their diabetes, high blood pressure, high cholesterol con-

trolled so they don't end up having strokes and heart attacks and coming into the ER for those things.

Mr. PERLMUTTER. Do you think a system like this would help you avoid some paperwork?

Dr. BROWNE. Most certainly.

Mr. PERLMUTTER. Okay. So you could be treating your patients?

Dr. BROWNE. Yes.

Mr. PERLMUTTER. Okay. Ms. Turner, and then I would like to go back to Mr. Barkan. So—and I appreciated your testimony because you really kind of laid it out as to, you know, 70 years ago, it was you paid out of your pocket or you got charity care. And a lot of that charity care was underwritten by the churches, by charitable organizations.

And then Kaiser came along and said people are getting hurt. We have got to do a war effort. And so Kaiser Steel and Kaiser Aluminum and all those guys, they created the employer—they started the employer system. So we are in this massive system, and to change it is obviously a big undertaking. So I agree with all of that.

With respect to Colorado, so I am from Colorado, and I support Ms. Jayapal's legislation and I support the—beefing up of the Affordable Care Act. And I support—there is an effort out there that says for anybody 50 and older, you can buy into the Medicare system. So I think all are improvements over where we are today.

But my question to you on Vermont and on Colorado, just as a voter on that thing, I voted against the ballot initiative because I didn't think Colorado on its own could undertake a Medicare for All system, that it was national in scope, and that is why I went this way. But I am happy to have you comment on it a little bit more.

Ms. TURNER. You know much more about the political debate in Colorado than I do. In Vermont, they were assuming that much of the money that currently is flowing to the State through healthcare, whether it would be employer contributions, ACA funds, existing taxes, et cetera, all would go toward funding the new single-payer system. They also were assuming there would be additional Federal funds coming in through a Section 1332 State Innovation waiver Vermont planned to request. And they still couldn't make it work.

Regarding Colorado, I did several debates in the State about the ballot initiative in 2016, and the feedback that we continually got was from people who were very nervous about losing their current coverage and the taxes that would be required to support single payer. Proponents talked about all of the funds currently supporting employer-based health insurance going toward the new plan, but that just wasn't enough. Studies showed the new taxes required would have significantly disrupted the economy.

Mr. PERLMUTTER. And I think you are right from a policy and a—kind of a political standpoint, it wasn't enough to overcome a number of the concerns and fears. But I think, you know, listening to the testimony of the economists and the doctors and just, you know, our own experience—you know, my wife had a difficult surgery, initially denied. I mean, I can't tell you the panic that hits a family when something like that happens.

You know, so there are all sorts of issues. And I am just pleased that Mr. Cole and Mr. McGovern were able to work out the details so that we could actually have this hearing and get this ball rolling, because I think it is a very important conversation for this Nation to have.

Mr. Barkan, do you—can you answer my questions? Are you ready for that?

Mr. BARKAN. Thanks very much for your questions. This healthcare system only works if you are a pharmaceutical or insurance industry executive who wants to maximize their own profit at the expense of people like me. It is simply unconscionable that I should have to pay \$9,000 per month for lifesaving medical care at a time when the insurance industry is raking in record profit. That is wrong, and it needs to stop.

Here is the thing. It is a huge stress to have to fight with insurance companies over what they will cover. It is a huge financial strain. But most of all, I have come to realize that our time on Earth is the most precious resource any of us have.

I wish I didn't have to be here today. I think you are wonderful Congressmen, but, frankly, I would rather be back at home being with my wife and playing with my son instead of trying to wake the conscience of this Nation's lawmakers.

Every day is precious for me. I don't have time on my side. Americans who are dealing with the everyday realities of their healthcare don't have time on their side. No one should have to fight to be treated with dignity again, and that is why I am here today.

Mr. PERLMUTTER. Thank you. I yield back.

The CHAIRMAN. Thank you very much.

Mr. Woodall.

Mr. WOODALL. Thank you, Mr. Chairman. And thank you for the holding of the hearing and the way you have conducted it so far.

We have a tough time. It may not be obvious to you though, Mr. Barkan, with your reference to awakening the conscience of Congress. It may be obvious to you that we don't always get a good, healthy conversation on issues of this.

I credit the young woman to your right there. Ms. Jayapal is—I cannot support her legislation, but I absolutely support her. And there is a way to have a conversation—I know you are, Pramila. I don't worry.

Ms. JAYAPAL. Open arms, buddy.

Mr. WOODALL. There is a way to have that hearing.

In fact, The Washington Post, I don't know if you all saw the article on you all this hearing. The Washington Post did an article on this hearing and you all as the witnesses and made a point of saying—in fact, they quoted Ms. Shalala saying that we are not going to make ourselves look crazy this morning, was the quote they grabbed.

The Washington Post observed that there are lots of ways to start this conversation and that the chairman and the leadership of the House went out of their way to pick a group of folks who were going to start it on a healthy, productive measure. And I hope you take your role in that with a great deal of pride, as I take the chairman's role in that with a great deal of pride.

I want to start with the numbers. Mr. Blahous, I appreciate what you do, what you did as a trustee. I used to read your work regularly. I read it less now that you are in the think tank world. I read it more when you were in the government world.

My understanding is that our payroll taxes, our Medicare and Social Security taxes are the largest tax that about 85 percent of American families pay. And yet every time I read a report from you or read those reports, and they haven't got any better, is that there is not enough money coming in to do the things that we have promised to do.

I can't believe that I read your testimony correctly, but I want to check it out with you. \$32 trillion over 10 years as the best-case scenario, not for the total cost of Medicare for All but just the addition to the current Medicare program that is already there. Am I reading that correctly?

Mr. BLAHOUS. Yes. That is a lower-bound estimate of the additional Federal obligations above and beyond current Federal health obligations.

Mr. WOODALL. I sit on the Budget Committee, and we are—you know, we are not able to pass a budget out of the Budget Committee because we couldn't even agree as a committee on how to sort out our current challenges, much less future challenges. But it is—it was going to be about a \$4.5 trillion budget, a little under that.

Best-case scenario, \$3.2 trillion annualized over 10 years. Worst but more appropriate scenario is your nearly \$40 trillion number. The worst-case scenario or an expected scenario?

Mr. BLAHOUS. I wouldn't say it is a worst-case scenario. I think, basically, the cost estimate over 10 years would be in the region of \$40 trillion, if you didn't assume any particular targeted savings from Medicare for All.

Of the different categories of potential savings from Medicare for All, I think the relatively most likely is probably administrative cost savings, which would bring the total down to about \$38.8 trillion over 10 years. But depending on your assumptions for provider payment rates, drug costs, things like that, the additional Federal cost would be somewhere between \$32.6 trillion and \$38.8 trillion.

Mr. WOODALL. Help me with that math. Looking at your best-case scenario, your lower bound, everything goes right. What are we talking about in a per-American cost, per-person cost?

Mr. BLAHOUS. Well, this is very crude, but it is about \$10,000 per capita, per person in additional Federal cost.

Mr. WOODALL. \$32 trillion, 320 million Americans? Okay.

Mr. BLAHOUS. So basically—exactly. I mean, \$35 trillion, 350 million Americans, it is about \$10,000 per person.

Mr. Woodall. Okay. That is real money.

And I was listening to your testimony, Dr. Collins, as you were going through some of those numbers and talking about after the Affordable Care Act, things that had gotten better. And I want to stipulate that I agree with everything that you said about increased outcomes.

What wasn't reflected there, though, is whether we got the best bang for our dollar. Of course, if I spend 1 trillion new dollars on healthcare subsidizing American families with their healthcare

costs, when I run a poll that says are your healthcare costs easier to manage today than they were yesterday, folks are going to say yes.

Mr. WOODALL. I don't think that is the right question, though. I think the question is, we agreed to spend \$1 trillion. Are we spending that \$1 trillion in the way that helps the most families do the most for themselves, reduce those stresses that we have talked about?

Have you seen any data along those lines? Not did we do better, but did we do the best we could do, given the enormous resources we invested?

Ms. COLLINS. We can actually do better. Seventeen States haven't expanded Medicaid. So that is one area where we haven't fully implemented the law. There have been some changes to the cost-sharing reduction subsidies in the marketplaces that have bumped up premiums on silver plans, which has hurt some people, but people's tax credits adjust. And actually, the Federal Government is paying a lot more because we are not paying these cost-sharing reduction subsidies.

So, in terms of implementation, there are definitely areas where we could do better. We could extend the subsidies so that people just over that threshold for marketplace tax credits could afford their plans.

But I also want to say too, before—didn't really—

Mr. WOODALL. Let me reclaim my time just for a second, because I understand that if we wanted to improve the Affordable Care Act in its current structure, there are lots of things that folks are doing. In fact, I suspect there are lots of men and women around this table who would rather do that than the Medicare for All plan. That wasn't the question I was asking, though.

My question is, and it goes a little bit to what Dr. Nahvi said. He said 41 percent of folks reported they didn't go to the ER, even though they thought they needed to go to the ER. Every ER physician I talk to says, Rob, we are in a conscious effort to keep people out of the ER. People keep wanting to come to the ER. We don't want them to come to the ER. We want them to go to our urgent care center right next door, because when they come to see us, if they don't really need to see us, we are wasting valuable resources on them in our environment, because it is hyper expensive. We could have served more people in more ways if we could have redirected them.

That is what I am thinking about, maximizing the dollar that we are spending. Let's agree we are going to spend more money, but let's demand the very best of that money.

And I think about that in your case, Dr. Nahvi. How does the Medicare for All plan, as Ms. Jayapal has crafted, what incentive is there than to do what all ER physicians are telling me needs to be done? We got to keep folks out of the ER, get them into urgent care instead. What is the skin in the game that keeps me out of your office?

Dr. NAHVI. There doesn't need to be skin in the game. People want to go to their primary care doctor. They don't want to see me, and, frankly, I don't want to see them. I agree with the doctors you talked to. When a patient comes to me and they want me to adjust

their diabetes medication, because I am the only doctor they could see, because I am the only doctor they could access because I am in the ER—I feel totally comfortable intubating someone, doing chest compressions, treating a heart attack or a stroke or stabbing or gunshot—But I don't feel comfortable adjusting someone's diabetes or high blood pressure medication. That is a primary care doctor's job.

Mr. WOODALL. Your experience is that overutilization in the ER doesn't come from my misunderstanding as a consumer what my needs are; it comes from EMTALA requires you to see me and that is why I show up on your doorstep?

Dr. NAHVI. Yeah. Patients often come in and they will come to the ER, they say, I took my blood pressure at a pharmacy. I went to the Rite Aid, and they had the machine there for free. It was through the roof, so I didn't know what to do, so I come to the ER.

I don't want them there. I want them to go to their primary care doctor. It will be cheaper for them. It will be better for them. It will be cheaper for all of us. It will be better for me. That is a win-win. I don't need to incentivize them. They already want to go there; they just can't get in.

Mr. WOODALL. That is a win-win. I think about that, Ms. Turner, in some of your testimony, about your desire to do better. You have invested a lifetime in trying to move us in a better policy direction.

I was visiting with a small town doc in Georgia. We did not expand Medicaid in Georgia. And he said, Rob, you hand out all the new Medicaid cards you want to if it will make you feel better, but I am the only doc in five counties who still sees Medicaid patients and I can't fit anybody else in my waiting room.

So we are not going to achieve Dr. Nahvi's goal of providing more care. We will just achieve a policy goal of feeling better about what we are doing in rural Georgia as it sits today.

What policy reason is there if I want to achieve Dr. Nahvi's goal of not seeing folks walk out the door because they can't pay for their care? I don't understand the policy reason to take away all of the DOD healthcare system that my men and women in uniform tell me that they love. I don't understand why we have to abolish every union healthcare system that my union members back home say, Rob, I have got the best healthcare on the planet. Why to achieve the goal of serving the underserved is the policy solution to take everything away from people who already feel well-served?

Ms. TURNER. I think that is really a crucial issue. We need to fix the current system rather than blowing it up—because there are a lot of existing programs in the employer community, in TRICARE, in Medicare—to provide coordinated care, to provide better access for people—more humane, more patient-centered care.

If Medicare fee-for-service is used as the model, all that is blown up. And can we create a new system for better coordinated care in 2 years? That would be extraordinarily difficult. I think we have to value what we have, build on that, and solve the problems that we have, not destroy what has worked in a system built over decades.

Mr. WOODALL. Well, even in the Medicare system, in my jurisdiction, I live in a suburban area, and so, we have lots of providers, but more than 40 percent of my seniors have opted for Medicare

Advantage. They have said, I don't want the traditional Medicare system. I have a better option now that you have provided that option. I am going to choose that. And, of course, that goes away, too.

We poison the well of productivity around here on a regular basis, and I want to thank each one of you in your testimony. No one went out of their way to poison the well. And, again, you were chosen for a reason, to get this conversation started. I think we can achieve Dr. Nahvi's goal of not having the underserved walk out on what ought to be an affordable procedure, though I think we can do it without what—Dr. Blahous is virtually doubling the Federal budget, a Federal budget that I am not paying for today, that I am borrowing from others.

What I love about Ms. Jayapal is she doesn't hide from those numbers that you have laid out. She recognizes it is going to be a tremendous increase in tax burden for the country—you can't get to \$40 trillion without that—and believes it is worth it. And that is the conversation that we have to have.

I want to ask, and I will ask the good doctor who has more experience in the military system than most of us do. I don't hear frustrations from my servicemen and women about their quality of care. In fact, what I hear them say is, Rob, because I am deployed all over the planet I have to have something different than what would work in just metro Atlanta in general.

Is it necessary to achieve the goal that you want for America and our healthcare system to abolish that system that we promised our men and women in uniform, or could we keep that system while trying to achieve some other goal?

Dr. BROWNE. I think you can keep that system and build on it. Medicare for All, whatever label you put on it, can be that system. And that is what I am saying. The government is paying for your health services, my health services, Medicare, Medicaid, VA, DOD already. You can duplicate that and label it whatever you want, because you see the efficiencies there.

And particularly when we talk about the goal that Dr. Nahvi is mentioning for the underserved, you have to have the educational component and address the social determinants of health. If you are in an area where there is a food desert and you can't get nutritious food, you can't exercise, you have to have a whole list of prescriptions when they come in to see you and they lay it out.

If you can provide them with preventive care and education, they will become healthier and not need the bag of pills, not need to go to the emergency room, and also, they have an assigned primary care provider that is going to keep them out of the emergency room.

Mr. WOODALL. I am glad you raised that. It is troubling to me, again, particularly given the trillions upon trillions that we are talking about investing here, that we are only talking about treating people after something bad has happened. There is nothing in here that says, what we ought to do is make sure that you are eating better before this happens. Diabetes, as it contributes over a quarter of our healthcare cost, nothing in here that says we need to get to exercise ahead of time. It is all a response to crisis instead of intervening before the crisis. So that is what healthcare professionals see. I don't go to my—

Mr. BARKAN. Representative, may I—

Mr. WOODALL [continuing]. On a good day. I go on a bad day.

Let me ask this, and it goes to what Mr. Barkan said. I think you said 10 percent of American families are grappling with someone who is disabled in their household, the healthcare costs there are related to that.

I do think it is outrageous that GoFundMe is what folks would call a successful healthcare system. I don't call that a successful healthcare system. But what I don't want to do is refocus America's resources away from your family and towards my family, if I am not in the 10 percent that is facing crisis. I want to focus the resources on the families that need them most.

Is it clear from your advocacy and your work that we have to change it for everybody, instead of doubling down on those families that we know—there is not a man or woman who is not touched by your testimony, and who doesn't want to do better for you, not just on this committee, but in this entire Congress. And I worry that we are losing an opportunity to agree on that by trying to take the conversation even broader.

Mr. BARKAN. Representative, may I please weigh in on the cost issue?

Mr. WOODALL. Please.

Mr. BARKAN. One thing I can't help but think about today, Congressman, is how we always seem to find the money for things like tax cuts for the wealthy, and for corporate tax cuts. We never ask where the money will come from when we declare war. We always seem to just find the money. We only ask how we will pay for it when it comes to our health.

This is such a clear problem with such a straightforward solution. We can save taxpayers money, we can save money for families, and we can provide high-quality medical care for every American by doing what every industrialized nation on earth already has.

Mr. WOODALL. If you would indulge me just one moment, Mr. Chairman, I thank you.

I have to disagree with you, Mr. Barkan. And I do worry that that kind of pithy one-liner makes it harder to get to where we need to go. It is not just healthcare that we have this conversation. I live in a district that is a majority/minority district. Twenty-seven percent of my constituents are first-generation Americans.

We have the best education system in the country in our district. So says the Broad Prize that awards us year after year. We pay for that, and it is hard to pay for it. Our taxes are very high, but we make a decision every day. Are we going to have the best education system, or the second best, or the bottom best?

Public housing in this country, Dr. Nahvi referenced that earlier, talking about some of our rights. We have people who live in desperately dangerous communities today, desperately unhealthy communities today, and we are not coming up with the money for those things either, because money is in every conversation.

And I want to agree with you 100 percent, I support a war tax. I think it is absolutely immoral that we have taken the war off of the front page of the paper, and unless you have a family member

who is at risk there. I know the chairman supports that as well, having that conversation and putting skin in the game.

I would share with you, most respectfully, I need you to believe that folks on every side of the aisle care as much about serving men and women in need as folks on any other side of the aisle. It is not a budget dollars and cents issue; it is paying for those things that we value. We value you and we want to pay that.

Mr. Chairman, you have been overly indulgent, and I am grateful.

The CHAIRMAN. But I want to make sure that Dr. Nahvi—he had his hand up, and I want to make sure he gets—

Dr. NAHVI. Yes, I just wanted to pick up on one thing you did say. You said that you talked to the men and women in uniform, and they are usually satisfied with their care. I work at a private hospital, a public hospital, and I also work at the VA as well. And that has been my experience too.

And I think you inadvertently just made a great case for Medicare for All. Our VA system is wonderful. We provide excellent care, and I never had a patient at the VA leave against medical advice because they were worried about the cost of their treatment.

So I think that our men and women in uniform have great care. And it is a federally funded program where the doctors there are employees of the government, and we have a single formulary, and we take care of patients in a great medical way, and also, a financially responsible way. So I do think if it is good enough for our men and women in uniform, it is good enough for all Americans.

Mr. WOODALL. Just so we don't confuse the issue, of course, the VA system stays under the Medicare for All plan. I am talking about the DOD system. Very different conversations I have with veterans about the VA system and DOD families who are serving abroad. But I take your point.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you. Before I get to Mr. Raskin, because I am the chairman and you are the ranking member, we have a little extra time.

Mr. COLE. When did I get that extra time? I am thrilled.

The CHAIRMAN. You do have that extra time. You just haven't used it, that is all. You can yield it back at the end if you want.

But just a couple of points. Just to Mr. Barkan's point about, you know, when it comes to certain things, we don't question money and the cost. When it comes to healthcare, we do. That is just a fact, and I know it is an uncomfortable fact, but it is.

I mean, we passed a tax cut bill, which I know you guys supported. We didn't. I didn't support it. But we didn't have a hearing on it in the committee of jurisdiction. And it came right to the Rules Committee, and it went to the floor. I mean, we could argue whether that was a good idea or bad idea. I think it was a bad idea. But it is just the issue of how we are going to pay for it never really came up.

And you and I agreed that when we are engaged in wars halfway around the world, we ought to pay for it, not just put it on the credit card. And we just don't do that, right? I mean, we make believe that we don't have to. But when it comes to healthcare, we do.

Mr. Woodall raised two important points. One was that Medicaid rates are lower than private insurers, but that is when they pay, right? But we know that private insurers don't always pay.

And Dr. Collins, I would appreciate if you could explain this for us, and also, would Medicare for All pay the lowest rates?

Ms. COLLINS. Actually, Medicaid rates would go up under the Medicare for All proposal.

The CHAIRMAN. And insurance companies don't pay oftentimes. We do casework all the time in our districts where we have people who have issues, and when it comes to paying for the bill, the insurance companies say no. I mean, that is a reality in this country, right?

Ms. COLLINS. That is exactly right. And surprise medical bills are a huge issue right now. Congress has taken up this issue. People are getting bills for services that they thought were covered. And that continues.

And outside of the surprise billing issue, people have very high deductibles. People talked about how great employer-based coverage is. People in employer-based plans across the country, their premiums and deductibles comprise about 12 percent of median income on average. Employer-based coverage is also one of the largest sources of increase in the underinsured rates that we are seeing. So it is a problem.

The CHAIRMAN. I have talked to a lot of hospitals. I have a lot of hospitals in my district. In Massachusetts, we have some really fine hospitals. But one of the things they complain to me about all the time is the fact that they invest so many man- and woman-hours into filing claims with insurance companies to get paid for what they provided. And sometimes, they get to the point where it is not worth the time, and they just eat the cost. I throw that out there to make sure that people appreciate that fact.

I am now happy to yield to Mr. Raskin from Maryland.

Mr. RASKIN. Mr. Chairman, thank you so much. Before I begin, I wanted to submit for the record a statement from Eagan Kemp, who is the healthcare policy advocate for Public Citizen, which makes the important point that even Americans who have insurance today are facing spiraling costs, and that a Medicare for All system will enable us to lower drug prices and restrain the extraordinary growth in drug prices we have been seeing.

[The document is printed at page 234]

Mr. RASKIN. I also want to recognize the presence today of the president of National Nurses United, Jean Ross, who is the leader of an organization that has been heroically fighting for healthcare for all Americans for many decades. And I just wanted to recognize her.

Mr. Chairman, thank you for calling this historic hearing, which is a breakthrough in the national dialogue about healthcare, and what we are going to do to deliver healthcare to all of our people. I think not since Senator Kennedy had a hearing several decades ago about healthcare have we had one that is this comprehensive, this detailed, and this serious. And I want to thank colleagues on both sides of the aisle for participating.

I especially want to thank you, Mr. Barkan, for your very lucid and poignant and compelling testimony today. And I wanted to

start by saying that 9 years ago, I sat where you sit, metaphorically speaking. I was suffering from reflux symptoms and went to the doctor, who recommended that I go in for an endoscopy. And they said, while we are at it, why don't we have a colonoscopy. We wouldn't normally do it this early. I think I was 47 at the time. But let's just go ahead and do it.

And when I woke up, they said, well, we have good news and bad news. The endoscopy went fine, but we found something in the colonoscopy. And I had Stage III colon cancer and was off to the races. And I did it all. I did radiation. I did chemotherapy. I had surgery twice. And I can't imagine any of my fellow citizens going through such a trauma, something of such an enormous emotional, psychological, and family strain as that, and not know where they are going to get insurance.

And I was a State Senator and I was covered by Maryland's health insurance plan. But most State legislators don't make very much money. I think we were getting paid \$40,000, \$45,000, but we had a great health insurance plan. And I was covered and I was able to deal with it. But it opened my eyes to the fact that this is a crisis in our country, that there are tens of millions of people who don't know what they would do in the event that they came down with a diagnosis like that.

Like Mr. Barkan, I decided that I was going to try to go through this personal crisis by staying at work and by engaging with the things that I loved. And one of the things I was working on was I was leading the floor fight in Maryland for marriage equality. And we adopted marriage equality. We became the first State in the Union to do so without a judicial order compelling us to do so.

Mr. Chairman, you know, all glory to Massachusetts in all cases, but Massachusetts did have that judicial order from the Supreme Judicial Court telling them they had to do. In Maryland, we didn't have that, but we passed it anyway.

And, you know, as the floor leader, you have got the opportunity when it is all over to make a little speech. And I got up to thank my colleagues, because I had been wearing a chemo belt to the debates, and to session for several weeks. The guy who sat next to me, Jim Brochin, who is a great conservative Democratic State Senator from Baltimore County, said that I just wore the chemo belt to try to get sympathy and votes for marriage equality, which is probably right. But we ended up pulling him over and changing his mind about it, so it worked, I guess.

But I got up and I said, you know, that I had learned something in this process about the difference between misfortune and injustice. Because if your life is going great, you have got not one, but two jobs that you love and a wife that you love—and my wife is here today—and kids that you love and constituents you love, and you go to the doctor and the doctor tells you, you got Stage III cancer and you got a 50/50 chance of coming through it alive, that is a misfortune. It is a terrible misfortune, but it is just a misfortune, because it is built into the nature of our species, you know. Any of us could be assigned such a verdict on any particular day. Anybody could get such a diagnosis.

But, but, if you experience such a misfortune, and you get such a diagnosis and you can't get healthcare, because you love the

wrong person or you lost your job, or you are not working or you are too poor, that is not a misfortune; that is an injustice, because we can do something about that.

And life is hard enough, Mr. Chairman, with all of the illness and accident and heartbreak, for government to be compounding the misfortunes of life with the injustice of denying people access to healthcare when they get sick. And in the richest country in the history of our species, at its richest moment, not to advance forward to adopt a Medicare for All system is to deny I think the common humanity of our fellow citizens.

And I read an essay during that period by Susan Sontag, who said that everybody is born with two passports. And one passport is to the land of the healthy and living; and the other is to the passport of the sick and the dying. And we all hope that we are just going to use one of our passports in life, but in truth, all of us are going to use both of those passports. And to me, it is an elementary question of democratic solidarity and equality whether we are willing to acknowledge that all of us are going to use those passports, and we should make everybody's trip as easy as possible.

So I am a cosponsor of this legislation. I am not going to hide that fact. I am not just a neutral objective questioner here. But I am fascinated about how we are going to get through this process and bring everybody aboard and come up with a system that makes sense to all Americans.

Now, I want to ask a question that came up before—I think Mr. Barkan raised it—about how we ended up tying in our society healthcare to people's employment. I read something, and I don't know whether it is true, but I read something which suggested that goes back to World War II when there were wage and price controls and employers, in order to attract new talent, had to give them something better than higher wages and they offered them health insurance. And that began quite accidentally, quite arbitrarily, the connection of employment and healthcare. And I just wonder if anybody could illuminate that for me. Perhaps, Mr. Baker, you could.

Mr. BAKER. That is, in fact, the history. And, of course, it spread, you know, to a wider range of employers, so that the vast majority of people below Medicare age are getting their insurance through their employer. And, you know, this has come up previously.

I could speak now as a former employer, because I was a co-director at Center for Economic and Policy Research for 17 years. We hated having to deal with our healthcare insurance, you know, just for obvious reasons. We were busy. We were trying to do lots of other things.

Mr. RASKIN. And most small businesses hate it, because they are not in the healthcare business, right?

Mr. BAKER. That is exactly right. And on top of that—

Mr. RASKIN. They are running a movie theater or they are running a think tank or a farm.

Mr. BAKER. And, you know, we are trying to keep our workers happy, obviously, our employees happy, and they have different needs. And, you know, we are trying to find—frankly, I don't know and I don't want to know what is the best insurance plan for my individual workers, but we had to pick—talk about one size fits all.

We had to pick one plan that was going to be better for some people, worse for others. We didn't want to be in the business, and I can't imagine any employer wants to be.

Mr. RASKIN. So a Medicare for All system will liberate small business in America from the obligation of trying to figure out what is the best healthcare plan for their workers and from paying for it. Is that right?

Mr. BAKER. That is right. And I should also point out we had an insurance broker, an additional cost. You know, we had someone who would go through the plans with us. You know, this is a total waste.

Mr. RASKIN. You describe in your testimony, Dr. Baker, how financing Medicare for All starts by looking at how we are spending money today and then making it more efficient. And in many ways, that description of how to finance it sounds remarkably similar to a study done by another witness here, Dr. Blahous from the Mercatus Center. And in a piece for the American Enterprise Institute, he wrote the following: Quote, "Medicare for All supporters are correct to observe that Americans already pay for the vast majority of health spending that would occur under Medicare for All and that most of the Medicare for All's costs are, therefore, not new to the national economy."

Do you agree on that point with—

Mr. BAKER. Absolutely. I mean, clearly, there would be some increase in utilization, and that is partially the point. But I think that is limited for two reasons: One, that the people who most heavily utilize care—and this is something we have to keep in mind—basically, 10 percent of people account for 70 percent of the cost. Most of those people already are not limited by cost, strictly speaking, because they are either on Medicaid or they have hit their out-of-pocket maximum. So these are, you know, where we might expect big increase in cost.

But the other point that has been made by several people here, you have a lot of people that incur high cost because they are not getting the care they should need at an earlier stage. So then they end up going to the emergency room with very expensive care, when they could have had very simple care if they had had access to a primary care physician.

Mr. RASKIN. The other industrialized countries on earth have arrived at national healthcare plans, the kind that has proven so elusive for us. I want to ask a couple questions about that and first, perhaps, Dr. Collins, we can start with you. What is the principal value they are seeking there? Is it justice for everybody, so that everybody gets healthcare; is it efficiency of the system; or is it the public health in general, to advance public health? What are the values they are seeking to vindicate?

Ms. COLLINS. I would say certainly all three. I mean, I think that having universal coverage enables people, everybody to get healthcare that they need. It definitely promotes efficiently run healthcare systems. People have access to care that makes them productive.

We have a big problem when we have 30 million people uninsured, so it reduces their overall productivity as well. So I would say it is all three of those things.

Mr. RASKIN. Okay. And, Dr. Browne, do you agree with that, that all of those values are achieved?

Dr. BROWNE. Certainly. And I think you also have to look at if you have a healthier workforce, you are going to have cost savings in your employment business, because the time that you lose for sick days and getting off and taking care of family and all of that would not be achieved, because you are then fully working and staying healthy. So yes.

Mr. RASKIN. Thanks. Dr. Nahvi, I have got a question for you, because I have received an increasing number of visits from doctors and nurses and people in the healthcare system who say that the current system we have got is not working for patients, and it is interfering with their ability to deliver quality healthcare to people for a whole host of reasons, including the ridiculous amount of time that they have to spend on bureaucracy and fighting with insurance companies whose financial model is to not pay for people's healthcare.

The question I want to ask you is this: I think it was Ms. Turner who said we shouldn't just blow the whole system up. Of course, some of my colleagues across the aisle voted '70 times to blow up the Affordable Care Act. They wanted to take that system down. But I want to ask you a tough question about the transition from the Affordable Care Act to one that covers everybody, and tries to lower cost in the system, squeezing out the money that we all pay for copays and deductibles and constantly escalating premiums.

As I understand it, President Obama said, We want to reach across the aisle and we will go to the plan that was cooked up at the Heritage Foundation. Now, that fact has been buried, but this was the Heritage Foundation plan, the Affordable Care Act. And it was the model for what Governor Romney did in Massachusetts, right? And so the idea was let's take the Republican plan of the individual mandate, which they came to revile and denounce, and put that at the heart of the system. They considered it an expression of individual responsibility.

Then what happened was it became politicized, and rather than that compromise working, they turned on it, they renamed it ObamaCare. They voted dozens of times to try to destroy it and not replace it, but destroy it and leave nothing there, despite the fact that tens of millions more people got healthcare because of the Affordable Care Act. It was a giant step forward. And yet, we know of what its limitations are.

Now, is it going to be possible for us to move from the Affordable Care Act, with its limitations, to a Medicare for All system? Is that going to be too complicated for us to accomplish?

Dr. NAHVI. I don't think it is too complicated. And I also would say that we actually need to do it. I think just expanding the Affordable Care Act wouldn't cut it.

And I gave three examples earlier: Of the 28-year-old female that had the urinary tract infection that tried to drink cranberry juice to solve it; and the gentleman that stopped taking his antiplatelet medication; and the lady with the depression medications. All these people—I don't know if I made this clear—they all had private insurance, and it just wasn't cutting it for them. They ended up having these problems despite having private insurance.

Mr. RASKIN. Well, sometimes people think Medicare for All is just for the 30 million people who have no health insurance. That for me probably would be enough. But it is actually for the 45- or 50 million Americans who have a weak insurance plan, where the premiums are always going up, the deductibles are going up, the copays are going up, and it doesn't work for them. So what we are looking for is a system that is going to serve all Americans.

Now, it has been suggested by our, you know, distinguished colleague that, well, we don't want to interfere with the plans that are working. The plans that are always cited in that question are single-payer plans, like the VA or the military. So they say, don't mess with the people who have single payer now, because they love it.

And then the point of the political opposition is to try to scare everybody into thinking, well, if we have single payer for all Americans, if we patriotically bring everybody in, then it is going to interrupt the single-payer provision that we have got now, right?

Is it the case that we cannot afford a system that works for all Americans without taking away healthcare for people who are getting it from the VA or getting it from the military and so on?

Dr. NAHVI. I am not an economist, but as an ER doctor, one of the first things you learn is that when things are getting crazy, you need to stay cool, calm, collected. Oftentimes, when everyone around you is yelling about all sorts of things, usually the problem is not that hard to deal with and we can deal with it.

So from a big-step-back perspective, I apply something that I call the "look test" to this. Just look at what is out there and what makes sense. So if someone is coming here and arguing that heavier-than-air flight is not possible, but I just point to an airplane, I say, but look, I see an airplane, so I hear what you are saying but that can't be true.

So the corollary to that is when everyone starts yelling and screaming that doctors are going to get paid so much less and these systems can't function, the hospitals are going to have to close, I would just point to other countries that are doing similar things and I would say, I hear you, but it seems to be working just fine.

Mr. RASKIN. Do any of the economists want to weigh in on this point? In order to have a Medicare for All system, do we have—

The CHAIRMAN. I am going to lend you 2 minutes of my time.

Mr. RASKIN. Oh, forgive me. Okay, I didn't realize I was over. Okay. Let me just—I thought it said 2.

Mr. BARKAN. Congressman, may I make a comment?

Mr. RASKIN. Mr. Chair, I will yield back. I will yield back.

The CHAIRMAN. I get my 2 minutes back.

Mr. BARKAN. Congressman, may I make a comment?

The CHAIRMAN. Sure.

Mr. BARKAN. Congressman Raskin, 10 years ago, just before you got sick, when I was in law school, you came to speak to a student group. I was so inspired and amazed by the vision you laid out, and I decided that you were the kind of lawyer and public servant I wanted to become. And your comments today once again inspire me and give me hope for the future. Thank you.

Mr. RASKIN. Thank you, Mr. Barkan.

The CHAIRMAN. Thank you very much.

Before I yield to Dr. Burgess, I want to ask unanimous consent to insert in the record an article that appeared in the Washington Post back in June of 2018 entitled “House GOP plan would cut Medicare, Medicaid to balance budget.”

[The document is printed at page 244]

The CHAIRMAN. And I do that not to break the spirit of camaraderie here, but simply to point out that, you know, when you complain about the lack of adequate reimbursement of Medicaid and that providers don’t want to oftentimes take Medicaid, and then you support a budget that cuts Medicaid, that it is a little bit kind of not consistent. I ask that be put in the record.

I also want to acknowledge that during the hearing Congressman Adam Schiff came in, and now we have Congresswoman Ilhan Omar here. We are happy to have you.

I am now happy to yield to Dr. Burgess.

Dr. BURGESS. Thank you, Mr. Chairman. I take it under advisement that you said you are happy to yield to me.

So it is interesting. I used to be a student of medical irony. I am a physician as well. Worked in the ERs when I was putting myself through residency at Parkland Hospital. We didn’t have CAT scans back in those days. So you got operated on for appendicitis. It was probably a lot cheaper and more direct.

However, I used to be a student of medical irony. Now I have kind of branched out and policy irony is part of my realm as well. And it is just I find it ironic that we are here today criticizing employer-sponsored insurance, that it is so bad, and yet the Affordable Care Act that we debated in this room many, many years ago had an employer mandate built into the Affordable Care Act. Employer insurance is so good we want to require one to have it. So just a point of historical context. And it is not my goal to relitigate the Affordable Care Act and how we got here. There are good books written on it. I think one of our witnesses has written a book, one of your committee members has written a book. So I encourage you all to check out Amazon; I am sure they are still available.

But I do have to say that, you know, as the Affordable Care Act, President Obama was elected. He was elected, he said, on a healthcare mandate. And I reached out to the transition team and I said, Look, I didn’t give up a 25-year medical career to come up here and sit on the sidelines while you all do this. Talk to me. There may be some places where we can work together. And they thanked me very much for my participation. That is the last I ever heard of them.

The same with then-Chairman Waxman, who was the new chairman of my committee, the Energy and Commerce Committee. And the same discussion with Chairman Waxman. I didn’t quit my day job to come up here and watch somebody else do healthcare reform. Talk to me. There are perhaps places where we could work together. And, again, I never got a response.

So, again, my purpose was not to relitigate the Affordable Care Act, but it has come up several times today. And yeah, there were some missed opportunities. And I say that having been part—and just for people who are watching at home, I don’t want to say this committee is not normal, but normally, healthcare policy would

come through one of the committees of jurisdiction, what are called authorizing committees.

Mr. Cole is an appropriator, so he pays for everything we authorize very graciously. But one of the authorizing committees would have had this type of hearing, and probably done it over several iterations. But this hearing in the Rules Committee is somewhat unusual. I mean, I haven't been on the Rules Committee more than 8 years, but it is unusual in my experience. We had two primary hearings when Republicans were in the majority, but they were on things that were outside of the normal realm of the authorizing committee. So just, I want you to know it is a little unusual to have this hearing, but it also indicates——

The CHAIRMAN. Would the gentleman yield?

Dr. BURGESS. No.

The CHAIRMAN. There is a new sheriff in town, that is why we are doing the hearing.

Dr. BURGESS. What is that?

The CHAIRMAN. There is a new sheriff in town, that is why we are doing the hearing.

Dr. BURGESS. Exactly the point. This issue is so important to the Speaker of the House. This is the Speaker's committee. This committee is not—this committee is nine to four. Mr. McGovern is never going to lose a vote in this committee. If he did, he would probably have to leave town. So this is the Speaker's committee.

The ratio was set up by a Texan, Sam Rayburn, who everything up here is named after Mr. Rayburn. Got a room downstairs. Got a building over there. I have got a freeway at home named for Mr. Rayburn. Mr. Rayburn set up the ratio of the Rules Committee in 1961 to facilitate enacting the agenda of a young activist, President John F. Kennedy. And the ratio has stood ever since.

But it is unusual to have this hearing in the Rules Committee. But I make that point because this is the Speaker's committee. The Speaker has elevated this. This is what the Speaker wants us to be talking about today, this week, this month, and so we shall.

I do have a number of specific questions, and I apologize for getting—it is just hard, because I devoted my time and experience to one of the authorizing committees that deals with healthcare, NIH. Our committee, our committee, Energy and Commerce Committee, produced Cures for the 21st Century. I mean, we can argue about how we are going to pay for things, but if we ain't got the things to pay for, it is a crazy argument.

And, Dr. Browne, thank you so much for being here. Thanks for your service to the National Medical Association. I will tell you when we were doing Cures, and it had gone through all of the machinations that we could go through in the committee and the House had passed it, the Senate dragged their feet, and then an election happened and they decided they better get busy and pass Cures, because things weren't getting any better for them after the 2016 election. So they did, they passed a version of Cures. We quickly got a conference committee together, worked out the differences.

And Mr. Rush, Bobby Rush, on our Energy and Commerce Committee came up to me and said, Doc, we forgot sickle cell. And, well, we didn't really forget sickle cell. We were trying not to be

disease specific. This was about funding for research in the broad perspective. But I got what he was saying, because several months before, we had had a hearing in the Energy and Commerce Committee in the summer of 2016. And we had a witness from the Sickle Cell Disease Association, and she made the statement that it had been 40 years since a new sickle cell treatment had been approved by the FDA, 40 years. That meant the stuff that I was using at Parkland Hospital in the 1970s, that was state of the art. I could probably go back to work tomorrow, because it hadn't changed. That was an astounding statement that day.

So, obviously, we were at a point with the Cures bill that nothing could be changed. The Senate had agreed, the House had basically agreed, and we were going to go to the floor for a vote and the President was going to sign it. I think it was the last bill signed by President Obama. It is a great bill, and evidence of what the Energy and Commerce Committee is capable of doing if we take our time and do things correctly.

I did make a commitment to Mr. Rush that I would work to get a new sickle cell authorization. It hadn't happened since 2004. That was tacked onto one of the Bush tax cuts. So it wasn't a true sickle cell reauthorization. And the next month, when I was chairman of the Health Subcommittee, we passed a sickle cell authorization bill. And it took the Senate forever, as it always does, but in October, they passed their version. We approved their version over here on the House floor and the President signed it into law, the first major sickle cell authorization that had been passed in certainly over a decade, and with no new therapy.

And then here is why this is important, because I normally don't watch 60 Minutes. I don't think I watched it the night it was broadcast, but someone said, you should go to YouTube and look at this 60 Minutes broadcast on sickle cell. And if I am not violating copyright laws, I encourage people to do that.

It was a fantastic discussion of what someone is doing at the NIH with fixing the genetic defect that causes sickle cell. I mean, that is unheard of. It is a two-base error and it seems like something—it is just a spelling error, simply spell check should have caught that, but it didn't. And this doctor has worked out a system where they are actually able to put that corrected DNA into a patient's cells. And I got to tell you, I am an Episcopalian, so I don't emote, but when I saw that picture of the blood film on 60 Minutes, that young woman who they were treating, and these were all normal red blood cells, I mean, I broke down and cried. That is incredible that that child could have that blood film picture.

And, Doctor, you know from your time in the emergency room, a sickle cell patient, I mean, they go into crisis and it is tough. There is not a lot you can do. And people worry about prescribing opiates now. We should be judicious, but at the same time, these are people who need pain relief. And the old treatments of hydration and Thorazine, I suspect, is still one of the things that you do. But this is a great step forward.

And, again, I bring that because the authorizing committee did that. Another bill that we did, I hated the sustainable growth rate formula. When you talk about Medicare for All, my God, there was one point where the Congress said, You know what, we are just

going to cut your medical reimbursement for doctors, not for hospitals and not for insurance companies, not for Pharma, just for doctors, 20-some percent every year. Oh my God.

And it never goes away. It was written in a way that even if Congress came back in and added some money, which we would do every year in December called the doc fix, if we did that, it still added onto what the eventual cost that the Congressional Budget Office would score as if you are going to repeal this, this is what it is going to cost due to the vagaries of something called the updated adjustment factor. And I am not an economist, I don't understand what that is, but it was bad, I know that.

Thirteen years it took me to repeal the sustainable growth rate formula, and I did. And I did it in a bipartisan fashion. We had a 51-to-0 vote in the Energy and Commerce Committee. We had 393 votes on the floor of the House. We had 92 votes on the floor of the Senate. So that was a great example of bipartisan cooperation to correct a major problem that we had with delivery of our healthcare.

But you can't stop there. And this is one of the things I learned. That when you finish a big bill like that and hand it off to the agency, with all due respect for anyone who might have worked at the agency at one time in their life, when you hand stuff to the agency, things can happen to it, and you have got to keep your eye on it. As members of the authorizing committee, we have had multiple oversight hearings on the implementation of what is called the Medicare Access and CHIP Reauthorization Act.

So this was a major Medicare improvement that was agreed to in a bipartisan fashion, but, I mean, there is not a day, not a week that goes by that someone does not call my office with some concern about something that they are going to either not be able to do, or be required to do because of something the agency said—rulemaking that the agency makes.

So I encourage people when they read this bill, this Medicare for All bill—and it is a real bill and is a real consideration. This is the Speaker's committee. We are considering this bill in the Speaker's committee. I worry about it, because of the number of times it says in that bill the Secretary shall, the Secretary shall. We are talking about the Secretary of Health and Human Services.

With all due respect to anyone who might have been the Secretary of Health and Human Services at one time, that is kind of a difficult way for health policy to evolve, because then it goes out of the realm of the people's House to the agency. And what was the statement that Mr. Raskin made? A ridiculous amount of time spent on bureaucracy.

If you think that is going away, if the fine folks over at the Hubert H. Humphrey Building are in charge of everything, if you think that ridiculous amount of time spent on bureaucracy is going away, it ain't. It will still be there in some form or fashion and it quite possibly could be worse.

So I appreciate your indulgence. I just had a lot I wanted to get off my chest.

Ms. Turner, let me ask you, because this comes up all the time in the issue of administrative cost in HHS and CMS. I mean, administrative cost, that is a little bit of—it is a little misleading, be-

cause if I want to go up and start an insurance company—I would never do it, but if I did, and I was going to take care of a lot of people, I would have to go borrow a lot of money. There would be a cost of capital that I would incur. CMS does not have to account for the cost of capital, do they?

Ms. TURNER. No, Dr. Burgess, it does not. Actually, Merrill Matthews with the Institute for Policy Innovation did a study with an economic consulting firm some time ago, looking at the comparisons of Medicare administrative cost with private insurance. And he said most of these comparisons are really apples to oranges. And when you include everything, including not only the cost of capital, but the Federal Government's ability to collect premiums and resources and the difference in the population of Medicare versus those that are younger, then it comes out pretty even.

But I think the key point is that somebody is going to have to determine what benefits are allowed or not, who is going to be an authorized provider, how those providers are going to get paid, how the paperwork is going to get collected. Those jobs still must be done.

Dr. BURGESS. And we turn all that over to the Secretary with this Medicare for All bill.

Ms. TURNER. There is no question that somebody is still going to have to do the administrative paperwork. All of the medical goods and services that the taxpayers will be paying for as part of the new Medicare for All program will have to be documented and payments will have to be processed, et cetera. That is not going to go away.

Dr. BURGESS. Let me just take what time I have remaining and I need to enter into the record, ask unanimous consent to enter into the record. We are limited, only have two witnesses on the Republican side, so we are not able to have a patient. I wanted to bring this article that was printed this morning in CBC.ca. A mother in Nova Scotia living with cancer is challenging Premier Stephen McNeil to meet with her after a years-long battle with the province's healthcare system. In an emotional video, she said she went undiagnosed for 2 years because she couldn't access a family doctor. By the time she was diagnosed, her cancer had progressed to Stage III. This is the face of healthcare in Nova Scotia. "I cannot receive help for trauma that I experienced because of the failed system until sometime in July." That is for the mental health that she thinks she requires.

Doctors for Nova Scotia replied. Tim Holland, president of Doctors for Nova Scotia, says this is the first time he has heard this kind of story. He said this experience has all the elements of the problems that Nova Scotians are facing with their healthcare system, lack of a family physician, lack of access to emergency care, and knowing full well that those emergency departments aren't equipped to be diagnosing cancer, are stretched thin themselves. And I would like to insert that for the record.

The CHAIRMAN. Without objection.

[The document is printed at page 246]

Ms. TURNER. Dr. Burgess, could I just say that I think we must not ignore what we see happening in other countries. In Canada, if you can't access a primary care physician, you can't get a referral

to an oncologist. The Fraser Institute, a Canadian think tank, actually spends a great deal of time tracking average wait times. The average wait time is about 5 months for specialty care.

In the U.K., we see ambulances driving around London for hours, waiting for the emergency room to have space to let a patient in. When they get in, patients are often warehoused in hallways. I cite an example in my testimony of people dying in a hospital emergency room hallway waiting to get care.

So we have to look at the experiences of other countries. That is how they ration care. They ration through waiting lines and the lack of access to surgeries, diagnostics, and new medicines. In the United States, we have access to almost more than 95 percent of all new medicines. In France, patients in the government system can access only half of these new medicines. So that sickle cell treatment you discussed earlier may be available theoretically, but are you going to get it if the government has to pay for it?

Dr. BURGESS. I need to yield back. I know I have more time later on.

The CHAIRMAN. I will use my time. Dr. Nahvi had a comment.

Dr. NAHVI. I just did want to bring something up. And first of all, I do want to say, Dr. Burgess, I am always impressed at the way medicine was practiced back then, and I always am thankful for the luxuries that our generation has in dealing with this. So I did want to say that.

But I did want to comment on something you said about kind of going through the normal protocols and taking our time and making sure we do it right. I do think that is critically important. If we are going to do something of this scale, we have to make sure we do it right.

But on the flip side, part of the reason I am here, because my patients are suffering and they are dying. So I want to advocate. We just need, I think, a little bit more of a sense of urgency. We have to go through the right channels, we have to do things right, and we have to take our time, but we have to do this with a sense of urgency that people are dying as we are waiting and as we are doing this, and we need to have that fire to keep moving, whatever the solution is. And I do think that is critically important.

At the end of the day, a lot of people here have mentioned that this is the United States. We are the richest country in the world. But we are also the boldest, most entrepreneurial country in the world. If we decide we want to do something, we can do it. And I am a little bit worried that there is a lot of finding problems with the solution rather than finding solutions to the problem, as my dad would say. And I think we need to invest more to try to start with the starting position that we can get this done and we need to get this done because people are dying and people are suffering, and then go through all the right channels, as you said, and do it the correct way.

The CHAIRMAN. Dr. Collins, I will yield to you, but I also would like some clarification here. We have heard that kids, seniors, workers, everybody would lose their coverage under Medicare for All. I mean, is that right? Will all of us be left without healthcare under Medicare for All, and how would that coverage be better than today?

Ms. COLLINS. I mean, the way the bills are structured, everybody would move from the current coverage they have, for the most part, and into a new system of plans with more comprehensive benefits in many cases. So it is not true that people would lose their insurance coverage.

The CHAIRMAN. Did you have a comment?

Ms. COLLINS. I did want to just address the wait times in other countries and the rationing of care. I mean, clearly, we are rationing care. Insurers are rationing care right now. We are rationing care by leaving so many people uninsured. So it is all a matter of how you use that term.

But also in other countries, we actually have wait times that are very consistent. In our surveys of international systems, we find that wait times for specialists are about the same as they are in the United States. In countries that have had wait time issues, like the U.K., they have addressed those. So it doesn't mean that a single-payer system there (in another country) is going to be the single-payer system here (that we develop). There are ways to address wait times, and certainly other countries have done that.

The CHAIRMAN. I want to add something about the Rules Committee, since it was brought up that it is unusual that we are having a hearing in the Rules Committee. It is not so unusual. Actually, this is the oldest committee in the Congress, and we do big things. I am proud of the fact that we moved the Affordable Care Act forward and we insured 20 million people who didn't have health insurance.

And I think it shouldn't be unusual that we do hearings. When we did the Affordable Care Act, the House held 79 bipartisan hearings and markups, and we had over 239 amendments. 121 amendments were accepted. I mean, this was an enormous undertaking. Is it perfect? No.

And we contrast that to the way my Republican friends handled the repeal bill. It basically bypassed the hearing process entirely. We just came right here to Rules and then right to the floor. So there is a contrast here. I don't think hearings should be viewed as unusual or undesirable. This is an opportunity for everybody to be able to say what is on their mind, pro and con, and that is not a bad thing. And, Dr. Nahvi, please go ahead.

Dr. NAHVI. Yeah. I just wanted to say one thing about rationing. You mentioned that we are already rationing with the uninsured, but we are also already rationing with the insured. When 41 percent of Americans felt like they needed to go to the ER in the past 12 months, but then didn't, and considering only 12 percent of Americans are unemployed, that is still about a third of Americans that have insurance that feel they need to go to the ER but don't. That is rationing by any other name. That is self-imposed rationing, and that is part of the crisis.

The CHAIRMAN. And, Dr. Browne, quickly.

Mr. BARKAN. Chairman, may I make a comment?

The CHAIRMAN. Absolutely.

Mr. BARKAN. Anecdotes aside, we know that single-payer systems in other countries have better outcomes than we do.

The CHAIRMAN. Dr. Browne.

Dr. BROWNE. I want to thank Dr. Burgess for the support of the sickle cell bill and how that has come about. And yes, we have one new drug that was just recently approved for the disease.

And speaking to Mr. Raskin's comment, I want to say that even though I have a niece who, unfortunately, died from colon cancer, she was at the age of 48 so she could not get the screening test, because her insurance did not cover it. She waited too late, and she had advanced stage disease and died.

So, again, having Medicare for All or universal health coverage, would allow those individuals to get the kind of screening test that does not follow those guidelines, because at any age, if you are having symptoms, you need to be treated.

The CHAIRMAN. Thank you. I appreciate that.

Ms. Scanlon.

Ms. SCANLON. Thank you, Chairman McGovern, for the opportunity to participate in this hearing, to help us explore how we continue to try to make good on a commitment to accessible and affordable universal healthcare. I am grateful for the expertise and effort that my colleagues, especially Congresswoman Jayapal and my fellow freshwoman colleague, Congresswoman Shalala, have put into introducing and analyzing this legislation.

I have no question that healthcare is a human right and that no family should have to go bankrupt or worry about putting food on the table due to medical costs or have to create a GoFundMe page. I understand that we have to find a way to address what my colleague, Mr. Raskin, called the injustice of being unable to afford medical care when hit with a misfortune of medical trauma.

You know, I have already supported measures that would try to lower prescription drug costs, allow Americans over 50 to buy into a public option, but I am trying to parse the best way forward from here to protect the Affordable Care Act and move to whatever our next step is.

There are constituents in my district who believe that Medicare for All is the best path forward, and there are others who are concerned about how it is going to work. And those concerns are multifaceted. They are rooted in fear of rising costs, changes to their existing employer or union-based insurance, and for many, the impact on their jobs.

So it is my hope that I can get some information from this panel to help get answers to these important questions that I can take back to my district as we have this critical conversation about what a just transition to Medicare for All would look like, and how we achieve that elusive universal coverage.

So, Dr. Collins and Baker, when we are talking about best ways to get to universal coverage, including Medicare for All, one of the things we talk about a lot is the financial burdens of the current health system on individuals. So whatever we do, how do we address the cost of rising premiums, prescription drugs, copays, deductibles?

Can you talk about the impact a Medicare for All system would have on those premiums, copays, and deductibles for individuals? Dr. Baker first.

Mr. BAKER. Well, of course, if you did go the full ride of Medicare for All, basically those all go away. I mean, this is—basically, what

we are doing is taking money that we are paying out of our pocket, our employers paying for us, that will go in taxes. I mean, it is a tax increase, if people think that is bad, whatever. But, I mean, it is money that we are paying now and instead it will be paid by the government for these services.

So it is—you know, it relieves that problem. There is no doubt about it. I mean, the question is, you know, how to do that in a way that is least disruptive, how to do that in a way that is as efficient as possible. But there is no doubt about it, it takes away those costs that are now borne by individuals.

Ms. SCANLON. Can I follow up on that? Is there any analysis of how an individual's tax burden would compare to their savings?

Mr. BAKER. Well, a lot will depend on how you actually structure the tax. My friend Bob Pollin, I think it was referenced earlier, at the University of Massachusetts, did an analysis and they have a payment plan. It is, I think, a reasonable one, but, I mean, it really would depend on how you decide to pay it.

And also, again, you know, I had emphasized this point earlier, getting cost down. Now, we do know we get administrative cost down and we could argue how much, but I think there is no doubt about it, we are getting rid of an insurance industry. We also get rid of the administrative expenses that hospitals, doctors' offices, other providers have. That is a clear savings.

The other question is what about the other inputs. How much will we save on drugs? I mean, I argue we should save a lot on drugs because I think we pay—I mean, basically, I think it is absurd. Drugs are cheap. We make them expensive. That seems stupid to me. Same with medical equipment. And I think our doctors' pay should be more in line with doctors elsewhere in the world. But those are all things that are up for debate, how much do you depress those costs.

But, again, you know, point of reference, we look at other countries, they pay about half as much per person on average. There is some range there. There is no reason we should be paying so much more than other countries.

So can we get as low as the average, can we—will it take us 5 years, 10 years? Those are all—you know, that is very, very much up for grabs. But it should mean that a typical person will pay much less in taxes than what they are paying now for their healthcare.

Ms. SCANLON. Ms. Collins. Dr. Collins.

Ms. COLLINS. Yeah, I would just say—add to that that, you know, there are—in my testimony, there are about 10 other bills that provide sort of smaller steps towards universal—ultimately towards universal coverage. And there have been lots of different reform approaches that have been modeled by the Urban Institute and RAND; approaches that the Commonwealth Fund has funded modeling for.

So there are lots of ways to improve people's cost sharing to lower premiums. Even in employer-based plans, there are lots of policies for moving this more slowly. Obviously there are tradeoffs. The Affordable Care Act, the lesson of the Affordable Care Act has been that we haven't seen any congressional legislation to improve

the Affordable Care Act since it was passed. So there are definitely tradeoffs.

But I would also say for people with employer-based coverage, there are lots of hidden costs in employer-based coverage. People make wage concessions so that they can have employer coverage. People contribute a lot in premiums even with the wage concessions, and they are seeing increasingly higher deductibles.

So a movement towards Medicare for All obviously would replace those costs because it would do away with the employer-based system, and taxes would rise in order to finance that. But for many people, depending on how you would structure the taxes, many people would probably see a net cost of health insurance go down depending on their income. So the incidence of taxation would matter quite a bit.

But I think the controversy in Vermont really did come down to legislators not being able to explain this change of financing from premiums to taxes to their constituents.

Mr. BAKER. If I could also just add quickly on Vermont. You know, I think every one of us agree that at least the goal, I mean, of Medicare for All is putting downward pressure on input prices like drugs, like medical equipment, which certainly the U.S. as a consumer can clearly do. Vermont with 600,000, 700,000 people probably doesn't have the same sort of bargaining power.

Ms. SCANLON. In speaking with experts in my home State of Pennsylvania, they have talked about long-term care as being one of the big drivers in cost and an issue that we really need to struggle with, particularly with all of the aging boomers coming into the system. How does Medicare for All deal with that?

Mr. BAKER. Well, the plan, you know, the Jayapal plan does cover long-term care, and that is a major problem in the current system, both because it is not covered in general, but also, you do have this coverage under Medicaid which creates this absurdity where you have many people that could get by fine with home healthcare that is not covered, but they could have nursing home care that is covered.

It is obviously a less desirable situation for that person and their family, if they could get by with having some minimal amount of home healthcare to then—rather than going into a nursing facility, but on top of that, of course, it is much more expensive.

So it is—you know, what we want to do is provide people with the care they need, not have them getting care that they may not need, but that is affordable because of the way we have structured the payment system.

Ms. SCANLON. You had something?

Ms. COLLINS. And I think too there has been talk about people losing their Medicare. But actually, under the bills, the Medicare for All bills, Medicare benefits would actually improve substantially, including with the addition of long-term care and home health services.

Ms. SCANLON. So that would be another area where there could be substantial savings as a result of transitioning to this system?

Mr. BAKER. Absolutely. I mean, you get all sort—you know, we have had references to this earlier. You have all sorts of perversions in our current system because some things are covered, I

mean, most importantly emergency room, so people can't see a primary care physician, run to the emergency room. So that is not good healthcare, and it is an incredible waste of resources. The people in the emergency room should be dealing with emergency situations, not someone who can't see a primary care physician.

Ms. SCANLON. In terms of a just transition for those whose livelihoods are dependent upon the current system, can you speak at all to how that would occur?

Mr. BAKER. It really depends on how you write in—what you write into the law. So can you have something where you have special employment benefits for people in the insurance industry? It would be the most obvious people who would lose out. I mean, I think that is a reasonable thing that has come up with climate change as well. So what are we going to do for people in the fossil fuel industry if we move aggressively to promote solar and wind energy.

So I think that is a reasonable thing for Members of Congress to look at. I mean, it is not in here in part. You know, I know the Jayapal bill has, you know, support for that, but, I mean, again, how you structure that, you know, it really depends on what Congress were to decide.

And obviously, it is a consideration that we don't want to see workers lose their jobs and suddenly be unemployed. Is the situation worse than in other industries, because, you know, better or worse, workers are always losing their job. I don't mean to be cryptic about that. I take that very, very seriously, but I am just saying we have to think carefully how does that fit in with our other benefits.

Ms. SCANLON. Can you also—

Mr. BARKAN. Representative—

Ms. SCANLON. Yes.

Mr. BARKAN [continuing]. May I please weigh in on the cost issue?

Ms. SCANLON. Please.

Mr. BARKAN. It is very important to emphasize the following point: These cost savings are only possible through a genuine Medicare for All system. Other proposals to increase health insurance coverage, such as those that would make Medicare compete with private insurance, would not facilitate administrative and billing savings.

Ms. SCANLON. Okay. I actually was just going to speak to that subject and whether—what you saw is the pluses and minuses of the proposals that we move to a public option that would force the private insurance companies to compete.

Mr. BAKER. Yeah. I actually am sympathetic to that as an interim measure. I mean, I would like to see us get to Medicare for All, but I laid out, you know, what would you do in a transition. And I said part of the story first is, you know, we have kind of glaring inadequacies of the current Medicare program. Most obviously, there is no out-of-pocket cap, which is something—I am embarrassed to say how long I was in Washington doing policy work before I realized that, because it is kind of like why is there not an out-of-pocket cap?

Also, the fact that prescription drugs are—we have a separate drug benefit, that makes no sense. You don't have separate drug benefits in the private sector. Why did we think that made sense in Medicare?

So having those together—and also, of course, Representative Woodall made reference to the fact that many people get Medicare Advantage. Well, part of the story is we are subsidizing that. So we pay about 15 percent—I think it is 13 percent more for a person on Medicare Advantage than we would pay for the person with the same healthcare condition in the traditional plan. Those are serious problems with the traditional plan.

But in terms of the savings, if you envision a situation where we actually fix the Medicare program, so we probably have instead of two-thirds of people on traditional Medicare, probably 80 or 90 percent. I mean, I am guessing here, but, you know, clearly a higher percentage. And then on top of that we let people buy into it, I think we are talking about a massive, you know, program at that point.

And I think there would be administrative savings for the simple reason that what I suspect is you would have a lot of providers that say we don't want non-Medicare people. You know, we—you know, this is a huge blind spot. They might ask “why do we want to deal with United Health and other insurers when it requires so much additional administrative staff?”

But the point is, you know, why do we want to play with them when we have this huge block, we know what they are doing, it is standardized, we don't have to play games. So I think there would be large administrative savings, which is not to say I don't want to see us go all the way towards Medicare for All, but I am just saying there would be savings with the intermediate step.

Ms. SCANLON. Dr. Collins.

Ms. COLLINS. I think there are some very critical design issues too in the Medicare for All in where you set the provider rate. The bills propose at Medicare rates, but clearly some of the analyses that have been done have looked at rates that are somewhat higher.

But that is also a key design issue for a public plan. And going with a public plan option based on Medicare, maybe rolling it out in certain parts of the country where there are very few insurance companies gives—would give us an opportunity to see how that would work, where you would set the price, and what might work the best. So that would be an advantage of starting with a public plan based on Medicare or Medicaid.

Ms. SCANLON. And that also relates back to the chairman's concern that if we keep slashing Medicare and Medicaid funding, then it becomes more difficult to get people on the provider side to buy in.

Ms. COLLINS. That is right, yep.

Ms. SCANLON. Okay. Thank you. I yield back.

The CHAIRMAN. Thank you very much.

Mrs. Lesko.

Mrs. LESKO. Thank you, Mr. Chairman.

I think it is important to note that all of us, no matter what side of the aisle we are on, want to improve healthcare.

The CHAIRMAN. Would the gentlelady yield just one second?

Mrs. LESKO. Yeah.

The CHAIRMAN. If it is okay, I think what I am being told is that everybody needs a little bit of a break. If it is okay with you, can we take a break for votes and then come back?

Mrs. LESKO. Sure.

The CHAIRMAN. Unless you can't come back, then we will go right to you.

Mrs. LESKO. Can I come back?

I can come back.

The CHAIRMAN. Okay. So we are going to take a little bit of a break.

Right. So we are going to take a little bit of a break, you know, and when votes are over with, we will come back. And we have a few more people to ask questions and then closing remarks and then we will bring this to a conclusion.

So I thank the witnesses for their patience, but I think you are entitled to a break now. Thank you.

[Recess.]

The CHAIRMAN. The Rules Committee will come back to order.

And before I yield to Mrs. Lesko, I just want to ask unanimous consent to insert into the record a statement from Congresswoman Norma Torres, who is on this committee, who wanted to be here today, but she was on a fact-finding mission to South America and she has encountered some unforeseen problems leaving the country so she can't be here. But I am hoping that means that——

Mr. COLE. We had nothing to do with that.

The CHAIRMAN. Right. I ask unanimous consent to put this in. But Mrs. Torres, I know, is a strong advocate for universal healthcare.

[The information follows:]

Statement of Representative Norma Torres of California*April 30, 2019*

While on a fact-finding mission to South America to conduct oversight of U.S. assistance, and assess the situation at the Venezuelan border, I encountered unforeseen problems leaving the country. As a result, I was not present for the Rules Committee hearing on the Medicare for All Act. However, I fundamentally believe that healthcare is a right and not a privilege, and that Congress must enact universal healthcare so every American can be covered by affordable, high-quality insurance—that means traditional medical coverage along with mental health, dental, vision and long-term care. How we get there, and how fast we can do it, is a debate Congress must have.

The CHAIRMAN. So at this point, where we left off, I will yield again to Mrs. Lesko.

Mrs. LESKO. Well, thank you, Mr. Chair. And I hope Rep. Torres comes back soon. That is—hopefully, she is not being held against her will or something.

Okay. You know, I just wanted to say we have had a long discussion here, and I think members on both sides of the aisle—I mean, I can speak for myself and my friends on the Republican side—we want to solve the healthcare problem. We do believe that there is problems in the healthcare right now and that improvements can be made. But I think we should do this in a bipartisan fashion, because I think really big issues like this actually need to be done in a bipartisan fashion.

So when I was in the State legislature in the State senate, I actually worked on legislation to address surprise medical bills, which had been brought up before. And I got everybody together in a room and we kind of hashed it out. It was controversial, but we got it done. So I think that if we did work in a bipartisan fashion, we actually could get things done, even though we disagree on certain issues. I do really believe it can be worked out.

However, this bill is not bipartisan. This is a very partisan bill. And I am sure that you know that most, if not all, Republicans in the House are probably going to vote against it, if it gets up for a vote. And certainly, the Senate is not going to hear it. So, you know, I don't know why we are doing this, but, you know, we are, so here we are.

So as we have discussed in this several hours here, several reputable studies have been—have put that the extra price tag to the government of a one-size-fits-all healthcare system is north of \$30 trillion, with a T, over 10 years. And as has been said before, some States have already tried to implement government-controlled healthcare, but the price tag is too high.

In Vermont, as was stated, they said no because it said that the payroll taxes were going to increase by 11.5 percent and income taxes by 9 percent. And that was enough for even the Bernie Sanders constituents to say no thank you to this government-controlled healthcare.

Given this history and that the Federal Government is already running massive debt deficits and the Medicare program is already reaching insolvency, I think that it is unclear that this new bill is going to solve any of our problems, and it is questionable how it is even going to be paid for.

I would like to spend some time now talking about one of the most successful innovations in Medicare since its inception, the Medicare Advantage plan programs. This bill would take that all away, as we have talked about before. All Medicare Advantage plans would be gone. And so Medicare Advantage enrollment has almost tripled from about 7 million people in 1999 to over 20.4 million people that want Medicare Advantage in 2018.

The 2019 annual report of the Medicare trustees released last week indicates that 37 percent of Medicare beneficiaries are currently in a Medicare Advantage plan and that this percentage is expected to rise to 40 percent over the next 10 years.

Also, according to the Kaiser Family Foundation, 88 percent of Medicare Advantage enrollees have plans which include prescription drug coverage, and about half of these beneficiaries pay no premium at all, which is the case of my mother. My mother is on a Medicare Advantage plan. She loves it. She doesn't pay anything extra for drugs. And I can tell you that if we took this away from her, she would not be happy. And if we forced her into another plan, she would be confused, because it is difficult, as you all know, to navigate this whole healthcare system.

So, I guess, I wanted to point out, I got some numbers of how many people in—are members here that are here present today have their constituents that are on Medicare Advantage and that would lose it under this bill.

So the first one, the one that has the most people under Medicare Advantage is actually Representative Morelle. You have 98,360 of your constituents or 66.4 percent of all the Medicare population has Medicare Advantage in your district. And, Ms. Shalala, you have 81,043 of your constituents that have Medicare Advantage, which makes up 60.3 percent of all the people on Medicare. I come in third at 75,887 of my constituents are currently on Medicare Advantage, which is 44 percent of all of the people on Medicare in my district. And I can go on and on. But my point is, Medicare for All would take away all of this from everyone.

And so my question is to Ms. Turner. What do you think about that? Do you think seniors are going to be happy that their Medicare Advantage plans are taken away?

Ms. TURNER. Medicare Advantage allows seniors to voluntarily, as you said, enroll in private plans that provide better coordinated care, integrated care so that they can have one plan that provides access to physician coverage, to hospital care, prescription drugs, vision, and dental. And MA plans often provide additional benefits.

So, yes, I think seniors have gravitated to these plans because they give them more resources to deal with an ever-more complex healthcare system, and they highly value this coverage. And now, about 20 million seniors overall are on Medicare Advantage, and as you say, the number grows all the time.

Mrs. LESKO. Thank you.

And my next question really has to do with how the bureaucracy would work under this program. So I would like to take a few minutes to walk through what I understand the process a hospital would need to go through to fix a leaking roof under this bill.

So let's start off with a simple example and what happens under the current system. The roof is leaking. The hospital administrator or maintenance division calls somebody out to inspect it. Maybe they get a couple of bids, decide on a contractor, and the leak gets fixed. Pretty simple.

But what happens, as I have been told, under this Medicare for All bill, well, first, since the hospital has a provider agreement, it needs to get funds from the government's capital expenditure budget to fix its roof. To get those funds, they have to submit an application to the regional director. Once they submit the application, they have to wait, wait until the regional administrator decides to review the application. How long will that take? What happens to the roof in the meantime?

But that is not the end of the process. After it goes through the regional director, the Secretary of Health and Human Services has to review the application and decide whether to approve the application and how much money should be provided.

Now, I am sure that the Secretary of the Health and Human Services has many more important things to do than go through applications for funding of a leaking roof. So how long does that take? Who knows. This bill doesn't set any limits on either of these two review processes.

So a hospital could be sitting for months in line waiting for their application to be reviewed. We all know how painful it can be going to DMV, department of motor vehicles, sitting in that line, waiting for your number to be called. Imagine having to go to a Federal Department of Motor Vehicle for every little thing you need. Need a new X-ray machine? New application and wait. Need to buy the software upgrade for your electric (sic) health records system? New application and wait.

And every single Medicare for All provider across the country is going to be forced through this one system. Everyone will be doing a lot of waiting. We need less bureaucracy in the system, not more. So that is a problem I see.

Also, Ms. Turner, you have spoken about wait times in your testimony in other countries who have government-run healthcare. Is there anything in this bill to protect the American people from astronomical wait times?

MS. TURNER. There is not. And I do believe the promises being made about Medicare for All evoke memories of earlier promises—that health insurance premiums would go down by \$2,500 a year for a typical family, that everybody could keep their doctor, everybody could keep their plan . . .

It is easy to say these things, but much, much harder to deliver. When you wind up with a system that is promising free access to the system without any checks, it is impossible to imagine the current infrastructure being able to meet the demands for care without having ever-lengthening queues.

And that is, of course, what we see in other countries and why the Fraser Institute keeps track of how long those waiting times are, and why in the U.K., people can be waiting for a year for surgery. In Canada, the province may run out of money before the end of the year. And if you had a surgery canceled in late November, sorry, the hospital is not doing any more surgeries this year. Get back in line.

Mrs. LESKO. Yeah. And so speaking of wait times, you know, it wasn't that long ago that Phoenix VA Medical Center was in the news, in the spotlight because of really long wait times for our veterans at the hospital. And some of the claims were that veterans died while they were waiting.

And so one of the solutions that has been worked on and was supported by our late Senator John McCain was that there be more freedom of choice for the veterans outside of the government-run healthcare plan so that they could go see a private doctor if there—the wait lines—the wait time was too long.

Now, to me, Ms. Turner, does this seem like the opposite approach, like we are going to more government-run healthcare instead of allowing patient choice?

Ms. TURNER. This plan is extraordinarily comprehensive in bringing everybody and virtually all current systems—public and private—under the Federal Government's control. Even in the U.K., people can buy private insurance. In Canada, patients who can afford it come to the U.S. for care. The Mayo Clinic has thousands of patients coming to the United States from Canada. So the fact that people would have a difficult time finding a private option in this country under Medicare for All, I think, would concern many Americans.

Mrs. LESKO. Well, thank you. It certainly concerns me.

Dr.—

Mr. BARKAN. Congresswoman, may I make a comment about Medicare Advantage?

Mrs. LESKO. Can I ask Dr. Blahous a question first, and then if I still have time, certainly.

Dr. Blahous, will this bill provide free healthcare for illegal immigrants?

Mr. BLAHOUS. Well, the bill I analyzed indicates that it would be—the benefits would be provided for every resident of the United States, and it is left to the Secretary of HHS to basically promulgate regulations that define who a resident is. There is nothing in the legislation that excludes the undocumented immigrants from receiving benefits, so my working assumption was that they would be eligible for benefits, yes.

Mrs. LESKO. Thank you.

And as members, as we have—you already know, I come from a district where the number one—the number one concern is border security and illegal immigration. I know we all come from different districts, and so I can tell you that my constituents and I would guess the majority of citizens in the United States would not feel happy that they are going to be forced to pay for illegals that aren't citizens free healthcare.

And so with that, I am done with my questions. And, sir, you had a comment.

Mr. BARKAN. Medicare for All would deliver all of the benefits that are currently provided for with Medicare Advantage. Seniors wouldn't lose the choice of paying for Medicare Advantage. They would receive better coverage for no cost.

Mrs. LESKO. Thank you. And thank you for your comment. But I can tell you, firsthand experience, my mother is on Medicare Advantage. It took quite some time to figure out which program was the correct one for her, and now she likes the doctors that she has, she is happy with that, she doesn't like changes.

And my understanding is that this bill would take away that program and require everyone, everyone, no matter what they are on, if they are on Medicare Advantage or not, they would all have to take this government-run program, and I just find that unacceptable. It is not based on choice. It is government-run mandated healthcare.

Thank you. And I yield back my time.

The CHAIRMAN. I know Dr. Nahvi was trying to be recognized. You still have 44 seconds, so why don't we yield to him.

Dr. NAHVI. I will be real quick. So I guess one thing that is worth pointing out is that regarding undocumented immigrants, we are already providing care for them for free in the most expensive way possible. They are coming to the ER because of that 1986 law signed by Ronald Reagan, and they are getting care and no one can stop them, and it is the most expensive place to get it.

Medicare for All would provide such that these patients who are already getting care would just get that care in a more fiscally responsible way at the primary care doctor's office.

Mrs. LESKO. Thank you, Mr. Chair.

And, sir, I thank you for your testimony. But most people in the United States are not going to voluntarily want to be paying for illegal immigrants' free healthcare. And so there is a difference between people coming here illegally and showing up in the ER.

And, by the way, we have a huge crisis at the border. And I hope—I am going to introduce several pieces of legislation, and I hope that Republicans and Democrats will get on board and realize we have a crisis at the border and we have to mitigate it.

But I can tell you, I go to a lot of different meetings in my district and, quite frankly, throughout the State, and there is not going to be anybody happy about paying their taxes for free healthcare for illegal immigrants.

Dr. NAHVI. But it is not about ideology. We are already doing that. The only difference would be we would save money in doing the same thing that we are doing now.

Mrs. LESKO. Well, we can debate this. Obviously, we disagree, but I can tell you, I have heard loud and clear from people consistently they do not want their taxes going to pay for free healthcare for illegal immigrants.

Thank you.

The CHAIRMAN. Thank you.

I have a couple of unanimous consent requests. First, without objection, I would like to insert into the record a letter from the Washington Community Action Network, Washington State's largest grassroots community organization with 44,000 members.

[The document is printed at page 253]

I would like to insert a letter from the Labor Campaign for single-payer healthcare with 15 national unions at eight State labor federations and a large number of local and regional organizations.

[The document is printed at page 254]

I would like to insert a letter from the Social Security Works, an organization which seeks to protect and improve the economic security of disadvantaged and at-risk populations; a letter from Dr. John Aldis, a doctor in West Virginia. And they all support Congresswoman Jayapal's Medicare for All legislation.

[The document is printed at page 255]

The CHAIRMAN. Also, Rebecca Wood's daughter, Charlie, who—this is Charlie right there—was born prematurely. I mentioned this at the beginning of my testimony. She had suffered through more infections, surgeries, physical therapists, and injections than most of us deal with in our lifetime. Her medical costs added up quickly, and much of that was paid for out of pocket. The financial devasta-

tion that forced her family to make tough choices regarding Charlie's treatment highlights the need for adequate long-term care in this country.

Without objection, I would like to insert into the record this story submitted by Rebecca Wood where she thanks Representative Jayapal for her work. In the story she says, and I quote: Long-term supports and services included in this bill are crucial to families like mine. The bill would provide mandatory coverage of community-based services that people with disabilities need and want. Additionally, it ensures that services are equal across geographic areas, a problem that I have personally had to contend with. I want that in the record as well.

[The document is printed at page 258]

The CHAIRMAN. And, Dr. Blahous, I want to thank you. This is a personal thing for me, but when talking about the issue of immigrants, you referred to this group of people as undocumented immigrants. I much prefer that than having people refer to them as illegals. It is just a personal thing with me.

I don't think anybody in this world is illegal, but I will just say to Mrs. Lesko who asked why are we doing this hearing, I mean, we are doing this hearing because many of us, not just Democrats but Republicans as well, are concerned about the fact that we have 29 million people who do not have insurance, over 40 million people who are underinsured, who are afraid to get sick because they are afraid they are going to go bankrupt, and we need to do better. The system that we have in place is deeply flawed and it is hugely expensive, and we all think we can do better.

I think Medicare for All is the way to go. Others have different opinions. But that is why we are here. And, you know, I would love to come up with a bipartisan solution here, but I will remind my colleague that—because I have been in the minority for 8 years. And every time there was a bill to repeal the Affordable Care Act, I don't recall ever being consulted or ever being asked to be part of any kind of discussion on how we should move forward.

And before I yield, I know Mr. Barkan had an additional comment he wanted to make.

Mr. BARKAN. Congresswoman Lesko, you said you are not sure why we are doing this hearing, given that the Republican-controlled Senate won't pass Medicare for All. First of all, if you don't remember, I want to remind you that we last ran into each other in Arizona during your election.

Mrs. LESKO. I do.

Mr. BARKAN. At that time, when I asked you about Paul Ryan's plans to cut Social Security, you had no idea what I was talking about.

Mrs. LESKO. That is not accurate.

Mr. BARKAN. Well, it seems you have chosen to not get your facts straight today either. Why are we having this hearing? To keep people alive.

The CHAIRMAN. Thank you.

Mrs. LESKO. Thank you. Mr. Chairman, if I could respond.

The CHAIRMAN. I yield.

Mrs. LESKO. Thank you.

You know, the reason that I said that statement is because we are going through the Rules Committee, first of all. It is not—this bill is not being heard in a regular committee.

The CHAIRMAN. Well, we are a committee.

Mrs. LESKO. And also, I would like—this is a big issue, and I do believe we need to have high-quality healthcare at a reasonable cost for patients. And I concede that we can definitely improve on our healthcare system.

But something this big, what—my point was something this big and this major, I think both parties need to work on together. And we are not going to agree on everything. I already know this. I did pension reform in my State. I did surprise medical bill. I did contentious things, but we worked through it.

And I know that, you know, Representative Cole has said that in the past here he has worked on big issues in bipartisan fashion, and that is what I think we should do. Now, this—I mean, you must concede that you don't think that this is going to pass because you didn't ask for input from Republicans.

And even though we are in the minority here, the Senate is still Republican and you still have a Republican President. And so that was my comment, why I said that, because we—I would hope that we would work on something that is actually going to pass, and that is what I would like to do.

Thank you.

The CHAIRMAN. Thank you.

And, again, we are the Rules Committee. We are the oldest committee in the Congress, and we are one of the committees to which this bill was referred. And I hope all the other committees do hearings. Unlike when my colleagues were in charge where there were no hearings on any of these issues, we are doing hearings.

And in terms of input, everybody is offering suggestions and we have witnesses who have all kinds of opinions, and we are having this discussion. This is what you are supposed to do. This is a deliberative process, right.

And I think this has been good. I think this discussion has been good. I don't agree with what most of my colleagues on the other side of the aisle have said. I think it has been a good discussion, and I think it needs to continue beyond this committee, and we are going to do that.

Having said that, I now yield to Mr. Morelle.

Mr. MORELLE. Thank you, Mr. Chairman.

First of all, thanks for organizing this hearing today. I think we have an extraordinary panel of people testifying. I think this is the appropriate place to begin the conversation around healthcare. And I would congratulate Congresswoman Jayapal for introducing an ambitious piece of legislation that has brought us together.

This is an important conversation about a critical issue facing Americans—America's patients and what we must do to ensure that we have quality, affordable healthcare for all of our citizens.

Tomorrow, May 1, I would—should be celebrating my daughter Lauren's 33rd birthday, but unfortunately, Lauren passed away nearly 2 years ago of triple-negative breast cancer.

Doctor, thank you for all your good work on breast cancer.

And while it is a personal tragedy for my family and myself, we are hardly unique. I don't think there is a member in this room, I don't think there is a member in this body that hasn't been personally touched by tragedy as it relates to healthcare. And we have certainly—there is no one who has not heard from countless citizens about the many ways in which their lives are touched by illness or by the difficulties in our healthcare system.

After making what I consider significant progress, we are backsliding now because of purposeful action taken by the White House. At the end of 2018, the percentage of U.S. adults without health insurance reached a 4-year high. More than 1 million people across the Nation have lost coverage since 2016, and almost 14 percent of Americans are without health insurance today. Those are numbers we haven't seen since the enactment of the Affordable Care Act.

And this is in part because of the actions of the President, cut funding for the ACA, push Americans into junk short-term health plans, which we don't even allow in the State of New York where I am privileged to represent, deny essential services, shorten enrollment periods for families to sign up for coverage, create burden after burden to seek Medicaid coverage, and repeated attacks on women's healthcare and essentially family—and essential family planning services.

The fact is, Donald Trump does not have a plan to address healthcare, unless you consider dismantling the Affordable Care Act, stripping away protections for people with preexisting conditions, leaving millions of hardworking Americans without health coverage, a plan, to say nothing of the nearly 70 million uninsured or underinsured people in this country.

Unlike the President, the members of this House believe it is critical we address the healthcare crisis head on, whether it is this plan or others. We can begin taking steps toward meaningful healthcare reform that lowers costs, improves and strengthens the quality of care, improve patient experience, the so-called triple aim of healthcare, and ensures every person in our Nation has coverage they can depend on.

And I think the American public has been clear. They want essential health benefits, protections from annual and lifetime caps without discrimination based on preexisting conditions.

And I would say that the President and many of his colleagues on the other side of the aisle, including Senator McConnell, who has indicated that the Senate, despite the talk about bipartisanship here, isn't prepared to even address healthcare until after the 2020 elections, which I consider reprehensible at the very least.

I think instead we welcome the opportunity to look to the future and begin the work of making our healthcare system, which has serious shortcomings and concerns, more affordable, more equitable, and simpler for people in my community and across this country. So I think this hearing is entirely appropriate.

Having said that, I—there are a number of concerns. I have a number of questions regarding the financing of this system, healthcare cost trend lines, cost containment measures, some of which have been talked about, provider reimbursement.

So I would like to start perhaps, and I would ask anyone to feel free to respond, but I note that, Dr. Collins, you have talked a little

bit about this, but Dr. Baker as well, the—currently, as I look at it, we spend, according to CMS, \$3.5 trillion a year in healthcare all in, that is all payers, private insurance, public insurers, and my back of the envelope, which is not very good.

But even if you assume the 3.5 percent increase in the CPI and healthcare, which is pretty low, but let's just for argument's sake, we would be at about 4 and 3-quarter trillion dollars in 2026 over the next 10 years, about \$41 trillion healthcare spent. Most of that, as I think you know, goes to healthcare spends in hospitals and physicians.

So what I am struggling to understand is—and right now, Medicare payroll is about, I think, \$289 million out of what is right now a \$3.5 trillion spent. So as I think about it, and I was trying to figure out how this works, we saw it today in The New York Times, the number of corporations in the United States are now paying zero taxes, some getting rebates, how we will struggle to make this work unless there is a pretty dramatic increase in payroll tax.

And I recognize—I apologize for the long question—but I recognize that people are paying premiums now. Those premiums presumably would go to pay, now instead of premiums, taxes, which will pay for the spend. So there is clearly a movement of those. But there are disparities as well. Some businesses pay for health insurance right now, coverage for their employees; others do not.

So this is not as though it is going to be a smooth transition. But if you could talk about how the financing would work, in some detail, and if you have thoughts about income taxes, payroll taxes, other forms of taxes or premiums to meet that spend.

Mr. BAKER. I will take a stab at that. First off, you know, there—you know, we have talked about this. There clearly are large administrative savings. You know, most immediately we know that the private health insurance industry spends about 20 percent, in fact, probably about 25 percent of what it pays out in benefits in administrative cost. Whereas our private—whereas the Medicare system, traditional Medicare system, it is less than 2 percent. If we use Canada as a reference point, it is less than 3 percent. You know, so that allows for very, very large savings. In addition—

Mr. MORELLE. Yeah. May I—

Mr. BAKER. Go ahead.

Mr. MORELLE. I apologize. But let me just—as I looked at it, the private insurance, this will help perhaps guide your answer, private insurance is about a third of the Medicaid—or of healthcare expense.

Mr. BAKER. Healthcare.

Mr. MORELLE. So about \$1.2 trillion right now. And I—if you estimate 18 percent savings, which is I think what others have talked about, translates to about \$214 billion. So I will give you that. So—but I want to talk about the tax. So let's take that out of the mix, but you still have a—even if you—

Mr. BAKER. Right.

Mr. MORELLE. Even if you could realize all \$200 billion, you would still be at a \$3.3 trillion spend. So let's—I will give you that—

Mr. BAKER. Okay. But there is also—and I am not trying to avoid your question. There is also administrative costs that are incurred

by hospitals, by doctors' offices, other providers, which would largely go away. They don't go to zero, but, again, comparing the U.S. to Canada, and there is research on this, our providers pay much more. So that would be additional savings.

I also—you know, and I talked about this in both my written testimony and my oral comments, we do have to reduce payments to providers. There is no—you know, we pay twice as much for our drugs, for our medical equipment, for our doctors. You know, how much do you get those down, you know, you could argue on that. But I do think we have to get those closer in line to the rest of the world.

Now, how do you get the rest of the money? To my view, I think a payroll tax has to be a very big part of the picture, because basically, healthcare premiums that are paid by employers are very similar to a payroll tax now. And as you point out, many employers don't pay that. Well, I think that is a problem, you know.

So, you know, just as we have had other mandates on employers and, in fact, we do have mandates on employers in the Affordable Care Act, then, you know, I think you would in effect have to do that with—you know, in effect, a payroll tax would be equivalent to a mandate. So I think that would be the biggest chunk.

I would also look—and, again, obviously this could be done a thousand different ways towards, other forms of progressive taxation where you would disproportionately have high-end earners, whether it be income tax. You know, there is Senator Warren running for President who is proposing a wealth tax. I think there is problems with that. I don't think you want me to get into that. But I think we can get more taxes from high-income people who have been the big winners in the economy over the last four decades. So—

Mr. MORELLE. Okay. I appreciate that.

Anybody have anything that they would like to add relative to the—how we pay for this?

Ms. COLLINS. I will just jump in real quick and just make the point I made earlier about the significant cost growth that is occurring from provider prices and private insurance. So that is a key growth push in the healthcare system right now.

Mr. MORELLE. Yeah. And you answered that earlier, and I wanted to just understand a little better what you said. As I sort of think about it, and this is borne by the experience of talking to hospitals, physicians, other providers in my district and around New York, is that essentially the public payers, Medicare, Medicaid, CHIPs, and other programs, are too low for providers, and essentially the commercial world of the private insurance, whether it is self-insurance or the commercials, essentially subsidize payments to allow providers to be successful.

Did you—but you said something earlier that I thought was at odds with that or—and I didn't really understand that.

Ms. COLLINS. Right. So that—so I will just—yes. So the literature on the cost shift, which is a cost shift from lower payments in Medicare program and Medicaid program, are made up by higher prices in the—

Mr. MORELLE. Correct.

Ms. COLLINS [continuing]. In private insurance. The literature really does not show that.

A study that was done in Colorado on this issue found that the higher margins that providers were getting—the higher prices providers were getting in Colorado were going towards more administrative costs, higher margins, buildings, other things like that. There wasn't evidence that there was a cost shift. The prices were not going to fund their lower rates on Medicare.

Mr. MORELLE. So would your argument be—I am sorry.

Ms. COLLINS. And there is an enormous amount of literature showing that too.

Mr. MORELLE. So would your argument be that we could pay at Medicaid or Medicare rates and not substantially affect the quality of providers or that we would not impact their ability to provide service?

Ms. COLLINS. You know, I think that they—so the—so a key thing about the healthcare market that is so different from every other market is that prices drive costs in this market. Costs in other markets drive prices, so prices are a fair reflection of the cost of production. In healthcare, and particularly in private insurance, we choose the prices we want to pay. We choose the cost level we want to be at.

So the—we know there is huge amount of evidence right now that the major growth in healthcare costs is occurring in what we pay providers and private insurance. If we want to get control of our healthcare costs, we have to start focusing on that issue. And this—

Mr. MORELLE. So—

Ms. COLLINS. What these bills have done—

Mr. MORELLE. Yes.

Ms. COLLINS [continuing]. Is bring this issue up.

Mr. MORELLE. The—so that—and I—some of you have looked at other health systems around the world. You know, in Rochester, it would not be unusual to pay a neurologist, a neurosurgeon 3 quarters of a million dollars or more, and we are not one of the higher costs compared to some other metro areas. What would be a comparison to what a surgeon of that kind would get compensated for in another place? Canada? Great Britain? Anyone know?

Mr. BAKER. Odds are it would be closer to \$200,000, \$250,000. They would be getting compensated considerably lower. Now, you know, I have had arguments with doctors about their compensation because they all think they get too little, but, you know, they don't pay for their education, for the most part, in other countries. I mean, to my view, that is not closely offsetting, but, you know—but they don't—that is a point to keep in mind.

Mr. MORELLE. Yeah. I want to talk just a little about—

Mr. BARKAN. May I comment, Congressman?

Mr. MORELLE. Yes, sir.

Mr. BARKAN. I want to say you are asking good questions. It is important to ensure we have a clear way to pay for such an ambitious policy proposal, but we are the richest country in the history of the world. We pay for far more expensive things like wars of choice. We can afford to do this. We just need to decide to make it happen. It is a political challenge, not an economic one.

Mr. MORELLE. Well, I appreciate that very much. And I agree with you that this is ultimately about what people are willing to do, but there are challenges to doing this and there will be disruptions in the marketplace. But we would—if we didn't go into it with a clear-headed view of what this will mean, then I think we are doing a disservice to have this conversation without talking about that.

I do want to talk—and I apologize, I only have just a couple minutes left. As it relates to cost containment, utilization issues, I was involved in a practice transformation grant that we got from the Affordable Care Act I chaired back in Rochester called the Rochester Health Innovation Collaborative, where we embedded essentially case managers that were nurse practitioners that worked on social determinants of care, really tried to drive down the cost curve for—particularly for older, chronically injured or chronically ill individuals.

We had some success. I am not really sure where I see the pressure to do that in this system. This is—from my mind, unless you have a different view, this is essentially a fee for service. Not sure how utilization declines or how you get better coordinated care, because I don't see incentives to do that, but perhaps in the last moment or so folks could comment, anyone on the panel.

Dr. BROWNE. Yes. Thank you so much for the question. I think if you are looking at the plan and the comprehensiveness of the services that you are going to provide, it behooves the plan to have those coordinators that are part of it that is going to go out, and whether it is community health workers in cancer, of course, we call them navigators, that is going to make the patients understand how to utilize the system in a more appropriate way.

So you are talking about a patient-provider partnership and you are going to bring about better care. You are looking at whether you are providing them nutrition and food services, exercise programs—

Mr. MORELLE. Well, and I—and I don't mean to cut you off. I think that those are all great, and I agree with you. The goal here ought to be try to reduce the healthcare spend or at least bend the cost curve down, and you can do that with some of those things.

I am just not sure that I see in a fee-for-service system that this essentially moves to where the incentives are to do that. I am not sure who provides that kind of coordination, because I don't see an incentive in this. I just see fee for service. I am really afraid of that because I think it blows out potentially the long-term healthcare trend lines in terms of cost.

Dr. BROWNE. Well, I am looking at it sort of in a prepaid way so you have incentives built in the program. If you are basing it on the kinds of system that we have in TRICARE or you are looking at—and, again, that is a large integrated health system, or even some of the services that is provided under the VA, so you focus more on the preventive aspect of it.

You want to keep—and TRICARE and all services want to keep our patients out of emergency rooms, and so you build in emergency care facilities, you then expand your hours, you get those people to practice prevention. And, again, that is not utilizing the

costs that is there, and then they can get an incentive for keeping people well and healthy.

Mr. MORELLE. Well, and I completely agree, if there is a system that allows us to do that, and I am not sure this entirely sets up the incentives—

Mr. BARKAN. Global billing is exact—global billing is exactly how we bend the curve. No more fee for service.

Mr. MORELLE. Well, I agree. I am just not sure that this proposal contains that, but—and if it does, what do you do in a metro region when you exceed your—I apologize, Mr. Chairman. I know I am—exceeded my time. But I appreciate your thoughts on it.

The CHAIRMAN. Did you want to finish your thoughts?

Ms. COLLINS. Yes. I am just going to say one more thing. Medicare has been a leader in innovative payment practices for providers in accountable care organizations. I mean, there is no reason why those kinds of innovations could be brought into a bill like this.

Mr. MORELLE. But haven't those largely been done by some of the private insurers that create the programs around Medicare because you use private insurance right now to do it? I would love to talk to you maybe offline.

Mr. CHAIRMAN, I apologize for taking up time.

The CHAIRMAN. All right. And I would yield to Mr. Cole because he has some unused time.

Mr. COLE. Thank you very much. I appreciate that, Mr. Chairman.

I only have a couple minutes here, so I am going to kind of move you along pretty rapidly. Forgive me for that.

Committees of primary healthcare jurisdiction right now are literally moving legislation that would make fixes to the ACA. And some of that legislation literally could be here in the next few weeks in front of this committee.

So my question is this, and if you can, give me a yes or no, I would appreciate it. And I will start with you, Ms. Turner, is do you support abandoning the—these committee efforts to reform the ACA in favor of Medicare for All?

Ms. TURNER. You know, the Trump administration is trying to do a lot of things to give people more choices who have been shut out of the market. Some of them are options such as short-term limited duration plans—

Mr. COLE. I have got to ask for a yes or no or I am not going to be able to get all the way through the panel.

Ms. TURNER. So should they—should the—

Mr. COLE. Should they abandon those efforts and focus on Medicare for All, or should we keep moving with the efforts to fix the ACA?

Ms. TURNER. I think we should try to do what we can to fix the ACA, both through administrative and legislative authority.

Mr. BLAHOUS. I agree.

Dr. NAHVI. I think that is a false choice. I think we could do both.

Mr. COLE. It is really not a false choice. There is only so much time up here, and there is only so much bandwidth to actually move something that become law. We can have—we have debated

a lot of legislation this year that is not going to become law. We have a chance, I think, to make some fixes that we probably all agree on in a bipartisan sense. So should they continue to prioritize working on that?

Dr. NAHVI. If you need more bandwidth, I am happy to help. I know a lot of citizens that would sign up for this.

Mr. COLE. I appreciate that, but I don't think that is quite within your power legislatively.

Dr. BROWNE. Universal health coverage is one way to fix it.

Ms. COLLINS. I think that there are a lot of good ideas on the table and many bills that would move the system towards universal coverage, and even small little fixes could help millions of people.

Mr. COLE. Mr. Barkan.

Mr. BARKAN. Both, please. Thanks very much.

Mr. COLE. Okay.

Mr. BAKER. Yeah, if you could do fixes that would move the situation forward, do them, but I just don't see this coming at the expense of a comprehensive solution.

Mr. COLE. Well, I am out of time. Could I ask one quick question?

The CHAIRMAN. Absolutely.

Mr. COLE. Okay. You are very kind, Mr. Chairman.

Mr. Blahous, let me ask you this, is Medicare going broke now?

Mr. BLAHOUS. The Medicare Hospital Insurance Trust Fund is projected to be insolvent in 2026. That is actually less than half of Medicare. The other half of Medicare, by definition, cannot go insolvent because it is statutorily constructed so that you always give it enough money, but it also has financial strains going forward. So both sides of Medicare are in trouble.

Mr. COLE. Let's fix what we have got first before we launch into a new system. I mean, I think there is a lot of risk involved in this when we have a system that millions of Americans depend on that is going broke right now under the current financing mechanism we have.

Thank you, Mr. Chairman.

Mr. BAKER. Before the Affordable Care Act it was projected to go broke in 2019, this year.

Mr. COLE. It suggests to me that we should be working on that, not Medicare for All.

The CHAIRMAN. I yield another 2 minutes for Mr. Woodall.

Mr. WOODALL. If you are offering, Mr. Chairman, I accept. Thank you. And if I could ask unanimous consent, Mr. Chairman, I have got a letter from the Partnership for Employer-Sponsored Coverage that I would like to have entered into the record.

The CHAIRMAN. Without objection.

[The document is printed at page 261]

Mr. WOODALL. As you would imagine, they support employer-sponsored coverage.

And, Dr. Collins, I just wanted to clarify. I think in response to a question the chairman asked you about plans going away, your response was it is not true that anyone would lose their insurance coverage. I think we so often conflate insurance coverage and healthcare access.

I think what is actually true is everyone would lose their insurance coverage because health insurance would no longer exist in America. Healthcare would exist in America. Am I misunderstanding the dynamic?

Ms. COLLINS. Well, this is a single-payer insurance plan so people would have access to a set of benefits, and that would give them access to healthcare. I guess maybe I am not understanding your question.

Mr. WOODALL. Well, let me go to one of our actuaries. The reason the trust fund is going to be insolvent isn't that we are planning to stop providing care to people. It is that we have prefunded it through payroll taxes. There is no insurance out there. We just have a pot of money, and we are using that pot of money to pay for every claim that comes through the door. We are no longer insuring against risk; we are indemnifying folks with first dollar coverage.

Mr. BLAHOUS. You are talking about under Medicare for All?

Mr. WOODALL. Under Medicare today.

Mr. BLAHOUS. Right. I mean, you are basically providing first dollar provision of the entirety of people's healthcare. So, right, in a sense you are not insuring them against the risk of a large future health expense or an unforeseen event. You are basically providing payment for every service, routine and large.

Mr. WOODALL. And I wasn't trying to wordsmith. I am just saying there is a different set of challenges to fix the insurance system than to fix "I am sick and I can't get access to care" system. I have not heard Mr. Nahvi care two hoots about solving problems for insurers. He wants to solve problems for patients, a different challenge.

Tell me, from a financing perspective—I appreciated Mr. Morelle's questions. We serve on the Budget Committee together. We are not paying for the promises we make today. We are not paying for the wars we are in. We are not paying for the healthcare promises we make. I have got \$3 trillion in revenue, \$4.5 trillion in expenditures. I am happy to spend my children's money, but apparently it is not important enough to me. I do think it should be important enough to us. This is an issue that is important to all of us.

What is the order of magnitude that your numbers suggest we would have to increase our individual citizen contribution to pay for Medicare for All?

Mr. BLAHOUS. Well, again, on the national level, we are talking somewhere between \$32 trillion, \$38 trillion in additional funds provided to the Federal Government. On a per-capita basis, that is about \$10,000 per head.

Now, to your other point, we have a very substantial financing shortfall in our current Medicare system, and we have not figured out how we are going to finance that yet. That is a much more manageable problem than trying to finance what is called Medicare for All. It is actually sort of a national single-payer system that differs from Medicare in many ways. But that is several orders of magnitude more difficult than financing current Medicare, which we have not yet figured out how we are going to do.

Mr. WOODALL. And that shortfall is not a Republican or Democratic shortfall. That is just an American shortfall. When you are talking about your numbers, these aren't Republican or Democratic numbers. There are conservative groups who are computing those scores and liberal groups computing the same order of magnitude?

Mr. BLAHOUS. The estimates are remarkably consistent, regardless of who makes them. I provided a table with my written testimony that shows if you adjust for the years being estimated and particular assumptions for administrative costs or drug costs or provider payments, you can basically get a lot of these different estimates to line up. And they are pretty much all in the same ballpark.

Mr. WOODALL. I am afraid I am out of time. I would welcome my chairman's indulgence, but in the——

The CHAIRMAN. But we let you go on for 2 minutes.

Mr. WOODALL. I thought I had abused it already.

The CHAIRMAN. Before I yield to Ms. Shalala, let me just say one thing, two things. First of all, Dr. Baker is going to have to leave at 3:10, so I don't know if there is anybody who has an urgent question for Dr. Baker. He is going to have to leave. He has got a hard stop. Thank you.

Let me just say one other thing. You know, the question, should we fix the Affordable Care Act, or should we do Medicare for All or single comprehensive; I believe we can do great things here if we want to, right? We can walk and we can chew gum at the same time. When we have an ACA fix ready to go that will help more people, we should pass it. But that doesn't mean you can't do more. We ought to be able to go on both tracks. I refuse to believe that we are incapable of doing great things. Look at our history, at what we have done. Medicare is a great thing, right? Social Security is a great thing. We don't have to be picking and choosing. We can be doing both.

And to my colleague, Mr. Woodall, I think I know what he is trying to do. He is trying to get a sound bite out here to say that people are going to lose their health insurance, you know, to add to the——

Mr. WOODALL. Mr. Chairman, I don't believe you are suggesting that my goal here is to get a sound bite on an issue as important as this one. I mean, I hope that is not your goal.

The CHAIRMAN. I hope I am wrong. I am simply saying that I think what is motivating us here is the fact that the system we have right now is deeply flawed and that we have 29 million Americans without insurance, over 40 million Americans underinsured. People are afraid to get sick. They are afraid to take their doctor's advice. There is something terribly wrong, and we need to fix it.

I know this is politically a hazardous topic to go down the road on, but we have to do it. I believe that this is a political condition, what we are faced with right now, because we can fix this. We have the resources to fix it. We have everything we need to fix it. It is whether we have the political will to fix it. And we will see whether we do or not. I hope we do, and that is why I think we can do small fixes, and we can do a larger piece here. Let me yield to Ms. Shalala.

Ms. SHALALA. Thank you, Mr. Chairman.

I actually think this has been a very smart hearing with very smart people and very good questions. So I want to thank all of my colleagues. The truth is if any of us had a chance to sit down and establish a healthcare system from scratch, none of us would have designed the system that we have.

It is a system in which we have cobbled together over the last half century or so a number of programs to fill gaps. Some people may call them incremental, but I don't consider Medicare and Medicaid or the Children's Health Insurance Plan or the passage of Medicare part D in the mid-2000s or the passage of the Affordable Care Act small steps.

We Americans are not afraid of giant steps. And certainly, Congress has demonstrated over and over again that they have the backbone to take on big problems, put their arms around it and try to find a solution. In fact, that Affordable Care Act actually extended the Medicare, the HI fund by 8 years once we established it because it offset a lot of costs that would have otherwise been there.

I want to see more changes in the healthcare system. I want to get to the place where Ady's family does not have to pay \$9,000 a month to allow him to live at home with his wife and child and where patients are not walking out of Dr. Nahvi's emergency room with treatable conditions. We need that kind of healthcare system.

I am for universal care. We have spent a lifetime filling in the blanks where the private sector couldn't fill in the blanks. Government has stepped up for the working, for working folks, for the poor, for senior citizens time and time again. But now what we have got is a system in which we thought the employer-based system was going to be the core of healthcare forever in this country. We adopted it after World War II. The unions bought into it. But it is deteriorating.

And anyone that has talked to employers or has looked at the statistics sees a deterioration of the employer-based system. I know that. I have been an employer. I have sat on corporate boards. CEOs are struggling with trying to predict their healthcare costs for the future. And what have they done? Most of us have shifted more cost to our employees, increased the deductibles. In fact, high deductibles have become the norm here in this country as we have tried to contain healthcare costs with very crude instruments.

Throughout all of that, Medicare in many places in many ways has been a star, because it has been better at reforming costs, at trying different kinds of reforms, but more importantly, from my point of view, at containing cost. But I am perfectly willing to debate the cost issue and how we are going to pay for it.

But we are here because the employee system is deteriorating in front of our eyes, as our companies have changed and as we have moved to a gig economy, as we have gotten smaller and smaller companies, as they have lost their leverage, and because we want better outcomes, because we pay twice as much as anyone else in the world for our healthcare.

I am far more interested in focusing on outcomes and how we get to outcomes and how we get an integrated health system. But I am for universal care. I think Medicare for All is one way of getting there. And looking at the VA and its integrated care system, at

TRICARE, at the military healthcare system, we got lots of experience.

And I am not afraid of transferring our system if that is what we decide to do because we have got platforms. We have got lots of experience in taking large-scale problems and integrating them, and we have got lots of platforms. Medicare happens to be one of the platforms that we could do it. I could build the system. I don't think I could do it in 2 years, but certainly our experience in the public system of taking advantage of platforms and extending it to more and more people is certainly possible.

Dr. COLLINS, I would really like to start with you, though. I have some questions. Private insurers have been less effective at controlling costs than Medicare itself. In fact, private sector costs have gone up faster. You have talked about that a little bit, but you haven't explained the reasons for it. Is it because they are a smaller part of the market than Medicare is? Could you talk us through the reasons why the private sector—before we laud the private sector, let's talk a little about the deterioration as well as the failure of the private sector to be able to control costs themselves.

Ms. COLLINS. Great question. One of the main reasons that we are seeing the price increases that we are seeing across the country in private insurance is the fact that prices are set through private negotiations between providers, hospitals, and insurers. And so providers, particularly in concentrated markets, have a lot of leverage to increase prices.

Ms. SHALALA. This is the complaints that hospitals have that they don't have enough docs to negotiate with, right? They don't have options?

Ms. COLLINS. Right. So insurers want a hospital in their networks because it makes their networks more valuable. So then that cost then gets shifted to the employers. So the employers have a higher premium than they might otherwise have, and they share those costs. They try to lower those costs, those premium costs, by increasing deductibles for employees.

Employees are already making wage concessions, but they are having to have benefits with higher deductibles that actually give them less coverage. That is really kind of a simple way of looking at how prices are determined and how that kind of filters through the system and hurts employees, particularly employees at the midrange of the income distribution.

Ms. SHALALA. Dr. Blahous, do you have anything to add to that, in terms of why the private sector has more trouble negotiating cost containment?

Mr. BLAHOUS. I really don't. I will be brutally honest, perhaps not that informative, but when I was doing the research for my paper, I found this area bewildering. I think Dr. Collins has a clearer view of the literature than I do. But obviously, I became informed in the course of the research of the paper about the discrepancies in payment rates between what Medicare pays and what the private sector pays, and I ran into a lot of conflicting explanations as to what was going on and why it was going on and what would be the consequences of making various changes.

I ultimately concluded that it would be a fool's errand on my part to venture too far into there and try to explain what was going on.

So, instead, I simply just flagged the issue. I noted where the payment rates are for private insurance relative to reported hospital costs, where Medicare's are. I flagged the issue, identified it, and noted some of the conflicting interpretations out there, but I fell well short of being able to explain it.

Ms. SHALALA. Do you, any of you, do you know very much about—I sat on the corporate boards, and one of the things that was apparent to me, particularly on healthcare boards, is that they are following the Medicare decisions on payment, that it is not the private sector setting up their own group to decide how much to pay; they are actually watching Medicare very carefully, and in many ways, Medicare is driving that cost. Is that your experience as well?

Ms. COLLINS. I will just jump in really quickly, but I think it goes to Congressman Morelle's question about Medicare and how it could lead in innovation in payment, bundled payment, all kinds of different ways of lowering healthcare costs. So it has been a leader. The Medicaid program has been a leader in lowering healthcare costs. There is not a lot of fat in the Medicaid program or the Medicare program. In fact, what is really driving cost in both those programs is enrollment rather than prices in the private—in the commercial market.

Ms. SHALALA. Do you know a way in which, without an integrated system, we can get better outcomes? Is there any experience in this country in getting better outcomes without an integrated system? It seems to me that the VA has better outcomes. TRICARE has struggled with outcomes, but have done a pretty good job, as has the military healthcare system.

Dr. BROWNE. But both of those are sort of integrated systems. So I don't think there is one that is not an integrated system. And I do want to add the comment, in terms of the Medicare costs, particularly for Mr. Cole, when you set—and I will just use the drive-by mastectomies that they had for a while, where patients had to stay in the hospital for a short time, get this procedure and go, so that you could lower the cost for those hospitals. The outcomes have been very different. They send patients home when they have congestive heart failure and some of those issues, and then the plans are penalized because, within a certain time period, those patients are coming back to the hospital. It is really not a cost savings under that program.

You have to, again, practice better healthcare if you are going to lower those costs, and that is an integrated system.

Ms. SHALALA. There is no question that Medicare Advantage has provided some integration, depending on the plan. And certainly in Florida, in my district, over 60 percent are in Medicare Advantage plans. They feel like it. But we are paying more for it. We are walking and we are paying at least 13 percent more for Medicare Advantage to get some integration, but it is still pretty fragmented when it comes to referrals for specialists.

And that is, it seems to me, where the system breaks down because Medicare Advantage, often the HMOs come together, but they are mostly providing primary care and then contracting for the specialty care and contracting with as low cost as they possibly can for the specialty care.

But I haven't seen the outcomes research on Medicare Advantage. Have any of you seen that outcomes research on Medicare Advantage? As far as I know, the research has not—even though we are paying more and people may be happier because they are going to one place, I would argue that Medicare Advantage is as close to Medicare as we are going to see—Medicare for All as we are going to see, but we don't know very much about the outcomes yet. And I assume that that is your experience as well.

And. Finally, let me give Mr. Barkan a chance to talk a little, again, about this fragmented healthcare system. How many interactions have you had to have with your private health insurance system in a month? Can you give us a feel for that?

Mr. BARKAN. Maybe 5 or 10.

Ms. SHALALA. You must be the best friend of your insurance company. These are all appeals, I assume, for them to cover more quickly?

Mr. BARKAN. I cost too much.

Ms. SHALALA. Mr. Barkan, of all of the people I have met on this Earth, you are the last person I would use that for. Thank you.

Mr. BARKAN. Congresswoman, I want to say how important your voice is in this debate. As Chairman McGovern said, this is a question of political will. Many Democrats are going to follow your lead on this, so I just want to plead with you to summon all the courage you can and help lead our country to a more rational, just, and humane system.

Ms. SHALALA. Mr. Barkan, I will try. I will try.

Thank you very much. I yield back my time.

The CHAIRMAN. Thank you very much.

I yield back to Mr. Cole.

Mrs. LESKO. Thank you, Mr. Chairman. One second, please.

You know, Mr. Chairman, as I was thinking about this, I thought of the different, like fire, police, teacher unions and associations that negotiate their health plans, and sometimes it takes them years to get what they want. And they often trade better health plans in lieu of higher wages or salaries and other things.

And so, Ms. Turner, would this bill take away the current healthcare plans negotiated by let's say the teachers' unions?

Ms. TURNER. Yes, it would. And I think one of the concerns that would be raised is the compensation that workers have forgone in order to get those benefits. Many believe that could be very, very disruptive, and it is something that would be of particular concern because union members make considerable sacrifices in their take-home pay in order to get their generous health benefits.

Mrs. LESKO. Thank you, Ms. Turner.

And, members, I am just actually a little surprised that some of my colleagues would—you know, understanding that these different unions—fire, police, teachers—negotiate a lot, and I know they do because they came to me when I was in the State legislature, and take away that and replace it with a one-size-fits-all government-run plan.

Thank you, and I yield back.

The CHAIRMAN. I acknowledge Congressman Chuy García from Illinois who is here, and we want to thank him for coming by.

I yield to Dr. Burgess.

Dr. BURGESS. Thank you, Mr. Chairman. Let's talk just a little bit about global budgeting and what it means. So, if you have a budget and you have more expenditures than your budget, what happens?

Mr. BLAHOUS. Well, then you are going to have to cut something. You are going to have to—you have to cut the excess or restrict what you are paying.

Dr. BURGESS. So can you envision a system where that would perhaps result in the rationing of care?

Mr. BLAHOUS. Well, yes. And if I might elaborate a little bit—

Dr. BURGESS. Please.

Mr. BLAHOUS. There has been some discussion here about the effects of Medicare for All upon the demand for services. The economic literature is actually very, very clear and unanimous on this point. People do use or demand more health services when their insurance covers more.

There was a very famous Rand insurance study several decades ago that demonstrated that when there is no cost-sharing, people utilize more services. There was a more recent study by Cabral and Mahoney about what happens when Medicare beneficiaries carry Medigap insurance that has first dollar coverage. Costs of the benefits that they claim goes up by about 22 percent.

So these are very real, very well-documented effects. So we would expect to see a very significant increase above and beyond currently projected health services under Medicare for All. So I am sorry, but just to quickly wrap up, when at the same time we are going to have various constraints upon supply because of the provider payment reductions. We don't know how those things will be balanced. The Urban Institute found there would be some insufficiency of supply to meet demand. I didn't have the ability to model that, but clearly something would have to give.

Dr. BURGESS. Something would have to give. I agree. And I am going to assume that the supplemental, Medicare supplementals have to go away under this bill that we are discussing today, I mean, because they would be duplicative and, by law, they would be unavailable to people, though it is not clear what the punishment would be for violating the law. I get that.

So, Ms. Turner, let me just ask you, on the innovation side, new products, new drugs, new treatments, new devices come to market. I got to tell you, I mean, I deal a lot with people who are affected by coverage determinations by CMS. So what happens to a patient? Do they have to just wait until the next budget cycle if there is one of these new CAR-T therapies or new sickle cell therapy? They just have to wait until the next budget?

Ms. TURNER. That is certainly what we see in Europe. We see that access to the most innovative and oftentimes the most effective medicines absolutely are restricted. As I said earlier, we have access to about 96 percent of new medicines over the last 11 years in the United States. In France, they only have access to about half as many new drugs. In Singapore, only 18 percent.

So other systems do provide chemotherapy, for example, but it is less likely to be with the newest and best chemotherapy drugs. And then innovation is crippled. We see in Europe that their formerly robust pharmaceutical, medical development, medical device indus-

tries have shrunk because of highly-restrictive payment policies in Europe.

The U.S. now is the medicine chest for the world. Most new drugs come from the United States because we continue to pay for them. We pay for research for the planet, and people object to that. But those new medicines are available because of the incentives that the companies have to continue to produce those new medicines. And without that, I think we would find that we have older drugs and leaky hospitals.

Dr. BURGESS. Right. And, of course, Cures for the 21st Century, an Energy and Commerce product, really moved the needle on that and Congress should be proud of that work.

So, Ms. Turner, if current medical care and hospital provider rates are mandatory rates set for all health services, that is going to have an impact on patient access, correct?

Ms. TURNER. Actually, the CMS actuary said that under cuts similar to those propose in Medicare for All, many hospitals would be forced to cut back dramatically on services, on operations, and some would have to close. Many physicians' offices would be operating in the red. So yes, and this is not us issuing this warning. This is the CMS actuary looking at the potential impact. Many medical facilities simply wouldn't be able to keep their doors open under the dramatic payment cuts required under Medicare for All.

Dr. BURGESS. True story, personal experience. If you are losing money on every patient, you can't make it up in volume. I learned that in the 1980s.

So, Dr. Blahous, you have made some assumptions regarding provider cuts. Is that correct?

Mr. BLAHOUS. Yes. Well, I have examined what was in the text of the bill, yes.

Dr. BURGESS. So someone asked a question about provider rates in other countries. Here is an op-ed from The New York Post, and I am going to ask unanimous consent to put it in the record.

The CHAIRMAN. Without objection.

[The document is printed at page 264]

Dr. BURGESS. Enrique Padron. In Cuba, doctors make the equivalent of 25 cents an hour, teachers 21 cents an hour, and pharmacists 8 cents an hour just for your reading pleasure.

So, Ms. Turner, in the first quarter of last year alone, Britain's National Health Service canceled 25,000 surgeries. Is this a problem for a one-size-fits-all system?

Ms. TURNER. It is a problem when you have a strict global budget, forcing hospitals to make decisions about canceling or delaying surgeries, and people are seriously impacted. And once again, patients in other countries with government-run systems have access to fewer of the new treatments. If you are in a private system, you do have access to more of the new treatments, better surgeons. If you are in a public system, you may not even know it, but you will have fewer options.

Dr. BURGESS. And, I mean, I do have to bring up the issue—and we talked about this offline a little bit—of patient autonomy. I have got a paper, Mr. Chairman, I would like to ask unanimous consent to put in the record—

The CHAIRMAN. Without objection.

[The document is printed at page 268]

Dr. BURGESS [continuing]. From the Journal of Bioethical Inquiry "When Doctors and Parents Don't Agree: The story of Charlie Gard," the very sad story from the National Health Service, where the determination was made by the hospital not to acquiesce to the parents' request to bring that child to the United States, where they thought they had a treatment for his mitochondrial disorder. And I would ask that be made part of the record.

So the 25,000 surgeries, is that isolated in government-run systems, or does that seem to be pervasive in government-run systems?

Ms. TURNER. Well, there is no one government-run system, obviously. And some do better than others in being able to reduce wait times.

Dr. BURGESS. That is a great point. I am going to interrupt you there.

Ms. TURNER. Yes.

Dr. BURGESS. With no thought for my personal safety, I attended the Commonwealth Fund's healthcare weekend. Thank you, Commonwealth Fund, for putting that on. I was the only Republican there. The director of the National Health Service was there. And he did point out to me that there is no single European health service. There is England. There is France. There is Germany. Canada, I believe, is structured provincially. The provinces run.

So this thing that we are building and with no cost-benefit analysis, with no double-blind controlled randomized study, no toxicity study, this thing that we are building, no one has ever seen a system that is this big. Our Medicaid system currently is larger than the National Health Service. I believe that is correct. But this Medicare for All bill that we have under consideration in the Speaker's committee, the Speaker's desire to have this bill heard today, that is going to be gargantuan. Is that a fair statement?

Ms. TURNER. It is a fair statement. And I do think you have to worry about centralized decisions over access to care. In the U.K., just recently, a commission that helps determine what benefits will be available decided that cataract surgery was not a high priority, and so cataract surgeries have been significantly curtailed.

If you have cataracts and you can't see, cataract surgery is not optional. But when you have centralized government bureaucracies deciding what services are available, that's what happens. I just don't think that is something that Americans are going to tolerate.

Dr. BURGESS. So, as a practical matter—and I don't understand from my reading of the bill, and I have read through it a couple times, and it is a frightening bill to read for me, but if you can't get your cataract surgery and there is an ophthalmologist down the street says, you know, I am doing these in my kitchen, what is to prevent that from happening? And what is to prevent a cottage industry of healthcare that then develops a black market of healthcare, if you will?

Ms. TURNER. Or offshore floating hospitals or Indian reservations could wind up being enclaves where you could actually be able to get private care.

Dr. BURGESS. And the cataracts are an interesting case study because during the Bush administration, the variable lens that could

be replaced during cataract surgery and do away with bifocals, Medicare said, "Hey, wait a minute, we don't pay for refractive services, so you only get a one-size lens," so Medicare patients were then—it was a pretty uncomfortable position for the Bush administration. We are going to deny the best treatment available to Medicare patients. And so they had to actually make a—and I remember when Dr. McClellan did it. And I was jubilant. I thought, oh, man, here is a balanced billing example that we can use. Patients were allowed to bring their own money to the transaction to get the state-of-the-art lens so they could read their Sunday paper without their readers. I mean, was I thought going to herald a new era of insight in the Medicare system, but I was wrong. But I did repeal the SGR. Thank you very much.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Okay. I want to—just some other people had wanted to say, so I will use the remaining time.

Let me just say one thing, a couple things before I yield to Dr. Nahvi and I think—who else wanted to? Dr. Collins. Dr. Browne.

I know, Dr. Burgess, you said you read the bill many times, and then you referred to the global budget. But the bill says, the reading that I read, that there will be a quarterly review of the global budget so we can choose to make sure that there are enough funds if there is any problem. So, I mean, that is actually written into the bill.

And, you know, I know, I mean, people like to speak in alarmist terms. And we talked about the Affordable Care Act. We talked, my friends will tell you, about death panels. Well, that wasn't true. It wasn't true then; it is not true now.

Dr. BURGESS. Well, Mr. Chairman, if we don't have a budget for this year, where are we going to get this budget?

The CHAIRMAN. Thank you. And then you also raised the issue of the U.K. and Canada and said that they can't get the latest, greatest services. I am not saying that we should be like the U.K. or Canada. I would like to think we can do even better.

But let me ask Dr. Collins just on this point. I mean, does that mean that the U.K. and Canada have worse outcomes than we do?

Ms. COLLINS. That is a really good point, and I was actually going to raise that. I mean, why is it then, such a gloomy picture was painted of the U.K., where, in fact, their outcomes and those in other industrialized countries with universal health systems are actually better than ours with less money spent.

I also think, Congressman Burgess, that at the conference, the director of the National Health Service did say that they were covering CAR-T service, CAR-T therapy. They made a determination that it was highly effective as a curative therapy, and so they made a decision to cover it. So there is a different metric that is applied I think than we often do.

Dr. BURGESS. I did relate to him that at MD Anderson Hospital in Houston, they have actually come up with a therapy that is as effective but much less expensive and can be administered as an outpatient without having to spend time in the ICU. I will be happy to provide a paper for you.

The CHAIRMAN. Dr. Nahvi.

Dr. NAHVI. Dr. Burgess, I did just want to respectfully point out that if we are going to be talking about a hypothetical future where there might be rationing, we need to make sure we don't forget that we have rationing right here today. And it is not for the most expensive and the newest drugs or not only for the most expensive and newest drugs, but patients that can't get antibiotics or antiplatelet medications. We have that rationing right here today.

And in regards to we would be the first country doing something like this, that is kind of what America is good at, to do things that no one else has done before.

The CHAIRMAN. Dr. Browne.

Dr. BROWNE. Thank you.

And, Mr. Burgess, just wanting to add to the point that we are really not talking about one size fits all, because we are talking about a universal coverage, but we have moved into precision medicine, where we are trying to give the therapy that is specific for those individuals. And when we take in the social determinants that are very important for those individuals, we know the kind of care. And so it is equity that we are talking about, not equality.

The CHAIRMAN. And I note Mrs. Lesko left, but someone just showed me a report that appeared in The Hill magazine, because she was curious about whether other committees would be doing hearings. And it says in that report that the Ways and Means Committee will do a hearing on this very bill. So she doesn't have to worry that we will be the only one.

I now yield to Mr. DeSaulnier.

Mr. DESAULNIER. Thank you, Mr. Chairman. You are almost done if you are down this end of the podium—the panel, I should say, you are almost done.

But I want to thank you all for your patience, your ability to articulate your thoughts and your professional experience. And I obviously want to thank Mr. Barkan for your tenacity and your being here and your good demeanor in spite of difficult personal lots. So thank you all for being here.

I am a little bit flummoxed, not unlike the hearing yesterday, with all due respect to my colleagues. The United States is number one in cost as a percentage GDP and as a cost per capita, almost twice other developed countries per capita for cost of healthcare. But our outcomes are the opposite of what you would expect, 28th in life and mortality, I think close to 30th in infant mortality.

So, for me, it just strikes me, not unlike the conversation yesterday about the energy economy and the environment, is that we are arguing about status quo versus a world that is already changing and how are we going to adjust to that. I am a co-author of the bill. I appreciate the author. And I think this is a discussion we have to have.

As a former small business person, I remember owning restaurants. And, fortunately, where I live in the bay area, Kaiser in the East Bay is very dominant. It started in the East Bay. So the closed system in Kaiser is over half the population of the two counties where I live. That is about 3 and a half million people. And they have been able in that closed system to provide a pretty good quality of care versus cost.

But when I started in the restaurant business 30 years ago, I could pay easily for Kaiser and pay a portion and, then after someone worked for me for 6 months, in full. But then towards the end, I had employees coming to me in tears, one manager in particular, where she couldn't pay the copay. So I came out of pocket as an employer, which goes to the statistics which Ms. Shalala talked about a little bit, is about the number of employees—employers I should say paying 100 percent or any portion. And I don't know what the numbers are for small businesses, but I think—I would imagine it is pretty staggering with small businesses and the cost of staying in business, just not being able to pay at all.

My memory from reading is in 2000 or 2001, almost 30 percent of employers paid 100 percent of their healthcare cost. Four years later, it had dropped by 10 percent. It has kept going down. So this model to me clearly doesn't work. So it is a question of what we are going to do about it.

Like Mr. Raskin, I am a survivor of cancer. Four years ago, I was diagnosed with stage IV chronic lymphocytic leukemia. I took a pill 35 minutes ago that keeps me alive that costs \$400. Senator Durbin said to me recently, because he knows of my health challenge, he says, "How is your health?" I said, "Fine, Dick, I have a pill in my pocket that I take every day that keeps me alive." And he goes, "How much does it cost?" And I said, "\$400." He said, "That is outrageous." I said, "Not to me; it keeps me alive." My oncologist said, "15 years ago, Mark, somebody would come in with the same diagnosis, and we would sprinkle some water on your forehead and say good luck." Now the life expectancy is 85 percent if you can get through the first 5 years, and I am almost there.

And a lot of this, as I have become familiar with it and gone out to NIH, actually was developed with taxpayer dollars. A doctor who worked for the Army for years and is now at Ohio State, Dr. Moynihan was nice enough, was the key person. And most of his research was taxpayer funded, much of the deployment. I went over to NIH and met with these young people making \$60,000, \$65,000 a year that went to Hopkins and Stanford and Harvard, and they are working at NIH because that is what they want to do.

So one of the things to me is apples and oranges, counting this right. And I am sorry that one of the panelists had to leave because this was directed at him, but I want to direct it at Dr. Nahvi, because I will lead into this, is, what are the real costs to the average consumer and then accurately. So, if we know those numbers about individual costs and outcomes in the GDP, see, it is a huge disadvantage to us, because if we weren't at 18 percent and if we were like the Japanese at 12 percent, with better outcomes, all that money could be going to more productive uses. Not that healthcare and keeping people alive, coming from me, isn't important, but we could be prioritizing.

So the reason why I have been able to afford this, there was an interesting story in *The Wall Street Journal* that I would ask everyone to read about people who are wealthy with my condition and having a challenge paying for what they are paying for on private care health insurance.

I was lucky enough to get elected to be a county supervisor. I chose to take my healthcare through what was the first county

public option of the United States when the Contra Costa Health Plan was approved, the HMO. And they paid—I am here alive today because of that. If not, if I had stayed a restaurant owner, I would have made a lot more money, but now when I look back in hindsight, if I was paying for Kaiser, Blue Cross Blue Shield, I wouldn't have nearly the service versus what the out-of-pocket cost would be.

So, Dr. Nahvi, I have an example from my experience as an elected official. In California, we delegate public health and delivery of services to the urban counties. Contra Costa, where I governed, was our biggest challenge, whether it is Los Angeles or all the urban counties, is the cost of the clinics and hospitals who do most of the indigent care. So one of the things we did when we rebuilt our county hospital—I was the swing vote—in L.A. at the time, their general fund contributions, with five hospitals and with an increasing indigent care population, was up to 23, 24 percent. Ours was going in the same direction. So we have tried in California to help the counties and say: You have got to cap your costs, be more efficient.

My point is, when we get down to 10 percent, that extra 15 percent we spent on libraries, the sheriff's department, economic development. So that is sort of the color of money. In your experience as a point-of-sale person, in different emergency rooms, you see people coming in the door, but their costs are all absorbed differently, but the consequences for who pays and subsidizes those costs are also different.

Could you speak to that on a personal level? And then I would ask Ms. Collins to also talk to that.

Dr. NAHVI. Sure. I think that if you go to different hospitals, people will be paying differently. And the interesting thing about New York is that we have a lot of hospitals that are right next door to each other that accept different types of insurance and different types of payments.

So there are two hospitals that I work at that are right next door to each other. If someone comes in and they have insurance, they will be taken care of, and if they don't, they often get referred next door to the public hospital, where they wind up receiving care and then that hospital does not get reimbursed for it. And then that contributes to the challenges of that hospital not having enough money, and it creates the cycle.

I think one of the good things about Medicare for All is that, in those hospitals that primarily serve the indigent population, they will be able to make more money because they will be reimbursed higher than Medicaid payments, and no one effectively will be uninsured. Every patient will be a paying patient.

Mr. DESAULNIER. Before we leave you, just another, some of the behavioral health costs. In Los Angeles, we see where they have been pushed out of the hospital. I know in my county, we always looked at—I was on Joint Conference Committee. We would look at indigent care in the psych ward. And we were stabilizing them and pushing them out, but they would go into the emergency room first. I think the statistic on people who commit suicide, 60 percent of them go to see a primary care physician within 60 days.

So that is another aspect I don't think we are talking about is we understand the neuroscience and the amazing research we are having on helping on behavioral health, but then the acuity of people who are going through the current system for medical conditions and then accruing greater liabilities, both real and financial on that side. And you saw that, I assume, in your experience.

Dr. NAHVI. Yes, I do. And the people that end up in the ER that can't be reimbursed, we end up all paying for that. I am not sure if that answers your question.

Mr. DESAULNIER. Yes, it does.

Ms. Collins.

Ms. COLLINS. Yeah. I just think on the benefits, the way we are designing benefits and the way employers are being forced to grapple with their higher costs are giving patients incentives or people incentives that goes against their own health interests.

So people are making decisions, based on their deductibles, about whether or not to fill a prescription, whether or not to skip doses of the prescriptions, because they are afraid of the cost. And it just really does run counter to how we would like people to think about their healthcare and getting better.

Mr. DESAULNIER. I don't know if others have had this experience, but I know the Rotary Clubs in my area take me out to their clinics where they have pro bono physicians and others who come. And especially in the disadvantaged communities, most of them who come to those Rotary clinics once a month, they won't go to the county hospital. They won't go because they are afraid of the cost. And some of it I am sure is part of white smock disease. Dr. Burgess would remember that. I have that. My blood pressure is usually off. I don't know why I don't trust doctors, Doctor, but I do now, because they have kept me alive. But the Rotary care stuff is really fascinating, because people will go to the Rotary clinics. And it is the same doctor, but the environment is different.

Just I guess I am really appreciative. I didn't fully anticipate this hearing. I think it was good and constructive and largely positive. I hope that we go on from here. And I think the genesis of this in the bill. I remember it was Madison—not that this is going to happen—who said: Just because a Member of Congress doesn't think their bill will happen immediately shouldn't inhibit them from introducing it. And I think this has, at the very least, restarted an important conversation in this country.

So, with that, Mr. Barkan, do you have anything to add to whatever is left of my 15 minutes, or is Mr. McGovern going to take it all?

The CHAIRMAN. No, no, no. You have your time.

Mr. DESAULNIER. As long as it is not Ed.

Mr. BARKAN. Thank you so much to members of this committee for having me. This has not been an easy trip to make, and it is a big risk for me, but I came here today because this is one of the most pressing crises facing our society. Every day I feel the weight of the moment. Every moment feels urgent, and I feel acutely my time running out.

I hope that sense of urgency is pressed on everyone here as we think about how to build a more fair and just society for all. We are at a crossroads as a Nation. We can either become a society

where care is rationed to those only with immense means to pay the most exorbitant, exploitative healthcare bills imaginable, or we can transform our society, alleviate families of the enormous financial burdens that come with a for-profit healthcare system, and live with more dignity and joy.

I sit before you today hopeful because I believe we will make the right choice. I believe the number of people demanding justice across the country will only grow, and I believe that we will win. Thank you again for having me.

Mr. DESAULNIER. It is all our pleasure. Thank you for being here.

The CHAIRMAN. Everybody has asked their questions. At this point, I will yield to Mr. Cole for his closing remarks, and then I will make closing remarks, and then we will let you all go home.

Mr. COLE. I want to begin, Mr. Chairman, by thanking you. I want to thank you for the manner in which you have conducted the hearing. You have been exceptionally generous with the time and kept us focused and very civil. So you can be very proud of your performance here, and we are all very proud of you.

And I want to thank all of our witnesses as well. Each of you have brought insight, knowledge, professionalism. You have all contributed to helping us grapple with what is, you know, a challenge at a societal level. And obviously, we heard a great deal today about the majority's highest priority in Congress, which is, in my view, putting everyone in a one-size-fits-all government-run health plan that will double everybody's taxes, eliminate choice, and put Medicare at risk.

It will take plans away from 173 million Americans and give them something they may or may not want and something they may or may not be willing to pay for. As we heard from Dr. Blahous, Medicare for All would cost a staggering amount, more than \$32 trillion over 10 years. Worth thinking about that.

The current Federal budget annually is about \$4.5 trillion. This would make it immediately \$7.7 trillion. The legislation has not proposed any way to pay for that. But Dr. Blahous told us that even if you doubled everybody's taxes and doubled the corporate tax rate, it still wouldn't cover these costs. And as my friend Mr. Woodall pointed out, we are not paying for all the healthcare we are getting now. We are putting an awful lot of it on the national credit card.

Dr. Baker offered up several ways to pay for this in his testimony. But many of those involve what euphemistically are called input costs or what everybody in the healthcare industry would call more than a 40 percent cut in their compensation. I can't imagine that an entire industry would accept that level of reduction.

And I would also note that such cuts would put everybody's healthcare at risk. Indeed, Ms. Turner testified that many hospitals would simply close if they had to take 40-percent pay cuts, as envisioned in this bill. If such cuts become law, the Medicare for All truly would become nothing more than a program that provided minimal care in exchange for astronomically high taxes and much longer wait times.

Most disturbingly to me, I think today's hearing made clear that Medicare for All would put the current Medicare system at risk. If

we force doctors and hospitals to take lower payments, we run the risk of pushing them out of the industry entirely, thus making it impossible for current Medicare beneficiaries who have paid into this program for a lifetime to receive healthcare.

In my home district, rural hospitals rely on higher reimbursement rates from private insurance to offset the lower reimbursement rates from Medicare patients. If these hospitals were to only be reimbursed at Medicare rates, most of them, quite frankly, would close.

If nothing else, today's hearing shows that the committees of jurisdiction need to consider this bill as well. And I am proud that you have both called on that, Mr. Chairman, and announced that at least one of those are going to take it up. I particularly hope my friend Mr. Burgess gets another crack at this in the Energy and Commerce Committee and the Ways and Means Committee and the Education and Labor Committee as well. All of them, frankly, have significantly more jurisdiction in this area than we have here. And to be uncharacteristically humble for our committee and ourselves, they probably have more expertise than we have here because they have both the staff and—I will let you argue that with Mr. Neal and his counterparts and Mr. Pallone, because, frankly, they do. I mean, they just focus on these things.

And guess what, I probably know more on Indian health than some of these things because I focus more on it. We don't have hearings up here. This is an unusual moment for us and a good one. I am not complaining about that, but I am glad you are going to have the opportunity for these issues to be discussed in front of the committees of jurisdiction.

Though I think the Democratic Medicare for All proposal is an extreme one, I would remind the majority that Republicans are, as Mrs. Lesko said, committed to working together to improve the system we currently have and to build on and improve what works and ensure that every American gets the quality of care that they deserve. And while it is always fashionable to want to do a once-and-for-all total comprehensive bill, we went through that with the ACA. And with all due respect to my friends, I heard phrases like "you can keep the doctor"—"if you like the doctor, you have you can keep him." "If you like the plan you have, you can keep it." And, you know, finally, "your insurance payments are going to decline by \$2,500." None of those things happened.

So count me as skeptical that a new one-size-fits-all system will achieve the objectives that its advocates have laid out with such optimism and such hope. And, you know, again, it is worth discussing for sure.

I would hope in the meantime, though, we do what everybody here agreed we ought to do in addition to looking at this, which I have no objection to, that we actually focus on smaller steps that we know can become law, that we know can actually happen. I look forward to working with my good friends on the other side of the aisle, certainly with you, Mr. Chairman, to make sure that we can do something that matters in the weeks and months ahead that makes a big difference.

And so, with that, Mr. Chairman, again, thank you for the hearing, thank you for the manner in which it has been conducted.

I yield back my time.

The CHAIRMAN. Thank you. And let me also thank our ranking member, Mr. Cole, for his participation in this hearing and for his courtesies and for his questions, quite frankly. I want to thank all my Republican colleagues as well. I don't agree with you on a lot of what you said, but I appreciate that this hearing, which is on a serious topic and was treated in a very serious manner.

And I was recounting to some of you that some members of the press and some colleagues who have been watching this on C-SPAN are kind of surprised that this has been such a civilized and in-depth hearing, and some of those people are on the committees of jurisdiction. I will tell Mr. Neal, who is the chair of the Ways and Means Committee, the second oldest committee in the Congress—we are the oldest—that he should follow our example.

I want to thank the staff on the majority and the minority side as well for all their work in this. I want to thank Congresswoman Jayapal's staff and Congresswoman Dingell's staff and Senator Sanders' staff and others who have been very helpful in working with us on what this hearing should look like.

I want to thank the panelists. You have been here since 10 o'clock this morning, nonstop with a short break. And I think everybody here was excellent. We may have some differences of opinion, but I think everybody did an excellent job. So I want to thank, again, all of our witnesses for their time today.

As this hearing comes to a close, let's remember why we are all here. We are here because 29 million Americans are still without health coverage; 44 million people are underinsured; and many more are paying ridiculous out-of-pocket costs for healthcare that just isn't there when they need it the most.

You know, there is no healthcare system like what we have in America, and I don't mean that necessarily positively. People are forced to go without care. Those with coverage have to wonder whether their insurance provider will play games with their coverage when they need it most. And all of us up here know exactly what I am talking about because that is the kind of casework we do each and every day.

What we have shown today, I believe, is that Medicare for All is possible, that we can build on the principles of the Affordable Care Act to make even bolder reforms, reforms that would give doctors like Dr. Browne and Dr. Nahvi the ability to treat patients and give them the best care every time without letting cost dictate medical decisions. That we can treat patients like Ady Barkan with the dignity that they deserve without forcing them to battle with insurance companies. If you walk away with nothing else today, know that we have the ability to do that.

Medicare for All is possible. It is reasonable. It can move forward, and I think it should, and I am proud to support this bill and to work with Congresswomen Jayapal and Dingell and many others who have been championing it. And by the way, that includes not just its supporters here in Congress but many advocates, the doctors, the nurses, the patient advocates, consumers and more all across the country who have worked tirelessly to make this historic day a reality. It has been a long time coming, and it is the result

of all the letters and the calls and the emails and advocating that has been going on for a very, very long, long time.

I believe in people power. I got to be honest with you. I don't think we would be talking about any of this if our constituents weren't raising their voices. I am proud to stand with you, alongside of you, for Medicare for All. And this is just the first phase of the conversation, and I look forward to continuing this dialogue with all of you.

Again, I want to say to Ady, I love this picture. And I look at your wife, Rachel, and your son, Carl, and I can't help but think how proud they all are of you. And I have been watching your dad, who is sitting behind you, and I could see how proud he is of your courage and your commitment to being here. This is a big deal, and your presence here is making a huge difference. I just want you to know that. We can do great things. We really can. But it means we have to stand up to the naysayers who tell us: No, you got to think small.

You know, we need to think bigger than tweets, right? We need to think about how we impact the lives of millions of people in this country, who are struggling every day, wondering whether or not they are going to go bankrupt because they are sick or their kids are sick. It just shouldn't be. As everybody has said on all sides, we can do better and we have to do better. So I again want to thank everybody for being here today. This is the first step. It is a big step, but we are on our way.

Thank you, and the Rules Committee is adjourned.

[Whereupon, at 3:55 p.m., the committee was adjourned.]



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**Testimony of National Nurses United
Before the House Rules Committee
Hearing on H.R. 1384—Medicare for All Act of 2019
April 30, 2019**

National Nurses United (“NNU”), the largest union representing registered nurses (“RNs”) in the United States, submits this testimony in support of the Medicare for All Act of 2019, H.R. 1384. With over 155,000 registered nurse members across the country, NNU proudly endorses the Medicare for All Act of 2019 and we urge the Committee to support H.R. 1384. NNU members, as registered nurses, care for people in their most difficult hours, when they are sick, injured, and dying. We witness the personal impacts of a flawed health care system in our hospitals and clinics every single day. Our primary responsibility is to protect the health and wellbeing of our patients by providing safe, therapeutic care at the bedside, but this is made increasingly difficult by our country’s broken health care system.

Under our current multi-payer system that is dominated by insurance, hospital, and pharmaceutical corporations, the basic health needs of tens of millions in the United States go unmet while health corporations soak-up billions of health care dollars. Today, the United States spends more money on health care than any other nation in the world, wasting hundreds of billions of dollars each year on unnecessary administrative costs, huge profit margins, and inefficiencies in our current system. The patchwork system of private for-profit insurers necessitates over \$200 billion per year in administrative-related activities, and represents 20 to 30 percent of U.S. health care costs.¹ Despite spending more money on health care than any other country, our country ranks at or near the bottom on many international health indicators, including on such critical barometers as average life expectancy, infant mortality, maternal mortality, and death from preventable diseases.²

Too many Americans—as individuals, families, businesses, and taxpayers—have been driven past their breaking point as a result of soaring health insurance costs. Health insurers, as market-driven corporations, enrich themselves by imposing harsh limitation in coverage and through perpetually increasing insurance premiums, deductibles, and co-pays. Private insurers deny between 11 percent to 24 percent of all claims for care,³ and they restrict patient choice through narrow provider networks, limited drug formularies, and other barriers to care.⁴ More than 40 percent of all U.S. adults under the age of 65 forego needed medical care, and 30 percent fail to fill a prescription or take less than the recommended dose.⁵ One third of U.S. adults say that, in the past year, they have had to

¹ Edward R. Berchick, Emily Hood, and Jessica C. Barnett. U.S. Census Bureau. “Health Insurance Coverage in the United States: 2017.” U.S. Census Bureau (Sept. 2018).

² Organization for Economic Cooperation and Development. “Health at a Glance 2017.” OECD Publishing (2017); Organization for Economic Cooperation and Development. “OECD Health Statistics 2018.” OECD Stat (Updated Nov. 2018).

³ U.S. Government Accountability Office. “Private Health Insurance: Data on Application and Coverage Denials.” GAO-11-268 (Mar. 2011), available at <https://www.gao.gov/new.items/d11268.pdf>.

⁴ See Grisat, Michelle. “Medicare for All vs. All the Healthcare that Each Can Afford.” National Nurses United & The Sanders Institute (Jun. 2017), available at <https://medicare4all.org/wp-content/uploads/MedicareForAll-Report-TSI-NNU.pdf>.

⁵ West Health Institute and NORC at the University of Chicago. “Americans’ Views of Healthcare Costs, Coverage, and Policy.” (Mar. 2018), available at <https://www.westhealth.org/wp-content/uploads/2018/03/WHI-Healthcare-Costs-Coverage-and-Policy-Issue-Brief.pdf>.

choose between paying for food, heating, housing, or health care.⁶ The inability to pay medical bills continues to be a leading cause of personal bankruptcy, with 66.5 percent due to medical debt and job loss due to illness.⁷ Of those whose illnesses led to bankruptcy, 75.7 percent had insurance at the onset of their illness.⁸

Even though the Patient Protection and Affordable Care Act enacted important improvements that have enabled more Americans to enroll in health insurance, out-of-pocket health costs continue to increase and many remain severely underinsured. These reform efforts temper, but do not resolve the fundamental problems embedded in the market-driven system of health care delivery. The rate of uninsured U.S. adults has risen in the past four years to nearly 30 million.⁹ An estimated 41 million more are underinsured,¹⁰ meaning that they have insurance but cannot obtain the care they need because they cannot afford their co-payments or deductibles.

Moreover, the ever-rising cost of health care and its discriminatory characteristics contribute to the growing national chasm in wealth inequality and health disparities. Of those uninsured, 59 percent are people of color.¹¹ African-Americans suffer higher death rates than whites at an earlier age due to heart disease, diabetes, cancer, HIV, and infant mortality,¹² and African-American women are three to four times more likely than white women to die in childbirth.¹³ High costs and poor health outcomes persist because access to insurance is not the same as guaranteed health care for all. Our country must do better.

The Medicare for All Act of 2019 improves and expands the overwhelmingly successful and popular Medicare program, so that every person living in the United States has guaranteed access to health care. Medicare benefits would be improved so that all comprehensive health services are covered, including dental, vision, prescription drugs, women's reproductive health, and long-term services and supports. It would require no out-

⁶ *Id.*

⁷ Himmelstein, David, et al. "Medical Bankruptcy: Still Common Despite the Affordable Care Act." *American Journal of Public Health*, (2019) Vol. 109 (3), available at <https://ajph.aphapublications.org/doi/10.2105/AJPH.2018.304901>.

⁸ Himmelstein, David, Elizabeth Warren, Deborah Thorne, Steffie Woolhandler. "Illness and Injury as Contributors to Bankruptcy." *Health Affairs* (2005).

⁹ Kaiser Family Foundation. "Key Facts about the Uninsured Population." (Dec. 2018), available at <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

¹⁰ Collins, Sara, Munira Gunja, and Michelle Doty. "How Well Does Insurance Coverage Protect Consumers from Health Care Costs?" *Commonwealth Fund* (Oct. 2017), available at https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_issue_brief_2017_oct_collins_underinsured_brief.pdf. Other studies estimate that up to 85 million people in the United States are underinsured. Pollin, Robert et al. "Economic Analysis of Medicare for All." Political Economy Research Institute (PERI), (Nov. 2018), available at <https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>.

¹¹ Kaiser Family Foundation. "Key Facts about the Uninsured Population." (Dec. 2018) available at <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

¹² U.S. Department of Health and Human Services. Office of Minority Health. "Infant Mortality and African Americans." (Last Updated Nov. 2017), accessed on April 26, 2019, available at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23>; Cunningham, Timothy et al. "Vital Signs: Racial Disparities in Age-Specific Mortality Among Blacks or African Americans — United States, 1999–2015." *Morbidity and Mortality Weekly Report* (May 5, 2017), available at <https://www.cdc.gov/mmwr/volumes/66/wr/mm6617e1.htm>; American Cancer Society. "Cancer Facts & Figures for African Americans 2019–2021." *Amer. Cancer Society*, 2019.

¹³ Centers for Disease Control and Prevention. CDC Public Health Grand Rounds. "Meeting the Challenges of Measuring and Preventing Maternal Mortality in the United States." Presented on Nov. 14, 2017, available at <https://www.cdc.gov/grand-rounds/pp/2017/20171114-maternal-mortality.html>.

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of-pocket costs for patients for any services, and would give all patients the freedom to choose the doctors, hospitals and other providers they wish to see.

Importantly, “gatekeeper” obstacles to receiving care—like insurance pre-authorization requirements, lifetime or annual limits, or network restrictions—would be eliminated under the Medicare for All Act of 2019. Health care choices would be a decision between you and your doctor and would no longer be a decision made by insurance company administrators. Similarly, the benefits under the program would be completely portable across the United States. There would no longer be gaps in coverage if you change jobs or move. And our health care would no longer be subject to the unpredictable network changes or the ability of your employer to annually negotiate a health plan.

The Medicare for All program would create huge cost-savings for the country through a series of measures. It would simplify the health system and cut administrative costs significantly. By improving payment systems to hospitals and other providers and by reducing the costs of prescription drugs through leveraged negotiations as a single-payer, the Medicare for All program would save the country trillions of dollars while also guaranteeing improved, quality health care to every person living in the United States.

Medicare for All is the only solution to the health care crisis in our country. On behalf of National Nurses United, we urge the Committee to support the Medicare for All Act of 2019, H.R. 1384.

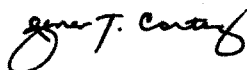
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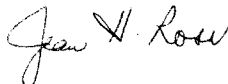
Bonnie Castillo, RN
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Deborah Burger, RN
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ATTACHMENTS

1. Medicare for All Act of 2019: Summary
2. Issue Brief, Medicare for All Act of 2019: Long-Term Supports & Services
3. Issue Brief, Medicare for All Act of 2019: Global Budgets & Other Reimbursements
4. Issue Brief, Medicare for All Act of 2019: Eliminating Health & Health Care Disparities
5. Medicare for All Act of 2019: Frequently Asked Questions
6. National Nurses United Report on Medicare for All

ATTACHMENT 1: Medicare for All Act of 2019: Summary

Today's health care system fails to provide quality, therapeutic health care as a right to all people living in the United States. Nearly 30 million Americans are uninsured, and at least 40 million more are underinsured, meaning that they cannot afford the costs of their copays and deductibles. The United States spends more money per capita on health care than any other major nation, yet the quality of our health care is much worse: life expectancy in the United States is lower, while our infant and maternal mortality rates are much higher. We waste hundreds of billions of dollars every year on unnecessary administrative costs, while health care industry executives measure success in profits, instead of patient care.

The current health care system in the United States is ineffective, inefficient, and outrageously expensive. It is time to remove the profit motive in health care, to resolve the inefficiencies, and to guarantee quality, therapeutic health care to every person living in the United States.

The Medicare for All Act of 2019, H.R. 1384 improves and expands the overwhelmingly successful and popular Medicare program, so that every person living in the United States has guaranteed access to health care with comprehensive benefits.

COMPREHENSIVE BENEFITS AND FREEDOM OF CHOICE

- The legislation provides comprehensive health care coverage, including all primary care, hospital and outpatient services, prescription drugs, dental, vision, audiology, women's reproductive health services, maternity and newborn care, long-term services and supports, prescription drugs, mental health and substance abuse treatment, laboratory and diagnostic services, ambulatory services, and more.
- Patients will have complete freedom to choose the doctors, hospitals, and other providers they wish to see, without worrying about whether a provider is "in-network."

NO PREMIUMS, COPAYS, OR DEDUCTIBLES

- Enrollment in Medicare for All would not require any premiums or deductibles. Upon receiving care, patients would not be charged any copays or other out-of-pocket costs.

LONG-TERM SERVICES AND SUPPORTS FOR PEOPLE WITH DISABILITIES AND OLDER AMERICANS

- Long-term services and supports will be fully covered by the Medicare for All program.

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- The legislation requires that the program presume that recipients of all ages and disabilities will receive long-term services and supports through home and community-based services unless the individual chooses otherwise.

REDUCING HEALTH CARE SPENDING AND IMPROVING CARE

- Medicare for All would simplify the health care system by moving to a single-payer model. This will reduce the hundreds of billions of dollars wasted on the administration of the current inefficient multi-payer system, allowing providers to focus on patient care instead.
- The legislation would prevent health care corporations from overcharging for the costs of their services and profiting off illness and injury. The legislation prevents providers from using payments from the program for profit, union-busting, marketing, or federal campaign contributions.
- The Medicare for All program would provide global budgets to all institutional providers to help contain the exorbitant costs present in the system today, and will allow the public to know where our health care dollars are being spent.

REDUCING THE COSTS OF PRESCRIPTION DRUGS

- The United States currently pays the highest prescription drug costs in the world. This legislation would allow Medicare to negotiate drug prices, as other countries do, to substantially lower the costs of prescriptions drugs.
- The legislation authorizes Medicare to issue compulsory licenses to allow generic production if a pharmaceutical company refuses to negotiate a reasonable price.

TRANSITION

- The transition to Medicare for All would occur in two years.
- One year after the date of enactment, persons over the age of 55 and under the age of 19 would be eligible for the program.
- Two years after the date of enactment, all people living in the United States would be eligible for the program.
- The legislation provides funding to help commercial insurance industry workers transition to other employment.

CARE FOR VETERANS AND NATIVE AMERICANS

- This legislation preserves the ability of veterans to receive their medical benefits and services through the Veterans Administration, and of Native Americans to receive their medical benefits and services through the Indian Health Service.

ATTACHMENT 2: Medicare for All Act of 2019: Long-Term Supports and Services

What are long-term services and supports (LTSS)?

Long-term services and supports (LTSS) are a critical health care benefit for people with disabilities and older adults. LTSS provides assistance for daily life activities, like bathing, eating, chores, and accessing the community. While LTSS can be provided in institutional settings like nursing homes, the vast majority of people with disabilities and older adults want to—and with LTSS can—live and participate in their own communities. LTSS is not just another service. LTSS is essential for people with disabilities to fully exercise their civil and human rights and fulfill the goals of the Americans with Disabilities Act: equality of opportunity, full participation, independent living, and economic self-sufficiency.

Current Coverage of LTSS

In our current health care system, LTSS is generally not covered by private insurance or the existing Medicare system, and few individuals or their families have the means to pay for these daily services out of pocket. The Medicaid program has become the primary payer of LTSS for people with disabilities and low-income older adults. But Medicaid has many disadvantages that restrict access to care. Medicaid's strict limits on assets and income force people into poverty to access LTSS. Medicaid also has an "institutional bias" that requires states to provide care in institutions but makes optional community-based LTSS—called Home and Community Based Services (HCBS). People are forced to wait on years-long waitlists for HCBS, having to rely on unpaid family caregivers (often women who are forced to leave the workforce) to avoid unwanted institutional care. There is a critical and growing need for HCBS as this country's population ages and more people want to age in place.

The Medicare for All Act of 2019 & LTSS

The Medicare for All Act of 2019 represents a major step forward for health care and particularly in providing LTSS for people with disabilities and older adults. It would dramatically expand and improve access to LTSS by eliminating all financial barriers to care, providing LTSS to all individuals regardless of income status, and replacing the institutional bias that currently exists in Medicaid with a presumption that services be provided to individuals in their own homes and communities instead.

Guaranteed Health Care for All Includes LTSS

- For people with disabilities and older adults, health care is both a matter of life and death and of liberty and civil rights. LTSS are vital to individuals' self-determination, independence, empowerment, and integration and inclusion in their communities.
- Medicaid's current eligibility guidelines trap individuals into poverty as a precondition to receiving services, hindering their economic opportunities and ability to save money for their future. Additionally, the coverage and quality of Medicaid-

funded LTSS varies by state, making access dependent more on their zip code than their needs.

- This legislation would ensure that all people with disabilities and older adults have access to the LTSS they need, including nursing and medical services, long-term rehabilitative and habilitative services, and services to support activities of daily living and instrumental activities of daily living, with an emphasis on services provided in the community.
- LTSS would not require any co-pays, deductibles, or premiums.
- LTSS would be provided when an illness, injury, or age limits an individual's ability to perform one or more activities of daily living or instrumental activities of daily living. Individuals with both physical and mental disabilities would be eligible.

Providing Community First Care

- The Medicaid program's institutional bias means that many states have limited access to LTSS provided to help people live in their own homes and communities, called HCBS, even though that is what the vast majority of people with disabilities and older Americans want. Over 500,000 individuals are currently on waitlists for HCBS.¹
- People currently have to wait years, sometimes even a decade or more, to receive HCBS. They are forced to rely on unpaid caregivers – often family members (and most often women) who have to leave the workforce to provide uncompensated care. Too many people are forced into unwanted institutional care because they cannot access HCBS in a timely manner.
- This legislation will reverse Medicaid's institutional bias by ensuring that all eligible individuals can timely access HCBS and presuming that recipients of all ages and types of disabilities will receive LTSS to help them live in the community unless the individual affirmatively chooses institutional care.

Community Consultation

- The legislation requires that the Secretary develop regulations in consultation with people who use LTSS, their families and caregivers, providers of LTSS, and disability rights, academic, and labor organizations.

¹ Kaiser Family Foundation, "Waiting List Enrollment for Medicaid Section 1915(c) Home and Community-Based Services Waivers". 2016.

ATTACHMENT 3: Medicare for All Act of 2019: Global Budgets & Other Provider Reimbursements

Medicare for All: Putting Patient Care Over Pocketbooks

The program outlined in the Medicare for All Act of 2019, H.R. 1384, takes several steps to ensure that providers can focus on patient care rather than on their pocketbooks.

- **Less Time on Billing, More Time for Patients.** Medicare for All would simplify the administrative process for doctors and other providers by having one payer. Precious time that doctors and other health care providers spend on billing and coding would be freed up, allowing providers to do what they do best—care for patients.
- **Negotiating Lower Prices.** Under the Medicare for All program, health care corporations would no longer be able to overcharge for their services. By leveraging its buying power as the single payer of health care, Medicare for All would be able to negotiate better, fairer health care prices for everyone. Reimbursement rates for hospitals and doctors will be based on negotiations with the regional directors. Negotiations over health care prices would include prescription drug price negotiations. The Act would also allow the HHS secretary to issue “compulsory licenses” to allow generic production if reasonable prices are not reached with pharmaceutical corporations.
- **Health Care Dollars No Longer Line Pockets.** The Medicare for All program would bar Medicare for All providers from siphoning off health care dollars to line their pockets. The Act does so through limits on executive pay and prohibitions on bonuses and other financial incentives for upcoding. Importantly, provider reimbursement must be used for the costs of providing care and could not be used for profit. The Act also prohibits Medicare for All providers from entering into financial relationships that could interfere with decisions on patient care. Health corporation board members would no longer be able to receive bonuses from pharmaceutical or medical device manufacturers for entering into exclusive contracts.

Global Budgeting for Hospitals & Other Institutional Providers

Under the Act, each hospital and each institutional provider—including skilled nursing facilities, federally qualified health centers, home health agencies, and independent dialysis facilities—will be paid through an institution-specific “global budget”.

- **Negotiated Annually.** The global budgets would be negotiated annually between institutional providers and regional directors. Institutional providers would receive a fixed annual allowance, paid and reviewed quarterly, to fund operating expenses related to furnishing health care to Medicare for All members. Major factors

included in negotiations are historical volume and costs of care, projected changes in volume and type of care, and wages for all employees, including physicians that work directly for the hospitals. Capital expenditures for costs such as renovating facilities or building new ones will require separate approval from the regional director.

- **Aligning Hospital Reimbursements With Actual Costs.** Global budgeting simplifies the reimbursement system so that payments more closely reflect the actual costs of providing health care to the population served by each hospital and institutional provider.² The global budgeting process would allow the Medicare for All program to ensure that providers get the appropriate funding for the health care services that their patient population needs—providers would be accountable for their spending and would no longer be able to overcharge.
- **Simplification of Hospital Reimbursements.** By eliminating the billing process, global budgets bring hospitals and other providers administrative simplicity and associated savings. Information necessary to predict annual global budgets—including financial cost data, case mix, and volume of services—is readily available and already captured by hospitals and other institutions.³ Additionally, this information is already reported to the Centers for Medicare and Medicaid Services in Medicare cost reports.
- **Transparent and Accountable Spending.** Global budgets allow for the public to know where our health care dollars are going and it helps us ensure that rural hospitals and hospitals in underserved areas are getting the funding that they need. Providers must report all relevant data associated with operational costs and justify their spending during annual negotiations. With periodic audits and review, providers would be held accountable for their projected spending and the program could monitor whether the provider is meeting program goals and standards. Budget shortfalls, unexpected or emergent public health conditions, or other marginal cost differences between planned and actual health care spending can be addressed through budget adjustments year-over-year or through quarterly reviews.
- **Funding Certainty for Hospitals Serving Vulnerable Communities.** Global budgets can be a blessing to hospitals that serve rural and underserved communities that currently have inconsistent or undependable funding streams. Global budgets would ensure that our safety net hospitals that provide care to low-income, rural, and minority communities are sufficiently funded and resourced. The American Hospital Association agrees that global budgets are good for stabilizing funding of vulnerable rural and urban hospitals.⁴
- **International Use of Hospital Global Budgeting.** Many countries with publicly-funded health care—Canada, Scotland, Wales, New Zealand, Australia,

² Dredge, Robert. *Hospital Global Budgeting*. World Bank Health Nutrition and Population Discussion Paper. World Bank (2004), pp. 37-38.

³ *Id.* at pp.18, 37-38.

⁴ American Hospital Association. “Ensuring Access in Vulnerable Communities – Taskforce Report and Resources.” (2016), available at <https://www.aha.org/system/files/content/16/ensuring-access-taskforce-report.pdf>.

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Denmark, Sweden, Switzerland, Norway, Iceland, Ireland, and Singapore—use global budgets as key components of their hospital payment methodologies.⁵

- **Successes in Global Budgeting in the U.S.** Notably, Maryland has been successfully paying all hospitals in the state through global budgets since 2014, and the city of Rochester, NY successfully implemented hospital global budgets in the 1980s for almost a decade under a Medicare waiver. In Rochester, global budgets led to lower overall health care costs for families and a 17% reduction in the hospital component of total health care spending. Administrative costs were 7% compared to 14-24% nationally. In Maryland, global budgeting resulted in \$429 million in hospital savings for Medicare within 3 years of implementation outperforming Medicare's initial goal of \$330 million in savings over 5 years.⁶ Following Maryland's successes, Pennsylvania recently adopted global budgets for its rural hospitals.

Payment Options for Doctors & Medical Group Practices

There are two payment options for doctors and doctor groups under the Medicare for All Act of 2019—reimbursements based on the Medicare fee schedule or salaries based on negotiated global budgets. The Secretary of the U.S. Department of Health and Human Services would establish a national fee schedule in consultation with doctors and regional directors. Instead of payments based on the national fee schedule, individual providers and group practices could opt to receive salaries through an institutional providers' global budget.

⁵ See Mossialos, Elias et al. "International Profiles of Health Care Systems." The Commonwealth Fund (May 2017); Wolfe, Patrice and Moran, Donald. "Global Budgeting in OECD Countries." *Health Care Fin. Rev.* (1993) Vol 14:3.

⁶ Sabatini, Nelson et al. "Maryland's All-Payer Model—Achievements, Challenges, And Next Steps." *Health Affairs Blog* (Jan. 31, 2017), available at <https://www.healthaffairs.org/doi/10.1377/hblog20170131.058550/full/>.

ATTACHMENT 4: Medicare for All Act of 2019: Eliminating Health and Health Care Disparities

Despite spending more on health care per capita than any other country in the world,¹ the United States has extreme health and health care disparities among racial and ethnic populations.² These disparities typically impact African Americans, American Indians, and Alaskan Natives the hardest, with the Latinx and immigrant communities also experiencing significant disparities.³ H.R. 1384, the Medicare for All Act of 2019 (Act), contains provisions that address these disparities.⁴

Unlike our current market-driven system, the Act would guarantee quality, therapeutic health care for all individuals in every community in the United States, including our medically underserved rural and urban areas. It begins to address the structures that drive income, racial, and ethnic inequality in our health and healthcare by providing comprehensive health care benefits to all without regard to the ability to pay—with no deductibles, copayments, or other out-of-pocket costs. This would remove the financial and administrative barriers to care created by private insurers seeking to extract profit at the cost off of our health.

Currently, many low-income and minority communities face overcrowded hospitals and clinics, hospital closures, and shortages of nurses, doctors, and other health care professionals. H.R. 1384 would ensure that our safety-net and critical access hospitals, both rural and urban, are sufficiently resourced and that our communities are staffed with sufficient nurses, doctors, and other providers to promote good health where possible and provide therapeutic care where needed.

The Act would end our tiered system of health care by directing funds based on human need and explicitly targeting health care disparities. The national health budget, allocated regionally, includes separate funding for day-to-day operating expenses such as wages, medical supplies, overhead; capital expenses such as renovating facilities or building new ones as well as major equipment purchases; and special projects that

¹ Organization for Economic Cooperation and Development. “How Does the United States Compare?” (2017). Accessed April 26, 2019. <https://www.oecd.org/unitedstates/Health-at-a-Glance-2017-Key-Findings-UNITED-STATES.pdf>

² Caruso, Dominic F., David U. Himmelstein, Steffie Woolhandler, MD. “Single-Payer Health Reform: A Step Toward Reducing Structural Racism in Health Care.” *Harvard Public Health Review* (2015). Accessed April 26, 2019. <http://harvardpublichealthreview.org/single-payer-health-reform-a-step-toward-reducing-structural-racism-in-health-care/>

³ *Id.*

⁴ H.R. 1384 contains several sections related to funding that are discussed and cited below. It also contains robust non-discrimination language (Section 104) and detailed reporting requirements on health and health care disparities based on race, ethnicity, gender, geography, and socioeconomic status so that funding can be directed where needed (Sections 401 and 502).

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address needs in medically underserved and health professional shortage areas.⁵ Each of these budget components takes health care disparities into account, particularly the funding for capital expenses and special projects.

Funding of Provider Operating Expenses

- H.R. 1384 explicitly includes “efforts to decrease health care disparities in rural or medically underserved areas” as one factor in determining operating expenses.⁶ Such efforts could include funding for additional staff, extended operating hours, and additional supplies.

Funding of Provider Capital Expenses

- Health care providers must apply for, and the HHS Secretary must approve, funding to renovate or build new health care facilities or to purchase major equipment. The Secretary prioritizes funding “to improve service in a medically underserved area ... or to address health disparities among racial, income, or ethnic groups, or based on geographic regions”.⁷
- In contrast, current private funding for renovating or building new health care facilities and purchasing major equipment generally is based on whether, and how quickly, the expense will be recouped based on the revenue it generates. Thus, privately owned or funded organizations, even those that are not-for-profit, typically favor investing in affluent suburban and urban neighborhoods with low numbers of uninsured.
- Publicly-funded facilities—such as health care provided by safety net hospitals and clinics—have been seriously underfunded leaving many minority, low-income, and rural communities with overcrowded facilities or no facilities at all. Under the Act, funding for capital expenses will be allocated based on need—with the express aim of reducing, and ultimately eliminating, health care disparities—rather than on maximizing revenue. This creates a strong foundation for publicly-funded health care facilities.

Funding of Special Projects

- Special projects funding is used exclusively “for the construction of new facilities, major equipment purchases, and staffing in rural or medically underserved areas ... including areas designated as health professional shortage areas ...”.⁸
- Medically underserved areas are geographically defined areas with a shortage of primary care services as well as sub-groups of people living within these

⁵ The national health budget in H.R. 1384 also includes funding for quality assessment, health professional education, and other expenditures. See Section 601.

⁶ H.R. 1384, Sec. 611(b)(2)(G)(ii).

⁷ H.R. 1384, Sec. 614(c)(2).

⁸ H.R. 1384, Sec. 601(a)(7).

areas including people who are homeless, low-income, Medicaid-eligible, Native American, or migrant farm workers. Medically underserved areas are designated based on the Index of Medical Underservice (IMU) which is calculated based on four criteria: the ratio of providers to the population, the percentage of the population with income below the federal poverty level, the percentage of the population over the age of 65, and the infant mortality rate.⁹

- Health professional shortage areas—areas that have a shortage of primary care providers, mental health practitioners, or dentists—are primarily rural and low-income urban areas, but also include specific population groups within a geographic area such as those described above, and facilities such as state mental hospitals, federally qualified health centers, Indian health facilities, and tribal hospitals.¹⁰
- In addition to purchasing new equipment and building or renovating health care facilities, special projects funds could be used to provide scholarships for medical education, loan repayment or in exchange for practicing in rural or medically underserved areas or areas with a shortage of health care professionals, additional compensation to attract and retain health care professionals, and other programs.

By redirecting money to care based on need, that currently is diverted to profit and high administrative costs in our complex multi-payer billing system, the Act ensures that everyone living in the United States receives the care they need.

⁹ Health Resources and Services Administration (HRSA). “Medically Underserved Areas and Populations (MUA/Ps).” *U.S. Department of Health & Human Services* (Reviewed Oct. 2016). Accessed April 25, 2019. <https://bhwh.hrsa.gov/shortage-designation/muap>.

¹⁰ Health Resources and Services Administration (HRSA). “Health Professional Shortage Areas.” *U.S. Department of Health & Human Services* (Reviewed Oct. 2016). Accessed April 25, 2019. <https://bhwh.hrsa.gov/shortage-designation/hpsas>.

ATTACHMENT 5: Medicare for All Act of 2019: Frequently Asked Questions

What is Medicare for All?

- The Medicare for All Act of 2019 would establish a single-payer health care system, which would expand the existing Medicare program to cover everyone in the United States and improve it so that everyone would be guaranteed comprehensive benefits without regard to their ability to pay.
- A single government agency would replace private insurance plans and provide public financing of health care. Because of the generous benefits package available under Medicare for All—including dental, vision, long-term services and supports, comprehensive reproductive services, and mental health services—with no cost-sharing, there would be no need for catastrophic or supplemental coverage to meet most health needs.

Would there be out-of-pocket costs, premiums, deductibles, or other cost-sharing under Medicare for all?

- Under Medicare for All there would no premiums, co-pays, deductibles, or other out-of-pocket payments. There would be uniform benefits and one standard of comprehensive care—guaranteed healthcare for everyone no matter what the size of your wallet.
- Employers would no longer be burdened with annually negotiating health plans or paying private insurer premiums.
- Seniors would immediately benefit from coverage that would be more comprehensive than Medicare, and would no longer need to purchase supplemental insurance to cover aspects of their care.

Would choice of doctors be limited?

- Medicare for All expands choice because you can see any doctor, go to any clinic, and be admitted at any hospital. Medicare for All is completely portable and not tied to any job, any doctors group, or any network.
- Medicare for All reforms only how health care dollars are collected and paid to providers; it does not dictate which providers individuals can visit.

Would the government be making decisions on care?

- Under the Medicare for All Act of 2019, the program would put health care decisions into the hands of you and your doctor instead of insurance companies and corporate boardrooms. Currently, unaccountable insurance companies call the shots on our health care and tell us which procedures are approved or what is necessary or unnecessary care.

- The Act also ensures that the professional judgment of doctors, nurses, and other health care professionals in consultation with their patients is the basis for health care decisions.

How is Medicare for All better than private insurance?

- With Medicare for All, Americans would no longer have to deal with persistent changes to their health insurance when their employers annually renegotiate plans, and we would no longer be at the mercy of commercial insurers that suddenly change which doctors or hospitals are inside or outside their network. Even if you are unemployed, or lose or change your job—your health coverage under Medicare for All stays with you.
- Even the best private insurance plans in this country do not cover the comprehensive list of services without any out-of-pocket costs or premiums paid by you or your employer. Under Medicare for All, everyone would have comprehensive benefits and full choice of provider without having to pay perpetually increasing premiums, copays, or deductibles.
- Under Medicare for All, everyone would have the same high standard of quality health care guaranteed, from birth to death. On the other hand, private insurers, as for-profit corporations, have an incentive to deny necessary care in order to maximize profits. When enrollees receive health care services, health insurers consider these losses. Insurers also view vulnerable populations, rural areas, women, and minority groups as risks to the corporate ledger.

Shouldn't we try a Medicare buy-in or public option first?

- Medicare buy-ins and public option plans perpetuate current inequities in our system of health care. These stop-gap measures placed on existing commercial insurance systems, shore up the profit-driven insurance system. Under a public option or Medicare buy-in, private plans would maximize revenue by cherry-picking coverage of only the healthiest people and leave the public plans to care for all the sickest and most expensive cases.
- Unlike Medicare for All, public options and buy-ins retain administrative complexity and will not produce the financial savings that we can capture with Medicare for All. These programs also cannot wield the massive negotiating power of single payer system to reduce health care prices and contain skyrocketing costs.
- Even worse, the public option and Medicare buy-in still place limits on coverage and eligibility, restrict the choice of providers, and impose costly premiums and out-of-pocket costs in the form of deductibles and copayments. "Access" to a health plan is not a guarantee of health care.

Would Medicare for All save taxpayer money?

- Taxpayers already finance nearly two-thirds of health care spending in the United States.¹ Medicare for All would produce savings because insurance industry profit, executive compensation, advertising, and marketing would no longer be necessary. We currently spend about 31 percent of total health expenditures on billing and insurance-related costs and other administrative costs.² And we spend at least \$30 billion per year on health care marketing.³
- Medicare for All would eliminate administrative waste created by private insurance and the attendant administrative complexity that comes with a multi-payer system.
- The Act would also control health care spending by eliminating marketing costs and prohibiting health industry profiteering, and excessive executive pay from public health dollars.
- The Medicare for All program through its bulk purchasing power, would negotiate not only lower drug and medical equipment prices, but also lower prices for other health care costs through global budget negotiations with hospitals and other institutional providers.
- Studies have shown that Medicare for All would save the country up to \$5.1 trillion over 10 years.⁴ Conservative estimates conducted by the Mercatus Center concluded that the U.S. would save \$2 trillion over a ten-year period under Medicare for All.⁵ The savings produced from reduced health care prices under Medicare for All would be allocated to expand benefits and to eliminate deductibles, copays, and out-of-pocket costs for everyone.

How much will doctors get paid?

- Reimbursement rates may go up for some doctors and down for others Medicare rates have tended to fall in between Medicaid and private insurer rates. Changes, if any, in how much a provider makes will depend on each specific provider's payer mix (or the mixture of payment sources the doctor gets now).

¹ Himmelstein, David and Woolhandler, Steffie. "The Current and Projected Taxpayer Shares of U.S. Health Costs." *Amer. J. of Pub. Health* (Mar. 2016), Vol 106:3, pp. 449-452.

² Total administrative costs are estimated to be over \$1,097 billion in 2017. Steffie Woolhandler and David U. Himmelstein. "Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs." *Ann Intern Med.* (2017) 166(8):587-588. According to the Centers for Medicare and Medicaid Services national health expenditures was \$3,492.1 billion in 2017. Centers for Medicare and Medicaid Services. "Historical National Expenditures." National Health Expenditure Accounts (2017), accessed on April 26, 2019, available at <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccounts/historical.html>.

³ Schwartz, Lisa and Woloshin, Steven. "Medical Marketing in the United States, 1997-2016." *JAMA* (2019) Vol 321:1, available at <https://jamanetwork.com/journals/jama/fullarticle/2720029>.

⁴ Pollin, Robert et al. "Economic Analysis of Medicare for All." Political Economy Research Institute (PERI), (Nov. 2018), available at <https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>.

⁵ Blahous, Charles. Mercatus Working Paper. "The Costs of a National Single-Payer Healthcare System." Mercatus Center at George Mason University, Arlington, VA (Jul. 2018), available https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf.

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- Rates may change based on the type of medicine a doctor practices because the Medicare for All program would ensure that primary care doctors in rural and underserved areas are sufficiently paid. Primary care physicians may see rates increase while specialists may see them reduced. Providers in rural and underserved areas would see reimbursements and funding stabilize.
- By reducing time on billing and paperwork, changes to rates could be offset because doctors have more time to spend on caring for patients and for other reimbursable services.

Does the legislation provide comprehensive reproductive services to women?

- Medicare for All would dramatically improve access to important reproductive services, including contraception coverage, comprehensive maternity and newborn care, reproductive health screening, abortion care, and family planning services.
- Medicare for All ensures that women have access to comprehensive benefits that include early and periodic screening, diagnostic, and treatment services. These services are important to prevent reproductive diseases and other illnesses that women are more at risk of developing, including lung and breast cancer.⁶
- The Act would ensure that any restrictions on the use of federal funds for reproductive health services, including the Hyde Amendment, would not apply to Medicare for All funds. The Act also includes a non-discrimination clause, which bars discrimination on the basis of pregnancy, including termination of pregnancy.
- Despite an international decline in maternal mortality rates, the United States has seen an increase. More women die of pregnancy-related complications in the U.S. than any other developed country.⁷ The Act includes comprehensive maternity and newborn care, which is critical to lowering mortality rates and improving health outcomes for women and babies.

What impact would Medicare for All have on workers and is there a plan for a just transition?

- The Act would direct at least 1% of the Medicare for All budget for the first 5 years towards assistance programs for any workers displaced from the implementation of the program, including workers in health insurance and billing-related jobs.
- Just transition funding would include wage replacement, retirement benefits, job training, and education benefits.

⁶ Jemal, Ahmedin et al. "Higher Lung Cancer Incidence in Young Women Than Young Men in the United States." *New Eng. J. of Med.* (2018).

⁷ Martin, Nina and Montagne, Renee. "The Last Person You'd Expect to Die in Childbirth." *ProPublica & National Public Radio* (May 12, 2017).

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How are community health care needs addressed under Medicare for All and how are preventive services covered?

- Medicare for All provides health planning by region through special projects and capital expenditure funds. Regional planning ensures that hospitals and clinics are built in communities where they are needed and ensures that providers who serve vulnerable communities, which insurers currently view as a risk to corporate bottom lines, are appropriately paid under Medicare for All. By increasing care capacity in local communities, many racial, economic, and geographic disparities in health and health care would be mitigated and life expectancy improved.
- By removing financial roadblocks to care, Medicare for All encourages preventive care. This not only reduces the occurrence of pain and illness but it also decrease the societal cost of untreated disease and overuse of emergency rooms.

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**ATTACHMENT 6: National Nurses United
Report on Medicare for All**

Full report included below.

MEDICARE FOR ALL VS. ALL THE HEALTHCARE THAT EACH CAN AFFORD

Michelle Grisat
National Nurses United
The Sanders Institute
June 2017



the
Sanders Institute

www.TheSandersInstitute.org www.NationalNursesUnited.org

MEDICARE FOR ALL VS. ALL THE HEALTHCARE THAT EACH CAN AFFORD

We stand at the crossroads between guaranteeing healthcare to everyone through an improved and expanded Medicare program and leaving increasingly more people at the mercy of the market with legislation such as the American Health Care Act. Now is the time to take on our market-driven system and fight for an improved and expanded Medicare for all.¹

In contrast to our current system, a Medicare-for-all health plan would provide comprehensive healthcare benefits for all medically appropriate care without regard to income, employment, or health status. Instead of many insurers, each with a variety of health plans and cost-sharing schemes, funding for healthcare would be administered from a single government fund based on a uniform set of benefits.² Payments would be negotiated by representatives of the Medicare-for-all plan and representatives of hospitals, physicians, and other providers. Finally, prescription drugs, medical devices, and other related supplies would be negotiated in bulk for the entire U.S. population at reduced prices. There would be a single standard of excellence in care for all – not bronze for some and platinum for others. People would be free to seek care from any participating healthcare provider. We would receive the care our doctors and nurses determine we need – not what a profit-seeking insurer deems it will cover or deny. Finally, care would be provided without deductibles or copayments thereby easing economic inequality and health disparities.

This paper begins by examining our market-driven healthcare system and the failings of our private insurance system. It includes discussions on why adding a government-run public insurance option to the ACA private insurance marketplaces could not remedy the problems the marketplaces face and on the limitations in care under a market-driven system. Finally, it will examine the major features of a Medicare-for-all system and how our country could provide healthcare as a right, not a privilege.

Corporate Healthcare and the Games that Insurers Play

For decades, corporate healthcare has played a major role in defeating attempts to guarantee healthcare for all. The influence of this sector decisively shaped the Affordable Care Act (ACA). In the years leading up to and following the passage of the ACA, 2006 through 2012, the health sector spent \$3.4 billion on lobbying – more than any other sector for four out of seven years and second for the other three.³ It also contributed a whopping \$709 million in campaign contributions over that same time period.⁴ Of this \$709 million, \$332 million went to Republicans, \$304 million went to Democrats (\$23 million to candidate Obama in 2008), and the balance went to outside spending groups. The “investment” in lobbying and campaign contributions paid off. By spending these vast sums, corporate healthcare was able to block measures that would have improved our healthcare system, but interfered with the health industry’s ability to reap enormous profits, and win provisions

that guaranteed increased healthcare industry profits.

Still, in many ways, the ACA was a step forward. Those with pre-existing conditions can no longer be denied coverage and insurers cannot base premiums on health status. The number of uninsured has dropped considerably, with 20.4 million gaining coverage from 2010 to 2016.⁵ Unfortunately, the ACA didn’t go far enough. With plans available in the ACA insurance marketplaces requiring cost sharing ranging from 10% to 40%, on top of premiums, cost continues to make it prohibitive for many to access healthcare. Catastrophic plans are even worse. Even though the federal government has been propping up the insurance marketplaces through premium support and cost-sharing subsidies, paid by taxpayers to private insurers, these insurance marketplaces have struggled from the beginning. These struggles have been exacerbated under the current administration.

Some contend that adding a public option to the ACA insurance marketplaces could serve as a corrective to the abuses of the profit-based insurance industry and, perhaps, even be a first step on the road to Medicare for all. The public option plans, as designed by a pair of current congressional bills,⁶ would be administered by the federal government, funded by premiums, and have their own provider networks. The public option plans would be offered alongside the private insurance plans in the marketplaces and be subject to the same terms and conditions, including the premium tax credits and cost-sharing reductions as the other metal plans – bronze, silver, gold, and platinum. The idea is that a public option would be able to drive down insurance prices by competing against private health plans as a low-cost option that would not need to spend huge amounts on executive compensation packages, turn a profit, or pay dividends to shareholders.⁷ However, the market for health insurance differs dramatically from markets for most goods and services in such a way that increased competition does not necessarily drive down prices. Though the differences are many, consider just two. First, those buying insurance are unable to predict in advance what type of healthcare they may need; even those currently being treated for a health condition may have unanticipated health needs arise. The second and crucial point is that the private insurance business model, which seeks to limit claims paid on policies, conflicts with the very reason most people have for purchasing health insurance, the need for healthcare. Insurers' biggest costs are what they term *medical loss*, or the costs of paying for policyholders' covered healthcare services. Thus, insurers strive to limit how much they pay out in claims for care provided to their enrollees. Health insurers do not focus on maximizing policy sales, but on maximizing sales to individuals who they deem will pay more in premiums than they cost in care. Competition among health insurers amounts to competing to sell policies to healthier individuals (also known as "cherry picking").

This practice continues under the ACA even with thousands of pages in statutes and related regulations. Studies have documented discriminatory insurance policies on the marketplaces that place key HIV/AIDS, cancer, and multiple sclerosis drugs in the

highest cost-sharing tier in a drug formulary.⁸ Selective provider network design offers another means of excluding costly patients. For example, the network may include a limited number of oncologists and other specialists or exclude academic medical centers and cancer treatment centers.⁹ Although increased competition generally may lower premiums in some of the ACA insurance marketplaces,¹⁰ the question remains whether a public option would have a sufficient competitive edge over private plans to keep premium rates affordable, particularly when the private insurers game the system.¹¹ As the public option would not want to replicate the unscrupulous practices of private insurers, it is likely to end up with a great number of costly enrollees that private insurers want to offload, making it nearly impossible for the public option to maintain competitively priced premiums, discrediting the role of the government, and undermining support for public programs such as Medicare and Medicaid.

Moreover, in many areas where the ACA marketplaces are down to a lone insurer, competition is not the problem.¹² Rather, many are losing money as the enrollees are much sicker and costlier.¹³ Insurers that remain in these areas have raised their premiums by double digits and, in one case, triple digits.¹⁴ In the four states which dropped down to one insurer in 2017, the increases ranged from 29% to 69%, while cities and counties with a single insurer saw increases ranging from 26% in Anchorage, Alaska to 145% in Phoenix, AZ – which dropped from eight insurers in 2016 to just one in 2017.¹⁵ Recent filings for 2018 indicate further dramatic rate increases.¹⁶ The only solution to bringing down premiums is to broaden the risk pool by inducing those who are younger, healthier, and less costly to enroll. Given the cost and quality of many of the insurance plans in the ACA marketplaces, this would be very challenging even without the sabotage of the current administration. It may prove to be impossible to cover costs while maintaining premiums at a level that enrollees can manage. Without federal premium support, the premiums required to cover the cost of care in these markets would surely outstrip many enrollees' ability to pay and, thus, end in a death spiral. The larger issue here is that even if a public option were the answer to saving the insurance marketplaces, we would still be left with the tiered plan model and 10% to 40% cost sharing or worse, a catastrophic plan.

Finally, not only do private insurers avoid covering the most costly patients, they also attempt to limit care to those they do cover. In a more insidious approach than outright denial, insurers impose clinical practice guidelines and protocols that interfere with physician autonomy by limiting the types of tests and treatments that the insurer will reimburse. Physicians may not be able to order a test because a patient does not meet the criteria in the “guideline” the insurer designates, whether or not the criteria are relevant to a particular patient’s circumstances.¹⁷ In cases where an insurer, hospitals, and physicians work together as a health plan, such as a health maintenance organization (HMO) or an accountable care organization (ACO), care is often limited through the electronic health record (EHR). EHRs go beyond an electronic version of a paper chart that merely records information.¹⁸ Protocols and guidelines, as well as programs to order tests and treatments, can be embedded in the EHR as clinical decision support. Although these software programs may be called clinical decision “support,” and the embedded clinical practice requirements may be called “guidelines,” they often function as hard-and-fast rules that override physicians’ professional judgment as well as limit the full professional practice of nurses and other practitioners that care for patients. As protocols and clinical practice guidelines are based on studies and data regarding a certain percentage of a patient population as a whole, they may not apply to a particular patient. Practitioners must be free to provide care based on their professional judgment about the tests and treatments appropriate for their individual patients.

All the blame for high premium costs cannot be laid at the feet of insurers, however. Consolidation in hospital and physician practices has also contributed to the increased cost.¹⁹ The rate of increase in hospital consolidation has accelerated in recent years. Since 2009, the number of hospital mergers and acquisitions has doubled and the number of independent community hospitals has dwindled.²⁰ In 2015, the most recent year for which data is available, only one in three hospitals remained independent.²¹ Price gouging in the hospital industry becomes readily apparent by examining charge-to-cost ratios – that is, the relationship between how much a hospital

charges compared to its costs. The latest data show that, on average, hospitals charge 379%, nearly four times, more than an item or service costs. Hospitals that belong to systems have, on average, charge-to-cost ratios that are 53% higher than independent hospitals.²² Hospitals are quick to say that this is what they charge, but it is not necessarily what they receive in payment. Yet, as insurers typically negotiate rates based on a percentage of what hospitals charge, the more they charge, the higher their profit margin.²³ Unfortunately, the horrifying irony of our current system is that the uninsured pay the highest rates of all.²⁴

If there is any doubt that our market-driven healthcare system is failing us, two measures, expenditures and health status, make it clear. Although the United States consistently spends more on healthcare than any other country, it typically has poorer results. The most recent data from the Organisation for Economic Co-operation and Development (OECD),²⁵ a widely utilized source for making international comparisons, show that the United States spent 16.9% of GDP, nearly twice the average rate of 9% for the 35 member countries.²⁶ The differences are even greater in the amount we spent per person. At \$9,451, we spent nearly two and half times the \$3,814 average of OECD countries.²⁷ Yet, despite the amount we spend, the patchwork U.S. “system” leaves 28 million uninsured and millions more underinsured.²⁸ The result is poorer health and shorter lives. A widely cited study by the Commonwealth Fund comparing the United States to ten other countries ranked the U.S. dead last overall as well as in the categories of healthy lives, cost-related problems to access, equity, and efficiency.²⁹ A second study, covering 195 countries regarding deaths that were preventable had the patient received “timely and effective medical care,” ranked the U.S. at number 35 on its Health Access and Quality index – in between Estonia and Montenegro.³⁰ The worst U.S. scores were for lower respiratory infections, ischemic heart disease (coronary heart disease), and chronic kidney disease. Looking strictly at the United States, we find a recent dip in the average life expectancy,³¹ a gap of 10 to 15 years in life expectancy between the richest and the poorest among us,³² and numerous health disparities related to class, race, and sex.

Medicare for All: How it Works

Corporate control of healthcare and our misguided faith in the market has resulted in an inefficient, fragmented “system” that leaves millions with little or no access to healthcare. Our current approach treats healthcare as a commodity on a par with other commodities rather than a public good. We have accommodated the failure of the private insurance market by cobbling together the most expensive public-private system the world has ever seen. The shift to a Medicare-for-all plan reorients our system to providing healthcare as a right, not a privilege. It would be a tremendous step toward ending health disparities and would mitigate economic inequality. Finally, recent public opinion polls demonstrate that a strong majority of Americans favor Medicare for all. In December 2015, the Kaiser Health Tracking Poll found:

When asked their opinion, nearly 6 in 10 Americans (58 percent) say they favor the idea of Medicare-for-all, including 34 percent who say they strongly favor it. This is compared to 34 percent who say they oppose it, including 25 percent who strongly oppose it. Opinions vary widely by political party identification, with 8 in 10 Democrats (81 percent) and 6 in 10 independents (60 percent) saying they favor the idea, while 63 percent of Republicans say they oppose it.³³

A 2017 poll by the Pew Research Center demonstrates that support is growing.

Currently, 60% of Americans say the government should be responsible for ensuring health care coverage for all Americans, compared with 38% who say this should not be the government’s responsibility. The share saying it is the government’s responsibility has increased from 51% last year and now stands at its highest point in nearly a decade.³⁴

So what’s stopping us? Supporters of our market-driven model typically sabotage efforts to provide Medicare for all by focusing on how we would pay

for it. This is disingenuous. We are already paying for it; we’re just not receiving it. Approximately two-thirds of U.S. healthcare expenditures already come from taxpayers in the form of federal, state, and local government spending.³⁵ Healthcare in the U.S. costs more both because of administrative complexity and higher prices, rather than increased utilization. The comparisons of U.S. spending and health outcomes to other countries strongly suggest that there is enough money in our current system to provide healthcare for all, if we spend that money fairly and wisely. The key point is to demonstrate that there is enough money currently being spent on healthcare in the U.S. to provide Medicare for all, rather than specifying particular funding mechanisms.³⁶

As mentioned above, we would reap enormous savings by eliminating private insurance company costs such as profits, shareholder dividends, excessive executive compensation, and marketing costs. Additional savings would come from the uniformity in health benefits and in claims and billing processing. Instead of many insurers, each with a variety of health plans and cost-sharing schemes, funding for healthcare would be administered from a single government fund based on a uniform set of benefits.³⁷ Hospitals, physicians, and other providers would no longer need large billing departments to manage payments or to pursue collections from the uninsured and the underinsured. Each of these areas is discussed in more detail below.

Cost sharing — copayments, coinsurance, and deductibles. Eliminating patient cost sharing is a first step to achieving health equity and easing the economic inequality that is rife in our country. The very idea of requiring patient cost sharing, also called “out-of-pocket costs,” derives from a market-based approach to healthcare. Those who take this economic approach to providing healthcare argue that people need to “have skin in the game,” meaning that they must have a financial stake in accessing

healthcare, otherwise they will use their health insurance indiscriminately and not just when they truly need it.³⁸

Research confirms that even minimal cost-sharing requirements reduce healthcare utilization.³⁹ Unfortunately, cost sharing keeps people from seeking both needed and unneeded care.⁴⁰ This should not come as a surprise; laypersons cannot be expected to know prior to seeing their healthcare provider whether or not they need medical treatment. As the cost of providing care has increased, costs have been shifted to individuals and families. Imposing higher deductibles, copayments, and coinsurance is a double win for insurers; healthcare utilization drops and they pay less when healthcare is used. Today, millions with health insurance delay seeking healthcare or filling a prescription because of high deductibles, but even copayments can be difficult for many to manage.⁴¹ Those who are sick or low income fare the worst.⁴² Thus, eliminating cost sharing reduces both health disparities and economic inequality.⁴³ Finally, while prompt treatment of injury and illness is reason enough to eliminate cost sharing, in some cases it also reduces the overall cost of treatment.⁴⁴

Administrative savings. Administrative savings would come from two primary sources: insurers and providers such as doctors and hospitals.⁴⁵ On the insurer side, eliminating private insurance company waste such as profits, shareholder dividends, excessive executive compensation, and marketing costs would produce tremendous savings. Having a single, comprehensive benefits package and a single payer, the federal government, creates uniformity in claims and billing processing. Doctors and hospitals would no longer need large billing departments to manage payments or to pursue collections from the uninsured and the underinsured, nor for preauthorizing tests and treatments or checking drug formularies before prescribing medications. This would produce additional savings that could be redirected to care. Overall, replacing our complex, fragmented health system with its many insurers – each with multiple benefit packages and numerous cost-sharing schemes – would produce savings of 9.3% to 14.7%.⁴⁶ Based on projected national health expenditures of more than \$3.5 trillion dollars in 2017, this would amount to \$330 to \$520 billion in administrative savings alone.⁴⁷

Global budgets. Hospitals, nursing homes, and similar facilities, as well as home care agencies, would receive a fixed lump-sum annual budget, called

a global budget, rather than getting paid separately for each patient's hospital stay. A global budget, typically paid out in monthly installments, would reimburse the facilities for all their operating expenses and, under a separate budget, for capital expenses such as new buildings and equipment. The savings would accrue primarily from reduced administrative costs related to billing and insurance. The administrative savings estimated above derive, in part, from global budgeting for hospitals and other healthcare facilities. Multiple studies have documented the savings achieved by using the global budget approach.⁴⁸ A recent study of hospital administrative costs in eight countries found that Canada and Scotland, which are paid using global budgets, had the lowest administrative costs at 12.4% and 14.3%, respectively.⁴⁹ In contrast, hospitals in the United States, which must manage a far more complex billing system, had the highest administrative costs at 25.3%.

Capital investment. A Medicare-for-all program would require approval for investment in expanding medical facilities and major equipment purchases to ensure they are allocated fairly and where needed. The approval process would prioritize capital investment in projects that address medically underserved populations and health disparities related to race, ethnicity, income, or geographic region. This approach contrasts sharply with a market-driven approach which seeks to maximize revenue. For years, hospital corporations have shuttered “underperforming” hospitals in communities with high numbers of uninsured, often reopening them a few miles down the road in areas with better insurance coverage and higher incomes. Most public hospitals, which typically care for the uninsured, on the other hand, have been severely underfunded and stand in need of critical infrastructure and equipment upgrades. Thus, relying on the market has resulted in a maldistribution of healthcare resources from what should be the guiding rationale, providing care to those who need it. Finally, our current system often leaves expensive equipment standing idle. For example, in a profit-seeking healthcare system with hospitals in relatively close proximity to one another, if one hospital purchases an MRI machine, the other

area hospitals may feel the need to do so in order to claim the same capabilities as they compete against each other. In contrast, a Medicare-for-all plan would direct investment in expensive equipment, new hospitals, and medical offices where it is needed, not where corporate healthcare deems most lucrative.

Bulk purchasing. The pharmaceutical/health products industry has spent more money lobbying than any other industry every year since 1999. The spending topped out at \$274 million in 2009, with spending at a still sizeable amount of \$246 million in 2016.⁵⁰ In addition, the industry has contributed millions to federal campaigns. According to the Center for Responsive Politics: “The pharmaceutical and health products industry ... is consistently near the top when it comes to federal campaign contributions. ... The industry’s political generosity increased in the years leading up to Congress’ passage in 2003 of a Medicare prescription drug benefit.”⁵¹ This appears to have been money well spent. As part of the Medicare Modernization Act of 2003, Congress not only created a Medicare prescription drug benefit, but also prohibited the Health and Human Services Secretary from negotiating prices or creating a formulary of approved prescription drugs.⁵² The Center for Responsive Politics also found that “industry spending levels have fluctuated, though they have usually hovered around the \$30 million range...”⁵³ That is until 2012, when campaign contributions increased to over \$50 million and topped out in 2016 at nearly \$60 million.⁵⁴

A Medicare-for-all plan would negotiate prices on drugs and medical devices for the entire U.S. population.⁵⁵ Thus, it would garner far greater bargaining power than our fragmented system of insurers, each competing against each other and seeking to maximize profits. Negotiating with pharmaceutical companies would bring the costs of prescription drugs in this country in line with the rest of the world. A recent study found that this alone would have saved \$113 billion in 2017.⁵⁶

Primary care. Research shows that access to primary care, understood as having a usual place of care, continuity over time, care coordination, and a whole-person focus—rather than focusing on a particular disease or body part as specialty care often does—leads to better health.⁵⁷ Greater emphasis on primary care lowers overall costs by facilitating

earlier intervention in disease processes, staying current with preventive measures, and reducing the use of emergency departments. Eliminating cost sharing is crucial to meeting these goals.⁵⁸

The U.S. lags behind other countries in both access and health status, and spends far more, partially due to a shortage of primary care physicians.⁵⁹ Although estimates differ as to the magnitude of the growing shortfall of primary care physicians, all agree that it is significant. The mid-range projected shortfall in primary care physicians is 7,800 to 32,000 by 2025, increasing to 7,300 to 43,100 by 2030.⁶⁰ In addition to this general shortage, many geographic regions and populations are currently suffering due to a severe shortage of primary care physicians. According to the U.S. Health Resources & Services Administration, there are 6,790 health professional shortage areas⁶¹ that need primary care physicians, predominantly in rural and low-income urban communities and among specific population groups within a geographic area such as the homeless, migrant farmworkers, and other groups.⁶² Over 69 million people live in a shortage area—more than one in five Americans.⁶³ More than 10,000 primary care physicians are needed now to provide the care they need.⁶⁴

The market has clearly failed to distribute primary care physicians where they are needed or to fulfill overall demand. A difference in compensation between specialists and primary care providers, coupled with the massive debt many students incur in becoming physicians, has resulted in too few primary care physicians. On average, primary care physicians earn far less than specialists. A recent survey found that average annual full-time physician compensation was \$294,000 with specialist compensation 46% higher than primary care physicians at \$316,000 and \$217,000, respectively.⁶⁵ Orthopedic surgeons, at the top of recent compensation surveys, make more than twice as much as family medicine physicians, who are at or near the bottom.⁶⁶ A Medicare-for-all program could address these needs, for example, by increasing the number of primary care residencies, scholarships, and loan-repayment programs; targeting education of primary care physicians through dedicated Graduate Medical Education funding; and increasing the reimbursement of primary care physicians.⁶⁷ Although none of these ideas is new, a Medicare-for-all program

would reorient our healthcare system to put primary care at the center with a focus on preventive care and early intervention and treatment.

Physician compensation. First, to prevent inequity in access and care, physicians who accept payment from the Medicare-for-all plan would be prohibited from also receiving compensation for patient care from private payers, including patients themselves. Second, physicians would be required to accept payment by the Medicare-for-all plan as payment in full. There would still be some physicians who would cater to the wealthy, but there would not be inequity in access or care within the system based on higher reimbursement from private payers or additional fees charged on top of the Medicare-for-all payment rate. Finally, no part of physician compensation would derive from incentives to provide less care such as performance bonuses linked to utilization or profitability.⁶⁸

Representatives of physicians, and other practitioners, would negotiate compensation with representatives of the Medicare-for-all plan. Physicians and their staff would spend far less time on insurance-related administrative matters such as billing and prior authorization for treatment. This decrease in overhead expenses would factor into overall compensation. Compensation would be on either a fee-for-service basis or by a fixed salary, for those working for an organization paid on a per capita basis or operating under a global budget.

The negotiations would also address the difference in compensation between primary care physicians and specialists. This pay inequity lies in undervaluing the cognitive-based services that primary care physicians provide compared to procedure-based services that specialists tend to provide.⁶⁹ Unlike surgeons and other specialty physicians who are paid based on the number of procedures they perform and often use complex, expensive equipment, “primary care physicians spend most of their time providing cognitive services, such as acquiring and assimilating information, developing management strategies, coordinating care, and counseling.”⁷⁰ While some specialists would still be compensated at higher rates than the primary care generalists, the difference between rates would be reduced.

Conclusion

Numerous studies document the many inefficiencies of our “system” and its high financial costs. Likewise, study after study documents our failure to provide healthcare to all those who need it, as well as the vast disparities in health and healthcare in terms of class, race, and sex. Finally, our failure to guarantee healthcare to all exacerbates economic inequality through high out-of-pocket costs for care, medical debt, and bankruptcy.

The reason is clear. As discussed above, a market-driven approach to providing care is based on a business model that fundamentally conflicts with the very reason that people purchase health insurance. Whereas private insurers aim at limiting the amount they “lose” by paying for healthcare, people purchase insurance for the express purpose of accessing healthcare when they need it. A Medicare-for-all program would be accountable to the people, not to shareholders and the bottom line. Rather, it would facilitate the distribution of healthcare resources, such as new facilities and equipment, based on human need, not market share. Compensation for physicians and other healthcare providers would encourage better primary and preventive care. Rural and low-income urban areas would no longer be neglected. Additional resources would be directed to medically underserved areas and populations.

The threat by Congress and the Trump Administration to repeal the ACA makes this a crucial and timely issue. Although the ACA has improved healthcare insurance access, it did so by further entrenching the private insurance industry. Improving our current Medicare system and expanding it to cover everyone is the best solution. If we stand together, we can achieve it.

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- ³ Center for Responsive Politics. Influence & Lobbying. (<https://www.opensecrets.org/lobby/>, accessed May 12, 2017). The health sector includes pharmaceuticals/health products, hospitals/nursing homes, health professionals, health services/HMOs and miscellaneous health. Calculations based on data retrieved from online database.
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- ³⁷ To prevent tiered care, insurers, including employers who self-insure, would be prohibited from providing coverage for benefits provided by the Medicare-for-all plan, but could offer supplemental insurance. Typically, temporary assistance for up to five years would be provided to workers displaced by the change.
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⁶⁷ Sanders, Bernard. (2013, January 29). Primary Care Access: 30 Million Patients and 10 Months to Go: Who Provide Will Their Primary Care. (<https://www.sanders.senate.gov/imo/media/doc/PrimaryCareAccessReport.pdf>, accessed May 18, 2017).

⁶⁸ The Working Group on Single-Payer Program Design. "Beyond the Affordable Care Act: A Physicians' Proposal for Single-Payer Health Care Reform." (http://www.pnhp.org/beyond_aca/Physicians_Proposal.pdf, accessed May 22, 2017). This proposal also identifies ways to address concerns that fee-for-service payments inappropriately drives up utilization such as "monitoring for extreme practice patterns; adjusting fee schedules to attenuate discrepancies between cognitive and procedural care; enforcing regional caps on fee-for-service payments; and facilitating education on low-value medical interventions."

⁶⁹ Goodson, J. D. (2010, June 1). Patient Protection and Affordable Care Act: Promise and Peril for Primary Care. *Annals of Internal Medicine*, 152(11):742-744. doi: 10.7326/0003-4819-152-11-201006010-00249 (<http://annals.org/aim/article/745811/patient-protection-affordable-care-act-promise-peril-primary-care>, accessed May 18, 2017).

⁷⁰ Ibid.



Testimony of Diane Archer,
President JustCareUSA.org

Before the U.S. House of Representatives
House Rules Committee

April 30, 2019

My name is Diane Archer. I am the President of Just Care USA, an online portal that helps older adults and their caregivers understand and navigate health and financial issues. I have devoted most of my professional life to Medicare policy. Thank you Chairman McGovern and members of the U.S. House of Representatives House Rules Committee for considering my written testimony in support of the Medicare for All Act of 2019, H.R. 1384.

I want to share my thoughts on a very important and often overlooked aspect of the Medicare for All debate: How Medicare for All will greatly improve the lives of people with Medicare. Any discussion of this issue starts with the unacceptable state of the broader American health insurance system.

Americans of all ages are increasingly being forced to make health care choices no one should have to make. Two in threeⁱ of us forego needed care in order to afford the rent, the heat, our dinner. In our commercial insurance marketplace, health care choice too often means gambling with our health. Not surprisingly, more than nine in ten Americansⁱⁱ are asking Congress to address health care costs.

Commercial health insurers charge Americans ever higher costs for their care. They have not succeeded at negotiating fair health care prices. Rather, prices are excessive and irrational. The same proceduresⁱⁱⁱ cost tens of thousands of dollars more in one hospital than in another. On average, the US spends twice as much^{iv} on health care as other wealthy countries; yet, the US ranks at or near bottom on most health outcomes, including infant mortality and life expectancy.

Americans suffer or die needlessly for lack of health care. I recently spoke with one woman, Eve Meikle who was forced to “backburner” treatment for her ulcerative colitis in order to pay for diagnosis and treatment of her daughter’s gastritis. Eve and her family have insurance and an annual income just over \$80,000. Still, it will take them years to free themselves of medical debt, and, left untreated, Eve’s condition may very well worsen and keep her from working.

Medicare for All is the only policy proposal before you that controls costs and guarantees health care as a right^v to everyone. Other proposals on the table-- Medicare buy-ins, Medicaid expansion or state-based reforms--neither rein in costs nor make health care affordable for all Americans.

Medicare for All guarantees health care for all. It promotes the public good. It provides greater security to older adults by filling Medicare coverage gaps, eliminating premiums, deductibles and coinsurance, and adding vision, hearing, dental and long-term services and support benefits. And, it does so while reducing national health care spending. It uses the leverage of all Americans to rationalize health care prices and eliminate administrative waste. Even by conservative estimates, it saves \$2 trillion^{vi} over 10 years. And, if we paid what other countries paid for their drugs, as President Trump and

Senator Sanders have both proposed, it would save still more.

Medicare for All builds on Medicare, which has a 50-year track record of providing health and financial security to older and disabled Americans. Medicare has helped significantly to reduce the poverty rate among older adults, which has fallen from 29 percent in 1965 to nine percent in 2016.^{vii}

Medicare works. I know firsthand. I am the founder and past president of the Medicare Rights Center, a national not-for-profit consumer service organization.

Medicare works because it is designed to meet the needs of everyone, including people in poor health with costly conditions. It works because it gives people the freedom to travel or move in with an out-of-area family caregiver and see the doctors they want to see, wherever in the US they happen to be. Medicare works because it allows its enrollees, their children and grandchildren, to sleep at night knowing they can and will get the care they need. Still, three in four older adults say the government is not doing enough to address health care costs.^{viii}

Medicare for All would significantly improve the health and financial security of older Americans. Older adults are counting on you^{ix} to expand Medicare benefits. Older adults, much like their kids, increasingly struggle to pay for health care that Medicare does not cover. One in four of them have less than \$15,000 in savings.^x Half live on annual incomes under \$26,200.^{xi} Social Security benefits are critical, but inadequate, to cover many basic needs. Private sector retiree benefits have eroded.

Even with Medicare, Americans have thousands of dollars in out-of-pocket health care costs for hearing, dental, vision and long-term services and supports. They also need supplemental coverage to fill Medicare coverage gaps and protect themselves financially, which can be extremely costly. A Gallup poll^{xii} released last week reveals that one in seven older adults, 7.5 million people, are unable to pay for the medicines their doctors prescribe. And, of those, eight in ten say that these medicines are for a somewhat or very serious condition.

Traditional Medicare, without supplemental coverage, has high out-of-pocket costs and no catastrophic cap. For this reason, many older Americans have no choice but to sign up for commercial Medicare plans, known as Medicare Advantage plans, which have a catastrophic cap. The commercial Medicare Advantage system is a looming tragedy for older Americans that can only be addressed through Medicare for All.

Commercial Medicare plans offer lower upfront costs than people with government-administered Medicare. Older and disabled Americans enroll in Medicare Advantage plans hoping to save money. But, there is compelling reason for serious concern that Medicare Advantage plans are keeping enrollees from getting needed care, jeopardizing their health, and overcharging the government and taxpayers. I want to highlight these three big issues.

Wrongful Delays and Denials of Care

Medicare Advantage plans routinely and improperly delay or deny coverage for needed care. The Office of the Inspector General^{xiii} reports that audits by the Centers for Medicare and Medicaid Services (CMS) reveal “widespread and persistent [Medicare Advantage] performance problems related to denials of care and payment.” This should come as no surprise. The less care they deliver, the more Medicare Advantage plans profit.

CMS has sanctioned dozens of commercial Medicare plans^{xiv} for, among other things, “threatening the health and safety” of their members and “charging incorrect copayments to enrollees for medical services.”

Poor Quality Care

In addition, Medicare Advantage plans may prevent their enrollees from receiving good quality care. A recent study published in Health Affairs^{xv} shows that Medicare Advantage plans send enrollees to lower quality nursing facilities than traditional Medicare. Research soon to be published shows that Medicare Advantage enrollees generally have less access to top hospitals than people in traditional Medicare. They also lack access to higher quality home care.

A recent study in JAMA Internal Medicine^{xvi} shows that people with significant health care needs are disenrolling from Medicare Advantage plans to traditional Medicare at far higher rates than people without significant health needs.

In addition, Medicare Advantage enrollees cannot rely on continuity of care from their doctors. Kaiser Health News^{xvii} reported earlier this month on a cancer patient in a Medicare Advantage plan who is losing the in-network doctors who have kept her alive over the last several years but are no longer in-network. She cannot afford to pay out-of-pocket for her doctors’ out-of-network services.

No trustworthy public data is available as to which, if any, Medicare Advantage plans promote access to quality providers and good care. The current five-star rating system for Medicare Advantage plans is regarded as a farce. CMS policy^{xviii} permits a Medicare Advantage plan to get a five-star rating even though CMS has sanctioned^{xix} it for threatening the health and safety of its members and has “a longstanding history of noncompliance with CMS requirements.”

Government Overcharges

Of concern as well, government overpayments to Medicare Advantage plans appear significant. Congress entrusts commercial Medicare Advantage plans with covering the healthcare of our most vulnerable citizens at significant taxpayer expense. Yet we know from government audits that the Medicare Advantage plans bill taxpayers for tens of billions of dollars^{xx} they are not due. They “upcode,” services, improperly claiming the health status of their enrollees is worse than it is in order to generate higher payments.

The GAO^{xxi} reports that the Centers for Medicare and Medicaid Services identified \$14.1 billion in overpayments to Medicare Advantage plans in 2014 alone but that CMS is not recovering nearly as much in improper payments as it could with better oversight.

A more recent study published in Health Services Research^{xxii} estimates that “upcoding” by Medicare Advantage plans could account for as much as 13 percent of payments^{xxiii} to Medicare Advantage plans and increase Medicare spending over ten years by \$200 billion. And, it is not clear whether CMS can recoup this money.^{xxiv}

The litany of wrongful and harmful behaviors by Medicare Advantage plans is likely greater than we know. Critical Medicare Advantage data is unavailable for analysis. We know more about how restaurants, automobiles and televisions perform and rank against one another than we do about Medicare Advantage plans. Yet, the government paid them \$210 billion in 2017^{xxv} alone.

With or without the data, we know that commercial health insurers are hard-pressed to meet the needs of people with Medicare or anyone else who develops a complex and costly condition. Imagine the best commercial health insurance company in the US. Let’s promise that it will always provide high value care for people with stroke, cancer and heart disease. This best health insurance company would be out of business before it opened its doors. Everyone in poor health would join, driving premiums up so high that no one could afford them. To make a profit, commercial health plans must compete to avoid high-cost enrollees.^{xxvi}

Instead of meeting our needs, commercial health insurers offer little health or financial security. They can and do change their network providers all the time, keep doctors from providing the care their patients need, shift costs onto their members who most need care and pull out of markets. They do whatever they need to do to promote their business interests.

Medicare for All—an improved and expanded Medicare system—can do what commercial health insurance can never do: Protect Americans from the high cost of health care, while ensuring access to good quality care.

To some, Medicare for All may seem too big a change too quickly. For Americans, the change could not come quickly enough.

Thank you for your consideration.

ⁱ Becker’s Hospital Review: <https://www.beckershospitalreview.com/finance/64-of-americans-avoid-treatment-due-to-cost-of-medical-care-5-survey-insights.html>

ⁱⁱ Politico.com: <https://www.politico.com/story/2019/01/07/politico-harvard-poll-medicare-for-all-1061791>

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- ⁱⁱⁱ Modern Healthcare: <https://www.modernhealthcare.com/article/20160427/NEWS/160429918/the-striking-variation-of-commercial-healthcare-prices>
- ^{iv} Peterson Kaiser Health System Tracker: <https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/>
- ^v Political Economy Research Institute: <https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>
- ^{vi} Blahous, Charles, The Costs of a National Single-Payer Health Care System: https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf
- ^{vii} Joint Economic Committee, Democrats, Medicare: Protecting Seniors and Families: https://www.jec.senate.gov/public/_cache/files/5f4be5d9-b297-467a-948a-e7525d04f924/medicare-final.pdf
- ^{viii} Gallup: <https://news.gallup.com/opinion/gallup/248741/seniors-pay-billions-yet-cannot-afford-healthcare.aspx>
- ^{ix} Gallup: <https://news.gallup.com/opinion/gallup/248741/seniors-pay-billions-yet-cannot-afford-healthcare.aspx>
- ^x Kaiser Family Foundation: <http://files.kff.org/attachment/Issue-Brief-Income-and-Assets-of-Medicare-Beneficiaries-2016-2035>
- ^{xi} Kaiser Family Foundation: <https://www.kff.org/medicare/issue-brief/how-many-seniors-live-in-poverty/>
- ^{xii} Gallup: <https://news.gallup.com/opinion/gallup/248741/seniors-pay-billions-yet-cannot-afford-healthcare.aspx>
- ^{xiii} Office of the Inspector General: <https://www.oig.hhs.gov/oei/reports/oei-09-16-00410.pdf>
- ^{xiv} CMS Compliance and Audits: <https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html>
- ^{xv} Meyers, David J. et al., Health Affairs: <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0714>
- ^{xvi} JAMA Internal Medicine: <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2725083>

^{xvii} Kaiser Health News: <https://khn.org/news/patients-caught-in-middle-of-fight-between-health-care-behemoths/>

^{xviii} CMS policy memo: https://s3.amazonaws.com/assets.fiercemarkets.net/public/004-Healthcare/external/star_ratings_memo.pdf

^{xix} CMS policy memo: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/Cigna_Sanction_01_21_16.pdf

^{xx} GAO: <https://www.gao.gov/products/GAO-16-76>

^{xxi} Ibid.

^{xxii} Health Services Research: <https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.12977>

^{xxiii} Van de Water, Paul, Center on Budget and Policy Priorities: <https://www.cbpp.org/blog/medicare-advantage-upcoding-overpayments-require-attention>

^{xxiv} UnitedHealthcare Insurance Company, et al. v. Alex M. Azar II, et al., Secretary of the Department of Health and Human Services: https://s3.amazonaws.com/assets.fiercemarkets.net/public/004-Healthcare/external_Q32018/UHvBurwell_overpayments.pdf

^{xxv} Cubanski, Juliette and Neuman, Tricia, Kaiser Family Foundation: <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>

^{xxvi} Archer, Diane and Marmor, Theodore, Health Affairs, Medicare and Commercial Health Insurance: The Fundamental Difference: <https://www.healthaffairs.org/doi/10.1377/hblog20120215.016980/full/>



April 29, 2019

The Honorable James P. McGovern
Chairman
The Committee on Rules
U.S. House of Representatives
H-312 The Capitol
Washington, D.C. 20515

Dear Chairman McGovern:

On behalf of The Children's Partnership, I am writing to thank you for your leadership on efforts to expand access to quality and affordable health coverage and care for families across the country and request your attention to the specific considerations for children as you and your Committee members consider H.R. 1384, the Medicare for All Act of 2019.

The Children's Partnership (TCP) is a California-based nonprofit child advocacy organization working to ensure every child, no matter their background, has the resources and opportunities they need for a bright and healthy future. TCP improves the lives of underserved children where they live, learn, and play with breakthrough solutions at the intersection of community engagement, research, and policy. In close partnership with a wide range of community-based, statewide, and national organizations and philanthropic partners, TCP works to ensure all children have access to quality care, community supports, and services so each child can reach their full potential.

As you review legislation to expand coverage to more Americans, we urge you to consider the specific and unique impacts on children in this proposal and any future efforts. Most importantly, children and adolescents are not little adults – children are going through a time of rapid brain and body development. Thus, their health care needs differ from those of adults, and it is essential that their health coverage reflect these unique health care needs.

Today, 1 in 20 children nationwide (just 5 percent) lack coverage. In states like California, fewer than 3 percent of children remain uninsured, a historic low. However, the need to consider child-specific impacts of efforts to further expand coverage has become even more pressing. Recent survey data is showing that the share of children who are uninsured has increased for the first time in at least a decade.¹ To ensure that every child has the opportunity to develop to healthy adulthood and realize his or her potential, efforts to expand coverage must build on what is working for millions of children and their families by keeping Medicaid and CHIP strong, strengthening private coverage, and working toward a health care system that meets the needs of all children regardless of their health, immigration status, family income, zip code, language, race, gender, sexual orientation or disability.

Given the unique health care needs of children, the paramount objective any health reform proposal, such as a "Medicare for All", must be first do no harm to children's current coverage. At a minimum,

any changes must not dilute or undermine the level of benefits and affordability protections provided to children today through programs like Medicaid and the Children's Health Insurance Program (CHIP), on which more than 35 million low-income children rely. Instead, efforts toward health coverage reform should further improve and innovate children's health coverage, access, and care utilization, including meeting children's unique health care needs by providing child-specific coverage for children – as distinct from adult coverage – regardless of its source. Further, any changes to the nation's health coverage landscape must place a greater emphasis on recognizing and responding to the social determinants impacting children's health and wellbeing.

As you consider a "Medicare For All" proposal, please consider the following critical components of health coverage and care for children. To ensure that any federal changes to health coverage and systems will work for children, the following principles should apply⁸:

COMPREHENSIVE BENEFITS: All children must have health coverage that provides all medically necessary, age-appropriate services that promote prevention and healthy development. Programs like Medicaid and CHIP were created with children in mind and have pediatric benefits, pediatric networks, and strong affordability provisions that offer children protections and standards. Most notably, Medicaid guarantees all eligible children the comprehensive child-specific benefit of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), which provides and promotes the necessary schedule of well-child care and screenings as well as coverage of medically necessary treatments, regardless of other program benefit or scope limitations. Also, for children, medical necessity is specifically defined as treatments that restore normal function but also correct, control and reduce health conditions. Low-income children in particular require the comprehensive benefit of EPSDT to address many of the conditions disproportionately afflicting low income children, such as obesity, asthma, elevated lead blood levels, untreated tooth decay, and behavioral health concerns. As "Medicare for All" is considered, there remain many questions about the continued availability of Medicaid's EPSDT benefit and how the protections and standards will be established and guaranteed in a new Medicare system. For example:

1. *How would the coverage expansion proposal affect Medicaid and CHIP coverage and benefits for children?*
2. *Would the new coverage expansion proposal's benefit package be tailored to children's unique needs, providing the comprehensive EPSDT benefit for children?*

AFFORDABLE COVERAGE: All children must have access to both health coverage and care that is affordable for their families. Families' financial security through excessive premiums and cost sharing must not be jeopardized in order to ensure all children get the coverage and care they need when they need it. Reasonable out-of-pocket limits on premiums, deductibles and cost-sharing such as those in Medicaid and CHIP must be preserved, and similarly reasonable limits must be extended to children in all sources of coverage, particularly for families that have children with special health care needs or complex conditions.

1. *What would be the premium and cost-sharing requirements under the new coverage expansion?*
2. *How would the coverage expansion proposal consider the needs of special populations of children when establishing out-of-pocket limits?*

CONTINUOUS COVERAGE/ENROLLMENT: All children must be continuously enrolled in consistent coverage without gaps in coverage or care. Reform proposals must make it easier, not harder, for children to get enrolled and stay enrolled in reliable, stable, and consistent health coverage. Building on what is working for children would see reform proposals include policy change to create pathways for longer-term coverage (e.g., continuous coverage from birth through age five). Such pathways would be available for families without interruptions such as lockouts, waiting periods, or frequent

recertification hurdles. If a change in coverage is necessary, transitions must be seamless and allow for a continuation of services, medications, and providers whenever possible to maintain existing provider-patient relationships and ensure children have timely access to needed care.

1. *What are the beneficiary access protections under the coverage expansion?*
2. *How will the coverage expansion be administered?*

HIGH-QUALITY HEALTH SERVICES: All children must receive high quality care informed by robust quality evaluation. Health care system reforms efforts should invest in and promote delivery systems that identify and respond to social determinants of health with an emphasis on children's integrative care, such as school-based integrative care models. At the same time, efforts to reform the health care system should seek to encourage the growth of a pediatric health care workforce that is more ethnically and linguistically diverse, and more balanced with respect to gender and sexual orientation with the goal of reducing health disparities particularly for the growing population of children of color across the nation.

1. *How would the coverage expansion measure and ensure quality of care for children?*
2. *What would be the health care delivery system under the coverage expansion and how would social determinants of health be integrated?*

As you continue to consider a "Medicare For All" health reform proposal, we urge you to ensure there is a clear understanding of the impacts on children and that those impacts do not harm or place at risk children's wellbeing. In the areas of benefits, access, affordability and quality of a "Medicare for All" proposal, please have the answers and the confidence to ensure any changes will have children's best interest in mind. At a minimum, we urge you to ask:

1. *How will children's needs specifically be addressed in any new coverage expansion?*
2. *What is the implementation timeline for the coverage and is there a transition period?*

The answers to the questions laid out in this letter will ensure children are a priority in any health reform proposal and the necessary standards and protections are in place so children are not left worse off.

Thank you for your consideration of this information. Please contact Aracely Navarro at (213) 341-1222 ext. 135 or anavarro@childrenspartnership.org for additional information. We thank you for your leadership on this important issue and look forward to working with you to make important strides in children's health and wellbeing.

Sincerely,



Mayra E Alvarez MHA
President

ⁱ Georgetown Center for Children and Families. Nation's Progress on Children's Health Coverage Reverses Course. <https://ccf.georgetown.edu/2018/11/21/nations-progress-on-childrens-health-coverage-reverses-course/>

ⁱⁱ Content is derived from resources of and discussions with the California Children's Coverage Coalition; First Focus; and the Georgetown Center for Children and Families



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**Statement
 of the
 American Hospital Association
 for the
 Committee on Rules
 of the
 U.S. House of Representatives
 “Medicare for All Act of 2019”
 April 30, 2019**

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit for the record our comments on the Medicare for All Act of 2019 and other proposals to expand access to health coverage through a government-run, single-payer program.

America’s hospitals and health systems are committed to the goal of affordable, comprehensive health insurance for every American. However, “Medicare for All” is not the solution. Instead, we should build upon and improve our existing system to increase access to coverage and comprehensive health benefits.

Our detailed comments follow.

THE IMPORTANCE OF HEALTH COVERAGE

Meaningful health care coverage is critical to living a productive, secure and healthy life. Studies confirm that coverage improves access to care; supports positive health outcomes, including an individual’s sense of their own health and wellbeing; incentivizes appropriate use of health care resources; and reduces financial strain on individuals and

families.¹ Coverage has broader community benefits as well, from ensuring adequate resources to maintaining critical health care infrastructure to being associated with decreased crime. We therefore appreciate Congress' focus on opportunities to close the remaining coverage gaps and achieve comprehensive health coverage for every American.

Despite recent coverage gains, approximately 9 percent of the U.S. population remains uninsured, a number that has increased over the past two years. The remaining uninsured tend to be young adults, disproportionately Hispanic, and workers in lower-income jobs. Many of the uninsured are likely eligible for but not enrolled in subsidized coverage, including through Medicaid, the Health Insurance Marketplaces or their employers. Millions of the lowest income uninsured could be covered if all states expanded Medicaid.

GOVERNMENT-RUN, SINGLE-PAYER MODEL IS THE WRONG APPROACH

While the AHA shares the objective of achieving health coverage for all Americans, we do not agree that a government-run, single-payer model is right for this country. Such an approach would upend a system that is working for the vast majority of Americans, and throw into chaos one of the largest sectors of the U.S. economy.

Indeed, payment under existing public programs, including Medicare and Medicaid, historically reimburse providers at less than the cost of delivering services. For example, Medicare paid only 87 cents for every dollar spent by hospitals caring for Medicare patients in 2017 – a shortfall of \$53.9 billion. Chronic underpayment can lead to access issues for seniors as some providers, especially physicians, may limit the number of Medicare patients they take or stop seeing them altogether. Indeed, hospitals and health systems only are able to stay open today to the extent commercial coverage makes up for the losses sustained providing care to beneficiaries of public programs. Congress' own advisory group, the Medicare Payment Advisory Commission (MEDPAC), reported in its March 2018 report that hospitals had a negative 9.6 percent Medicare margin in 2016, on average, and projects that hospital Medicare margins will decline to negative 11 percent in 2018, the lowest such margin ever recorded.

Results from a recent study give some idea of the financial impact a single-payer program based on Medicare rates could have on the health care system. The study found that a proposal to create a government-run, Medicare-like health plan on the individual exchange could create the largest ever cut to hospitals – nearly \$800 billion – and be disruptive to the employer-sponsored and non-group health insurance markets, while resulting in only a modest drop in the number of uninsured as compared to the 9 million Americans who would gain insurance by taking advantage of building upon the existing public/private coverage framework. This coverage proposal would enroll significantly fewer people than a single-payer model, and yet the reimbursement cuts would be catastrophic.

Even if the proposed single-payer program increased reimbursement rates above Medicare's rates, our members' experience suggests that the government does not always act as a reliable business partner. Delays in payment and retroactive changes to

reimbursement policies leave providers at risk of inadequate payment. Politicization means that providers cannot always trust that the rules of today will be the rules of tomorrow, which presents a challenging – if not impossible – environment for large, complex organizations. Recent examples of the uncertainty of working with government include the defunding of critical elements of the Health Insurance Marketplaces, including outreach and education, and raids on the Medicare and Medicaid programs to offset spending on other priorities.

We also are deeply concerned that a single-payer model would seriously distract from the important delivery system reform work underway. Hospitals and health systems have invested billions of dollars in technology and delivery system reforms to improve care, enhance quality and reduce costs. Moving to a single-payer model could stymie these efforts by, at best, diverting attention and, at worst, being deemed irrelevant if the government can simply ratchet down provider rates to achieve spending objectives.

Finally, moving to a single-payer model would be highly disruptive not only to health coverage, but also to the broader economy. Approximately 90 percent of Americans are currently enrolled in comprehensive coverage with high rates of satisfaction. Not only would this move more than 250 million people into some new form of coverage, it could radically alter the coverage of the more than 55 million people currently enrolled in the Medicare program, including the tens of millions who have voluntarily opted to enroll in Medicare Advantage, which would no longer exist.

WAYS TO PROMOTE BETTER CARE FOR AMERICA

Health coverage is too important to risk such levels of disruption. The better path to achieving comprehensive coverage for all Americans lies in continuing to build on the progress made over the past decade. To advance our objective of covering all Americans, we support:

- Continued efforts to expand Medicaid in non-expansion states, including providing the enhanced federal matching rate to any state, regardless of when it expands. This would give newly expanded states access to three years of 100 percent federal match, which would then scale down over the next several years to the permanent 90 percent federal match.
- Providing federal subsidies for more lower- and middle-income individuals and families. Many individuals and families who do not have access to employer-sponsored coverage earn too much to qualify for either Medicaid or marketplace subsidies and yet struggle to afford coverage. This is particularly true for lower-income families who would be eligible for marketplace subsidies except for a “glitch” in the law that miscalculates how much families can afford. We support both expanding the eligibility limit for federal marketplace subsidies to middle-income families and fixing the “family glitch” so that more lower-income families can afford to enroll in coverage.

- Strengthening the marketplaces to improve their stability and the affordability of coverage by reinstituting funding for cost-sharing subsidies and reinsurance mechanisms and reversing the expansion of “skinny” plans that siphon off healthier consumers from the marketplaces, driving up the cost of coverage for those who remain.
- Robust enrollment efforts to connect individuals to coverage. The majority of the uninsured are likely eligible for Medicaid, subsidized coverage in the marketplace or coverage through their employer. We need an enrollment strategy that connects them to – and keeps them enrolled in – coverage. This requires adequate funding for advertising and enrollment efforts, as well as navigators to assist consumers in shopping for and selecting a plan.

We also must ensure the long-term sustainability of Medicare, Medicaid and other programs that so many Americans depend on for coverage.

CONCLUSION

While we agree with the Committee that there is more work to be done, we believe we should come together and build upon and improve our existing system to increase access to coverage and comprehensive health benefits.

¹ American Hospital Association, “The Importance of Coverage,” November 2018.
<https://www.aha.org/system/files/media/file/2019/04/report-coverage-overview-2018.pdf>



Statement for the record of

Eagan Kemp

Health Care Policy Advocate, Public Citizen

for the

Committee on Rules

U.S. House of Representatives

Hearing on the Medicare for All Act

April 30th, 2019

Thank you for the opportunity to submit this statement for the record on this vitally important issue. And thank you for holding this historic hearing on Medicare for All. Public Citizen is a national non-profit organization with more than 500,000 members and supporters. We represent the public interest through legislative and administrative advocacy, litigation, research, and public education on a broad range of issues including ensuring access to health care. Pertinent to this hearing, Public Citizen has supported the creation of a single-payer health care system since our founding in 1971. Our health care system currently fails to meet the needs of the American people, while a single-payer Medicare for All system would guarantee coverage to everyone in the United States. Despite the successes of the Affordable Care Act (ACA) in expanding access to coverage, more than 30 million Americans remain uninsured and tens of millions more are underinsured, meaning they are unable to afford the care they need despite having health insurance.¹

I. OUR HEALTH CARE SYSTEM COSTS TOO MUCH WHILE COVERING TOO LITTLE

1. Health care in the U.S. is far too expensive

In the United States, we spend \$3.5 trillion, or more than \$10,000 per person, on health care annually—a staggering sum—a great deal of which is wasted or unnecessary.² As a country, we spend far more on health care than other comparably wealthy nations. Our public spending on health care, per capita, alone is higher than what nearly all other wealthy countries pay, per capita, for their *entire* health care systems. This is all the more remarkable because all of these countries, unlike the United States, provide nearly universal coverage to their residents. Despite this excessive spending, the United States has the worst health outcomes compared to similar countries.³

It hasn't always been this way. In the 1980s our spending was much more in line with similar countries, before rapidly rising over the last few decades.⁴ Similarly, U.S. life expectancy was about average in 1980, but we have been losing ground with comparable countries since that time.⁵

Increased administrative costs are one of the key reasons that health care costs have risen sharply over the past 40 years. The United States has the highest rate of administrative health care costs among wealthy countries.⁶ Excessive administrative spending is wasteful because it contributes nothing to treating patients or improving public health. Around one-third of U.S. health care dollars are spent on administrative functions, including insurance company overhead; administrative costs of hospitals,

¹SARAH R. COLLINS, MUNIRA Z. GUNJA, AND MICHELLE M. DOTY, THE COMMONWEALTH FUND, HOW WELL DOES INSURANCE COVERAGE PROTECT CONSUMERS FROM HEALTH CARE COSTS? — FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY, 2016, at 1 (October 2017), <https://bit.ly/2D3WbG5>.

²CENTERS FOR MEDICARE AND MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURES 2016 HIGHLIGHTS, at 1 (January 2018), <https://go.cms.gov/1V5YDcl>.

³Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1024 (2018).

⁴OECD.Stat – *Health Expenditure and Financing*, ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, <https://bit.ly/2sNaLUX> (viewed on January 27, 2019).

⁵*Id.*

⁶ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (OECD), TACKLING WASTEFUL SPENDING ON HEALTH, at 232 (January 2017), <https://bit.ly/2yVVrhT>.

practitioners, nursing homes and other providers; and costs incurred by employers in managing their workers' benefits.⁷

Costs relating to managing health insurance are a major component of these rising administrative costs. Private insurers spend around 12 percent of their annual budgets on administration.⁸ Traditional Medicare is much more efficient, spending only around two percent on administrative costs.⁹ Higher costs for hospitals also contribute to our excessive spending. If hospital administrative spending were brought in line with more efficient countries, the U.S. could save more than \$150 billion each year on hospital spending alone.¹⁰

2. Americans struggle to get the care they need

Americans have the worst health outcomes and report the highest rates of unmet health care needs of comparable countries.¹¹ Nearly one in four Americans reported skipping a health care appointment due to the cost, a number more than double the average across comparable countries.¹² Further, more than 40 percent of Americans with below-average income reported having unmet health care needs due to cost—meaning not going to the doctor; skipping a test, treatment or follow up; or not filling a prescription or skipping doses.¹³ Even around one-third of Americans with above-average incomes reported having unmet health care needs due to the cost of care, more than twice the average rate of the other countries surveyed.¹⁴ Finally, the U.S. ranked worst out of 16 industrialized countries for deaths that could be prevented with proper medical care.¹⁵

Further, Americans reported being more afraid of paying the medical bills resulting from getting seriously ill than they were about health consequences of getting seriously ill.¹⁶ Nearly half of uninsured working-age adults lacked a regular source of care, compared with approximately 10 percent of those who were insured, whether through public or private coverage.¹⁷ Finally, nearly one in four reported postponing care due to cost and one in five reported going without needed care or prescription medication due to cost.

⁷Steffie Woolhandler, Terry Campbell and David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENGLAND JOURNAL OF MEDICINE 768-775, 772 (2003).

Alexis Pozen and David M. Cutler, *Medical Spending Differences in the United States and Canada: The Role of Prices, Procedures, and Administrative Expenses*, 47 INQUIRY 124-134, (2010).

⁸CONGRESSIONAL BUDGET OFFICE, PRIVATE HEALTH INSURANCE PREMIUMS AND FEDERAL POLICY, at 27 (February 2016) <https://bit.ly/1Qw9DD0s>.

⁹Nick Buffie, *Overhead Costs for Private Health Insurance Keep Rising, Even as Costs Fall for Other Types of Insurance*, CENTER FOR ECONOMIC AND POLICY RESEARCH (CEPR) BLOG (February 6, 2017), <https://bit.ly/2l6XYR0>.

¹⁰David U. Himmelstein, et al., *A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far*, 33 HEALTH AFFAIRS 1586-1594, 1589 (2014).

¹¹Eric C. Schneider, et al., The Commonwealth Fund, *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care*, at 5 (July 2017), <https://bit.ly/2PTfy2>.

¹²Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1037 (2018).

¹³*Id.*

¹⁴*Id.*

¹⁵Ellen Nolte and Martin McKee, *Variations in amenable mortality—Trends in 16 high-income nations*, 103 HEALTH POLICY 47-52, 49 (2011).

¹⁶*Id.* at 4.

¹⁷KAISER FAMILY FOUNDATION, KEY FACTS ABOUT THE UNINSURED POPULATION, at 5 (September 2017), <https://bit.ly/2q8AEU7>.

And when Americans seek care, many face medical debt or bankruptcy. A survey by the Consumer Financial Protection Bureau found that medical debt was the most common reason for debt collection calls in the United States.¹⁸ Nearly 60 percent of consumers who were contacted about debt collection were contacted due to outstanding medical debt.

Even Americans with insurance may have difficulty paying their medical bills. More than one in four working-age adults reported being concerned about being able to afford normal health care, and almost half reported being worried about being able to afford their medical bills if they get sick.¹⁹ Nearly one in four working-age adults reported they are currently paying off medical bills over time.²⁰

3. Even Americans with insurance face rising costs and challenges in getting care

Premiums continue to rise rapidly for employer-sponsored insurance, creating challenges for both employees and employers. Even when employers contribute the same percentage to their employees' health insurance premiums year after year, rising premiums mean that workers' paychecks continue to shrink. A recent survey found that between 2006 and 2016, the average cost of employer-sponsored family coverage rose 58 percent to \$18,000 a year.²¹ At the same time, the average employee's share of covering the cost of their premiums rose even faster, increasing 78 percent.

In addition to rising premiums, many workers have experienced increased out-of-pocket costs and decreased options for in-network health care providers, doctors and hospitals. The percentage of working-age adults with insurance through their job who were underinsured—meaning they face excessive out-of-pocket costs—rose from 10 percent in 2003 to 25 percent in 2016.²² Further, a recent survey found that middle-income Americans with private insurance were the most likely to report increases in their out-of-pocket costs.²³

Even when employees receive treatment at hospitals or other facilities that are in their insurer's network, they face the risk of unexpected bills that can devastate their finances and even send them into medical debt or bankruptcy. This is because some providers in those facilities may not be included in their insurer's network. Referred to as “surprise billing” or “balance billing,” this practice leaves patients on

¹⁸CONSUMER FINANCIAL PROTECTION BUREAU (CFPB), CONSUMER EXPERIENCES WITH DEBT COLLECTION: FINDINGS FROM THE CFPB'S SURVEY OF CONSUMER VIEWS ON DEBT, at 21 (January 2017), <https://bit.ly/2ODJkk5>.

¹⁹KAISER FAMILY FOUNDATION, KEY FACTS ABOUT THE UNINSURED POPULATION, at 6 (September 2017), <https://bit.ly/2q8AEU7>.

²⁰*Id.*

²¹KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS: 2016 SUMMARY OF FINDINGS, at 9 (September 2016), <https://bit.ly/2iGSqh9>.

²²A person in the study was considered underinsured if they had out-of-pocket cost, excluding premiums, over the prior 12 months were 10 percent or more of household income (or 5 percent of household income for households making less than 200 percent of the federal poverty level) or if their deductibles was 5 percent or more of their household income. SARAH R. COLLINS, MUNIRA Z. GUNJA, AND MICHELLE M. DOTY, THE COMMONWEALTH FUND, HOW WELL DOES INSURANCE COVERAGE PROTECT CONSUMERS FROM HEALTH CARE COSTS? — FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY, 2016, at 1 (October 2017), <https://bit.ly/2D3WbG5>.

Rich Daly, *Narrow Networks Spread From ACA Plans to Employers*, HMFA (December 5, 2017), <https://bit.ly/2O6GLSo>. Stephen Miller, *Employers May Adopt 'Narrow Networks' of Health Care Providers*, SHRM (January 10, 2017), <https://bit.ly/2ikrVLj>.

²³Nearly sixty percent of respondents with private insurance responded that their out-of-pocket health care spending had increased, compared with 51 percent of the uninsured, 46 percent for Medicare, 43 percent for Medicaid and 39 percent for VA & TRICARE.

IPSOS, HEALTH CARE EXPERIENCE STUDY, at 3 (April 2018), <https://bit.ly/2TjIRpr>.

the hook for the difference between the amount the insurance company is willing to pay and a provider's total fee.²⁴

Even a patient who is vigilant and tries to ensure they are being treated by in-network providers may have trouble avoiding surprise bills. For example, during an emergency, a patient doesn't have time or the ability to check whether each provider that is treating them is considered in-network by their plan. And during surgery, there could be multiple doctors and nurses, some of whom may not be in-network.²⁵

Nearly 70 percent of respondents who experienced surprise bills that they were unable to pay did not know that the health care provider was considered out-of-network when they received care.²⁶ In addition, more than half of Americans received a medical bill for something they thought their health insurance covered.²⁷

II. MEDICARE FOR ALL WOULD ENSURE EVERYONE IN THE U.S. HAS ACCESS TO THE CARE THEY NEED WHILE REDUCING HEALTH CARE SPENDING

1. Medicare for All would guarantee access to needed care

Medicare for All would finally allow everyone to access the care they need, when they need it. Having access to medically necessary care, including preventive services, would reduce the incidence of many preventable diseases and allow earlier treatment for a variety of illnesses. This, in turn, would reduce both personal and system-wide spending on treating preventable illnesses or treating illnesses at a stage when they are cheaper and easier to treat, preventing later complications and more expensive medical interventions.

By eliminating out-of-pocket costs, Medicare for All would ensure access to needed care for everyone in the United States, and would reduce the administrative burden of collecting and processing those payments. Studies have found that out-of-pocket costs cause consumers to decrease their use of potentially valuable health care.²⁸ Under Medicare for All, improved payment mechanisms would be used to reduce wasteful health spending while improving access to high value care.

Medicare for All would build on Medicare's current success at providing timely access to care. Medicare patients reported having consistent access to care, with more than 95 percent reporting having a usual source of care, such as a doctor's office or primary care clinic.²⁹ Around 90 percent of Medicare beneficiaries reported that they were able to schedule timely appointments for primary and specialty

²⁴Adam Crowther, PUBLIC CITIZEN, OUT OF CONTROL: PATIENTS ARE UNWITTINGLY SUBJECTED TO ENORMOUS, UNFAIR, OUT-OF-NETWORK 'BALANCE BILLS', at 4 (April 2014), <https://bit.ly/2yyzrda>.

²⁵GARY CLAXTON, ET AL., KAISER FAMILY FOUNDATION, AN ANALYSIS OF OUT-OF-NETWORK CLAIMS IN LARGE EMPLOYER HEALTH PLANS, at 3 (August 2018), <https://bit.ly/2QOHNaN>.

²⁶KAREN POLLITZ, KAISER FAMILY FOUNDATION, SURPRISE MEDICAL BILLS, at 1 (March 2016), <https://bit.ly/2ObKpe0>.

²⁷NORC AT THE UNIVERSITY OF CHICAGO, AMERICANS' VIEWS ON HEALTHCARE COSTS, COVERAGE AND POLICY, at 7 (March 2018), <https://bit.ly/CuBUXo>.

²⁸Zarek C. Brot-Goldberg, et al., *What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, 132 THE QUARTERLY JOURNAL OF ECONOMICS 1261-1318, 1261 (2017).

²⁹CRISTINA BOCCUTI, CHRISTINA SWOOPÉ, ANTHONY DAMICO AND PATRICIA NEUMAN, KAISER FAMILY FOUNDATION, MEDICARE PATIENTS' ACCESS TO PHYSICIANS: A SYNTHESIS OF THE EVIDENCE, at 2 (December 2013), <https://bit.ly/2D6KFTl>.

care.³⁰ Seniors with Medicare were more likely than adults age 50-64 with private insurance to report that they had never had to wait longer than they wanted for a routine care appointment.³¹

Medicare for All would also improve provider choice for all Americans by allowing people to choose their doctor and hospital. Currently, Americans must spend a lot of time figuring out where they can get the care they need, including those now enrolled in Medicare Advantage. More than one-third of Medicare Advantage enrollees have to deal with narrow networks—defined as including less than 30 percent of physicians in a given county—and fewer than one in four Medicare Advantage enrollees has access to a broad network of providers.³² Medicare for All would mean no more networks, as enrollees could finally be free to get their care from the provider and in the setting of their choice.

Medicare for All would also improve access to vision and dental services, which many Americans, including seniors, struggle to afford. Lack of access to dental services can put Americans at risk for infection, decreased quality of life, and difficulty eating. Low-income seniors were particularly likely to not have had a dental visit, with only around one in four having done so in the past year, compared to nearly 75 percent of beneficiaries with higher incomes.³³ By including vision and dental services in Medicare for All, everyone in the U.S. would finally be able to be guaranteed access to the services they need to live a full life.

2. Medicare for All would improve access to long-term care

Medicare for All would also ensure access to long-term care, improving patients' quality of life while also bringing down the cost of care, as more people would be able to receive care in their homes instead of in expensive institutions, like nursing homes. The long-term care benefits available under Medicare for All would provide more comprehensive and sensible benefits than Medicaid, including ensuring that beneficiaries could be served in the setting of their choice with the services they need. And by providing more care through long-term home and community-based services (HCBS), Medicare for All could save money compared to institutional care, given that a year of care in a nursing home costs more than twice as much as having a home health aide for a year and five times as much as a year of care through adult health day care.³⁴

Under our current system, the availability of HCBS varies widely by state, because states must request waivers of certain federal Medicaid requirements in order to do so.³⁵ However, even states with waiver programs often have waiting lists for their programs and face challenges ensuring access to services for all who need them.³⁶ And regardless of waivers, before someone can receive Medicaid long-term care,

³⁰*Id.* at 3.

³¹*Id.*

³²GRETCHEN JACOBSON, ET AL., KAISER FAMILY FOUNDATION, MEDICARE ADVANTAGE: HOW ROBUST ARE PLANS' PHYSICIAN NETWORKS?, at 4 (October 2017), <https://bit.ly/2D714Ri>.

³³*Id.*

³⁴ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), <https://bit.ly/2CAzEPY>.

³⁵ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), <https://bit.ly/2CAzEPY>.

³⁶MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, DATA DO NOT SUPPORT RELATIONSHIP BETWEEN MEDICAID EXPANSION AND HOME AND COMMUNITY-BASED SERVICES WAIVER WAITING LISTS, at 1 (March 2018), <https://bit.ly/2Q25tTZ>.

they must prove they are already in poverty or spend down their assets.³⁷ These requirements can create significant hardship for many families, especially those who may face significant or unexpected expenses not covered by Medicaid after having spent down their assets.

Advocates have successfully pushed to improve access to home and community-based services in recent decades. As a result, HCBS recently overtook institutional coverage, in terms of overall Medicaid long-term care spending.³⁸ But availability of HCBS still varies widely. The states with the highest percentage of HCBS spending—Minnesota, New Mexico, and Oregon—devote more than 75 percent of their Medicaid long-term care spending to HCBS, while the states with the lowest spending—Mississippi, Florida and Indiana—all devoted only around a third of their spending toward home and community-based services.³⁹

Around 70 percent of people over 65 will require at least some long-term care in their lifetimes.⁴⁰ Given our changing demographics—by 2030 all baby boomers will be 65 or older and by 2035 Americans age 65 and older will outnumber the number of children under 18 for the first time in U.S. history—we must ensure that we are providing access to needed long-term care in the most humane and efficient way possible.⁴¹ Medicare for All would meet both of these goals and begin the crucial transition from the institutional bias of our current long-term care system to a system that serves patients in the setting and community of their choice.

3. Medicare for All would reduce health care spending

Medicare for All would create enough savings that even a significant increase in the amount of care rendered would be more than offset.⁴² This would be achieved by reducing administrative waste, harnessing the federal government's negotiating power to bring down the price of care, and setting global budgets for institutions that would reduce the incentive for providers to administer unnecessary, expensive treatments.

Numerous studies have analyzed the prospective effectiveness of single-payer plans nationally and at the state level, as well as other universal coverage approaches.⁴³ Most of these studies found savings, to varying degrees. These findings are supported by the experiences of countries that already have universal

³⁷ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), <https://bit.ly/2CAzEPY>.

Harold Pollack, *Health-Care Reform's Disability Blind Spot*, THE AMERICAN PROSPECT (January 9, 2018), <https://bit.ly/2yxmi4l>.

³⁸STEVE EIKEN, ET AL, TRUVEN HEALTH ANALYTICS, MEDICAID EXPENDITURES FOR LONG-TERM SERVICES AND SUPPORTS (LTSS) IN FY 2015, at 10 (April 2017), <https://bit.ly/2PUZmm3>.

³⁹*Id.* at 11.

⁴⁰Emily Gurnon, *The Staggering Prices of Long-Term Care 2017*, FORBES (September 26, 2017), <https://bit.ly/2W5hEZp>.

⁴¹Press Release, U.S. Census Bureau, *Older People Projected to Outnumber Children for First Time in U.S. History* (Sep. 6, 2018), <https://bit.ly/2p8zoQY>.

⁴²ROBERT POLLIN, ET AL, POLITICAL ECONOMY RESEARCH INSTITUTE, ECONOMIC ANALYSIS OF MEDICARE FOR ALL, at 2 (November 2018), <https://bit.ly/2E6AhCw>.

⁴³See e.g., *Listing of Single Payer Studies*, HEALTHCARE-NOW, <https://bit.ly/2yplxwr> (viewed April 24, 2019).

health care and provide care more efficiently than the United States.⁴⁴ A recent study found that Medicare for All could save nearly 20 percent versus our current system, with the largest sources of savings being increased administrative efficiency and significantly lower pharmaceutical prices.⁴⁵ Another recent estimate found that simplified administration under Medicare for All would save the U.S. more than \$500 billion a year.⁴⁶

One reason our health care is so expensive is that prices for common procedures, such as appendectomies, hip replacements, and angioplasties, are often significantly higher in the United States than in other comparably wealthy countries.⁴⁷ In addition, basic health care prices for the same procedure vary wildly between health care providers, which reveals inefficiencies and overpriced services.⁴⁸ Providers and insurers generally negotiate prices behind closed doors and refuse to disclose their negotiated prices, citing trade secrets.

Allowing the federal government to use its full negotiating power would make health care pricing more rational and wring out the massive amount of abusive overcharging. Under Medicare for All, the U.S. government would be able to negotiate reasonable prices for services and would prevent providers from charging vastly different prices for the same services.

Finally, by also using global budgets—comprehensive budgets negotiated between the government and health care institutions (such as hospitals and nursing homes)—Medicare for All would control overall spending while ensuring access to medically necessary services.⁴⁹ Under global budgets, institutions have the incentive to control costs as they provide care. In contrast, our current system creates incentives for institutions to maximize revenue, for example by building expensive new hospital wings and then pressuring providers to refer patients for care, instead of furnishing the most sensible and necessary care.⁵⁰

4. Medicare for All would reduce drug prices and improve access

Spending on prescription drugs in the United States totaled more than \$480 billion in 2016, almost 15 percent of the \$3.3 trillion total spent on health care that year.⁵¹ Instituting a Medicare for All system would finally allow the government to negotiate the price of prescription drugs on behalf of all Americans. Under its prescription drug benefit, known as Medicare Part D, Medicare is currently prohibited from negotiating

⁴⁴Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1024 (2018).

⁴⁵ROBERT POLLIN, ET AL., POLITICAL ECONOMY RESEARCH INSTITUTE, ECONOMIC ANALYSIS OF MEDICARE FOR ALL, at 66 (November 2018), <https://bit.ly/2E6AhCw>.

⁴⁶Steffie Woolhandler and David U. Himmelstein, *Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs*, 166 ANNALS OF INTERNAL MEDICINE 587-588, 588 (2017).

⁴⁷INTERNATIONAL FEDERATION OF HEALTH PLANS, 2015 COMPARATIVE PRICE REPORT: VARIATION IN MEDICAL AND HOSPITAL PRICES BY COUNTRY, at 17, 22, & 24 (September 2016), <https://bit.ly/2RS7R6K>.

⁴⁸Elisabeth Rosenthal, *The \$2.7 Trillion Medical Bill*, THE NEW YORK TIMES (June 1, 2013), <https://nyti.ms/2yW7Gef>.

⁴⁹STEPHEN H. LONG AND M. SUSAN MARQUIS, RAND CORPORATION, TOWARD A GLOBAL BUDGET FOR THE U.S. HEALTH SYSTEM: IMPLEMENTATION ISSUES AND INFORMATION NEEDS, at 1 (July 1994), <https://bit.ly/2Q3v3YS>.

⁵⁰ROBERT A. BERENSON, ET AL., URBAN INSTITUTE, GLOBAL BUDGETS FOR HOSPITALS, at 2 (April 2016), <https://urban.is/202ExmU>. JOSHUA M. SHARFSTEIN, ET AL., THE COMMONWEALTH FUND, AN EMERGING APPROACH TO PAYMENT REFORM: ALL-PAYER GLOBAL BUDGETS FOR LARGE SAFETY-NET HOSPITAL SYSTEMS, at 3 (August 2016), <https://bit.ly/2Ra6awE>.

⁵¹Nancy L. Yu, Preston Atteberry, and Peter B. Bach, *Spending on Prescription Drugs in The US: Where Does All the Money Go?*, HEALTH AFFAIRS BLOG, (July 31, 2018) <https://bit.ly/2LlPRbm>.

drug prices.⁵² In contrast, the Veterans Health Administration (VHA) does negotiate the price of drugs for the veterans it serves. As a result, the VHA pays much lower drug prices than the general public. A researcher from Carleton University and the founder of Public Citizen's Health Research Group, Sidney Wolfe, concluded in a study published in 2015 that Medicare Part D would save around \$16 billion a year if the agency were able to negotiate similar prices to those negotiated by the VHA on the same brand-name drugs.⁵³

Given that Medicare for All would mean the government would have negotiating power on behalf of a much larger population—all Americans—drug prices would be even lower under Medicare for All than they are for the VHA. A recent estimate found that Medicare for All could save over \$100 billion a year on drug costs.⁵⁴

One recent study compared our health care spending with 10 other wealthy nations and found that the United States spent around \$1,450 per capita on prescription drugs, the most of any wealthy country and more than double the roughly \$750 per capita average of all 11 countries.⁵⁵ Further, an analysis by *The Wall Street Journal* compared U.S. prices across a number of drugs to prices in England, Norway, and Ontario, Canada. It found that U.S. drug prices were almost always higher, often significantly higher.⁵⁶

Drug prices remain high because they produce huge profits for pharmaceutical companies.⁵⁷ Pharmaceutical companies defend their enormous profits by emphasizing the importance of pharmaceutical innovation. But these companies often spend less than one in five dollars in revenue on research and development (R&D).⁵⁸ Further, much of their R&D is directed to products expected to maximize profits rather than meet priority health needs. (So, for example, they invest heavily in drugs that compete with medicines already on the market, often referred to as “me-too” drugs, rather than novel therapies.)⁵⁹ Finally, most pharmaceutical breakthroughs come from publicly funded research, not from Big Pharma.⁶⁰

And, of course, innovations in pharmaceuticals mean nothing if people can't afford them. At the same time that pharmaceutical companies are reaping enormous profits, too many Americans cannot afford to take the medicines they need. Nearly one in five Americans report that they or a family member has not filled a prescription, cut pills in half, or skipped doses because of cost.⁶¹ Medicare for All would ensure that

⁵²JULIETTE CUBANSKI AND TRICIA NEUMAN, KAISER FAMILY FOUNDATION, SEARCHING FOR SAVINGS IN MEDICARE DRUG PRICE NEGOTIATIONS, at 1 (April 2018), <https://bit.ly/2i1ffYJ>.

⁵³MARC-ANDRÉ GAGNON AND SIDNEY WOLFE, MIRROR, MIRROR ON THE WALL: MEDICARE PART D PAYS NEEDLESSLY HIGH BRAND-NAME DRUG PRICES COMPARED WITH OTHER OECD COUNTRIES AND WITH U.S. GOVERNMENT PROGRAMS, at 11 (July 2015), <https://bit.ly/2p8ERli>.

⁵⁴Steffie Woolhandler and David U. Himmelstein, *Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs*, 166 ANNALS OF INTERNAL MEDICINE 587-588, 588 (2017).

⁵⁵Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1035 (2018).

⁵⁶Jeanne Whalen, *Why the U.S. Pays More Than Other Countries for Drugs*, THE WALL STREET JOURNAL (December 1, 2015), <https://on.wsj.com/2pe6SiS>.

⁵⁷U.S. GOVERNMENT ACCOUNTABILITY OFFICE, DRUG INDUSTRY: PROFITS, RESEARCH AND DEVELOPMENT SPENDING, AND MERGER AND ACQUISITION DEALS, at 17 (November 2017), <https://bit.ly/2DhdcVQ>.

⁵⁸*Id.* at 32.

⁵⁹*Id.* at 5.

⁶⁰*Id.* at 17.

⁶¹KAISER FAMILY FOUNDATION, KAISER HEALTH TRACKING POLL: HEALTH CARE PRIORITIES FOR 2017, at 22 (December 2016) <https://bit.ly/2FTWdBA>.

Americans are able to access the prescription drugs they need while lowering drug costs for the entire health system.

III. CONCLUSION

It is inhumane to have 30 million Americans lack any form of health care coverage, placing them at risk of personal and financial ruin if they get sick. Further, having so many Americans uninsured leads to tens of thousands of needless deaths each year.⁶² The United States has for too long debated creating a universal health care system without delivering. Despite this failure, Medicare has successfully achieved universal coverage for Americans 65 and older since its passage more than 50 years ago. The success of Medicare highlights the importance of building on that program's success and finally extending guaranteed access to health care to everyone in America.

Everyone depends on the health care system at some time in their lives. From the moment you are born (likely at a hospital) to the day you die, you are part of the health care system whether you are healthy or sick. Even when we feel perfectly fine and haven't had a checkup, the health care system serves and protects us through the development of vaccines, control of infectious disease, and research on ailments likely to befall us, our family, or our community.

And because we rarely know when we might experience our next brush with illness or injury, we need the health care system ready and waiting, just in case.

Thankfully, momentum for a better system is growing. The public outcry for a fairer system that allows everyone access to the care they need will only get stronger as costs of the status quo continue to rise. For example, a recent poll found that 70 percent of Americans, including a majority of Republicans, support providing Medicare to every American.⁶³

Medicare for All would improve the current Medicare program and expand it to everyone in the United States. Such a health care system would provide better access to care and would be far more efficient than our fragmented health care system. The successful experience of other nations implementing similar programs for their citizens shows what great potential such a system has for improving the lives of everyone in the United States.

For questions, please contact me at ekemp@citizen.org.

⁶²Steffie Woolhandler and David U. Himmelstein, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?*, 167 *Annals of Internal Medicine* 424-431, 429 (2017).

⁶³Julia Manchester, *70 percent of Americans support 'Medicare for all' proposal*, THE HILL (October 22, 2018), <https://bit.ly/2FZqv9N>.

House GOP plan would cut Medicare, Medicaid to balance budget

By [Erica Werner](#), Washington Post

June 19, 2018

House Republicans released a proposal Tuesday that would balance the budget in nine years — but only by making large cuts to entitlement programs, including Medicare, that President Trump vowed not to touch.

The House Budget Committee is aiming to pass the blueprint this week, but that may be as far as it goes this midterm election year. It is not clear that GOP leaders will put the document on the House floor for a vote, and even if it were to pass the House, the budget would have little impact on actual spending levels.

Nonetheless the budget serves as an expression of Republicans' priorities at a time of rapidly rising deficits and debt. Although the nation's growing indebtedness has been exacerbated by the GOP's own policy decisions — including the new tax law, which most analyses say will add at least \$1 trillion to the debt — Republicans on the Budget Committee said they felt a responsibility to put the nation on a sounder fiscal trajectory.

The Republican budget confronts this enemy by taking a whack at entitlement spending. Lawmakers of both parties agree that spending that is not subject to Congress's annual appropriations process is becoming unsustainable. But Trump has largely taken it off the table by refusing to touch Medicare or Social Security, and Democrats have little interest in addressing it except as part of a larger deal including tax increases — the sort of "Grand Bargain" that eluded President Barack Obama.

The House Republican budget, titled "A Brighter American Future," would remake Medicare by giving seniors the option of enrolling in private plans that compete with traditional Medicare, a system of competition designed to keep costs down but dismissed by critics as an effort to privatize the program. Along with other changes, the budget proposes to squeeze \$537 billion out of Medicare over the next decade.

The budget would transform Medicaid, the federal-state health-care program for the poor, by limiting per capita payments or allowing states to turn it into a block-grant program — the same approach House Republicans took in their legislation that passed last year to repeal the Affordable Care Act (the repeal effort died in the Senate, but the GOP budget assumes that the repeal takes place). It also proposes adding work requirements for certain adults enrolled in Medicaid. Changes to Medicaid and other health programs would account for \$1.5 trillion in savings.

Social Security comes in for more modest cuts of \$4 billion over the decade, which the budget projects could be reached by eliminating concurrent receipt of unemployment benefits and Social Security disability insurance.

The budget also proposes a number of other cost-saving measures, some of which could prove unpopular if implemented, such as adding more work requirements for food-stamp and welfare recipients and requiring federal employees — including members of Congress — to contribute more to their retirement plans. It assumes repeal of the Dodd-Frank Act that regulated banks after the financial crisis 10 years ago, something Congress recently rejected in passing a banking bill into law that softened some of the key provisions of Dodd-Frank but left its overall structures intact. And the

budget proposes \$230 billion in cuts from education and training programs, including consolidating student loan programs and reducing Pell Grant awards.

The budget also relies on rosy economic-growth projections and proposes using a budgetary mechanism to require other congressional committees to come up with a combined \$302 billion in unspecified deficit reduction.

Overall, the partisan proposal is reminiscent of the budget released in 2011 by now-House Speaker Paul D. Ryan (R-Wis.), who was then the Budget Committee chairman and advanced a bold proposal attacking entitlements, slashing spending — and creating lines of attack for Democrats once Ryan became Mitt Romney's vice presidential running mate on the GOP ticket the following year.

Democrats were quick to criticize the GOP proposal while contending that Republicans were opening themselves up to election-year attacks by releasing it at all.

“The 2019 Republican budget scraps any sense of responsibility to the American people and any obligation to being honest,” said Rep. John Yarmuth (Ky.), the top Democrat on the Budget Committee. “Its repeal of the Affordable Care Act and extreme cuts to health care, retirement security, anti-poverty programs, education, infrastructure, and other critical investments are real and will inflict serious harm on American families.”

Nova Scotia

'This is the face of the health-care crisis': Woman issues plea to N.S. premier

Social Sharing

'I fought for my life,' says cancer patient Inez Rudderham in emotional viral video

Alex Cooke · CBC News · Posted: Apr 25, 2019 1:29 PM AT | Last Updated: April 25



Inez Rudderham speaks about her issues with Nova Scotia's health-care system in an emotional video that's since gone viral. (Marilyn Inez/Facebook)

A mother in Nova Scotia living with cancer is challenging Premier Stephen McNeil to meet with her after a years-long battle with the province's health-care system.

In an emotional video posted to her Facebook page this week, Inez Rudderham said she went undiagnosed for two years because she couldn't access a family doctor. By the time she was diagnosed, her anal cancer had progressed to its third stage.

"I dare you to take a meeting with me, and explain to me, and look into my eyes and tell me that there is no health-care crisis in my province of Nova Scotia," said Rudderham, 33, as she wiped away tears.

"I dare you."

Rudderham said she was turned away from emergency departments three times before her concerns were taken seriously.

"I fought for my life," said Rudderham, who said radiation treatments on her pelvis has left her "barren and infertile."

"At 33, I am in menopause because when my tumour was a polyp I did not have access to a family doctor and the ERs wouldn't help me."

Rudderham also spoke about mental-health services in Nova Scotia.

She said she began pursuing mental-health services in January to help her cope with her diagnosis. She said she will have to wait until the summer to receive counselling.

"This is the face of the health-care crisis in Nova Scotia. I cannot receive help for trauma that I experienced because of this failed system until July," she said.

"What about my four-year-old daughter who doesn't have me there, fully, because I need help and I'm not receiving it?"

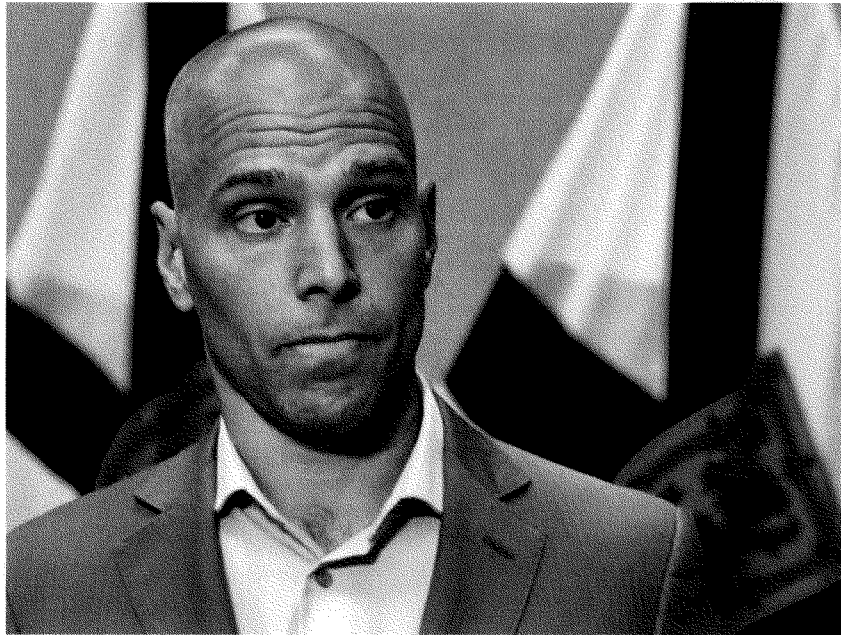
The video has taken social media by storm, amassing over 50,000 shares since it was posted on Tuesday.

Experience is all too common: Doctors Nova Scotia

Tim Holland, the president of Doctors Nova Scotia, said this isn't the first time he's heard this kind of story.

He said Rudderham's experience has all of the elements of the problems Nova Scotians are facing in the health-care system.

"Lack of a family physician, having to access emergency department services for health care — knowing full well that those emergency departments aren't equipped to be diagnosing cancer like this, and are also stretched thin themselves," he said.



Dr. Tim Holland, president of Doctors Nova Scotia, says he's heard stories like Rudderham's all too often. (Craig Paisley/CBC)

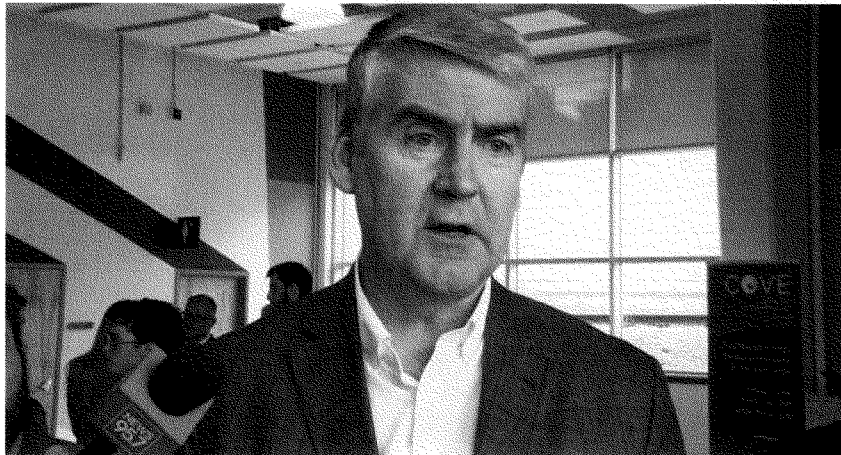
He said these challenges are being seen across the country, and said the fix is "multi-factorial:" recruiting and retaining doctors and improving work environments by engaging them in important decisions and cutting back on red tape.

Response from the province

On Thursday, Premier Stephen McNeil said he has asked the Health Department to reach out to Rudderham to find out more about her situation.

He would not commit to meeting with her until he had heard back from the department.

"There are challenges in the health-care system in parts of accessing primary care. We've always acknowledged that," he said. "But we've continued to make adjustments."



Premier Stephen McNeil said he's asked the Health Department to contact Rudderham, and he won't commit to a meeting with her until he hears back from the department. (George Sadi/CBC) Speaking with reporters following a cabinet meeting in Halifax, Health Minister Randy Delorey said staff with the Nova Scotia Health Authority have tried to make contact with Rudderham.

"I think, again, there's some very specific concerns that were being raised about an individual's personal experiences within the health-care system," said Delorey.

"I think the health authority's taking the right approach to reach out, to connect ... with the individual as they do and provide opportunities."

Delorey shied away from using terms like "crisis" in reference to the province's health-care system, saying issues within the system are shared across the country.

He also said the province is making progress through new investments and programs.

"We've been focused on these efforts for the last number of years," he said. "Our focus has been on primary care and we've been seeing those improvements."



Health Minister Randy Delorey said the issues Nova Scotia's health system faces are part of a nationwide problem. (Craig Paisley/CBC)

Also speaking after the meeting, Tory MLA Tim Halman said there has to be a "sense of urgency" when it comes to fixing gaps in Nova Scotia's health-care system.

"This is heartbreaking. If anyone knows my story, watching that video, I see a lot there on so many levels," he said, referencing his wife who died from cancer in 2017.

"From the perspective of an MLA, our system failed her."

Attempts to reach Rudderham for comment were unsuccessful.

'There's no stopping me'

Rudderham has been documenting her journey through Nova Scotia's health-care system since June 2018, about two weeks after she said she was diagnosed with cancer.

In the first video she posted after being diagnosed, she explained that she had been feeling unwell for about a year and that three doctors looked at her before she was given a rectal exam.

Rudderham said she used to have a family doctor but she left.

"You need to advocate for your own health," said Rudderham. "I should have started advocating for myself sooner than I did."

She also asked that people put pressure on the government instead of blaming health-care workers.

"Our doctors and our nurses are working in a system that does not support them," she said.



Rudderham says she went to three different emergency departments before she was given a rectal exam. (Robert Short/CBC)

In a follow-up video, Rudderham said she was initially diagnosed with a colorectal tumour, and later found out the tumour was actually in her anus. She said this was a good thing because its placement would make it easier to operate.

She joked that the growth, which was initially about six inches, had been named "Arnold," before she became serious once again.

"I don't want to make it seem like I'm taking light of this, because I'm not. I know full well what I'm facing," she said.

I can choose to see it for what it is, which is a really beautiful opportunity for me to stand up and fight a really good fight and come out on the other side however I choose to."

Rudderham added: "Because after this, there's no stopping me."



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April 29, 2019

Representative Jim McGovern, Chair
 House Rules Committee
 U.S. House of Representatives
 H-312 The Capitol
 Washington, D.C. 20515

Thank you for taking the time to view our testimony. And thank you for holding the upcoming hearing on HR 1384 the Medicare for All Act of 2019. This hearing is part of a greater movement in our country towards a Health Care system that achieves racial and gender equity, and guarantees Health Care as a Human Right for all people in our country. Through the years, Washington CAN has had many moments where we have been leaders on Health Care. We helped pass Universal Health Care legislation in 1993, we passed the Basic Health Plan, long before the Exchange was available through the Affordable Act, we implemented the CHIP legislation in such a way that every single child in our state has access to health care, and two of our members were in the room when the Affordable Care Act was signed into Law, as recognition for their activism. These are achievements we are proud of, but we are not done.

Today there are over 400,000 people in our state who are uninsured, and millions across the country. The financial and health risks for the uninsured are great. There are many more that are underinsured and avoid medical help due to the cost of high co-pays, deductibles, and prescriptions. People should never have to choose between food and medicine, yet many in our country face this challenge every day.

This is a crucial moment in which our country has an opportunity to finally lead on Health Care. We must invest in a health care system that provides choice, affordability, and comprehensive coverage. The Medicare for All Act of 2019 is essential to getting health care costs under control, and achieving coverage for all residents in a way that puts their dignity before the enormous profits of our current Health Care system.

Thank you again for your time and consideration of our testimony.

Nathan Rodke
 Washington CAN!

Labor Campaign for Single-Payer

Healthcare Is A Right -- Not A Privilege

www.laborforsinglepayer.org

April 26, 2019

Chairman Jim McGovern
Ranking Member Tom Cole
The Committee on Rules
U.S. House of Representatives
H-312-The Capitol
Washington, DC 20515

Dear Chairman McGovern and Ranking Member Cole,

The Labor Campaign for Single Payer Healthcare's affiliates include 15 national unions, 8 state labor federations and a large number of local and regional union organizations. We write today in support of HR-1384, the Medicare for All Act, which will be considered by the Rules Committee on April 30.

HR 1384 would expand and improve Medicare and make healthcare a birthright for all Americans. It would provide seamless and comprehensive coverage with no financial barriers to care and freedom to choose physicians and healthcare providers. Nearly all economists agree that a well-constructed Medicare for All system would cost significantly less than our current dysfunctional multi-payer system. Most importantly, from our perspective, it would sever the unsustainable link between healthcare and employment that is undermining good jobs, eroding the United States' international competitive advantage and placing increasing burdens on America's working families.

None of the alternative healthcare reform proposals would come close to achieving the healthcare security and cost savings that HR 1384 could achieve. No other healthcare proposal would take healthcare off the bargaining table by making it a right for everyone in America. Preservation of employment-based health insurance guarantees that healthcare will continue to be the biggest cause of strikes, lockouts and concession bargaining and that workers' wages will stagnate and their job prospects diminish in order to pay the costs for the world's most expensive and inefficient healthcare system.

We urge the Committee to give HR 1384 your full consideration and to launch it on a path that will allow the House to debate and vote on the Bill this session.

Sincerely,

Mark Dudzic
National Coordinator



April 29, 2019

Chairman James McGovern
Committee on Rules
U.S. House of Representatives
H-312 The Capitol
Washington, D.C. 20510

Chairman McGovern:

We are writing to express our enthusiastic support for the Medicare for All Act of 2019 and hope that this hearing in the House Committee on Rules is just the first legislative step to ensuring health care for everyone in our nation.

The current state of our nation's health care system is unacceptable. Every day that goes by, more Americans go without recommended care, fail to see a doctor when sick, or neglect to fill a prescription because of high costs. It staggers belief that in the wealthiest nation on Earth, 30 million people remain uninsured, and an additional 41 million people are underinsured. It is outrageous that the United States spends twice as much on health care as other major industrialized countries, and yet Americans continue to experience worse health outcomes, with more preventable deaths under the age of 75 and a higher infant mortality rate than many peer nations. It is time to reorient American health care around the needs of patients, not profits. The Medicare for All Act will improve and expand Medicare and finally secure health care as a human right for every American, once and for all.

The Medicare for All Act of 2019 would guarantee access to health care with comprehensive benefits. Under this single-payer system there would be no premiums, co-pays, or deductibles. This system is better for every group in our country and especially seniors, people with disabilities, people of color, people in rural areas, and women.

Seniors have, perhaps, the most to gain from the Medicare for All Act of 2019. They would benefit from its more comprehensive coverage of vital services, including dental, vision, and hearing. In addition, long-term services and supports for people with disabilities and older Americans, through both home and community-based services, would be fully covered. The Department of Health and Human Services estimates that a semi-private room in a nursing home, on average, costs over

\$80,000 a year, far beyond the income of most Americans. Under Medicare for All these costs are completely covered.

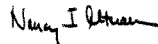
Seniors would receive these additional benefits, but pay far less than they are today. This legislation would reduce health care spending, including the cost of prescription drugs. Seniors would no longer face the difficult decision between medicine and food with Medicare for All.

Medicare for All will also be a vehicle for racial equity and the elimination of minority health disparities. Rural hospitals would receive special support and investments. Women, with the support of their physicians, would not be denied any coverage for any reason.

Representatives Jayapal and Dingell have been persistent in their leadership in this effort and are fiercely pressing forward until that day when every American will finally be able to receive the medical care they need, without worrying that they are one emergency away from bankruptcy. We encourage every member of Congress to work together and realize this vision. We believe Americans are ready to see this sort of change and we look forward to more conversations and action after the hearing in the Rules Committee.

Thank you for holding this historic hearing. We hope and trust that it will be the first of many.

Sincerely,



Nancy J. Altman
President



Alex Lawson
Executive Director

John W. Aldis, MD, MPH & TM

4911 River Road, Shepherdstown, WV 25443 | (304) 283-0041 | jwaldis@gmail.com

April 22, 2019

Dear House Rules Committee:

My name is Dr. John W. Aldis, and I am a family physician in West Virginia. I graduated from medical school in 1971 and I completed my specialty training and my degree in Public Health and Tropical medicine after that. My father (an obstetrician/gynecologist) graduated from medical school in 1941. Our careers taken together give me a firsthand image of nearly 80 years of clinical practice in the United States. Over those 80 years I can say that I have never seen the promise of my profession as broken as it is today.

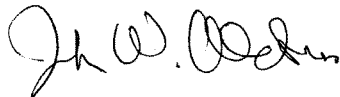
Much of this situation is due to the horrendous degree of “wealth inequality” which both hinders the ability of the people in the lower end of the economic range to receive anything close to adequate medical care while it facilitates those in the higher economic range to receive the level of care for which all Americans can justifiably be proud. Those in the lower range struggle on in silence while the others happily accept what they perceive to have “deserved” because of the wealth they possess.

Representative Pramila Jayapal’s “Improved Medicare For All” bill does not attempt to solve all the issues of “wealth inequality.” Rather, the bill focuses on limiting how “wealth” assures access to adequate medical care while the lack of wealth denies many Americans that basic human right.

Rep. Jayapal’s bill also removes health insurance companies from the picture. They are not (and never have been) there for the patients; rather, they only serve as the gateway to separate the “haves” and “have-nots” in healthcare. Their goals remain their “bottom lines,” not the healthcare of Americans. They make demands on medical practices which seriously compromise the providers’ abilities to care for their patients while denying many patients their basic right to choose from which providers they want to receive care.

The success of national single-payer programs internationally demonstrates that it is possible to offer more, and better, care for less. With H.R. 1384 (Medicare For All of 2019), we can hopefully, finally, agree to address this national disgrace. We can show what it means to truly care about the health and future of every American.

Sincerely,



John Aldis, MD
AAFP, MPH & Tropical Medicine

Statement of Rebecca Wood*April 30, 2019*

This is my daughter, Charlie. She loves the color pink, princesses, the outdoors, the band Dispatch, and Nancy Pelosi.

Charlie's story began in May of 2012. Due to severe preeclampsia, she was delivered via emergency c section ten hours into her twenty sixth week of gestation. She weighed one pound twelve ounces and was the size of my hand.

In the beginning, we didn't know if she would survive. My NICU bedside vigil started because I did not want her to die alone.

Charlie was tough and a fighter. After three months, she was well enough to come home. We thought it was over. But, it was merely the end of the beginning.

Issues from her premature birth appeared one after another. Each one required treatments and therapies.

There were specialists, medications, injections, physical therapists, occupational therapists, speech therapists, specialty formula, formula thickeners, orthotics, therapeutic equipment, attendant care, and, later, a feeding tube. Charlie was in diapers years longer than most kids and needed adaptive cups, silverware, and plates. The costs added up quickly.

My husband's employer's insurance covered many of the bills. Additionally, Charlie had a medicaid waiver to cover some of the other expenses. But, because there is a waiting list in our state for the waiver that Charlie is entitled to, much of the cost of her care came out of our pocket.

Right now, over half a million people are on waiting lists for home and community based services; often people have to wait a decade or longer for services. In Virginia, our waitlists are so long that people get ranked on

how urgent their needs are – over 10,000 people in Virginia are “urgent” priorities yet still waiting. The appropriate waiver would have covered most of the expenses that Charlie’s primary insurance didn’t.

Over time, medical expenses drained and financially devastated us. I had to, and have to, make impossible choices.

Should I pay for her therapy or my overpriced asthma medication? Choices like these aren’t really impossible. I choose to pay for hers and go without mine.

One day, I needed an expensive dental procedure. Unfortunately, it was at the same time a therapy payment was due. Charlie’s speech was emerging. I was afraid we would miss a window of opportunity in her development if we cut therapy. I chose to pay her therapy payment and put off my dental procedure. The decision cost me dearly.

Due to the delay, an infection spread throughout my mouth and jaw. I went to the emergency department because the swelling in my mouth obstructed my airway. After a course of IV antibiotics, I was discharged. The next day, I had all of my teeth pulled, the infection drained, and parts of my jaw scraped away in a six hour procedure under local anesthesia. I could not afford to have it done under general anesthesia. I cried the entire ride home afterwards.

While I juggle needs and sacrifice, Charlie did and does her part too. She survived a brutal beginning in which every breath was strenuous and touch was agony. She willed uncooperative muscles to move, pushed her sensory threshold to the limit, gagged down food in feeding therapy, endured countless therapy sessions, and visited a multitude of doctors.

Charlie never quit.

At the age of one, she was able to sit independently. At twenty months, with the assistance of orthotics, she took her first steps. Last September,

she learned to eat and her feeding tube was removed. Because she was able to receive services at home, her hospitalizations have been minimal and we did not have to consider institutional care. Currently, she is hard at work on speech and fine motor issues.

Today, when people see Charlie, they call her a miracle. They say she is amazing. Or, they tell me we are blessed.

But, there is nothing special about Charlie. She is merely an example of what is possible when kids are given the medical supports and services they need.

Long term supports and services included in this bill are crucial to families like mine. The bill would provide mandatory coverage of the community based services that people with disabilities need and want. Additionally, it ensures that services are equal across geographic areas, a problem I've personally had to contend with.

This is truly groundbreaking and the result of Congresswoman Jayapal listening to the disability community. I thank Congresswoman Jayapal for making clear that Medicare for All means Medicare FOR ALL.

I'm lucky Charlie survived. I'm fortunate she thrived. However, it shouldn't have cost me nearly everything.

No one should have to pay the price I paid for my child to have a chance to reach her full potential. Medicare For All will ensure families aren't faced with challenges and struggles like mine.



**PARTNERSHIP FOR
EMPLOYER-SPONSORED COVERAGE**

STATEMENT FOR
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON RULES
HEARING ON
MEDICARE FOR ALL ACT OF 2019 (H.R. 1384)
APRIL 30, 2019

The Partnership for Employer-Sponsored Coverage is an advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and the over 181 million American workers and their families who rely on employer-sponsored coverage every day. We are committed to working to ensure that employer-sponsored coverage is strengthened and remains a viable, affordable option for decades to come.

Employer-sponsored coverage has been the backbone of our nation's health system for nearly eight decades. Employers of all sizes contribute vast resources to employees and their families through the employer-sponsored system. Employers have a vested interest in health care quality, value, and system viability. Employers have been on the leading edge of health delivery innovation and modeling for decades.

Benefits offerings and coverage plans in the employer-sponsored system are as diverse as employers and employees themselves. With self-insured coverage under the Employee Retirement Income Security Act (ERISA), an employer can tailor coverage to meet their workforce's specific needs across state lines, pays all health claims and bears the financial risk, and utilizes a third-party administrator (insurance carrier) for daily plan management. Through the fully-insured state regulated insurance market, employers purchase a prescribed benefit insurance product sold in a state from an insurance carrier and does not bear the full financial risk of claims.

Employers have led the way in benefits design and innovation for decades and will continue to do so for decades to come. There is no one-size-fits-all employer health plan nor should the federal government enact or implement laws that stifle an employer's ability to develop benefits offerings that meet the needs of their specific workforce. All levels of government should work constructively with private sector employers to ensure that employers have the tools and flexibility to foster benefits design and innovations that provide employees with benefits that are crucial to the wellbeing of themselves and their families.

The foundation of the employer-sponsored coverage system is rooted in workforce policy and business operations. Employers of all sizes offer coverage for employee recruitment and retention, and the functionality of a business is centered around a productive, thriving, and healthy workforce.



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PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

The ability to offer coverage to employees and the capacity to operate a business for its core purpose are not mutually exclusive functions. An employer offer of coverage is not merely a transaction in which an employee fills out paperwork, enrolls in coverage, and receives an insurance card – it is a multifaceted fiscal and operational commitment at the core of any business. As employers are making the decision to offer coverage and determine which type of coverage to offer their employees, a critical aspect of this deliberation is the administrative compliance costs and complexities associated with coverage.

When considering legislative and regulatory policy development and implementation, federal lawmakers and regulators must understand and appreciate the societal and economic commitments employers make to our nation's workforce through the employer-sponsored coverage system. The following policy and implementation questions should be carefully considered in the context of today's hearing and future deliberations.

- What would Medicare for All mean for employment? Recruitment and retention of employees?
- How would a Medicare or Medicaid buy-in program be an advantage or disadvantage to employees and employers?
- How would expansion of Medicare/Medicaid through a buy-in program effect current program beneficiaries and resources?
- How would a Medicare/Medicaid buy-in program effect timely access to providers and services for the influx of new beneficiaries?
- How would the employee-employer relationship change by a Medicare buy-in plan? Specifically with regard to working Americans between 50-64?
- What is a Medicare buy-in program striving to accomplish? Cohort of uninsured?
- How would a Medicare/Medicaid buy-in program effect take-up rates for fully-insured employer-sponsored plans? How would it effect other populations of employees?

The Partnership for Employer-Sponsored Coverage opposes Medicare for All. Dismantling our nation's private sector employment-based health system which provides coverage for the largest percentage of the population would create utter chaos and massive disruptions to the care system for all Americans. We urge Congress to devote its attention and resources toward issues to improve our current health care system such as increasing market competition, providing more coverage choices and access to providers for all Americans, and addressing systematic cost drivers and wasteful spending. Our public principles include:

- Preserving the current tax treatment of employer-sponsored coverage
- Promoting innovations and diversity of plan designs and offerings for employees
- Providing employers with compliance relief from burdensome regulations
- Repealing the Affordable Care Act taxes on employer-sponsored coverage
- Protecting ERISA



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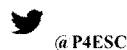
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As a coalition representing businesses of all sizes, the Partnership for Employer-Sponsored Coverage has the unique ability to provide operational input across the full spectrum of the employer system – from the smallest family-owned business to the largest corporation. Employers have a great stake in the development and implementation of health care policies. We stand ready to work with the 116th Congress in a bipartisan manner strengthen and preserve our nation's private sector employment-based health system.

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

American Hotel & Lodging Association
 American Rental Association
 American Staffing Association
 Associated Builders and Contractors, Inc.
 Associated General Contractors of America
 Auto Care Association
 The Council of Insurance Agents & Brokers
 Food Marketing Institute
 HR Policy Association
 International Franchise Association
 National Association of Health Underwriters
 National Association of Wholesaler-Distributors
 National Restaurant Association
 National Retail Federation
 Retail Industry Leaders Association
 Society of American Florists
 Society for Human Resource Management



Hey, Democrats: Here's the price I paid for your socialist dream

By [Enrique Padron](#)

April 17, 2019 | 9:16pm



Fidel Castro/Getty Images

American Democrats are pining ever more loudly for socialism these days, for “free” education, “free” health care and much else.

Let me tell you about socialism as I lived it under the Fidel Castro regime.

The house where I was born in Communist Cuba had a dirt floor, a bathroom hole-in-the-ground, which we shared with six other families, and a zinc roof that left us unbearably hot in the summer and shivering in the winter.

We had no running water, no refrigerator and no door in the back of the house. We cooked with charcoal. My mother raised four boys by herself in that "house," working 12 hours a day to earn 160 Cuban pesos, or approximately \$6, a month.

Why didn't we fix it? In addition to the meager income, we had no access to hardware stores to buy nails or cement to fix our humble house. In fact, the local member of the National Assembly was the only person authorized to approve whether we could buy a bag of cement or a roll of roof paper — if they were available.

We couldn't buy these simple materials without that precious piece of paper. Can you imagine going to your congressional representative to ask for permission to buy a box of nails? Or roof tiles? Or roof paper? It seems unthinkable in the United States. But in Cuba, where we lacked the necessities of life, we had to. And when we complained, the authorities scolded us to be grateful for free education and free health care.

In Cuba, it is illegal to speak against the government or complain about living conditions. We were prohibited from speaking with local media, but the journalists were state employees and wouldn't publish our stories anyway. We couldn't express our unmet needs and were reminded that we shouldn't complain anyway, because we were promised — you guessed it — free education and free health care.

In Cuba, doctors make the equivalent of 25 cents an hour and teachers 21 cents an hour. Pharmacists earn eight cents an hour.

In Cuba, there is no right to free speech and virtually no independent media.

There are no free, fair, multiparty elections. In fact, there is just one political party (Communist), and only members of the Communist Party may run as candidates for any office. But we were told we couldn't object to this system, lest we lose our free education and free health care.

Two of my brothers were sent to fight in Angola when I was a boy. After years of risking their lives for a strange cause, they came back to Cuba to find out

that their mother and little brother were living under worse conditions than before they left. They learned that the promise of going to another country to fight for the “big, beautiful future of socialism” was just a big lie.

In Cuba, if you dare to yell something true — like “Fidel and Raul are dictators!” — you could spend many years in prison. Dictatorship is another price we had to pay for free education and free health care.

I desperately needed something more than the promises of free education and free health care. I knew that I needed freedom — freedom to speak my mind and vote my conscience. It was worth the risk of being eaten by sharks than to continue living a life with no purpose and no freedom.

On August 16, 1994, I decided to get into a boat with 20 other Cubans in search of a future.

One of my two brothers followed me to the United States, also in a raft, nearly dying of thirst and hunger during the journey. My other brother is still awaiting the visa I filed for him.

Throughout their ordeals, my brothers have been promised free education and free health care.

After arriving in the United States, I worked as an international sales manager, owned a restaurant, hosted a radio program and authored two books. Today, I work for a member of Congress. None of those opportunities would have been possible for me in socialist Cuba.

I wish that one day I might have a conversation with some of these young American socialists, who have no experience with actually existing socialism. They like to think they can have democracy and a socialist economy. But everywhere it's been implemented, public ownership of the means of production has led to political repression.

Not least in my native Cuba, with its promises of “free” cradle-to-grave services.

I chose so much more than the promise of "free." I chose freedom.

Enrique Padron is the southwest Florida director for Rep. Mario Diaz-Balart.



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PAPER

Charlie Gard and the weight of parental rights to seek experimental treatment

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Received 19 December 2017
Revised 28 March 2018
Accepted 28 April 2018
Published Online First
17 May 2018

ABSTRACT

The case of Charlie Gard, an infant with a genetic illness whose parents sought experimental treatment in the USA, brought important debates about the moral status of parents and children to the public eye. After setting out the facts of the case, this article considers some of these debates through the lens of parental rights. Parental rights are most commonly based on the promotion of a child's welfare; however, in Charlie's case, promotion of Charlie's welfare cannot explain every fact of the case. Indeed, some seem most logically to extend from intrinsic parental rights, that is, parental rights that exist independent of welfare promotion. I observe that a strong claim for intrinsic parental rights can be built on arguments for genetic propriety and children's limited personhood. Critique of these arguments suggests the scope of parental rights remains limited: property rights entail proper use; non-personhood includes only a small cohort of very young or seriously intellectually disabled children and the uniqueness of parental genetic connection is limited. Moreover, there are cogent arguments about parents' competence to make judgements, and public interest arguments against allowing access to experimental treatment. Nevertheless, while arguments based on propriety may raise concerns about the attitude involved in envisioning children as property, I conclude that these arguments do appear to offer a *prima facie* case for a parental right to seek experimental treatment in certain limited circumstances.

INTRODUCTION

The case of Charlie Gard concerned the right of parents of an infant with a genetic illness to take him to the USA to receive experimental treatment against medical advice. In July 2017, a spokesperson for the family announced that frustrating this right amounted to Charlie being 'taken prisoner by the NHS'.¹ In this article, I consider the basis and scope of parental rights (PR) in relation to the details of Charlie's case, primarily drawn from the legal records.²⁻⁴ Discussion of moral rights is justified here because these should be accounted for in future cases. Further, moral rights can translate to legal rights, and thus may ultimately compel particular decisions. I argue that, although the case was decided on welfare grounds, there is evidence of attention to rights of Charlie's parents that are independent of a welfare basis—what I shall term 'intrinsic PR'. Exploring the basis of such rights, I suggest that the strongest philosophical argument for PR is that Charlie was a non-person and genetically his parents' property. These rights are strictly

limited, and in Charlie's case PR were outweighed by a precautionary approach to the uncertain harms accruing to Charlie. However, in future similar cases, PR may prove determinative where harms are excluded and potential benefits are great. I argue that parents are competent to exercise these rights, and that public interest concerns over access to experimental treatment can be allayed.

CHARLIE'S CASE

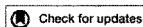
Charlie was born with infantile-onset mitochondrial DNA depletion syndrome (MDDS). MDDS is a genetic disease where abnormal mitochondrial DNA causes cells to malfunction. Different strains of MDDS cause variable levels of disability. Charlie's rare 'RRM2B' mutation of MDDS caused progressive brain and muscle damage.

Charlie was admitted to hospital at 2 months. A ventilator helped him to breathe and he had recurrent seizures. He could not move his limbs and opened his eyes only intermittently, making it difficult to tell when he was in pain. Charlie's parents became aware of experimental treatment (nucleoside therapy), where biochemical food supplements stimulate the repair of mitochondrial DNA. Results of nucleoside therapy on mice with the TK2 variant of MDDS (which usually leaves the brain unaffected) increased lifespan slightly. Human trials saw 13 (of 18) children with TK2 MDDS grow, and one improve their walking ability over 4 years. There was no evidence the therapy repaired the brain, nor was it tried on RRM2B MDDS. Nevertheless, a US expert claimed it might help Charlie.

Charlie's doctors agreed to try the therapy. However, before a trial commenced, Charlie suffered several weeks of refractory epileptic fits. This caused severe brain damage and Charlie's doctors believed he had no hope of improvement, counselling fatal withdrawal of ventilation. Charlie's parents remain steadfast in their wish for further treatment, including nucleoside therapy. The hospital sought a court order that it would be lawful to withdraw treatment because treatment was not in Charlie's best interests. Charlie's parents argued that they knew Charlie best, and cared for him more deeply than anyone else. Yet, apart from Charlie's parents and the clinician offering treatment, all witnesses agreed with Charlie's doctors. The order the hospital sought was eventually granted, and affirmed in three subsequent appeals.²⁻⁴ A final spate of litigation settled when and where withdrawal would take place. Charlie's parents bitterly complained that the outcome left



► <http://dx.doi.org/10.1136/medethics-2017-104705>
► <http://dx.doi.org/10.1136/medethics-2017-104706>
► <http://dx.doi.org/10.1136/medethics-2017-104720>
► <http://dx.doi.org/10.1136/medethics-2017-104721>
► <http://dx.doi.org/10.1136/medethics-2017-104723>
► <http://dx.doi.org/10.1136/medethics-2018-104744>



To cite: Birchley G.
J Med Ethics
2018;44:448–452.

them 'very little time' before Charlie died.⁷ Withdrawal did not take place immediately, but after an unspecified period of time set out in a confidential annex to the court order.⁸ Evidently, this was brief as reports of Charlie's death were published after 18:00 the following day.^{9–10}

PR AND THE LIMITATIONS OF WELFARE

Broadly speaking, a right may be seen as a way of empowering an individual against collective goals that disregard that individual's legitimate interests.¹¹ Moral rights are normative claims supportable by reasoned arguments. Legal rights can be (and often have been) argued for on the basis of a putative moral right.¹² Legal rights may impose binding duties on others to either enable or, more commonly, not to impede the exercise of that right. The potential to influence the actions of decision-makers makes it pertinent to consider moral rights when assessing whether Charlie's case should alter our attitudes to the parental role in decision-making in similar cases.

In disputes about children's care '[m]any of today's critics of children's rights are passionate defenders of ... the rights of parents'¹³; different ethical approaches to children and parents make asymmetric claims about the putative moral rights of both parties. Arguments about rights may suggest that children: have rights; have rights that others (especially parents) should articulate; do not have rights. That parents: have rights based on their ability to advance the welfare of their child(ren); have rights over their children that are intrinsic to their status as parents. Broadly speaking (and leaving aside thornier issues of competence), my own considered moral judgement is that decisions concerning children who are unable to articulate their own wishes should be attentive to the child's welfare. In other words, PR are derivative of their ability to advance the welfare of their child. This view is shared by many^{14–16} even if they disagree about the scope of such rights or how welfare should be measured. In Charlie's case, welfare was a key factor for the courts. All sides (including the clinician proposing to deliver the innovative therapy) agreed that the chances of Charlie benefiting from treatment were 'vanishingly small'. Yet, while a focus on welfare suggests that the only basis of PR in this case was Charlie's welfare, some unremarkable aspects of the case do not comfortably fit this welfare thesis. In particular, the decision to delay withdrawal of treatment for a brief period after the courts had reached their decision, however appropriate we might feel such behaviour is, clearly continued whatever harms Charlie was experiencing. Delaying withdrawal is not unusual in similar cases.¹⁷ Delays are likely to be motivated, at least in part, by consideration of the interests of Charlie's parents rather than resting exclusively on Charlie's parents' ability to advance Charlie's welfare. To coherently explain why parents should be owed such respect, and to explore whether a similar basis suggests PR to have demands for experimental treatment met, it is important to consider the philosophical basis of intrinsic PR. The next section explores some of these arguments.

INTRINSIC PR

Arguments suggesting parents have an intrinsic right to be decision-makers for their children include the argument that parenting has a teleological basis and is a good in itself.^{18–19} Other arguments are based on the child being parental property, termed 'proprietary' accounts.¹² I consider the latter to contain the strongest arguments for PR. Therefore, after briefly

dismissing a teleological account, my discussion concentrates on these.

While teleological accounts vary, Page¹⁸ offers a particularly rich account. It asserts that both procreation and rearing children are essential parts of being human, and thus a good in themselves. PR, Page argues, are like sexual rights; restriction of either offends human nature. Page's arguments more strongly assert a right to procreate (eg, against parental licensing)²⁰ than a right to rear. While a teleological account depends on the optimal fulfilment of human nature, known as 'flourishing', it is by no means clear that having children is essential to flourishing. Indeed, depending on how flourishing is construed, it may be salient to consider that having children may not be fulfilling for parents,²¹ nor that adults without children lack fulfilment. The status of parenting as a good in itself is open to question. More promising than teleological accounts are proprietary accounts. Although thorough-going proprietary arguments are rare, inclinations towards proprietaryism may be more widespread. For example, some detect proprietaryism in Nozick's influential libertarian philosophy.^{12–22} Indeed, English common law has been argued to implicitly recognise a property right in the child.²³

Proprietary accounts^{24–25}—including that of the bioethicist H Tristram Engelhardt²⁶—have a common root. They use claims made by John Locke²⁷ about the nature of property and self-ownership as a basis for proprietaryism.²⁶ Locke's first claim is that producers have rights of ownership over the products their labours create. According to Locke, these ownership rights are gained by 'mixing' the producer's labour with the product. Locke himself argued that children were not parental property. Some find Locke's reasons for excluding children—that they are owned by God, not parents—unconvincing,²⁸ and apply his arguments to children nevertheless.^{12–29} Yet the 'mixed labour' argument is a problematic source of PR, implying that anyone who makes efforts affecting a child has rights over that child,^{12–29} and struggling with parental equality.^{12–30} Locke's second argument is that people own themselves. This is commonly^{29–31} tied to claims that PR stem from their children being (in some sense) part of the parent's bodies. Some think this could only realistically apply to pregnant women.^{12–32} Others argue that ownership follows parental provision of the child's genetic material³³ or genetic information.³⁴ These arguments suffer a regress problem. Parents were children once and logically, parents must still be owned, in turn, by their own parents. To overcome the regress, children must sometime stop being parental property. However, genetic *material* is rapidly subsumed in a sea of new cells, meaning genetic propriety is lost early in gestation, while genetic *information* lasts a lifetime and so remains susceptible to the regress.³⁵ However, the regress may be overcome if dwindling ownership is based on emerging personhood.²⁶

Personhood is a way of distinguishing morally important, and morally less important, beings. One account of personhood, from Singer,³⁴ argues that being human is not a morally relevant property. Instead he argues that moral status is conferred by being a *person*. A person in Singerian terms must be capable of conscious introspection and a sense of futurity. Thus, some animals will be persons (eg, chimpanzees) while some genetic humans are non-persons (eg, anencephalic infants). Although suffering to non-persons is morally undesirable, non-persons are less morally important than persons.³⁵ Engelhardt links children's putative non-personhood to proprietaryism, asserting children lack the faculties necessary to be persons, and thus start as the moral inferiors of their parents.²⁶ As children mature, they attain personhood and become morally equivalent to their parents. Such an

Charlie Gard

account overcomes the regress problem. I suggest an account on PR based on this reasoning, *prima facie*, fairly strong. In the next section of this article, I critique this account to determine some limits of intrinsic PR.

THE LIMITS OF INTRINSIC PR

I have postulated a basis for intrinsic PR relies on two key elements: genetic propriety and children's non-personhood. The scope of PR depends on the strength of these elements.

An obvious objection to this account is that children ought not to be described as property. An extraordinary range of commentators take pains to emphasise this position.^{15,16,17} One basis given for this claim is that it harms children to be treated as property.²⁹ Yet proprietarians argue that parents are still bound to treat their children non-malevolently.²⁶ Restrictions against misuse are a well-argued feature of legitimate property rights, including an obligation not to use property to harm others.³⁸ Lyons²³ argues that misuse of children could be prohibited by classing them as inalienable property, and this suggests the obligation against harm could extend to the child themselves. Argued this way, some consider the consequences of proprietorship are proximate to the welfare view of PR.³⁰ While describing children as property may evoke concern, it is difficult to devise a convincing argument against PR founded solely on this basis. Nevertheless, we should note that the scope of proprietorship PR is restricted, although based on avoiding harm and misuse, rather than promoting welfare.

The proprietorship account appears more vulnerable in claiming that children are non-persons. The non-personhood claim coheres with widespread public intuitions that the life of a fetus is less morally important than the woman who carries it.¹⁹ Without consideration of the moral status of fetuses here, these intuitions at least suggest arguments using personhood should be seriously considered when asserted in relation to older children. However, even if^{40,41} we accept that personhood is morally legitimate, it is arguable that under common personhood criteria, most children are persons, suggesting further limits to the scope of PR. Based on criteria of futurity and self-awareness, Singer¹⁴ argues children in the neonatal period (<1 month) are non-persons. Ross^{42,43} suggests that children up to late adolescence are not capable of rational decisions and thus 'not full Kantian persons'. There is evidence that disputes these assumptions. Neonates appear to anticipate familiar events⁴⁰ and distinguish their own touch⁴⁴ and cry.⁴⁵ This suggests neonates may possess a sense of futurity and self-consciousness—meeting Singerian criteria for personhood. Further, interviews with chronically ill children and their clinicians suggest that children as young as 3 years old may be capable of making rational decisions,¹⁶ challenging Ross' claims. On this basis, parents' rights over their children arguably begin waning between a few days and a few years after birth. However, PR may be much more persistent in children who are severely intellectually disabled, like Charlie.

A final criticism of proprietorship, which may further reduce the scope of PR, is based on criticism of genetic propriety. If parental property rights stem from parental ownership of the child's genetic information, it appears to support the claim that genetically related parents should have a greater say in decisions about their child than non-genetically related parents, such as adoptive parents. Yet it seems unconvincing to suggest this when the genetic parents have no interest in, care for, or knowledge of, their child. Even if we disregard these objections, genetic similarity seems a fragile basis on which to base *exclusively* parental rights. Although familial resemblances are

commonly cited as important flags of identity,⁴⁶ it is by no means clear that these socially constructed meanings rest on genetic resemblances rather than being proxies of social connection.⁴⁷ The global population has extensive genetic similarity⁴⁸; otherwise unconnected individuals have vastly more genetic information in common than they do not.⁴⁹ Genetic propriety accounts rest on a very slender material basis for such a connection between the child and the parent. Indeed, taken proportionately, it may also imply a shared genetic propriety of children. If the proportion of unique parental property in children is discernible, but very small, perhaps the rights of parents that can derive from this property are proportionately small.

These arguments do not suggest that intrinsic PR cannot be made out. However, the scope of these rights is restricted. By being based on a property right they limit the PR to non-harmful acts. On the most generous account the emergent personhood of the child causes intrinsic PR to expire after a few years in most cases. Finally, intrinsic PR based on genetic propriety are little greater than the rights of unrelated humans. These tangible, but weak, reasons for intrinsic PR may support transient delays in securing their child's welfare. However, they are unlikely to be strong enough to allow parents to undertake prolonged acts against their child's well-being.

LOOKING TO THE FUTURE: PR TO ACCESS TO EXPERIMENTAL TREATMENT

Given the justifiable, but slim, bases for PR, one of the considerations to arise from Charlie's case is to ask under what circumstances PR could influence future cases about accessing experimental treatment. Having established that PR beyond those based on enhancing the welfare of the child are both weak and limited, crucial to such questions will be the harms and benefits likely to arise from experimental treatment. The experimental basis means benefits will be uncertain. Indeed, a defining feature of potentially fatal cases involving critically ill children is the disagreement about whether the same outcome is a harm or a benefit. On one side, living with intensive care may be understood to amount to harm, and death a benefit⁵⁰; on the other side, loss of life is the greatest harm, and continued intensive care is a benefit. This disagreement is additionally complicated by the uncertain outcomes of experimental treatment. In Charlie's case, the risks of experimental treatment alone (a food supplement) were inconsiderable. Intrinsic PR combined with uncertain and minimal potential benefit (because of Charlie's brain injuries) were too weak to overcome the presence of uncertainty about harms, and a precautionary approach was taken. By precautionary approach, I mean broadly, the exercise of the principle of precaution, where uncertainty about the harms and risks that arise from a technology new to science means we should err on the side of caution. While I lack space to offer detailed argument, such an approach has been cogently argued to be pertinent to the regulation of innovation in health-care⁵¹ and neonatal non-treatment.⁵² Yet the ability to overcome reservations about uncertainty in pursuit of potentially great benefits may be a feature of intrinsic PR. In future cases where harm is minimal and benefits are uncertain, but potentially great, intrinsic PR may be determinative. However, there are other objections to accessing experimental treatment. First, are parents competent to make these judgements? Second, are there public interests grounds on which to deny competent demands?

If parents have rights to demand experimental treatment, an additional concern is whether they can rationally exercise these rights. Questioning the ability of terminally ill persons to make

rational judgements about experimental treatment, Caplan argues that terminally ill people are likely to view any experimental treatment with undue optimism.¹³ The moral weight of these elements changes where the patient is a child. The question of *parental competence* to decide is a thorny one. The challenges to parental competence are clear if we consider Charlie's case, where Charlie's parents were vulnerable to manipulation by third parties.¹⁴ These emotional challenges lead some to question the ability of parents to offer meaningful consent in life and death situations.¹⁵ Yet the enormity of parental bereavement suggests that the degree of parental incompetence should be extreme indeed, if it is to over-rule a parental right of say (in practice, this circle is of course squared by the current legal process, which allows the courts to make a decision if parents and clinicians disagree).¹⁶

Bender *et al.*¹⁷ offer public interest arguments for restricting access to experimental treatments. They argue that premature access to experimental treatments may raise false expectations among those with similar illnesses, igniting public demand. If this demand is not resisted, drugs may be made widely available before their effectiveness is proven, leading to potentially ineffective treatments becoming the standard of care. The authors also argue that early access to unproven drugs may both hamper recruitment to, and reduce industry incentives to run, clinical trials. First, recruitment is hampered because early access physically reduces the number of potential drug trial participants. Second, if drug companies are paid for access to unproven drugs, it provides a commercial disincentive for clinical trial sponsorship. Not only are trials costly and time consuming, but the fact they risk jeopardising a proven source of profit if the experimental treatment proves ineffective provides a clear conflict of interest. These arguments suggest that, whatever the benefit to the patient, early access has opportunity costs, because inadequate knowledge of effectiveness denies future patients access to treatments with a proven basis. Ultimately there is a price to pay beyond the risks and benefits to an individual patient. However, preventing the exercise of individual choice to protect public interests may appear to be a paradigm case of group interests impinging on individual interests. This is what rights are designed to prevent. Certainly, it has been argued that where patients seek innovative lifesaving treatments a rights approach requires that any prohibition on treatment must be undergirded by extremely weighty risks if they are to defensibly outweigh the patient's right to life.¹⁸

The choice of patients who are terminally ill to access treatment may carry enough moral weight to overcome objections in the public interest. The weakness of PR alters the dynamics of such choices when the choice is a parental one. My analysis suggests that in a future case intrinsic PR could overcome uncertainty in the face of large potential benefits. Certainly, the English courts have in the past allowed access to innovative treatment in such circumstances without an obvious prohibition in the public interest.¹⁹ Indeed, with the right approach these factors could be mitigated further in a future similar case to Charlie's. There is little prospect of clinical trials on a rare mutation like RRM2B. Early access linked to a robust, if novel, trial design may accelerate understanding of the experimental drug, and thus allay public interest concerns. It is notable in Charlie's case that no evidence was advanced that access was to be part of such a trial. Public interest concerns may therefore have placed additional obstacles in the way of PR in Charlie's case.

CONCLUSION

Charlie's case brought questions about the moral status of parents and children into the public eye. The case apparently fell on welfare grounds; however, not every fact of the case is consistent with the promotion of Charlie's welfare. Reviewing the grounds for intrinsic PR that are independent of the welfare of their child, I suggest the strongest of these lie in arguments for genetic propriety and children's non-personhood. Critiquing these claims suggests limits to intrinsic PR. Nevertheless, I argue that these claims provide grounds to accept PR for experimental treatment in future cases involving children who cannot contribute an opinion. These cases must involve no harm to the child and benefits, despite being uncertain, must be potentially great. Further, I argue parents are competent to exercise these rights, and that objections in the public interest may be overcome by evidence of robust trial design in the experimental treatment.

Acknowledgements Thanks to the Wellcome Trust for funding both a Biomedical Ethics for Health Professionals and Scientists for the 'Judging Best Interest in Paediatric Intensive Care (BIPIC)' project (WT097725MF) and a Seed Award for the 'Best Interests in Medical Ethics and Law (BABEL)' project (110076/Z/15/Z), during which bulk of the research in this paper was undertaken. Special thanks to Richard Huxtable as PI of the second project.

Contributors GB is the sole author of the manuscript.

Funding This study was funded by the Wellcome Trust (grant nos. WT097725MF and 110076/Z/15/Z).

Disclaimer GB remains responsible for any errors or omissions herein.

Competing interests During the Charlie Gard case, GB made a statement to the Science Media Centre expressing an opinion about the case, which was circulated to the news media.

Patient consent Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

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Ady Barkan**Longer version**

Ady Barkan is a social justice activist who has built two programs at The Center for Popular Democracy: FedUp campaigns and the Local Progress network and is the founder of the *Be A Hero PAC*. Ady came to notoriety when he confronted Jeff Flake on a plane back in 2017 asking him to "be a hero" and vote no on the tax bill. Ady was named one of the Top 50 Political Thinkers in 2016 by Politico. He was a law clerk to the Hon. Shira A. Scheindlin in the Southern District of New York and a Liman Fellow with Make the Road New York. He graduated from Yale Law School and Columbia College. Ady was diagnosed with ALS at the age of 32. He lives in California with his 3 year old son, Carl and his wife, Rachel. Ady spent the last election cycle travelling the country: 22 states in 40 days, talking to voters about healthcare. His healthcare ads were run in over 100 districts across the country and his PAC played a critical role in flipping multiple seats. Ady's ad was nominated alongside Colin Kaepernick's Nike Ad as "most inspiring". At the end of 2018, Ady's PAC ran the Susan Collins campaign raising over \$4m in small dollar donations to fund her future opponent if she voted for Kavanaugh. Ady Barkan is using his final months to fight for healthcare and for the American People. His book, *Eyes to the Wind: A Memoir of Love and Death, Hope and Resistance*, will be published in September by Atria Books.

Shorter bio

Ady Barkan is a social justice activist who has built two programs at The Center for Popular Democracy: Up campaigns and the Local Progress network and is the founder of the *Be A Hero PAC* that was responsible for raising over \$4m in small dollar donations against Susan Collins for the Kavanaugh fight. He was a law clerk to the Hon. Shira A. Scheindlin in the Southern District of New York and a Liman Fellow with Make the Road New York. He graduated from Yale Law School and Columbia College. He lives with his wife Rachael and their young son Carl in Santa Barbara, California. His book, *Eyes to the Wind: A Memoir of Love and Death, Hope and Resistance*, will be published in September by Atria Books.

Truth in Testimony Disclosure Form

In accordance with Rule XI, clause 2(g)(5)*, of the *Rules of the House of Representatives*, witnesses are asked to disclose the following information. Please complete this form electronically by filling in the provided blanks.

Committee: Rules

Subcommittee: _____

Hearing Date: April 30, 2019

Hearing Subject: _____

H.R. 1384 — Medicare for All Act of 2019 [Original Jurisdiction Hearing]

Witness Name: Ady Barkan

Position/Title: Principal

Witness Type: ☐ Governmental ☒ Non-governmental

Are you representing yourself or an organization? ☐ Self ☒ Organization

If you are representing an organization, please list what entity or entities you are representing:

Be A Hero

If you are a **non-governmental witness**, please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current calendar year and previous two calendar years. Include the source and amount of each grant or contract. *If necessary, attach additional sheet(s) to provide more information.*

None

If you are a **non-governmental witness**, please list any contracts or payments originating with a foreign government and related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current year and previous two calendar years. Include the amount and country of origin of each contract or payment. *If necessary, attach additional sheet(s) to provide more information.*

None

Charles Paul "Chuck" Blahous III is the J. Fish and Lillian F. Smith Chair and Senior Research Strategist at the Mercatus Center at George Mason University, as well as a visiting fellow at Stanford University's Hoover Institution. From 2010 to 2015 he served as one of two public trustees for the Social Security and Medicare programs. Dr. Blahous was Deputy Director of the National Economic Council under President George W. Bush from 2007 to 2009, previously serving from 2001 to 2007 as a Special Assistant to the President for Economic Policy. Prior to that, he served from 1996 to 2000 as Policy Director for Senator Judd Gregg of New Hampshire. Between 1989 and 1996, Dr. Blahous worked for Senator Alan Simpson of Wyoming, first as a Congressional Science Fellow in 1989-1990, then as a legislative assistant from 1990-94 and as Legislative Director in 1994-1996. His writing has been published by entities including *economics21.org*, University of Chicago Press, *Washington Post*, *Wall Street Journal*, *Roll Call*, *Harvard Journal on Legislation*, *Journal of Chemical Physics* and *Baseball Research Journal*. His media appearances range from the *Diane Rehm Show* to C-Span's *Washington Journal* to *Fox News*. Dr. Blahous is the author of the books *Social Security: The Unfinished Work* and *Pension Wise*, both published in 2010 by Hoover Institution Press. Dr. Blahous served from 2014-16 on the Bipartisan Policy Center's Commission on Retirement Security and Personal Savings and has continued to work with the BPC as a shadow trustee monitoring the finances of Social Security and Medicare. He has published studies with the Mercatus Center on subjects including the federal budget costs of Medicare for All, the fiscal ramifications of the Affordable Care Act, the origins of federal deficits, the multiemployer pension solvency crisis, the implications of health care inflation for Medicare financing, Social Security benefit adequacy, work incentives and self-financing, and the incentives facing states with respect to expanding Medicaid. He writes frequently on budget issues with a focus on Social Security and federal health programs. Dr. Blahous holds a Ph.D. in computational quantum chemistry from the University of California/Berkeley and also an A.B. in chemistry from Princeton University, where he won the McKay physical chemistry prize.

Truth in Testimony Disclosure Form

In accordance with Rule XI, clause 2(g)(5)*, of the *Rules of the House of Representatives*, witnesses are asked to disclose the following information. Please complete this form electronically by filling in the provided blanks.

Committee: Rules

Subcommittee: _____

Hearing Date: April 30, 2019

Hearing Subject: _____

H.R. 1384 — Medicare for All Act of 2019 [Original Jurisdiction Hearing]

Witness Name: Charles P. Blahous

Position/Title: J. Fish and Lillian F. Smith Chair, Senior Research Strategist, Mercatus Center at George Mason University

Witness Type: ☐ Governmental ☒ Non-governmental

Are you representing yourself or an organization? ☒ Self ☐ Organization

If you are representing an organization, please list what entity or entities you are representing:

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None.

Curriculum Vitae

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Education

1981 B.A., Swarthmore College, History-Major, Economics-Philosophy-Minors
 1983 M.A., University of Denver, Economics
 1988 Ph.D., University of Michigan, Economics, Dissertation: "The Logic of Neo-Classical Consumption Theory," W.H. Locke Anderson, Chair

Employment

1983–88 Teaching Assistant-Instructor, University of Michigan
 1988–89 Lecturer, University of Michigan
 1989–92 Assistant Professor, Bucknell University
 1992–97 Economist, Economic Policy Institute
 1997–98 Senior Economist, Economic Policy Institute
 January–December 1999 Senior Research Fellow, Preamble Center
 1999–2018 Co-Director, Center for Economic and Policy Research
 2018–present Senior Economist, Center for Economic and Policy Research

Books

Rigged: How Globalization and the Rules of the Modern Economy Were Structured to Make the Rich Richer, Center for Economic and Policy Research, 2016

Getting Back to Full Employment: A Better Bargain for Working People (with Jared Bernstein), Center for Economic and Policy Research, 2013

Getting Back to Full Employment: A Better Bargain for Working People (with Jared Bernstein), Center for Economic and Policy Research, 2013

The End of Loser Liberalism: Making Markets Progressive, Center for Economic and Policy Research, 2011

Taking Economics Seriously, MIT Press, 2010

False Profits: Recovering From the Bubble Economy, PoliPointPress, 2010

Plunder and Blunder: The Rise and Fall of the Bubble Economy, PoliPointPress, 2009

The United States Since 1980, Cambridge University Press, 2007.

The Conservative Nanny State: How the Wealthy Use the Government to Stay Rich and Get Richer, Center for Economic and Policy Research, 2006.

The Benefits of Full Employment (with Jared Bernstein), Economic Policy Institute, 2003.

Social Security: The Phony Crisis (with Mark Weisbrot), University of Chicago Press, 1999.

Globalization and Progressive Economic Policy, edited with Gerald Epstein and Robert Pollin, Cambridge University Press, 1998.

Getting Prices Right: The Battle Over the Consumer Price Index, M.E. Sharpe Press, 1997. (Selected for 1998 Choice Outstanding Academic Book List.)

Web Site Features

Beat the Press, author, daily, April 2006–present
(www.cepr.net/blogs/beat-the-press/)

Economic Reporting Review, author, weekly, August 2000–April 2006
(www.TomPaine.com)

Economic Reporting Review, author, weekly, January 1999–July 2000 (www.fair.org)

Reading Between the Lines, primary author, weekly, April 1996–December 1998
(www.epinet.org)

Commentaries on Major Economic Data reports, January 1995–present (www.cepr.net, since January 2000)

Beige Book Analysis and Review, January 1999–February 2004 (www.fmcenter.org)

Other Publications

“The Future of the Pharmaceutical Industry: Beyond Government-Granted Monopolies,” Washington, DC: Center for Economic and Policy Research, March 2019.

“Working Paper: A Progressive Trade Policy,” Washington, DC: Center for Economic and Policy Research, November 2018.

“Voluntary Part-Time Employment and the Affordable Care Act: What Do Workers Do With Their Extra Time?” Washington, DC: Center for Economic and Policy Research, October 2018, (with Hannah Archambault).

“Working Paper: Is Intellectual Property the Root of All Evil? Patents, Copyrights, and Inequality,” Washington, DC: Center for Economic and Policy Research, October 2018.

“The Housing Bubble and the Great Recession: Ten Years Later,” Washington, DC: Center for Economic and Policy Research, September 2018.

“Measuring the Inflation Rate: Is Housing Different?” Washington, DC: Center for Economic and Policy Research, June 2018.

“The Availability of Data from Clinical Trials: The Case of Crohn's Disease,” Washington, DC: Center for Economic and Policy Research, June 2018, (with Ravi Katari and Alex Provan).

“Does Tax Deductibility Affect CEO Pay? The Case of the Health Insurance Industry,” Washington, DC: Economic Policy Institute, March 2018, (with Jessica Schieder).

“State Payroll Taxes: A Tool for States to Circumvent the Republican Tax Plan,” Washington, DC: Center for Economic and Policy Research, February 2018.

“The Wealth of Households: An Analysis of the 2016 Survey of Consumer Finance,” Washington, DC: Center for Economic and Policy Research, October 2017, (with Cherrie Bucknor).

“The Impact of Low Unemployment Rates on Disadvantaged Groups,” Washington, DC: Center for Economic and Policy Research, October 2017, (with Cherrie Bucknor).

“Innovation, Intellectual Property, and Development: A Better Set of Approaches for the 21st Century,” Washington, DC: Center for Economic and Policy Research, July 2017, (with Arjun Jayadev and Joseph Stiglitz).

“The Full Employment Mandate of the Federal Reserve: Its Origins and Importance,” Washington, DC: Center for Economic and Policy Research, July 2017, (with Sarah Rawlins and David Stein).

“The Affordable Care Act and the Change in Voluntary Part-time Employment by States,” Washington, DC: Center for Economic and Policy Research, March 2017, (with Cherrie Bucknor).

“Working Paper: Economic Policy in the Trump Era,” Washington, DC: Center for Economic and Policy Research, February 2017, (with Cherrie Bucknor).

“Eight Market-Oriented Proposals That Reduce Income Inequality,” Washington, DC: American Enterprise Institute, January 2017.

“The International Trade Commission’s Assessment of the Trans-Pacific Partnership: Main Findings and Implications,” Washington, DC: Center for Economic and Policy Research, November 2016.

“The Housing Bubble: Is It Back?” Washington, DC: Center for Economic and Policy Research, November 2016, (with Lara Merling).

“Working Paper: The Compensation of Highly Paid Professionals: How Much Is Rent?” Washington, DC: Center for Economic and Policy Research, August 2016.

“Working Paper: Rents and Inefficiency in the Patent and Copyright System: Is There a Better Route?” Washington, DC: Center for Economic and Policy Research, August 2016.

“Reining in Wall Street to Benefit All Americans,” New York, NY: The Century Foundation, July 2016.

“The Wrong Tool for the Right Job,” Washington, DC: Economic Policy Institute, May 2016, (with Josh Bivens).

“Trade and Jobs: Can We Trust the Models?” Washington, DC: Center for Economic and Policy Research, April 2016, (with David Rosnick).

“Still Working Hard: An Update on the Share of Older Workers in Physically Demanding Jobs,” March 2016, (with Cherrie Bucknor).

“Publicly Funded Clinical Trials: A Route to Sustained Innovation with Affordable Drugs,” March 2016.

“Working Paper: The Upward Redistribution of Income: Are Rents the Story?” Washington, DC: Center for Economic and Policy Research, December 2015.

“The Incidence of Financial Transactions Taxes,” Washington, DC: Center for Economic and Policy Research, December 2015, (with Nicole Woo).

“Frequently Asked Questions On the Federal Reserve Board, Monetary Policy, and the Proposed Full Employment Federal Reserve Act,” Washington, DC: Economic Policy Institute, December 2015, (with Josh Bivens).

“Pension Funding and the Economy: Would “Proper” Funding Cost Jobs?” Washington, DC: Center for Economic and Policy Research, November 2015, (with Nick Buffie).

“Rising Disability Payments: Are Cuts to Workers’ Compensation Part of the Story?”
Washington, DC: Center for Economic and Policy Research, October 2015, (with Nick Buffie).

“The Impact of Exempting the Pharmaceutical Industry from Patent Reviews,”
Washington, DC: Center for Economic and Policy Research, July 2015.

“Patent Monopolies and the Costs of Mismarketing Drugs,” Washington, DC: Center for Economic and Policy Research, April 2015, (with Ravi Katari).

“From Recession to Collapse: The Bush Administration and the Over-Valued Dollar,”
Washington, DC: Center for Economic and Policy Research, March 2015.

“The Budgetary Implications of Higher Federal Reserve Board Interest Rates,”
Washington, DC: Center for Economic and Policy Research, March 2015.

“Do Welfare State Liberals Also Love Regulation?,” Washington, DC: Center for Economic and Policy Research, January 2015.

“The Social Security Benefits of Sitting Senators in 2015,” Washington, DC: Center for Economic and Policy Research, January 2015, (with Alan Barber).

“The Wealth of Households: An Analysis of the 2013 Survey of Consumer Finances,”
Washington, DC: Center for Economic and Policy Research, November 2014, (with David Rosnick).

“The Big Tax Increase Nobody Noticed,” Washington, DC: Center for Economic and Policy Research, September 2014.

“The Affordable Care Act: A Family-Friendly Policy,” Washington, DC: Center for Economic and Policy Research, September 2014, (with Helene Jorgensen).

“Stimulus and Fiscal Consolidation: The Evidence and Implications,” Germany:
Macroeconomic Policy Institute, July 2014, (with David Rosnick).

“Living in the Short-Run: Comment on Capital In the Twenty-First Century,”
Washington, DC: Center for Economic and Policy Research, April 2014.

“The Trade Deficit: The Biggest Obstacle to Full Employment,” Washington, DC: Center for Budget and Policy Priorities, March 2014

“Bringing Back Subprime? The Hazards of Restructuring the GSEs,” Washington, DC:
Center for Economic and Policy Research, October 2013, (with Nicole Woo).

“The Affordable Care Act: A Hidden Jobs Killer?,” Washington, DC: Center for Economic and Policy Research, July 2013, (with Helene Jorgensen).

“Financial Engineering: The Simple Way to Reduce Government Debt Burdens,” Washington, DC: Center for Economic and Policy Research, July 2013, (with Shiava Diagne).

“Savings with an Efficient Medicare Prescription Drug Benefit,” Washington, DC: Center for Economic and Policy Research, March 2013, (with Nicole Woo).

“Reducing Waste With an Efficient Medicare Prescription Drug Benefit,” Washington, DC: Center for Economic and Policy Research, February 2013.

“Debt, Deficits, and Demographics: Why We Can Afford the Social Contract,” Washington, DC: New America Foundation, November 2012.

“The Problem with Structural Unemployment in the U.S.,” Washington, DC: Center for Economic and Policy Research, October 2012.

“Missing the Story: The OECD's Analysis of Inequality,” Washington, DC: Center for Economic and Policy Research, July 2012, (with David Rosnick).

“Attacking the Treasury View, Again,” Washington, DC: Center for Economic and Policy Research, June 2012.

“States Could Save .7 Billion Per Year with Federal Financing of Work Sharing,” Washington, DC: Center for Economic and Policy Research, May 2012 (with Nicole Woo).

“First Time Underwater: The Impact of the First-Time Homebuyer Tax Credit,” Washington, DC: Center for Economic and Policy Research, April 2012.

“The Impact on Inequality of Raising the Social Security Retirement Age,” Washington, DC: Center for Economic and Policy Research, April 2012 (with David Rosnick).

“The Relationship Between Financial Transactions Costs and Economic Growth,” Washington, DC: Center for Economic and Policy Research, March 2012 (with Helene Jorgensen).

“It's So Hard to Get Good Help,” Washington, DC: Center for Economic and Policy Research, February 2012.

“The Necessity of a Lower Dollar and the Route There,” Washington, DC: Center for Economic and Policy Research, February 2012.

“Pension Liabilities: Fear Tactics and Serious Policy,” Washington, DC: Center for Economic and Policy Research, January 2012 (with David Rosnick).

“The Impact of Cutting Social Security Cost of Living Adjustments on the Living Standards of the Elderly,” Washington, DC: Center for Economic and Policy Research, September 2011 (with David Rosnick).

“Do Tax Cuts Boost the Economy?” Washington, DC: Center for Economic and Policy Research, September 2011 (with David Rosnick).

“The Social Security Benefits of Sitting Senators Revisited,” Washington, DC: Center for Economic and Policy Research, September 2011 (with Kris Warner and Alan Barber).

“When Numbers Don't Add Up: The Statistical Discrepancy in GDP Accounts,” Washington, DC: Center for Economic and Policy Research, August 2011 (with David Rosnick).

“Work Sharing: The Quick Route Back to Full Employment,” Washington, DC: Center for Economic and Policy Research, June 2011.

“7 Things You Need to Know About the National Debt, Deficits, and the Dollar,” Washington, DC: Center for Economic and Policy Research, June 2011 (with David Rosnick).

“Federal Reserve Board Policy and the Price of Oil,” Washington, DC: Center for Economic and Policy Research, May 25, 2011 (Testimony before the Subcommittee on Regulatory Affairs, Stimulus Oversight and Government Spending, Committee on Oversight & Government Reform, U.S. House of Representatives).

“Representative Ryan’s \$30 Trillion Medicare Waste Tax,” Washington, DC: Center for Economic and Policy Research, April 2011 (with David Rosnick).

“The Ryan Medicare Plan: Winners and Losers,” Washington, DC: Center for Economic and Policy Research, April 2011 (with David Rosnick).

“The Wisconsin Retirement System is One of the Healthiest in the Country,” Washington, DC: Center for Economic and Policy Research, March 2011.

“State and Municipal Debt: The Coming Crisis? Part II,” Washington, DC: Center for Economic and Policy Research, March 15, 2011, (Testimony before the Subcommittee on TARP and Financial Resources, Committee on Oversight & Government Reform, U.S. House of Representatives).

“The Potential Savings to Social Security from Means Testing,” Washington, DC: Center for Economic and Policy Research, March 2011 (with Hye Jin Rho).

“The Origins and Severity of the Public Pension Crisis,” Washington, DC: Center for Economic and Policy Research, February 2011.

“A Voluntary Default Savings Plan: An Effective Supplement to Social Security,” Washington, DC: Center for Economic and Policy Research, February 2011 (with David Rosnick).

“The Deficit-Reducing Potential of a Financial Speculation Tax,” Washington, DC: Center for Economic and Policy Research, January 2011.

“The Social Security Benefits of Sitting Senators,” Washington, DC: Center for Economic and Policy Research, January 2011 (with Kris Warner).

“Letter to Senator Michael Bennet on Social Security Comments,” Washington, DC: Center for Economic and Policy Research, November 2010.

“Action on Social Security: The Urgent Need for Delay,” Washington, DC: Center for Economic and Policy Research, November 2010.

“The Impact of Income Distribution on the Length of Retirement,” Washington, DC: Center for Economic and Policy Research, October 2010 (with David Rosnick).

“The Myth of Expansionary Fiscal Austerity,” Washington, DC: Center for Economic and Policy Research, October 2010.

“Feel No Pain: Why a Deficit in Times of High Unemployment is Not a Burden,” Washington, DC: Center for Economic and Policy Research, September 2010.

“The Gains From Right to Rent in 2010,” Washington, DC: Center for Economic and Policy Research, September 2010 (with Hye Jin Rho).

“Seven Key Facts About Social Security and the Federal Budget,” Washington, DC: Center for Economic and Policy Research, September 2010.

“Has the Congressional Budget Office Joined the Push for Cutting Social Security?” Washington, DC: Center for Economic and Policy Research, July 2010.

“The Impact of Social Security Cuts on Retiree Income,” Washington, DC: Center for Economic and Policy Research, July 2010 (with David Rosnick).

“The Benefits of Financial Transactions Taxes,” Washington, DC: Center for Economic and Policy Research, May 17, 2010 (Statement to the Bundestag).

“New Strategies for Supporting Public and Noncommercial Media,” Washington, DC: Center for Economic and Policy Research, April 30, 2010 (Statement at the Federal Communications Commission’s Future of Media Workshop).

“The Successes and Shortcomings of the Homeowner Affordability Modification Program,” Washington, DC: Center for Economic and Policy Research,

April 14, 2010 (Testimony before the Subcommittee on Housing and Community Opportunity).

"Profits on Citigroup Stock: Can They Be the Basis for Financing Stimulus?" Washington, DC: Center for Economic and Policy Research, April 2010.

"Work-Sharing: An Effective Tool Against Chronic Unemployment," Washington, DC: Center for Economic and Policy Research, March 17, 2010 (Testimony before the Congressional Black Caucus).

"The Budget Deficit Scare Story and the Great Recession," Washington, DC: Center for Economic and Policy Research, February 2010.

"Responses to Criticisms of Taxes on Financial Speculation," Washington, DC: Center for Economic and Policy Research, January 2010.

"The Potential Revenue from Financial Transactions Taxes," Washington, DC: Center for Economic and Policy Research, December 2009 (with Robert Pollin, Travis McArthur, and Matt Sherman).

"Public Investment, Industrial Policy and U.S. Economic Renewal," Washington, DC: Center for Economic and Policy Research, December 2009 (with Robert Pollin).

"Taming the Deficit: Saving Our Children from Themselves," Washington, DC: Center for Economic and Policy Research, December 2009 (with David Rosnick).

"The \$1 Trillion Wage Deficit," Washington, DC: Center for Economic and Policy Research, December 2009 (with John Schmitt).

"The Federal Reserve Must Counteract Asset Bubbles," Washington, DC: Center for Economic and Policy Research, November 2009 (with Jane D'Arista and Gerald Epstein).

"The Failures of TARP," Washington, DC: Center for Economic and Policy Research, November 19, 2009 (Testimony before the Congressional Oversight Panel for the Troubled Asset Relief Program).

"Issues in Trade and Protectionism," Washington, DC: Center for Economic and Policy Research, November 2009.

"Job Sharing: Tax Credits to Prevent Layoffs and Stimulate Employment," Washington, DC: Center for Economic and Policy Research, October 2009.

"Free Trade in Health Care: The Gains from Globalized Medicare and Medicaid," Washington, DC: Center for Economic and Policy Research, October 2009 (with Hye Jin Rho).

“The Value of the ‘Too Big to Fail’ Big Bank Subsidy,” Washington, DC: Center for Economic and Policy Research, September 2009 (with Travis McArthur).

“CBO Projects More Severe Downturn,” Washington, DC: Center for Economic and Policy Research, August 2009.

“Hitting Bottom? An Updated Analysis of Rents and the Price of Housing in 100 Metropolitan Areas,” Washington, DC: Center for Economic and Policy Research, August 2009 (with Danilo Pelletiere and Hye Jin Rho).

“The Gains from Right to Rent,” Washington, DC: Center for Economic and Policy Research, July 2009 (with Hye Jin Rho).

“The Right to Rent Plan,” Washington, DC: Center for Economic and Policy Research, July 2009 (updated April 2010).

“The State and Local Drag on the Stimulus,” Washington, DC: Center for Economic and Policy Research, May 2009 (with Rivka Deutsch).

“Pay for Play? Tax Credits for Paid Time Off,” Washington, DC: Center for Economic and Policy Research, March 2009.

“The AIG Saga: A Brief Primer,” Washington, DC: Center for Economic and Policy Research, March 2009.

“The Foreclosure Crisis and President Obama’s Making Home Affordable Program,” March 19, 2009 (Testimony before the Subcommittee on Housing and Community Opportunity of the House Financial Services Committee).

“Is the U.S. Unemployment Rate Today Already as High as It Was in 1982?” Washington, DC: Center for Economic and Policy Research, March 2009 (with John Schmitt).

“The Housing Crash Recession and the Case for a Third Stimulus,” Washington, DC: Center for Economic and Policy Research, March 2009.

“Investment Bank Welfare?” Washington, DC: Center for Economic and Policy Research, March 2009 (with Matt Sherman).

“The Wealth of the Baby Boom Cohorts After the Collapse of the Housing Bubble,” Washington, DC: Center for Economic and Policy Research, February 2009 (with David Rosnick).

“The Impact of the Current Economic Crisis on the Elderly,” Washington, DC: Center for Economic and Policy Research, February 25, 2009 (Testimony before the Special Senate Committee on Aging).

"The Problems of the Current System of Retirement Income," Washington, DC: Center for Economic and Policy Research, February 24, 2009 (Testimony before the House Committee on Education and Labor).

"Spending Versus Tax Cuts: Who Pays the Cost of Political Compromise?" Washington, DC: Center for Economic and Policy Research, January 2009.

"The Impact of the Medicare Drug Benefit on Health Care Spending by Older Households," Washington, DC: Center for Economic and Policy Research, December 2008 (with Ben Zipperer).

"IOUSA Not OK," Washington, DC: Center for Economic and Policy Research, October 2008 (with David Rosnick).

"The Credit Squeeze Scare," Washington, DC: Center for Economic and Policy Research, October 2008.

"Slow-Motion Recession: What Congress Can Do to Help," Washington, DC: Center for Economic and Policy Research, July 2008 (with Eileen Appelbaum and John Schmitt).

"The Impact of the Housing Crash on Family Wealth," Washington, DC: Center for Economic and Policy Research, July 2008 (with David Rosnick).

"Offshore Drilling and Energy Conservation: The Relative Impact on Gas Prices," Washington, DC: Center for Economic and Policy Research, June 2008 (with Nichole Szembrot).

"The Housing Bubble and the Financial Crisis," Washington, DC: Center for Economic and Policy Research, May 2008.

"The Cost of Maintaining Ownership in the Current Crisis: Comparisons in 20 Cities," Washington, DC: Center for Economic and Policy Research, April 2008 (with Danilo Pelletiere and Hye Jin Rho).

"The Benefits and Savings of Publicly-Funded Clinical Trials of Prescription Drugs," Washington, DC: Center for Economic and Policy Research, March 2008.

"Subprime Rescue Plans: Backdoor Bank Bailouts," Washington, DC: Center for Economic and Policy Research, March 2008.

"Subprime Borrowers Deserve an Own to Rent Transition," Washington, DC: Center for Economic and Policy Research, January 2008.

"What We're In For: Projected Economic Impact of the Next Recession," Washington DC: Center for Economic and Policy Research, January 2008 (with John Schmitt).

"Changes in the Cost of Medicare Prescription Drug Plans, 2007-2008," Washington, DC: Center for Economic and Policy Research, November 2007 (with Joshua Lanier).

"Midsummer Meltdown: Prospects for the Stock and Housing Markets," Washington, DC: Center for Economic Policy and Research, August 2007.

"'Usable Productivity' Growth in the U.S.: An International Comparison, 1980-2005," Washington, DC: Center for Economic Policy and Research, June 2007 (with David Rosnick).

"The Economic Impact of the Iraq War and Higher Military Spending," Washington, DC: Center for Economic and Policy Research, May 2007.

"The Productivity to Paycheck Gap: What the Data Show," Washington, DC: Center for Economic and Policy Research, April 2007.

"Celebrating Pork: The Dubious Success of the Medicare Drug Benefit," Washington, DC: Center for Economic and Policy Research, March 2007.

"Stagnation in the Drug Development Process: Are Patents the Problem?" Washington, DC: Center for Economic and Policy Research, March 2007.

"Behind the Gap Between Productivity and Wage Growth," Washington, DC: Center for Economic and Policy Research, February 2007.

"Universal Voluntary Accounts: A Step Toward Fixing the Retirement System," Washington, DC: Center for Economic and Policy Research, December 2006.

"Recession Looms for the U.S. Economy in 2007," Washington, DC: Center for Economic and Policy Research, December 2006.

"Old Europe Goes to Work: Rising Employment Rates in the European Union," Washington, DC: Center for Economic and Policy Research, September 2006 (with John Schmitt).

"The Impact of Undercounting in the Current Population Survey," Washington, DC: Center for Economic and Policy Research, August 2006 (with John Schmitt).

"The Origins of the Doughnut Hole: Excess Profits on Prescription Drugs," Washington, DC: Center for Economic and Policy Research, August 2006.

"Waste in the Medicare Drug Benefit: Why the Doughnut Hole Is Unnecessary," Washington, DC: Center for Economic and Policy Research, July 2006.

"Are Protective Labor Market Institutions Really At the Root of European Unemployment: A Critical Perspective," July 2006 (with Andrew Glyn, David Howell, and John Schmitt).

"Is the Housing Bubble Collapsing: Ten economic Indicators to Watch," Washington, DC: Center for Economic and Policy Research, June 2006.

"Missing Inaction: Evidence of Undercounting of Non-Workers in the Current Population Survey," Washington, DC: Center for Economic and Policy Research, September 2006 (with John Schmitt).

"The Savings From an Efficient Medicare Drug Plan," Washington, DC: Center for Economic and Policy Research, January 2006.

"Will a Bursting Bubble Trouble Bernanke?: The Evidence for a Housing Bubble." Washington, DC: Center for Economic and Policy Research, November 2005 (with David Rosnick).

"Bird Flu Fears: Is There a Better Way to Develop Drugs?" Washington, DC: Center for Economic and Policy Research, October 2005.

"Taxing Exxon's Windfall From Hurricane Katrina." Washington, DC: Center for Economic and Policy Research, September 2005.

"Are Copyrights a Textbook Scam? Alternatives for Financing Textbook Production in the 21st Century." Washington, DC: Center for Economic and Policy Research, September 2005.

"Scorecard on Development: 25 Years of Diminished Progress." Washington, DC: Center for Economic and Policy Research, September 2005 (with Mark Weisbrot and David Rosnick).

"Is There a Housing Bubble?" Washington, DC: Center for Economic and Policy Research, September 2005 (with David Rosnick).

"Gender Bias in the Current Economic Recovery?: Declining Employment Rates for Women in the 21st Century," Washington, DC: Center for Economic and Policy Research, August 2005 (with Heather Boushey and David Rosnick).

"Asset Returns and Economic Growth," *Brookings Papers on Economic Activity* 1:2005 (with Brad DeLong and Paul Krugman).

"The Reform of Intellectual Property," PAE review (www.paecon.net), iss. 32, 5 July 2005.

"The Housing Bubble Fact Sheet," Washington, DC: Center for Economic and Policy Research, July 2005.

"Things That Will Happen Before Social Security Faces a Shortfall," Washington, DC: Center for Economic and Policy Research, June 2005.

"Social Security Rates of Return with 'Progressive Indexation'," Washington, DC: Center for Economic and Policy Research, May 2005 (with David Rosnick).

"The Regressive Impact of the Progressive Indexation of Social Security Benefits," Washington, DC: Center for Economic and Policy Research, May 2005.

"Bigger Than the Social Security Crisis: Wasteful Spending on Prescription Drugs," Washington, DC: Center for Economic and Policy Research, April 2005.

"The Social Security Shortfall and the National Defense Shortfall," Washington, DC: Center for Economic and Policy Research, April 2005.

"The Burden of Social Security Taxes and the Burden of Excessive Health Care Costs," Washington, DC: Center for Economic and Policy Research, April 2005 (with David Rosnick).

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"Who's Dreaming? Homeownership Among Low Income Families," Washington, DC: Center for Economic and Policy Research, January 2005.

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"Going Down With the Dollar: The Cost to Developing Countries of a Declining Dollar," Washington, DC: Center for Economic and Policy Research, September 2004 (with Mark Weisbrot and David Rosnick).

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"Fool's Gold: Projections of the U.S. Import Market," Washington, DC: Center for Economic and Policy Research, 2004.

"The Housing Bubble in New England," Washington, DC: Center for Economic and Policy Research, 2004.

"The Artistic Freedom Voucher: Internet Age Alternative to Copyrights," Washington, DC: Center for Economic and Policy Research, 2003.

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“The Real Budget and the Real Budget Deficit,” Washington, DC: Center for Economic and Policy Research, 2003 (with David Rosnick).

“Homeownership in a Bubble: The Fast Path to Poverty?” Washington, DC: Center for Economic and Policy Research, 2003 (with Simone Baribeau).

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“When Rivers Flow Upstream: International Capital Movements in the Era of Globalization” Washington, DC: Center for Economic and Policy Research, 2003 (with Monique Morrissey).

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Economic and Policy Research, 2002.

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Truth in Testimony Disclosure Form

In accordance with Rule X1, clause 2(g)(5)*, of the *Rules of the House of Representatives*, witnesses are asked to disclose the following information. Please complete this form electronically by filling in the provided blanks.

Committee: Rules

Subcommittee: _____

Hearing Date: April 30, 2019

Hearing Subject: _____

H.R. 1384 — Medicare for All Act of 2019 [Original Jurisdiction Hearing]

Witness Name: Dean Baker

Position/Title: Senior Economist, Center for Economic and Policy Research

Witness Type: ☐ Governmental ☒ Non-governmental

Are you representing yourself or an organization? ☐ Self ☒ Organization

If you are representing an organization, please list what entity or entities you are representing:

Center for Economic and Policy Research

If you are a non-governmental witness, please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current calendar year and previous two calendar years. Include the source and amount of each grant or contract. *If necessary, attach additional sheet(s) to provide more information.*

N/A

If you are a non-governmental witness, please list any contracts or payments originating with a foreign government and related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current year and previous two calendar years. Include the amount and country of origin of each contract or payment. *If necessary, attach additional sheet(s) to provide more information.*

N/A



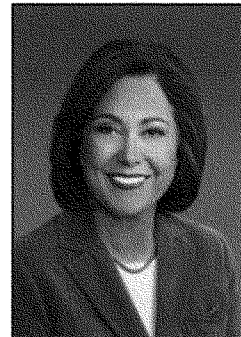
A not-for-profit health and tax policy research organization

**Grace-Marie Turner
President, Galen Institute**

Grace-Marie Turner is president of the Galen Institute, a public policy research organization that she founded in 1995 to promote an informed debate over free-market ideas for health reform.

She has been instrumental in developing and promoting ideas for reform to transfer power over health care decisions to doctors and patients. She speaks and writes extensively about incentives to promote a more competitive, patient-centered marketplace in the health sector.

- She testifies regularly before Congress and advises senior government officials, governors, and state legislators on health policy.
- She was named by the Speaker of the House in 2013 to serve as a member of the Long Term Care Commission.
- Previously, Grace-Marie served for a three-year term on the National Advisory Board for the Agency for Healthcare Research and Quality, and she served as a member of the Medicaid Commission, making recommendations to modernize and improve Medicaid.



She has been published in hundreds of major newspapers, including *The Wall Street Journal*, *The New York Times*, and *USA Today*, and has appeared on hundreds of radio and television programs. She edited *Empowering Health Care Consumers through Tax Reform* and has contributed to numerous other books. Grace-Marie speaks extensively in the U.S. and abroad, including Harvard University, the London School of Economics, Oxford University, and the Gregorian University at the Vatican.

Grace-Marie is founder and facilitator of the Health Policy Consensus Group which serves as a forum for analysts from market-oriented think tanks around the country to analyze and develop policy recommendations. She serves on the board of the Steamboat Institute and is a volunteer advisor to the Catholic Medical Association, Docs4PatientCare, and other organizations.

She received the 2007 Outstanding Achievement Award for Promotion of Consumer Driven Health Care from Consumer Health World. In the mid-1990s, Grace-Marie served as executive director of the National Commission on Economic Growth and Tax Reform. For 12 years, she was president of Arnett & Co., a health policy analysis and communications firm. Her early career was in politics and journalism where she received numerous awards for her writings on politics and economics.

Officers/Trustees: Grace-Marie Turner, *President* • John S. Hoff, Esq., *Secretary* • Beth Haynes, M.D., *Treasurer*
P.O. Box 130 • Paeonian Springs, VA 20129 • 703-687-4665 • www.galen.org • AmericanHealthCareChoices.org

Truth in Testimony Disclosure Form

In accordance with Rule XI, clause 2(g)(5)*, of the *Rules of the House of Representatives*, witnesses are asked to disclose the following information. Please complete this form electronically by filling in the provided blanks.

Committee: Rules

Subcommittee: _____

Hearing Date: April 30, 2019

Hearing Subject: _____

H.R. 1384 — Medicare for All Act of 2019 [Original Jurisdiction Hearing]

Witness Name: GRACE-MARIE TURNER

Position/Title: President

Witness Type: ☐ Governmental ☒ Non-governmental

Are you representing yourself or an organization? ☐ Self ☒ Organization

If you are representing an organization, please list what entity or entities you are representing:

Galen Institute

If you are a non-governmental witness, please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current calendar year and previous two calendar years. Include the source and amount of each grant or contract. If necessary, attach additional sheet(s) to provide more information.

None

If you are a non-governmental witness, please list any contracts or payments originating with a foreign government and related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current year and previous two calendar years. Include the amount and country of origin of each contract or payment. If necessary, attach additional sheet(s) to provide more information.

None

Sara R. Collins, Ph.D., is vice president for health care coverage and access at The Commonwealth Fund. An economist, Dr. Collins directs the Fund's program on insurance coverage and access. She also directs the Fund's research initiative on Tracking Health System Performance. Since joining the Fund in 2002, Dr. Collins has led several multi-year national surveys on health insurance and authored numerous reports, issue briefs and journal articles on health insurance coverage, health reform, and the Affordable Care Act. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine, Division of Health and Science Policy. Earlier in her career, she was an associate editor at *U.S. News & World Report*, a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. She holds an A.B. in economics from Washington University and a Ph.D. in economics from George Washington University.

Truth in Testimony Disclosure Form

In accordance with Rule XI, clause 2(g)(5)*, of the *Rules of the House of Representatives*, witnesses are asked to disclose the following information. Please complete this form electronically by filling in the provided blanks.

Committee: Rules

Subcommittee:

Hearing Date: April 30, 2019

Hearing Subject:

H.R. 1384 — Medicare for All Act of 2019 [Original Jurisdiction Hearing]

Witness Name: Sara R. Collins, Ph.D.

Position/Title: Vice President, Health Care Coverage and Access, The Commonwealth Fund

Witness Type: ☐ Governmental ☒ Non-governmental

Are you representing yourself or an organization? ☒ Self ☐ Organization

If you are representing an organization, please list what entity or entities you are representing:

NA

If you are a non-governmental witness, please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current calendar year and previous two calendar years. Include the source and amount of each grant or contract. *If necessary, attach additional sheet(s) to provide more information.*

None.

If you are a non-governmental witness, please list any contracts or payments originating with a foreign government and related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current year and previous two calendar years. Include the amount and country of origin of each contract or payment. *If necessary, attach additional sheet(s) to provide more information.*

None.

Doris Browne, M.D., M.P.H.
118th President of the National Medical Association
President and CEO, Browne and Associates, LLC.

Dr. Doris Browne is the 118th President of the National Medical Association (NMA) and the President and CEO, Browne and Associates, LLC (BAI), a health consultancy company that manages programs addressing national and global health disparities. As President of the NMA, Dr. Browne's program theme focused on a ***Collaborative Approach to Health Equity*** entitled ***"The Urgency of Now: Creating a Culture for Health Equity"***. She tirelessly champions many causes that have significantly contributed to improving the health status of vulnerable population. She has achieved both national and international recognition as an expert educator and speaker. She has been either featured or quoted in many news articles to include the Army Times, US Medicine, Ebony, Essence, Washington Post, PBS News Hour, and ePolitico to name a few. She specializes in and is passionate about health issues, especially women's health, breast cancer, sickle cell, HIV/AIDS, and radiation casualties. Dr. Browne has made numerous briefings before senior executive government, congressional and White House officials. Her public health background includes health education programs on substance abuse, sex education, breast cancer, sickle cell disease, HIV/AIDS, and community health education programs, including participating in an international disaster preparedness and humanitarian assistance program for 17 West African Nations following the Ebola epidemic of 2015. She retired as a Colonel from the United States Army, Medical Corps where she was the Director for Medical Research and Development at the U.S. Army Medical Research and Materiel Command. She also retired from the National Institutes of Health, National Cancer Institute where she managed the breast cancer portfolio in the Division of Cancer Prevention. Dr. Browne is a graduate of Tougaloo College (BS), University of California at Los Angeles (MPH), and Georgetown University (M.D.) and completed an internship, residency, and fellowship at Walter Reed Army Medical Center in Hematology-Oncology. She is member of Trinity Episcopal Church, numerous professional organizations, Alpha Kappa Alpha Sorority, and recipient of plentiful awards including the NIH Merit Award and the 2018 Top Blacks in Healthcare award.

Truth in Testimony Disclosure Form

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Committee: <u>Rules</u>
Subcommittee: _____
Hearing Date: <u>April 30, 2019</u>
Hearing Subject:
H.R. 1384 — Medicare for All Act of 2019 [Original Jurisdiction Hearing]

Witness Name: Doris Browne, MD, MPH

Position/Title: President & CEO, Browne and Associates, LLC/ Immediate Past President, National Med Assn

Witness Type: ☐ Governmental ☒ Non-governmental

Are you representing yourself or an organization? ☒ Self ☐ Organization

If you are representing an organization, please list what entity or entities you are representing:

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If you are a **non-governmental witness**, please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current calendar year and previous two calendar years. Include the source and amount of each grant or contract. *If necessary, attach additional sheet(s) to provide more information.*

I have no federal grants or contracts related to this hearing's subject matter
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If you are a **non-governmental witness**, please list any contracts or payments originating with a foreign government and related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current year and previous two calendar years. Include the amount and country of origin of each contract or payment. *If necessary, attach additional sheet(s) to provide more information.*

I have no contracts or payments from any foreign government related to this hearing's subject matter.

Farzon A. Nahvi is a board certified attending physician and Clinical Assistant Professor of Emergency Medicine at New York University Langone Medical Center, the Manhattan VA, and Bellevue Hospital in New York City. He is a graduate of Cornell University and New York University School of Medicine, and completed his residency training in emergency medicine at New York University/Bellevue Hospital.

Dr. Nahvi is on the board of directors for the New York Metro chapter of Physicians for a National Health Program and has been a longtime advocate for comprehensive universal healthcare in America. Dr. Nahvi has written for *The New York Times*, *The Guardian*, the *New York Daily News*, *New York Magazine*, the *ACP Hospitalist*, the *ACP Internist* as well as academic journals *Academic Medicine* and the *Spine Journal* and serves as a reviewer for the *Bellevue Literary Review*.

Dr. Nahvi has been inducted into the Arnold P. Gold Humanism Medical Honor Society and has been awarded the Alex Rosen Excellence in Medicine and Humanities award. He is fluent in both Spanish and Farsi and is currently working on his first book.

Truth in Testimony Disclosure Form

In accordance with Rule XI, clause 2(g)(5)*, of the *Rules of the House of Representatives*, witnesses are asked to disclose the following information. Please complete this form electronically by filling in the provided blanks.

Committee: Rules

Subcommittee: _____

Hearing Date: April 30, 2019

Hearing Subject:

H.R. 1384 — Medicare for All Act of 2019 [Original Jurisdiction Hearing]

Witness Name: Farzon A. Nahvi

Position/Title: Attending Physician and Clinical Assistant Professor of Emergency Medicine

Witness Type: ☐ Governmental ☒ Non-governmental

Are you representing yourself or an organization? ☒ Self ☐ Organization

If you are representing an organization, please list what entity or entities you are representing:

If you are a **non-governmental witness**, please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current calendar year and previous two calendar years. Include the source and amount of each grant or contract. *If necessary, attach additional sheet(s) to provide more information.*

n/a (none)

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n/a (none)

H.R. 1384, MEDICARE FOR ALL ACT OF 2019

HEARING BEFORE THE COMMITTEE ON RULES HOUSE OF REPRESENTATIVES ONE HUNDRED SIXTEENTH CONGRESS FIRST SESSION

TUESDAY, APRIL 30, 2019

HEARING BEFORE THE COMMITTEE ON RULES—H.R. 1384, MEDICARE FOR ALL ACT OF 2019