PROPOSALS TO ACHIEVE UNIVERSAL HEALTHCARE COVERAGE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

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C O N T E N T S

WITNESSES

[1] Ms. Ross' prepared statement has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF14/20191210/110313/HHRG-116-IF14-Wstate-RossJ-20191210.pdf.

SUBMITTED MATERIAL

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[2] Dr. Atlas' prepared statement has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF14/20191210/110313/HHRG-116-IF14-Wstate-AtlasS-20191210.pdf.

[3] Dr. Atlas did not answer submitted questions for the record by the time of printing.

[4] The proposed legislation has been retained in committee files and also is available at https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=110313.

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[5] The report has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF14/20191210/110313/HHRG-116-IF14-20191210-SD013.pdf.

[6] The report has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF14/20191210/110313/HHRG-116-IF14-20191210-SD014.pdf.

[7] The report has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF14/20191210/110313/HHRG-116-IF14-20191210-SD015-U5.pdf.

PROPOSALS TO ACHIEVE UNIVERSAL HEALTHCARE COVERAGE

TUESDAY, DECEMBER 10, 2019

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:31 a.m., in room 2322, Rayburn House Office Building, Hon. Anna G. Eshoo (chairwoman of the subcommittee) presiding.

Members present: Representatives Eshoo, Engel, Butterfield, Matsui, Castor, Sarbanes, Luján, Schrader, Kennedy, Cárdenas, Welch, Ruiz, Dingell, Kuster, Kelly, Barragán, Blunt Rochester, Pallone (ex officio), Burgess (subcommittee ranking member), Shimkus, Guthrie, Griffith, Bilirakis, Long, Brooks, Hudson, Carter, Gianforte, and Walden (ex officio).

Staff present: Jeffrey C. Carroll, Staff Director; Tiffany Guarascio, Deputy Staff Director; Zach Kahan, Outreach and Member Service Coordinator; Saha Khaterzai, Professional Staff Member; Josh Krantz, Policy Analyst; Una Lee, Chief Health Counsel; Aisling McDonough, Policy Coordinator; Meghan Mullon, Staff Assistant; Kaitlyn Peel, Digital Director; Alivia Roberts, Press Assistant; Samantha Satchell, Professional Staff Member; Rebecca Tomilchik, Staff Assistant; Rick Van Buren, Health Counsel; C.J. Young, Press Secretary; Nolan Ahern, Minority Professional Staff Member, Health; Margaret Tucker Fogarty, Minority Legislative Clerk/Press Assistant; Theresa Gambo, Minority Financial and Office Administrator; Tyler Greenberg, Minority Staff Assistant; Peter Kielty, Minority General Counsel; Ryan Long, Minority Deputy Staff Director; Kate O'Connor, Minority Chief Counsel, Communications and Technology; J.P. Paluskiewicz, Minority Chief Counsel, Health; Kristin Seum, Minority Counsel, Health; and Kristen Shatynski, Minority Professional Staff Member, Health.

Ms. ESHOO. Good morning, everyone. The Subcommittee on Health will now come to order. The Chair now recognizes herself for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

And welcome to our colleagues that are at the table and everyone that is here in the hearing room.

Today's hearing features House colleagues who will present their legislative proposals to advance what I have always called the

North Star of the Democratic Party, and that is to achieve universal healthcare for the American people. Five members are or will be at the witness table. Two representatives, Mr. Luján and Ms. Schakowsky, will speak from the committee seats and two others, Representative Cedric Richmond and Representative Veasey, are submitting written statements.

Every American should feel secure that, if they get sick or if they are hurt, they will receive the care they need without going bankrupt. That principle is why President Johnson signed Medicare and Medicaid into law, despite the protests at that time that it was "socialized medicine" and the "Moscow party line." Today, Medicare covers 44 million Americans and Medicaid covers 75 million Americans.

Our goal to achieve universal coverage motivated Congress to pass the Children's Health Insurance Program in 1997. It is why President Obama signed the Affordable Care Act into law in 2010, which today provides health coverage to more than 20 million Americans. But we know there is more work to be done to achieve universality. During our second panel today, we will hear the stories of fellow Americans who live in daily fear that they will lose their healthcare because of a decision by their employer, their insurer, or this President.

My hope rises as I see the talented colleagues before us who will present their proposals and broaden our thinking. That is why I specifically asked each to be here today. My hope rises as I look out at doctors, nurses, and patients in the audience who have dedicated their lives to achieving quality healthcare for every American. Advent is a season of hope and an appropriate time for colleagues on both sides of the aisle to approach this hearing with open minds and hearts, knowing that the goal is to have healthcare for every American.

Shortly before his death, Senator Ted Kennedy wrote a letter to President Obama about health reform and what he called "that great unfinished business of our society." He wrote, "What we face is, above all, a moral issue; that at stake are not just the details of policy, but fundamental principles of social justice and the character of our country." I think we all need to reflect on that moral issue today.

[The prepared statement of Ms. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO

Today's hearing is historic and hopeful. It continues our near century-long work to achieve universal healthcare for the American people.

Every American should feel secure that if they get sick or hurt, they will receive the care they need without going bankrupt.

That principle is why President Johnson signed Medicare and Medicaid into law despite protests that it was "socialized medicine" and the "Moscow party line."

Today, Medicare covers 44 million Americans and Medicaid covers 75 million Americans.

Our goal to achieve universal coverage motivated Congress to pass the Children's Health Insurance Program in 1997.

It's why President Obama signed the Affordable Care Act into law in 2010, which has provided health coverage to more than 20 million Americans.

But there's more work to be done.

During our second panel today we will hear stories from fellow Americans who live in daily fear that they'll lose their healthcare because of a decision by their employer, their insurer, or this President.

It shouldn't be this way. The question is: How to fix it?
Today, we'll hear nine plans to do just that.
Those nine plans are why this hearing isn't only historic, but hopeful.
I feel hope looking at my talented colleagues before me who will present their proposals.
It's why I specifically asked you to be here today.
I feel hope looking at the doctors, nurses, and patients in the audience who've dedicated their lives to achieving quality healthcare for every American.
And I feel hope during this Advent season, that my colleagues on both sides of the aisle can approach this hearing with open minds and hearts knowing that the goal is to ensure universal healthcare, including for the most vulnerable among us.
Shortly before his death, Senator Ted Kennedy wrote a letter to President Obama about health reform and what he called "that great unfinished business of our society."
He wrote, "What we face is above all a moral issue; that at stake are not just the details of policy, but fundamental principles of social justice and the character of our country."
Let us all reflect on that moral issue today.
I yield the rest of my time to Representative Dingell.

Ms. ESHOO. I now would like to yield the remainder of my time to Congresswoman Dingell.

Is she here? Not here? Pardon me? She is on her way. Well, we are going to move on, because the Chair is now going to recognize Dr. Burgess, the ranking member of the subcommittee, for his 5 minutes for an opening statement.

Mr. BURGESS. Actually, before I start that, may I ask a unanimous consent request, unanimous consent to insert into the record the two letters that Mr. Walden and I sent asking for this hearing earlier in the year?

Ms. ESHOO. So ordered.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. And also, I am OK with you yielding your final minute and a half to Mrs. Dingell when she gets here.

Ms. ESHOO. Thank you.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. So, thank you for leading the hearing. Certainly, Mr. Walden and I have requested this, and we requested it very early in the year and I appreciate that you took our request seriously.

So, Chairman Pallone and Chairwoman Eshoo stated in noticing this hearing that universal healthcare coverage has long been the North Star of the Democratic Party. Every bill before us today is paving the road to the North Star, if that is even possible. The idea is we accomplish one-size-fits-all healthcare.

Another Advent analogy: The Three Wise Men—not quite the same, but I am not sure they would appreciate your comparison, as this North Star journey would lead our healthcare system as we currently know it to disintegrate. If, in fact, we are listening to the great philosopher Joni Mitchell, then the Northern Star is not very reliable, as it is constantly in the dark.

Medicare for All would eliminate private insurance, employer-sponsored health insurance, Medicaid, the Children's Health Insurance Program upon which many Americans depend. I am concerned about the consequences for existing Medicare beneficiaries. The policy would raid the Medicare Trust Fund, which is already slated

to go bankrupt in 2026. This will not help. Our Nation's seniors have been paying into and depending upon the existence of Medicare for their healthcare needs in retirement for, literally, their entire lives.

More than 70 percent of Americans are satisfied with their employer-sponsored insurance, which does provide robust protections. We should focus on strengthening the parts of our health insurance markets that are working. However, instead of building upon the success of our existing health insurance framework, a one-size-fits-all policy would tear it down.

I also feel obligated to mention, having been in the healthcare provider business, the doctor business, coverage does not equal care. It never has and never will. Single-payer healthcare would be another failed attempt. As a one-size-fits-all approach to healthcare, single-payer is in reality not one-size-fits-all, it is one-size-fits-no one. Single-payer healthcare would cost over $33 trillion for the first 10 years. This high price tag would require new tax increases. In fact, it would double the currently projected Federal individual and corporate income tax collections in order to pay for it, according to the Mercatus Center.

So each and every one of these bills before us today is about Medicare for All and the pathway to socialized medicine. We have all seen the reports of increased wait times for patients in countries like Canada of up to almost 9 weeks for a specialist consultation. Hospitals stand to lose billions under a Medicare for All plan. The New York Times reported rural hospitals saying that they would virtually close overnight, while others said that they would try to offset the steep cuts by laying off hundreds of thousands of workers and abandoning the lower-paying services such as mental health services.

We simply cannot afford the financial or human suffering that would accompany such a misguided policy. It is clear that this takeover of even one sector of the healthcare industry we are going to be talking about later this week, prescription drugs in Speaker Pelosi's H.R. 3 bill—and it would reduce the number of new drugs coming to the market—the Congressional Budget Office estimated between 8 to 15 new drugs would fail to come to the market over the course of the next 10 years. The Council of Economic Advisors anticipated as many as a hundred drugs. It doesn't matter which figure you use, everyone is in agreement that it would reduce new drugs coming that we have all wanted through innovation.

I support commonsense, market-driven improvements to our healthcare system. The goal should be to increase access to healthcare services and drive down the costs for our patients. These universal healthcare coverage bills are all going in the wrong direction. In fact, I introduced H.R. 1510, the Premium Relief Act of 2019, which does include reinsurance that is coupled with a structural reform of the Affordable Care Act. This would give States more choice on how to repair their markets that have been damaged by previous legislative attempts. Even better, this legislation is fully paid for by stopping bad actors from gaming the system.

There are policies that we could work on to get Americans—to reduce their cost and complexity of healthcare, but we have before

us today nine bills that fail to have a single Republican cosponsor among them. I am glad we finally are having this hearing, Madam Chair. It has been a long time coming and certainly something we should have done as we started this year. But at the end of the day, I would really hope the Energy and Commerce Committee can open the blinds and reveal what the North Star really looks like, completely in the dark. I yield back.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Thank you, Madam Chair. Thank you for holding this hearing on various universal heath care coverage proposals, including Medicare for All. Ranking Member Walden and I requested a hearing on Medicare for All numerous times this year, and I appreciate that you took our request seriously enough to hold today's hearing. I would like to ask unanimous consent that our two letters be included in the record. Coverage does not equal care.

Chairman Pallone and Chairwoman Eshoo stated in noticing this hearing that "universal healthcare coverage has long been the North Star of the Democratic Party." Every bill before us today is paving that road to the North Star—to accomplishing one-size-fits-all healthcare coverage.

I'm not sure the Three Wise Men would appreciate your comparison, as this North Star journey would lead our healthcare system as we currently know it to disintegrate into ashes. If we're listening to Joni Mitchell, then the Northern Star is not very reliable as it is constantly in the dark.

Medicare for All would eliminate private insurance, employer-sponsored health insurance, Medicaid, and the Children's Health Insurance Plan, upon which many Americans depend. I am concerned about the consequences for existing Medicare beneficiaries, as this policy would raid the Medicare Trust Fund, which is already slated to go bankrupt in 2026. Our Nation's seniors have been depending on the existence of Medicare for their healthcare needs in retirement for their entire lives.

More than 70 percent of Americans are satisfied with their employer-sponsored health insurance, which provides robust protections for all individuals. We should be focused on strengthening the parts of our health insurance markets that are working. However, instead of building upon the successes of our existing health insurance framework, a one-size-fits-all policy would tear it down.

Single-payer healthcare would be another failed attempt at a one-size-fits-all approach to healthcare. Single-payer is not one-size-fits-all, it is really one-size-fits-no-one. Single-payer healthcare would cost $32.6 trillion for the first 10 years of full implementation. This high price tag would require new tax increases. In fact, doubling all currently projected Federal individual and corporate income tax collections would be insufficient to finance Medicare for All, according to the Mercatus Center.

Let me be clear, each and every one of these bills before us today is about Medicare for All and the pathway to socialized medicine. We have seen reports of increased wait times for patients in countries like Canada of up to almost 9 weeks for a specialist consultation. Hospitals stand to lose billions under a Medicare for All plan. The New York Times reported rural hospitals saying they would virtually close overnight, while others said they would try to offset the steep cuts by laying off hundreds of thousands of workers and abandoning lower-paying services like mental health. We simply cannot afford the financial or human suffering that would accompany such misguided policy. To further lay out that argument, I would like to request unanimous consent to insert statements from the Texas Hospital Association and American Hospital Association into the record.

It is clear that a socialist takeover of even one sector of the healthcare industry—prescription drugs—in Speaker Pelosi's HR 3, there would be a reduced number of new drugs coming to market. The Congressional Budget Office estimated between 8–15 new drugs would fail to come to market over the course of 10 years.

Whereas the Council of Economic Advisors anticipated as many as 100 drugs would not reach Americans. This is the effect of a socialist policy, the ramifications of which would be even greater under Medicare for All.

Evidently, the House Democrats are looking to socialize all of medicine and our whole healthcare system.

While I support commonsense, market-driven improvements to our healthcare system that would increase access to healthcare services and drive down costs for patients, these universal healthcare coverage bills are steps in the wrong direction.

I introduced HR 1510, the Premium Relief Act of 2019, which includes reinsurance that is coupled with a structural reform of the Affordable Care Act. This would give states more choice on how to repair their markets that have been damaged by Obamacare.

Even better, this legislation is fully paid for by stopping bad actors from gaming the system.

There are many policies that we could work on that would get to providing more Americans healthcare coverage; however, nine bills that fail to have a single Republican cosponsor among them, is not the answer. I am glad we finally had a hearing on Medicare for All so the Energy and Commerce Committee can open the blinds and reveal what this "North Star" really looks like to the American people—completely in the dark. I yield back.

Ms. ESHOO. The gentleman yields back. I now would like to yield the minute and a half that I want to yield to Congresswoman Dingell so that you can make use of the time that you asked for.

Mrs. DINGELL. Thank you.

Today, we have the opportunity to discuss legislation that would, once and for all, address the cost and access issues that continue to deny millions of Americans the right to quality, affordable healthcare. Every member of this committee has heard from—and every Member of this Congress—has heard from constituents who are fearful and frustrated by our current health system. We have received letters and calls from individuals who face devastating financial hardship as a result of predatory health insurance companies enabled by the current system.

And as I have always said, when I would take John to the doctor, it was like holding a town hall. Person after person would come up and share their stories that were just—they were people that were desperate and scared and needed help. We can and must do better. This is the promise of Medicare for All, a comprehensive system of coverage that empowers all Americans.

The Medicare for All of 2019 would provide coverage for all Americans, improve traditional Medicare for seniors by offering additional benefits at lower cost, and utilizing administrative efficiencies and negotiations to bring down prices. This is a historic day. I thank you, Madam Chair, for scheduling this hearing. We have never had a Medicare for All hearing in this committee, and I look forward to discussing this legislation further with our distinguished experts today and to keep answering questions and giving people the facts as we go forward. Thank you, Madam Chair.

Ms. ESHOO. The Chair now recognizes the chairman of the full committee, Mr. Pallone, for his 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Madam Chair.

Since the passage of the Affordable Care Act, more than 20 million Americans have gained the peace of mind that comes from knowing that they and their loved ones have health insurance. This landmark law resulted in the highest insured rate in our Nation's history. It also expanded consumer protections so that, no matter where you live or work in the U.S., your family would have access to affordable, comprehensive healthcare.

The ACA ended decades of insurance companies price gouging older Americans, charging women more than men, and discriminating against people with preexisting conditions. It not only prevented health insurance companies from discriminating against people with preexisting conditions, it also required insurance companies to cover a set of essential health benefits like hospitalization, emergency services, maternity care, and substance use disorder services. It also eliminated annual and lifetime limits on coverage that for years had forced people with preexisting conditions into bankruptcy. Thanks to the ACA, young Americans can stay on their parents' plan until they turn 26.

The law also expanded Medicaid, which made health insurance available to millions of low-income Americans, including many with serious and chronic preexisting conditions and unmet medical needs. Yet, millions more would be covered today if it were not for the continued resistance of Republican Governors to the law's Medicaid expansion and the repeated attempts by congressional Republicans and the Trump administration to undermine and dismantle the law.

House Republicans voted 69 times to repeal the ACA. Luckily, they failed to do so, but they did repeal the law's individual mandate, increasing prices for everyone. Meanwhile, 20 Republican attorneys general and Governors sued the Federal Government, challenging the constitutionality of the law. The Trump administration has taken the extraordinary position of refusing to defend the law in the courts. If the Republicans are successful in court, it would cause millions of people to lose their health insurance, eliminate protections for people with preexisting conditions, and immediately spike healthcare costs for all Americans.

I firmly believe that today we would be very close to universal coverage had it not been for the sabotage and for the refusal of Republican Governors to expand Medicaid. I also believe that, had the final law included the public option as supported by the majority of this committee and the House at the time, that we would be even closer to universal coverage. Now, unfortunately, that is not the case, and millions of Americans remain uninsured, particularly in States that have refused to expand Medicaid.

Also, among the uninsured are undocumented immigrants and their families. When we drafted the ACA, I worked to include the undocumented, but I couldn't get the votes, and I would like to know how the various bills before us today would address the undocumented. When people get sick, they get other people sick, so it makes no sense to exclude any group of people regardless of their legal status. And, under the Trump administration, the uninsured rate has gone up and American families have lost coverage, including hundreds of thousands of children. We need to enact policies that include all the uninsured, and that is why we are here today.

The bills we are considering reflect Democrats' continued commitment to achieving universal coverage and making healthcare more affordable and accessible for all Americans. I believe that we must continue to build on the success of the ACA until healthcare is truly a right for all Americans, which it should be.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Since the passage of the Affordable Care Act, more than 20 million Americans have gained the peace of mind that comes from knowing that they and their loved ones have health insurance. This landmark law resulted in the highest insured rate in our Nation's history. It also expanded consumer protections so that, no matter where you live or work in the United States, your family would have access to affordable, comprehensive healthcare.

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Meanwhile, 20 Republican attorneys general and Governors sued the Federal Government, challenging the constitutionality of the law. The Trump administration has taken the extraordinary position of refusing to defend the law in the courts. If the Republicans are successful in court, it would cause millions of people to lose their health insurance, eliminate protections for people with preexisting conditions, and immediately spike healthcare costs for all Americans.

I firmly believe that today we would be very close to universal coverage had it not been for the sabotage and for the refusal of Republican Governors to expand Medicaid. I also believe that had the final law included the public option, as supported by the majority of this committee and the House at the time, that we would be even closer to universal coverage.

Unfortunately, that's not the case and millions of Americans remain uninsured, particularly in States that have refused to expand Medicaid. Also, among the uninsured are undocumented immigrants and their families. When you have more uninsured people, costs go up for everyone. And, under the Trump administration, the uninsured rate has gone up and American families have lost coverage, including hundreds of thousands of children. We need to enact policies that include all the uninsured.

And that's why we are here today. The bills we are considering reflect Democrats' continued commitment to achieving universal coverage and making healthcare more affordable and accessible for all Americans. I believe that we must continue to build on the success of the ACA until healthcare is truly a right for all Americans.

I look forward to the discussion today and I yield back.

Mr. PALLONE. I look forward to the discussion and yield the balance of my time to the gentlewoman from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you so much. Today really does mark a landmark day to discuss ways that the United States of America can join the rest of the industrialized world in saying that healthcare is a right and not a privilege for all of our people. You know, we spend more than any other country on healthcare right now, yet millions of people don't have access to care. We have the highest rates of infant—or maternal mortality, we have a shorter life span, and we can do better.

So I have been a cosponsor and a supporter of single-payer healthcare since a lot of you in this room were even born, but I also want to say that I am a cosponsor of every single bill that is going

to improve healthcare in this country because we have to move forward. I am a cosponsor of a bicameral public option bill ever since the Affordable Care Act didn't include it. I am a cosponsor—and you will hear from Representative DeLauro—on Medicare for America. I am a Medicare for All—I am a cosponsor of that and was there at its inception.

So we don't know exactly what path we are going to take, but over the last 50 years we have seen some dramatic changes. We have seen Medicare and Medicaid get passed, we have seen the ACA, and these are examples of the dynamic changes that we can make and that we should be making. We need to work together. Americans are asking us, begging us to improve our healthcare system. They all want to be covered. We can do this, and we are going to hear about how we can do this today. I thank the panel, and I yield back.

Ms. ESHOO. Does the gentleman yield back? Mr. Pallone?

Mr. PALLONE. I am sorry. Yes, I yield back, Madam Chair.

Ms. ESHOO. What are you dreaming about there, over there?

Mr. PALLONE. Dreaming about a better world.

Ms. ESHOO. Lovely.

I now would like to recognize the ranking member of the full committee, my friend Mr. Walden, for his 5 minutes for an opening statement.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Thank you. I want to join the chairman in dreaming about a better world. It is that spirit we should have here this holiday season.

Ms. ESHOO. Well, I believe it is. I believe it is.

Mr. WALDEN. Madam Chair, yes. Thanks for holding this hearing. I think it really is important to flesh out these issues and learn a lot about them.

As you know, our committee has moved forward on maternal mortality legislation. Ms. Schakowsky referenced that as a huge issue, and it is, and I am glad we have moved forward on some of those specific issues. This is the committee that created Medicare Part D to help seniors get access to affordable prescription drugs that had never been a part of Medicare before. We did that. The House passed it. I helped write it and support it all along.

This is the committee that led the effort in a bipartisan way on 21st Century Cures. I know there is an effort beginning to look at a Cures 2.0 so we can find these magic miracles that are saving people's lives and invest in American innovation and research. This is the committee that is on the cusp of reauthorizing fully funding our community health centers for the next 5 years. I am a big fan of our community health centers. When I chaired the committee, I helped lead the effort to fully fund them.

And Chairman Pallone and I are working together on legislation to stop surprise billing so consumers aren't ripped off when they go to the emergency room. One in five are getting a surprise bill today. That is wrong. We are on the cusp of dealing with that. And we fully funded Children's Health Insurance Program in the last

Congress, when I chaired the committee, for 10 years. It had never been fully funded for more than 5.

So I think we all share a commitment to trying to find answers to the cost of healthcare, to access issues when it comes for healthcare. Some of us, however, think that Medicare for All is not the right approach; that it would actually take away the health insurance that 180 million Americans have today, many of whom have bargained for that health insurance as part of very aggressive union-employer bargaining agreements. They have traded away wages in order to have better healthcare or lower-cost deductibles and all. Medicare for All would strip that away from them, as it would take away Medicare Advantage Plans and put it all under one system. And I will just tell you, when Washington politicians promise you something for free, you better hold on to your wallets.

As you know, 84 percent of Americans actually like the health insurance they have today. We all think it is probably too expensive. We all wish it were a little better. We can work to make changes to fix some of those issues, but a one-size-fits-all system that rations care and restricts access and blows a hole in the budget is not where many of us are at.

At the presidential debate in October, a top Democrat said, and I quote, "If you eliminated the entire Pentagon, every single thing, it would pay for about a total of 4 months" of this Medicare for All plan. These plans are so complex and confusing and costly that even the Congressional Budget Office could not figure out the price tag. However, two think tanks, one on the left and one on the right, came up with a range of between 28 trillion and 32 trillion dollars over the next 10 years. Other versions we have heard about would cost upwards of $52 trillion.

Even doubling the current—doubling the current—personal and corporate taxes would not cover the costs. Doubling. Doctors and hospitals could see payment cuts of 40 percent. Forty percent. How would they keep their doors open? What happens to our access to care? We can look north to Canada. The Fraser Institute did some research on this and found that a doctor's referral for specialty care, the medium wait time was 20 weeks, double what it was 25 years ago. That is a government-run system.

Canada is facing a shortage of medical providers, and in some provinces some hospitals have responded by actually closing their emergency rooms 2 days a week. In British Columbia, 300 patients died waiting for surgery between 2015 and 2016 because of a lack of anesthesiologists. And, according to the British Columbia Anesthesiologists' Society, they say that is a huge problem.

Canada has 16 CT scans for every million people. In America, we have 45 for every million people. That means that you can get access to care quicker here, get those scans. Delay and denial of care is how government-run healthcare systems control costs. You see what is going on in England right now with a young boy that was being treated, I think, in a hallway. They ration care. They delay care. If the government decides a treatment or drug you need is not cost effective, you are denied access. We had that debate in this committee. The data are clear about how long you wait to get access to miracle drugs in other countries. Upwards of 40 percent of the new drugs are not available. These are cancer drugs. These are

new drugs on the market that would save lives, and do, in America.

We have got to deal with the issue of costs, certainly, but there is a way to do that. And by the way, most of these government-run systems prevent you from going around the government-run system. Some people do flee a country, come to another one, mainly America, to get access to care when their own government system fails them. It is not just a theory. It is what happens in some of these countries.

So I am not a fan of that complete government takeover. I am a fan of reform and of making sure we have the network in place. So, Madam Chair, thanks for having this hearing. I yield back.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Today we're here to talk about the greatest government takeover of private business, and the greatest denial of individual choice, in modern history. Medicare for All would not only take away your health insurance, but also end Medicare as we know it. It would ban private insurance and rob consumers of any choice they have in making healthcare decisions that work for them.

We hear all the time, "don't worry, Medicare for All will give you free healthcare from Washington, D.C. that's better than what you get today." When Washington politicians promise you something for free, you better hold onto your wallet.

Let's look at what Medicare for All would do. More than 180 million Americans lose the health insurance plan they've chosen or bargained for. Even Medicare Advantage plans for seniors are wiped out.

A recent poll found that 84% of Americans are satisfied with the healthcare plans they're on. These are union members and workers who have negotiated their healthcare benefits for decades—under the Democrats' plan, they would lose the coverage they've chosen for their families and are shoved into a one-size-fits-all system that rations care, restricts access and blows a hole in the budget.

At the presidential debate in October, a top Democrat said, 'If you eliminated the entire Pentagon, every single thing. it would pay for a total of four months.'

These plans are so complex, confusing and costly that even the Congressional Budget Office could not figure out the price tag. However, independent studies from think tanks on the left and the right arrived at similar conclusions: Medicare for All would cost between $28 trillion and $32 trillion over 10 years. Other versions could cost up to $52 trillion. Leading Democrats are forced to admit this would require massive tax increases on working families and American companies.

But even doubling current personal and corporate taxes would NOT cover the costs. DOUBLING—still not enough. Doctors and hospitals could see payment cuts of 40%! How would they keep their doors open? What would happen to our ability to access care?

We can look north to Canada to see what Canadians deal with every day. The Fraser Institute found that after a doctor's referral for specialty care, the median wait time is 20 weeks, double what it was 25 years ago.

Canada is facing a shortage of medical providers and in some provinces, some hospitals have responded by closing their emergency rooms on certain days of the week. In British Columbia, 300 patients died waiting for surgery between 2015 and 2016 because of a lack of anesthesiologists, according to the British Columbia Anesthesiologists' Society. Canada has 16 CT scanners for every million people. Here in the U.S. we have nearly three times as many CT scanners.

Delay and denial of care is how government-run healthcare systems control costs. They ration care. If the government decides the treatment or drug you need are not "cost effective," you are denied access. And the law prevents you from going around the government to get care.

This is not just a theory, this is what happens in other countries with government-run healthcare administered by bureaucrats—care is rationed, access is restricted, and patients have worse outcomes. That's not what Republicans want for Americans.

Mr. Chairman, I do want to thank you for having this hearing. The American people deserve to hear the facts about what a government takeover of their health insurance will mean for access to care in a timely manner. These plans ration care

and deny life-saving treatments. Importing foreign healthcare systems to the U.S. runs counter to our shared goal of expanding access to the latest cures and improving access to lifesaving therapies.

Ms. ESHOO. The gentleman yields back.

The Chair wants to remind Members that, pursuant to committee rules, all Members' written opening statements shall be made part of the record, and certainly the written statements of the two Members that are part of the nine proposals that we are going to hear about today.

So they don't really need any introduction, but I think that it is appropriate to still do so. It is an honor to welcome our colleagues here today for this hearing. Each of them is going to speak for 5 minutes to present their specific proposal. Each one differs, and I think that, as I said in my opening statement, that it is important for everyone to listen because we have varying sets of ideas, and I think that we need to have an open mind about them.

So, beginning with Congresswoman Rosa DeLauro from my home State where I was born and raised, Connecticut, welcome to you; to Representative Jayapal from the State of Washington, welcome to you; to Representative Higgins from New York, thank you for making yourself available today; to Representative Delgado from the State of New York; and Representative Malinowski from New Jersey. Welcome to each one of you. Thank you for the work that you have put into the product that—the legislation that you are going to explain to us today.

So we will start with Congresswoman DeLauro. You are recognized for 5 minutes to speak to your legislation, 1384, the Medicare for—no, 2452, I am sorry, the Medicare for America Act. You all know the light system, so I don't need to explain that to anyone.

Welcome. Thank you, Rosa.

STATEMENT OF HON. ROSA DELAURO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Ms. DELAURO. Thank you so much, Madam Chair. Congressman Pallone, Congresswoman Eshoo, Ranking Members Walden and Burgess, I am delighted to be here this morning. It is an honor for me join with the members of this committee and also to be with all of my colleagues here this morning on what is a critical, critical discussion on what are the pathways that we can move forward to universal care.

I am here this morning to advocate for Medicare for America, which I first introduced with my dear friend and my colleague, Congresswoman Jan Schakowsky. We did this in December 2018, and we reintroduced it this May. Medicare for America achieves universal, affordable, high-quality health coverage by creating a program based on Medicare and Medicaid that covers all Americans through auto enrollment starting at birth while maintaining high-quality, affordable employer coverage.

Medicare for America moves every individual currently enrolled on the individual exchanges and Medicare beneficiaries on to the program. Individuals and children enrolled in Medicaid and CHIP are transitioned on to Medicare for America, over time, to ensure that their care is not disrupted as we transform our healthcare system. We made this deliberate choice after working with members

of the disabilities community who know all too well about disruptions in the face of budget cuts and other complications.

For those with employer-sponsored coverage, two things can be true, and are true: employers have shifted many Americans to high-deductible plans with less generous coverage, and many are very satisfied, including those union members that negotiated very good coverage in lieu of wages in lean budget years. So Medicare for America allows high-quality, affordable, private employer-sponsored coverage to remain, or employers can enroll their employees in Medicare for America and continue to pay a contribution, or those employees who work for these employers that continue to offer private coverage can choose Medicare for America and their employer contributes toward the premium. This way, no one is locked into employer-sponsored coverage.

Let me touch on something that I hear from most of my constituents and that is cost. For individuals, seniors, families living below 200 percent of the Federal poverty level, they will have no premiums and no cost sharing. There are never out-of-pocket costs for children under 21 and for maternity services, for preventive and chronic services, for long-term services and supports, and for prescription drugs. There are also zero deductibles. Zero. Annual out-of-pocket costs are no more than $3,500 for individuals, $5,000 for families on a sliding scale, and premiums are capped no more than 8 percent of income for enrollees and are determined on a sliding scale.

And, additionally, on the topic of the cost of the program, our bill included pay-fors. I ask you to read it. I won't enumerate all of them, but the pay-fors are there.

Let me discuss what is innovative about Medicare for America. Today, healthcare benefits are too dependent on your ZIP Code. Universal coverage must be universal, so Medicare for America is explicit in the benefits covered, especially with respect to long-term services and supports.

We are in a crisis. Families spend themselves into poverty to get the care their aging loved ones need, hundreds of thousands of individuals with developmental and intellectual disabilities that wait years for services that may never come, so Medicare for America establishes the gold standard for long-term services and support. We partnered with members of the disability community on the entire bill in order to ensure their needs. The resulting coverage: home health aides, personal attendant care services, hospice, care coordination, respite services, to name a few.

We prioritized those supports and services for workforce development, raising the reimbursement rates for direct-care workers and ensuring a career pipeline, credentialing, and worker rights. Then, in the interim, the bill recognizes the central role that family caregivers play by compensating them for their work, because it is work. Beyond the LTSS workforce, Medicare for America preemptively raises reimbursement rates for primary care and mental and behavioral health and cognitive services.

Far too many individuals face roadblocks because reimbursement rates are too low. Far too many providers are weighed down or scared off because of mounting debt and choose only private insurance. So Medicare for America establishes all-payer rate setting.

Private insurance pays the Medicare for America rate. It all comes back to getting patients the care they need. That is why we ban private contracting. Current law allows providers to cover individuals and private coverage. They also talk about paying out-of-pocket for care even if their insurance covers the benefit. It is a two-tiered system that must not continue. Patients deserve to be treated fairly to get the care they need.

We acknowledge the crippling of the student loan debts that many healthcare workers face that often leads to private contracting, so we say to providers: Pay our rates, see our patients, and we forgive 10 percent of your student loan. By making smart investments upfront, the American people save a great deal of money in the long run. At its core——

Ms. ESHOO. Rosa.

Ms. DELAURO. One second. At its core, Medicare for America is about ensuring that every American has healthcare, and as we debate into the future on universal healthcare coverage, my view: Medicare for America is the best way forward in providing historic change.

Ms. ESHOO. Amen.

Ms. DELAURO. Thank you. And thank you for inviting me.

[The prepared statement of Ms. DeLauro follows:]

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REMARKS OF THE HON. ROSA L. DELAURO
E&C HEALTH SUBCOMMITTEE: PATHWAYS TO UNIVERSAL COVERAGE
TUESDAY, DECEMBER 10, 2019

Thank you, Chairs Frank Pallone, Anna Eshoo and Ranking Members Greg Walden, Michael Burgess. I am here to advocate for Medicare for America, which I first introduced with my dear friend, Congresswoman Jan Schakowsky in December 2018 and reintroduced this May.

Medicare for America achieves universal, affordable, high-quality health coverage by creating a program based on Medicare and Medicaid. And, it covers all Americans through auto-enrollment starting at birth, while maintaining high-quality, affordable, employer coverage. Medicare for America moves every individual currently enrolled on the individual exchanges and Medicare beneficiaries onto the program. Individuals and children enrolled in Medicaid and CHIP are transitioned onto Medicare for America over time to ensure that their care is not disrupted as we transform our health care system. We made this deliberate choice after working with members of the disabilities community who

know all to well about disruptions in the face of budget cuts and other complications.

For those with employer-sponsored coverage, two things can be true and are true. Employers have shifted many Americans to high-deductible plans with less generous coverage; and, many are very satisfied including those union members that negotiated very good coverage in lieu of raises in lean budget years. So, Medicare for America allows high-quality, affordable private employer-sponsored coverage to remain or employers can enroll their employees in Medicare for America and continue to pay a contribution. Or those employees who work for these employers that continue to offer private coverage can choose Medicare for America, and their employer contributes toward the premium. This way no one is locked into employer sponsored coverage.

I want to touch on what I hear about most from my constituents. Cost.

For individuals, seniors, and families living below 200% of the Federal Poverty level, they will have no premiums and no cost-sharing.

There are never any out of pocket costs for children (under 21) and for maternity services, for preventive and chronic disease services, for Long Term Services and Supports, and for prescription drugs. There are also zero deductibles. Zero.

Annual out of pocket costs are no more than $3,500 for individuals and $5,000 for families on a sliding scale.

And premiums are capped: no more than 8% of income for enrollees, and are determined on a sliding scale.

Additionally, on the topic of cost of the program, our bill does include pay-fors.

Now, I want to discuss what is innovative about Medicare for America.

Today, health care benefits are too dependent on your zip code. Universal coverage must be universal. So, Medicare for America is explicit in the benefits covered especially with respect to long-term services and supports.

We are in a crisis. Families spend themselves into poverty to get the care their aging loved ones need. Hundreds of thousands of individuals with developmental and intellectual disabilities that wait years for services that may never come.

So, Medicare for America establishes the gold standard for LTSS. We partnered with members of the disabilities community on the entire bill to ensure we met their needs. The resulting coverage: home health aides, personal attendant care services, hospice, care coordination, respite services. To name a few. We also prioritized LTSS workforce development. Raising reimbursement rates for direct care workers and ensuring a career pipeline, credentialing, and worker rights. Then, in the interim, the

bill recognizes the central role family caregivers play by compensating them for their work. Because it is work.

Beyond the LTSS workforce, Medicare for America preemptively raises reimbursement rates for primary care and mental and behavioral health and cognitive services. Far too many individuals face roadblocks because reimbursement rates are too low. Far too many providers weighed down or scared off because of mounting debt choose only private insurance. So, Medicare for America establishes all-payer rate setting. Private insurance pays the Medicare for America rate.

It all comes back to getting patients the care they need. That is why we also ban private contracting. Current law allows providers to covered individuals whether its Medicare, Medicaid, CHIP, private coverage to pay out of pocket for care, even if their insurance covers the benefit. This two-tiered system must not continue. Patients deserved to be treated fairly, and get the care they need. We acknowledge the crippling the student loan debt so

many in the health care workforce face that often leads to private contracting. So, we say to providers: pay our rates and see our patients and we forgive 10% of your student loans. By making smart investments up front, the American people save a great deal of money in the long-run.

At its core, Medicare for America is about ensuring every American has health care. Medicare for America is the best way forward to achieve this historic change.

Thank you again to my colleagues for welcoming me today.

Ms. ESHOO. Thank you, Congresswoman DeLauro. With all the energy she always brings to everything that she does, thank you.

Next, we welcome and thank Congresswoman Jayapal. She is the sponsor of H.R. 1384, the Medicare for All Act. So you have your 5 minutes to present your proposal.

Ms. JAYAPAL. Thank you.

Ms. ESHOO. And thank you again for being here today. I know that you have Judiciary as well, so away we go.

STATEMENT OF HON. PRAMILA JAYAPAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Ms. JAYAPAL. Thank you so much, Chairwoman Eshoo, Ranking Member Burgess, and Chairman Pallone and Ranking Member Walden, and distinguished members of the Subcommittee on Health. Thank you for holding this historic hearing. This is a great day.

And let me start by saying that the Affordable Care Act was critically important in expanding healthcare for tens of millions of Americans across the country and providing insurance for those who had preexisting conditions, but equally important, the Affordable Care Act allowed Americans to dream of a future where everybody had the right to healthcare. And for us, we need to ensure that we don't stop with the Affordable Care Act and that we get to the place where we have universal care for all people in our country.

And that is why I am so proud to have introduced, along with my esteemed colleague, Representative Debbie Dingell, H.R. 1384, the Medicare for All Act of 2019. Our 119 cosponsors, over half of the Democratic Caucus, many of you on this committee, thank you for your input and your support as we developed this bill. This is now the fourth historic hearing we have had on Medicare for All in the House of Representatives, and that would not be possible without an enormous movement for Medicare for All.

And I want to particularly recognize, quickly, a few groups: Physicians for a National Health Program; National Nurses United, who you will hear from today; Public Citizen; the labor coalition; the Disability Rights Coalition; and a racial justice coalition and a women's coalition that worked with us for over 6 months to develop this piece of legislation, I would submit, the most comprehensive and bold solution to fix our broken healthcare system. We simply wouldn't be here without their leadership.

Our Nation's healthcare system is the most expensive in the world. Contemplate that. This year, we will spend almost $3.9 trillion, or 18 percent of our GDP, on healthcare expenditures, and that is almost double what every other industrialized country in the world spends. Over the next decade, our current healthcare system will cost America about $55 trillion. What does that astronomical spending get us? The highest maternal and child mortality rates among our peer countries and the lowest life expectancy. It gets us 500,000 Americans who every year are forced into bankruptcy because of medical costs. It gets us 70 million people who still remain uninsured or underinsured, and that is just a bad deal.

Why is America so far behind our peer countries? You might ask that. Because profit-making motives are baked into our system and

our healthcare system incentivizes putting profits over patients. For-profit insurance companies with extremely high administrative waste stand between Americans and good quality, affordable healthcare. Every American knows someone, a loved one, a friend, a child, or a parent, who has suffered a healthcare crisis, and they know that the system we have doesn't work.

So how do we respond to this? I think, if we really want to fix this, we have to do three things. First, any plan that proposes to fix our healthcare crisis has to cover everyone. Not just expand coverage for some, but cover everyone, guaranteed. Second, it has to provide comprehensive benefits and high-quality healthcare when you need it. And, finally, it has to take on the out-of-control costs, administrative waste, and for-profit motive of the current system and bring down costs for American families.

Our bill, H.R. 1384, is a 125-plus-page bill, a comprehensive plan to lay out exactly how we get there, and it is the only plan that does all three of those things. Our bill improves the successful Medicare program that we have, but it expands it to cover everyone with a guaranteed government insurance plan, including comprehensive benefits, vision, hearing, dental, mental health, and of particular importance, long-term care for people with disabilities and older Americans.

All of this with no copays, no private insurance premiums, and no deductibles. And because all doctors and hospitals will be in network, Medicare for All gives the American people more choice than ever before. No more worrying about a massive surprise bill that you might get. No more worrying about what happens if you have to quit your job because you are too sick to work. No more worrying if you want to go start a small business but you can't afford the cost of healthcare.

H.R. 1384 also includes important cost-containment measures to ensure that we rein in health spending. It bolsters rural hospitals and safety-net hospitals with special provisions to help these hospitals stay open and thrive and have patients who are all insured. I want to be clear that every study, including the Koch Brothers' conservative study, says that we will save money with a Medicare for All plan.

American families will pay 14 percent less than they currently pay in healthcare costs, and that is why over 250 economists sent a letter to Congress saying that Medicare for All is the right plan for our economy. It is why former CMS Administrator under President Obama, Don Berwick, said that, after being the Director of Medicare for some, he now believes it is time for Medicare for All, and it is why 30 unions for the first time—don't listen to the arguments that unions don't want this. For the first time, 30 unions, including the major unions in our country, have supported this bill.

Ms. ESHOO. Pramila?

Ms. JAYAPAL. Now it is up to us.

Ms. ESHOO. Pramila?

Ms. JAYAPAL. And it is time for us——

Ms. ESHOO. Wind up.

Ms. JAYAPAL [continuing]. To pass Medicare for All.

I am just listening to my mentor, Rosa DeLauro, who took a minute more—

Mr. SHIMKUS. Regular order. Regular order.
Ms. ESHOO. Yes. Yes.
Ms. JAYAPAL [continuing]. To continue to say——
Ms. ESHOO. Just wrap up.
Ms. JAYAPAL [continuing]. That it is time for us to pass Medicare for All. Thank you, Madam Chair.
[The prepared statement of Ms. Jayapal follows:]

U.S. HOUSE OF REPRESENTATIVES
ENERGY & COMMERCE SUBCOMMITTEE ON HEALTH
Hearing on "Proposals to Achieve Universal Health Care Coverage"
Testimony of Congresswoman Pramila Jayapal (WA-07)
DECEMBER 10, 2019

Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of the Subcommittee on Health: Thank you for holding this important and historic hearing on proposals to achieve universal health care, in particular, H.R. 1384, the Medicare for All Act of 2019—the bill I'm proud to lead, alongside my esteemed colleague, Congresswoman Dingell and 117 other co-sponsors.

It's important to start by acknowledging the dedication of the Medicare for All coalition, which has been working for decades to make universal, guaranteed, comprehensive health coverage a reality. The list is long: Physicians for a National Health Program, National Nurses United, Public Citizen, Social Security Works, the Labor Coalition for Single Payer, the disability rights coalition, a strong racial justice coalition, women's groups and so many more—worked very closely with me for over six months to make sure H.R. 1384 is the most comprehensive and bold proposal to fix our broken health care system. We simply would not be where we are today without their leadership.

Every day, people feel the weight of our health care crisis. They feel it when they have to decide between paying their rent or rationing their insulin; feeding their families or paying off medical bills. They feel it when their wages stagnate because employers have to cut back on employee salaries to pay private insurance premiums for plans that cover less and less and cost more and more; and, they feel it when they are forced into bankruptcy or start a GoFundMe to beg for money from family and friends because their insurance does not cover the care they desperately need.

Our nation's health care system is, by far, the most expensive in the world. By the end of this year, we will have spent almost $3.9 trillion, or 18 percent of our GDP.[1] Our current system will cost us about $55 trillion over the next 10 years. And what does this astronomical spending buy? The highest maternal and child mortality rates among our peer countries, and the lowest life expectancy. More than 34 million adults who have lost someone in the last five years because their treatment was too expensive.[2] Five-hundred thousand Americans forced into bankruptcy because of medical costs.[3] And 70 million people who remain uninsured or underinsured.

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[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected
[2] https://news.gallup.com/poll/268094/millions-lost-someone-couldn-afford-treatment.aspx
[3] https://www.cnbc.com/2019/02/11/this-is-the-real-reason-most-americans-file-for-bankruptcy.html

So, the first question we must ask is why can every other major country guarantee universal healthcare, generally for half the cost of what we spend on healthcare?

It comes down to the profit-making motives that are baked into our system; a system that puts profits over patients; a system that has a very expensive set of middlemen that stand between Americans and good quality, affordable health care. Twenty-five to 30 percent of all health care expenditures in our system go to administrative costs.[4] Some of those costs are necessary to administer any health care system, but much of it is wasted on an overly complex claims system that denies necessary care, paying for advertisements and maintaining CEO salaries. In 2018 alone, the top 62 health care CEOs made $1 billion in take-home pay while over 70 million people remained uninsured or underinsured.[5]

Any health care plan that seeks to address this crisis must do three things:

- First, it must cover everyone. Not just expand coverage for some, but guarantee health care for everyone.
- Second, it must expand the kind of benefits provided so that everyone has comprehensive, high quality health care when they need it;
- And finally, it must take on the out-of-control costs, administrative waste, and profit-motive of the current system and bring down costs for the vast majority of American families.

Medicare for All is the only plan out there that does all of these things. My bill ensures that every American has access to the health care they need by transitioning to a single-payer, government-financed, guaranteed health insurance plan for all Americans that provides comprehensive benefits, including long-term care. My bill eliminates cost-sharing, which would lower health care costs for families. And, my bill eliminates the middleman and curbs administrative waste, which would save hundreds of billions of dollars and lower costs for the overall health care system.

Medicare for All improves upon the overwhelmingly popular and successful Medicare program to include benefits such as vision, hearing, dental, mental health and, of particular importance, long-term care that is essential for seniors and people with disabilities—and then it expands Medicare to cover everyone with a guaranteed government insurance plan. It does all of this with no copays, private insurance premiums or deductibles. The American people will have more choice than ever before with Medicare for All—because all doctors and hospitals will be in-network, private insurance companies would no longer cannot limit Americans' choices or stand between them and the care they need. Private insurance companies are allowed to provide supplemental insurance for benefits not covered under Medicare for All.

My bill also includes important cost-containment measures to ensure that we reign in health spending while guaranteeing everyone in the U.S. can get the care they need. My

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[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5839285/
[5] https://www.axios.com/health-care-ceo-salaries-2018-3aff66cd-8723-4ec8-abe8-dd19edd24390.html

bill includes a global budgeting system, which reimburses hospitals and providers for their operating costs upfront to allow them to focus on value and efficiency, while ensuring health care dollars spent reflect actual health care costs. Global budgets allow a level of transparency that will ensure hospitals have the funds they need to provide for their communities but are also incentivized to focus on the health of their patients—not on profit or excessive administrative costs. This has worked in Canada and Australia, where their administrative costs are less than half of what the we spend in the United States[6]. Global budgeting will significantly lower the 25 percent of revenue hospitals currently spend on administrative costs, and streamline the billing process, because they would no longer be billing hundreds of insurance plans. My bill also reins in escalating drug prices by finally allowing the government to negotiating reasonable prices for all drugs—using the stick of licensing generics if drug manufacturers refuse to participate.

Studies have shown that a Medicare for All system costs less than our current system. Therefore, the whole cost and financing debate surrounding Medicare for All is disingenuous at best, and deeply misleading at worst. You cannot look at the cost of Medicare for All without thinking about what we currently spend today. A typical American family of four with the most common employer-sponsored health plan can expect to spend more than $28,000 on health care in 2018, with employers sharing only some of that cost.[7] One comprehensive study found that Medicare for All could save our health care system $5 trillion over the next 10 years.[8] Even a think tank funded by the conservative Koch Brothers estimated that Medicare for All would save our system $2 trillion over the next 10 years.[9] Therefore, when people ask "how will we pay for it," we must remember that Medicare for All costs *less* than what we currently pay for a system that costs so much and performs so poorly. Under our plan, the average American family will pay 14% less than they currently pay in healthcare costs. Bottom line? American families will save money on health care through Medicare for All *and* have guaranteed comprehensive care.

Medicare for All means everyone is covered. Regardless of whether a person has a job, gets fired or is let go, or wants to start a business, they will have insurance, guaranteed. People will no longer have to worry about rapidly rising premiums and out-of-pocket costs or narrowing provider networks that can limit their ability to find a doctor. Also, a Medicare for All system would allow us to leverage health care dollars for public health crises and invest in addressing social determinants of health and a "preventive care" system instead of our current "sick care' system.

Medicare for All provides universal long-term care for individuals with disabilities and older Americans with no cost-sharing.[10] It is past time we take care of our seniors and people with

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[6] OECD. Tackling Wasteful Spending on Health. OECD Publishing, Paris (2017), p. 241.
[7] https://www.beckershospitalreview.com/finance/28k-the-average-price-healthcare-will-cost-a-family-of-4-in-2018.html
[8] https://peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all
[9] https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf
[10] https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-home-and-community-based-services-waiver-waiting-lists/

disabilities so that they can live their lives with dignity in the setting of their choice and with their loved ones. My bill also switches the default from institutional care to home and community-based care so that the 700,000 Medicaid recipients currently waiting for waivers for home-based care services can be cared for outside of nursing homes.[11]

Medicare for All will bolster rural hospitals and hospitals that mostly care for people who are poor and low-income. Between 2010 and 2016, 72 rural hospitals shut down leaving thousands of people without local access to the care they need.[12] Today, rural and safety-net hospitals often cannot collect anything for the care they give to low-income and uninsured patients. Medicare for All levels the playing field and makes sure that everyone gets care, not just the wealthy. That means that all hospitals, including the ones that care for the poorest patients today, would have the funds needed to operate—and even expand—because everyone would have health insurance. Furthermore, my bill contains special provisions to help rural hospitals and critical safety net hospitals stay open and begin to thrive again.

Medicare for All will end the vice-like grip of health care on businesses and our global economic competitiveness. Currently, people are unable to take entrepreneurial risks or have to stay in a job that they hate because they cannot risk losing their employer insurance. Employers cannot invest in their businesses or employees' wages because they must pay staggering health insurance premiums, which only continue to rise. Our peer countries learned a long time ago that you cannot leave health care to for-profit industries, nor should health care be tied to something as impermanent as employment. That's why over 250 economists sent a letter to Congress, stating that Medicare for All will give the United States a much needed competitive advantage, with American companies no longer bearing such high costs of insuring employees.[13] Economists from across the country know that when American families, workers and employers no longer have to bear the responsibility of navigating an incomprehensibly complex insurance system or pour significant amounts of their time, money and resources into obtaining unreliable coverage, we promote well-being, stronger social and business networks and greater economic growth.

The Medicare for Act of 2019, H.R. 1384, is a big, bold, comprehensive plan. The for-profit health care industry is doing everything it can to maintain the status quo. The industry lobby has been pouring hundreds of millions of dollars into killing this bill, perpetuating misinformation to try to convince Americans that we cannot afford a health care system that works for everyone. They cannot bear the idea of giving up enormous profits they are making for their CEOs and shareholders. So, let me make one thing perfectly clear: What we can't afford, is our current health care system. Big Pharma CEOs and shareholders are lining their pockets while millions of people go without health care. We are facing not only a moral, but also economic imperative to fix our health care system. Medicare for All gets rid of wasteful spending and makes sure no

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[11] https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-home-and-community-based-services-waiver-waiting-lists/

[12] https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/

[13] https://www.nesri.org/sites/default/files/Economists_for_Medicare_for_All_0.pdf

more lives are lost because people cannot access health care. It is time we stand up against corporate interests and stand up for a health care system the American people deserve. It is time for Medicare for All.

Ms. ESHOO. Thank you. Thank you very much for being here today and testifying.

We will now call on Congressman Brian Higgins. Welcome, Brian. It is wonderful to see you here, and you have 5 minutes to present your proposal.

STATEMENT OF HON. BRIAN HIGGINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. HIGGINS. Yes, thank you very much, Chairwoman Eshoo and Chairman Pallone and Ranking Member Burgess. I just want to say that I was a proud supporter of the Affordable Care Act, which will be 10 years old this March. But even the President, the Speaker, recognized that the passage of the Affordable Care Act represented a start, not a finish, and that it was highly imperfect in many ways, including the lack of a public option, to be a real countervailing force to private insurance, because I think by and large private insurance screws people. They jack up premiums. They jack up deductibles. They jack up copays. And then, when you go to use the insurance that you already paid too much for, there is very little underlying insurance.

You know, before the Affordable Care Act, if you had a kid that was stuck with childhood cancer, an insurance company could deny you coverage because of a preexisting condition. You can't do that anymore. It is against the law. And the only Federal law that protects people with preexisting conditions is the Affordable Care Act. In 2010, Democrats lost control of the House because of healthcare; 2018, Republicans lost control of the House because of healthcare. We are even. Let's move forward.

I want to talk about three things: complexity, cost, and leverage. The human body has 11 organ systems. There are 70,000 ways that those organ systems can fail. There are 4,000 medical procedures. There are 6,200 FDA-approved prescription drugs. There are 206 bones in the human body. There are 30 trillion cells in 200 cell types. The human body and healthcare are fascinating but complicated.

The United States Government pays $1.3 trillion for healthcare this year under Medicare, Medicaid, and the Veterans Administration, then another $360 billion in prescription drugs. That is a lot of money. The Federal Government pays about a third of the Nation's entire healthcare bill. But it is also a lot of leverage, and that is what I want to talk about today.

All of these bills are outstanding. We need to make progress by using the best public option that already exists, and that is Medicare. Medicare has been around for 54 years. It is wildly popular with those who have it and those who provide services for those who have that as their health insurance. Ninety-six percent of Medicare beneficiaries have access to both a primary care doctor and a physician specialist, and all of the hospital institutions take Medicare as well.

I have a bill that would allow people 50 to 65 to buy Medicare as a medical option. The Henry J. Kaiser Family Foundation that has done extraordinary work in this regard says that 77 percent of the American people support a Medicare buy-in 50 to 65. Why that age demographic? Because this age demographic, 50 to 65, is to

this century what the traditional Medicare population was to the previous century, and that is that private insurance had every opportunity to write policies for people that were older and sicker but chose not to do it. And a good and generous nation responded by establishing the Medicare program, and then all the privates wanted in on it when it was deemed to be profitable and successful under the Medicare Advantage program.

This age demographic experiences very high preexisting conditions, about 50 percent. Their premiums are very high, their deductibles are very high, and their copays are very, very high. I will give you an example. A 60-year-old able to buy into Medicare at their own cost that will not adversely affect the Medicare Hospital Insurance Trust Fund, according to the Rand Corporation and the Henry J. Kaiser Family Foundation, would save 48 percent when compared to a Gold Plan on the individual market.

Now Rand also said that 6 million Americans would take advantage of that plan. That is almost 14,000 people per congressional district. And I would remind you that that age demographic also votes, so it is good on the politics. It is good on the substance. I think we have an obligation to, much like we said 10 years ago, we need the next iteration, the next exciting iteration of Medicare expansion, and I believe that my bill should be in that conversation relative to that goal. Thank you very much.

[The prepared statement of Mr. Higgins follows:]

Congressman Brian Higgins
Energy and Commerce Committee
Health Subcommittee
"Proposals to Achieve Universal Health Care Coverage"
Tuesday, December 10, 2019

Chairwoman Eshoo, Ranking Member Burgess, thank you for holding this important hearing on ways to achieve universal health care coverage in America.

This coming March will mark ten years since President Obama signed the Affordable Care Act into law. The accomplishments of the ACA are many, and the law's impact over the last decade is indisputable. Twenty million Americans have gained health insurance. The uninsured rate has been cut almost in half. Required essential health benefits ensure that insurance plans actually cover the care that individuals and families need. Preventive care is covered with no cost-sharing. And, of course, protections for people with pre-existing conditions mean that no one with ailments like cancer, or diabetes, or HIV can be denied coverage.

I was proud to vote for the ACA, but I have always viewed the bill as a start, not a finish. We must continue to push toward the end goal of a universal health care system where health care truly is a right for all, not a privilege for only those who can afford it.

As evidenced by the bills being discussed today, there are a number of ideas about how we might move forward to achieve this goal. While I am a proud cosponsor of several of these bills, I am here today to testify about a bill I have introduced, the Medicare Buy-In and Health Care Stabilization Act.

Put simply, this bill would allow those Americans aged 50-64 to buy into the existing Medicare program. Medicare would be listed alongside existing private plans on the ACA's insurance marketplace, and if an individual's income qualified them for subsidies to help buy a marketplace plan, they could apply those subsidies towards the buy-in plan as well. The existing Medicare program would remain the same, and the buy-in would be funded by premiums placed into a separate buy-in trust fund, leaving the Medicare Hospital Trust Fund unaffected.

Why does a Medicare buy-in make sense as an immediate next step to expand health care coverage? Americans aged 50-64 face particularly high premiums on the individual market, especially if they do not qualify for subsidies. According to the Kaiser Family Foundation, a 60-year-old making $50,000 a year can expect to pay $8500 in annual premiums for the cheapest individual market plan in 2019. That's about 17% of their income. Allowing folks in this age group the option of buying into Medicare would give them a better, more affordable option for health care coverage and can be implemented comparatively quickly, providing relief to an age cohort that could truly use it.

A study released last month by the highly respected, nonprofit RAND Corporation analyzed the potential impact of several versions of a Medicare buy-in scenario, outlining a number of benefits it would bring to those who enrolled. In their base buy-in scenario for those aged 50-64,

which closely mirrors my bill, RAND estimated that six million people would enroll in the buy-in. The buy-in would be significantly cheaper than comparable individual market gold plans. In the first year the buy-in would be offered, the annual buy-in premiums for a 50-year-old would be $2500 less than a gold plan. For a 60-year-old, the annual buy-in premium would be $8300 less than a gold plan.

The study also found that overall out-of-pocket spending for those choosing the buy-in would go down 28 percent. And the buy-in would save the federal government money as well, reducing federal spending by $4 billion.

Furthermore, allowing those 50-64 to buy into Medicare is incredibly popular with the American people. In a poll released earlier this year, the Kaiser Family Foundation found that 77 percent of Americans support a Medicare buy-in. That includes 85 percent of Democrats, 75 percent of Independents, and even 69 percent of Republicans. Of all the health care coverage expansion options included in the poll, none was more popular than the Medicare buy-in.

Medicare has been a reliable, popular, and often life-saving health care program for millions of Americans for more than 50 years. Despite the successes of the Affordable Care Act, too many people, especially those 50-64, are still paying too much for their health care. The Medicare Buy-In and Health Care Stabilization Act would provide the access to high-quality care offered by Medicare to a new segment of the population, saving both consumers and the government money in the process. We must not relent in our efforts to ultimately achieve a universal health care system, and I firmly believe that a Medicare buy-in is the prudent, logical, and necessary next step toward that goal.

Ms. ESHOO. Thank you very much. And thank you for being on time as well, on time with your conclusion using your 5 minutes.

It is a pleasure to welcome and thank Representative Delgado from New York to present his idea, his proposal, which is H.R. 2000, the Medicare-X Choice Act. So welcome and——

STATEMENT OF HON. ANTONIO DELGADO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. DELGADO. Thank you. Thank you, Chairwoman Eshoo. Thank you, Ranking Member Burgess. Chairman Pallone. It is really nice to be with you all this afternoon, or this morning. I am pleased to see the committee considering my bill, the Medicare-X Choice Act, and I am honored to have the opportunity to explain why it is a priority of mine.

The title of today's hearing, "Proposals to Achieve Universal Healthcare Coverage," an urgent need, indeed. We are the richest nation in the world and yet the only developed one without some form of universal coverage. If unable to qualify for Medicare, TRICARE, or Medicaid, Americans are left to fend with a system that is entirely beholden to the profit motives of the private insurance marketplace. As a result, millions of Americans are priced out of the market and left uninsured or have insurance but simply can't afford to take advantage of it. It is unacceptable.

We have got to achieve universal healthcare coverage, and I believe we can get there with a public option. I promised my constituents I would pursue this path, and with that promise in mind, this spring introduced the Medicare-X Choice Act along with my colleagues including Representative Higgins and Larsen. Medicare-X establishes a public option, a government-run insurance plan available in the marketplace for anyone to buy if they are uninsured or unhappy with their current plan. The effect of a public competitor in the private insurance marketplace will undoubtedly bring down the skyrocketing costs of premiums and deductibles.

The plan starts in rural areas, where coverage options can be scarce, and it automatically enrolls every child in the CHIP program. Critically, Americans who like their current plans, like many union members who have spent years bargaining for what they have now or seniors on Medicare Advantage, can keep them. This plan covers every American in just 3 years, but also attacks the underlying affordability crisis that plagues families across the country, an issue not discussed nearly enough.

We start by, one, requiring Medicare to negotiate drug prices; two, increasing Federal support for those who need it by eliminating the subsidy cliff for Americans above the 400 percent of the Federal poverty line and increase in the tax credit for those individuals below it; and three, authorizing 30 billion over 3 years for a national reinsurance program. Under this bill, a family of four with an income of $101,000 would see their premiums cut in half. We do all that without costing the Federal Government a dime.

The Congressional Budget Office recently found that Medicare-X would actually add money to the Treasury over time. Medicare-X fulfills the promise of the Affordable Care Act that healthcare coverage will be simpler, more accessible, and more affordable when families can choose the plan that works best for them.

Every time I have held a town hall—and I have held quite a few—I hear from folks about the cost of healthcare. Congress needs to get this done so families don't have to choose between paying medical bills or buying groceries. As this committee considers the healthcare legislative options, I hope you will find two main takeaways from my testimony today: more choice, lower costs. Two concepts I hope everyone on this panel can get behind.

I thank the committee again for your time and the opportunity to share my priorities with all of you.

[The prepared statement of Mr. Delgado follows:]

Testimony before Energy and Commerce Committee

Rep. Antonio Delgado

"Thank you Chairwoman Eshoo, thank you Ranking Member Burgess, Chairman Pallone. It's really nice to be with you all this morning. I'm pleased to see the committee considering my bill, the *Medicare-X Choice Act,* and am honored to have the opportunity to explain why it is a priority of mine.

"The title of today's hearing is 'Proposals to Achieve Universal Health Care Coverage' – an urgent need indeed. We are the richest nation in the world—and yet, the only developed one without some form of universal coverage. If unable to qualify for Medicare, Tri-Care, or Medicaid, Americans are left to fend with a system that is entirely beholden to the profit motives of the private insurance marketplace. As a result, millions of Americans are priced out of the market and left uninsured, or have insurance but simply can't afford to take advantage of it.

"This is unacceptable. We have got to achieve universal health care coverage. And I believe we can get there with a public option. I promised my constituents I would pursue this path, and with that promise in mind, this Spring introduced *the Medicare-X Choice Act*, along with my colleagues, including Representatives Higgins and Larson. Medicare-X establishes a public option – a government-run insurance plan, available in the marketplace, for anyone to buy if they're uninsured or unhappy with their current plan. The effect of a public competitor in the private insurance marketplace will undoubtedly bring down the skyrocketing costs of premiums and deductibles.

"The plan starts in rural areas, where coverage options can be scarce, and it automatically enrolls every child in the CHIP program. Critically, Americans who like their current plans – like many union members who have spent years bargaining for what they have now, or seniors on Medicare Advantage – can keep them.

"This plan covers every American in just three years. It also attacks the underlying affordability crisis that plagues families across the country—an issue not discussed nearly enough. We start by 1) requiring Medicare to negotiate drug prices, 2) increasing federal support for those who need it by eliminating the subsidy cliff for Americans above 400% of the federal poverty line and increasing the tax credit for those individuals below it; and 3) authorizing $30 billion over three years for a national reinsurance program.

"Under this bill, a family of four with an income of $101,000 would see their premiums cut in half. We do all of that without costing the federal government a dime; the Congressional Budget Office recently found that Medicare-X would actually add money to the Treasury over time.

"Medicare-X fulfills the promise of the Affordable Care Act: that health coverage will be simpler, more accessible, and more affordable when families can choose the plan that works best for them. Every time I've held a town hall—I've held quite a few—I hear from folks about the cost of health care. Congress needs to get this done so families don't have to choose between

paying medical bills or buying groceries.

"As this committee considers the health care legislative options, I hope you will find two main takeaways from my testimony today: more choice and lower costs—two concepts I hope everyone on this panel can get behind. I thank the committee again for your time and the opportunity to share my priorities with all of you."

Ms. ESHOO. We thank the gentleman. It is a great source of pride to all of us that of the five that are speaking at the witness table this morning that Mr. Delgado and Malinowski are new Members of Congress. This is their first term. And you are a source of pride to us, and you more than hit the ground running with ideas. You are fresh off the campaign trail, and it is always refreshing to see what new people bring to the Congress, so thank you as a combination with the others.

Mr. DELGADO. Thank you.

Ms. ESHOO. Now it is a pleasure to both welcome and recognize Mr. Malinowski for your 5 minutes to talk about your proposal, which is H.R. 4527, the Expanding Healthcare Options for Early Retirees Act.

STATEMENT OF HON. TOM MALINOWSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. MALINOWSKI. Thank you so much for those kind words, Chairman Eshoo, Mr. Ranking Member Burgess. Thank you for the opportunity to testify today alongside my colleagues, each of whom have put together thoughtful proposals to get us closer to that North Star of universal coverage. And speaking of North Stars, Mr. Burgess, Joni Mitchell is Canadian, which means she comes from a country with lower healthcare costs and higher life expectancy. So I am hoping you might have her for the next panel to answer some of Mr. Walden's concerns. All right.

Chairman Pallone, I also want to thank you for your leadership and your work with Mr. Walden, especially on the surprise-medical-billing issue. Let's please get that passed before we go home for the holidays. That would be a huge win, I think, for all of our constituents. I am here to talk about a bill that I also hope that we can find common ground on.

My bill, the Expanding Healthcare Options for Early Retirees Act, would allow retired first responders—firefighters, police officers, EMTs—to buy into Medicare beginning at age 50. Due in part to the physically demanding nature of their work, first responders often retire earlier than other workers and can experience gaps in coverage until they become eligible for Medicare. This legislation would close that gap. Coverage under this bill would be identical to the coverage provided under the existing Medicare program. Retirees would be eligible for tax credits, subsidies, and tax advantage contributions from their former employers or pension plan. Further, the bill specifically requires that it be implemented in a way that will not harm the existing Medicare program beneficiaries or trust fund.

We are grateful to have the support of the International Association of Fire Fighters, the Fraternal Order of Police, the National Association of Police Organizations, the National Sheriffs' Association, the National Troopers Coalition, the International Union of Police Associations, the National Conference on Public Employee Retirement Systems, AFSCME, among other organizations. Many of their representatives are with us today.

And since introducing the bill in September, my office has received dozens of phone calls and letters and messages from people all across the United States describing how it would help them or

a family member. A person from Wilson County, Tennessee, wrote to us, "This is a such a needed law. More and more agencies are washing their hands of insuring first responders when they retire. It is not a young person's job. And when we retire, we are damaged physically and emotionally and need the healthcare that eats up most of our pension."

A paramedic from Florida wrote, "I am 53 and can retire in 2 years. Healthcare has been my major concern after my retirement. I pray for all of you working on this proposed bill."

A paramedic firefighter from Oregon wrote, "I was born to be a firefighter in the community I was born and raised in. You naturally never think about your body wearing out. I have had several Toradol and steroid shots in both my elbows, shoulders, and neck over my career so that I can be at work answering my community's calls. It would be so helpful being eligible for Medicare benefits when I retire."

A newspaper in Texas quoted the head of the Abilene Police Officers Association saying, "The bill would allow us to retire at a good age and be able to afford healthcare. This affords us the opportunity to retire earlier, spend more time with our families, and enjoy life."

This is why we are here today examining how to improve our healthcare system so that every American can spend more time with our families and enjoy our lives so that we can choose a profession we love and to change it when we please without the crushing existential anxiety that comes from being uninsured or underinsured, without the fear that an accident or an illness could lead to bankruptcy.

Now, I believe that everybody who wants Medicare—teachers, caregivers, coal miners, farmers, service workers, everyone—should be able to live with the dignity and security that the program provides. But, as we debate how to free every American of the anxiety of dealing with the current healthcare system, let us at least do something to free the few, the dedicated and brave few, who risk their health and their lives to protect us.

Thank you so very much, and I yield back.

[The prepared statement of Mr. Malinowski follows:]

Committee on Energy and Commerce Subcommittee on Health
Hearing on Proposals to Achieve Universal Health Care Coverage
Rep. Malinowski Testimony
December 10, 2019

[Chairman Pallone, Chairwoman Eshoo, Ranking Member Walden, Ranking Member Burgess, Members of the Committee.] Thank you for the opportunity to testify this morning alongside my colleagues—each of whom has put forth sincere, thoughtful proposals to move us closer to the North Star of universal coverage. I'm grateful to the Committee for providing this venue to examine these proposals in more detail.

I'm here to talk about a bill to address the unique health care-related challenges facing retired first responders.

My bill, the "Expanding Health Care Options for Early Retirees Act," would allow retired first responders—police officers, firefighters, and EMTs—to buy into Medicare beginning at age 50. Senator Sherrod Brown of Ohio—whose leadership on this issue predates my service in Congress—introduced the Senate version.

Due in part to the physically demanding nature of the work, first responders often retire earlier than other workers, and can experience gaps in coverage until they become eligible for Medicare at 65. This legislation ensures that retired first responders who are 50 and older will have access to comprehensive health insurance—whether or not their pension plan provides for coverage upon retirement.

Coverage under this bill would be identical to the coverage provided under the existing Medicare program. And retirees would be eligible for tax credits, subsidies, and tax-advantaged contributions from their former employer or pension plan. Further, this bill specifically requires that it be implemented in a way that will not harm the existing Medicare program, beneficiaries, or trust fund.

We're grateful to have the support of the International Association of Firefighters, the Fraternal Order of Police, the National Association of Police Organizations, the National Sheriffs Association, the National Troopers Coalition, the International Union of Police Associations, the National Conference on Public Employee Retirement Systems, and AFSCME, among other organizations.

Since introducing the bill in September, my office has received dozens of phone calls and messages on social media from people from across the United States describing how it would help them or a family member.

- A person from Wilson County, Tennessee wrote: "This is such a needed law. More and more agencies are washing their hands of insuring first responders when they retire. It is not a young person's job, and when we retire we are damaged physically and emotionally and need the health care that eats up most of our pension."

- A paramedic from Okaloosa County, Florida wrote: "I am 53 and can retire in 2 years. Healthcare has been my major concern after retirement. I've had numerous injuries on the job and have been exposed to more than my fair share of bad inhaled substances. I pray for all of you working on this proposed bill. God Bless you all."

- A firefighter paramedic from Oregon wrote: "I was born to be a f/f paramedic in the community I was born and raised in. You naturally never think about your body wearing out. I have had several Toradol and steroid shots in both my elbows, shoulders and neck over my career. Lived

on prescription anti-inflammatories and muscle relaxers. So I can be at work answering my community's calls. My neck, shoulders and elbows are tired. I'm retiring December 31st, 2019. It would be very helpful being eligible for Medicare Benefits. It is extremely difficult to admit my body cannot take working in the fire service any longer."

- A local news article in Texas quoted the head of Abilene's Police Officers' Association saying the bill would "allow us to retire at a good age and be able to afford healthcare. This affords us the opportunity to retire earlier, spend more time with our families, enjoy life."

This is why we are here today — examining how to improve our health care system so that Americans can spend more time with our families and enjoy our lives, so that we can choose a profession we love and change it when we please, without the crushing, existential anxiety that comes from being uninsured or underinsured; without the fear that an accident or illness could lead to bankruptcy.

I believe that everyone who wants Medicare—teachers, caregivers, coal miners, farmers, service workers, *everyone*—should be able to live with the dignity and security that the program provides. But as we debate how to free every American of the anxiety of dealing with our current health care system, I hope we can at least agree on a way to free those who choose to risk their lives and their health to protect us.

Since introducing this bill, I've heard from other folks in Arlington, TX; Scottsdale, AZ; Moneta, VA; Plainfield, IN; New Iberia, LA; Council Grove, KS; Belton, MO, and elsewhere who agree.

I say all this to show that support for this effort is diverse and widespread. It's a more modest proposal than many of the others presented today, but it's an important, targeted effort designed to bring a sense of security to first responders, who always come when we need them.

Thank you again for the opportunity to testify this morning, and I look forward to your questions.

Ms. ESHOO. The gentleman yields back. And let me express on behalf of all of the members of the committee, both sides of the aisle, for not only accepting our invitation to be here today to describe your idea, your legislative proposal, but the clarity in which you have done so. We are legislators. We are lawmakers, and it is incumbent upon us to respect the thinking that goes into each person's proposal, and your thoughtfulness is on display this morning.

I know that two of our colleagues have left, but my kudos to each of you, all five of you. So thank you for spending time with us here this morning, and now you can go on with the rest of your full schedule for the day, and the staff will prepare the table for the second panel of witnesses.

And you can come—let's see. We need to change the name tags at the table so that they know where they are sitting. But can we do that with some sense of timeliness? Who is going to do that on the staff?

All right, let's get to it. Maybe everyone can check their phones while we are waiting.

Mr. BURGESS. Are you expecting a call?

Ms. ESHOO. No, I am not expecting a call, but people like to see what messages they have received.

[Pause.]

Ms. ESHOO. 0K. We are now going to hear from our second panel of witnesses on this all-important issue, and we welcome you. We thank you for making yourselves available to us today.

First, Ms. Sara Rosenbaum. She is a health law and policy professor at the Milken Institute of Public Health at George Washington University. Welcome and thank you to you.

Mr. Peter Morley, patient advocate, thank you to you, and welcome.

Ms. Jean Ross, the president of the National Nurses United, welcome to you.

Dr. Douglas Holtz-Eakin, president of the American Action Forum. It is nice to see you again, and thank you for being here today.

Dr. Scott Atlas, a senior fellow at the Hoover Institution at Stanford University, which I have the privilege of representing, thank you, and it is wonderful to see you again.

So I will now recognize Ms. Rosenbaum for your 5 minutes of testimony, and you can begin. I think you all know what the lighting system—green. When you see the yellow light speed up, because on the heels of the yellow light comes the red light. Welcome, and you may proceed.

STATEMENTS OF SARA ROSENBAUM, HAROLD AND JANE HIRSCH PROFESSOR, HEALTH LAW AND POLICY, GEORGE WASHINGTON UNIVERSITY DEPARTMENT OF HEALTH POLICY AND MANAGEMENT; PETER MORLEY, PATIENT ADVOCATE; JEAN ROSS, R.N., PRESIDENT, NATIONAL NURSES UNITED; DOUGLAS HOLTZ-EAKIN, PH.D., PRESIDENT, AMERICAN ACTION FORUM; AND SCOTT W. ATLAS, M.D., DAVID AND JOAN TRAITEL SENIOR FELLOW, HOOVER INSTITUTION, STANFORD UNIVERSITY

STATEMENT OF SARA ROSENBAUM

Ms. ROSENBAUM. Thank you, Madam Chair and Ranking Member Burgess and members of the subcommittee for this opportunity.

Over the past half century, Congress has pursued various solutions in its effort to insure all Americans, as the limits of what could be achieved through a voluntary employer insurance system became evident, especially for the elderly, the poor and low-income people, and people with disabilities. We have embraced over many years a range of solutions ranging from a single-payer solution in the case of Medicare to efforts to strengthen public and private insurance and expand our largest public health program, Medicaid. Much work remains to be done, and, of course, this work takes place against a backdrop of the highest-cost health system among wealthy nations.

After years of progress, the number of uninsured is growing again, and millions more are underinsured because costs are too high and coverage is too limited. Using an incremental payer approach, the Affordable Care Act accomplished a great deal. Immediately before the law took effect, 44 million people were uninsured. By 2016, the number had dropped 26.7 million. Progress occurred at all income levels and in all States, but especially among lower-income people and, of course, in the ACA's Medicaid expansion States.

Preventive coverage has improved markedly, and coverage has improved for children and adults with disabilities. People with serious health conditions have benefited from the law's essential health benefit rules that broadened coverage and limited out-of-pocket exposure while promoting actuarial value. Fifty-four million Americans have benefited from the protection against preexisting condition exclusions and discriminatory coverage practices. Medicare prescription drug coverage has improved, 2.3 million young adults have coverage through their parents' plans, and community health centers have doubled their capacity.

But now the latest census data show that we are moving backwards. The percentage of uninsured Americans is growing, from 7.9 percent in 2017 to 8.5 percent in 2018. We are up to 27.5 million uninsured children and adults. The Trump administration is championing a lawsuit that could disinsure over 20 million people overnight. Fourteen States remain without the Medicaid expansion, and over 2 million people are caught in this coverage gap, ineligible for Medicaid but too poor for tax subsidies.

Other administration initiatives are aiming to push Medicaid enrollment still lower through block grants, work experiments, and other administration strategies. The administration has targeted

the private insurance reforms under the ACA in order to erode access to higher-value policies in favor of what experts call "junk insurance," while taking constant aim at the law's essential health benefit and affordability provisions.

I think that we face two major challenges, one set in the near term and one set for longer-term discussion, and they are reflected in the amazing range of bills you have before you today and the deeper thinking that has gone on behind those bills. The first is to what I would call "stanch the flow." We need steps to redouble the effort to incentivize the Medicaid expansion where it has not happened and people who depend on subsidized private insurance need more help. The ACA insurance market needs to be stabilized in order to promote affordable coverage. That is an immediate set of needs.

In the longer term, you face bigger decisions, as you well know. What is the best mix of public and private insurance coverage? Do we preserve employer coverage? Do we maintain multiple programs or consolidate various public programs into one major alternative? If we move in this direction, should this program be open to employers and individuals, or just individuals? And should it remain—instead, should we retain multiple public programs with various targeting built in?

How broad should public coverage be? Should it subsume long-term care? Should we use auto-enrollment to cut down on churn? What is the best approach to financing reform? And in order to achieve true health equity, do we need to think beyond coverage itself and also focus on community-level investments in order to ensure accessible healthcare and a broad continuum of health-promoting policies?

Thank you very much for this opportunity.

[The prepared statement of Ms. Rosenbaum follows:]

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Department of Health Policy and Management

STATEMENT OF

SARA ROSENBAUM, J.D.

HAROLD AND JANE HIRSH PROFESSOR, HEALTH LAW AND POLICY

FOUNDING CHAIR, DEPARTMENT OF HEALTH POLICY

BEFORE THE SUBCOMMITTEE ON HEALTH

COMMITTEE ON ENERGY AND COMMERCE

U.S. HOUSE OF REPRESENTATIVES:

PROPOSALS TO ACHIEVE UNIVERSAL HEALTH CARE COVERAGE

DECEMBER 10, 2019

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Introduction

Madame Chair, Ranking Member Burgess, and Members of the Subcommittee:

I am Sara Rosenbaum, Harold and Jane Hirsh Professor of Health Law and Policy at the Milken Institute School of Public Health, George Washington University. Thank you for inviting me to offer testimony at today's important hearing on proposals to achieve universal health coverage.

Progress and Challenges

Over the past half century, Congress has been on a journey to address the question of how to make affordable, high quality health insurance a reality for all Americans. By the mid-1960s, the limits of a voluntary employer-sponsored system -- which by then had risen to dominance through favorable tax treatment and collective bargaining -- were evident. The shortcomings were particularly obvious for the elderly, the poor, and those with disabilities. The ensuing five decades have witnessed a range of tested strategies. Policymakers have taken a single payer approach in the case of Medicare. They have also pursued incremental reforms for targeted populations. These incremental strategies are represented by Medicaid (which straddles the worlds of public insurance and public health and whose flexibility has enabled federal and state policymakers to fashion solutions to major population health challenges) and its companion Children's Health Insurance Program (CHIP). This approach is also reflected in tax policies aimed at addressing the problem of affordability for lower and moderate-income people. All of these reforms have a common goal -- to strengthen the accessibility, affordability, and effectiveness of insurance health insurance for all Americans.

The journey remains far from over. Millions of Americans remain uninsured. Millions more are under-insured because premiums and cost sharing are too high, and coverage is too limited for people with serious and chronic health conditions that require ongoing care. All of this is taking place against a backdrop of the U.S. health system, whose costs are the highest among wealthy nations. Even preventive care and primary care, as well as standard treatments for conditions that can be well managed at low cost, are financially out of reach without reliable, steady health insurance.

Because of what we have been able to accomplish in the decade since passage of the Affordable Care Acct, it is especially important to keep moving forward. What you seek to address through this hearing is your options for doing so, both incremental and sweeping.

What the Affordable Care Act Has Accomplished

As we approach the tenth anniversary of the Affordable Care Act, it is worth taking stock of what has been accomplished using a multi-payer, incremental approach. The major elements of this approach have been creation of a pathway to affordable private insurance, extension of Medicaid to low income adults left out of the traditional program, and crucial market reforms aimed at promoting coverage access and quality.

The ACA's multi-pronged approach has produced lasting, measurable achievements. In 2013, immediately before the ACA's major provisions took effect, 44 million people (16.8 percent of the

nonelderly population) lacked any insurance; by 2016 that figure had dropped to 26.7 million (10.0 percent).[1] Millions have gained coverage. Measurable progress has occurred across all income levels, but especially among low-income people, where the risk of being without insurance historically has been the greatest. Advances have been most significant in those states that elected to expand Medicaid, and they have been at visible across all racial and ethnic groups and all ages.[2]

Coverage has become more comprehensive. Most privately insured families are now guaranteed coverage for their children's ongoing preventive health needs, and all family members qualify for recommended immunizations at no cost. The proportion of women reporting out-of-pocket spending for oral contraceptives has declined from 23.3 percent to 2.7 percent.[3] Those whose coverage is governed by the rules that apply to qualified health plans sold in the individual and small group markets are assured of coverage for mental health and addiction-related services, and parents of children with serious developmental disabilities who are insured through plans meeting these standards have a guarantee of access to habilitative care.

Extensive research has documented the ACA's impact not only on coverage but also on access to care itself. Experts attribute the ACA expansions to a 21 percent and 25 percent decline in the probability of not receiving medical care. The probability of having a usual source of care (a key test of a well-functioning health care system) has grown by between 47.1 and 86.5 percent.[4] The Medicaid expansions have received particular attention, with scores of studies showing measurable impact on health care access, health outcome measures themselves, greater economic stability within community health systems (especially in poorer communities), and increased employability. [5] Some 54 million

[1] Rachel Garfield et al., The Uninsured and the ACA: A Primer (Kaiser Family Foundation, 2019) (Figure 2) http://files.kff.org/attachment/The-Uninsured-and-the-ACA-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-amidst-Changes-to-the-Affordable-Care-Act

[2] Id. Figure 3

[3] Laurie Sobel et al., New Regulations Broadening Employer Exemptions to Contraceptive Coverage: Impact on Women (Kaiser Family Foundation, 2018), https://www.kff.org/health-reform/issue-brief/new-regulations-broadening-employer-exemptions-to-contraceptive-coverage-impact-on-women/

[4] Sherry Glied et al., Effect of the Affordable Care Act on Health Care Access (Commonwealth Fund, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/may/effect-affordable-care-act-health-care-access

[5] Larisa Antonisse et al., The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review (Kaiser Family Foundation, 2019), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/

people (27 percent of the nonelderly population) have benefitted from the law's pre-existing condition protections; in a pre-ACA world, their conditions would have triggered a denial of coverage. [6]

Other ACA investments have yielded notable results. The law's Medicare reforms have improved preventive services coverage and have reduced beneficiaries' financial exposure for out-of-pocket prescription drug costs. Its dependent coverage provisions have enabled 2.3 million young adults to gain insurance. The law's investment in community health centers has enabled health centers to double their sites in medically underserved urban and rural communities while increasing the number of patients served by over 50 percent.[7] Coupled with the Medicaid expansion, the health center investment has given community health centers the financial investment they need to expand their care to include opioid addiction treatment and prevention, expanded oral health care, expanded services for patients with serious and chronic health conditions, and other types of care.[8]

Stalled Progress

Today, however, progress has stalled. Indeed, the nation shows signs of slipping backward. As a result of the United States Supreme Court's 2012 decision in *National Federation of Independent Businesses v Sebelius,* the Medicaid expansion effectively became optional. As a result, 2.5 million people fall into a coverage gap – ineligible for Medicaid but too poor for tax subsidies, whose lower income threshold in non-expansion states sits at 100 percent of the federal poverty level.[9] Beyond the problems created for the poorest people by the Court's decision are aspects of the ACA that need to evolve; the need to improve complex legislation over time is an inevitable part of the lawmaking process. Chief among these are premium and cost-sharing structures that are insufficiently protective, benefits that need to be strengthened, and strategies to inject greater competition into the market for private insurance as a strategy for helping to hold down costs.

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[6] Potential Impact of Texas v. U.S. Decision on Key Provisions of the Affordable Care Act (Kaiser Family Foundation, November 2019), https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/

[7] Sara Rosenbaum et al., Community Health Centers: Growing Importance in a Changing Health Care System (Kaiser Family Foundation, 2018), https://www.kff.org/medicaid/issue-brief/community-health-centers-growing-importance-in-a-changing-health-care-system/

[8] Corinne Lewis et al., The Role of Medicaid Expansion in Care Delivery at Community Health Centers (Commonwealth Fund, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/apr/role-medicaid-expansion-care-delivery-FQHCs

[9] The Uninsured: A Primer, op. cit.

Beyond these follow-on challenges is a need to reverse this administration's systematic efforts to undermine the law. The two most prominent aspects of this effort are its multi-strategy campaign against Medicaid (not just the expansion but traditional populations as well, as evidenced by its embrace of a block grant), as well as its aggressive pursuit of policies that carry serious implications for a stable and affordable risk pool for comprehensive coverage. Since the President assumed office, over 1 million people have dropped individual coverage because of high cost. Experimentation on the poorest people through Medicaid work rules – approved by the Administration without considering its impact on the experimental subjects -- cost over 18,000 people their coverage in one state before the courts stepped in. Leading research in the field concluded that 95 percent of those losing Medicaid coverage in Arkansas – the first experimental state to go live – remained eligible for coverage or exempt from the experiment but lost their benefits in a welter of confusion.[10]

Finally, of course, the ACA did not address the fundamental and underlying cost of health care. These costs have grown so steeply that insurance is now riddled with cost-sharing and coverage limits, and even standard care is out of reach, especially for those who depend on prescription drugs to manage treatable health conditions.

No payer can cope with this problem alone, one driven principally by the price of medical care along with intensity of services. By themselves, these two factors accounted for over 50 percent of the spending increase between 1996 and 2013. Population growth and aging together were minority contributors (slightly less than 35 percent), changes in disease prevalence or incidence contributed only modestly (about 2.4 percent) and changes in utilization did not contribute at all over this time period.[11] Even drugs like insulin that previously cost literally pennies per day are now completely unaffordable.

Surging spending has placed immense strains on public programs and has eroded the level of protection against covered health risks offered by private insurance, including employer plans. Research shows that between 2014 and 2018, the percentage of people reported being underinsured (out-of-pocket health care costs, excluding premiums, that exceed 10 percent of household income) increased from 23 percent to 29 percent. Growth in underinsurance was biggest for those insured through job-based plans – from 20 percent in 2014 to 28 percent in 2018.[12] In 1992 my own employer, George Washington University, offered its employees a workplace health plan that allowed us a wide choice of insurers and provided actuarial value of better than 90 percent. Today GW offers a single plan for workers and their

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[10] Benjamin D. Sommers et al., Medicaid Work Requirements – Results from the First Year in Arkansas New Eng. J. Med (2019) 381:1073-1082

[11] Joseph L. Dielman et al., Factors Associated with Increases in US Health Care Spending, 1996-2013. *JAMA* 2017; 318(17): 1668-1678

[12] Sara R. Collins et al., Health Insurance Coverage Eight Years after the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured (Commonwealth Fund, 2019), https://www.commonwealthfund.org/sites/default/files/2019-02/EMBARGOED_Collins_hlt_ins_coverage_8_years_after_ACA_2018_biennial_survey_sb_v4.pdf

families, whose actuarial value is slightly more than 80 percent value – a better-than ten-percentage point drop in value, with significantly elevated cost sharing.

Furthermore, the percentage of nonelderly insured Americans has declined from its 2016 high. In 2017, 7.9 percent of the total population was uninsured; in 2018, this figure rose to 8.5 percent – 27.5 million people, including children.[13] In addition to rising costs, other factors contributing to this trend and identified by experts have been federal policies that weakened the individual insurance market and that are associated with the departure of over a million people from the individual market. An additional major cause of this drop was a 1.6 million-person decline in Medicaid coverage. A strong economy and better access to employer coverage might explain some of this decline. However, at the same time, this is occurring at a time that the administration has effectively weaponized Medicaid's important Program Integrity safeguards in order to target expansion states and warn non-expansion states of what they can expect should they decide to adopt the expansion.

Continuing Challenges

Even as we make progress, we thus find ourselves in 2019 confronting the same basic set of challenges that led to the enactment of Medicare and Medicaid in 1965, the creation of CHIP, and ultimately the Affordable Care Act in 2010. The first challenge is the absence of a coverage guarantee for all Americans regardless of place of residence, family social or economic circumstances, or other factors unrelated to the need for coverage. Among the more than 27 million uninsured Americans in 2018, three quarters lived in families with one or more full-time workers, and nearly half had incomes below twice poverty. The greatest risk of being completely uninsured is borne by Americans who are members of racial and ethnic minority groups. Moreover, certain states reflect an especially high risk of being uninsured; in 18 states, the uninsured rate continues to exceed 10 percent. Nearly half the uninsured report cost as the single greatest barrier even though more than half are eligible for a subsidy through Medicaid or Marketplace coverage.[14] What to do in states that have not adopted the Medicaid expansion and whose decision has stranded the poorest people in the country represents an especially urgent aspect of the problem.

Should the ACA be overturned as unconstitutional, the number of people without a meaningful coverage pathway will skyrocket. This outcome, which the administration is actively advocating for in the courts, would mean coverage losses for nearly 13 million Medicaid beneficiaries and over 9 million Marketplace enrollees (5.5 million of whom receive marketplace subsidies). Tens of millions would lose the ACA's access and market protections; ending the vital protection against denial of coverage based on preexisting condition would end, affecting an estimated 54 million people who depend on this reform. Several million young adults would stand to lose dependent coverage. Community health

[13] Edward Berchick et al., Health Insurance Coverage in the United States: 2018 (United States Census Bureau, Current Population Reports, P60-267(RV))

[14] The Uninsured and the ACA: A Primer (op. cit.)

centers would face a loss of 70 percent of their grant funding and widespread care reductions would follow.[15]

Beyond the absence of any coverage is the problem of coverage "churn", which produces constant breaks in coverage. This problem disproportionately affects lower income families who are likely to experience more frequent income fluctuations owing to the nature of work and changes in life circumstances that can disrupt insurance enrollment in a nation whose main source of benefits comes from fulltime workplace employment at jobs with good wages. People who experience coverage churn are also likely to experience disruptions in medical care and access to needed drug prescriptions, increased reliance on emergency departments, and worse self-reported quality of care and health.[16]

A third problem is inadequate coverage, reflected in the high proportion of under-insured Americans. However, being under-insured entails more than high cost sharing for covered services; it can also involve the extensive coverage exclusions and limitations – increasingly a tool of insurers along with cost-sharing and narrow networks in order to hold down premium costs. These restrictions and exclusions disproportionately affect children and adults with serious and chronic physical, mental, and developmental disabilities. In modern private insurance products, coverage exclusions are pervasive, especially the use of medical necessity criteria that restrict coverage to patients who can "improve" in insurer parlance, with exclusions applicable to patients who need treatment to maintain functioning or avert functional deterioration. A variation on this problem is prescription drug tiering that places essential drugs out of financial reach, even if ostensibly covered.

High health costs, of course, loom over the challenge of coverage. The cost of care is such a foundational issue that it simply must be tackled if the nation is to move decisively toward coverage universality.

The final issue is one that the ACA grappled with to a certain degree and that over time has commanded increasing attention. This is the problem of health inequity, which strikes not only individuals but entire communities. This set of challenges has many dimensions: community impoverishment and elevated health risks that in turn contribute to deep health care shortages, especially for primary care and basic medical management of treatable conditions. We have only to look at U.S. maternal and infant mortality rates – two of the most sensitive measures of population health – to see a manifestation of these problems. The opioid epidemic is yet another manifestation of the combined effect of widespread poverty and the adverse social conditions that accompany it, combined with an acute shortage of health

[15] Kaiser Family Foundation, Community Health Centers Prepare for Funding Uncertainty (September 2019), https://www.kff.org/medicaid/issue-brief/community-health-centers-prepare-for-funding-uncertainty/

[16] Benjamin D. Sommers et al., Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many

care. These problems are now so bad that we are actually witnessing rising mortality among nonelderly adults and declining life expectancy. In rural communities, the health care system is literally collapsing.

Certainly moving to universal coverage would help stabilize health care systems and provide badly needed resources for hospitals, physicians and clinics, all of which face overwhelming survival odds stacked against them in communities with badly elevated rates of uninsured people. But direct economic investment is also necessary to support the modernization of regional health systems weakened by years of neglect. National health reform needs to include approaches that complement insurance expansions, such as direct investments in health care infrastructure necessary to modernizing rural hospitals, creation of new primary care access points, and continuation of past, highly successful investments in community health centers, teaching health centers, and the National Health Service Corps. New care models must be designed to take advantage of major strides in communication technology that enable good quality care even in remote areas. Also essential are regional-level public health investments that assist communities, working with public health agencies and health care and social service providers, in tackling community-wide health problems whose solution lies in better coordination across health care, public health, education, job development, and social service systems.

The Proposals Before this Subcommittee

This hearing represents an important effort by this Subcommittee to begin serious consideration of its options. The bills under consideration today differ from one another in important ways. All, in my view, represent steps forward. The central legislative and political question lawmakers face is how broadly to aim.

Should Congress take a sweeping approach that essentially replaces the multi-payer system with one that operates under strong, uniform standards of federal design and program administration as is the case with Medicare? If so, should the shift happen in the relative near term (within a few years) or only over a lengthier phase-in period? Alternatively, should lawmakers pursue a more incremental approach designed to address the important but discrete and specific challenges that tend to arise a multi-payer system but at the same time, doing so in a more coordinated fashion? What tools should be introduced that can hold down costs in multi-payer markets? Moreover, should one of those tools include competition by a public insurer?

Medicaid poses separate questions in my view. A key one is whether Medicaid should be preserved because of its programmatic uniqueness and flexibility. If Congress proceeds with a public option, what flexibilities should states have to merge Medicaid into a larger public program, and if so, for what populations and for what services? Must Medicaid be retained to carry out public health functions that traditional insurance – public or private – simply cannot be expected to play, such as coverage whenever care is needed, retroactive eligibility, and the ability to flexibly expand to meet new needs? Moreover, should Congress assure that all poor Americans have a guaranteed pathway to coverage regardless of the Medicaid expansion choice their state of residence might make?

Finally, is investment in stabilizing and strengthening the health care system in medically underserved communities to be viewed as integral to any reform effort? Furthermore, should health care itself be

viewed as part of a larger health and social welfare enterprise, in which health care systems work with other community programs and providers, not just as clinicians, but as public health and social actors?

These are the enormous issues that this Subcommittee -- and Congress as a whole -- will need to confront in the coming years.

I welcome questions.

Ms. ESHOO. Thank you. It is so wonderful to have people widen the lens.

Welcome again and thank you, Mr. Morley. You have 5 minutes to offer your testimony.

STATEMENT OF PETER MORLEY

Mr. MORLEY. Sorry, OK. Sorry.

Thank you, Chairwoman Eshoo, Ranking Member Burgess, and members of the subcommittee. I am honored to speak with you today on my 28th trip to DC since July 2017 to fight for healthcare.

My name is Peter Morley. In 1997, I had an injury during a lapse of insurance coverage. All treatment and medication costs were paid out of my own pocket. When I later needed surgery, my insurance company considered my injury to be a preexisting condition and my claims were denied. It was a financial burden totaling in tens of thousands of dollars. In 2007, I was permanently disabled from an accident. I was spared the costly medical bills of four spinal surgeries because I had continuous health coverage.

In 2011, I survived kidney cancer and fought my way into remission after losing part of my right kidney. In 2013, I was diagnosed with lupus, which causes me severe fatigue, and most days it is a struggle to get out of bed. I now manage over 10 preexisting conditions, take 38 different medications, and receive 12 biologic infusions to slow the progression of my disease. I live on the brink of financial ruin and only live modestly thanks to insurance and the fact that I can't be discriminated against because of a preexisting condition.

Preexisting conditions are a way of life as well as millions of others. Most people like me with chronic diseases can live happy and productive lives, but only if we are provided access to health insurance that can't be taken away from us because an insurance company decides it is in their best interest not to cover something, or if Congress decides to repeal our insurance, or if the Trump administration sabotages and refuses to defend the Affordable Care Act.

As someone who spends the majority of my waking hours in doctors' offices, the ACA has meant focusing on healing, not bankruptcy. I did not ask to be chronically ill. I used to be very private about my health, but once President Trump was elected and set to repeal the ACA, I could no longer be silent. In December 2016, I decided to foster awareness for lupus and advocate for healthcare. My congresswoman, Carolyn Maloney, has taken up my cause and those of people like me. In the last 2½ years, I have traveled to DC 27 times. I have collected the healthcare stories of thousands of people who shared their personal stories and concerns with me. I have held over 350 meetings with Democratic and Republican Members of Congress alike. Many of you actually sit here in front of me today.

My message is simple. If you think people don't get hurt when this administration doesn't defend the ACA, think again. We do. I do. Millions do. And if you think preexisting condition protections are not important, remember, someone you love could have an accident, be diagnosed with cancer or lupus at any time, and that will change how you think about this. I know firsthand your healthcare can change in an instant.

This past July, I testified for the late Congressman Elijah Cummings. He thanked me for taking my pain, turning it into a passion to do my purpose. I will never forget those words. So, today, in the spirit of our beloved Congressman, I have an ask of this entire subcommittee. Please work together to make healthcare of all Americans your passion.

I put my health at great risk to travel here and share these stories. I never know if this is the last time I am healthy enough to come to DC. But I am here today to ask you to protect the ACA so we can enhance it and move towards universal health insurance for all Americans. Thank you for allowing me the opportunity to testify, and I am happy to answer your questions.

[The prepared statement of Mr. Morley follows:]

Proposals to Achieve Universal Health Care Coverage
Tuesday, December 10, 2019 10AM
Subcommittee on Health of the Committee on Energy and Commerce
Room 2322 – Rayburn House Office Building

STATEMENT OF PETER MORLEY – DISABLED PATIENT AND PATIENT ADVOCATE

Thank you, Chairwoman Eshoo, Ranking Member Burgess and Members of the Committee, I am honored to be here to speak with you today regarding Proposals to Achieve Universal Health Care Coverage.

My name is Peter Morley. I live in New York City. I appreciate the opportunity to share my personal healthcare journey with you. In 1997, I had an injury during a lapse of insurance coverage. The costs of my physical therapy, epidural steroid injections, and medications were paid out of my own pocket. Consequently, when I needed surgery after securing health insurance at a new employer, my injury was considered a pre-existing condition and all my claims were denied for the procedure. It was an incredible financial burden for years; totaling in tens of thousands of dollars.

In 2007, I was permanently disabled from a fall off a ladder and unable to work, I was fortunate to be spared the entire cost of my medical bills because I had continuous insurance coverage. Since then, I have had 10 surgeries in 12 years, including 4 spinal surgeries (3 of which are failed spinal fusions; the last one caused irreversible nerve damage); I was subsequently diagnosed through an incidental finding with kidney cancer in 2011 and lost part of my right kidney, but I fought my way into remission in

2016; I have had 2 neurosurgeries for benign pituitary tumors; 2 carpal tunnel surgeries; and one surgery to remove a malignant melanoma.

In addition, I have had diagnoses over the last 12 years that have catapulted me well-above 10 pre-existing conditions including but not limited to: Spinal Fusion Failure; Chronic Neuropathic Pain; Degenerative Disc Disease in both my cervical and lumbar spine; Renal Cell Carcinoma; BPH; Osteoporosis; Angiomyolipoma on my left kidney; Fibromyalgia; Sjogren's Syndrome; Raynaud's Phenomenon; Small Fiber Neuropathy; Nodular Regenerative Hyperplasia (non-cirrhotic Liver Disease) w/Portal Hypertension and Obliterative Portal Venopathy; and Adhesive Arachnoiditis (which there is no cure or successful treatment, and I am progressively losing the function of my right leg as it becomes paralyzed).

In 2013, I was diagnosed with what has become my primary health concern to-date: Lupus, which is an autoimmune disease when activated, creates autoantibodies that attack not only an invading infection, but will turn and continue to destroy healthy cells and organs, thus causing inflammation known as a Lupus flare. Therefore, I must be checked frequently by my rheumatologist. Lupus has a multitude of side-effects, but for me, the most challenging is the chronic fatigue that I fight every day. It is a struggle and challenge to get out of bed every single day.

I take 25 different medications daily, 38 yearly, and receive 12 lifesaving infusions yearly for my Lupus. Without access to insurance, I could not afford to pay for these medications and would lose access to my team of doctors. As a result, my disease would progress, and I would die.

Despite all my health challenges, I have flourished by the continuity of care provided to me by the 17 doctors I see on a monthly, quarterly, semi-annual and annual basis. Depending on the week, I spend about 60-70% of my waking moments in doctors' offices. And as someone who has faced my own mortality on more than one occasion, I am grateful to be here. I know how first-hand how essential it is to protect our care. I also realize that due to my advancing diagnoses I am thankful and appreciative for every day.

In December 2016, shortly after President Trump's election, I joined Twitter and created the handle @morethanmySLE with the goal of fostering awareness of men who have Lupus. My account gave me visibility that led me to work with my U.S. Congresswoman, Carolyn Maloney to advocate for healthcare that is accessible and affordable to people with Lupus and other chronic illnesses.

I want you to know that I was a very private person prior to the 2016 election, but once President Trump was elected, I realized I could no longer keep quiet. I had to in good conscience do something to promote healthcare advocacy and empowerment. I recognized that meant I had to share the very personal details of my own story on social media. There are people in my life that were not aware I had kidney cancer or Lupus and have found out through Twitter -- that's how guarded I was. But listening to President Trump's campaign rhetoric for 18 months caused me incredible stress and motivated me to speak my truth.

In the last two years, I have traveled to DC twenty-seven times to advocate not only for myself, but for thousands of people who have reached out to me through Twitter and my website, morethanmySLE.com. These are only three of the thousands of stories

people have shared with me who have benefited from the ACA. They have given their permission and consent to share their own personal stories of how the Affordable Care Act has helped them:

PATIENT STORIES:

Ben Jackson, Natick, MA, father to Emma Jackson: "Emma Jackson is a 17-year-old girl who has spent almost half of the last 5 years hospitalized. Without Medicaid, we would be bankrupted by hospital costs alone, and that does not take into account durable medical equipment, outpatient services, or medications. In addition, Emma would be forced to live only in States who choose to offer robust Medicaid programs. She would be denied the fundamental freedom of choosing where to live. She is about to become an adult, and her entire financial future will be ruined the day she turns 18 if she lost access to Medicaid."

Gloria Palencar, Sykesville, MD: "The ACA saved my life 4 years ago when I became very ill. I went to the ER in excruciating pain and the moment I stated I didn't have health insurance I was no doubt placed at the bottom of the priority list. After going to a public clinic, they advised me to apply for the ACA and qualified for Medicaid. I had gallbladder surgery and recovered. A year later I visited the ER 5 times in 7 days because the ER doctors kept discharging me without a diagnosis for the severe gastrointestinal symptoms. Thanks to having ACA health insurance, I was eventually diagnosed and properly treated. My children still have a mother thanks to the ACA.

The pre-existing conditions coverage under the ACA is keeping my younger sister alive after years of weekly chemotherapy for what now appears an incurable rare condition. I

plead with you to work to ensure American citizens like my sister will not lose their health insurance due to a pre-existing condition. A few weeks ago, the ACA saved my premature grand nephew's life. He received all the medical care he needed while his parents couldn't work."

Mina R. Schultz, Washington, D.C.: "When I was 25, I was finishing my graduate program at the University of Missouri and preparing to enter the Peace Corps. I had student insurance, but it would end upon graduation, and I would have about 9 months without coverage before my Peace Corps service began. I didn't give it much thought; I was young, healthy, didn't go to the doctor much. I would just go without coverage for a few months, no problem. My parents foresaw the gap in coverage and told me about a new law that would allow me to stay on their coverage until I turned 26. I said, sure, sign me up. It didn't really matter to me, but why not? So, I joined their plan. The pain started in April 2011, about a month before graduation. I wrapped my knee, iced it, and took a break from running for a while so it would heal. I walked the stage with a wrapped knee and a limp. After graduation I was planning on taking a temporary job in rural Montana, to pay the bills until my Peace Corps service started. I was still having pain, and not wanting to end up in the middle of nowhere Montana with a torn ligament, I scheduled an MRI. I will never forget the MRI techs telling me, "You'll be glad you came in." I was sure I had torn something. I was on my parents' insurance at the time. I will never forget the phone call, when the doctor said, "Ms. Schultz, it appears you have a tumor." I called my mom and asked her to come home from work. I cried for days because I was scared to die. The tumor was osteosarcoma, an aggressive bone cancer usually found in children and adolescents. I endured 5 surgeries, including a

total knee replacement, and 9 rounds of chemotherapy (each involving 3 doses of chemo, so 27 doses all together) over the course of a year. Most of my treatment was inpatient, though I also received at-home physical therapy and IV services. Just one of my post-chemo injections cost thousands of dollars. My knee surgery cost almost as much as my mother's house. In January 2012, my port, through which I received my chemotherapy, became infected. During this time, I regained consciousness for a bit and realized my mother was present in my hospital room. She was there because the doctors didn't think I was going to make it. But I did. I beat it. And because I had taken that insurance, most of my treatment was covered, and my family avoided bankruptcy. I would not have qualified for charity care. I don't know how we would have afforded my lifesaving treatment had I chosen to forgo coverage because I was 25 and thought I was healthy. I think about it every day. Today I depend on medical services to keep up my good health so that I can work and advocate. I'm proud to have just finished my second Master's, this time in Public Health. I have four chronic conditions that I must control and monitor with medications and lab work. I also need yearly scans to make sure my cancer doesn't come back and that my extensive knee hardware is functioning. Without these services, I could die. I depend on many of the 10 essential health benefits, as well as the pre-existing conditions protections provided to me by the Affordable Care Act. The ACA not only saved my life, it keeps me alive. I could not afford my health care without access to insurance. Please protect my care so I can continue to work and contribute to my community."

My Personal Story of Advocacy:

I was inspired to make that first trip to Washington, D.C., on July 27, 2017 the day of the Vote-a-Rama in the Senate for the "Skinny Repeal". Mostly because I felt helpless sitting at home waiting for the outcome, which seemed likely to be that the ACA was doomed. I also happened to watch then Energy and Commerce Subcommittee on Health Ranking Member, Gene Green on July 25, 2017 on C-SPAN use his one-minute on the floor to say, "recently we learned the Trump Administration has diverted taxpayer funds allocated for the enrollment of the Affordable Care Act. Activities to create a social media video's content claiming the Affordable Care Act is failing, a deliberate act of sabotage. Instead of making sure that Americans remain healthy and improve the risk pools the HHS is peddling misleading online propaganda to discourage enrollment in health insurance." This was happening at a time when the Kaiser Family Foundation published reports that the ACA markets had stabilized, and polling showed over 50% of the American people were in support of the ACA. The Congressman went on to say: "The President has repeatedly declared that he would let the ACA fail just to score political points. It's unbelievable that a sitting President would wish catastrophic harm on his own people but unfortunately that's what is happening. Colleagues, the ACA is not failing on its own, it's being actively sabotaged by the President and our Republican Congress. The administration has repeatedly wavered in its responsibility to administer cost-sharing reduction payments, relaxed enforcement of the insurance mandate, and refused to help state governments shore-up their own healthcare exchanges. The majority and the Trump Administration should quit playing politics with our healthcare system."

I was outraged by Congressman Green's recitation of the facts, and I was even more aghast that there wasn't a collective gasp from the House. What I heard the Congressman say sounded criminal, illegal, and extremely personal to me. So, I booked a 3:25am Amtrak train for the morning of 7/27/17 and with two meetings set before I arrived, I walked in and out of every Senate office I could and spoke with anyone who would listen, Democrat and Republican alike. The very last office I visited was Senator McCain's office at around 5:15pm. I'd gone to his office twice before that day, and his staffers kept telling me to come back so I did. I knew how important his vote was. On the train ride down, I kept thinking if anyone would listen, it would be him. On the third try, is when I spoke with one of his staffers. I shared my story about my healthcare fight and told her I had Lupus and she burst into tears. She shared with me her story, about her best friend who also had Lupus. I had seen some emotional responses that day, but I hadn't seen one like this. I paused and asked, 'Are you okay?' She said, 'I'm sorry. My best friend worked here in D.C. and she suffers from Lupus as well and had to move to a climate more conducive to her Lupus. And you sharing your story just reminds me of her and her struggle.' I asked how her friend was doing and she said she doesn't have the same resources she had here in D.C.

I gave her some info about a hotline number that could help her friend so she could have access to care and therapy wherever she was. The assistant was so grateful. She said, 'I'm here to listen to you. You're not here to listen to me.' And I told her it works both ways. The entire exchange was very symbiotic. There was a lot of empathy. I asked her to please ask Senator McCain to reconsider and vote 'no.' I begged her and told her there were so many people who would suffer.

Ultimately, I felt a calling on that day. I had felt that magnetic pull to D.C. I'd never been here in this city before that day, but I knew it was where I needed to be. On my way home I got dinner at Union Station. Strangers were talking to me out of the blue, everybody was on edge because of the vote. I'd spent the day sharing my story with anyone who would listen. I wanted to feel like I did everything in my power to stop the repeal. I gave 150% that day. I had a mission, and I felt I had done all I could. I woke up in the morning and somehow managed to get out of bed with my body ravaged by the energy I expended and the chronic fatigue from my Lupus had been triggered. I fully expected to turn on the TV and learn that the ACA had been repealed.

Instead, I saw an image of John McCain giving the vote a thumb's down and I couldn't believe what I was looking at. People began sharing their stories with me and asking me to represent them in D.C. This is my twenty-eighth trip, since July 2017. I have held over 350 meetings. I have met with Representatives and Senators' staff of both parties to share these healthcare journeys: because healthcare is a bipartisan issue. In fact, I spent January 8, 2018 in the House for sixteen meetings and met with mostly Republican offices.

People have told me because of the December 14, 2018 Federal Ruling in the Texas v. United States case that declared the entire ACA unconstitutional, that they feel alone, scared, and afraid, when they should be focusing their energy on their own well-being. The truth is, we all know someone who has been helped by the ACA. I know firsthand that your health can change in an instant. That is why I fight for my life for those who will be left vulnerable if they lose their healthcare. I will continue to use my voice and encourage people to call their state and federal policy makers, because being

proactive is empowering. No one should ever have to worry about having their healthcare taken away from them, simply because they became ill!

President Trump's desire to repeal and replace the Affordable Care Act (AKA "Obamacare") and all the protections that it comprises -- such as barring discrimination against those with pre-existing conditions and allowing children to continue to be covered under their parents' plan through age 26 -- horrifies me. From his campaign to the inauguration, I have witnessed the unrelenting attacks on the ACA in ways that are tantamount to writing prescriptions with purposeful, harmful side-effects, including but not limited to: an Executive Order on day one allowing dismantling of the ACA 'to the maximum extent permitted by law.'"; shortening Open Enrollment; slashing ACA advertising and navigator budgets; not enforcing and then repealing the individual mandate; withholding cost-sharing reduction (CSR) subsidy payments to insurers, thereby threatening the stability of the individual insurance marketplace; HHS stopping staff in its regional offices from participating in insurance enrollment events; allowing employers to opt-out of covering contraception based on moral or religious objections and potentially affecting 62 million women; allowing states to implement Medicaid work requirements, which have resulted in a loss of 17,000 people having access to care in Arkansas; proposing rules to expand the use of short-term "junk" insurance plans as an alternative to plans under the ACA, exposing consumers to coverage gaps and higher costs; The Department of Justice (DOJ) filing a legal brief declining to defend the constitutionality of the ACA in a suit brought by 20 states; and the Labor Department issuing rules to increase enrollment in association health plans (AHPs) that lack ACA

coverage requirements. (These rules would also allow insurers to charge higher rates for older people or based on gender or occupation.)

I lay awake at night worried about the more than 130 million Americans with pre-existing conditions who would lose their protections if the Texas v. United States court case ruling is upheld. Losing access to healthcare means different things to everyone. For many people I know with Lupus that are protect by the Affordable Care Act, it would mean losing access to continuity of care, not affording prescriptions, and infusions that are keeping them alive.

Due to the chronic fatigue that Lupus causes and my other diagnoses, I put my own health at great risk to travel and share these stories with you. I frequently schedule mass meetings because I never know if this will be the last time, I will be healthy enough to travel here. But having the opportunity to speak to legislators where there might be one who will listen to me and could change their mind, is the reason I keep coming back here. It energizes me and has given me a new sense of purpose in my life.

Before the ACA guaranteed health insurance coverage to those with pre-existing conditions, many people like myself with Lupus and my multitude of diagnoses could be denied health insurance policies by many providers. The ACA defined what benefits insurers would be required to include in order to enroll consumers in "health insurance" products (including Medicare and Medicaid). It's important to understand what it was supposed to do. Before the ACA was passed, each insurance company had different restrictions as to what services it would cover, at what premium cost, and from what providers. Someone at the company would then review each claim and decide what to pay. Standardization of options was intended to reduce non-medical administrative

costs and make insurance more affordable. I think we can all agree that the ACA is not perfect and could greatly benefit from being enhanced. We need to return to the intent to cover 10 "essential health benefits," including preventive (wellness exams, colonoscopies, mammograms, chronic disease management, etc.); doctor visits, surgery, and hospital stays; outpatient care; maternity (including pregnancy and newborn care); mental health (including substance abuse); lab services; prescription drugs; emergency services; pediatric (including children's dental and vision care); and rehabilitative care. And most importantly improve accessible and affordability for everyone, which includes lowering premiums, deductibles and drug costs.

I'm here today to ask you, on my twenty-eighth trip to DC, to not only protect the Affordable Care Act, but to enhance it. I believe it's an opportunity for us all to work together to build on its foundation as a pathway to Universal Coverage.

As a patient, I have often found myself holding my breath and worrying about such things as Texas v. United States, which would strike down and reverse the health care and protections of millions of Americans. I believe I speak for all patients when I say we need a life of focusing our energy on our health without the stress of inability to access or our current protections being ripped away from me. Thank you for allowing me the opportunity to testify, for making my voice heard, and for hearing the voices of the thousands of others I have advocated for in the last two-and-a-half years throughout Congress.

Ms. ESHOO. What an honor to have you here. Thank you for your courage and your tenacity. It really is an honor to have you here, and we are going to do everything to help keep you healthy. And I will never forget your testimony and your words, just as you will never forget our late Elijah Cummings.

And now it is a pleasure to recognize Ms. Jean Ross, the president of the National Nurses United, for your 5 minutes of testimony. Thank you again for being here and for what you will say, so you are recognized.

STATEMENT OF JEAN ROSS

Ms. ROSS. Good morning and thank you, Chairwoman Eshoo, Ranking Member Burgess, and members of the subcommittee for inviting me to testify today. My name is Jean Ross. I have been a registered nurse in Arizona for 45 years, and I am president of National Nurses United, the largest union representing bedside nurses in the United States, with over 150,000 members.

In my testimony today, I want to illustrate two main points. First, our current patchwork system of public programs and private for-profit insurers is ineffective, inefficient, and financially unsustainable. Second, the only way we can guarantee every person living in this country receives the care they need is by adopting a single-payer Medicare for All system. Every day, nurses witness the failure of our current health system. I have watched as patients don't seek the care they need because they can't afford their copays or deductibles or don't have insurance. I have watched as insurers refused to cover the care that my patients need.

Over many years, I cared for countless patients who showed up in the ER with severe illnesses only because they could not afford preventive care. One patient always stands out to me. He arrived in the ER in a hypertensive crisis. We treated him for an imminent stroke. I learned he was rationing his blood pressure medication. Instead of taking it every day as prescribed, he was taking it every 2 days. He knew he needed to take those pills daily, but he could not afford the medication even with his private insurance plan.

As a nurse I have so many stories like this, but I am also a mother and a grandmother, and this broken system has affected my family too. My son, Tony, suffers from a leaky heart valve. For the past 15 years he has been consistently unable to afford the cardiology care he needs, so he just doesn't see his cardiologist. As a nurse, I know that this valve could lead to heart failure. As his mother, I live with the constant fear this could happen to my son because the health system I work in is failing him.

My daughter is a single parent, and she struggled to pay the copays for my grandchildren's care. When my grandson, Evan, was an infant, my daughter called me because he was sick, she wanted my advice as a nurse. She didn't have the money to take him to the doctor. I told her I would pay the copay because I knew that Evan needed immediate attention, medical attention, now. Indeed, he was suffering from encephalitis, which is an inflammation of the brain, which can cause permanent brain damage and even death. I am so grateful that I had the economic resources to help, because if I hadn't, like so many other patients who don't have the means, Evan would have been in severe trouble.

As a grandmother, I want to leave my grandchildren with a country where healthcare is a right, where they know when they or their children get sick, they will only have to worry about their health and not the cost. As a nurse for 45 years, I know these stories are not unique. Thirty million people have no health insurance, an additional forty-four million people are underinsured, yet the U.S. spends more money on healthcare per capita than any other nation in the world.

But despite paying top dollar for our healthcare, we get poor results. Our country ranks poorly on many international health indicators, including average life expectancy, infant and maternal mortality, and death from preventable diseases. High cost and poor health outcomes persist because access to insurance is not the same as guaranteed healthcare for all.

This brings me to my second point. Single-payer Medicare for All is the only way we can guarantee healthcare while also reducing the amount of money we spend on healthcare overall. Under Medicare for All, we will transform our profit-driven health system—insurance system—into a healthcare system, one that prioritizes patient care. Everyone will receive quality, comprehensive, therapeutic care without any financial barriers. With Medicare for All, doctors and nurses will be able to provide care based on our professional judgment without insurance company interference. We will have better patient outcomes, and we will save money too.

As you consider different options to improve our health system, I encourage you to consider the following questions. Will this proposal guarantee safe, therapeutic healthcare to every person in the country regardless of their ability to pay? Will it allow people to get healthcare independent of where they work or if they have a job? Will it reduce administrative complexity and waste in the system and control costs?

There is only one bill before the subcommittee today that will achieve all of these things, H.R. 1384, the Medicare for All Act of 2019, authored by Congresswomen Jayapal and Dingell. The primary responsibility of a registered nurse is to protect the health and well-being of her patients. In my professional judgment, the only way we can put our patients first, as we are ethically and morally bound to do, is through Medicare for All. I urge every Member of Congress to support H.R. 1384. Thank you. 1A[1]

Ms. ESHOO. Thank you, Ms. Ross.

It is now a pleasure to recognize Dr. Holtz-Eakin, who is—you are recognized for your 5 minutes of testimony, and thank you again for joining us today.

STATEMENT OF DOUGLAS HOLTZ-EAKIN, PH.D.

Mr. HOLTZ-EAKIN. Chairwoman Eshoo, Ranking Member Burgess, and members of the committee, thank you for the privilege of being here today to discuss these proposals for progress towards universal coverage, which is, indeed, a very important goal for the United States. The proposals fall into two broad categories, as you have heard. Some are like Medicare for All, sweeping single-payer

[1] Ms. Ross' statement has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF14/20191210/110313/HHRG-116-IF14-Wstate-RossJ-20191210.pdf.

reforms which would cover everybody in the United States, and then a series of more targeted reforms that take the character of Medicare buy-ins, Medicaid buy-ins, and then public options, and I want to discuss them in turn.

The proposal for Medicare for All is a truly sweeping reform unlike any single-payer elsewhere on the globe. Other single-payers do not ban private insurance, indeed, often supplement it; do not eliminate a role for regions and States, but often rely on them to deliver their healthcare and their insurance. They don't eliminate copays and other incentives for individuals to utilize care effectively. And in one case, Britain, they actually own and operate the hospitals. In this case, that no such thing goes on.

So this is not something where you can say we are going to get something that looks like something elsewhere in the world. This is like nothing else that has ever been proposed, and it has embodied in it, inevitably, some serious tradeoffs. Among them will be the tradeoff between covering folks in this manner and access to care and the quality of that care.

In the data, it is quite clear that, as hospitals try to reach higher-quality goals, they can be more successful the larger the fraction of commercial payers they have in their patient base. That relationship between the rate of reimbursement and the quality of the care is quite strong and important in the research. These proposals would diminish the rate of reimbursement for hospitals and thus would inevitably degrade the quality of that care.

In the extreme, one would worry that the reimbursements would be so low that hospitals could not actually be able to remain open and thus diminish access to care entirely, which is obviously counter to the basic intention, but it is something that needs to be dealt with in these proposals. The easiest way to deal with it, of course, is to reimburse at higher rates, but that is going to be extraordinarily expensive. As proposed, the Medicare for All is on the order of 30 trillion expense, or 32, 35, get in that ballpark. To give you a flavor for what that means as a matter of public finances, if you were to finance that in the traditional fashion of Medicare with a payroll tax, you would need to have a 21-percentage point increase in the payroll tax, according to a Heritage Foundation study.

And in doing that, the additional payroll taxes would outweigh the savings and health premiums for two-thirds of American households, so they would financially be worse off by the imposition of this proposal. And to what end? The goal, obviously, is universal coverage, but if you look at the 30 million-odd uninsured individuals in America, half of them are already eligible for an important public program, the ACA, Medicaid, or CHIP. Others are turning down an offer for employer-sponsored insurance. They have been offered that.

Indeed, if you can identify the group that, really, you might be able to get, it is about two and a half million individuals who are relatively low income and did not reside in a Medicaid expansion State. Is it worth overturning the enormous heterogeneity and rich complexity of the U.S. healthcare system for two and a half million individuals? There has got to be a better way to do that.

Some of the other approaches are more targeted. So, for example, there is a Medicare buy-in proposal that you heard Congressman Higgins describe. We have taken a look at that at the American Action Forum, the think tank that I run, and in our estimate that bill would get about 293,000 Americans to buy a Medicare buy-in the first year. By the end of 10 years, it will be down to about 170, 187,000 individuals.

To the extent that there are increases in coverage from that bill, it comes from adding additional funding to the existing ACA channels. But even with $180 billion in additional Federal money, total coverage only rises by about 500,000 individuals. So we have these two approaches, a sweeping turnover of the American healthcare system to little gain, and some approaches that are targeted but probably not very effective.

And so, I would encourage the committee to continue to search for ways to get to universal coverage, but these don't appear to be the way to go. I thank you and look for the chance to answer your questions.

[The prepared statement of Mr. Holtz-Eakin follows:]

Testimony Regarding:
"Proposals to Achieve Universal Health Care Coverage"

U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

Douglas Holtz-Eakin, President*
American Action Forum

December 10, 2019

*The views expressed here are my own and not those of the American Action Forum. I thank Christopher Holt and Andrew Strohman for their assistance.

Chairwoman Eshoo, Ranking Member Burgess, and members of the committee, thank you for the opportunity to testify today on the subject of proposals to expand insurance coverage. You have before you a number of legislative proposals aimed at expanding insurance coverage ranging from a single-payer "Medicare for All" system, to expanding access to Medicare and variations on the concept of a public option plan. While I will not go into each proposal in detail, I believe they can be organized into two general categories.

1. The first category is made up of proposals like H.R. 1384, the "Medicare for All Act of 2019." Medicare for All proposals would seek to achieve universal health insurance coverage by replacing the entire United States health care system with a single-payer, government-financed and managed health care system.

2. The second category—which includes the majority of the proposals before the committee today—encompasses proposals that can be described as short of Medicare for All. These proposals would not aim to achieve universal coverage directly but would instead attempt to make marginal gains in coverage rates through the establishment of new, or expansion of existing, federal insurance programs. These proposals appear mostly intended to serve as stepping stones to an eventual single-payer approach.

I believe both approaches are flawed. Medicare for All would be one of the most disruptive policy undertakings in our nation's history, both in terms of the health care system and the wider economic impacts. Further, I do not believe the tradeoffs in terms of access and quality of care, inherent in such a transition, have been adequately considered. Finally, the costs of financing such a system would be substantial, and the incentives could well exacerbate rising health care costs.

As for those proposals short of Medicare for All, they typically would spend a great deal of money to achieve minimal increases in coverage because they are not targeting the portion of the population that lacks coverage options.

Let me discuss each of these categories and their pitfalls further.

Medicare for All: Considering the Implications

First, Medicare for All would be incredibly disruptive. Disruption in and of itself is not always a bad thing, but it is an important factor to consider in setting policy. A key characteristic of our country and our health care system is phenomenal diversity. There are for-profit and not-for-profit providers, clinics and large hospitals, large multi-specialty practices and sole-practitioners, huge differences in population health across the country, and both state and federal regulations. As a result it would be extremely complicated to implement a one-size fits all approach, and such an approach would almost certainly have unforeseen ripple effects.

Second, coverage expansion under a Medicare for All system would come with tradeoffs. You will invariably sacrifice some quality and some access in exchange for government

control and universal coverage. Dr. Craig Garthwaite of Northwestern University's Kellogg School of Business has done some excellent work in this area. He argues that hospitals make investments in improving quality when they believe they will able to recoup that investment from private payers, even when such investments decrease their margin on care provided to Medicare recipients whose payment rates will not change to reflect the quality of care being provided.[1] One can extrapolate that a hospital with a disproportionate share of Medicare beneficiaries and fewer privately insured patients will be less inclined to make investments that they are unlikely to be able to recoup. While the exact payment rates under a Medicare for All proposal are unclear, if one objective is to control health care spending it would follow that rates would be set close to, or at, current Medicare reimbursement rates. Dr. Garthwaite argues that under a scenario where the government paid Medicare rates for all patients, hospitals would make fewer investments in quality, concluding "The decline in overall quality in exchange for expanded coverage and reduced prices might be an optimal decision from the view of society. This, however, is the ultimately the debate that we should be having."

More broadly, a federally run system will need to constrain costs, whether those cost reductions come from lower investment in improved quality, lower overall medical innovation (including the area of pharmaceuticals), fewer providers due to lower reimbursements, or all of the above. There will be trade-offs around quality of care and access to care of varying degrees, depending on the specifics of the proposal. Further, expansion of coverage will only exacerbate demands on the system, impacting access to care more.

Third, the cost of a Medicare for All, single-payer system would be high. Assuming rates close to Medicare reimbursement, the Urban Institute has estimated that the Medicare for All legislation from Senator Bernie Sanders would cost roughly $32 trillion.[2] AAF's Center for Health and Economy modeled the Sanders proposal in 2016 and showed a ten-year cost between $34.67 trillion and $47.55 trillion, depending on the generosity of the plan's benefits.[3] A Medicare for All system would almost certainly end up being a fee-for-service system because it's simply easier to pay providers for services. Any attempt to do otherwise could well cut into any anticipated administrative cost savings. Additionally, any increase in rates to mitigate the aforementioned tradeoffs would necessarily increase the cost of the program. Financing such a program would require substantial tax increases.

In fact, recently published research by the Heritage Foundation found that funding Medicare for All at a cost of $2.387 trillion in 2020 "would require additional payroll taxes equal to 21.2 percent of all wage and salary income." That rate is in addition to current taxes. They further determined that most American households would pay more in new taxes than they would save by no longer paying for their health care. According to the research, 65.5 percent of all households and 73.5 percent of the total population would pay more in taxes than they otherwise would have spent on health care services, making them worse off financially under a Medicare for All system.[4]

The irony is that most uninsured Americans already have access to federally subsidized insurance programs. According to the Kaiser Family Foundation, of the 27.4 million individuals who were without insurance coverage for some portion of 2017, 8.2 million were eligible for premium tax credits for coverage through the Affordable Care Act's (ACA) individual market exchange but did not elect to sign up. Another 4.4 million adults and 2.4 million children were eligible for Medicaid or other public insurance programs but not enrolled. Additionally, 3.8 million individuals declined an offer of employer-sponsored insurance, and 1.9 million individuals had incomes above 400 percent of the federal poverty level (FPL) making them ineligible for subsidies. There were also 4.1 million immigrants who did not qualify for public assistance because of their undocumented status. It is not clear that a single-payer system would necessarily cover these individuals either.

Finally, there are about 2.5 million individuals who are in the coverage gap as a result of states electing not to expand their Medicaid programs under the ACA and subsidies for individual market coverage only going down to 100 percent of FPL.[5] All told, 15 million of the 27.5 million uninsured in 2017 were eligible for existing federal insurance programs. Another 3.8 million had access to tax preferred employer-sponsored insurance, and only 4.4 million individuals legally residing in the United States were uninsured without access to federal assistance—almost 2 million of whom have household incomes higher the 400 percent FPL. Systemwide reform on the scale of Medicare for All seems disproportionate to the problem actually before us.

Incremental Steps to Single Payer: More Spending, Few Results

The rest of the proposals before the committee are efforts that do not attempt universal coverage; they are framed as more moderate approaches to expanding coverage and consist largely of new federal programs aimed at specific populations. While AAF has not undertaken a detailed review of every one of these proposals, we have recently undertaken modeling of one of the proposals before the committee, H.R. 1346, the "Medicare Buy-in and Health Care Stabilization Act of 2019." This legislation, similar to other proposals, would allow people from 50-64 years old to buy Medicare coverage for a premium based on the cost of their benefits. The premium charged will be the average of the amount per person "for benefits and administrative expenses that will be payable under parts A, B, and D." The legislation also makes a number of changes to the ACA. Our modeling found that the legislation would cost a bit more than $184 billion over the first 10 years. Despite this price tag, only 293,000 individuals are expected to sign up for the Medicare plan in the first year, and the number enrolled drops to 187,000 by 2029. According to our modeling, because of low uptake, most of the cost of H.R. 1346 comes not from the Medicare Buy-in portion but from spending on the ACA's individual markets—in particular a new reinsurance program. Those changes do result in lower individual-market premiums, but the overall rise in the number of covered individuals is still less 500,000.[6] This analysis is instructive of many of the proposals seeking to expand coverage short of single-payer. The proposals spend a

great deal of money to target narrow populations, who often already have coverage options, and make only incremental improvements in the total number of insured.

Conclusion

In summary, ensuring that all Americans have access to reasonably priced insurance coverage is a laudable goal. Many of the legislative efforts before you today, however, seem aimed at forcing people to take advantage of that coverage. I would advise a different approach. Policymakers would be well served to identify those populations that are truly without coverage options and target solutions directly to those individuals. Of primary concern are the 2.4 million people in the Medicaid coverage gap. Helping that population does not require a complete restructuring of the American health care system, a one-size-fits-all approach, or $30 trillion or more in increased federal spending.

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[1] https://economicstrategygroup.org/resource/the-economics-of-medicare-for-all/
[2] https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending
[3] https://healthandeconomy.org/medicare-for-all-leaving-no-one-behind/
[4] https://www.heritage.org/health-care-reform/report/how-medicare-all-harms-working-americans
[5] https://www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act/
[6] https://www.americanactionforum.org/research/the_medicare_buy-in_and_health_care_stabilization_act_of_2019/

Ms. ESHOO. Thank you for your testimony.

It is a pleasure to welcome Dr. Atlas, and you have 5 minutes to present your testimony.

STATEMENT OF SCOTT ATLAS, M.D.

Dr. ATLAS. Thank you, Chairwoman.

Ms. ESHOO. Thank you again for accepting our invitation to be here.

Dr. ATLAS. OK. Thank you, Chairwoman Eshoo, Ranking Member Burgess, and members of the committee for the opportunity to speak today. The overall goal of U.S. healthcare reform should be to broaden access for all Americans to high-quality medical care and not simply to label them as insured. The notion that single-payer healthcare represents a goal for health system reform is mainly driven by the attractiveness of a simple concept: the government explicitly "guarantees" medical care.

In England, the NHS constitution explicitly states "you have the right to receive NHS services free of charge," despite taxing citizens $160 billion per year. The opposition to single-payer care, though, should not focus only on massive new taxes that will be required, but instead on the well-documented half century of its failure in the medical literature to provide timely, quality medical care. The truth is that single-payer systems—including in the U.K., Canada, Sweden, and other European and Nordic countries—impose shockingly long waiting times for doctor appointments, diagnostic procedures, drugs, and surgery that are virtually never found in the United States specifically as a means of rationing care.

Indeed, the Supreme Court of Canada in the 2005 Chaoulli decision, famously stated "access to a waiting list is not access to healthcare." Barua calculated that over a 16-year period, over 44,000 additional Canadian women died due to Canada's imposed wait times for medically necessary care. In England alone, a record 4.2 million patients are on NHS waiting lists, a hundred thousand of whom have been waiting for more than 6 months for treatment after receiving their diagnosis.

The average Canadian woman—maybe not Joni Mitchell—waits 5 months for her GP visit to her treatment by her gynecologist. In the U.K.'s single-payer system, more than 19 percent of those referred for "urgent treatment for cancer" wait more than 2 months for their first treatment. In Canada, almost 8 months for brain surgery after seeing the doctor. These long waits are the defining feature of all single-payer systems, and they stand in stark contrast to U.S. healthcare.

Waiting lists are not a feature in the United States, as stated by the OECD and verified by numerous studies. Even for low-priority checkups, U.S. wait times are far shorter than for seriously ill patients in countries with single-payer care. Single-payer systems also restrict the availability of new drugs, including cancer drugs, sometimes for years. Of the world's 54 new cancer drugs from 2013 to 2017, by 2018, 94 percent were available for Americans, for Brits 70 percent, in Canada 53 percent, in France 43 percent, in Australia 28 percent.

These long waits have major consequences. In the medical literature—not anecdote—worse health outcomes than the U.S. system from cancer, heart disease, stroke, hypertension, diabetes. Why would Americans voluntarily move toward a system proven worse than current U.S. healthcare? Americans should also ask why the U.S. would move towards single-payer care when every other country with decades of that experience now use private care to solve their failures.

Governments in Finland, Ireland, Italy, the U.K., The Netherlands, Norway, Spain, Sweden, Denmark—all with single-payer care—spend taxpayer money now, sometimes even outside their own country, on private care to solve their unconscionable failures. Americans should also wonder why those with financial means spend even more money than their already high taxes for something that is "guaranteed and free." Half of all Brits earning more than 50,000 pounds now buy or plan to buy private insurance. Here is the reality: Only the poor and lower middle class are stuck with nationalized single-payer healthcare because only they cannot afford to circumvent the system.

Those who advocate a conversion to Medicare for All fail to acknowledge this widely published evidence in the world's top medical journals, and they fail to acknowledge that continued access to care is already at risk according to the Actuary of CMS who calculated that most hospitals, nursing facilities, and in-home healthcare providers already lose money per patient with Medicare. And they fail to acknowledge this, that about 70 percent of seniors choose to rely on private insurance supplementing or replacing traditional Medicare coverage. Why would beneficiaries need that if pure government insurance was so satisfactory?

What is wrong with offering government insurance as an option? Because government insurance expansions only erode or crowd out private insurance. The public option is not a moderate or compromised proposal. It is simply a more insidious pathway to single-payer healthcare where only the affluent could afford to circumvent that.

Contrary to the false guarantees, the only valid guarantees from single-payer healthcare is worse healthcare for Americans and higher taxes. Rather than compelling Americans to accept an inferior government-run system that literally restricts medical care to regulate cost, why not focus on creating conditions long proven to bring down prices while simultaneously improving quality in every other good or service in the United States?

Incentivizing empowered consumers to seek value for their money with cheaper, broadly available, higher-deductible care less burdened by regulations; markedly more valuable expanded health savings accounts; tax reforms to eliminate counterproductive incentives; and then coupling that with strategic increases by deregulation and breaking down anti-consumer barriers to competition in the supply of doctors and hospitals.

These reforms would permit all Americans, rich or poor, to access the same excellence of medical care that the affluent—including some of the most strident advocates for single-payer care for the

rest of us—all use for their own personal healthcare. Thank you. 1A[1]

Ms. ESHOO. Thank you.

Now we will—we have concluded the witnesses' opening statements, and we will move to Member questions, so I am going to recognize myself for 5 minutes for questions.

Now we have, obviously, the whole span of what, thinking, on public and private health insurance and that has been expressed rather eloquently by each witness. I am taken with the following, and that is that the percentage of people that still are not insured in our country. I don't understand why people that are eligible are not enrolled. It is such a loss because they are subjected to all of the things that we know—Mr. Morley, you spoke to them and that they are not enrolled, that is a whole other issue—but at 6.8 million people in our country.

Now, in terms of the ACA, we have brought the percentage of uninsured down, so—but we need to always remember that there were 14 States where Governors denied their own constituents the coverage that they were entitled to where the Federal Government for 5 years was picking up the full tab.

I would like to hear from each one of you—and I am sorry to say this, Dr. Atlas, but I think that you don't agree with anybody on the panel, but you can try to answer the question. You may have——

Dr. ATLAS. I will give it a shot.

Ms. ESHOO [continuing]. Something that you like somewhere. But for each one of you, in terms of the thoughtful proposals that have been put forward by the nine Members of Congress, what do you think will best help to achieve universal healthcare in our country? So I will start with Ms. Rosenbaum.

Ms. ROSENBAUM. Thank you very much.

Ms. ESHOO. And everyone be brief. You have 3 minutes to answer that, and that will be my only question. But I am curious to hear from each one of you what fits with your thinking.

Ms. ROSENBAUM. Thank you. So, if you look at the number of people in the United States who are not enrolled but who are eligible for something, the overwhelming majority will tell you that they can't afford it. And getting to affordable quality coverage, of course, is a very complicated thing to do. I think the reality for this country over the past half century has been an employer system that was limited in its reach to begin with. It worked very well and continues to work well for people who are in a position——

Ms. ESHOO. But what do you think? I mean, my question is very specific.

Ms. ROSENBAUM. Right.

Ms. ESHOO. Of the nine proposals, is there anything—given your background, research, all that you know—that you think would best help us achieve universal healthcare in the country?

Ms. ROSENBAUM. Yes. I think, because of the backdrop, there has got to be some combination, and it may change over time, of a

[1] Dr. Atlas' prepared statement has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF14/20191210/110313/HHRG-116-IF14-Wstate-AtlasS-20191210.pdf.

strong public insurance option coupled with potentially private insurance option for people who have good comprehensive coverage.

Whether you ever take the next step——

Ms. ESHOO. Thank you. Thank you. But we need to get to the others, all right. And you are going to have the opportunity to tell me more with written questions that will be submitted to all the witnesses.

Mr. Morley?

Mr. MORLEY. Thank you for asking this question. I just have to say I have, you know, the majority of my advocacy has been defending the Affordable Care Act, so——

Ms. ESHOO. Thank you for that.

Mr. MORLEY. You are so welcome. But I have very limited opportunity to think proactively, but I take my cues from Congresswoman Schakowsky, all of them. I support all of them. Anything that is going to get us access, to increased access, I believe in all of them.

Ms. ESHOO. You are so beautiful.

Ms. Ross, we already know where you are, right? But if you want to restate it.

Ms. ROSS. I would like to start by saying that we have always been very appreciative of the ACA, very appreciative.

Ms. ESHOO. Oh, and we appreciate what the United Nurses did in that effort, certainly.

Ms. ROSS. Because it moved us so much closer to making sure that everyone got care. Now we need to take the next step. It won't do it anymore, not as long as private insurers are involved.

Ms. ESHOO. OK.

Ms. ROSS. We have to eliminate barriers to care and, really, Medicare for All is the only one that will do that.

Ms. ESHOO. Thank you.

Dr. Holtz-Eakin?

Mr. HOLTZ-EAKIN. Yes, I would say two things. First, I want to echo the importance of genuine delivery system reforms to make whatever gains in coverage you achieve sustainable, because they just won't stay unless we do that. It is why I am very worried with the Medicare for All. That is going backwards to fee-for-service medicine, which this committee with MACRA recognized was not the way to go.

In terms of the low-hanging fruit, there is a report out today that there are 4.7 million people who could sign up for a zero-premium Bronze Plan today, so it can't be cost. There is something else going on. Cover those people.

Ms. ESHOO. Thank you very much.

Dr. ATLAS. Yes, I mean the disconnect, in my view and with my proposal, is that the goal is not to label someone as insured. The goal should be to bring the cost of medical care down. And when you bring the cost of medical care down, insurance premiums come down because 80 percent of insurance premiums are due to cost of care, and all government outlays for programs for healthcare are much less, and by that way you broaden access to care.

So the way to do that is to empower patients by putting them in the driver's seat in controlling the money, to getting rid of the regulation that has falsely stopped competition——

Ms. ESHOO. Yes, I appreciate it, and it reflects your original testimony.

And I should just announce that December 15th is the deadline for enrollment, so whomever is listening in—if it is C–SPAN and everyone else—we are talking about insurance, affordable coverage, everyone understand, December 15th.

And now I would like to recognize—thank you, witnesses, for answering my question. Now it is a pleasure to recognize the ranking member, the gentleman from Texas, Mr. Burgess, for his 5 minutes of questions.

Mr. BURGESS. Thank you.

And, Dr. Atlas, let me just give you a few minutes to wrap up what you were saying, or a few seconds to wrap up what you were saying.

Dr. ATLAS. Yes. Well, the basic plan should be to get people to be incentivized to save money on healthcare by higher deductibles, paying more directly, cheaper insurance, and therefore care about the cost of care to increase the supply of competitors for that money, and to get rid of the, really, incorrect incentives in the current tax code that make people, incentivize people to spend more on healthcare.

That is the way everything in the United States gets reduced price with higher quality. That is exactly how it works, and it can work with healthcare, as we have evidence that it does.

Mr. BURGESS. Well, and I thank you for your observations. I thank you for your testimony. It was some of the most interesting I have read in a while.

Dr. Holtz-Eakin, can you talk somewhat about the—well, I guess the phenomenon is cross-subsidization. Currently, the current Medicare system does not reimburse for the cost of the care so that cost, that delta, is covered by generally employer-sponsored insurance or individual insurance. Can you speak to that? What would happen in a world where there was no longer the ability for that cross-subsidization?

Mr. HOLTZ-EAKIN. I am deeply concerned about that in these proposals, (A) because there is evidence that many institutions have negative Medicare margins. They lose money seeing a Medicare beneficiary. Proposals that would move everyone to Medicare levels of reimbursement or something close to that run the risk of turning everyone into that position, and that risks cutting off access to care entirely, particularly if you have a single rural hospital. It can't pay the bills. That is a concern to me.

The importance of that level of reimbursement for things is brought home by some of the work the administration did on international drug prices where the attention was that drugs are cheaper elsewhere. But what was not caught in that proposal was that, of the 27 most expensive drugs that Medicare patients in the United States get and use, only 11 were available in all of the other 16 countries that were studied.

If you don't reimburse at adequate levels, people do not get access to modern care. That is what I am concerned about. Getting rid of the commercial subsidy runs that risk.

Mr. BURGESS. And, of course, as you know, I spent years of my life trying to get rid of a Medicare formula called the sustainable growth rate formula and——

Mr. HOLTZ-EAKIN. Congratulations.

Mr. BURGESS [continuing]. The effect of that, of course, was to limit the number of providers who would—I mean, one of the questions I got at town halls when I first became a Member of Congress was, How come you turn 65 and you have got to change your doctor? And the answer was because their doctor was no longer taking Medicare, was not a participating physician because of the ratcheting down of reimbursement rates that happened automatically every year, year in and year out.

Dr. Atlas, if you could—and you didn't mention it in your oral testimony—but in your written testimony you talked a little bit about the difference in infant mortality rates—United States, other parts of the world—and I think the statement that you have is about how in the United States the effort to save some of the most premature infants is different from other parts of the world.

Some people would argue, well, maybe that is not a worthwhile activity. But I will just tell you, in 1976, I am in medical school and a neonatal intensive care unit was unheard of, and today every good-sized hospital has one, so our ability to take care of those infants has increased because of that. I just wonder if you had any thoughts on that.

Dr. ATLAS. Yes, I do. I think this is very important vis-a-vis what has been said about both life expectancy and infant mortality. These statistics are very coarse and poorly calculated numbers, and I will give you the specific reason why. Infant mortality, for instance, is not a valid indicator at all because, when you look at the way it is calculated, the European countries—the United States counts every live birth as a live birth with one heart rate, one heartbeat, one respiration. That is WHO criteria. When you look at countries in Western Europe who are so-called pure nations, some of them don't count infants as having been born unless they are a certain gestational age or unless they survive 24 to 48 hours. They don't count the babies who died as having been born if they don't live that long.

So you can imagine, in a fraction, if you change the denominator you have a totally invalid statistic. This is documented in the peer-reviewed medical literature. This is not my assertion.

Same thing with life expectancy, although a little bit different. Most of the deaths in young people in the United States are not even due to illness. Immediate gunshot wound to the head in murder is not a reflection of healthcare quality, OK. And when you look at, for instance, lifestyle behavior is very different in the U.S. than other countries. Forty percent of the difference in life expectancy between the U.S. and other countries is due to one lifestyle behavior: obesity.

If you standardize for these things, you see these statistics are not meaningful. That is why, to me, the best way to sort of compare health systems is to look at outcomes in diseases.

Ms. ESHOO. It is hard for me to cut people off, but you are——

Dr. ATLAS. I am sorry there are too many facts, but——

Mr. BURGESS. A lot of facts.

Ms. ESHOO. Yes.

Mr. BURGESS. But, just before I yield back, I would like to ask unanimous consent to add to the record a letter from the Texas Hospital Association and the American Hospital Association.

Ms. ESHOO. So ordered, happy to place it in the record. Thank you. The gentleman yields back.

Now it is a pleasure to recognize the chairman of the full committee, Mr. Pallone.

Mr. PALLONE. Thank you, Chairwoman. I should thank you for having this hearing. I was one of the drafters of the ACA and obviously very proud of that fact, and I do believe that the ACA could have and still can achieve almost universal coverage. I mean, the idea was that, you know, 65-some percent of the people get their insurance through the employer, and then we had this large group of people who buy insurance individually on the marketplace but can't afford it, so the idea was to try to make it affordable, and that is where the subsidies came in.

And the mandate, you know, the idea of the mandate was that, you know, we will give them enough of a subsidy so they will buy insurance rather than paying a penalty to not buy it. But there were still two groups that were still out there even with that scenario, one where those who wouldn't be able to pay a premium—and that is why we wanted to expand Medicaid—and then the last group were the uninsured—I mean, I am sorry, not the uninsured, the undocumented, which as far as I am concerned, you know, we should have addressed and we had a debate, but we couldn't get the votes.

So I wanted to ask Ms. Rosenbaum, you know, with regard to the Medicaid expansion, you know, it was not supposed to be optional under the ACA, but the Supreme Court holding in *NFIB* v. *Sebelius* said they had a choice whether to expand or not, and if all of the States were willing to put aside this partisanship and act in the best interest of their residents, I think we would be much closer to the goal of universal coverage.

So let me quickly, because I want to get to the undocumented, can you tell us as of today how many States have expanded Medicaid?

Ms. ROSENBAUM. Everybody but 14. A couple are still on the verge of phasing in, but there are 14 left.

Mr. PALLONE. OK. And for those States that expanded Medicaid, you know, they got a pretty generous deal in terms of how much of that cost is paid for by the Federal Government, correct?

Ms. ROSENBAUM. Yes.

Mr. PALLONE. And Congressman Veasey's bill that we are considering today, the Incentivizing Medicaid Expansion Act, would make that offer even more generous, correct?

Ms. ROSENBAUM. Yes.

Mr. PALLONE. So, if all States were to expand Medicaid as originally intended by the ACA, how many people do you think would gain coverage that don't have it now?

Ms. ROSENBAUM. We are at about 15 million now. It is roughly another 2 million people, a little more than 2 million people.

Mr. PALLONE. OK. Now do you want to—and not open-ended, because I want to get to the undocumented—but would you give me

any sense of why you think these States are still rejecting the Medicaid expansion? Is it strictly ideology? What is it, do you think?

Ms. ROSENBAUM. This has been looked at a lot. I would say it is a deep philosophical opposition to the expansion. Cost certainly doesn't explain it. The Federal financing doesn't explain it, even at the current rate. So I would say we are dealing with something deeper.

Mr. PALLONE. Ideological, all right.

Now let me get to the undocumented. You know, we know that a large portion of this country's uninsured rate comes from undocumented individuals. What would you—like, if we covered all the undocumented, what, you know, what do you think percentage-wise that would mean?

Ms. ROSENBAUM. Well, I mean, that would be universal coverage, their proposals that are universal up to legally present immigrants and also that address the short-term, the people who have been here for less than 5 years.

Mr. PALLONE. Well, let me put it to you this way.

Ms. ROSENBAUM. But undocumented——

Mr. PALLONE. Let's assume that everybody who was——

Ms. ROSENBAUM. Yes.

Mr. PALLONE [continuing]. Legally here, documented, had insurance coverage. I think we—would it be accurate to say we would still maybe be only at 95 percent because there would be another 5 percent that are undocumented? I mean, I know that is a huge——

Ms. ROSENBAUM. Right. No, and it is not a good thing for any healthcare system to leave anybody out, in my opinion.

Mr. PALLONE. OK. But would you agree, you know, even if everyone was covered who is legal, you would probably still have another 5 percent of the total population that is not covered because they are undocumented.

Ms. ROSENBAUM. Yes. Yes.

Mr. PALLONE. OK. So, I mean, I agree with you. It doesn't make any sense. You get sick, you spread disease. I mean, what are we talking about here? It is, you know, you can't operate in isolation, so, I mean, those undocumented people obviously have healthcare needs. How do they get that care, and what cost does that add to our system? How is this—does this make any sense—I don't think so—to not cover the undocumented in terms of the cost to our system and how we operate?

Ms. ROSENBAUM. Those who are willing to come forward use isolated public health services. In extreme situations they would turn to an emergency department, but the care is uneven, too late, and too many people live in the shadows, really, without any healthcare at all. There are no waiting lists for people who are uninsured.

Mr. PALLONE. But also doesn't it just not make sense from a cost point of view, because if those people got preventive care and were able to see a doctor, they wouldn't end up in the hospital emergency room because they wouldn't get as sick. I mean, do you want to comment on that?

Ms. ROSENBAUM. Absolutely. And it is very difficult to begin to quantify these kinds of shifts, but very important to bring every-

body in to deal with health problems before they become serious enough to be high cost.

Mr. PALLONE. All right, thank you so much. Thank you, Madam Chair.

Ms. ESHOO. The gentleman yields back. It is a pleasure to recognize the gentleman from Illinois, Mr. Shimkus, for his 5 minutes of questions.

Mr. SHIMKUS. Thank you, Madam Chairman, and I appreciate the hearing and I appreciate the people in the healthcare sector because this compassionate, trying to do the right thing, even those who are trying to make sure we can pay for it adequately, we are on it for the right reasons.

You know, I was here when we passed Medicare Part D. It was helpful. I was here when we did expansion of Medicare Advantage, very helpful. So—but numbers and budgets and dollars matter. So, Dr. Holtz-Eakin, what happens with the hospital insurance, HI Trust Fund in 2026?

Mr. HOLTZ-EAKIN. At that point it will be exhausted and——

Mr. SHIMKUS. What does that mean, "exhausted"?

Mr. HOLTZ-EAKIN. It means that the payments out to hospitals will have cumulatively exceeded the payroll taxes that go in, and at that point there will not be the legal authority to reimburse for care.

Mr. SHIMKUS. Can you say that again?

Mr. HOLTZ-EAKIN. At that point it will be illegal for you to reimburse hospitals for their care to Medicare beneficiaries. They will have to do it, but——

Mr. SHIMKUS. So how do—by adding more people to Medicare, how does it help solve this 2026 funding problem?

Mr. HOLTZ-EAKIN. It would not help solve. That would increase the outflow without raising the inflow.

Mr. SHIMKUS. So it actually would create an insolvency much sooner.

Mr. HOLTZ-EAKIN. Yes.

Mr. SHIMKUS. And, Dr. Atlas, you identify this in your testimony, kind of, on your Figure 3 here in your statement. And this is no different than our problems with Social Security: Workers today pay for Medicare for our retirees. That more people are retiring and living longer, it is financially unsustainable. Is that what you are trying to say here on this Figure 3?

Dr. ATLAS. Yes. What figure you are alluding to shows that the number of workers funding per Medicare beneficiary started out when the program started at 4.6, and now it is about 2-point-something. And so, when you have not enough people working to fund the program at the same time as this explosion of an aging population and actually a positive of people living longer, living longer also means incurring more medical expenditures because older people have these——

Mr. SHIMKUS. Well, let me reclaim my time, and I appreciate that. So I want our friends here to understand that there is a funding crisis. I have said it for 20 years. Someday, someone is going to believe us, that there is a funding problem on Social Security, there is funding problem with Medicare.

And we are part of the problem on Medicare, because who in this room—who doesn't get visited by people saying the coding for fee-for-service is screwed up, pay us more, right? Who doesn't get visited by folks here in the audience who say we are not compensated enough, right? And that is going to continue.

Let me ask a question to both of you, Dr. Holtz-Eakin and Dr. Atlas, what happens when a new product comes to market under Medicare for All?

Mr. HOLTZ-EAKIN. It is not clear.

Mr. SHIMKUS. OK. And we are talking about this too. We have this big H.R. 3 drug debate about, well, maybe 10 new blockbuster drugs won't get to market, some estimates are a hundred. If you are the patient who is looking for that lifesaving new drug, you want to be able to get it. And it is, I think, the countries that we have talked about who have single-payer systems, their actuary—not actuary, but their listing—it takes a long time for new products to come on the market, is that correct?

Mr. HOLTZ-EAKIN. That is absolutely correct. In the U.S. of new brand-name drugs, new therapies becoming available, 95 percent are available in 3 or 4 months. That number is about half that size elsewhere.

Mr. SHIMKUS. Right. And Medicare Advantage under Medicare for All, what happens to that?

Mr. HOLTZ-EAKIN. It is gone.

Mr. SHIMKUS. It is gone.

Let me finish with this. I am from rural America. A lot of our hospitals are not-for-profit, faith-based institutions and who do their best to cover folks.

Madam Chairman, I would like to submit two letters for the record from the National Right to Life Committee, April 29, 2019, and the March for Life Action, and whenever you are willing to do that, and I know you may want to look at it.

But I want to read a statement: "There are certain key details of this legislation that would mean dramatic and radical departure from longstanding abortion-related policy. The legislation would require government funding of abortion without limitation and also likely would require unwilling hospitals and doctors to perform abortion procedures."

When you go into a government system and you don't have choice, you have to play by the rules.

And, Madam Chairman, I would like to submit those two, and I yield back my time.

Ms. ESHOO. I will review them and advise the gentleman as to whether they will be placed in the record.

Mr. SHIMKUS. Thank you.

Ms. ESHOO. OK, it is a pleasure to—the gentleman yields back. It is a pleasure to recognize our colleague, Mr. Engel from New York, for his 5 minutes of questions.

Mr. ENGEL. Thank you, Madam Chair, and I have a lot to get in. I am going to see if I can do it all, but let me first say healthcare continues to eat a growing share of every American family's income. We know that from years of watching this and also from the testimony today.

The trend is reflected by the healthcare sector consuming an increasing portion of our Nation's GDP. In 2016 it has accounted for 18 percent of our GDP, but in 2026 it will jump to 20 percent, and that trend is unaffordable and unsustainable. And every day, like my colleagues, I hear heartbreaking stories from my constituents about how families are having to choose between paying for life-saving healthcare and other necessities such as groceries.

So I am pleased to be an original cosponsor of the Medicare for All Act and a founding member of the Medicare for All Caucus. This legislation will improve and expand Medicare for all Americans and will provide new benefits, including dental, vision, and hearing, all without copays, premiums, and deductibles. As I have said many times before, healthcare is a human right, and I believe that H.R. 1384 will help every American access high-quality healthcare.

Ms. Ross, let me ask you, could you please describe how Medicare for All will save money and put our Nation's healthcare expenditures on a sustainable financial footing?

Ms. ROSS. I think the biggest savings in Medicare for All will come from administrative costs, because right now there are so many different plans to administer. Nurses and doctors just want to care for their patients. That is their main goal, so without the interference of those insurance companies we can actually do that. So you have got the lowering of the administrative costs. You have got accurate budgeting which we have not had before that is actually sustainable.

Mr. ENGEL. Thank you.

Madam Chairwoman, I would like unanimous consent to submit into the record a letter in support of H.R. 1384 from 253 leading economists discussing how this bill will reduce healthcare costs while guaranteeing every American access to comprehensive care.

Ms. ESHOO. So ordered.

[The information appears at the conclusion of the hearing.]

Mr. ENGEL. Thank you. Let me also say again, Madam Chair, I want to thank you and Mr. Pallone for holding today's important hearing.

The ACA, the Affordable Care Act, which I helped author, I was on this committee when we tried so hard, first to get everyone covered and then—for a public option—we didn't have the votes. But the ACA has enabled over 20 million Americans to become covered, including a hundred thousand of my constituents, and yet despite this remarkable progress, the Trump administration is taking actions to gut the ACA, including promoting junk plans and curtailing outreach programs. This committee has led the charge to reverse this sabotage through legislation such as the Strengthening Healthcare and Lowering Prescription Drug Costs Act, and I want to thank Chairwoman Eshoo for her hard work with that.

With that said, we must continue to build on the ACA's success, and two of the bills before us today introduced by New York, my colleagues in New York, Brian Higgins and Antonio Delgado, would create public options to help improve access to coverage. Let me ask Ms. Rosenbaum, how would a public option as envisioned by the bill as drafted by Congressmen Higgins and Delgado help strengthen the ACA marketplaces?

Ms. ROSENBAUM. What they would do is introduce a competitive alternative to private plans for especially vulnerable older Americans, whose healthcare costs are quite expensive, relatively speaking. This would give them a more affordable way to buy care.

Mr. ENGEL. Thank you.

And, finally, Mr. Morley, I have a question for you because I want to thank you for coming from my hometown, New York City, to testify. One of the hallmark features of the ACA is that it prohibits health insurance companies from discriminating against Americans living with preexisting conditions such as diabetes. The Center for American Progress estimates that nearly 311,000 of my constituents below the age of 65 have a preexisting condition, and the Trump administration's efforts to weaken these protections through regulatory actions jeopardize the health coverage of my constituents.

So I want to thank the leadership of Members like Congresswoman Kuster who authored the Protecting Americans with Preexisting Conditions Act. The House is fighting back against these policies. So, Mr. Morley, could you describe the impact that eliminating the ACA's protections for preexisting conditions would have on your ability to access healthcare services?

Mr. MORLEY. It wouldn't just obviously be mine, it would be for 130 million Americans so I can't really speak for myself on that. I think the stress of all the sabotage that has been done by the Trump administration has been really overwhelming at times. I have lost a lot of sleep, as I am sure a lot of people have. That is the number one concern I hear from people.

But limiting my access to care, insurance companies can go back to discriminating against me. And, as I stated in my oral testimony, you know, I have experienced that already, and it has cost me tens of thousands of dollars. And I had the ability to work at that point in my life, and I don't have the ability to work anymore, so there is no way that I could pay for that. I have monthly infusions. Each one of my infusions for my lupus costs $10,000, and there is no way I could pay for that.

Mr. ENGEL. Thank you. Thank you, Madam Chair.

Ms. ESHOO. The gentleman yields back.

I just want to add something to what the gentleman from New York said relative to the ACA and the public option. The House passed that. It was the Senate that fell short on—we all feel strongly about it because we fought so hard and we achieved what we wanted to achieve in the House, but I think it is important to have that as part of the record.

It is a pleasure to recognize the gentleman from Missouri, Mr. Long, for his 5 minutes of questions.

Mr. LONG. It is a pleasure to be recognized by my buddy, the Madam Chairwoman, and thank you. And thank you all for being here today on this extremely important topic. Every day we hear of someone. In fact, when I go home, I usually give them the health report, and it just seems like every day someone is coming down with a disease, someone we know, someone we are close to, near and dear to.

My daughter—she is 30 now—25 years old she was diagnosed with Hodgkin's lymphoma. She went through all of the treatments

and lost her hair, got her hair back, and is doing very good now. In fact, going to get married next October. And I am wearing today my St. Jude's Children's Research Center tie that I am very passionate about and have been for over, well, close to 40 years now, I guess, but over 30 years.

When I was an auctioneer before this life, for 30 years I was on the National Auctioneers Board of Directors, and we picked one national charity to support, and that was St. Jude, so I always try and showcase my St. Jude tie at any opportunity.

Sunday night, we were at the Kennedy Center Honors. Two of the honorees, one that founded Earth, Wind and Fire, suffered from Parkinson's disease before his demise, and Linda Ronstadt, who had to give up singing—one of the most beautiful voices ever—was honored Sunday, and she had to give it up due to Parkinson's disease. So, again, it is a very, very important topic, and thank you all for being here.

Dr. Atlas: First name Charles, middle name Charles, any?

Dr. ATLAS. Not many people know who that was anymore, I don't think.

Mr. LONG. I am showing my age, but I have never met an Atlas that wasn't named Charles, so I am just——

Dr. ATLAS. OK.

Mr. LONG [continuing]. Curious, but inquiring minds want to know.

But if you think back to 2013, with the rollout of healthcare.gov and all the issues that they had getting the website opening up, and I think six people actually were able to sign up that first day. It took months and months to get it where it was fully functional and more than $1½ billion over budget to get it up and going. In the end, healthcare.gov website finally launched about 3½ years after the passage of the Affordable Care Act.

The Medicare for All bill is estimated to cost over $30 trillion and would fully transition from our current healthcare system to a single-payer system in 2 years. So if the United States Government couldn't build a functioning website in 3½ years and went massively over budget trying, how can we possibly expect the Government to successfully transition to a single-payer system in just 2 years and stay on budget? Any comment?

Dr. ATLAS. Yes. I don't think there is an answer to the question, except I would say to the point about why single-payer, why Medicare for All will save money, it is because the same reason that every other single-payer system is less than the United States. They restrict the use of healthcare and they have worse results for that. So, if that is what people, voters are interested in doing, having worse healthcare and having more people die like Canada and England and everywhere else and no access to these drugs that we enjoy as Americans, you know, that would be a reform that would be appropriate.

I think the best way to get access is to reduce the cost for everyone just like it is done—that is why the cellphone in your pocket, it is a supercomputer, doesn't cost $20,000, from competition and empowering consumers who care about the price of what they are actually directly buying.

Mr. LONG. OK. The Harvard School of Business determined that the lack of relevant experience, lack of leadership, and time constraints were the primary factors leading to healthcare.gov's initial failure. Do you believe the United States Government currently has the manpower, resources, management talent, and expertise to fundamentally take over our healthcare system?

Dr. ATLAS. Not in the Government, no. The private sector would.

Mr. LONG. OK. In your testimony, the opposition to single-payer should not—you said the opposition to single-payer should not focus only on requirement for massive new taxes, but instead on the well-documented half century of its failure to provide timely, quality medical care. This failure is not just about low=priority checkups or routine appointments, it is about people that are seriously ill. You note that the U.K.'s NHS system has set a standard and declared it would be acceptable for 15 percent of cancer patients.

And I have spoken of cancer patients, including my daughter, here this morning to wait 2 full months. And when I think of the day that I took her to the emergency room here in Washington and first was told her there was nothing wrong and go home, but they had an IV in her arm and she couldn't get dressed and go home. They decided to do an x ray and they came back and they said "You have a large mass in your chest, and it is malignant." Waiting 2 full months for treatment would definitely have not been acceptable in her case, or it should not be in anyone's case, and one out of five patients has to wait over 2 months for their first treatment of cancer.

And I am beyond my time by 20 seconds, and I yield back to my friend.

Ms. ESHOO. The gentleman yields back. I am a kind chairwoman. I have a hard time cutting people off. It is only at the urging of others that I do this. So it is a——

Mr. LONG. That is an auctioneer's gavel. I can do that.

Ms. ESHOO. Yes. He is a real live auctioneer. You can hear it in his voice, can't you?

Now all the—let's see, we have all of our women to ask questions. The gentlewoman from California, Ms. Matsui, is recognized for 5 minutes for her questions.

Ms. MATSUI. Thank you very much. And I want to thank the witnesses for all being here today and thank Chairwoman Eshoo for having this hearing here today.

You know, for the past decade, our healthcare system has been constantly under attack. Republicans in Congress and the statehouses across the country have made it their mission to repeal or systematically undermine the Affordable Care Act. The goal of universal coverage has long been, as we always say, a North Star for the Democratic Party. We believe everyone should have access to care, and I was disappointed when more progressive policies to expand coverage were ultimately left out of the Affordable Care Act.

But that is why this moment presents a unique opportunity. The ACA improved the quality of basic care everyone receives. It unlocked access to care for Americans who have been historically shut out of or priced out of the system. It has expanded coverage to over 20 million Americans since it was signed into law. While acknowl-

edging our successes, we must also recognize the need for improvement, the need to look up again at the North Star of universal coverage and ask ourselves what comes next.

It is my hope that today we can have a productive conversation about how to obtain universal coverage, increase the role of Federal Government in lowering the cost of care, and maintain our role as the global leader in cutting-edge treatments and health technology. Our path forward will say a lot about who we are as a nation.

Healthcare touches all of our lives in some way. That is why I am excited by the proposals before us today, all of which are united by the common goal of improving the access and affordability of healthcare. California is the first State in the Nation to improve coverage affordability for low- and middle-income consumers by expanding subsidies available through our ACA marketplace, Covered California. California has also reinstated the individual mandate tax penalty. As a result of both policies, plans sold through our health insurance marketplace saw A record-low statewide average rate change of less than 1 percent for 2020, bringing savings and stability to the entire individual market.

Many of the bills we will discuss here today would enhance ACA premium tax credits and cost-sharing subsidies to marketplace enrollees. Ms. Rosenbaum, can you briefly explain how the ACA subsidy cliff works and what groups face the biggest affordability challenges as a result of this phenomena?

Ms. ROSENBAUM. Yes. There are two kinds of subsidies under the ACA: There is a premium subsidy, and then there is a cost sharing subsidy. The premium subsidy begins at the Federal poverty level and it ends at 400 percent of poverty, and it essentially works by keeping down your cost of coverage to a certain percentage of your income. Currently, the subsidy has sort of a steep cliff and ends completely at 400 percent of poverty.

The cost-sharing assistance is similar in that it essentially discounts the cost of care at the point of service, but its cliff is steeper. It ends at 250 percent of poverty.

Ms. MATSUI. Right. So you would agree that improving subsidies is key to increasing coverage for both low- and middle-income individuals?

Ms. ROSENBAUM. Absolutely. It is the number-one reason why people——

Ms. MATSUI. So if we were to scale these solutions nationwide, how would you expect enhanced subsidies coupled with return of the individual mandate to impact overall uninsured rates and the stability individual marketplace?

Ms. ROSENBAUM. Estimates suggest that just those two changes alone, probably along with, of course, something for the Medicaid expansion States that have not expanded, would probably raise the insured levels by at least 10 million people, even more with autoenrollment.

Ms. MATSUI. Sure. Now, in the Medicaid expansion States, the ACA is working as we envisioned, filling historical coverage gaps tied to income level by expanding Medicaid eligibility and providing subsidies for purchasing coverage. In nonexpansion States, many adults whose incomes are above Medicaid eligibility but below the threshold for subsidies are trapped in a coverage gap.

Ms. Rosenbaum, how many people nationwide would be eligible for Medicaid if their States expanded?

Ms. ROSENBAUM. It is slightly more than 2 million people.

Ms. MATSUI. So are larger populations of people caught in the coverage gap concentrated in certain States or parts of the country?

Ms. ROSENBAUM. Yes. They are disproportionately people of color. They are disproportionately residents of southern States.

Ms. MATSUI. Mr. Morley, I just want to make a comment. Thank you for your testimony. We really do understand what you have been going through, and we really want to work on behalf of you and many other patients such as yourself. And thank you for sharing your unique perspective with us. I am equally concerned about the actions taken by the administration to undermine Medicaid and the ACA protections and that have increasingly exposed, you know, consumers to coverage gaps. And, believe me, that is what we are trying to do today, to ensure that we level the playing field and understand how important it is. Thank you very much, appreciate it.

Mr. MORLEY. Thank you very much for saying that. I appreciate that.

Ms. ESHOO. The gentlewoman yields back. It is a pleasure to recognize the gentleman from Kentucky, Mr. Guthrie, for his 5 minutes of questions.

Mr. GUTHRIE. Thank you very much. Sorry. There is another hearing of this full committee, a subcommittee that was meeting earlier, and it was on foreign drug inspections, so I wasn't able to hear your stories, Mr. Morley. But God bless you and thanks for being here to share.

What I kind of want to talk about with Dr. Atlas and Dr. Holtz-Eakin is, I think all of us here are wanting people to be covered with—the question is that we get to when you look at Medicare for All, how does it change the healthcare system we have today?

We are currently in discussion this week about H.R. 3, which is setting a price for pharmaceuticals. We all want lower drug prices, and there is a bipartisan bill to do that, but now we are going to where we are setting drug prices to the point where CBO says we will get less, 8 to 15 less drugs over the next 10 years. And people on this committee in that hearing said, if we are going to lose miracle cures or—they didn't say that, I won't put the words—if we are going to lose some cures because we are going to have lower drug prices, that is a tradeoff we are willing to pay.

I like to take people when they come to my district to Owensboro, a fantastic medical center; Bowling Green, two medical hospitals; Elizabethtown, a medical hospital; Danville, Ephraim McDowell, father of modern gynecology, hospital, and just say, if we were in a European state or Canada, a city this size would not have a hospital of this quality, in my opinion. I mean, and I tell them, take me to a city of less than a hundred thousand people that have world-class—we can do heart surgery. We do a lot of different things.

So the concern as we go down this path is—and we have to—it is not just a slogan that we can put on a bumper sticker or a T-shirt, it is, How is this going to affect the healthcare system that Americans have? We can cure sickle cell anemia. We—cystic fibro-

sis is going to be a disease that people can live with further. It is going to be a maintenance disease. Artificial pancreases, available now. Just the things that are coming out of this country, and we are subsidizing the rest of the world. And that is an issue that we try to address in H.R. 19 on drugs, is that we have a U.S. trade negotiating or negotiate with other drugs.

But just ramping down payments and giving, in order to get a hundred percent universal coverage in one plan, Medicare for All, at the expense of that which I don't see how you take that much money out of the system and not lose hospitals. For example, under the Affordable Care Act we did Medicaid expansion and within—and my State expanded, Kentucky—and with Medicaid expansion, it was paid for by decreasing the DSH payments, disproportionate share payments, because if everybody is covered, we are not going to have to have these subsidies.

Well, I will tell you, every rural hospital in Kentucky today, an expanded State, would say if—and we are making it up, we are doing Medicaid expansion and DSH payments because it just doesn't work—they would all say they would close or have difficult—particularly the smaller ones. I won't say Owensboro or Bowling Green, but the smaller hospitals would close, they tell me, if we didn't make up the DSH payments when the policy was everybody be covered, but the problem is the payments are so low, even the people covered, the hospitals can't make it up.

So, Dr. Atlas or Holtz-Eakin—or I will open it up to anybody—what do you see, if we go to a one-size reimbursement for Medicaid, Medicaid to all of our hospitals and our providers, what kind of healthcare system would you see? For instance, we know under H.R. 3 that 50 percent of the drugs that would be priced under H.R. 3 are not available in Canada. They are not. They are just not available. That is just a fact.

And so, what would you see with our——

Dr. ATLAS. Well, I will answer about the drug pricing issue that hasn't been brought up. You look at what a single-payer system does with drug pricing, we can look at the NHS. They have a budget impact test of 2017. They set a number, and if the system is going to cost 20 million pounds or more for a drug, they are not going to have that drug available, and they are going to "negotiate," and they give themselves 3 years.

If your wife has breast cancer and wants one of these new drugs, she is going to sit there for 3 years while the government, the NHS, negotiates that price down. It has been calculated by the NHS itself and the Alzheimer's Foundation in the U.K. that a drug for Alzheimer's would have to cost less than $4 a month to be approved, because so many people need it. So if you look at this way, ironically, the more people that need the drug when you are capping the total expenditure—the more people that need the drug, the less likely it will be available. That is what the NHS Budget Impact Test does.

You can't have the government, a third party—the government doesn't care if your wife doesn't get her drugs. She cares if she doesn't get them.

Mr. GUTHRIE. Well, this is what I want to point out, is that we can't just sell that we are creating a whole new payment system

and not affect the healthcare system we have. I think people are envisioning we are going to have exactly what we have and somebody else is paying for it, and that is not what will happen, in my opinion.

Dr. ATLAS. Well, we know that the CMS Actuary just now said it that their warning in 2018, hospitals and nursing facilities and in-home care are going out of business because they are losing money per patient. If you lose money per patient, you don't make up for that in volume, as the old joke goes.

Mr. GUTHRIE. Dr. Holtz-Eakin—well, I am out of time.

Mr. HOLTZ-EAKIN. Yes, I mean, that restricts access to existing technologies. And in the data we see that increasing quality, which is the adoption of a medical innovation, is correlated with higher reimbursements, you put all that risk. And the international evidence shows it. Our domestic evidence shows it as well.

Mr. GUTHRIE. Thank you very much. I yield back.

Ms. ESHOO. The gentleman yields back.

I have a factoid, and that is a lot of people have said things about the Affordable Care Act. All Members of Congress receive their healthcare through the Affordable Care Act. All staffers receive their healthcare through the Affordable Care Act. I think there is only one member who has not accepted it, and that is Dr. Burgess, but that was his choice. So I think that we have a lot of people invested in it and I just can't help but say, "Thank God for Medicare and Medicaid." Where would people in this country be without that coverage?

So it is a pleasure to recognize the gentlewoman from Florida, Ms. Castor, for her 5 minutes.

Ms. CASTOR. Well, thank you, Chairwoman Eshoo. And let me thank you for this hearing, because it isn't it refreshing that we can focus on how we are going to lower the cost of healthcare in America, expand access, build upon Medicare and Medicaid and the Affordable Care Act, so thank you very much.

Dr. Rosenbaum, in your testimony you cite the lasting and measurable achievements under the Affordable Care Act.

And, Peter Morley, thank you for being here and speaking on behalf of millions of Americans with preexisting conditions.

When you say the Affordable Care Act, here we are 10 years later, it is time to take stock. What stands out to you overall, Dr. Rosenbaum?

Ms. ROSENBAUM. I think the remarkable effect of the affordability provisions, the enormous impact of the market reforms for people like Peter Morley, and the vision of combining access to affordable coverage with, actually, improvements in communities to access to care.

Ms. CASTOR. So the protection. No longer can an American be discriminated against for any preexisting condition. It has been very meaningful for young people to stay on their parents' policies until they are age 26.

And to Mr. Shimkus, who was here: Remember, the Affordable Care Act extended the life of the Medicare Trust Fund, and it strengthened Medicare, and it helped to close the doughnut hole. Now, the Democrats this week are going to pass one of the missing links to allow Medicare to negotiate prices and drive down drug

costs and then carry that over to private insurance, so that is going to be a great thing for families.

You know, coming from the State of Florida, boy, there is some good news and there is some really difficult news. We have led in the marketplace every year. We have about 1.8 million Floridians who sign up for affordable coverage under healthcare.gov. At the same time, we have a little less than a million of our residents who are stuck in the coverage gap. That means they are too poor to access the tax credits. This is crazy, OK. Floridians—and this goes for Texans too—we want to bring our tax dollars home. And Leavitt Partners did a study—recently it came out—$13.8 billion of your tax dollars, they want to give them back to the State of Florida so that about a million of our residents can get signed up for Medicaid health services.

Chairwoman Eshoo, when you talk about this cohort of people who don't have health coverage, because of that Florida, the fact they haven't expanded Medicaid, 10 percent of all working adult or all uninsured adult population comes because of that coverage gap, so I appreciated Chairman Pallone and Congresswoman Matsui highlighting this.

Dr. Rosenbaum, can we just—we can look at Mr. Veasey's legislation to increasing incentives, but I mean $13.8 billion, we would cover people, it would help our GDP, we would be able to hire, we would be healthier, infant—I mean across the board. What else can we do? We have to just go ahead and say we intended Medicaid to be expanded under the Affordable Care Act. Do we have to craft that again and pass it, and would it withstand scrutiny of the Supreme Court?

Ms. ROSENBAUM. Well, certainly, further incentivizing States to expand coverage is a good idea. Why a State would not expand coverage is a bit of a mystery, especially since the expansion would not only extend coverage to all the people who are left out, but would actually bring down the cost of premiums in the marketplace because, in States that start their marketplace coverage at 138 percent of poverty, the premiums tend to be lower, so it is good all around.

Ms. CASTOR. Can we just pass the law? Go back and——

Ms. ROSENBAUM. Unfortunately, the Supreme—well, the Supreme Court has said that expansion on a mandatory basis is no longer constitutional, but certainly many people have thought—I am among them—that sweetening the pot is a very good thing to do in hopes that the expansion will happen.

Ms. CASTOR. So, Peter Morley, thank you for providing a real-world example of how meaningful it is to have healthcare coverage. You know, we are in the holiday season now, and is there any better gift to a loved one than health insurance? And remind us what the deadline is.

Mr. MORLEY. First of all, thank you for saying that. I spent 3 days in Congress last week, in the House and the Senate, making videos with people like Congresswoman Castor. The deadline, the Federal exchange deadline, is December 15th.

Ms. CASTOR. Wow. That is Sunday, I think.

Mr. MORLEY. It is Sunday. Go to healthcare.gov. That is the way that we keep enhancing the ACA. And just to add, when you talk

about Medicaid expansion, a lot of people—I have heard for the majority of people in Texas and Florida—those are two major States that have not expanded Medicaid, and I am very sympathetic and compassionate to that, so thank you for mentioning that.

Ms. CASTOR. Thank you.

Ms. ESHOO. I made the announcement, December 15th, whomever is tuned in.

It is a pleasure to recognize the gentlewoman from Delaware, Ms. Blunt Rochester, for her 5 minutes of questions.

Ms. BLUNT ROCHESTER. Thank you, Madam Chairwoman. And I want to thank both panels for your testimony and the deliberations.

As I was sitting here listening to the testimony, I thought of a quote from Martin Luther King that says of all the forms of inequity, injustice in healthcare is the most shocking and inhumane. A decade ago, this very subcommittee debated one of the country's most sweeping and comprehensive pieces of healthcare policy, the Affordable Care Act. Twenty million Americans gained health coverage through either the marketplace or Medicaid expansion, and for the first time, patients received critical protections from things like coverage denials because of a preexisting condition, like you shared, Mr. Morley, or lifetime limits on essential health benefits. Delaware alone saw the State's uninsured rate drop to 5 percent.

But an issue that it still plaguing our healthcare system is cost. I held town hall meetings, I met with families, I met with small businesses in my State, and three things kept coming up. For many, the out-of-pocket costs were unaffordable. For some there were gaps in coverage or they were underinsured. And, number three, health inequities and disparities still persist, which is why we are still talking about maternal mortality in this country.

Since hearing those concerns, I have been working on a comprehensive strategy, the Cap Costs Now Act. I am going to say it again, the Cap Costs Now Act. My bill would cap out-of-pocket costs, including premiums, deductibles, and copays, so no one is spending their whole paycheck for healthcare, no matter where they are getting their health insurance. The Cap Costs Now Act would allow us to achieve truly universal coverage by automatically covering everyone through an easy-to-navigate system with new options for coverage such as a Medicare E program for those 50 to 64. Finally, the bill would align incentives in our healthcare system to better tackle health inequity and continue our nation's move towards value-based care.

Unaffordable, out-of-pocket healthcare costs aren't just an issue in my State. The Commonwealth Fund has found that about one in six Americans face healthcare costs they can't afford, even with health insurance. Deductibles alone have tripled in the last decade. More than 4 in 10 workers enrolled in a high-deductible plan reported that they don't have enough savings to cover their deductible. In other words, in the words of one of our previous witnesses, if you can't afford it, you don't have it.

So I would like to thank my colleagues for their leadership, who were on the first panel, and their work on the various pieces of legislation, and I would like to thank all of you who are on this panel. We all want our constituents to have quality healthcare, and we all

want our constituents to be able to afford it. With my plan, we can move towards affordable, universal coverage without starting from scratch or removing the 180 million Americans in employer-sponsored insurance from their existing plans. We can immediately get to the work by building on the current foundation of our Nation's healthcare system to provide everyone with coverage that is affordable and universal.

As I begin to roll out my healthcare proposal in the upcoming weeks, I want to encourage my colleagues to look out for it and to support the Cap Costs Now Act. Thank you, and I yield back.

Ms. ESHOO. The gentlewoman yields back. A pleasure to recognize the gentleman from Georgia, Mr. Carter, for his 5 minutes of questioning.

Mr. CARTER. Thank you, Madam Chair. And thank all of you for being here. I appreciate this very much, you taking time out. This is extremely important, extremely important to the future of our country, to the future of healthcare in our country in particular.

I find it interesting that we are having this discussion during the same week that we are also going to be voting on Speaker Pelosi's bill, H.R. 3, that is going to essentially keep up to a hundred life-saving drugs from coming to the market if it were to be enacted, and that comes from the Economic Development Commission, and that is what they have proposed. Even CBO tells us that we can expect anywhere from 8 to 15 drugs not to come to market if this were to be passed.

But, Dr. Atlas, I wanted to ask you, because I think your testimony really tells the full story. It has come up in our debates about the anticures bill, H.R. 3, as you mention in your testimony as well that other single-payer systems have far fewer choices in terms of medicines available to them. Is that correct?

Dr. ATLAS. That is absolutely true. And, since most new drugs are cancer drugs, people die because of that.

Mr. CARTER. You cited some figures. I listened attentively to your opening statement about other countries and comparing us to what is available here in America as opposed to what is available in those other countries. Do you have that by chance again?

Dr. ATLAS. Yes, I do, because I was speaking so quickly that probably no one remembers what I said.

Mr. CARTER. I would like to make sure they do remember what you said, because I certainly heard it.

Dr. ATLAS. The latest data on the 54 new cancer drugs launched from 2013 to '17 in the world, within the 2 years, the United States' patients had 94 percent available, Brits had 70 percent, Canada's cancer patients had 53 percent of those drugs, France 43 percent, Australia 28 percent. It is proven in economics but not in—and in drugs in particular. when you cap prices, you are going to stop the production, the availability of good and the innovation of that good.

The real solution to drug prices is to figure out why they are costing so much, because the cost of developing a drug has exploded over the past decade to $2½ billion in 15 years, and nobody is going to develop a drug if they are not going to get that money back. So we as a government, really, have added a lot of bureauc-

racy and a lot of hurdles and therefore cost to the development of new drugs, and that is where the attention should be focused.

Mr. CARTER. And, you know, for those of you who don't know—and I am sure members of the committee know—currently I am the only pharmacist serving in Congress. I spent my professional career dealing with this. I have seen nothing short of miracles.

Ms. ESHOO. We are so glad that you said it.

Mr. BURGESS. Yes, who knew?

Ms. ESHOO. Who knew? That is right.

Mr. CARTER. Excuse them.

But anyway, I have seen nothing short of miracles through the way of research and development and what has come on the market. I give the example all the time of the drug Sovaldi. Now here is a drug that, when I first started practicing pharmacy in 1980, if you were diagnosed with hepatitis C, you were going to die. I mean, that is all there was to it. Now how phenomenal is it that we can cure that disease with a pill? That is simply phenomenal to me. Someone who was there at that time, who saw people who came in who were diagnosed with that disease and knew that they were diagnosed that they were going to be dying soon, but now we can treat them. That is phenomenal.

Now, you know, the thing that concerns me so much is that both sides, both Democrats and Republicans, want the same thing. I get it. I understand that if a drug costs $85,000 and is not accessible to you, it does you no good whatsoever. I get the fact that we need to bring prescription drug prices down. But I also understand that there are other things that we can do aside from what is being posed in H.R. 3 that will lower drug prices without stifling innovation, and that is what I am trying to get to here.

And let me ask you, Dr. Atlas, why would these countries restrict their patients' access to these medications? Is it simply just to manage the cost of government?

Dr. ATLAS. That is exactly—well, they are trying to minimize the cost that they are paying out for their healthcare system, and the way that they all do it is to restrict the use of care, the availability of technology, the availability of drugs, and their results of their survivals in these specific diseases are worse than ours.

Mr. CARTER. Exactly. And again, I don't fault my colleagues on the other side of the aisle. They want the same thing I want. We all want the same thing, to bring the prescription prices down, and we can do that. And I see the need for transparency so much, because I know what is going on here and I know that there are middlemen who are bringing no value whatsoever to the system but are taking profits out of the system.

And thank you again, Dr. Atlas, for being here and for bringing up this important point. Thank all of you for being here. Thank you, Madam Chair, and I yield back.

Ms. ESHOO. The gentleman yields back. It is a pleasure to recognize the gentleman from Massachusetts, Mr. Kennedy, for his 5 minutes of questions.

Mr. KENNEDY. Thank you, Madam Chair. I want to thank my colleagues for, I think, unanimously, as this one, all agreeing how important this hearing is. Grateful to be here for it. I want to thank our witnesses for your courage, for your testimony, for your

service, and for your perspective. It is important that we get this right.

Let's start by just walking through some of the comments that I think some of our colleagues have made and has been put forward in testimony, this question that some aspect of a more robust guarantee of access to coverage is somehow going to make sure that drugs are not available. Ms. Ross, are you familiar with the statistic that roughly 26 percent of patients in need of insulin ration their care?

Ms. ROSS. I am.

Mr. KENNEDY. And so does that seem like insulin is in fact readily available in the United States of America?

Ms. ROSS. It does not.

Mr. KENNEDY. When we talk about the fact that procedures might end up in expanded wait times, are you aware that for GoFundMe, that popular crowdsource fundraising website, that a third—a third—of the donations of a GoFundMe page are used for healthcare costs. Were you aware of that?

Ms. ROSS. I am aware of that.

Mr. KENNEDY. Are you aware that the founder of GoFundMe said that, quote—I will get this more or less right—that he did not, they did not intend to found a site that would be one of the most influential healthcare companies, but it turns out that they did, as a GoFundMe page?

Ms. ROSS. I did hear that, yes.

Mr. KENNEDY. And we talked about wait times and access to care. Are you aware, Ms. Ross, that 55 percent of the counties in our country do not have a single practicing psychiatrist, psychologist, or social worker?

Ms. ROSS. I am aware.

Mr. KENNEDY. Are you aware of the fact that about over 50 percent of the adults in this country in need of mental behavioral illness will not get the access to care today?

Ms. ROSS. Yes.

Mr. KENNEDY. Are you aware of the fact that that is actually worse for kids?

Ms. ROSS. Absolutely.

Mr. KENNEDY. So I was at a regional hospital on my district a little while ago—keep in mind, in a State with 98 percent, 98 percent of people covered with health insurance, 98—there was a little boy that was waiting that was being boarded. He had been waiting for over 150 hours and counting, waiting for a bed. That they couldn't get the stretchers down the hallways in the emergency room because there are so many patients suffering from mental illness waiting for a bed.

That a mom had come in to my office, now a couple years ago, detailing her daughter's challenges with mental behavioral illness, and at one point their daughter was boarded on the neurology floor at an academic medical center in Boston for 19 days as they called looking for a bed from Virginia to Maine. Nineteen days. Any guess as to how much it would cost to board a child at a neurology floor waiting for a bed in Boston?

Ms. ROSS. A lot.

Mr. KENNEDY. That sounds about right to me.

Mr. Holtz-Eakin, I think, would agree with "a lot" figure. Fair enough?

Mr. HOLTZ-EAKIN. It is a good estimate.

Mr. KENNEDY. So I point these stories and these statistics out because I think the reality that I think many of us experience in our healthcare system today is that, when we talk about quality, when we talk about access, when we talk about what treatments are available, without question—without question—they are right. Without question from a perspective, Dr. Atlas, what you just said is correct.

The challenge—where I would challenge you and challenge others on this is that the focus of that system ends up being on those who have access to it and not the drastic number of Americans that don't. And the fact that, even today in a place like Massachusetts that is so proud of the healthcare industry that we have invested in and that we have nurtured, that a story that ran in the Boston Globe about 8 months ago—no, about a year ago—about an African-American woman who slipped and fell in a minority part of Boston, broke her wrist, got in a cab and went to Boston Medical Center, the old city hospital. She broke her wrist out in front of or down the block from New England Baptist. It is where the Boston Celtics go to get an orthopedic surgery. She didn't even know that the hospital was there. And, even if she did, it wouldn't have mattered, because it is a private hospital and they don't take Medicaid.

But when we have, when Medicaid—shifting gears—is the largest payer of mental behavioral services in this country, and the vast majority of providers won't take Medicaid because the reimbursement rates are so low, yes, if I can afford to pay out of pocket, I have access. But for so many others that don't, they don't. Mr. Morley would not be here but for the grace of God, of Affordable Care Act, and the fact that certainly—I mean, Mr. Morley, you have been eloquent about your story, but how many people in this country, how many people are even forced to have to tell your story?

Mr. MORLEY. Honestly, I have lost track. I really—it is, I mean, I will never understand why all can't just work together to bring that access for everyone.

Mr. KENNEDY. And so, my time is up here. I will just say this. This is complex, and this is complicated, and there are tradeoffs. But the core question here is that, for a system that every single one of us will draw on, whether you are born into a system or whether you welcome a new child or watch a loved one pass through it, why would we not want to make sure that it is a system that is there for everyone else, the same system that we want for a loved one? And I yield back.

Ms. ROSS. Could I add one comment to that?

Mr. KENNEDY. That is up to the chair.

Ms. ROSS. Would I be allowed?

Ms. ESHOO. Well, I think we need to move along because it is 24 minutes past—or yes, seconds past the gentleman's time. I now would like to recognize the gentleman from Virginia, Mr. Griffith, for his 5 minutes of questions.

Mr. GRIFFITH. Thank you, Madam Chair..

Ms. Ross, we try to get along on this committee. If you have something short, say it.

Ms. ROSS. Thank you. It is very difficult for me to hear the comparisons to other countries' single-payers with the constant comment that people are dying and denied care. As long as the for-profit motive is present in this country, that is what is happening now. The only way for them to make their profit is to deny care.

Mr. GRIFFITH. Well, and I don't necessarily agree with you on that and would take exception, but we try to be courteous on this committee and try to work together.

That being said, Dr. Atlas, today many rural hospitals are closing because they cannot afford to stay in business, leading to access problems for sick Americans. One of the major reasons for these closures is that Medicare—and Mr. Kennedy mentioned Medicaid—doesn't pay hospitals enough. According to MedPAC, hospitals are unable to make money caring for Medicare patients. If it wasn't for privately insured patients, even more hospitals in rural communities would close. Research by the consulting firm Navigant predicts that a Medicare public option plan would put up to 55 percent of rural hospitals at high risk for closure.

Now I say this with the backdrop that my rural western Commonwealth of Virginia district has lost two hospitals in the last few years. We are trying to get one of them back. But many of the plans we are discussing today involve expanding Medicare. If more patients are covered by government healthcare, won't that lead to even more rural hospital closures and access problems?

Dr. ATLAS. Well, absolutely, of course. Like I said before, the CMS Actuary put out the statistic that—and in fact the statement that—we expect access to Medicare-participating physicians to become a significant issue, quote/unquote. And the reason is because Medicaid and Medicaid pay not just lower than private insurance, but below the costs of delivering the care. That is the point. And so it brings you back to what I believe is the whole solution that should be the focus, which is to reducing the cost of care without needing to limit or restrict the use of care. If you reduce the cost of care, everybody gets access, including those on government programs.

Mr. GRIFFITH. Yes, and I appreciate that. And I guess, you know, the question is begged, How can we guarantee access to care for patients in rural areas on a Medicare for All plan if there are no open hospitals in rural communities? And, for those who haven't heard me say this before, sometimes you can look at a map and Point A to Point B doesn't look like it is very far, but when you have a mountainous district like I do—it may be Haysi to Dickenson—the mayor of Haysi plans on an hour if he is going to a meeting in Dickenson for travel time.

And the same is true when we closed down the Scott County Hospital. That meant a minimum of 45 minutes to an hour for many of the people in Scott County to get to the nearest hospital just for basic stuff, not even counting something that might be more complex.

But how can we guarantee that those folks are actually going to have care? It is not like getting in a cab and going to the next hospital down the road. There is no hospital down the road.

Dr. ATLAS. Well, that is—again, the solution is to introduce the forces that bring down the prices for every other good or service in the United States. That is how you ensure access. Not just based on price, but based on value or quality.

Mr. GRIFFITH. Dr. Holtz-Eakin, anything to add to that?

Mr. HOLTZ-EAKIN. Well, I think that is the essence of it. I don't think anyone is here to defend the status quo. The question is, How can you go forward and what set of reforms would deliver a downward pressure on delivering the cost of quality care?

Mr. GRIFFITH. I appreciate it. And with that, I yield back. Thank you.

Ms. ESHOO. The gentleman yields back. Actually, you know, the GAO analyzed data and found that rural hospitals in States that had expanded Medicaid as of April 2018 were less likely to close compared with rural hospitals in States that had not expanded Medicaid. So we deal with a lot of complexities, but I think the facts need to be stated so that, you know, that we build on the foundation of facts. And it seems to me that we are in an era where that foundation continues to be eroded on a daily basis.

It is a pleasure to recognize the gentleman from California, my friend Mr. Cárdenas, for his 5 minutes of questions.

Mr. CÁRDENAS. Thank you, Madam Chair, and I appreciate the opportunity to have this hearing. And also, to the Ranking Member Burgess, thank you so much. And I want to say thank you for pointing out that statement that, when the politicians take the politics out of their decision making, more people have access to healthcare under the current system, which you just pointed, out with certain States not accepting that responsibility and opportunity. I appreciate the opportunity to hear from my colleagues and other experts such as yourselves—thank you very much—on what it is most important of the issues facing our Nation. I am proud to serve on a committee that does not shy away from topics simply because they are difficult.

And I myself know what it is to grow up in a family, a working family, where my parents faced the choice between going to the doctor or having enough food to feed their family, a choice that too many American families face today. To say that the establishment of federally qualified health centers changed our lives is an understatement. For the first time, we could get preventive care. We could go to the doctor when we first started feeling sick instead of when it was a dire emergency.

The Affordable Care Act provided these same opportunities for more than 20 million Americans that before then did not truly have access to healthcare. Many of them live in the very district that I am proud to serve. Although I was not yet a member of this committee when the Affordable Care Act passed the House, I know many of my colleagues were. I think most of my Democratic colleagues are united in our firm belief that all Americans deserve access to quality health coverage. Together it is imperative that we continue that work, because while many Americans have benefited from these reforms, there are still too many without care. That is why it is so important that we are having this hearing today and discussing this very critical issue.

Mr. Atlas, some of the comments that were made—and you, in fact, pointed out that some hospitals are closing. Hospitals closing, is that a new phenomenon in the United States, or have we had that happen over the past decades, hospitals closing and/or every American having access to healthcare? Are those two new phenomenons? Do all Americans have access to healthcare today?

Dr. ATLAS. Well, it is illegal to turn somebody away when they come to the hospital, so the answer——

Mr. CÁRDENAS. Yes, OK. You know, OK, I am sorry. Let me qualify my question a little bit better. How many Americans actually have healthcare coverage and direct access to preventive care today, a hundred percent or not?

Dr. ATLAS. Well, everyone with insurance has free preventive care.

Mr. CÁRDENAS. Does that cover a hundred percent of Americans?

Dr. ATLAS. No, not everybody opts for insurance.

Mr. CÁRDENAS. OK. OK, got it.

Dr. ATLAS. And if I could——

Mr. CÁRDENAS. Thank you, Mr. Atlas, reclaiming my time. I was trying to have a nice dialogue with you and a simple one, but you are complicating the answer.

The bottom line is this: In the United States of America, we have—a hundred percent of Americans have never had truly access to healthcare. Just like I outlined in a period of time in my family's history when I was growing up, we truly didn't have access to healthcare, preventive care. Excuse me. Today, Americans don't—before the Affordable Care Act we never were at a hundred percent. During the Affordable Care Act, the new system, we are not at a hundred percent. Hospitals have closed and opened, et cetera, over the history of time in the United States of America.

My point is this: What I don't appreciate is, when Members of Congress try to point out that today's system is the worst that it has been, and that is just not true. We have a system that needs improvement. That is true. We have a system that is trying to get more working families and every family and every child more access to healthcare, and to me that is what the core of this hearing is about today. How do we improve our system? How do we get to a better system where the percentages go up and the individuals and the families and the children truly have access to real healthcare, preventive care, et cetera? I hate to point out that an emergency room cannot turn somebody down, that is a conversation for another day. I hope we never have to narrow ourselves to that conversation.

So the main thing that I think this hearing is about today is, How can we as elected Members of Congress in the House of Representatives—the people's house—how can we advance some legislation that will bring us to a better state, a better place where more Americans can appreciate the fact that they can live through a healthcare situation instead of die because of nonaccess to healthcare? That is at the core of what this hearing is about, and I really do appreciate all of you coming forward.

Mr. Morley, thank you so much for your bravery of coming forth before all of us and letting us know that no one should suffer through what you have had to suffer through.

Thank you very much, Madam Chair. I yield back.

Ms. ESHOO. The gentleman yields back. The Chair now recognizes the gentleman from Florida, Mr. Bilirakis, for his 5 minutes of questions.

Mr. BILIRAKIS. Thank you, Madam Chair. I appreciate it so much.

Dr. Holtz-Eakin, does Medicare for All repeal Obamacare? That is the first question.

Mr. HOLTZ-EAKIN. Yes.

Mr. BILIRAKIS. OK. If so, why would Democrats now support to repeal Obamacare?

Mr. HOLTZ-EAKIN. You will have to ask them. I don't know.

Mr. BILIRAKIS. OK. Could this be taken as an admission of Obamacare's failure to make healthcare more affordable and more accessible through increased government intervention and mandates?

Mr. HOLTZ-EAKIN. Again, I would direct you to the authors.

Mr. BILIRAKIS. OK. Let me ask you this: Can it be guaranteed that taxes will not be raised on the middle class to pay for Medicare for All, or that individuals and families will not lose coverage under Medicare for All or that seniors' benefits will not be changed or reduced? Of course, your Medicare Advantage is very popular in my district. About 40 percent of Medicare recipients are on Medicare Advantage, and we have got to protect Medicare Advantage and Medicare for seniors in general.

So that is what my main concern is. Are seniors that are on Medicare now—traditional Medicare but also Medicare Advantage—could they be affected by this Medicare for All bill?

Mr. HOLTZ-EAKIN. The bill would eliminate Medicare, Medicare Advantage included, so that would be gone. So would Medicaid. It would eliminate private insurance, so those individuals would definitely be affected. The bill is silent on financing the costs, which are substantial. I personally believe having looked at a variety of these that it is implausible to imagine that that taxpayer cost could be picked up by a small subset of affluent Americans. It is simply too big of a number.

Mr. BILIRAKIS. OK, so when you say that Medicare for All—did you feel that the reimbursement would be cut for hospitals, doctors and nurses, et cetera, healthcare providers in general?

Mr. HOLTZ-EAKIN. Reimbursements would be cut to Medicare reimbursement rates and some variations slightly above that, which is well below the average of what they get now from commercial players, and this would produce financial stresses, and those would be solved by either diminishing access and quality or by raising other reimbursements and the taxes necessary to finance it.

Mr. BILIRAKIS. OK, thank you.

Dr. Atlas, does Medicare for All lead to government rationing? If so, why?

Dr. ATLAS. Well, the purpose of Medicare for All, as other single-payer systems, part of it is going to be controlling costs. And the way that controls costs is certainly not by letting people be price-sensitive. It eliminates concern for price. So yes, the only way to control costs in the single-payer systems is to restrict care, and that means rationing of care. Yes.

Mr. BILIRAKIS. OK.

Dr. ATLAS. That is proven all over the world.

Mr. BILIRAKIS. Yes. Well, give me a specific country where that takes place, the rationing, please.

Dr. ATLAS. Well, the United Kingdom, Canada, every Western European—you know, Denmark, Netherlands, Italy, France, everywhere.

Mr. BILIRAKIS. OK, thank you very much. I appreciate the answer. This is very dear to my heart. I am cochair of the Rare Disease Caucus. Increasing access to breakthrough cures and treatments, again, are one of my priorities, and I am sure the entire committee, both Democrats and Republicans, that is one of their priorities as well. How would Medicare for All impact patients with rare diseases, in your opinion, Dr. Atlas?

Dr. ATLAS. Well, I think that there is sort of an indirect, longer-term problem with single-payer systems, and that is they don't just control the costs by restricting access to things like new drugs. I mean, the drugs, new drugs, are the basis for the new survivals for these rare diseases, generally speaking, but they also are going to inhibit innovation because, if you are reducing the costs by restricting the use and restricting the upside of developing new technology and new drugs, the goods are not produced. That is just a fact.

Mr. BILIRAKIS. OK, thank you very much.

Madam Chair, if no one else wants my time, I will yield back. And I do appreciate you holding this hearing and then allowing us to ask the questions.

Yes, I will be happy to yield, if you would like, please.

Ms. KELLY. Thank you so much. I just wanted to——

Ms. ESHOO. Put your microphone on, please.

Ms. KELLY. I was looking right at you, Ms. Ross, so—and you were shaking your head. I just wanted to give you an opportunity to respond to my colleague's question or comments.

Ms. ROSS. Well, obviously we are not proponents of denying care to people. We are proponents of making sure that everybody gets them. There has been a lot of discussion about the rural hospitals, very near and dear to our hearts too. You are right. The main reason is the nonexpansion of Medicaid, but the other is the for-profit motives of private employers, hospital corporates that come in and they opt for a model that will serve them better, make them more money, so they close off services that people in those communities really need and they move them to other places so that our patients cannot get the care that they need that they once were able to. So Medicare for All actually has globalized budgets, and it has a budget for special projects which ensures that those rural hospitals and others will be built and opened.

Ms. ESHOO. Does the gentleman yield back?

Mr. BILIRAKIS. Yes.

Ms. ESHOO. Thank you. The gentleman yields back. Pleasure to recognize, from California, Dr. Ruiz for his 5 minutes of questions.

Mr. RUIZ. Thank you very much for having this hearing, this very, very important hearing, and I am so happy that we are now presenting a variety of different options that can move the healthcare system in America forward, because I truly believe—and I know many of us in this room believe—that every American

should get the care they need when they need it at an affordable low cost, and that should be our goal. Our goal in order to achieve that should be universal coverage. Everybody should have coverage. And that is how we should, (1), look at our efforts, and (2), making sure that out-of-pocket costs are low for people, for patients.

Ms. Ross, you and I are made from the same fabric because we worked in the emergency departments, and so we know what it means to fight for people, for our patients, and put them at the very center of our universe. And, you know, we have made some progress. The ACA went a long way in moving us towards that goal. In fact, because of the ACA, over 20 million individuals are now insured.

Let me just remind people that being uninsured is a health risk. Some may say how can that be? I tell you straight up it is a health risk, because if you don't have insurance you can't afford your medicine if you get sick, and you will get sicker. And you will present to the emergency department, if you make it, with ICU-type-level care and your ability to recuperate is even worse. So yes, being uninsured is a risk factor, health risk factor, and you can die for not being able to prevent certain illnesses.

So this is of important urgency for all of us. We can see the benefits of Medicaid expansion when we look at expansion States versus nonexpansion States in terms of the providers and the hospitals. If you just expanded Medicaid in those States that could expand Medicaid but for political reasons chose not to, you would reduce the uninsured rate by 5 percent, just by that alone.

So—but, unfortunately, the ACA has not been fully implemented. There has been a lot of changes since then to make it worse because the number-one singular goal of the—of, you know, the Republican Party since Obama passed this—was to destroy it, to sabotage it, to then say, "See, it is not working," at the expense of the American people's health.

And so, what are our next steps? You know, well, definitely we need to stabilize the market. We need to reduce overall healthcare costs. And then we have got to look at adding some provisions that would increase the ability for Americans to have coverage and therefore to eliminate the uninsured problem, health risks, of the American people here.

So, Professor Rosenbaum, you know, there are a variety of Federal public option plans that we have looked at today to accomplish universal coverage. And I know the specifics of how we do that varies, but can you talk generally about the benefits of adding a public option to our current system? Specifically is there research to suggest that a public option will increase competition, lower costs?

Ms. ROSENBAUM. Yes. Thank you very much. I do believe that adding a strong public option both gives people access in communities that right now are poorly served by private insurance plans and by injecting additional competition into the system helps stabilize the cost of care and keep it under control.

Mr. RUIZ. Well, you know, the thing we have to focus here is that we need a preferential option. We need not just any option, we need a preferential option. And when you look at health insurance, you want to make sure that it is expansive and protects you and

will cover what you need to be covered. And let's—I am an emergency medicine doctor, so there is nobody who is immune to accidents. Nobody is immune to that unfortunate surprise diagnosis that you get that you never thought you would ever get, like cancers and whatnot.

So we need to make sure that it is affordable and that it can cover as many ailments that we need to protect patients. In addition to that we must address a couple of other issues, and one is the provider shortage that we have in our country. We need to. We don't have enough nurses. We don't have enough doctors. And we need to also look at the delivery of our healthcare system and where we focus our resources for prevention and public health, not on expensive end-of-life kind of care, but the prevention and the public health at the beginning. Thank you.

Ms. ESHOO. And the gentleman——

Mr. RUIZ. Yields back.

Ms. ESHOO [continuing]. Yields back. That is right. A pleasure to recognize the gentleman from North Carolina, Mr. Hudson, for his 5 minutes of questions.

Mr. HUDSON. Thank you, Madam Chair. I appreciate you holding this hearing today. I thank the witnesses for your time being with us today.

While I support the broad goals of all the pieces of legislation we are considering today, which is to expand access to affordable health coverage, I have grave concerns with the impacts these bills would have on real people who need to access our healthcare system.

And, Madam Chair, my friend from California just finished speaking, and he is and truly my friend, but I have to disagree with his characterization that Republicans want to destroy the healthcare system to score some political point. I think everyone in this room wants to make the system better, wants to make it more affordable, and I think the question is, How do we get there?

First, broadly speaking, the population we are trying to help is roughly 28 million Americans who cannot afford insurance or who have decided not to purchase insurance. By comparison, 293 million Americans do have insurance, which is a little more than 9 out of every 10 people in this country are insured. Medicare is already going broke. The program currently covers roughly 44 million people in this country. Under Medicare for All, it would have to cover 327 million people. That is seven times the size it currently covers. To think that we could add seven times more people to the Medicare program without a cut in benefits defies common sense.

Second, we would also be eliminating an entire segment of our economy and giving providers a massive pay cut. I shudder to think what would happen to access to care in rural areas in my district which are already hamstrung. For example, Montgomery County in my district, there is only one psychiatrist and only two part-time psychiatrists for the entire county, and further cuts in benefits or pay rates would exacerbate this problem.

Dr. Atlas, you spoke at length in your testimony about the quality of care in this country compared to other countries, including wait times experienced by those patients. Have you ever studied the private systems that exist alongside the public system in those

countries, such as in Canada or Great Britain, and if so, can you speak to who has access to these private systems?

Dr. ATLAS. Yes. There is an increasing trend in countries with single payers—specifically the U.K. is a florid example, but also all the other countries of Western Europe—that people with money opt out of the system—or not opt out, they pay their taxes, but they then supplement. There is a significant increase in buying private insurance, significant increase in paying out of pocket, and they all avoid using their single-payer system of the people who are affluent enough to do it.

And that was my point, that the only people stuck with the single-payer system are the very people that everybody in this room wants to help, the low-income people.

Mr. HUDSON. So in single-payer countries the average taxpayer has to wait while wealthy customers don't have to. They can see a doctor immediately.

Dr. ATLAS. Well, that is exactly right. There is a parallel system, basically, in the U.K. as there is here, really, with the Medicaid system, which everybody in this room probably knows has worse outcomes than comparable patients with private insurance. To celebrate an expansion of Medicaid when no one in Congress would want that coverage for their family I find a little bit unconscionable.

Medicaid has worse outcomes from surgery, cancer, heart procedures, lung transplants than the same patients with private insurance, because of the restrictive access to technology and drugs that Medicaid covers. My plan is to make Medicaid money go for a bridge towards private insurance. We want everybody in the country to have excellence, to have access to the excellence of American healthcare, not a separate parallel pathway for poor people.

Mr. HUDSON. I agree. It doesn't sound fair to have one system for the wealthy and a different one for those who aren't. You also testified that the trend in single-payer countries is moving towards private options for health insurance to supplement or even completely circumvent the government-run system. Why do you think it is, and should it be instructive for us as we examine these extreme proposals looking forward?

Dr. ATLAS. What is the question? I didn't hear it.

Mr. HUDSON. Well, just to continue on the thought, you are saying that, for the folks who can afford it, private insurance options are supplementing or replacing it. And maybe you have answered it already, but why do you think this phenomenon is happening in these other countries, that the wealthy go to a separate system and everybody else is stuck in the government?

Dr. ATLAS. Because the single-payer coverage restricts care. And as we see in the United States, we can expand Medicaid all we want, but Medicaid is not accepted by more than half of doctors, including doctors who have signed contracts to accept Medicaid, according to HHS data. So you label someone as insured, but that is not the same as having access to care.

Mr. HUDSON. All right. Well, as my time is expired, Madam Chair, I will yield back and thank you.

Ms. ESHOO. The gentleman yields back.

I just want to add, Dr. Atlas, what you said about Medicaid, Mr. Morley would not be alive were it not for it.

Now we would like to——

Dr. ATLAS. Yes. We are talking about data, not individuals.

Ms. ESHOO. Well.

Dr. ATLAS. I am talking about the data in the medical literature.

Ms. ESHOO. So that doesn't include Mr. Morley?

Dr. ATLAS. No, it does. I am thrilled he is here. I mean, it is fantastic.

Ms. ESHOO. Yes, we all are. And we have many Mr. Morleys in our country.

The Chair now would like to recognize the gentlewoman from California, Ms. Barragán, for her 5 minutes of questions.

Ms. BARRAGÁN. I thank you.

So there was a conversation about a system for the wealthy and a system for the poor. That, actually, very much describes what we have happening in this country. You have—it is even worse. You have people who don't have access to any care at all. And so, this is the problem, and this is why we need to figure out how to get to universal care, because access to healthcare is a human right. Everybody should have access to it.

Now I represent a district that is a majority minority district. It is almost 90 percent Latino, African American, and it is very working class. One of my colleagues likes to hand out a list of where your congressional district lies by income. Mine is 358 out of 435. People are struggling, and people don't have access to healthcare. Now, the ACA was a step in the right direction. It did help increase access to healthcare, but there are still a lot of people who are left behind, still a lot of people who don't have that access. And some people who may have something, they get duped into buying some of these junk plans, and then they realize they really don't have coverage.

And so, I want to thank the panelists for being here today and for this conversation. Ms. Ross, I want to thank you for your work. My sister is a nurse, and I know that you have been on the front lines of fighting for Medicare for All in making sure that everybody has access to healthcare. And I think the bottom line is we can probably all agree that everybody should have access to healthcare, and the disagreement happens to be on how we get there.

And I mentioned to you the district, the makeup of my district. Can you explain what the benefit would be to communities of color if we had Medicare for All and how the bill would reduce minority health disparities?

Ms. ROSS. I think I would point to again what I talked about with how it is administered, the globalized budgets. There would be negotiations between the hospital and the regional directors, and you would look at what you would need for the following year, looking at what you needed for the year before, for one thing, and then you would project. So if you knew you had rural hospitals, communities that are underserved, and you needed more staff in those hospitals, maybe you needed to build a hospital, those are the kinds of things you would look at putting into the budget so that people who had previously been unserved and underserved would be able to get care.

Ms. BARRAGÁN. Great. Thank you. Ms. Ross, in addition to being a registered nurse, you are also a national union leader. As the president of the largest union of registered nurses in the country, we often hear politicians telling us that Medicare for All would be bad for union members and that unions wouldn't support it. But your union does support Medicare for All, as do many national and local unions across the country. Ms. Ross, can you tell us, why do unions support this bill?

Ms. ROSS. Well, right now, there is at least 9.3 million unions that represent New Yorkers that do want Medicare for All. And I think, if you look back at our history, we are to the point now where we can't negotiate anymore for better wages and working conditions, pension benefits, because everything is taken up with bargaining for healthcare. If you look at most of the strikes across the country in the last several years, they have all been over healthcare benefits. So I think we see the handwriting on the wall. And also, I know union workers who might like to switch jobs, but they are afraid to because they have got their insurance tied to their employer.

Ms. BARRAGÁN. Thank you.

Mr. Morley, thank you for your advocacy. You are on the Hill all the time, and you are very active on social media and you are telling your story and telling people about how important it is for us to fight on healthcare, something that I am proud Democrats have been doing and have been working on a bipartisan basis to make sure we find solutions as best we can under current conditions.

Mr. Morley, is there anything you want to share with us, any considerations you want to tell us about any of the bills before us today?

Mr. MORLEY. I just want to say I really think it is so important for—I would love to see more of a bipartisan effort. There was no need to bring up anything about H.R. 3 today because this is not an H.R. 3 hearing, so that makes me kind of angry. So any and all bills that will get us towards coverage, increase our coverage towards all Americans, is what I am trying to achieve as a patient and for all the patients that have reached out to me through social media. That is all I have ever wanted. And to protect the protections for preexisting conditions that are already in place, the expanded Medicaid, the ways that the ACA has helped Medicare, that is all I have ever wanted, and I don't want to see those protections removed.

Ms. BARRAGÁN. Great. Thank you all for your work. I yield back.

Ms. ESHOO. The gentlewoman yields back. The Chair now recognizes the gentleman from Montana, Mr. Gianforte.

Mr. GIANFORTE. Thank you, Madam Chair. This is a very important hearing for the future of our country. I appreciate the panelists being here.

Medicare is critical to Montana seniors. We should work to protect these benefits that they have earned. I believe the Federal Government must honor the commitment it made to our seniors, but Medicare for All will destroy Medicare as we know it. To a casual observer, Medicare for All sounds appealing on its face, but it is really just a marketing gimmick. To dig deeper beyond the slick marketing efforts of a catchy name, Medicare for All is nothing

more than a government-run, single-payer healthcare system. It would end Medicare as we know it and leave our seniors in the cold. Medicare for All in practice is Medicare for none.

Now, some of my Democrat colleagues will claim Medicare for All is a proposal out of a fringe, out-of-touch wing of the Democrat Party, but the truth is it has taken over the Democratic Party by storm. Many Democrats jockeying for the presidency in 2020 support Medicare for All, and half of the Democrats in the House have cosponsored Medicare for All. Let's be clear. Medicare for All would gut Medicare and the VA for our veterans and force 225,000 Montana seniors who rely on Medicare to the back of the line. Montana seniors have earned these benefits, and lawmakers shouldn't undermine Medicare and threaten healthcare coverage of Montana seniors.

Medicare for All would devastate rural healthcare, we have heard that on the committee today, especially those in Montana. They already face overwhelming challenges. Since 2010, more than a hundred rural hospitals have closed their doors, and nearly 40 percent of all rural hospitals operate on a budget shortfall. Under Medicare for All, hospitals in Montana would take a 40 percent payment reduction. Hospitals in our rural areas would struggle further, and patients would lose access entirely to critical providers, like oncologists and heart surgeons. Medicare for All will lead to worse access to care in our rural communities.

In addition to gutting Medicare and eliminating access to care in our rural communities, Medicare for All is a fiscally irresponsible budget buster. Elizabeth Warren, a frontrunner in the Democrat primary, has proposed Medicare for All that would cost $52 trillion. With a straight face, she campaigns that her plan will not raise taxes on the middle class. I don't believe that. It doesn't pass the reasonability test. Medicare for All would terrify Americans who rely on Medicare and who like their employer-sponsored plans. Under Medicare for All, private insurance would be banned.

Folks, this is a government takeover of healthcare, plain and simple. We are not a socialist country. Medicare for All will gut Medicare and the VA as we know it and put Montana seniors at the back of the line. To force 225,000 Montanans who rely on Medicare to share their pool with everyone isn't fair to Medicare seniors, Montana seniors.

In reality, Medicare for All is Medicare for none. Instead of a reckless government takeover of our healthcare system, we should take a bipartisan approach to fix our broken healthcare system. We should protect patients with preexisting conditions, increase transparency and choice, preserve rural access to care, and lower costs. Let's get to work on that and end this socialist charade.

Now, Dr. Atlas, as I said earlier, it seems like our rural providers will struggle under a Medicare for All proposal. What do you believe will happen to rural hospitals and other providers under Medicare for All?

Dr. ATLAS. Well, under a single-payer system where private insurance is banned, we already know that Medicare pays less than the cost of delivering the care. These hospitals survive because of the extra reimbursement they get from the private insurers. So it is very naive to think that, oh, we are just going to wipe out pri-

vate insurance and have the Medicare payments support all these hospitals. The hospitals will go out of business, just like the CMS Actuary said in 2018.

Mr. GIANFORTE. OK. Dr. Atlas, would you agree that this legislation and bills like it would also require taxpayers to fund elective abortion with no limitation?

Dr. ATLAS. I don't know the answer to that.

Mr. GIANFORTE. How would you rate—well, with that, Madam Chair, I am glad we are having this hearing today. It is very important for the American people that we preserve access to quality care and get costs down, and with that I yield back.

Ms. ESHOO. The gentleman yields back. The gentleman from Maryland, Mr. Sarbanes, is recognized for 5 minutes.

Mr. SARBANES. Thank you, Madam Chair. I want to thank the panel.

First of all, I want to push back pretty hard on the doomsday scenario that is being painted by some of our colleagues on the other side of the aisle, which to me amounts to fearmongering. There is a lot of distortions of what the cost of the Medicare for All proposal would be, these scenarios about what would happen to hospitals, rural hospitals. The fact of the matter is that, under the current Medicare and Medicaid programs there is a lot of investment, and that is what it is that goes into those kinds of hospitals and delivery systems. And so, if you had a Medicare for All system, I think you would continue to see that kind of investment. It is not like we would just walk away from these critical parts of our delivery system, so that has to be accounted for when we are having this discussion.

The thing about the Medicare for All proposals—and there are many that have been presented, they all have different merits—to me it is the most honest in the sense that I think that is where we are going to land, ultimately. The fact of the matter is, Americans like Medicare, they like Medicaid, they like the veterans' healthcare system, they have basically already made a judgment that these systems that are delivered and led out of the public sector are ones that give them a sense of confidence about their healthcare, and so I think that it is just a matter of time before we get to a place where we have a Medicare for All system.

As Representative Jayapal described it, it has got the three things you want. It has got universal coverage and access so everybody is covered. It has got a comprehensive set of benefits so people understand that when they need to see a doctor, they need to go to the hospital, they need to get care, that that is going to be available to them. And it eliminates the wasteful overhead and the predatory practices of the health insurance industry, which have inflicted a lot of suffering on people for decades now. So that is what Americans want. That is where we are going to be, ultimately.

The discussion that we are having—we are seeing it play out even in the sort of the presidential sweepstakes—is how do you transition? How quickly do you get there? I think there is an appetite to get there as quickly as we can, and that is being discussed and it is part of what I think are very robust and meaningful and carefully executed analyses of the Medicare for All plan that have

been put forward. So it doesn't help things to just engage in this kind of knee-jerk denigration of Medicare for All, pulling out of thin air some of these numbers, predictions, and fearmongering. That is not a constructive contribution to the discussion.

Now, I wanted to ask Ms. Ross—the only thing, I only have a minute and a half left because I couldn't stop talking. But there is—Maryland just—there is just a report released by CMS about Maryland's all-payer model, which includes global budgeting, and it did show that, when you put global budgeting in place, in that instance you are reducing Medicare expenditures by 2.8 percent, hospital expenditures by 4.1 percent, reducing admissions and avoidable hospitalizations, and I was just curious to get your perspective on kind of global budgeting.

Obviously, many of the proposals included here, Medicare for All as well, incorporates, conceptually, this idea of more global budgeting. And so, if you could speak to how that would promote transparency, potentially lower costs, and benefit patients in underserved and vulnerable communities, if you think that kind of approach would achieve those things.

Ms. ROSS. I do, indeed. And I think we are lucky that we have the example of Maryland, because it has worked so well there. For those who might not know, Maryland started their what amounts to global budgeting in 2010, and they started with rural hospitals, and it was so successful then they put it in the rest of their hospitals, private and public. And what they found was—I have got some figures. Their global budget saved Medicare as a payer over 420 million in just 3 years. And, originally, their goal was to save 330 million over 5 years, so it was a whopping success. And, from a nurse's perspective, what it does for patients is wonderful, because it reduced infection rates, it improved care, it reduced readmission rates, and those are all things to look at.

Ms. ESHOO. I need to interrupt. The gentleman's time has expired.

Mr. SARBANES. Thanks very much.

Ms. ESHOO. And we have votes on the floor. I just want to inform Members that the Members that are not part of the subcommittee I don't think are going to have the opportunity. I would stay were it not for the fact that we have votes on the floor.

So where is Mrs. Dingell? Is she here?

All right, I am going to call on Ms. Kelly from the State of Illinois for her 5 minutes. And if Mrs. Dingell comes back, I will take her, but then we are going to have to close the hearing. So the gentlewoman from Illinois is recognized for her 5 minutes.

Ms. KELLY. Thank you all for your testimony today and your patience. One thing I have to say, you know, we worked hard on—I wasn't here, but my colleagues worked hard on the Affordable Care Act, and I don't think there is a Democrat that would say that was a perfect bill. But a lot of people that didn't have coverage received coverage, but as we know there is still about 27½ million people that don't have the coverage.

But when I came here, instead of spending time and time and time trying to repeal the bill, we should have been working on how we could make it better, but all we faced was a wall, and I think we voted to repeal it 63-plus times. So, you know, let's be honest

about, you know, what happened. And then there was the trifecta of Republican Senate, House, and the President, and we still didn't improve healthcare in this nation.

I am the chair of the Congressional Black Caucus Health Braintrust, so I am very concerned about the disparities in health for minorities. We, when it comes to morbidity and mortality, I mean we lead the cause. I had a bill, the MOMMA's Act, that dealt with maternal mortality, and as some of you know black women die at 3 to 4 times the rate of white women. I had a bill that would take the Medicaid coverage to a year instead of 2 months, but I could not get one Republican on that bill even though we talk about, you know, we don't want two different healthcare systems for the poor and for the rich, but then when we have the opportunity we don't do it. Now we got a bill out, but we had to water it down.

Now, Ms. Rosenbaum, you mentioned the need for coordination across healthcare, public health education, and job development service systems. Could you expand upon this and explain what are the ways to address disparities and improve community health aside from increasing access to care, which we all know is needed?

Ms. ROSENBAUM. Yes. I would like to actually begin by disagreeing with Dr. Atlas. I think the infant mortality problem in the United States is very real. It is not simply a matter of numbers and how we count, and it is made all the more real by the terrible disparities on the basis of race and income.

I think it is very important to couple any health coverage reform legislation with provisions that do the kinds of things that the Braintrust has been such an advocate for, which is bulking up public health, bringing healthcare providers under sort of a broader public health umbrella, making sure that part of the healthcare experience is care management to be able to get better access to the kinds of services and interventions that we commonly call the social determinants at this point, making sure that when you walk in the door for healthcare you not only have good healthcare, but you have access to nutrition, to housing assistance, to the other things that make people healthy.

The Affordable Care Act actually did a good job of starting that process of bridging between health and healthcare. The community health center expansion was, of course, incredibly important. The Public Health Trust Fund was important. And I think it is absolutely key that the Black Caucus continue as it was, it was the leader on those kinds of equity measures, that it continue to lead on these issues.

Ms. KELLY. Thank you. And because of time, I yield back.

Ms. ESHOO. The gentlewoman yields back. And do we have anyone else? Is—Mrs. Dingell leave?

All right, I am going to place in the record the following documents: an article from the Century Foundation, "Health Reform's North Star;" report from the Century Foundation, "Road to Universal Coverage;" coalition letter from Advocates for Youth, et al.; a letter from NAACP, et al., regarding Medicare for All; letter from the Fraternal Order of Police in support of H.R. 4527; letter from the International Association of Fire Fighters in support of H.R. 4527; letter from the Healthcare Leadership Council; statement

from the American Nurses Association; and the statement from Representative Cedric Richmond; and a statement from BCBS of California; as well as the documents that Congressman Shimkus asked to be entered in the record. Hearing no objections, so ordered.[1]

Ms. ESHOO. We will recognize the gentleman from Virginia for his additions.

Mr. GRIFFITH. Thank you, Madam Chair. I ask unanimous consent to include the following into the record. I understand these documents have been shared previously with the majority. It would be statements from the American Hospital Association; America's Health Insurance Plans; Blue Cross Blue Shield Association; Chamber of Commerce; Partnership for America's Healthcare Future; Partnership for Employer-Sponsored Coverage; Texas Hospital Association; March for Life letter; National Right to Life; Ethics and Religious Liberty Commission; Susan B. Anthony List; American Action Forum; American Hospital Association; Committee for a Responsible Federal Budget; Heritage Foundation; Mercatus Center; Partnership for America's Healthcare Future; polling from Partnership for America's Healthcare Future; news articles and op-eds from the Hill, the Washington Post; one-pagers from Blue Cross Blue Shield Association; Congressional Pro-Life Caucus; Partnership for America's Healthcare Future; and Partnership for Employer-Sponsored Coverage.

Thank you, Madam Chair.

Ms. ESHOO. So ordered.[2]

Ms. ESHOO. All Members, pursuant to committee rules, have 10 business days to submit additional questions for the record to be answered by the witnesses who have appeared today, and I ask each witness to respond as promptly as possible to any questions that are submitted to you.

Before I gavel the adjournment of the subcommittee, I want to thank each one of you. You have taken a great deal of your time, put a great deal of effort into your written testimony. Each one of you has the passion that you have brought to the witness table. You have traveled to come to be with us. I thank each one of you.

At the beginning of this year, as when my colleagues elected me the chairwoman, the question was asked, "Will you have a hearing on Medicare for All?" And I said that I would. No one had to twist my arm off for it. This subcommittee has been the most productive subcommittee of the Energy and Commerce Committee, so it may be December that we are having this hearing, but we have taken up major legislation all year long. And that was appropriate, and now this hearing.

So I thank all the advocates that have traveled to be with us. Thank you for your passion, for your big dreams—keep it up. And with that, the subcommittee is adjourned.

[Whereupon, at 1:57 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

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[1] The information has been retained in committee files and also is available at https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=110313.

[2] The information has been retained in committee files. The American Hospital Association, Heritage Foundation, and Mercatus Center reports also are available at https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=110313.

Economists in Support of a Medicare for All Health Care System

An Open Letter to the Congress and People of the United States

November 19, 2019

As economists, we understand that a single-payer "Medicare for All" health insurance system for the U.S. can finance good-quality care for all U.S. residents as a basic right while still significantly reducing overall health care spending relative to the current exorbitant and wasteful system. Health care is not a service that follows standard market rules. It should therefore be provided as a public good.

Evidence from around the world demonstrates that publicly financed health care systems result in improved health outcomes, lower costs, and greater equity. As of 2017, the U.S. spent $3.3 trillion annually on health care. This equaled 17 percent of U.S. GDP, with average spending at about $10,000 per person. By contrast, Germany, France, Japan, Canada, the U.K., Australia, Spain and Italy spent between 9 – 11 percent of GDP on health care, averaging $3,400 to $5,700 per person. Yet average health outcomes in all of these countries are superior to those in the United States. In all of these countries, the public sector is predominant in financing heath care.

For these reasons the time is now to create a universal, single-payer, Medicare for All health care system in the United States.

Public financing for health is not a matter of raising new money for healthcare, but of reducing total healthcare outlays and distributing payments more equitably and efficiently. Implementing a unified single-payer system would reduce administrative costs and eliminate individuals' and employers' insurance premiums and out-of-pocket costs. If combined with public control of drug prices and a dramatically simplified global budgeting system, a sensible Medicare financing system would reduce healthcare costs while guaranteeing access to comprehensive care and financial security to all.

As such, we support publicly and equitably financed health care through a Medicare for All system at the Federal level, as described in H.R. 1384 and S. 1129. We encourage Congress to move forward with implementing a public financed Medicare for All plan to achieve the equitable and affordable universal health care system that the American people need.

Signed,

1 Randy Albelda, Professor of Economics, University of Massachusetts Boston

2 Carolyn B. Aldana, Professor Emeritus, California State University, San Bernardino

3 Mona Ali, Associate Professor of Economics, SUNY New Paltz

4 Larry Allen, Professor of Economics, Lamar University

5 Jack Amariglio, Emeritus Professor of Economics, Merrimack College

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85 Anthony Gabb, Associate Professor, St. John's University, NY
86 Barbara Garson, Author, *Money Makes the World Go Round*
87 Alison Garnham, Chief Executive, Child Poverty Action Group
88 Barbara Garson, Author, Money Makes the World Go Round,
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94 Don Goldstein, Emeritus Professor of Economics, Allegheny College
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168 Reynold F. Nesiba, Professor of Economics, Augustana University

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188 Leanne Roncolato, Assistant Professor of Economics, Franklin and Marshall College

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215 Linwood Tauheed, Associate Professor, University of Missouri Kansas City

216 Daniele Tavani, Associate Professor, Colorado State University

217 Pavlina R. Tcherneva, Program Director and Associate Professor of Economics, Bard College, and Research Associate, Levy Economics Institute

218 Chris Tilly, Professor of Urban Planning, UCLA Luskin School of Public Affairs

219 E. Ahmet Tonak, Visiting Professor, Economics, University of Massachusetts Amherst

220 Mariano Torras, Professor, Adelphi University

221 Andres Torres, Distinguished Lecturer, Lehman College (retired)

222 Mayo Toruno, Professor Emeritus, California State University San Bernardino

223 Eric Tymoigne, Associate Professor of Economics, Lewis & Clark College

224 Vamsi Vakulabharanam, Associate Professor of Economics, University of Massachusetts Amherst

225 Hendrik Van den Berg, Professor Emeritus, University of Nebraska, and Lecturer, University of Massachusetts Amherst

226 Wouter van Ginneken, International Delegate, ATD Fourth World, and Ex-official, ILO

227 William Van Lear, Economics Professor, Belmont Abbey College

228 Ramaa Vasudevan, Associate Professor, Colorado State University

229 Tanadej Vechsuruck, Assistant Professor, University of Rhode Island

230 William Waller, Professor of Economics, Hobart and William Smith Colleges

231 John P. Watkins, Professor of Economics, Westminster College, and Adjunct Professor of Economics, University of Utah

232 John Weeks, Professor Emeritus, SOAS, University of London

233 David F. Weiman, Professor of Economics, Barnard College, Columbia University

234 Scott A. Weir, Ph.D. in Economics, Retired

235 Jeannette Wicks-Lim, Associate Research Professor, Political Economy Research Institute

236 Noé Wiener, Lecturer, University of Massachusetts Amherst

237 Robert B. Williams, Professor of Economics, Guilford College

238 John Willoughby, Professor, Department of Economics, American University

239 Benjamin Wilson, Assistant Professor, SUNY Cortland

240 Lucas Wilson, Professor, Mount Holyoke College

241 Valerie Wilson, Director, Program on Race, Ethnicity & the Economy, Economic Policy Institute

242 Andrew J. Winnick, Professor of Economics Emeritus, California State University, Los Angeles

243 Jon D. Wisman, Professor of Economics, American University

244 Richard D. Wolff, Professor of Economics Emeritus, University of Massachusetts Amherst

245 Hyun Woong Park, Assistant Professor, Denison University

246 L. Randall Wray, Professor of Economics and Senior Scholar, Bard College and Levy Economics Institute

247 Brenda Wyss, Associate Professor, Wheaton College Massachusetts

248 Yavuz Yasar, Associate Professor, University of Denver

249 Tai Young-Taft, Assistant Professor of Economics, Bard College at Simon's Rock, and Research Scholar, Levy Economics Institute of Bard College

250 June Zaccone, Associate Professor of Economics, Emerita, Hofstra University

251 Ajit Zacharias, Senior Scholar, Levy Economics Institute

252 German A. Zarate-Hoyos, Associate Professor, SUNY Cortland

253 Gabriel Zucman, Assistant Professor of Economics, University of California, Berkeley

THE CENTURY FOUNDATION

Health Reform's North Star: 10 Guidelines to Reach Universal Health Care Coverage

NOVEMBER 13, 2019 — JAMILIA TAYLOR AND JEN MISHORY

THE CENTURY FOUNDATION

Health Reform's North Star: 10 Guidelines to Reach Universal Health Care Coverage

NOVEMBER 13, 2019 — JAMILIA TAYLOR AND JEN MISHORY

Dozens of members of Congress, presidential candidates, and state policymakers have released and debated proposals to make access to health coverage universal—or to make strides toward that goal. Proponents of a public, single-payer system argue that to achieve true universal health care, we must take private insurers out of the picture entirely, and provide universal coverage through a system such as Medicare. Others argue that the nation can approach or achieve universal coverage by the introduction of a public option or by expanding the ability of people to buy into existing public insurance. Regardless of which path wins out, the next iteration of health care reform must focus on both providing affordable, comprehensive coverage for individuals and boldly supporting better access to quality care, particularly for marginalized communities.

Below are ten guidelines to direct policymakers looking to build on the gains of the Affordable Care Act and move boldly toward achieving a truly universal, comprehensive, and equitable health care system:

- **Protect and expand access to insurance coverage and comprehensive benefits by reversing Trump deregulation attempts and bolstering the ACA benefit provisions and nondiscrimination guarantees.** The Affordable Care Act created a set of private market reforms designed to end blatant discrimination against women, people with preexisting conditions and health status more broadly, and people in protected classes. All new reform efforts must not only reverse Trump administration efforts to weaken both protections against explicit discrimination and baseline coverage standards, but also further codify protections that ensure that benefit inclusion and design decisions do not result in limiting access to care for people by health status or protected class. It must also use evidence-based strategies to build on the essential health benefits package to address, for example, long-term care needs.

- **Provide access to health care for U.S. residents, regardless of immigration status.** Noncitizens are almost five times as likely to be uninsured (though just as likely to be in a family with an employed individual), making up one-quarter of the total uninsured population—in large part due to limited access to employer coverage and explicit barriers to public and individual coverage. Our country's uninsured rate will never reach zero if health reform does not address those barriers.

This report can be found online at: https://tcf.org/content/commentary/health-reforms-north-star-10-guidelines-reach-universal-health-care-coverage/

- **Make any premiums or out-of-pocket costs affordable for consumers across the income spectrum.** Achieving universal coverage will require both significant public investments and provider payment restructuring to bring down premiums to affordable amounts at every income level. In order to make coverage a practical way to access health care, reform efforts must also limit out-of-pocket costs, such as deductibles, surprise bills, high prescription drug costs, and other point-of-service charges. Efforts that provide advances on premiums without addressing out of pocket costs may achieve universal coverage but may fall short of universal access to care, particularly for communities with low- and moderate-median income and/or limited wealth.

- **Ensure that consumers have access to quality providers, which means both anticipating increased demand and addressing existing provider shortages and hospital closures.** Health reform efforts must make any new access to coverage usable in practice—in particular, people in both low-income communities of color and rural communities, who currently have limited options, must be able to see a doctor or get to a hospital nearby—and those care options must be of quality. Additionally, a larger insured population may result in an increase in demand for care, and therefore requires transitional planning to ensure that the health care workforce pipeline expands and diversifies.

- **Support the development of a robust, diverse, and culturally competent health care workforce.** Ensuring a health care workforce that is robust, diverse, well-trained and culturally competent is essential to health reform efforts. Diversity should be encouraged and facilitated throughout the health care system and care teams, including physicians, nurses, and medical specialists, as well as community health workers and paraprofessionals. All staff and personnel should be adequately trained on an ongoing, periodic basis to ensure cultural competency. Payment rates and coverage guidelines for health care coverage, including coverage under a public option or safety net program, should be developed in a way that supports fair, living wages and pay equity in the health care professions and jobs.

- **Promote health equity by adequately addressing racism, bias, discrimination, and other systemic** barriers within the health care system. Structural racism and discrimination plague communities of color and pose barriers to attaining quality health care. Black and Hispanic patients with chronic health conditions are more likely to report experiencing discrimination in health care. Health reform efforts must promote health equity and acknowledge the historical foundations of racism in this country, particularly against African Americans, indigenous people, and those of Latin descent, while also incorporating mechanisms to adequately address discrimination. Health care providers, personnel, and staff should be trained to recognize and eliminate both explicit and implicit bias. Trainings should be substantive and take place at regular intervals. Health reform plans should also include accountability measures at both the individual and systems levels, including measures that link payment to quality and professional certification and licensure.

- **Incorporate evidence-based tools to adequately address health disparities that focus on quality of care and extend beyond health insurance coverage.** Health insurance coverage is just one aspect in helping to ensure that all people have the highest attainment of health and well-being, not the full picture. How a country performs in addressing health disparities is a measure of progress toward achieving health equity, and the United States continues to fall short. Across health conditions, people of color experience worse health outcomes than whites. Health disparities also exist

based on income level. Health reform efforts must build upon the work to address health disparities as implemented under the Affordable Care Act, and be steadfast in focussing on both insurance coverage and the quality of health care. This must include taking into account the social determinants of health and working across sectors to support individuals and families at greatest risk for poor health outcomes. Any health reform plan must hold providers accountable for reducing health disparities and providing all people, regardless of income-level, race/ethnicity, gender, disability, or sex, with high quality, compassionate health care.

- **Promote the destigmatization of mental health conditions and increase meaningful access to mental health care by better integration within the health care system, ensuring the availability of a diverse mental health workforce and affordable coverage.** According to the American Psychological Association, mood disorders and rates of suicide have significantly increased in the United States. Despite some integration of mental health screenings into other health care services and better insurance coverage under the Affordable Care Act, it is still woefully challenging to find a mental health care provider and cover the out-of-pocket costs associated with this care for many people in the country. Indeed, these burdens fall hardest on low-income communities and people of color. Health reform efforts must prioritize ensuring the availability of mental health care, including support for a diverse mental health workforce. For people of color, culturally competent care is critical in the true attainment of physical, mental, and emotional health. Mental health providers must be accessible and new insurance options must cover nontraditional service provision, such as through telehealth in lieu of in-person visits, in order to support care for hard-to-reach populations, including rural communities. Public and private health insurers also have a responsibility to help promote the destigmatization of mental health care by ensuring adequate coverage for mental health services within health plans and minimal cost-sharing.

- **Strengthen access to trusted community-based providers currently available through safety net programs.** Safety net programs such as Medicaid, Medicare, the Children's Health Insurance Program, and Title X have helped to ensure health care coverage and access for low-income people for decades. Community-based health care providers, which are also key components of the safety net, work on the frontlines to serve individuals and families with or without health insurance. These providers often reflect the demographics of the communities they serve and offer basic health care services at free or reduced cost. Health reform plans should ensure continued access to these vital sources of care, as well as seamless coordination with health insurance payers for people with coverage. Regardless of the health reform vehicle or structure, safety net programs will always be important to ensuring health care access for marginalized communities.

- **Guarantee comprehensive coverage of sexual and reproductive health care, including insurance coverage of abortion.** The Affordable Care Act helped to revolutionize the provision of comprehensive, affordable women's health care. Contraception, maternity care, well-woman visits, screenings for reproductive cancers, breastfeeding supports, and a host of other services are supported under the law without cost-sharing. The Affordable Care Act also made it illegal to charge women more than men for health insurance coverage. Unfortunately, insurance coverage of abortion was not included in the package of women's health services supported under the Affordable Care Act. Health reform plans must maintain these critical women's health care supports and finally treat abortion as the health care it is by covering it without restriction or onnerous administrative burdens in all plans, regardless of the payer.

The Affordable Care Act has helped transform insurance coverage and the delivery of health care for millions of people in this country. And while it is important to reflect on the progress made, it is equally important to build on coverage gains and improvements in health outcomes. Health care reform has been central to the national debate on how best to move the country forward. Regardless of the structure or vehicle, the guidelines outlined in this document chart the way forward for a health reform that not only focuses on ensuring universal health insurance coverage, but also promotes health equity and proactively addresses better access to quality, affordable health care for all. In order to realize truly universal coverage and health care access, the U.S. health care system must work for and adequately serve all people in this country.

Authors

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Jen Mishory is a senior fellow at The Century Foundation, working on issues related to workforce, higher education, and health care, and a senior policy advisor. Prior to joining TCF, Jen co-founded and served as the Executive Director of Young Invincibles, which has grown to become the largest advocacy organization in the country representing young Americans.

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REPORT HEALTH CARE

Road to Universal Coverage: Addressing the Premium Affordability Gap

SEPTEMBER 18, 2019 — JEN MISHORY AND KATIE KEITH

Editor's note: This blog first appeared on September 18th, 2019 in Health Affairs, available here.

The Affordable Care Act (ACA) expanded coverage to 20 million Americans and improved the quality of private health insurance for millions more. Low- and moderate-income individuals experienced the greatest coverage gains: the uninsurance rate dropped by almost 10 percentage points for those whose income is at or below the federal poverty level (FPL) and over 11 percentage for those just above the FPL. Much of this progress is attributed to Medicaid expansion and the availability of marketplace subsidies, the latter of which brought federal financial assistance to individuals purchasing private health insurance. Both policies are targeted to low- or middle-income people.

Despite this progress, significant premium affordability gaps remain, especially for those on the lower half of the income scale. These gaps persist because the Medicaid expansion and marketplace subsidies do not reach all low-income or middle-class individuals, either because they don't qualify for assistance, do not know about subsidies, or because they struggle to afford coverage even with available subsidies. Of the 28.5 million people who were uninsured in 2017, almost 23 million earned below 400 percent FPL.

Furthermore, in that year, nearly 17 percent of people at or below 100 percent FPL (e.g., a family of four earning less than $25,000) and 12 percent of people earning between 100 and 300 percent FPL (e.g., a family of four earning up to $75,000) did not have insurance—and about half of uninsured people said they were uninsured due to cost. (And even those who did have health insurance still faced affordability gaps, created by high deductibles or excessive out-of-pocket costs; underinsurance is also a significant challenge not discussed in this post.)

Current proposals to expand access to coverage—such as state or federal public options, Medicaid or Medicare buy-in proposals, and single-payer plans—reflect a range of strategies to make premiums more affordable. Many of these proposals would also extend to people who are currently ineligible for ACA coverage or subsidies. This post discusses the impact that these different approaches would have on premium affordability for low- and middle-income families and individuals.

Affordability Considerations For Public Coverage Proposals

Given the high costs for millions of families (and the fact that health care costs are seen as a top priority for voters), there has been no shortage of new proposals to leverage public coverage to reduce premiums. Many of these proposals rely on some mix of decreasing provider reimbursement rates and profits, shifting risk to other types of coverage or markets, and expanding subsidies. We will discuss each of these approaches in turn.

Lowering Provider Reimbursement Rates

One way for a public option to reduce health care costs is to leverage projected market power to simply pay providers less. Private insurers and employers typically reimburse providers at rates that far exceed Medicare or Medicaid, and public options could generate savings by using lower reimbursement rates more closely tied to traditional public insurance. (A lower-premium public option plan could then, in turn, increase competition in the marketplace, driving down premiums for private competitors.)

To date, all of the federal public coverage proposals would base their provider reimbursement rates off of Medicare or Medicaid payment standards. States considering public options are similarly exploring rate setting that might hew to public rates. In addition to lower provider reimbursement rates, these proposals generally eliminate or limit profits and taxes, resulting in further savings. (This effect will vary based on factors such as whether the public plan is administered by private companies, and on current profit margins in the commercial market.)

Projections on the impact of lower provider reimbursement rates on premium affordability vary significantly:

- Washington's new public option—which will be administered by private health insurers and sold through the state's ACA marketplace—will reimburse providers by up to 160 percent of Medicare rates and is expected, in aggregate, to reduce individual market premiums by about 10 percent.
- In Colorado, Medicare-based reimbursement rates are projected to reduce premiums for a future public plan by about 15 percent as compared to the individual market, with additional savings from eliminating taxes and profits of between 6 and 10 percent.
- In New Mexico, analysts project that a Medicaid buy-in public option—that uses Medicaid rates and networks, and without profit margins—would have premiums between 15 and 28 percent lower relative to ACA marketplace options.
- Single-payer proposals assume that the government will pay Medicare rates or rates based on a negotiated global budget. Under the Senate and House Medicare for All proposals, enrollees would pay no premiums. Therefore, the cost for low- and middle-income consumers would depend on the progressivity of the financing mechanism.

The success of these efforts in bringing down premiums will depend in part on the reference rates that are used and how high the rates are in the private health insurance market. States with high provider rates, such as Oregon, could see a much greater impact in moving to a Medicare-based reference price than states with lower existing provider reimbursement rates.

Success will also depend on whether the public option can garner enough market share to convince providers to participate in their plan even at lower rates. Other factors include the payer and enrollee mix (including income level) in a given market as well as the possibility of cost-shifting to private insurers and employers (although recent research suggests that cost-shifting from Medicare to private health insurance is not inevitable or a foregone conclusion).

Because many low-income consumers receive ACA subsidies that allow them to pay based on their income, the effects of these rate reductions may be felt most by middle-income consumers eligible for minimal or no subsidies.

Risk Pool Migration

Insurance works by pooling risk. A larger risk pool helps keep premiums stable by better ensuring an appropriate balance between healthier and sicker people. Except for single-payer proposals (which would eliminate separate risk pools), public coverage proposals would generally maintain a multi-payer system. Having multiple payers—such as Medicaid, Medicare, and the commercial insurance market—affects the size of each risk pool and impacts premiums.

The effects of risk pool migration, where populations migrate from one risk pool to another, will be critical to understanding many of the public coverage proposals, which draw heavily on expansions of Medicare, Medicaid, and the individual market. For instance, states that have expanded their Medicaid programs have lower premiums in their individual market. A recent analysis of Medicaid expansion in Wisconsin confirms this trend.

Additional actuarial analysis is needed, but federal proposals that expand marketplace subsidies (and thus expand the risk pool) or allow older adults to buy in to Medicare (and thus reduce health care costs in the individual market) could have the added impact of improving the risk pool of the individual market, driving down premiums.

States must balance similar considerations with smaller populations. If, for instance, a Medicaid buy-in or public option proposal offers a narrower provider network, the buy-in might be more attractive to healthier consumers who are willing to accept a limited network in exchange for lower premiums. In developing a buy-in model in Colorado, actuaries assumed the buy-in would have a narrower network and that enrollees would be 10 percent healthier than individuals that remained in the individual market. While this risk mix would produce savings for the buy-in program, it would likely slightly increase individual market premiums as healthier people migrated out of ACA coverage and into the buy-in program. If the buy-in is part of the individual market single risk pool, this effect could be mitigated by the ACA's risk adjustment program. Low-income consumers may feel these effects less because they are insulated from premium increases due to marketplace subsidies.

To address potential market uncertainty and help sustain a robust risk pool, some proposals, such as Medicare X, include reinsurance to insulate insurers from heavy losses if they attract a higher-risk population. A renewed federal reinsurance program for the ACA would reduce premiums nationwide and would most significantly help middle-income people who are not subsidy-eligible. For 2020, 12 states are expected to operate state-based reinsurance programs under ACA waiver authority.

Expanding Subsidies And Discounts (Up to Free)

Several public coverage proposals would expand the eligibility for subsidies to purchase both the public option and private competitors. Expanded subsidies are likely critical to expanding coverage to additional low- and middle-income consumers, many of whom remain uninsured even with available ACA subsidies. Examples of incorporating expanded subsidies (or offering sliding scale premiums) into public coverage expansions include:

- As part of its public option bill, Washington will expand premium tax credits to people earning up to 500 percent FPL and limit premiums for individuals at 500 percent FPL to 10 percent of income.

- Many federal proposals would allow individuals to receive subsidies or pay reduced rates for premiums at higher incomes than currently allowed, or would eliminate income limits on those discounts altogether. Medicare for America would offer sliding-scale premiums at all income levels and cap premiums at 8 percent of income, while the federal Medicaid buy-in proposal would cap buy-in premiums at 9.5 percent of income for all income levels.

- Single-payer proposals in the House and Senate would eliminate premiums altogether, effectively subsidizing 100 percent of premiums regardless of income.

Some federal proposals would additionally make subsidies more generous. Medicare Part E, for instance, would peg subsidies to more comprehensive gold coverage (rather than silver coverage), thereby increasing the generosity of premium tax credits. Other proposals would reduce the contribution that individuals must make towards premiums. Medicare X, for example, would require an individual earning 200 percent FPL to contribute 5.8 percent of their income towards premiums (down from 6.5 percent under the ACA).

Expanding Eligibility For New Coverage Options

Proposals to expand the availability of public coverage should also account for the fact that the ACA includes some significant eligibility gaps. These include the failure of some states to expand Medicaid to cover all people up to 138 percent FPL after the Supreme Court made the expansion voluntary; the lack of coverage options for undocumented individuals; and the "family glitch" under which an employee's family members are deemed ineligible for marketplace subsidies as long as the employee is offered affordable, self-only employer-based coverage, even if family coverage through the employee's workplace would be unaffordable. New proposals that fail to account for these gaps will continue to leave millions of low- and middle-income people uninsured.

Closing The Medicaid Gap

To date, thirty-six states and Washington, D.C. have expanded their Medicaid programs to extend coverage to millions of low-income childless adults. Fourteen states have declined to do so. This leaves billions in federal funding on the table and a total of 2.5 million people in the "Medicaid coverage gap"—the dead zone between the maximum income threshold for Medicaid eligibility (or zero income for childless adults in states where they are not eligible for traditional Medicaid) and qualification for market subsidies at 100 percent FPL. Individuals earning between 100 and 138 percent FPL may be eligible for subsidized marketplace coverage, but this coverage is not as generous as Medicaid.

Some, but not all, public coverage proposals would effectively close the Medicaid gap. Proposals such as Medicare for America and Medicare for All would provide free public option coverage to individuals who fall within the Medicaid coverage gap. Other proposals, such as Medicare X, would heavily subsidize coverage for people earning less than 138 percent FPL. Federal proposals could also further encourage states to close the gap themselves or to allow cities and counties to expand Medicaid on their own.

Expanding Options For Undocumented Individuals

About one-quarter of the uninsured are non-citizens (either lawfully present or undocumented). While undocumented individuals are just as likely to be in a family with an employed individual, they are almost twice as likely to be low income, working in jobs with limited access to insurance. These individuals are also barred from Medicaid, CHIP, and marketplace coverage. As a result, this population is five times as likely as citizens to be uninsured.

States can expand access to this population but must, for the most part, use their own funds and cannot rely on individual marketplaces in the absence of a waiver. This year, California expanded parts of its Medicaid program using state dollars for income-eligible undocumented individuals under 26.

Few federal proposals provide details on how undocumented individuals would be affected. Single-payer proposals explicitly offer coverage regardless of citizenship but allow the federal government to further define eligibility requirements. Other proposals—such as Medicare Part E and Medicare for America—would offer coverage to all residents but similarly leave discretion to the federal government. To the extent that proposals incorporate ACA restrictions, they would presumably exclude undocumented individuals from subsidized or marketplace coverage.

Fixing The Family Glitch

Addressing the so-called "family glitch" would mean clarifying that an offer of "affordable" job-based coverage for an employee does not bar that employee's family from being eligible for marketplace subsidies. Doing so could extend marketplace subsidies to between 3 and 6 million people under 400 percent FPL, saving them thousands of dollars annually and boosting economic security for low-income families.

Proposals that do not rely on the existing premium subsidy model, such as single-payer proposals or Medicare for America, would automatically end the glitch. But while new public coverage proposals may offer cheaper unsubsidized premiums for families affected by the glitch, many of these proposals—such as state public options and Medicare X—still incorporate existing ACA subsidy restrictions, including the family glitch, leaving millions of low- and middle-income families locked out of the further savings that come with subsidies.

Public coverage proposals require intentional policy design to improve affordability for low- and middle-income families. Their success in lowering premiums and moving toward universal coverage may depend on how aggressive they are in bringing down health care costs, how heavily they subsidize coverage, and how expansive their eligibility rules become.

Jen Mishory, Senior Fellow

Jen Mishory is a senior fellow at The Century Foundation, working on issues related to workforce, higher education, and health care, and a senior policy advisor. Prior to joining TCF, Jen co-founded and served as the Executive Director of Young Invincibles, which has grown to become the largest advocacy organization in the country representing young Americans.

Katie Keith, Contributor

Katie Keith, JD, MPH, provides "Following the ACA" rapid response analysis for the Health Affairs Blog. She is a principal at Keith Policy Solutions, LLC, where she advises nonprofits and foundations on health care issues and conducts original legal, policy, and qualitative analysis to support policy goals. Her work includes an emphasis on implementation of the Affordable Care Act (ACA) and its impact on underserved populations, such as the lesbian, gay, bisexual, and transgender (LGBT) community.

December 10, 2019

U.S. House of Representatives
Committee on Energy & Commerce
Subcommittee on Health
Washington DC, 20515

Dear Chairwoman Eshoo and Ranking Member Burgess:

We, the undersigned organizations, commend the Committee leadership for convening today's hearing on "Proposals to Achieve Universal Health Care Coverage." While the Affordable Care Act (ACA) made important progress in expanding access to quality, affordable health insurance for millions of people in the United States, persistent gaps remain. Research shows that, in particular, significant numbers of low-income women, women of color, and immigrant women are still uninsured or underinsured, and that these groups experience disparities in health care access and outcomes as a result. Cost, both premiums and cost sharing, remains a barrier for many, and gaps in covered benefits mean that many people – particularly women, LGBTQ people and people with disabilities – are still unable to access the health care services that they need.

Universal coverage proposals have the potential to remedy these barriers and gaps. And while there are many pathways to achieving universal coverage – whether through a single payer system, a public option, more competition among health plans or other strategies – we write today to express that **any proposal, in order to truly meet the health care needs of all people, must include comprehensive coverage for reproductive health care, including abortion care.**

Specifically, universal coverage proposals should explicitly include comprehensive coverage for abortion care – including both medication abortion and abortion procedures, as well as pre- and post-care – for all enrollees. Ensuring insurance coverage is foundational to recognizing that abortion care is in fact a component of basic health care, and is also necessary to foster better health and economic outcomes for individuals and their families.

Proposals must also provide coverage for the full range of reproductive health care services that people need, including contraception and related counseling; maternity, prenatal and postpartum care; gender-affirming health care; and fertility care. Proposals should enable people to seek care in the setting and with the providers that they trust and that can help them achieve the health outcomes they desire. And all people should receive health care that is free of shame, stigma, bias and discrimination – and health care entities must continue to be prohibited from discriminating based on an individual's race, sex – including gender identity and sexual orientation – ethnicity, national origin, immigration status, language proficiency, disability, age, income, religion or health status. Universal coverage proposals should also prohibit the use of religion as a way to deny anyone, and particularly women and LGBTQ people, from receiving the care, information and coverage they need.

Again, we thank the Committee for holding this important hearing, and look forward to continuing to work with Members of Congress to ensure that comprehensive reproductive health care and coverage are foregrounded in their consideration of universal coverage proposals.

Sincerely,

Advocates for Youth
African American Ministers In Action
American Civil Liberties Union
American Society for Reproductive Medicine
Black Womens Health Imperative
Global Justice Center
In Our Own Voice: National Black Women's Reproductive Justice Agenda
Jacobs Institute of Women's Health
Jewish Women International
NARAL Pro-Choice America
National Abortion Federation
National Asian Pacific American Women's Forum (NAPAWF)
National Center for Lesbian Rights
National Council of Jewish Women
National Family Planning & Reproductive Health Association
National Health Law Program
National Institute for Reproductive Health (NIRH)
National Latina Institute for Reproductive Health
National LGBTQ Task Force Action Fund
National Network of Abortion Funds
National Organization for Women
National Partnership for Women & Families
National Women's Law Center
National Women's Health Network
People For the American Way
Physicians for Reproductive Health
Planned Parenthood Federation of America
Positive Women's Network-USA
Power to Decide
Raising Women's Voices for the Health Care We Need
Sexuality Information and Education Council of the United States (SIECUS)
Union for Reform Judaism

URGE: Unite for Reproductive & Gender Equity
Women of Reform Judaism

July 10, 2019

Dear Honorable Members of the United States Congress:

As organizations that represent people of color, we respectfully urge you to co-sponsor the "Medicare for All Act of 2019" (H.R. 1384/S. 1129).

Medicare for All, the only truly single-payer, universal health care system, guarantees that health care is a right and enables every person living in the United States to receive the health care they need to survive and thrive.

Despite many gains, 30 million people in the United States lack health insurance, and tens of millions of households have health insurance but cannot afford to receive the medical care they need. One in five working-age Americans report having problems paying their medical bills despite having health insurance, driven by pocketbook-busting premiums, copays and deductibles.[1]

Universal health care is also a racial justice necessity because communities of color, in particular, suffer from a lack of access to affordable health insurance.

People of color make up 42% of the nonelderly U.S. population, yet account for over half of the total nonelderly uninsured population. Latinx and Black people have significantly higher uninsured rates (19% and 11%, respectively) compared to white people.[2]

Medical debt remains a glaring issue for Black Americans. Nearly one in three Black Americans aged 18 to 64 has past-due medical bills.[3] Black uninsured populations face burdensome out-of-pocket medical expenses when seeking care, which often means they are forced to delay preventative care and get treated as a last resort – the most expensive form of treatment.[4]

Latinx patients are the most uninsured population in the United States today. Latinx individuals already comprise much of the workforce that is unable to get health coverage through their job. Lawmakers have curtailed the Affordable Care Act's health enrollment program, which has severely challenged the ability of outreach workers to reach Latinx patients for new coverage.

Undocumented Latinx patients suffer further as they are ineligible for government-funded insurance and subsidized private health plans. Despite the fact that undocumented adults pay taxes[5], they are ineligible to receive Medicaid health benefits and financial subsidies to buy health plans from the federal-state health insurance marketplaces.

Disturbingly, racial bias mars the entirety of American health care. In particular, Black maternal and prenatal health access remains in crisis levels. In the state of New York between 2013 and

2015, 54 Black women died for every 100,000 births -- nearly four times the rate of white women.[6]

Indeed, half of maternal deaths in our country are preventable.[7] While there are many reasons why Black mothers and mothers-to-be experience poor treatment and care, a lack of quality health access is a significant factor.

Medicaid – a lifeline for many people of color and low-income patients – is not accepted at many hospitals and doctors' offices. Black and low-income women are more likely than others to be treated at under-resourced hospitals, increasing the chances they may experience complications during and after childbirth. Hospital quality can account for nearly 50%t[8] of the racial disparity in maternal illness. With Medicare for All, there are no "out of network" provider limits. Patients can get the care they seek, when it is appropriate and convenient for them.

Communities of color need a health care system that rectifies these long-standing structural biases and challenges. Medicare for All is that system. Medicare for All universal health care would support the health and economic security of patients of color, including finally providing full health coverage for all reproductive health services, alongside controlling the costs of prescription drugs – both glaring affordability and access issues for low and moderate-income patients of color.

Some health plans sold on the federal and state health insurance marketplaces discriminate on the basis of drug affordability for certain diseases, such as HIV/AIDS. By categorizing medications for particular conditions in the highest co-payment "tier," these plans price out patients with those ailments. These additional co-payments can result in thousands of dollars a year in extra expenses, crushing millions of households of color as they seek the care they need to survive.

There is only one form of universal health care that covers everybody, without exception, and lowers overall health care expenditures. Just as the passage of Medicare over 50 years ago helped spur hospital integration and improved health access, it can today usher in true universal health care.

It is time for Medicare for All.[9] We implore you to join the movement in support of this bill.

Sincerely,

A. Philip Randolph Institute
Action Center on Race and the Economy (ACRE)
Black Women's Health Imperative
Center for Popular Democracy
Color of Change
League of United Latin American Citizens (LULAC)
NAACP
People's Action
Policy Link
United We Dream

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[9] https://www.cnn.com/2015/07/28/opinions/das-gaffney-racial-injustice-health-care/index.html

NATIONAL
FRATERNAL ORDER OF POLICE®

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PHONE (202) 547-8189●FAX (202) 547-8190

PATRICK YOES
NATIONAL PRESIDENT

JIM PASCO
EXECUTIVE DIRECTOR

9 December 2019

The Honorable Anna G. Eshoo
Chairman
Subcommittee on Health
Committee on Energy and Commerce
Washington, D.C. 20515

The Honorable Michael C. Burgess
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
Washington, D.C. 20515

Dear Madam Chairman and Representative Burgess,

I am writing on behalf of the members of the Fraternal Order of Police to advise you of our continued support for H.R. 4527, the "Expanding Health Care Options for Early Retirees Act," which is one of several bills to be considered at the subcommittee's hearing entitled: "Proposals to Achieve Universal Health Care Coverage."

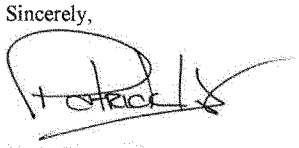
We share the perspective of many Members of this Committee that our nation can improve the access to health care and we are pleased that the Committee has included H.R. 4527 in this hearing. The FOP is particularly concerned with the tens of thousands of law enforcement officers who are left without coverage when they retire. Due to the physical demands of our profession, law enforcement and other public safety officers often retire earlier compared to those in other occupations. In fact, many local, State and Federal agencies have mandatory retirement ages for law enforcement officers. These retirees may lose their employer-provided health insurance upon or shortly after their retirement—a time when they are years away from being eligible for Medicare.

The "Expanding Health Care Options for Early Retirees Act" legislation remedies this problem by allowing law enforcement and other public safety professionals the option to buy into Medicare at the age of 50. The U.S. Secretary of Health and Human Services would establish the premiums based on the risk pool for those public safety officers who opt into the program as a separate population, but they would remain eligible for tax credits and cost-sharing subsidies to help them purchase insurance. When the officer reaches the age of 65, he or she would be seamlessly entered into the traditional Medicare program.

We believe this legislation addresses a very real and critical need for the men and women who served their communities as public safety officers by providing them with a bridge of coverage following their retirement until they reach Medicare eligibility. The Committee may not untangle the Gordian knot of universal healthcare in this hearing or the next, but we know that enacting H.R. 4527 will help retired law enforcement officers keep their access to healthcare following their decades of public service.

On behalf of the more than 349,000 members of the Fraternal Order of Police, thank you for your leadership on this important issue. If I can be of any further assistance to you, please do not hesitate to contact me or my Executive Director, Jim Pasco, in my Washington office.

Sincerely,



National President

INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS ®
HAROLD A. SCHAITBERGER
General President
EDWARD A. KELLY
General Secretary-Treasurer

December 10, 2019

The Honorable Tom Malinowski
U.S. House of Representatives
426 Cannon House Office Building
Washington, DC 20515

Dear Representative Malinowski,

On behalf of the nation's more than 320,000 professional fire fighters and emergency medical personnel I am writing to express our support for your bill H.R. 4527, the Expanding Health Care Options for Early Retirees Act. This important piece of legislation would offer the option for retired public safety workers to buy into Medicare starting at age 50, providing a stable and cost-effective healthcare option to those who have spent their lives serving their communities.

Fire fighters and EMS personnel work in dangerous and demanding conditions day in and day out, taking a serious toll on their physical and mental health. They face unique health challenges, including greater occurrences of chronic conditions like cancer, and a higher likelihood of acute conditions such as heart attack and stroke. These working conditions can be unique to the fire service, and our workers are often forced to retire well before they become eligible for Medicare.

In the absence of this legislation, fire fighters find themselves with few options for post-retirement healthcare. In relatively few instances former employers provide some semblance of insurance in retirement. Unfortunately, due to rising costs this benefit is being offered less and less. Without this type of coverage option, retirees are forced to either buy back into their old plan at a higher rate or go hunt for something on the open market – without assistance from their former employer and at a cost that only continues to rise.

H.R. 4527 will help ease the transition from work to retirement for public safety workers by providing an additional option for accessing health insurance while doing so at an affordable rate. Expanding Medicare in a targeted and efficient way will help increase coverage and lower costs for my members and many other hard-working and deserving Americans.

Respectfully,

Harold A. Schaitberger
General President

December 10, 2019

The Honorable Frank Pallone, Jr.
Chairman
U.S. House of Representatives
Committee on Energy and Commerce
Washington, D.C. 20515

The Honorable Greg Walden
Ranking Member
U.S. House of Representatives
Committee on Energy and Commerce
Washington, D.C. 20515

Dear Chairmen Pallone and Ranking Member Walden:

Thank you for conducting a hearing on "Proposals to Achieve Universal Health Care Coverage." The Healthcare Leadership Council (HLC) appreciates the opportunity to share its thoughts with you on this important issue.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

H.R. 1384, Medicare for All Act

Like you, HLC believes all Americans should have access to affordable coverage of high-quality healthcare. However, a universal healthcare system as outlined in H.R. 1384, the "Medicare for All Act" is not a practical solution. Polling has consistently shown Americans are not seeking a radical overhaul of our healthcare system. Further, there is no compelling evidence they would be better off if it did occur. The most striking aspect of a single payer healthcare system is not what it gives to millions of working families and individuals, but what it takes away. It forces everyone, no matter how much they value their current health coverage, to give that up and enter into a one-size-fits-all system that would require significant tax increases to provide adequate financing.

H.R. 1277, State Public Option Act and H.R. 1346, Medicare Buy-In and Healthcare Stabilization Act

It is impossible to overstate the extent to which a government-run public health insurance option (such as called for in H.R. 1277, the "State Public Option Act") or a Medicare buy-in approach (as proposed in H.R. 1346, the "Medicare Buy-In and Healthcare Stabilization Act") could destabilize the health insurance marketplace and generate unexpected adverse consequences for consumers and healthcare providers.

Assuming that a public option or Medicare buy-in are successful in attracting a significant number of enrollees – entirely probable because the government would have the power to establish below-market out-of-pocket costs – private health plans would find it more difficult to remain competitive in the individual coverage marketplace and some would undoubtedly cease participation. In fact, a recent study by FTI Consulting found that, over the next decade, up to two million enrollees in the individual marketplace would lose their private health insurance coverage in the event a public option is enacted.

Should this occur, not only will we see Americans lose choice in their healthcare decision making, but also healthcare providers and participants in employer-based private insurance plans could be harmed if a public option or Medicare buy-in utilizes Medicare-level reimbursement levels. That would force a destructive level of cost shifting. Thus, HLC strongly urges Congress to oppose both H.R. 1277 and H.R. 1346.

Healthcare is currently in a period of evolution, transitioning from a fee-for-service system to one that emphasizes value, improved outcomes, elevated population health, and greater cost-efficiency. To halt this progress in order to create a massive new healthcare system would serve the interests of neither taxpayers nor patients. HLC believes that Congress should continue improving and building upon the current healthcare system instead of pursing a universal healthcare system that would set back patient-centered health innovation instead of advancing it. These improvements could include:

- Establishing a permanent health reinsurance program to help lower premiums for all consumers in the individual insurance market.
- Encouraging states to establish their own reinsurance programs, perhaps through state waivers in which the reinsurance program is partially funded by federal passthrough savings.
- Revising federal assistance to help more people afford coverage through premium tax credits in addition to cost-sharing protections to help lower-income consumers access medical care.
- Increasing federal funding for outreach and awareness to encourage consumers to purchase and maintain health insurance coverage.
- Fixing the family glitch in which the cost to add family members to an individual's employer-sponsored health insurance is not considered when determining "affordability."

- Offering employers and consumers more choices for their coverage, increasing competition in the marketplace (e.g., value-based insurance designs).
- Modernizing health plans that are linked to health savings accounts

Thank you for the opportunity to share our concerns regarding these legislative proposals to advance universal healthcare coverage. HLC looks forward to continuing to collaborate with you on this important issue. If you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435 or dwitchey@hlc.org

Sincerely,

Mary R. Grealy
President

ANA
AMERICAN NURSES ASSOCIATION

December 10, 2019

The Honorable Anna Eshoo
Chairman
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Michael Burgess
Ranking Member
2322 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Eshoo and Ranking Member Burgess:

Various iterations of Medicare for All bills have been debated in Congress and will continue to be introduced as members continue to discuss access to health care and the rising costs of care. The American Nurses Association (ANA) supports a health care system that ensures:

- Access to a package of essential health care services for all citizens and residents;
- Optimization of primary, community based and preventative services;
- Cost effective use of innovative, technology driven, acute, hospital based services; and
- Sufficient supplies of skilled health care professionals dedicated to providing high quality health care services.

While Medicare for All bills try to address some of these foundational principles, ANA is concerned about the potential negative impact on APRNs and RNs in some of these legislative proposals including decreased reimbursement for the quality care they are providing. Some versions do not incorporate the role of the nurse to provide input on safe staffing levels. For many communities, APRNs are the sole provider and access point to health care services and these proposals do not recognize the value and quality care they provide across the country. ANA will continue to monitor legislation and advocate for a health care system that meets the needs of communities and the providers that serve each and every person across the country.

The American Nurses Association is the premier organization representing the interests of the nations 4.1 million registered nurses. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA is at the forefront of improving the quality of healthcare for all.

Sincerely,

Ingrida Lusis
Vice President, Policy and Government Affairs

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Silver Spring, MD 20910
www.nursingworld.org

STATEMENT OF REP. CEDRIC L. RICHMOND ON H.R. 2463, THE CHOOSE MEDICARE ACT

SUBCOMMITTEE ON HEALTH

COMMITTEE ON ENERGY AND COMMERCE

DECEMBER 10, 2019

"PROPOSALS TO ACHIEVE UNIVERSAL COVERAGE"

Thank you Chairwoman Eshoo, Ranking Member Burgess, and Members of the Subcommittee for holding this important hearing, considering this legislation, and allowing me to submit this statement for the record.

Though Americans have significant disagreements on healthcare policy in the United States, a large majority of Americans agree on one thing: They support Medicare. That is why my approach to expanding healthcare coverage is to offer every American an opportunity to choose Medicare coverage.

The Choose Medicare Act would expand access, competition, and choice by creating a new public health plan – Medicare Part E. Medicare Part E would be available in the individual market, small group market, and large group market. Every American resident, except those already eligible for Medicaid, CHIP, or traditional Medicare. Under the Choose Medicare Act, every American will have access to a form of public health insurance.

The Choose Medicare Act would provide comprehensive coverage for Americans who choose to enroll. Medicare Part E plans would be offered at the gold-level tier, meaning that, on average, beneficiaries would pay 20% of the cost of their care, while the plans cover the remaining 80%. The plan would cover all services covered by Medicare, as well the Affordable Care Act's (ACA's)ten Essential Health Benefits, including maternity and newborn care, pediatric services, mental health and substance abuse treatment, and prescription drugs. Medicare Part E would also cover abortion services. The Choose Medicare Act, therefore, brings the best of the ACA to the Medicare program, which already works so well for 55 million Americans.

The Choose Medicare Act will improve affordability not only for Medicare Part E recipients, but for all Americans. The bill would authorize the Secretary of Health and Human Services to deny, modify, or require consumer rebates for excessive premium increases in states where state regulators do not correct these excessive rates. This will ensure a process to block excessive, unjustified, or unfair health insurance premium increases.

The Choose Medicare Act would take several additional steps to improve affordability. It would extend protections against surprise out-of-network billing to Medicare Part E. It would establish, for the first time, an annual out-of-pocket maximum of $6,700 for traditional Medicare recipients, indexed to inflation to provide some desperately needed financial relief to seniors. It would direct the Secretary of Health and Human Services to negotiate the price of prescription

drugs to bring down the cost of medication. If, after one year, a negotiated price is not reached, Medicare Part D will purchase drugs at the same rate as the Department of Veterans Affairs.

Too many Americans continue to struggle to afford health insurance on the exchanges, even with the ACA's premium tax credits. That is why the Choose Medicare Act would extend and increase the premium tax credits to middle-income earners. Currently, families earning up to four times the federal poverty level are eligible for the credits. The Choose Medicare Act would make credits available to families with up to six times the federal poverty level. Currently, tax credits are benchmarked to the cost of the second-lowest available silver tier plan. The Choose Medicare Act would change the benchmark to the more generous gold-tier plan. Finally, the bill provides $10 billion per year for a reinsurance program to help states stabilize and improve affordability in their markets.

Though the Affordable Care Act was a tremendously important and effective step towards universal coverage, too many Americans still find themselves unable to afford quality healthcare. I believe that the Choose Medicare Act will ensure that every American has access to quality, comprehensive care, improve affordability, and allow Americans to choose the care that works best for themselves and their families.

Texas Hospital Association

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Austin, Texas 78701
512/465-1000
www.tha.org

December 9, 2019

House Energy and Commerce Subcommittee on Health

Hearing: Proposals to Achieve Universal Health Coverage

The following statement is from John Hawkins, Texas Hospital Association Senior Vice President of Advocacy and Public Policy, in anticipation of the House Energy and Commerce Subcommittee on Health hearing "Proposal to Achieve Universal Health Coverage."

"Texas hospitals are committed to ensuring access to quality care for all Texans, but a number of complex policy variables are coming together to create a difficult and uncertain financial and regulatory landscape for Texas hospitals. As the U.S. Congress and the Administration consider policy solutions for the nation's health care challenges, Texas hospitals oppose policies that would strain, not protect, the fragile health care safety net. Medicare is not designed for or capable of providing health care for every American. Texas hospitals support free market competition to incentivize innovation, reduce costs and enhance consumer choice."

About the Texas Hospital Association
Founded in 1930, the Texas Hospital Association is the leadership organization and principal advocate for the state's hospitals and health care systems. Based in Austin, THA enhances its members' abilities to improve accessibility, quality and cost-effectiveness of health care for all Texans. One of the largest hospital associations in the country, THA represents more than 85 percent of the state's acute-care hospitals and health care systems, which employ some 369,000 health care professionals statewide. Learn more about THA at www.tha.org or follow THA on Twitter @texashospitals.

American Hospital Association™
Advancing Health in America

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Two CityCenter, Suite 400
Washington, DC 20001-4956
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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce
Subcommittee on Health

of the

U.S. House of Representatives

"Proposals to Achieve Universal Health Care Coverage"

December 10, 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 "Proposals to Achieve Universal Health Care Coverage."

America's hospitals and health systems are committed to the goal of affordable, comprehensive health insurance for every American and believe we should build upon and improve our existing system to increase access to coverage of comprehensive health benefits. However, "Medicare for All" and other public option and buy-in proposals are not the solution.

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. 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% 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. For example, millions of the lowest-income uninsured could be covered if all states expanded Medicaid.

SINGLE-PAYER, PUBLIC-OPTION AND BUY-IN PROPOSALS ARE 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. Moreover, we are concerned that the alternative approaches being considered – mainly those creating opportunities to buy government-run health insurance coverage through one of the existing public programs or a new program – are equally detrimental to the health care system, without achieving the desired coverage results.

Payment under existing public programs, including Medicare and Medicaid, historically reimburse providers at less than the cost of delivering services. For example, Medicare and Medicaid reimbursed only 87 cents for every dollar spent by hospitals caring for these patients in 2017 – a shortfall in payments of $53.9 billion for Medicare and $22.9 billion for Medicaid. 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 2019 report that hospitals had a negative 9.9% Medicare margin in 2017, on average, and projects that hospital Medicare margins will decline to negative 11% in 2019, the lowest such margin ever recorded.

Results from a recent study give some idea of the financial impact on the health care system of shifting more, or all, Americans into programs based on Medicare rates. 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. At the same time, this proposal would result 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.

Even if the legislative proposals being considered today increased hospital reimbursement rates above current Medicare and Medicaid 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 cuts to the Medicare and Medicaid programs to offset spending on other priorities.

We also are deeply concerned that implementing any of these new proposals would seriously distract from the important delivery system reform work already underway. Hospitals and health systems have invested billions of dollars in technology and delivery system reforms to improve care, enhance quality and reduce costs. These proposals to revamp the system could easily stymie these improvement 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, creating such fundamental shifts to the health care system would be highly disruptive not only to health coverage, but also to the broader economy. For example, almost half of all Americans, roughly 156 million people, receive coverage through an employer and these enrollees report being satisfied with their current coverage. Not only would a single-payer system move over 240 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.

WAYS TO PROMOTE BETTER CARE FOR AMERICA

Health coverage is too important to risk the potential disruption these legislative proposals would cause. 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% federal match, which would then scale down over the next several years to the permanent 90% 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 upon for coverage.

MAY 2019 CBO REPORT

In May, the Congressional Budget Office released a report examining the possible components of a single-payer system and their potential impact on health care. This report makes clear that establishing a single-payer system would be a "major undertaking that would involve substantial changes in the sources and extent of coverage, provider payment rates and financing methods of health care in the United States."

The CBO report details possible implications of paying providers Medicare rates in a single-payer system and states "such a reduction in provider payment rates would probably reduce the amount of care supplied and could also reduce the quality of care." The instability of changes to the health care system with a "Medicare for All" type system could have the unintended impact of jeopardizing access to care for everyone. This report raises serious concerns that we believe Congress should listen to and we

would urge caution in moving forward with any system that would decrease availability of care or add to the length of time for availability of service.

CONCLUSION

The AHA appreciates the Committee holding this hearing and we look forward to working with Congress on this important issue. We believe we should come together and build upon and improve our existing system to increase access to coverage and comprehensive health benefits.

October 11, 2019

The Honorable Michael C. Burgess
Energy & Commerce Committee
Subcommittee on Health, Ranking Member
2161 Rayburn House Office Building
Washington, DC 20515

Dear Ranking Member Burgess,

It has been announced that the Subcommittee on Health of the Committee on Energy and Commerce will hold a hearing on Wednesday, October 16, 2019, entitled, "Legislation to Reverse the Youth Tobacco Epidemic." I am writing on behalf of the Texas Food and Fuel Association (TFFA) to express our ***opposition*** to the menthol cigarette ban within H.R. 2339 and to formally request that our ***opposition*** to this provision be preserved in the official Committee record and distributed to each member of the Health Subcommittee.

The TFFA represents 15,740 convenience retailers and petroleum marketers in the State of Texas. H.R. 2339 has drawn the attention and grave concern of our membership because we believe that the ban would produce troubling consequences for the small businesses our association represents, the working families depending on them, and their communities; while producing little public health benefit.

Convenience store retailers in Texas employ more than 250,000 individuals. We provide food in many areas where major grocery chains simply do not operate. A ban on menthol cigarettes could threaten many members' very existence.

No one can disagree with the objective of reducing smoking and, in particular, working to keep cigarettes out of the hands of youth. The retailer members of Texas Food and Fuel Association work hard to that end. They are bound by contractual restrictions and take steps to ensure their clerks obey laws prohibiting sales to youth. Many of them participate voluntarily in training programs—such as We Card—which not only puts young people on notice that age-restricted products will not be sold to them illegally, but also provides training to team members on how to prevent underage sales.

This is why it is so concerning that members of Congress are once again seeking to eliminate the use of menthol in cigarettes and ban other tobacco products. The Food and Drug Administration acknowledged that eliminating menthol from combustible cigarettes does not reduce the inherent risk of smoking-related diseases, and certain smokeless and vapor products have the potential to move smokers down the continuum of risk to potentially less risky products.

A ban on menthol cigarettes would not prevent menthol sales. Rather, it will very likely drive many purchases to illicit markets where sellers are unconcerned about age-of-purchase laws and other efforts to prevent youth access the age-restricted products. The results could actually mean increased access to combustible cigarettes at a time when youth smoking rates are at an all-time low.

One thing is even more certain: the sudden removal from the market of products representing 35% of in-store cigarette sales—at a time when volumes are already declining—will strike a major blow to Texas Food and Fuel Association members. The impact on their top and bottom lines could result in layoffs or

TEXAS FOOD & FUEL ASSOCIATION
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reduced employment opportunities, especially for the people who rely on our member stores as a first step in their career path.

For all of these reasons, I encourage you to oppose H.R. 2339. Thank you for your support.

Best Regards,

Paul Hardin, CAE
President/CEO

TEXAS FOOD & FUEL ASSOCIATION
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national RIGHT TO LIFE committee, inc.
512 10th Street, NW Washington, DC 20004-1401
(202) 626-8800 FAX: (202) 737-9189 Website: www.nrlc.org

April 29, 2019

Re: Pro-life concerns with H.R. 1384 and similar "Medicare for All" proposals

Dear Representative:

At some point during the current Congress, the House of Representatives may vote on one or more so-called "Medicare for All" proposals. The National Right to Life Committee (NRLC), the federation of state right-to-life organizations, strongly opposes one such measure, H.R. 1384, the "Medicare for All Act of 2019," sponsored by Rep. Pramila Jayapal.

While H.R. 1384 is a general roadmap, scarce on specifics, there are certain key details of the legislation that would mean a dramatic and radical departure from long-standing abortion-related policy. The legislation would require government funding of abortion without limitation and also likely would require unwilling hospitals and doctors to perform abortion procedures.

National Right to Life vigorously opposed enactment of the Obamacare law in 2009-2010, because of its multiple provisions authorizing federal subsidies for abortion insurance, multiple provisions allowing abortion-expansive federal mandates, and various provisions that could lead to the denial of medical treatment. H.R. 1384, as well as other Medicare for All proposals, will go radically further to expand abortion funding and deny medical treatment.

The National Right to Life Committee (NRLC) urges you to oppose H.R. 1384 or any similar Medicare for All proposals and intends to include any possible roll call votes in our scorecard of key right-to-life roll calls of the 116th Congress.

Requirement to Cover Reproductive Health Services and Elimination of the Hyde Amendment

Whereas President Obama repeatedly claimed that his Obamacare legislation would not allow "federal funds" to pay for abortions, a claim reiterated in a hollow executive order, the law itself explicitly authorized massive federal subsidies to assist many millions of Americans to purchase private health plans that today cover abortion on demand in the 24 states and D.C. that failed to pass laws to limit abortion coverage.

However, unlike the false claims made by the Obama Administration and its defenders that Obamacare was not aimed at expanding abortion, H.R. 1384 and similar Medicare for All proposals **explicitly** and **directly** take aim at long-standing provisions that limit funding of abortion.

H.R. 1384 defines mandatory comprehensive health services to include "comprehensive reproductive, maternity, and newborn care." In addition, H.R. 1384 states that "Any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health service shall not apply to monies in the Trust Fund."

This will mean that a number of federal laws that generally prohibit federal subsidies for abortion in various specific programs, the best known of these being the Hyde Amendment, which governs funds that flow through the annual federal health and human services appropriations, will cease to apply.

The Hyde Amendment alone is estimated to have saved on the order of two million lives.

In their February 27, 2019 press release, NARAL Pro-Choice America President Ilyse Hogue praised H.R. 1384 stating, "Representative Jayapal has been an unwavering champion for women and reproductive freedom and we applaud her leadership today. Rep. Jayapal's Medicare for All proposal recognizes the simple truth that women will never be equal members in society until we have full access to reproductive healthcare. Put simply, a right is not a right if you cannot access it."

Requirement that Physicians and Other Health Providers Perform Abortions

Various federal laws seek to prevent discrimination against health care providers who do not wish to participate in providing abortions (often called "conscience protection" laws). However, H.R. 1384 contains policies that are directly contrary to the principles that they embody.

H.R. 1384 includes a provision that states in Section 103 that "Any individual entitled to benefits under this Act may obtain health services from any institution, agency, or individual qualified to participate under this Act."

H.R. 1384 and similar Medicare for All proposals are likely to require hospitals and doctors to perform abortion procedures, at least if they already offer or are trained to provide reproductive health care of any kind.

In addition, a non-discrimination provision in Section 104(a) states in part that "No person shall, on the basis of ... pregnancy and related medical conditions (including termination of pregnancy), be excluded from participation in or be denied the benefits of the program established under this Act...or be subject to any reduction of benefits or other discrimination by any participating provider ... or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, pursuant to this Act."

Section 301 provides that "Items and services to eligible persons shall be furnished by the provider without discrimination, in accordance with section 104(a). Nothing in this subparagraph shall be construed as requiring the provision of a type or class of items or services that are outside the scope of the provider's normal practice."

Working in tandem, Sections 103 and 104 and 301 are likely to be interpreted to require physicians to perform an abortion even if they are morally opposed to them, as this would constitute discrimination under this definition. Further, because Sec. 301 does not define "normal practice," it is unclear if physicians or other health professionals who typically do not perform abortions could be forced into becoming certified, for example, to dispense medication abortions.

Rationing Threats

Since its inception, the National Right to Life Committee has been just as committed to protecting those who have been born, especially older people and people with disabilities, from euthanasia, as it has been committed to protecting unborn children from abortion. Our efforts to protect the vulnerable from euthanasia have been directed at opposing not only direct killing such as assisting suicide but also denial of life-saving medical treatment, food and fluids necessary to sustain life.

In particular, NRLC has fought involuntary euthanasia–the denial of life-saving treatment and sustenance to patients against their will. This includes our opposition to government rationing of health care. NRLC does not believe that the government should limit the right of Americans, if they choose, to use even their own private funds for health care to save their lives and those of their family members.

NRLC strongly opposes legislation that would create or lead to a national, single-payer, government-run healthcare system, including Medicare for All proposals. Medicare for All would eliminate privately funded health plans, including the employer-sponsored coverage in use by 56% of all Americans. Under the current system, because of budget constraints, the Medicare reimbursement rates for health care providers tend to be below the cost of giving the care—a deficit that can only accelerate as cost pressures on Medicare increase. To cope with this, providers engage in cost shifting by using funds they receive in payment for treating privately insured working people to help make up for what the providers lose when treating retirees under Medicare. While cost shifting can be uneven, it does help to ease the cost pressures. Under H.R. 1384, cost shifting would disappear and all Americans would be forced into a progressively underfunded system, one bound to begin reducing treatment and access to healthcare.

While everyone would prefer to pay less – or nothing – for health care (as for anything else), government price controls, in fact, prevent access to lifesaving medical treatment that costs more to supply than the price set by the government. Under a Medicare for All scheme, the government will ration lifesaving medical treatment as they are squeezed more and more tightly each year by the declining "real" (that is, adjusted for health care inflation) value of the tax dollars they take in. These day-to-day rationing decisions will have the most direct and visible impact on the lives – and deaths – of people with a poor "quality of life."

While there are few specifics in H.R. 1384 and similar Medicare for All proposals, single-payer health care will lead to government price setting, and lessening access to healthcare. And more directly, H.R. 1384 would lead to a dramatic departure in abortion funding.

Thank you for your consideration of National Right to Life's strong opposition to H.R. 1384 and similar Medicare for All proposals.

Respectfully submitted,

Sincerely,

Carol Tobias	David N. O'Steen, Ph.D.	Jennifer Popik, J.D.
President	Executive Director	Legislative Director

April 29, 2019

U.S. House of Representatives
Washington D.C. 20515

Dear Representative:

On behalf of March for Life Action and the millions of pro-life Americans who march to end abortion, I am writing to voice our opposition to H.R. 1384, the Medicare for All legislation. This legislation specifically seeks to eliminate all pro-life and conscience protections in current law. While the legislation is in the hearing process, it is supported by a large number of Members of the Democratic Party as well as most of the announced Democratic Party presidential candidates. If the legislation reaches the House floor, March for Life Action will score a "yes" vote negatively in our scorecard for the 116th Congress.

Medicare for all is not your run of the mill proposal. The legislation would outlaw private insurance, which Vox points out would mean 153 million Americans would lose coverage they get from their employers as well as the freedom those plans afford. Vox also points out repealing the Hyde Amendment is "front and center" in the bill.

Section 701 of Sanders' Medicare for all is titled "Universal Medicare Trust Fund" and states that "any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health service shall not apply to monies in the Trust Fund." Since Hyde restricts federal funds from being used toward abortion, section 701 is effectively stating that Hyde doesn't apply to Medicare funds.

The Hyde Amendment has largely prevented federal Medicaid dollars from paying for abortions and for over 40 decades has garnered widespread, bipartisan support. According to the most recent Marist polling, on the subject a supermajority — 60 percent — oppose tax dollars financing abortions in the U.S., with just 36 percent in support. This includes 60 percent of women. A study by the Charlotte Lozier Institute indicates that the Hyde Amendment has saved over 2 million unborn children since 1976.

Conscience rights also are eliminated under the bill. Sec. 104 explains that "No person shall, on the basis of race, color, national origin, age, disability, or sex, including sex stereotyping, gender identity, sexual orientation and pregnancy and related medical conditions (including termination of pregnancy), be excluded from participation in, be denied the benefits of, or be subjected to discrimination by any participating provider as defined in section 301, or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, pursuant to this Act."

In other words, this proposed legislation would strong-arm doctors, nurses and all other health care professionals into performing and participating in abortions — regardless of whether they

have any moral objections. Section 104 goes on to say that refusing to participate could result in heavy court damages and fees.

This legislation is truly the holy grail of the pro-abortion movement, mirroring the extremes we have seen in states like New York. For these reasons, March for Life Action will score against the legislation in our annual scorecard for the First Session of the 116th Congress.

Sincerely,

Thomas McClusky
President, March for Life Action

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

October 28, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Commissioner of Insurance Michael Conway
Division of Insurance
1560 Broadway, #110
Denver, CO 80202

RE: Comments Regarding the Draft Report for Colorado's State Coverage Option

Dear Director Bimestefer and Commissioner Conway:

I write today on behalf of America's Health Insurance Plans (AHIP)[1] to provide feedback on behalf of our member companies regarding the draft report for Colorado's State Coverage Option. We appreciate the opportunity to comment and look forward to working with the Department of Health Care Policy and Financing (HCPF) and the Division of Insurance (DOI) to find the best path forward to provide access to affordable health care to all Coloradans.

As the draft report recognizes, our members have the knowledge and infrastructure to achieve the best value for their enrollees. We applaud the DOI and HCPF's willingness to address plan affordability while protecting market stability. We are similarly appreciative of the draft proposal's contemplation of the incorporation of innovative, value-based payment reforms. Our members have been leaders in developing payment arrangements that align reimbursement with enhanced quality.

However, we have significant concerns regarding several other aspects of the proposal. We believe that the draft proposal will not meet the state's goals of improving affordability, access, plan choice, and competition. The implementation of a coverage option, as proposed, would actually decrease competition, innovation, and choice overall as well as reduce the total federal premium subsidies available for Colorado consumers. We appreciate the state's effort to address

[1] AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers. Our members provide a range of products to millions of consumers, including major medical coverage, disability income insurance, dental insurance, LTCI, reinsurance, pharmacy benefits, and administrative services for self-funded health plans.

affordability, and we want to work with the state to develop policy alternatives that will further bolster market stability, increase coverage rates, and improve overall affordability. To that end, we offer the following feedback on several of our concerns.

Mandated Carrier Participation Will Have an Adverse Effect on all Aspects of Colorado's Health Insurance Market

Overall competition in Colorado's individual market is strong; however, mandated participation runs the risk of destabilizing the market by making continued participation in Colorado's market less sustainable for some plans and less feasible for plans that may otherwise wish to enter. Each individual plan is in the best position to decide if its financial and market position can sustain adding a state option plan offering to its existing offerings. Our members have spent years pursuing strategies to enable them to compete in the regions in which they operate, and to address the needs of consumers within those regions. This proposal would undercut those efforts. It would require carriers to go beyond areas of traditional experience and expertise to invest in networks and services in new areas and develop strategies to address consumer needs that they may not be familiar with. All of this would entail significant costs. While the thresholds for mandated carrier participation in the state option plan have not yet been established, we are concerned this proposal may have significant unintended consequences, including reductions in market participation and significant added cost.

Additionally, we are concerned that the proposed state plan offering risks creating an unlevel playing field. Fundamentally, compelling participation — especially into new markets and regions — risks creating market disruption and the reduction of consumer choice in Colorado — exacerbating a problem which the state option proposal seeks to remedy.

Capped Reimbursement Rates Reward Volume Over Value and Risks Destabilizing the Non-State Option Markets

Adding products to the market that include price controls on health care providers poses a danger to both choice and competition in the individual market. The well-documented phenomenon of cost-shifting makes it likely that consumers of non-state option plans will bear the cost of the rate reductions mandated in the state option plans. This will likely to raise prices for consumers of those plans and threaten the viability of such plans going forward.

The combination of these factors is likely to create a textbook example of an unlevel playing field, with state option plans having the advantage of government-controlled rates, and the non-state-option plans bearing ever higher costs shifted by providers away from such plans. For consumers to benefit from choice and competition, there needs to be a level playing field for all

carriers in all markets who want to offer products to individuals and families purchasing coverage.

The market damage caused by capped reimbursement in the state option plans will not be limited to the individual market. Higher reimbursement rates charged by facilities and providers seeking to shift lost revenue will place upward pressure on premiums for small and large employer groups, and self-insured plans — where the vast majority of the state gets coverage. Any health care solution, including the state option plan, should not increase rates for those remaining in individual, small group, large group, or ERISA plans.

The state option plan discusses the need for carriers to utilize value-based payments to reward providers who achieve quality and pricing targets. AHIP supports improving quality through value-based payments. However, under a Medicare-linked capped reimbursement model, there is no room to negotiate or reward quality because the payment rate is linked to a fee-for-service methodology. A capped rate in a fee-for-service system, as this option proposes, drives up overall health care costs while at the same time leaving no room to provide the right incentives to improve quality of care or lower overall costs. This is not mere conjecture as we have seen this in other markets. For example, in the state of Montana:

> *Montana's State Employee Plan implemented a flat-fee pricing methodology for medical services at a payment rate of approximately 234% of Medicare rates for reimbursement of hospital claims and the majority of hospitals in the state contracted to accept this rate.*[2] *This policy initially resulted in savings for the state plan. However, in the years since the state plan implemented this reimbursement model, costs have continued to rise. Overall, 2018 resulted in a $2.3 million loss and plan expenses are expected to exceed revenues in 2020 and 2021.*[3] *Per member per month (PMPM) spending on medical claims in 2018* ***increased by 11.2%*** *over 2017.*[4] *These increases in medical cost trend for the state plan are in stark contrast to the national medical cost trend, which has remained steady at 5.7% in 2018 and 2019.*[5] *Additionally, the average high cost claim was approximately* ***$235,000, which is higher than the previous 6 years' average.***[6]

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[2] NAIC Health Innovations (B) Working Group 2019 Summer National Meeting, page 35. August 3, 2019. Available at https://www.naic.org/meetings1908/cmte_b_health_inn_wg_2019_summer_nm_materials.pdf.
[3] State of Montana Employee Group Benefits Advisory Council Meeting Minutes, May 22, 2019, page 3.
[4] State of Montana Employee Group Benefits Advisory Council Meeting Minutes, March 28, 2019, page 2.
[5] "Medical cost trend: Behind the numbers 2020," page 3. June 2019. PricewaterhouseCoopers' Health Research Institute. Available at https://www.pwc.com/us/en/industries/health-industries/assets/pwc-hri-behind-the-numbers-2020.pdf.
[6] State of Montana Employee Group Benefits Advisory Council Meeting Minutes, May 22, 2019, page 3.

While more is to be learned to fully understand the Montana story, it is clear that simply capping rates has not resulted in long-term savings. Given the critical nature of assuring the lowest cost and highest quality care be available to Colorado residents, we are deeply concerned that a similar fact pattern would result from the proposed state option.

Raising the Medical Loss Ratio (MLR) Could Raise Costs and Reduce Vital Consumer Services

The Affordable Care Act (ACA) included requirements for carriers to spend 80 cents of every premium dollar in the individual market on medical care and quality improvement activities. The ACA's MLR requirements are working, and consumers have benefited from MLR rebates in instances when a carrier does not meet the required MLR threshold. Carriers are also required to meet state and federal regulatory requirements and provide important consumer services that improve customer care – nearly all of which are not counted as medical care under the MLR.

Examples of these "administrative costs" include (varies by market segment):

- Network engagement with provider recruitment and retention, negotiations with doctors, hospitals, and pharmaceutical companies, and timely payment of claims;
- Customer services, including call centers, interactive websites, mobile apps, cost transparency tools, provider directories, medical interpreters, and translation services;
- Clinical experts to ensure patients receive evidence-based care and cost-effective treatments, 24/7 nurse advice lines, and Pharmacy & Therapeutics Committees to review drug safety and use; and
- National certifications and accreditations (NCQA, URAC, etc.), quality reporting, regulatory audits and surveys, and other regulatory requirements such as rate filings, annual reports, actuarial analyses, and fraud, waste, and abuse prevention, detection, and correction.

Recognizing that, on average, only 2.7 cents of every premium dollar goes to net profit,[7] carriers would still be required to meet all their statutory obligations under a higher MLR. Premium rates must be actuarially sound and account for total health plan spending. Raising the MLR does not automatically equate to lower overhead costs, it just changes the ratio between the delivery of medical care and the amount available to provide high-quality customer service, meet accreditation and regulatory requirements, and meet state mandated solvency requirements.

[7] "Where Does Your Premium Dollar Go?" America's Health Insurance Plans. March 2, 2017. Available at https://www.ahip.org/health-care-dollar/.

Additionally, federal regulations require states to demonstrate why a lower MLR would be necessary for market stabilization, but they also require states seeking to enact a ***higher*** MLR to demonstrate the need for and impact of such a change:

> *In adopting a higher minimum loss ratio than that set forth in §158.210, a State must seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.*[8]

As drafted, we do not believe the state option meets these prerequisites. By making it more difficult for carriers to perform their required administrative functions, this proposal discourages, rather than encourages, innovation, competition, and choice. We strongly urge the state to maintain the MLR requirements outlined in the ACA.

The Underlying Drivers of Health Care Costs Need to be Adequately Addressed

Rather than capping the reimbursement rate to certain providers, the state's solutions should focus on the underlying cost drivers and market dynamics driving premium increases — prescription drug pricing, third party payments, monopolistic market behavior — including hospital acquisition of provider practices and provider consolidation, and other tactics that game the system to drive up costs. For example, recent research has shown that there is a correlation between increased provider and facility consolidation and integration and higher prices for physician and hospital services.[9] In addition, private equity firms are implementing business strategies to consolidate physician groups to generate higher revenue through market consolidation and aggressive contracting tactics.

Most importantly, this proposal ignores the single largest driver of health care costs – prescription drug prices. Nationally, prescription drugs represent the largest segment of commercial health care spending, making up more than 23% of commercial premiums.[10] These recommendations have no levers aimed at lowering the prices that drug makers set, which continue to increase year over year. There are no requirements on drugmakers to do anything under these proposals to be accountable for the prices they set. Regulating drug prices or cost-sharing through health plans or their PBM partners will not bring down prices, and in fact could increase drug prices and their impact on premiums.

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[8] 45 C.F.R. § 158.211
[9] Polyakova, Maria, M. Kate Bundorf, Daniel Kessler, and Laurence Baker. "ACA Marketplace Premiums and Competition Among Hospitals and Physician Practices." The American Journal of Managed Care, February 2018. Available at https://www.ajmc.com/journals/issue/2018/2018-vol24-n2/aca-marketplace-premiums-and-competition-among-hospitals-and-physician-practices.
[10] "Where Does Your Premium Dollar Go?" America's Health Insurance Plans. March 2, 2017. Available at https://www.ahip.org/health-care-dollar/.

There are a number of alternative approaches that could more efficiently and directly address rising health care costs. For example, Colorado has already joined with private entities to address costs. Colorado's community-based purchasing alliance will be offering plans for the first time in 2020. Additionally, the state has been promoting an employer-based purchasing alliance, an effort that is in its infancy. AHIP's members are not necessarily endorsing these approaches, but we have yet to see the full impact of these programs and would urge the state to allow time for such programs to take effect before implementing anther significant reform. We are concerned that any positive gains achieved by these programs may be jeopardized by the implementation of a state option.

To tackle access and affordability issues, we need to build upon what works in Colorado and expand choice and competition through free-market solutions. For example, we know that well-crafted reinsurance programs can help stabilize the individual market. Colorado's newly implemented reinsurance program is being credited with lowering premiums for plan year 2020 by an average of 20.2% across Colorado. We must also seek to address the drivers of unit costs and overall consumer out-of-pocket costs, which increasingly create a barrier to accessing care. We look forward to working with the state on opportunities to address these affordability concerns without compromising market stability and consumer choice. To that end, we offer the following proposed solutions to lower premiums.

These proposals are adapted from a comprehensive list of 12 proposed solutions[11] supported by our members, and are based on three tested and proven methods for driving down the costs of premiums for consumers: reducing the cost of health care, offering premium savings to consumers, and increasing enrollment and retention to balance the pool of enrollees in the insurance marketplace.

The proposals in which Colorado policymakers can play a role include:

- **Reduce Surprise Medical Billing** by protecting patients from surprise medical bills and preventing unnecessary premium increases related to out-of-network care. The Colorado Legislature recently adopted surprise medical billing legislation that has not been fully implemented. This measure will save consumers money and bring predictability to carriers and consumers when fully implemented.
- **Curb Inappropriate Third-Party Premium Payments** by limiting the list of third-party entities from which carriers must accept premium and cost-sharing payments. Colorado

[11] "12 Solutions to Lower Premiums for Hardworking Americans Who Buy Their Own Coverage." America's Health Insurance Plans. November 2018. Available at https://www.ahip.org/wp-content/uploads/2018/11/AHIP_AffordabilityWorkgroup-111518.pdf.

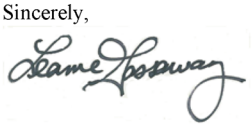
may also prohibit the use of copay coupons for brand-name drugs if there is a less expensive, equally effective alternative. These marketplace schemes seek to increase overall health care costs, thus increasing premiums for all.

- **Increase Drug Competition and Transparency** by requiring manufacturers to publish true R&D costs and explain price setting and price increases.
- **Create a State Premium Assistance Program** for individuals and families earning more than 400 percent of the federal poverty level.

AHIP shares your goals to make health care more affordable for Colorado residents. However, government rate setting, MLR adjustments, and mandatory participation are not solutions to address the underlying costs of health care in the state. Our members stand ready and eager to work with policymakers and other stakeholders to inform policy approaches to make coverage more affordable, but such efforts can and should be done in a way that strengthens the market and does not pose the risk of higher costs to consumers.

We appreciate this opportunity to comment and welcome the opportunity to remain engaged as this proposal is developed. Please contact Leanne Gassaway at lgassaway@ahip.org or (202) 861-6365 if you have any questions or concerns.

Sincerely,



Leanne Gassaway
SVP, State Affairs and Policy

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

March 7, 2019

Chairman Matt Lesser
Chairman Sean Scanlon
Insurance and Real Estate Committee
Legislative Office Building, Room 2800
Hartford, CT 06106

Re: AHIP's Comments on HB 7267

Chairman Lesser, Chairman Scanlon, and Members of the Insurance and Real Estate Committee:

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

Every American should be able to get affordable, comprehensive coverage regardless of their income, health status, or pre-existing conditions. We agree that hardworking Americans who buy their coverage on the individual market increasingly find that their premiums are out of reach if they don't qualify for premium subsidies. Our members stand ready to work with the legislature to make coverage more affordable for all in Connecticut.

However, health care works for hundreds of millions of Americans today. They have affordable coverage they value. And they get the care they need when they need it – from the best doctors and hospitals in the world. We believe that a public health option would cause several significant, unintended consequences including increased costs of coverage for those enrolled in other plans and the destabilization of the health insurance marketplace.

A public option and buy-in is not the solution for rising health care costs for these central reasons:

- Rate setting is not the right approach to rein in costs;
- A standardized public option in the individual market only shifts costs elsewhere; and
- It will destabilize:
    - The non-public option individual health insurance market.
    - The group health insurance market; and
    - The rural hospitals and other health care providers.

Rate setting will not lower or even stabilize health care costs.

Creating a new set of health plans that look identical to other plans but with capped reimbursement rates moves us in the wrong direction of rewarding value over volume. We must focus on the underlying cost drivers and market dynamics driving premium increases – prescription drug pricing, which represents the largest segment of health care spending, making up more than 23 percent of commercial premiums, predatory hospital contracting, third party payments and other tactics that game the system to drive up costs, and overly restrictive market rules inhibiting innovation and value-based insurance designs.

Standardizing benefit designs removes insurer flexibility to innovate and shifts costs elsewhere.

A public option proposal generally attempts to set a level playing field for plans sold on the individual market. By standardizing benefit designs, plans are left to compete based on their ability to put together high-quality provider networks at the most cost-effective rates, which ultimately determine their premiums.

If providers decide to contract with these "public option" plans, they may cover their losses by shifting costs to other commercial plans, including the other plans sold in the individual market. This gives the "public option" plans a huge advantage at the one thing that individual market plans are competing on – provider contracting rates which render the lowest premiums – and abandons the legislature's desire to provide standardization and fairness.

Health plans are committed to working with the legislature to implement a structure for plans that benefits consumers and does not destabilize the market. The goal should continue to be offering individuals and families choice in the market so they can select a product that meets their needs.

A public health option will destabilize the insurance and provider markets, risking health care access.

Individual Market

Health insurance providers offering non-public option plans will not be able to compete with a "public option", which can reimburse providers at much lower rates than commercial individual market plans. There needs to be a level playing field for all health insurance plans who want to offer products to individuals and families purchasing coverage.

Public health option could significantly hinder competition by either of the following scenarios:

1. Allowing the state to select certain bidders for offering "public option" plans instead of allowing all health insurance providers to offer these types of plans could lead to less competition in the individual market. If private health insurance providers who have

managed to develop a network of providers at these government set rates are not chosen to offer the new "public option" plans in a specific region, they may be reluctant to offer traditional individual market plans that are unable to compete on price. Fewer carriers will participate in the individual market than when they are all playing on a level playing field.

2. Because there is no mandate for providers to participate in the networks of these "public option" health plans, it will be difficult for carriers to contract with providers at below-commercial market reimbursement rates. If carriers are unable to create an adequate network of providers willing to accept the mandated reimbursement rates, they will not be able to offer these plans and "public option" plans will cease to be offered.

Group Market

By setting reimbursement rates for doctors and facilities at below-commercial market rates, providers may require higher reimbursement rates in their contracts for other products to cover their losses from participating in the "public option" plans. Higher reimbursement rates will put upward premium pressure on small and large employer groups, self-insured plans, and Taft-Hartley trust plans. Our members are also concerned about their ability to continue to assemble networks in group health plans that offer consumers a choice of providers and access to high-quality facilities at reasonable rates.

These "public option" plans may also lead to a loss of enrollment in the small group market. Small employers may decide that their employees could pay less for "public option" or buy-in plans and stop offering small group coverage to their employees. Combined with the Trump administration's expansion of health reimbursement accounts, the individual market "public option" plans would look like an increasingly attractive option for small employers and their employees.

We are concerned that paying providers below-commercial market rates in a market that could potentially grow in size is unsustainable and, given underlying access issues, this sets up these "public option" plans to fail in the future.

Providers

Another potential area for instability is the potential harm that Medicare-based reimbursement rates will cause to smaller and rural hospitals, and physicians serving those communities. These providers are unlikely to be able to sustain large new blocks of business at below-commercial market levels of reimbursement. Federal price-cap proposals have repeatedly been dismissed because they pose too many risks to the health care delivery system. This proposal could create major patient access problems in portions of the state, and have devastating effects on patients' access to the care that they need.

We believe there are policy solutions that exist—that build on the best of both the private and public sectors—that can improve affordability and coverage for everyone in Connecticut.

AHIP and its member plans have proposed twelve solutions to lower premiums for hardworking Americans who buy their own coverage. Our proposals are based around the three, overarching tested and proven methods for driving down the costs of premiums for consumers: reducing the cost of health care, offering premium savings to consumers, and increasing participation to balance risk. We welcome the opportunity to work with you and other stakeholders on addressing these issues that would make a real difference in lowering costs.

The proposals in which Connecticut policymakers can play a role include:

- **Reducing Surprise Billing** by protecting patients from surprise bills and preventing unnecessary premium increases related to out-of-network care.
- **Curbing Inappropriate Third-Party Premium Payments** by limiting the list of third-party entities from which health insurance providers must accept premium and cost-sharing payments. States may also prohibit the use of copay coupons for brand-name drugs if there is a less expensive, equally effective alternative.
- **Increasing Drug Competition** by requiring manufacturers to publish true R&D costs and explain price setting and price increases. States may also inform patients and physicians on effectiveness and value and reduce regulatory barriers to value-based pricing.
- **Expanding the Use of Telehealth** by enhancing flexibility and avoiding state mandates on reimbursement and/or payment parity, site-specific use, prior visit requirements, or specific technology use. States may also designate telehealth as a means of satisfying network adequacy requirements and support the establishment of multi-state licensure compacts.
- **Creating Reinsurance Programs** that are not solely funded by carrier assessments, but instead shared by a variety of stakeholders that benefit from reinsurance.
- **Creating State Premium Discount Programs** for individuals and families earning more than 400 percent of the federal poverty level.
- **Providing Savings to Consumers who Engage in Wellness Programs** by preserving flexibility for plans to promote safe, effective, high-value care.
- **Investing in Marketing and Outreach** to support state-based exchange investments, so long as these approaches do not increase premiums.

Although AHIP shares your goals to make health care more affordable for Connecticut residents, we do not believe a public option is the solution to address the underlying costs of health care in the state. Our members stand ready and eager to work with policymakers and other stakeholders to make coverage more affordable, but we must do so in ways that do not destabilize an already fragile individual market. Thank you very much for your consideration of our comments.

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

May 1, 2019

The Honorable Jay Inslee
Governor of Washington
Office of the Governor
PO Box 40002
Olympia, WA 98504-0002

Re: SB 5526 – Cascade Care – Veto Request

Dear Governor Inslee:

I write today on behalf of America's Health Insurance Plans (AHIP) to request your veto of SB 5526. We know that health care needs to be improved. But a one-size-fits-all, government-controlled health care system is not the answer. Americans want to improve what's working and fix what's broken. **We believe that this bill will limit access, stifle innovation, and reduce choices for Washingtonians.**

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

Today, over 3.7 million residents in Washington are covered through a job, with the average employer paying more than the vast majority of the cost of each employee's coverage. Throughout the nation, more than 70 percent of employees are satisfied with their coverage – and among the main reasons why they like their coverage is because they have choice and control.

Consumers in the United States have more personal choices than anywhere else in the world when it comes to coverage, doctors, and treatments. SB 5526 will result in fewer choices for Washingtonians, and create uncertainty regarding whether their local doctors and hospitals will be able or willing to provide services under the terms set by the state. More specifically, this bill will:

- Threaten choice and competition as insurance providers exit the individual market, per previous reform efforts.
- Do nothing to truly bring down out of control drug prices, and the impact those prices have on consumers and patients. The greatest percentage of premium dollars go toward drug prices, consuming nearly 25% of every premium dollar spent. This bill would do nothing to change that.
- Establish government price setting for all hospitals, doctors and other care providers.

- Allow the government to choose winners and losers, and limit comprehensive affordable coverage options. More specifically, the government can restrict health coverage how they see fit, including reducing the number of products available.
- Shift costs from the individual marketplace to the employer-provided coverage market, making health care more expensive for hardworking Washingtonians and their families.

There is a better way. Government and the free market must work together to protect patients and their choices, control, and coverage while bringing down costs for everyone. Consumers deserve a stable system, and the certainty that health care services will be available when they are needed.

The stakes are simply too high for legislation that has been rushed through in the waning days of the 2019 Legislative Session. While we all want to be attentive and responsive to the needs of the insurance-buying public, making a mistake with this policy could have profoundly negative consequences for all concerned. **We respectfully request that you veto SB 5526 to allow for further work and policy analysis on this important issue in the interim, to develop a well-considered plan before the 2020 legislative session.**

Sincerely,

Leanne Gassaway
Senior Vice President, State Affairs

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

March 13, 2019

Representative Andrea Salinas
House District 38
900 Court St. NE
H-485
Salem, Oregon 97301

Re: HB 2009 and 2012 – Medicaid Buy-In (OPPOSE)

Dear Representative Salinas:

I write today on behalf of America's Health Insurance Plans (AHIP) and our member plans to express our opposition to the Medicaid buy-in portions of HB 2009 and HB 2012.

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

These bills fail to distinguish the "buy-in" plans from other qualified health plans (QHPs) sold on the Exchange and provide no rationale for whether – and how – these new plans would be more affordable than QHPs. We are also concerned the proposed buy-in program will not improve the current uninsured market, does nothing to help the unsubsidized population, and fails to address the underlying cost of care.

Every American should have access to affordable, comprehensive coverage regardless of their income, health status, or pre-existing conditions. We agree that hardworking Americans who buy their coverage on the individual market increasingly find that their premiums are out of reach if they don't qualify for premium subsidies. Our members stand ready to work with the legislature to make coverage more affordable to Oregonians.

Medicaid buy-in has been touted as a workable solution to access and affordability problems, but these programs have the potential to be extremely disruptive to patients and the health care system. These types of proposals must undergo a careful review of their design, implementation, and potential consequences. Unfortunately, the lack of detail in these bills makes it difficult to assess the specific impacts they would have on the current market and how they will impact coverage and affordability for existing enrollees and the taxpayers who fund the Medicaid program. We offer the following comments on the Medicaid buy-in portion of HB 2009 and HB 2012.

The effects on the current individual market have not been studied.

The Oregon Health Authority reported that approximately 41.1 percent of Oregonians are covered by Medicare or the Oregon Health Plan.[1] The majority of Oregonians are already covered by Medicaid, Medicare, or employer-sponsored coverage – only about 5.2 percent of the population purchases coverage in the individual market.[2]

Such a small market share means that the Oregon individual health insurance market is vulnerable to market instability and rising costs. A Medicaid buy-in proposal could further eliminate choices in the individual market and drive up prices for those that continue to purchase commercial coverage. If younger, healthier individuals leave the unified risk pool, it could increase costs in the QHP market. This would hit unsubsidized consumers and small business especially hard. We are also concerned that any "rate setting" for providers at below commercial levels for the buy-in plans would cause cost-shifting, raising costs for the rest of the commercial market (individual, small group, and large group). Lower provider rates could also affect patient access, if rural hospitals and providers are not able to sustain large blocks of business at below commercial market levels of reimbursement. Eliminating choice and disrupting current options for anyone is not a favorable outcome.

Though the Universal Access to Healthcare Workgroup spent months studying this issue, a detailed analysis of how this proposal would impact those individuals purchasing coverage on the Exchange has not been completed. We believe it is critical to wait for this analysis to be completed before moving forward.

There is no evidence that a buy-in plan will be cheaper than existing commercial coverage.

These bills provide no evidence that the coverage provided by coordinated care organizations (CCOs) will be more affordable than existing coverage sold on the Exchange. Coverage by coordinated care organizations in the Oregon Health Plan (OHP) is extremely comprehensive – in addition to federally mandated services, OHP covers all services prioritized by the Health Evidence Review Commission without cost sharing. OHP is also afforded a number of benefits not enjoyed by the rest of the commercial market – providers are paid less for the services and drug costs are low, thanks to the Medicaid best price rule.

If CCOs are required to provide the same level of benefits as they do under OHP but do not enjoy the same provider rates or Medicaid drug rebates, then the cost of coverage will be more akin to a platinum plan on the Exchange – not a realistically affordable option for most of the populations targeted by this bill.

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[1] *Oregon Health Insurance Survey, 2017*. Oregon Health Authority. Available at https://www.oregon.gov/oha/HPA/ANALYTICS/InsuranceData/2017-OHIS-Gaps-Health-Coverage.pdf.
[2] *Oregon Health Insurance Survey, 2017*.

If these bills envision this buy-in coverage requiring the same provider rates and Medicaid drug pricing, then more work needs to be done to make those objectives a reality. Doctors and hospitals will have to agree to accept lower reimbursement rates for a larger population and the destabilizing effects on the rest of the health insurance market will have to be studied. The federal government will have to agree to expand the federal Medicaid best-pricing rule beyond Medicaid, which will be met by vehement opposition by the pharmaceutical industry.

These bills fail to address the fiscal impact of the program.

In addition to providing no details on what the cost of coverage will be, HB 2009 and 2012 provide no details on how these buy-in plans will be funded, if at all.

In the 2017-19 biennium, total state spending in the Oregon Health Plan (OHP) already totaled 4.5 billion dollars.[3] This represents about 29 percent of total OHP funding – the remaining 71 percent is funded by the federal government. It is unknown if – and how much – federal financial support would be made available for this endeavor. We believe that an 1115 waiver would be required to receive federal funding for new Medicaid enrollees beyond federal eligibility levels. Developing such a waiver application is tremendously time and cost consuming and must be carefully constructed to meet federal requirements. Specific program details on how the program will function must be included as part of the waiver submission process, but none of those details are included in either of these bills.

If no federal funding is sought, the state will have to pay for whatever short fall remains between the premium paid by enrollees and the true cost of the coverage that they receive. The state Medicaid budget is under tremendous strain, currently facing a $950 million shortfall[4] which has only partially been addressed by HB 2010. This new state funding would only add to the strain on the state budget and the rest of the health care market.

If no federal or state funding is sought for these plans, then consumers will be responsible for the full cost of coverage. As discussed above, this coverage could be prohibitively expensive and would not address the currently affordability problems in the individual market.

This bill provides the wrong solutions for the majority of Oregon's uninsured market.

About 77 percent of Oregonians purchasing coverage on the Exchange receive tax credits to lower their premiums and 36 percent are in enhanced silver plans that also reduce their copays and deductibles.[5] These are the enrollees in the 138-400 percent FPL population targeted by

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[3] *Oregon Health Plan Financing and Provider Taxes*. Oregon Health Authority. February 7, 2019. Available at https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/157276.
[4] Cunningham, Paige. *States scramble to head off future Medicaid shortfalls*. Washington Post. February 21, 2019. Available at https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/02/21/the-health-202-states-scramble-to-head-off-future-medicaid-shortfalls/5c6db0641b326b71858c6bec.
[5] *Marketplace Effectuated Enrollment and Financial Assistance*. Kaiser Family Foundation. Available at https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance.

these bills. Of the 6.3 percent of Oregonians who are uninsured, OHA estimates that 80 percent qualify for either OHP or financial assistance.[6]

There have been no compelling arguments or data presented to explain why Medicaid buy-in is the right solution to help these populations rather than building off existing programs. The benefits need to outweigh the costs of creating a brand-new program. Billions of dollars have been spent to get to where we are today – that success should be leveraged to expand coverage to the remaining uninsured and lower costs for everyone. These consumers would be better served by strengthening the Exchange marketplace, ensuring that all Oregonians eligible for financial assistance receive it, and lowering underlying cost drivers to make coverage more affordable for everyone.

Furthermore, this proposal does nothing to lower health care costs for those Oregonians who do not currently receive federal subsidies to purchase individual coverage, beyond those who meet the narrow parameters provided in the bill. These consumers increasingly find themselves priced out of the individual market. We believe that efforts to address cost drivers in the health care market would better address the needs of this population, as well as the currently uninsured.

Health plans are committed to working together to develop meaningful solutions to lower costs and increase coverage without destabilizing the individual market.

AHIP and its member plans have proposed twelve solutions to lower premiums for hardworking Americans who buy their own coverage.[7] Our proposals are based around the three tested and proven methods for driving down the costs of premiums for consumers: reducing the cost of health care, offering premium savings to consumers, and increasing participation to balance risk.

Although we share your goals to make health care more affordable for Oregon residents, we do not believe that Medicaid buy-in is the solution to address the underlying costs of health care in the state. Our members stand ready and eager to work with policymakers and other stakeholders to make coverage more affordable, but we must do so in ways that do not destabilize an already fragile individual market. **We welcome the opportunity to work with you on addressing the issues that would make a real difference in lowering costs for all Oregonians.**

Sincerely,

Stephanie Berry
Regional Director, State Affairs

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[6] *Oregon Health Insurance Survey, 2017.*

[7] *12 Solutions to Lower Premiums for Hardworking Americans Who Buy Their Own Coverage.* AHIP. November 2018. Available at https://www.ahip.org/wp-content/uploads/2018/11/AHIP_AffordabilityWorkgroup-111518.pdf.

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

January 30, 2019

Representative Eileen Cody
34th Legislative District
303 John L. O'Brien Building
PO Box 40600
Olympia, WA 98504

Senator David Frockt
46th Legislative District
224 John A. Cherberg Building
PO Box 40446
Olympia, WA 98504

Re: HB 1523/SB 5526 – "Public Option" and Standardized Health Plans

Dear Representative Cody and Senator Frockt:

I write today on behalf of America's Health Insurance Plans (AHIP) to express our opposition to HB 1523/SB 5526, which would create health plans with state-regulated provider reimbursements. We are concerned that this type of mandate will drive up the cost of coverage for those enrolled in other plans and destabilize the individual health insurance market.

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

Every American should be able to get affordable, comprehensive coverage regardless of their income, health status, or pre-existing conditions. We agree that hardworking Americans who buy their coverage on the individual market increasingly find that their premiums are out of reach if they don't qualify for premium subsidies. Our members stand ready to work with the legislature to make coverage more affordable to Washingtonians. But we believe that this proposal heads in the wrong direction and would cause several significant, unintended consequences including the destabilization of the health insurance marketplace.

We offer the following comments on the "public option" portion of HB 1523 and SB 5526:

Rate setting is not the right approach to rein in health care costs.

Creating a new set of health plans that look identical to other plans but with capped reimbursement rates moves us in the wrong direction of rewarding value over volume. We must focus on the underlying cost drivers and market dynamics driving premium increases – prescription drug pricing, predatory hospital contracting, third party payments and other tactics that game the system to drive up costs, and overly restrictive market rules inhibiting innovation and value-based insurance designs.

Furthermore, this bill ignores the single largest driver of health care costs – pharmaceuticals. Prescription drugs represent the largest segment of health care spending, making up more than 23 percent of commercial premiums.[1] Ever-higher launch prices for new drugs and thousand-percent price hikes on decades-old medications are the biggest threat to the sustainability of our health care system, but HB 1523 and SB 5526 are silent with respect to prescription drugs.

This proposal will destabilize the non-public option individual health insurance market.

Adding price-regulated health plans poses a danger to both choice and competition in the individual market. Health insurance providers offering non-public option plans will not be able to compete with "public option" counterparts, which are required to reimburse providers at much lower rates than commercial individual market plans. There needs to be a level playing field for all health insurance providers who want to offer products to individuals and families purchasing coverage.

This proposal could significantly hinder competition by either of the following scenarios:

1. Allowing the state to select certain bidders for offering "public option" plans instead of allowing all health insurance providers to offer these types of plans could lead to less competition in the individual market. If private health insurance providers who have managed to develop a network of providers at these government set rates are not chosen to offer the new "public option" plans in a specific region, they may be reluctant to offer traditional individual market plans that are unable to compete on price. Fewer carriers will participate in the individual market than when they are all playing on a level playing field.

2. Because there is no mandate for providers to participate in the networks of these "public option" health plans, it will be difficult for carriers to contract with providers at below-commercial market reimbursement rates. If carriers are unable to create an adequate network of providers willing to accept the mandated reimbursement rates, they will not be able to offer these plans and "public option" plans will cease to be offered.

The "public option" proposal conflicts with the proposal to standardize individual market plans.

Section 1 of HB 1523 and SB 5526 attempts to set a level playing field for plans sold on the individual market. By standardizing benefit designs, plans are left to compete based on their ability to put together high-quality provider networks at the most cost-effective rates, which ultimately determine their premiums.

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[1] *Where Does Your Health Care Dollar Go?* America's Health Insurance Plans. May 2018. Available at https://www.ahip.org/wp-content/uploads/2017/03/HealthCareDollar_FINAL.pdf.

If providers decide to contract with these "public option" plans, they may cover their losses by shifting costs to other commercial plans, including the other plans sold in the individual market. This gives the "public option" plans a huge advantage at the one thing that individual market plans are competing on – provider contracting rates which render the lowest premiums – and abandons the legislature's desire to provide standardization and fairness.

Health plans are committed to working with the legislature to implement a structure for standardized plans that benefit consumers and do not destabilize the market. The goal should continue to be offering individuals and families choice in the market so they can select a product that meets their needs.

This proposal will destabilize the group health insurance market and cause premiums to increase for large employers and small businesses.

By setting reimbursement rates for doctors and facilities at below-commercial market rates, providers may require higher reimbursement rates in their contracts for other products to cover their losses from participating in the "public option" plans. Higher reimbursement rates will put upward premium pressure on small and large employer groups, self-insured plans, and Taft-Hartley trust plans, where the vast majority of the state gets coverage. Our members are also concerned about their ability to continue to assemble networks in group health plans that offer consumers a choice of providers and access to high-quality facilities at reasonable rates.

These "public option" plans may also lead to a loss of enrollment in the small group market. Small employers may decide that their employees could pay less for "public option" plans on the individual market and stop offering small group coverage to their employees. Combined with the Trump administration's expansion of health reimbursement accounts, the individual market "public option" plans would look like an increasingly attractive option for small employers and their employees.

We are concerned that paying providers below-commercial market rates in a market that could potentially grow in size is unsustainable and, given underlying access issues, this sets up these "public option" plans to fail in the future.

This proposal will destabilize rural hospitals and other health care providers.

Another potential area for instability is the potential harm that Medicare-based reimbursement rates will cause to small rural hospitals and physicians serving those communities. These providers cannot sustain large new blocks of business at below-commercial market levels of reimbursement. Federal price-cap proposals have repeatedly been dismissed because they pose too many risks to the health care delivery system. This proposal could create major patient access problems in large geographic portions of the state and have devastating effects on patients' access to the care that they need.

AHIP is committed to working together to develop meaningful solutions to lower costs and increase coverage without destabilizing the individual market.

AHIP and its member plans have proposed twelve solutions to lower premiums for hardworking Americans who buy their own coverage.[2] Our proposals are based around the three tested and proven methods for driving down the costs of premiums for consumers: reducing the cost of health care, offering premium savings to consumers, and increasing participation to balance risk. **We welcome the opportunity to work with you and other stakeholders on addressing these issues that would make a real difference in lowering costs for all Washingtonians.**

The proposals in which Washington policymakers can play a role include:

- **Reducing Surprise Billing** by protecting patients from surprise bills and preventing unnecessary premium increases related to out-of-network care. Legislation has already been introduced by Representative Cody and Senator Rolfes to achieve this goal.
- **Curbing Inappropriate Third-Party Premium Payments** by limiting the list of third-party entities from which health insurance providers must accept premium and cost-sharing payments. States may also prohibit the use of copay coupons for brand-name drugs if there is a less expensive, equally effective alternative.
- **Increasing Drug Competition** by requiring manufacturers to publish true R&D costs and explain price setting and price increases. States may also inform patients and physicians on effectiveness and value and reduce regulatory barriers to value-based pricing.
- **Expanding the Use of Telehealth** by enhancing flexibility and avoiding state mandates on reimbursement and/or payment parity, site-specific use, prior visit requirements, or specific technology use. States may also designate telehealth as a means of satisfying network adequacy requirements and support the establishment of multi-state licensure compacts.
- **Creating Reinsurance Programs** that are not solely funded by carrier assessments, but instead shared by a variety of stakeholders that benefit from reinsurance.
- **Creating State Premium Discount Programs** for individuals and families earning more than 400 percent of the federal poverty level.
- **Providing Savings to Consumers who Engage in Wellness Programs** by preserving flexibility for plans to promote safe, effective, high-value care.
- **Investing in Marketing and Outreach** to support state-based exchange investments, so long as these approaches do not increase premiums.

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[2] *12 Solutions to Lower Premiums for Hardworking Americans Who Buy Their Own Coverage.* America's Health Insurance Plans. November 2018. Available at https://www.ahip.org/wp-content/uploads/2018/11/AHIP_AffordabilityWorkgroup-111518.pdf.

Although we share your goals to make health care more affordable for Washington residents, we do not believe a public option is the solution to address the underlying costs of health care in the state. Our members stand ready and eager to work with policymakers and other stakeholders to make coverage more affordable, but we must do so in ways that do not destabilize an already fragile individual market.

Sincerely,

Stephanie Berry
Regional Director, State Affairs

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

September 26, 2018

Legislative Health & Human Services Committee
New Mexico State Legislature
352 Don Gaspar
Santa Fe, NM 87501

Dear Committee Members,

I write today on behalf of America's Health Insurance Plans regarding recent proposals for a Medicaid Buy-In program in New Mexico. America's Health Insurance Plans (AHIP) is a national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. AHIP and our members support access by all consumers to affordable health coverage without regard to health status and through the coverage program that best meets their needs based on their specific circumstances and eligibility.

New Mexicans have expressed concern with health care affordability and access. This stems from a combination of rising health care prices and some instability in the commercial private insurance market. We fully support having robust discussions on how best to address these issues.

As we begin this important dialogue in the state, we believe it is most prudent to ask this fundamental question: What problem are we trying to solve? If the goal is finding avenues to provide access to affordable health care services to New Mexicans, there are many ways to achieve this goal.

While Medicaid Buy-In proposals on their face present a workable solution to access and affordability to health care services; these programs, in fact, have the potential to be extremely disruptive to the health care system serving those patients, and patients themselves. Therefore, such proposals must undergo a careful review with respect to how such a program will be implemented, and the various consequences that are very real possibilities. For these reasons, we would like to discuss several critical considerations regarding this proposal.

Operational Concerns

As a threshold matter, we note that no specific Medicaid Buy-In proposal has been proposed in New Mexico. Two popular formulations of Medicaid Buy-In programs[1]exist, and which could serve as the basis for the development of a Medicaid Buy-In program in New Mexico. One would permit individuals not currently eligible for Medicaid to purchase Medicaid coverage. The second would create specific health care plans that are administered by Medicaid Managed Care Organizations and make them available on the individual market. These plans would share some of the features with the Medicaid program, but would not be Medicaid coverage. Both of these options have their operational hurdles.

The first hurdle that both of these formulations must overcome before being considered is securing either a Section 1115 Medicaid waiver or Section 1332 State Innovation waiver from the federal government. As you may know, developing a waiver application is tremendously time-consuming and must be carefully constructed to meet federal requirements. Specific program details with respect to how the program will function must be included as part of the waiver submission process.

Several other operational questions must be answered in any proposal, including:

- eligibility criteria of enrollees,
- provider participation and reimbursement,
- what health care services are covered under the program,
- what would enrollees pay for premiums or copays, and
- how it will be financed.

None of these details have been presented at this time and must be thoroughly evaluated so that the impacts on New Mexicans can be understood and explained to all affected stakeholders.

Fiscal Concerns

In New Mexico, approximately 31 percent of the residents are covered by Medicaid, CHIP, or have dual eligibility and are also covered by Medicare.[2] Spending on Medicaid programs in New Mexico exceeds $900 million and has placed considerable strain on the state's budget.[3]

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[1]Anderson, David, and Emma Sandoe. "A Framework for Evaluating Medicaid Buy-In Proposals." The Physician Payments Sunshine Act. March 23, 2018. Accessed September 17, 2018. https://www.healthaffairs.org/do/10.1377/hblog20180320.297250/full/.

[2] "Health Insurance Coverage of the Total Population." Kaiser Family Foundation. September 2017. Accessed September 17, 2018. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-mexico%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Other%20Public%22,%22sort%22:%22asc%22%7D#notes

[3] Lee, Morgen. "Medicaid Strains New Mexico State Finances." U.S. News & World Report. September 15, 2017. Accessed September 17, 2018. https://www.usnews.com/news/best-states/new-mexico/articles/2017-09-15/medicaid-strains-new-mexico-state-finances.

Expansion of New Mexico's Medicaid program may add to this budgetary pressure. Moreover, it is unknown how much federal financial support would be made available for this endeavor.

New Mexico's population is unique because the majority are already covered by Medicaid or Medicare. Therefore, a smaller segment of the New Mexico Insurance Market purchases private coverage is vulnerable to market instability and rising costs. Any Medicaid Buy-In proposal could further eliminate choices in the individual market and drive up prices for those that continue to purchase their own insurance. Implementation of a Medicaid Buy-In program could diminish the size of the individual market and cause people to lose the plans they currently have. Approximately 49,792 New Mexicans purchased coverage on New Mexico's individual market during the open enrollment period for 2018.[4] Eliminating choice and disrupting current options for those individuals is not a favorable outcome. Any proposal should include a study of how those individuals that purchase insurance individually, on the exchange, for example, would be impacted.

Resource Allocation Concerns

Because the Medicaid program currently serves vulnerable populations, careful consideration must be paid to what effects this program will have on current Medicaid beneficiaries. It is estimated that 230,000 New Mexicans remain uninsured.[5] The state will need to identify and possibly add infrastructure and hire more staff to accommodate changes to the current Medicaid program. Appropriate timelines are necessary to reduce unnecessary disruption or impacts to those in the current Medicaid program and those in the individual market.

Possible Alternatives

To achieve the goal of improving health care coverage affordability and access for New Mexicans, there are other options that should also be evaluated:

- Improving marketing and outreach for those already eligible for Medicaid but not enrolled. This outreach could expand coverage to 83,000[6] residents, while pulling additional federal funds to help cover the cost of providing health care to more New Mexicans;

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[4] "Final Weekly Enrollment Snapshot For 2018 Open Enrollment Period." Centers for Medicare & Medicaid Services. Accessed September 26, 2018. https://www.cms.gov/newsroom/fact-sheets/final-weekly-enrollment-snapshot-2018-open-enrollment-period.

[5] "Health Insurance Coverage of the Total Population."

[6] Garfield, Rachel, Anthony Damico, Kendal Orgera, Gary Claxton, and Larry Levitt. "Estimates of Eligibility for ACA Coverage among the Uninsured in 2016." The Henry J. Kaiser Family Foundation. June 19, 2018. Accessed September 19, 2018. https://www.kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/.

- Implementing state-based premium assistance programs and/or reinsurance programs. Specifically, reinsurance programs have been shown to lower premiums in other states that have recently implemented them. For example, Alaska's reinsurance program was projected to lower premiums by 20% in the individual market;
- Providing incentives for small business owners to provided employer-sponsored health insurance coverage; and
- Taking steps to lower costs for everyone, including improving the transparency, competition, and value in prescription drug pricing, which is a leading cost driver today. Additionally, the state should protect consumers from surprise out-of-network bills, and eliminate taxes and fees that harm consumers and increase premiums.

We look forward to participating in the discussions to come on this important issue. If you have any questions about the concerns raised in this letter, please to contact me at sorrange@ahip.org or (703) 887-5285; or our counsel J. Brent Moore at bmoore@montand.com or (505) 986-2648.

Sincerely,

Sara Orrange
Regional Director, State Affairs
America's Health Insurance Plans

Cc. Health Action New Mexico
New Mexico Center on Law and Policy

WA SB 5526: Cascade Care

On April 27, 2019, the Washington legislature approved SB 5526 to create standardized benefit plan designs, require the state to contract with carriers to offer qualified health plans (QHPs) that meet additional benefit design criteria, and direct state agencies to develop recommendations for additional affordability measures.

Standardized Benefit Plans

The Exchange must establish standardized QHPs for each actuarial metal level (bronze, silver, and gold) that are designed to meet specified goals (i.e. reduce deductibles, maximize subsidies, etc.).

- The actuarial value (AV) of a non-standardized silver plan may not be less than the AV of the standardized silver plan with the lowest AV.
- The Exchange must provide a notice and comment period on the proposed designs.

Beginning January 1, 2021, carriers offering QHPs on the Exchange must offer one silver and one gold standardized plan.

- If a carrier offers a bronze plan, it must offer a bronze standardized plan.
- Carriers may also offer non-standardized plans.
- By December 2023, the Exchange must analyze the impact of allowing only standardized plans beginning in 2025.

Cascade Care: Selective Contracting and Reimbursement Caps

Beginning in 2021, the Washington Health Care Authority (HCA) must contract with carrier(s) to offer bronze, silver, and gold standardized QHPs on the Exchange that also meet the additional criteria described below ("Cascade Care plans").

- Carriers may contract to offer Cascade Care plans in one or multiple counties.
- Carriers offering Cascade Care plans may offer other individual QHPs on the Exchange and/or other individual market health plans outside the Exchange.

Plan Design

A Cascade Care plan must:

- incorporate health quality and technology recommendations;
- meet additional requirements to reduce barriers to maintaining and improving health;
- align to state agency value-based purchasing; and
- satisfy specified utilization review criteria.

A Cascade Care plan may use an integrated delivery system or a managed care model.

Reimbursement Cap

Statewide, a Cascade Care plan's total reimbursement of providers and facilities for all non-pharmacy covered benefits may not exceed 160% of the Medicare reimbursement.

- Critical access or sole community hospitals may not be reimbursed less than 101% of allowable costs, as defined by CMS.
- Primary care services may not be reimbursed less than 135% of Medicare.
- HCA may establish additional requirements to address pharmacy benefit expenditures.
- A carrier may not require a provider or facility to accept these reimbursement rates for health plans that are not Cascade Care plans.

HCA may waive the 160% aggregate provider reimbursement cap if:

- selective contracting will result in premium rates that are no greater than the Cascade Care plan's previous plan year rates; or
- a Cascade Care plan cannot form a provider network that meets network access standards, but can achieve premium rates that are 10% lower than the plan's previous plan year rates through other means.

Providers will receive a business and occupations tax exemption for amounts received for services performed on patients covered by a Cascade Care plan, including reimbursement from the carrier and any cost-sharing amounts collected from the patient.

Future Recommendations

The HCA must submit recommendations by December 2022 on:

- The impact of requiring any carrier participating in the public employees' benefits board (PEBB), school employees' benefits board (SEBB), and HCA programs also offer a Cascade Care plan on the Exchange.
- The impact of linking provider participation in Cascade Care plan networks with participation in PEBB, SEBB, and HCA programs networks.
- Whether a Cascade Care plan's utilization review process should align with HCA's clinical criteria.

Premium Subsidy Study

By November 2020, the Exchange must develop a plan to implement and fund premium subsidies for individuals whose income is less than 500% of the federal poverty level.

The Exchange must also assess providing cost-sharing reduction benefits to plan participants and the impact on premium subsidies on the uninsured rate.

BlueCross BlueShield Association

Statement for the Record to:

ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

Hearing: Proposals to Achieve Universal Health Coverage

Submitted by:

Blue Cross Blue Shield Association

December 10, 2019

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to comment on critical issues impacting health care access and cost and share our views regarding the best approach to achieve universal health care coverage.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies that collectively provide health care coverage for one in three Americans. For 90 years, BCBS companies have offered quality health care coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

BCBSA strongly believes everyone should have access to health care, no matter who you are or where you live, and we commend the House Energy and Commerce Health Subcommittee for holding today's hearing to examine "Proposals to Achieve Universal Health Care Coverage."

We agree the health care system has to work better and provide more affordable insurance and care options. As we seek meaningful solutions, it is important to recognize that while our health care system is not perfect, we have made great progress in expanding access to coverage, and most people like the coverage they have today, so we should not start over from scratch. When it comes to improving health care, we should take the best from the public and private sectors and build on what we have to make it better and ensure everyone has insurance.

We are committed to working with policymakers and partners throughout the health care system to make sure everyone has access to affordable, quality coverage and care that best meets their needs. That is why, earlier this year, BCBSA released a series of recommended steps, that taken together, will reduce premiums in the individual market by an average of 33 percent and provide 4.2 million more people with access to affordable health insurance at a fraction of the cost of many proposals being debated today. When coupled with changes to improve access to Medicaid, enroll those eligible for existing programs and address rising costs, these proposals offer the fastest and most pragmatic path toward achieving universal coverage.

BCBSA's specific recommendations are outlined below.

Step 1: Closing Current Gaps in Coverage

Today, 90 percent of Americans are covered. Moving forward, we must close the gap that leaves the remaining 10 percent uninsured, without disrupting coverage and care for those who already have health insurance.

Most of the uninsured today already are eligible for coverage with financial assistance available to help them afford it. Of the estimated 27.4 million uninsured in the U.S., more than half are estimated to be eligible for Medicaid (6.8 million) or tax credit assistance to help purchase coverage in the individual market (8.2 million).[1] Many more are eligible for employer coverage. Only a small percentage of the uninsured are ineligible for financial assistance due to higher

[1]Garfield R, Orgera K, "The Uninsured and the ACA: A Primer," Kaiser Family Foundation. January 2019. http://files.kff.org/attachment/The-Uninsured-and-the-ACA-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-amidst-Changes-to-the-Affordable-Care-Act.

incomes or citizenship status. However, too many people simply do not know they are eligible. A recent Commonwealth Fund survey found that 40 percent of uninsured, working-age adults were not aware of their state's marketplace or HealthCare.gov.[2]

To get more people covered, we must educate them on why obtaining and maintaining insurance is important and provide information on how to do it. BCBSA urges Congress to restore federal funding for outreach to those who are eligible for coverage to 2014 levels and encourages states to reinvigorate their enrollment efforts.

In fact, a recent Commonwealth Fund report found that the U.S. could achieve near-universal coverage and even decrease national health spending by building on our current public-private insurance system. The report analyzes how eight health care reforms – ranging from modest changes to the current system to single-payer – could affect insurance coverage, national health care costs and spending by government, consumers and employers.[3]

The report found that reaching true universal coverage requires an auto-enrollment mechanism for those not voluntarily enrolling in insurance. This finding underscores the need for Congress to take steps to make it easier for states to identify their eligible uninsured populations and support simplified pathways to enrollment.

For example, Maryland's Easy Enrollment program leverages the tax filing process to identify the state's uninsured, and with taxpayers' consent, the state automatically enrolls those eligible for Medicaid into coverage and facilitates enrollment for those eligible for coverage on the exchange marketplace, often at no premium cost. More than a third of the uninsured have incomes below 200 percent of the federal poverty level (FPL), and over half of rating areas across the U.S. offered premium-free Bronze coverage to individuals with incomes below 200 percent of poverty in 2018.[4,5] With Congress' support, states could make significant and rapid progress towards lowering their uninsured rates by facilitating enrollment into subsidized coverage.

Another step to lowering uninsured rates among low-income individuals would be to incentivize states that have not previously expanded Medicaid to expand eligibility (up to 138 percent FPL). States considering options to curb the uninsured rate among low-income Americans should be provided with the same incentives offered to early adopters. To accomplish this, Congress should provide incentives to states to expand Medicaid by offering an enhanced federal match (100 percent) for the initial three years of expansion, phasing down annually for five years to 90 percent federal match, in perpetuity.

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[2] Collins S, Gunja M, Doty, M., "Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage?," September, 2017. https://www.commonwealthfund.org/publications/issue-briefs/2017/sep/following-aca-repeal-and-replace-effort-where-does-us-stand.

[3] Bloomberg L, Holahan C, et. al., "Comparing Health Insurance Reform Options: From "Building on the ACA" to Single Payer," October, 2019. https://www.commonwealthfund.org/publications/issue-briefs/2019/oct/comparing-health-insurance-reform-options-building-on-aca-to-single-payer.

[4] Kaiser Family Foundation. "Uninsured Rates for the Nonelderly by Federal Poverty Level (FPL)." https://www.kff.org/uninsured/state-indicator/rate-by-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[5] BCBS analysis of public Marketplace data.

Step 2: Making Coverage and Care More Affordable

In order to achieve universal coverage, it also is imperative to address the persistently high cost of coverage and care. Premiums and out-of-pocket costs remain too high, putting health insurance out of reach for many.

Many consumers purchasing coverage in the individual market pay substantially more in premium and out-of-pocket costs than those in the employer market, even after subsidies are considered. For example, someone age 45 with an income at 300 percent FPL would be required to pay about 10 percent of their income on premiums and another 5 percent on out-of-pocket costs – even with the assistance available under current law today.

In the exchange market, BCBSA urges Congress to adjust the current tax credit structure to ensure no one purchasing coverage in the individual market pays more than 12 percent of their income for health insurance – a level that would bring more people into coverage while being mindful of the cost to taxpayers. In addition, lawmakers should enhance tax credits for younger people to make coverage more affordable and boost enrollment among younger, healthier adults to help balance the cost of caring for those who are ill. We also support expanding cost-sharing protections to reduce out-of-pocket costs for lower-income people who are having trouble affording the care they need.

BCBS data show 5 percent of people who buy coverage in the individual market represent almost 60 percent of medical claims' costs. To protect those with serious conditions and lower premiums for everyone, Congress should establish a sustained federal funding mechanism to support the cost of caring for those with significant medical needs. Analysis from the actuarial firm Oliver Wyman concludes that such a mechanism alone would reduce average premiums in the individual market by 27 percent and increase enrollment by 1.2 million.

Step 3: Addressing the High Cost of Chronic Disease

For at least the last decade, the national health policy debate has centered on expanding access to coverage, with a limited focus on the underlying reasons that health care costs so much for consumers and taxpayers alike. As we work to expand coverage to all, we urgently need to address causes like the prevalence of chronic illness and the escalating cost of prescription drugs, which make health care more costly in the United States than anywhere else.

Treating people with chronic disease such as diabetes, heart disease and behavioral health conditions like depression accounts for 90 percent of U.S. health care spending,[6] which totaled $3.5 trillion in 2017. Nearly 150 million Americans – six in 10 – are living with at least one chronic condition, and about 100 million people have more than one chronic illness.[7] Almost a

[6] Buttorff C, Ruder T, Bauman M., "Multiple Chronic Conditions in the United States." RAND. 2017. https://www.rand.org/content/dam/rand/pubs/tools/TL200/TL221/RAND_TL221.pdf.
[7] Ibid.

third of Americans live with three or more chronic conditions, and spending on their care accounts for more than half of all U.S. health spending.[8]

BCBSA commissioned Professor Ken Thorpe of Emory University to examine trends in spending on chronic disease among privately insured adults, with a focus on common chronic conditions. His research shows that, even as the number of people with chronic conditions has been climbing, growth in the per capita cost of treating each patient has slowed. This is largely because patents on brand-name drugs treating many chronic diseases have expired, and lower-cost generics are now widely used to treat these conditions.

Yet, overall spending to treat chronic disease continues to climb because of increased prevalence of these conditions. BCBSA recommends that policymakers take action to combat chronic illness and manage these diseases more effectively.

The entry of newer, higher-priced drugs, combined with manufacturer strategies to extend patent protections for current brand drugs, could quickly reverse this trend. Without rebalancing the laws governing brand-name and generic drugs, patients will be deprived of lower cost generic drugs and biosimilars.

Congress can rein in prescription drug costs, in part, by taking action to bring more low-cost generic drugs to the marketplace faster, as envisioned under the CREATES Act. Lawmakers also should restrict the use of drug "discount" coupons when there is a lower-cost, equally effective medication available. Manufacturer coupons for brand drugs can help some patients, but they contribute to higher overall drug costs by eliminating incentives for patients to seek lower-cost alternatives, such as generics. One recent study estimated that national spending on drugs, on average, grew by $30 million to $120 million for each copayment coupon for a particular brand drug over a five-year period following the entry of generic competitor drugs.[9] Coupons also provide a way for manufacturers to charge the highest price possible for their products, maximizing the revenue from better-insured consumers while discounting the price to under-insured consumers.

In addition, Congress should ensure changing care delivery to emphasize prevention and better management of chronic illness is supported and speeded where possible. Private insurers are well-positioned to manage the delivery of care, but need the flexibility to continue to innovate in care management programs and insurance benefit designs that will encourage the most effective treatments. To that end, BCBSA urges policymakers to protect insurer flexibility to develop value-based insurance designs.

In recent years, insurers have devoted considerable effort to developing clinician networks that deliver high-quality health care. They have also developed insurance benefit designs that encourage members to obtain necessary care to effectively and efficiently treat chronic disease, and to avoid developing chronic diseases in the first place. Policymakers should be careful to

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[8] Ibid.

[9] Dafny L, Ody, C Schmitt, M. "Undermining Value-Based Purchasing — Lessons from the Pharmaceutical Industry." The New England Journal of Medicine. November 2016. https://www.nejm.org/doi/full/10.1056/NEJMp1607378.

not undermine this progress toward value-based care by moving the nation toward fee-for-service programs without similar incentives for consumers to manage their health.

Step 4: Avoiding Actions that Cause Additional Harm

At the same time, it is also critical to avoid undermining recent progress to build on existing coverage and close gaps for the uninsured. It is clear that most Americans do not support eliminating private health insurance in favor of a single-payer system. While some present a public option or Medicare buy-in as just another choice for consumers, these plans could also have detrimental impacts on access to and affordability for ACA plans and employer coverage.

Proposals to allow those aged 50-64 to buy into Medicare would cause ACA premiums to increase by up to 9 percent.[10] Individual market ACA premiums would increase because individuals aged 50-64 are helping to stabilize that market today. Collectively, they make up 40 percent of the enrollment and 60 percent of the premium revenue. Importantly, their premiums are allowed to be set at a level to adequately cover their claims. By contrast, individuals under age 50 are relatively less healthy and their claims are higher compared to premiums issuers can charge under standard age rating criteria.

If the 50-64 year-old population moves out of the individual market, the remaining market will be much smaller and more volatile. As actuarial experts at Milliman recently concluded, "A buy-in option has the potential to further fragment the ACA markets and introduce selection opportunities that may be challenging or impossible to predict or control."[11] With enrollment declining and premium revenues shrinking, many issuers might decide it's simply not worth it to stay.

Thus, proposals for a Medicare buy-in could help those aged 50-64, but lead to higher premiums and fewer choices in the individual market.

Conclusion

The foundation is there for us to build on what we have to make our current health care system better and ensure everyone has coverage at a more affordable price. Rather than introducing complexity and disruption into the system, we recommend that Congress build on recent progress in expanding access to coverage and make changes that encourage more affordability, competition and choice for consumers.

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[10] Eibner C, Vardavas R, et. al, "Opening Medicare to Americans Aged 50 to 64 Would Cut Their Insurance Costs, but Drive Up Insurance Prices for Younger People," RAND. November, 2019. https://www.rand.org/news/press/2019/11/18.html.

[11] Kotecki L, Westrom, S, "Actuarial Implications of a Medicare Buy-in Option," June, 2019. https://www.soa.org/globalassets/assets/files/e-business/pd/events/2019/health-meeting/pd-2019-06-health-session-038.pdf.

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

NEIL L. BRADLEY
EXECUTIVE VICE PRESIDENT &
CHIEF POLICY OFFICER

1615 H STREET, NW
WASHINGTON, DC 20062
(202) 463-5310

March 18, 2019

TO THE MEMBERS OF THE U.S. HOUSE OF REPRESENTATIVES:

The U.S. Chamber of Commerce strongly opposes legislation that would create or lead to a national, single-payer, government-run healthcare system, including "Medicare for All" proposals (H.R. 1384) and "Medicare Buy-In" proposals (H.R. 1346). These proposals would limit access, increase costs for employers and workers, and inhibit innovation. **Members that do not cosponsor this legislation will receive credit as part of the leadership component of their rating in the Chamber's "How They Voted" Congressional scorecard.**

Medicare for All would eliminate privately funded health plans, including the employer-sponsored coverage enjoyed by over 181 million Americans. Medicare Buy-In would erode the employer-sponsored system by disrupting insurance pools and increasing the level of cost-shifting onto private healthcare that already occurs under the existing Medicare system.

Both Medicare for All and Medicare Buy-In would limit access as providers struggle with the artificially low reimbursement rates under Medicare. It is worth noting that for this reason, the Affordable Care Act did not attempt to impose Medicare rates on insurance provided through the exchanges. Expansion of Medicare rates would also reduce resources available for medical innovation.

Rather than pursuing a government-run, single-payer health care system, policymakers should work to address the problems in our current system by taking the following steps:

- Help reduce costs for all Americans by moving towards a more value-based system that rewards outcomes and limits costs, and by repealing the Cadillac tax, the health insurance tax, and the medical device tax;
- Help Americans with out-of-pocket costs through expansion of Health Savings Accounts and Health Reimbursement Arrangements;
- Expand coverage options through mechanisms like Association Health Plans;
- Solidify the ACA's exchanges through the use of risk corridors and funding cost-sharing reduction payments.

The Chamber looks forward to working with Congress on legislation that improves access to and reduces the cost of healthcare, and which preserves the employer-sponsored system.

Sincerely,

Neil L. Bradley

The Partnership for America's Health Care Future

Who We Are

Every American deserves access to affordable health coverage and high-quality care. Our health care system allows tens of millions of patients and families to receive world-class care delivered by world-class doctors and hospitals.

But we can and must do more to ensure health care works for all Americans.

That's why we're working together. The nation's leading doctors, nurses, clinicians, community hospitals, health insurance providers, and biopharmaceutical companies are committed to working together to ensure every American has access to the affordable, high-quality coverage they deserve.

PRESERVE CONTROL
Empower patients with more choice and control over their health care decisions

PROTECT OUR MOST VULNERABLE
Keep the promise of Medicare for our nation's seniors and strengthen Medicaid

IMPROVE QUALITY
Improve patient care by expanding access to the world's best doctors, nurses, specialists, treatments, and technology

EXPAND ACCESS
Provide access to affordable coverage for every American, no matter where they live or how much they earn

STRENGTHEN EMPLOYER-PROVIDED COVERAGE
Build on the strength of the employer-provided health coverage that more than 180 million Americans rely on today

Our Mission

The Partnership for America's Health Care Future's (PAHCF) mission is to build on what's working in health care and fix what's not.

We want to work together to lower costs, protect patient choice, expand access, improve quality and foster innovation. And whether it's called Medicare for All, Medicare buy-in, or the public option, **one-size-fits-all health care will never allow us to achieve those goals.**

That's why we support building on the strength of employer-provided health coverage and preserving Medicare, Medicaid, and other proven solutions that hundreds of millions of Americans depend on – to expand access to affordable, high-quality coverage for every American.

People Want Improvements To Our Health Care System, Not Dramatic Changes

While the majority of Americans are insured, most still worry about health care

90%
The percent of Americans who currently have health insurance
(National Center for Health Statistics, 5/1/2019)

71%
Say bringing down health care costs is the most important priority to improve the U.S. health care system *(Voter Vitals, 8/15/2019)*

But people do not want to disrupt their – or others' – current health care coverage

80%
Rate the quality of their health care as excellent or good *(Gallup, 5/21/2019)*

58%
Oppose Medicare for All when told it eliminates private health insurance
(Kaiser Family Foundation, 1/23/2019)

Americans want improvements, not upending the entire system

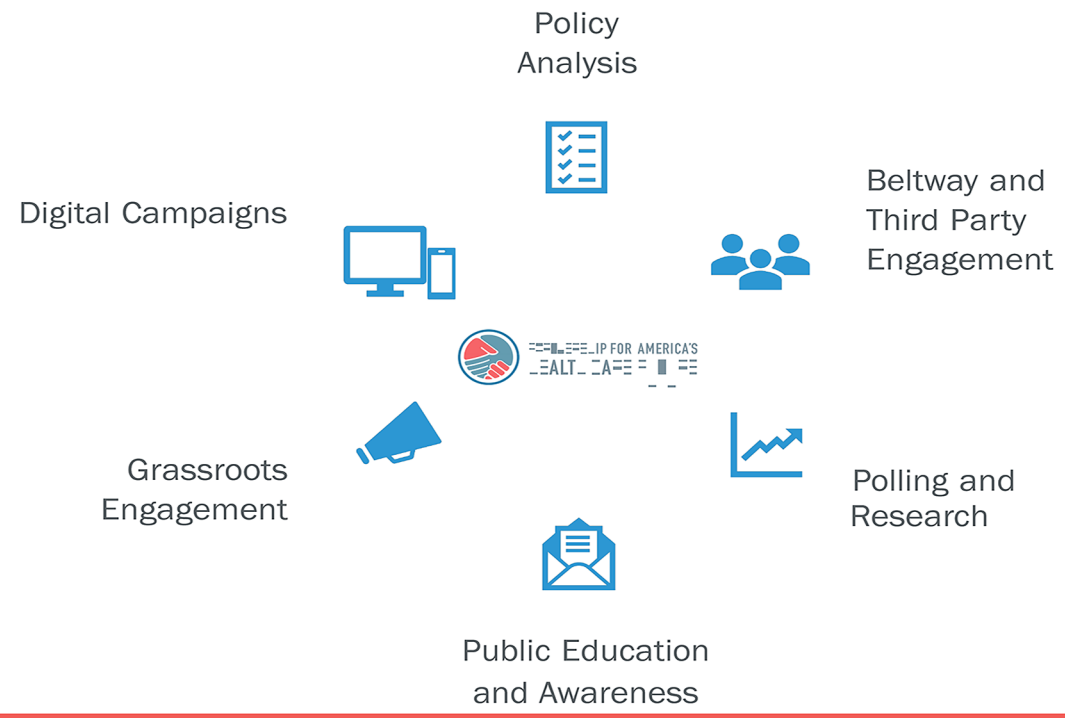
57%
Would rather build on and improve our current health insurance system, instead of starting over
(Voter Vitals, 8/15/2019)

-12%
The decrease in Democratic voters who **"strongly favor"** Medicare for All between April 2019 and July 2019
(Kaiser Family Foundation, 7/30/2019)

Members


AAHU
AAHU
aam
ABC Michigan
ABC
ACC
ACR American College of Radiology
ACR American College of Radiology Virginia Chapter
AHIP America's Health Insurance Plans
American Hospital Association Advancing Health in America
ames Chamber of Commerce
AMGi Expertise in Health Benefits.
Ardent Health Services
Ascension
AFRG
BIG 1
Bio Biotechnology Innovation Organization
Black Chamber
BlueCross BlueShield Association
Brecksville Chamber Of Commerce
Brehme Drug
The Chamber of Commerce in Broadview Heights
Caribbean Chamber of Commerce of Texas
CHS Community Health Systems
Community Liver Alliance
The Council of Insurance Agents & Brokers
Delaware County Chamber of Commerce
DetroitRegionalChamber
Dismas Home New Hampshire
Dubuque Area Chamber Where Business Belongs
Federation of American Hospitals
Federation of Iowa Insurers
FAHU
Green Area Chamber
Grow Cedar Valley
HAFA Health Agents for America
Harrisburg Chamber of Commerce
HCA
Healthcare Leadership Council
healthy women
IAHU
IFA International Franchise Association
IRF Iowa Retail Federation
KHL Solutions
Kingsolver Insurance Agency
Latin Chamber of Commerce Las Vegas – Nevada
LifePoint Health
Loudoun Chamber Be More. Together.
Lupus Foundation New England
MBI
mahp
MAHU
Benefits Professionals
Montana Chamber of Commerce
MichBio Driving Bio-Industry Growth
Michigan Chamber of Commerce
Minnesota Business Partnership
Minnesota Chamber of Commerce Growing Minnesota
MPLS Regional Chamber
NAHU
Northern Virginia Chamber of Commerce
NAIFA Alabama
NAIFA Iowa
NAIFA Pennsylvania
NFADA
National Association of Manufacturers
Helping Ohioans with Healthcare Benefits Choices
Ohio Chamber of Commerce
PhRMA
PMA Pennsylvania Manufacturers Association
RetireSafe
RNS Rheumatology Nurses Society
SACC
Saginaw County Chamber of Commerce
Small Business Association of Michigan
Tenet Health
Texas Health Resources
UHS
VADA Virginia Automobile Dealers Association
VAHP Virginia Association of Health Plans
VAHU Virginia Association of Health Underwriters
Virginia FREE
Virginia Restaurant · Lodging · Travel Association
100+ years VRMA Virginia Retail Merchants Association
WR Washington Retail Association
WVAHU West Virginia Association of Health Underwriters
Yuma County Chamber of Commerce Since 1905

Our Work (1/2)


Policy Analysis
Digital Campaigns
Beltway and Third Party Engagement
Grassroots Engagement
Polling and Research
Public Education and Awareness

Our Work (2/2)

BLOG

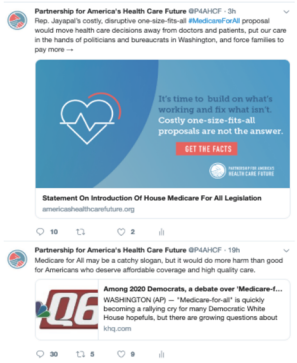
HEALTHY PERSPECTIVE – House Dem: Americans Won't Embrace "Hard Line" Approach On Health Care

February 20, 2019

There's been no shortage of attention paid to Medicare for All-style proposals. But as *The Washington Post* reports, the "increasingly liberal bent" of some Democrats on divisive issues such as health care is "creating dilemmas" for House leaders and the Members in swing districts who delivered the Majority to the party last fall. This includes the platform of eliminating our nation's health care system and starting from scratch with Medicare for All, instead of fulfilling the promise to protect what is working and fix what is broken in our current system.

As U.S. Rep. Josh Gottheimer (D-N.J.) explained to *The Post*:

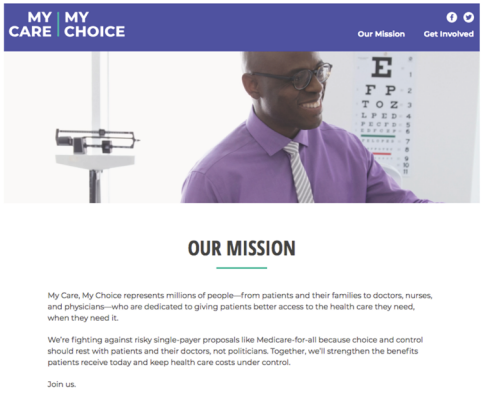
"We won the House through the middle," said Rep. Josh Gottheimer (D-N.J.), who co-leads the Problem Solvers Caucus. "Our party has to be open and recognize that. And if we don't and insist that everyone takes a hard line view on everything, (a) I don't think that's going to attract votes in the next election, and (b) it puts our majority at risk."

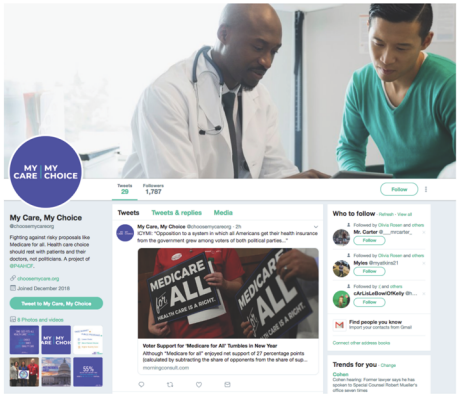


My Care, My Choice (1/2)

Serving as the grassroots arm of our Partnership efforts, the My Care, My Choice program is a **social-first, people-powered program** aimed at building relationships with likely supporters over time, so when the time to take action against Medicare for all comes, we have an **army of advocates at the ready to activate.**

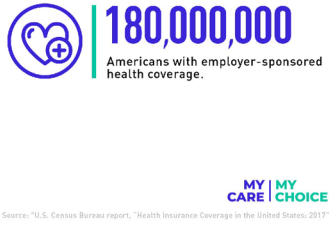
With a robust email program, social channels optimized to convene conversation, and a website that ranks first in search thanks to our paid program in our key states – **My Care, My Choice educates target audiences through the online communication channel they prefer best.**





My Care, My Choice (2/2)

Our tone is solutions-oriented and people-first, leveraging the faces and stories of real consumers and the issues they would face if Medicare for all was to be enacted. While impressing the seriousness of the situation, **our content also facilitates legislator outreach**, communicating the potential of our audience's collective power and inspiring them to take action.



Comparison of Health Care Proposals

Bill	Type of Plan	Who is Eligible?	Benefits	Provider Reimbursement Rate	Financing
Medicare X S. 981/H.R. 2000 (Bennet/Kaine/Delgado)	Public Plan Option (Federal/Medicare)	Marketplace/SHOP Eligible	ACA Essential Health Benefits	Medicare sets reimbursement rates; Secretary establishes for non-Medicare services	Self financed; $1 billion up front appropriation
Choose Medicare/Part E S. 1261/H.R. 2463 (Merkley/Richmond)	Public Plan Option (Federal/Medicare)	Marketplace/SHOP Eligible	ACA Essential Health Benefits	Medicare sets reimbursement rates; Secretary can block excessive private insurance rates.	Self finance: $2 billion up front appropriation
Medicaid Buy-In S. 489/H.R. 1277 (Schatz/Lujan)	Medicaid Buy-In	Marketplace eligible in states electing plan	Medicaid alternative benefit plan, must be at least ACA EHB	Medicaid sets reimbursement rates	Federal Medical Assistance Percentages for costs above premium revenue
Medicare at 50 S. 470/H.R. 1346 (Stabenow/Baldwin/Higgins)	Medicare Buy-In	Adults 50-64	Medicare Parts A, B, and D	Medicare sets reimbursement rates	Self-financed
Medicare for America H.R. 2452 (DeLauro)	Public Plan	All legal U.S. residents; newborns are automatically enrolled	Robust set of benefits including dental, vision, and prescription drugs	Current Medicare and Medicaid rates; Secretary has authority to raise rates as needed to ensure there are no barriers to care	Repealing GOP Tax Bill, 5% tax on adjusted gross income above $500K, taxes tobacco, beer, and sugary beverages
Medicare for All S. 1129/H.R. 1384 (Sanders/Jayapal)	Single Payer	All U.S. residents	All medically necessary	Medicare sets reimbursement rates in Sanders bill. Jayapal bill has a global budgeting to pay providers the average of the past three years of operating costs	No financing mechanism in Jayapal bill or Sanders bill. Sanders has white paper suggesting 70% marginal tax rate for income over $10M

Source: *"Side-by-Side Comparison of Medicare-for-All and Public Plan Proposals Introduced in the 116th Congress,"* Kaiser Family Foundation

Recent Legislative Activity

- House Committee on Rules Original Jurisdiction Hearing, “Medicare For All” – April 30
- House Committee on the Budget Hearing,“Key Design Components and Considerations for Establishing a Single-Payer Health Care System” – May 22
- Ways and Means Committee Markup, “Pathways to Universal Health Coverage” – June 5

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PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

TO: Interested Parties
FROM: Lauren Crawford Shaver, Partnership for America's Health Care Future
RE: What patients, families and taxpayers could expect under Medicare for all
DATE: May 20, 2019

Overview

When the House Committee on the Budget holds a hearing this Wednesday on a one-size-fits-all government-run health care system known as Medicare for all, Congress and the American people will hear testimony from experts at the non-partisan Congressional Budget Office (CBO), which recently issued a report that warns of what patients, families and taxpayers could expect under this proposed legislation.

The Bottom Line

Under Medicare for all, Americans would have *no choice* but to *pay more* to *wait longer* for *lower quality care*.

For starters, the CBO found that Medicare for all "could cause **substantial uncertainty for all participants**," and that its implementation "could be **complicated, challenging, and potentially disruptive**." But that's only the beginning.

Under Medicare for all, **"patients might face increased wait times and reduced access to care,"** they write, adding that such a system could also "**reduce the quality of care."**

The CBO also found that Medicare for all's steep provider payment cuts could cause **a long-term shortage of health care professionals like doctors and nurses** while **"[t]he number of hospitals and other health care facilities might also decline as a result of closures**, and there might be less investment in new and existing facilities."

These findings are supported by additional research, including a study prepared by KNG Health Consulting for the American Hospital Association and the Federation of American Hospitals, which found that Medicare for all **"would compound financial stresses [hospitals] are already facing, potentially impacting access to care and provider quality."** Another recent study found that Medicare for all could force hospitals to limit the care they provide and even "force the closure of essential hospitals."

And when it comes to costs, the outlook under Medicare for all grows even worse.

While the House Medicare for all bill notably **"doesn't include a price tag or specific proposals for financing the new system,"** the CBO confirms that Medicare for all **"would significantly increase government spending and require substantial additional government resources,"** which would of course demand unaffordable tax increases on working families.

Independent analysts estimate the cost of Medicare for all could be as high as $60 trillion over 10 years, and the nonpartisan Committee for a Responsible Federal Budget (CRFB) finds that even a low-end estimate of $30 trillion over a decade **"would mean increasing federal spending by about 60 percent (excluding interest)" and "require the equivalent of tripling payroll taxes or more than doubling all other taxes."**

"There's no possible way to finance [Medicare for all] without big middle class tax increases," CRFB's Marc Goldwein explained to *The Washington Post*. Not surprisingly, national polling by the Kaiser Family Foundation indicates that **six in 10 Americans oppose Medicare for all once they learn it forces families to pay more in taxes.**

Meanwhile, leading up to this week's hearing in his committee, **Chairman John Yarmuth (D-Ky.) became the latest prominent Democrat to douse Medicare for all with cold water**, telling *The Washington Post*:

"A lot of people, I think, co-sponsored Pramila's [Medicare for all] bill for the same reason they co-sponsored H.R. 676; it was the metaphor for Medicare-for-all," said Rep. John Yarmuth (D-Ky.), the chairman of the House Budget Committee, referring to the legislation from progressive caucus chair Rep. Pramila Jayapal (D-Wash.). ***"Now, people have seen some of the details and said, 'Okay, we need to look at this.' There doesn't seem to be much of a sense of urgency because it's not going anywhere."***

Recently, the House Committee on Rules held a hearing on Medicare for all, following which Rep. Donna Shalala (D-Fla.), who serves on the Rules committee, explained that her constituents tell her they want to keep their private coverage, not be pushed into a one-size-fits-all government-run health care system:

REP. SHALALA: *"…Out of my own experience and out of what my constituents tell me –* ***they want to keep their private health insurance. They do not necessarily want to go into a government program****. For those people who have very good private health insurance,* ***they don't want to go to a lesser program****. Medicare is not as good as many of the private insurance plans we currently have … But, more importantly, why should we spend money when people have good private health insurance? We need to cover those who don't have coverage now."*

And, in yet another reality check for the bill's prospects, *The Post* also took note of **the "decline in support for the actual Medicare-for-all bill" within the House Democratic Caucus**, reporting: "By the end of the past Congress, the legislative vehicle for Medicare-for-all, H.R. 676, had 124 co-sponsors in the House. The new Congress has 40 more Democrats in the House, but the new version of Medicare-for-all, H. R. 1384, has just 108 co-sponsors."

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

As *The Hill* reports, **"[c]entrist Democrats who helped their party win back the House majority with victories in key swing districts last fall are sounding the alarm that the liberal push for 'Medicare for all' could haunt them as they try to defend their seats and keep control of the House."** But Speaker Nancy Pelosi, Democratic Congressional Campaign Committee (DCCC) Chairwoman Rep. Cheri Bustos, Energy and Commerce Committee Chairman Rep. Frank Pallone and other key House Democrats have also weighed in with their concerns about Medicare for all.

This is no surprise: A recent national survey by the Kaiser Family Foundation finds that **a majority of Americans want elected leaders to focus on "targeted actions" to improve and build upon what is working in American health care and fix what isn't**. Kaiser finds that **most Democrats and Democratic-leaning independents "say they want Democrats in Congress to focus their efforts on improving and protecting the ACA,"** while previous polling conducted this year by Kaiser reveals that **most Americans don't support Medicare for all once they understand what it would do to them**.

Today, **roughly 90 percent of Americans are covered** and U.S. Census data indicate that **more than 217 million Americans benefit from private coverage,** including 180 million who receive coverage through their employers and 10 million who shopped for coverage in the marketplaces last year. More than 20 million American seniors are enrolled in the Medicare Advantage program.

Public opinion research shows that **a majority of Americans are satisfied with their coverage and care**. "Perhaps the greatest political danger for Democrats is that Medicare for all **would disrupt coverage" for every one of these Americans**, *Bloomberg* notes.

But our health care system today is far from perfect, and more can and should be done to help every American access affordable, quality care. To continue making progress towards this goal, our leaders should use the powerful tools already available to help them expand access and control costs, such as:

- Expanding Medicaid in the states that have not yet to do so, which would immediately cover millions of Americans.
- Strengthening federal subsidies so Americans of all income levels can choose market-based coverage that fits their needs.
- Using proven tools like reinsurance to stabilize premiums and control costs for families and patients.

Constructive steps like these will help us improve and build upon what is working today. In contrast, scrapping the foundations of American health care – including employer-provided coverage, the Children's Health Insurance Program, the Affordable Care Act, Medicaid and Medicare – to start over with a one-size-fits-all government-run system called Medicare for all, would hurt patients, families and taxpayers, and ultimately take us backwards.

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

- To learn more about the Partnership for America's Health Care Future, CLICK HERE.
- To sign up for email updates, CLICK HERE.
- Follow the Partnership on Twitter: @P4AHCF.
- And reach out to us any time with inquiries at: Press@AmericasHealthCareFuture.org.

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

December 9, 2019

The Honorable Anna Eshoo
Chairwoman
House Energy and Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Michael Burgess
Ranking Member
House Energy and Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairwoman Eshoo and Ranking Member Burgess:

The Partnership for America's Health Care Future (PAHCF) welcomes and supports an open discussion on how to best protect our health care future and make sure every American has access to affordable, high-quality coverage during the "Proposals To Achieve Universal Health Care Coverage" hearing held by the U.S. House Committee on Energy and Commerce's Health Subcommittee. However, many of the proposals being considered would have severe consequences for taxpayers, consumers, patients and families. In fact, studies show that new government-controlled health insurance systems – namely Medicare for All, Medicare buy-in and the public option – could mean higher taxes and premiums, longer wait times and lower quality care.

The Partnership is a nonpartisan coalition of the nation's leading doctors, nurses, clinicians, community hospitals, health insurance providers and biopharmaceutical companies committed to working together to ensure every American has access to the affordable, high-quality coverage they deserve. Our mission is to build on what's working in health care and fix what's not. We want to work together to lower costs, protect patient choice, expand access, improve quality and foster innovation. But whether it's called Medicare for All, Medicare buy-in, or the public option, one-size-fits-all health care will never allow our nation to achieve those goals.

Studies show that a Medicare for All system would cause American families to pay more to wait longer for worse care. In fact, Medicare for All is estimated to cost more than $50 trillion over 10 years. The non-partisan Committee for a Responsible Federal Budget (CRFB) finds that "fully offsetting the cost would require higher taxes on the middle class," and would "require the equivalent of tripling payroll taxes or more than doubling all other taxes." And despite arguments that most families would see their overall costs decrease, a wide range of experts agree that it is impossible to make those guarantees, warning that "most taxpayers would pay more in taxes than they would save from having the federal government absorb the cost of health-care premiums."

Even worse, instead of increasing access to quality care, a one-size-fits-all government-controlled health insurance system could actually reduce it, according to the non-partisan Congressional Budget Office (CBO). The CBO also finds that a new one-size-fits-all system may not address the needs of some people and could lead to "a shortage of providers, longer wait times, and changes in the quality of care." Medicare for All would also pose a tremendous threat to our nation's rural hospitals, which are already struggling to stay open. Some "would close virtually overnight," further limiting access to care for American patients. Findings like these have been backed up by economists across the ideological spectrum.

Likewise, studies also show that so-called "moderate" alternatives to Medicare for All – such as the public option, Medicare buy-in and Medicare for America – would ultimately lead to the same consequences. A recent study, conducted by FTI Consulting, finds that the public option would cause millions of Americans to lose their current coverage and could result in the loss of all other private plans in the individual market. According to the study, "[i]n the first year following introduction of the public option, over 130,000 Americans enrolled in ACA coverage would be forced off of their existing health plan. Over a decade, up to two million enrollees could experience a loss of private coverage as insurers exit the marketplaces." At the end of that decade, more than seven million Americans would no longer have their private coverage through the marketplaces.

While Medicare for All would eliminate every American's existing health coverage virtually overnight, new government-controlled health insurance systems such as the public option will lead to the same harmful consequences over time. A study by KNG Health Consulting, LLC found that Medicare for America, another government-controlled health insurance system, could force one-third of American workers off of their current employer provided health care coverage.

Other recent studies have also shown these government-controlled systems like the public option would limit patients' access to quality care, as hospitals could be forced to offer less care or even shut their doors entirely. According to a study by Navigant Consulting, the public option could put more than 1,000 rural U.S. hospitals – which serve more than 60 million Americans – "at high risk of closure." And a study from KNG Consulting found that "[f]or hospitals, the introduction of a public plan that reimburses providers using Medicare rates would compound financial stresses they are already facing, potentially impacting access to care and provider quality."

The public option would also increase costs for American families. Another KNG study finds that instead of addressing rising health care costs, it "would increase total health care spending, with the largest spending increases occurring among those who already had public coverage through Medicare or Medicaid." Americans' premiums could sky-rocket and experts have noted that a public option system "could prove costly."

Today, about 90 percent of Americans are covered and millions more are eligible for coverage under our current system. Patients with pre-existing conditions are protected and young adults can stay on their parents' health plans until they are 26 years old. By building on what's working, we can expand access without compromising the coverage and care a majority of Americans are satisfied with.

The Partnership welcomes and supports an open and honest discussion on how to best expand access to affordable, high-quality coverage for all Americans and appreciates your focus to this critical issue. We look forward to a frank conversation about the consequences of new government-controlled health insurance systems and urge lawmakers to instead work together to build on what's working and fix what isn't.

Sincerely,

Lauren Crawford Shaver
Executive Director
Partnership for America's Health Care Future

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

Explaining The Facts On Medicare For All

With so much discussion of new government-controlled health insurance systems like Medicare for all, it can be tough to cut through the clutter. Here are some key facts to keep in mind.

When politicians say "Medicare for all," they are talking about a **one-size-fits-all system** that would:

- **Slam working families with unaffordable tax hikes.**
- Subject Americans to **longer wait times and a lower quality of care**.
- **Take away the choice and control** Americans enjoy under our current system, where market-based coverage and government programs *work together* to cover roughly 90 percent of Americans.
- Push everyone off their current plan, into **a single, government-controlled health insurance system run by politicians**.

Here's what others have to say…

Medicare For All Would Force Americans To Pay More…

Independent analysts estimate **the cost of Medicare for all could be more than $32 trillion** over 10 years, and the nonpartisan Committee for a Responsible Federal Budget (CRFB) finds that even a low-end estimate of $30 trillion over a decade **"would mean increasing federal spending by about 60 percent (excluding interest)"** and **"require the equivalent of tripling payroll taxes or more than doubling all other taxes."**

- "According to a study from the Urban Institute (and a follow-up paper), **Medicare-for-all would still add $32.6 trillion to national health spending over 10 years.** The study goes on to state that **Sanders's proposed tax increase would be insufficient and that additional revenue would be needed."** (Atthar Mirza, "Would Bernie Sanders's Medicare-for-all save Americans money?" The Washington Post, 6/3/19)

- "[F]or many [Americans], higher taxes would exceed any savings … [T]he **181 million taxpayers with employer-sponsored coverage could miss out on the benefits** of the Sanders plan, and **even those receiving Medicaid could pay more, according to health-care policy experts on both sides of the political spectrum … payroll taxes and income tax increases would necessarily have**

to be part of the plan … Many of the 181 million taxpayers with **employer-sponsored coverage are likely to see their taxes go higher than their current health care spending,** because about 56% of their medical costs are covered by their company … Those on **Medicaid**, the government-sponsored insurance program for the poor, **are likely to see their tax burdens rise far beyond their current health spending."** (Laura Davison, "Bernie Sanders Predicts His $10,000 Tax Hike Will Save You Money. Watch The Fine Print," Bloomberg, 7/2/19)

- **CRFB's Marc Goldwein: "There's no possible way to finance [Medicare for all] without big middle class tax increases."** (Jeff Stein, "Democrats' 2020 Policy Proposals Almost Certainly Require Middle-Class Tax Hikes," The Washington Post, 3/28/19)

- "Tax experts … say that **you can't raise enough money from taxing the rich** and that the levies on all Americans may exceed the savings for more people …. **This may be particularly true of low-income folks**…**"** (Tami Luhby, "Can Taxing The Rich Pay For Bernie Sanders' Medicare For All Plan?" CNN, 4/16/19)

- *The New York Times* editorial board pointed out that "[i]n Vermont and Colorado, **legislators dropped bids for a state-run single-payer system when it became clear that people would not support the tax increases needed to sustain such a program."**

- Vermont's Democratic governor admitted that the **11.5 percent payroll tax and 9.5 percent income tax** that were proposed to finance the system **were too much for taxpayers to accept:** "'The biggest problem was money,' Shumlin said at Harvard. And he **couldn't promise lawmakers that they wouldn't need to hike taxes again later** to accommodate rising health care costs." (Lauren Clason, "Single-Payer Health Care Systems Are No Easier In The States," Roll Call, 3/29/19)

- Democratic New York Governor Andrew Cuomo said **"no sane person will pass it,"** and **"you'd double everybody's taxes" to pay for it.** (Edward-Isaac Dovere, "Andrew Cuomo's Case For 2020 – No, Really," The Atlantic, 3/3/19)

… To Wait Longer For Worse Care …

***"*[P]roviders warn [Medicare for all] could significantly hurt their ability to provide adequate, widespread care.** A recent report from the Congressional Budget Office [(CBO)] reinforces this concern: **'Such a reduction in provider payment rates would probably reduce the amount of care supplied and could also reduce the quality of care.'"** (Atthar Mirza, "Would Bernie Sanders's Medicare-for-all save Americans money?" The Washington Post, 6/3/19)

- **CBO: "**If the number of providers was not sufficient to meet demand**, patients might face increased wait times and reduced access to care,"** and such a system **"could also reduce the quality of care,"** while **"[t]he number of hospitals and other health care facilities might also decline as a result of**

closures, and there might be **less investment in new and existing facilities."** ("Key Design Components And Considerations For Establishing A Single-Payer Health Care System," Congressional Budget Office, 5/1/19)

- Experts are growing increasingly worried about the **"violent upheaval"** a Medicare for all system **would cause hospitals**, cautioning**: "Some hospitals, especially struggling rural centers, would close virtually overnight,** according to policy experts. Others, they say, **would try to offset the steep cuts by laying off hundreds of thousands of workers and abandoning lower-paying services like mental health."** (Reed Abelson, "Hospitals Stand To Lose Billions Under 'Medicare For All,'" The New York Times, 9/23/19)

- **Medicare for all "would all but end private insurance and regulate hospitals in a vastly different way,** dramatically changing operators' business model and **costing community hospitals as much as $151 billion a year,** according to one estimate published in JAMA," all while **"slashing hospitals' pay rates and putting up to 1.5 million jobs at stake."** (Adam Cancryn, "'Medicare For All' Backers Find Biggest Foe In Their Own Backyard," POLITICO, 5/25/19)

… And Push Every American Into A One-Size-Fits-All System Run By Politicians …

Medicare for all "would force the roughly 150 million Americans who are insured through their employer to switch to a government-run program … Larry Levitt, a health policy expert at the nonpartisan Kaiser Family Foundation, said … 'As a practical matter, **Senator Sanders' Medicare for all bill would mean the end of private health insurance … Employer health benefits would no longer exist, and private insurance would be prohibited** from duplicating the coverage under Medicare.'" (Sahil Kapur, "Kamala Harris Says 'Medicare for All' Wouldn't End Private Insurance. It Would," Bloomberg, 7/5/19)

- **The New York Times: "[P]rivate health insurance would be abolished."** (Matt Stevens, "Bernie Sanders On Medicare For All," The New York Times, 6/27/19)

INSTEAD, LET'S BUILD ON WHAT'S WORKING AND FIX WHAT'S BROKEN:

For millions of Americans, our current health care is working, even though more can and should be done to improve it. Market-based coverage like employer-provided care is working together with public programs to extend quality health care coverage to roughly 90 percent of Americans.

- Nearly 180 million Americans are now covered by employer-provided health insurance, and with the Affordable Care Act, individuals who are not covered by their employers can finally access more affordable coverage for themselves and their families.

- Thanks to the progress we've made, **roughly 90 percent of Americans are covered, patients with pre-existing conditions are protected and young adults can stay on their parents' health plans until they are 26 years old**.

- Public opinion research consistently shows that **most Americans are happy with the coverage and care they and their families receive. But we can all agree that there is more work to be done.**

That's why the Partnership for America's Health Care Future supports building on the strength of employer-provided health coverage and preserving the crucial public programs many Americans depend upon, like Medicare and Medicaid.

Our mission is to promote solutions that provide Americans with greater affordability, expanded health care options, greater access and the benefits of critical innovation.

ICYMI: "Medicare Buy-In, Public Option Proposals Would Harm Our Health Care System"

In a new op-ed published today by the *Morning Consult*, the Partnership for America's Health Care Future's Lauren Crawford Shaver writes that a "buy-in" or "public option" Medicare for all-style proposal "does nothing to address the actual cost of providing health care — and as a result it would affect providers' ability to continue to offer services, endangering patients' access to doctors and care."

> *While proposals such as this are being touted by some as a more moderate approach, Americans should understand the consequences. These would drastically change health care in our country. They are nothing less than a slippery slope toward one-size-fits-all, government-run health care.*
>
> *A study released this month by the American Hospital Association and the Federation of American Hospitals found that implementation of Medicare-X would result in nearly 4 million fewer Americans receiving health care coverage than if our existing health care system were simply shored up. In fact, the study found that our nation already has the framework in place to increase access to health insurance for more than 9 million Americans through realistic solutions that improve upon our current system, such as expanding Medicaid and boosting Affordable Care Act enrollment.*
>
> *Further, the AHA-FAH study found that under Medicare-X, hospitals would be hit by $774 billion in cuts, which would "compound financial stresses already faced by the nation's hospitals, potentially impacting access to care and provider quality," hurting vulnerable patients throughout the country.*
>
> *Already, America's hospitals are under pressure, and a significant cut in funding could exacerbate hospital closure rates and further strain the nation's hospital network. In fact, a separate study released by Navigant Consulting found that "Medicare-for-all" proposals could force hospitals to limit the care they provide, cause significant layoffs and "potentially force the closure of essential hospitals." Because the "capacity to reduce/manage cost will vary markedly from system to system and hospital to hospital," the report finds single-payer proposals "appear to have financial effects that exceed the capacity of hospital managements to reduce their expenses."*

To read the Partnership's full op-ed at the *Morning Consult*, CLICK HERE.

To learn more about the Partnership for America's Health Care Future, CLICK HERE.

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

ICYMI: 'Medicare For All Means Layoffs'

WASHINGTON – Last week, one of the main architects of Medicare for All admitted to *POLITICO* that in order to pay for the costly new system, **"the savings don't come out of the sky … that means layoffs. there's just no way around it."**

In the story, entitled **"Medicare for All's jobs problem,"** *POLITICO* reports that according to the University of Massachusetts Political Economy Research Institute (PERI), **"1.8 million health care jobs nationwide would no longer be needed** if Medicare for All became law, **upending** health insurance companies and **thousands of middle class workers** whose jobs largely deal with them, including insurance brokers, medical billing workers and other administrative employees."

Meanwhile, studies and economists agree that Medicare for All would force Americans to pay more.

Medicare for All **"would cost more than $50 trillion over 10 years,"** *Yahoo! Finance* reports, while Ronald Brownstein of *The Atlantic* notes that the **new government-controlled system would cost "more than the federal government will spend over the coming decade on Social Security, Medicare, and Medicaid combined."**

The Committee for a Responsible Federal Budget (CRFB) finds that **"fully offsetting the cost would require higher taxes on the middle class,"** and would **"require the equivalent of tripling payroll taxes or more than doubling all other taxes."**

- The bill's author, Senator Bernie Sanders (I-VT), acknowledged that **Americans making more than $29,000 per year would "pay more in taxes" for Medicare for all.**

- Economists agree that proposed funding mechanisms like the $9 trillion tax on employers, **"will get passed onto workers through reduced wages,"** *Axios* reports. *The Washington Post* adds that **"[b]asic economic theory holds that such payments are essentially a tax on employees because it comes out of compensation." "[P]ayroll costs of this sort are essentially middle-class taxes on employees.** Fixing per-employee business costs at some future date would also be an incentive for companies to reduce

their coverage now to reduce future costs. **So employees would get worse coverage than they have now,"** *The Wall Street Journal* reports.

- **Medicare for All "would require aggressive changes in taxes, spending or borrowing,"** and **"the middle class would be forced to shoulder some of the burden,"** *Axios* reports.

- **"No matter how you cut the numbers, there is absolutely no way to pay for Medicare for all without tax increases – or spending cuts – on the middle class,"** Marc Goldwein of CRFB told *POLITICO*. **"There's no question it hits the middle class,"** Kenneth Thorpe, Chairman of the Health Policy and Management Department, Emory University told *The Washington Post*.

- "Although [Medicare for All's supporters] have frequently stressed that the middle class would see **overall costs go down**, **a wide range of experts … say it is impossible to make those guarantees based on the plans that the candidates have outlined so far** … 'It's impossible to have an 'everybody wins' scenario here,' said Kenneth Thorpe, chairman of the health policy department at Emory University … **'There's no question it hits the middle class,'** he added. John Holahan, a health policy expert at the nonpartisan Urban Institute agreed: 'Even though high-income people are going to pay a lot more**, this has to hit the middle class.'**… **'Most of the proposals to move to Medicare-for-all would involve substantial tax increases that would affect most people,'** said Katherine Baicker, an economist at the University of Chicago who specializes in health policy. **'These are going to be big tax increases.**' … 'I think it seems likely **under most proposals taxes would have to go up substantially unless you dramatically cut the health care you're getting,'** she added." (Matt Viser & Sean Sullivan, "Will Medicare-For-All Hurt The Middle Class? Elizabeth Warren And Bernie Sanders Struggle With Questions About Its Impact." The Washington Post, 10/5/19)

And the 'public option' and other so-called 'moderate' incremental proposals would ultimately lead to the same consequences.

A new study from FTI Consulting reveals a new government-controlled health insurance system known **as the public option could eliminate consumer choice for millions of Americans and "eventually cause the elimination of all private plans in the individual market."** The study finds:

- After the first 10 years of the public option, **more than seven million current enrollees would no longer have private coverage through the marketplaces – with two million of those enrollees being forced off their private plans** as insurers exit the marketplaces altogether.

- The study also warns that **the public option could eventually cause the elimination of all private plans in the individual marketplaces, eliminating choice for millions of health care consumers**, even those with the resources

or subsidies available to cover their preferred plan.

- In fact, the report finds that by 2050, **70 percent of state marketplaces (34 U.S. states) would no longer offer a single private insurance option.**

- **Rural families** – millions of whom already find their access to quality care at risk – would be **especially hard hit by the public option,** the study warns, and could find few if any options available to them.

Another study by KNG Health Consulting, LLC reveals that "Medicare for America," **a proposed new government-controlled health insurance system, could force one-third of American workers off of their current employer provided health care coverage,** also known as employer-sponsored insurance (ESI). And *The Wall Street Journal* reports that new government health insurance systems like **the public option, Medicare buy-in and 'Medicare for all who want it,' represent "stepping stones to single payer."**

"The public option would cause premiums for private insurance to skyrocket because of underpayment by government insurance compared with costs for services … A single-payer option is not a moderate, compromise proposal. Its inevitable consequence is the death of affordable private insurance … **Massive taxation would be needed to expand Medicare, whether optionally or not."** (Scott W. Atlas, "Public Option Kills Private Insurance," The Wall Street Journal, 7/16/19)

- **The public option "could also lead to a 10 percent increase in premiums for the remaining pool of insured people."** (Reed Abelson, "How A Medicare Buy-In Or Public Option Could Threaten Obamacare," The New York Times, 7/29/19)

- **"[A] government buy-in** that attracted older Americans **could indeed raise premiums** for those who remained in the A.C.A. markets, especially if those consumers had high medical costs." (Reed Abelson, "How A Medicare Buy-In Or Public Option Could Threaten Obamacare," The New York Times, 7/29/19)

- **"[A] government plan that attracted people with expensive conditions could prove costly."** (Reed Abelson, "How A Medicare Buy-In Or Public Option Could Threaten Obamacare," The New York Times, 7/29/19)

- And a report found that an effort to implement **the public option** in Colorado, **"could imperil thousands of jobs in the health-care industry or take hundreds of millions of dollars out of the state's economy."** (Ed Sealover, "Colorado Public-Option Insurance Plan Could Cost Health-Care Jobs, Study Argues," Denver Business Journal, 9/10/19)

Another study, conducted by Navigant for the Partnership for America's Health Care Future, finds that **the public option could put more than 1,000 rural U.S. hospitals in 46 states "at high risk of closure." These hospitals serve more than 60 million**

Americans, and as *Kaiser Health News* and *NPR* report, **hospital closures can have "profound social, emotional and medical consequences,"** while *RevCycleIntelligence* also reports, **"[p]atient access to care suffers when a rural hospital closes its doors for good, and consequently, patient outcomes can deteriorate."**

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

ICYMI: Medicare For All Was 'Spectacular Failure' & 'Financial Train Wreck' In Vermont

WASHINGTON – As the costs of new government-controlled health insurance systems continue to dominate the national debate, a new editorial in the swing state of Nevada reminds readers that **the effort to implement a one-size-fits-all system in Senator Bernie Sanders's (I-VT) home state of Vermont "was a spectacular failure."** The editorial, from the *Las Vegas Review Journal*, recounts how the unaffordable costs and massive tax increases associated with a new government-controlled system ultimately led to its demise:

> *The first step toward implementing it was* ***figuring out how to pay for it. Despite promises that a state takeover of health care would save money, the required tax hikes proved prohibitive.*** *Like Sen. Sanders,* ***Mr. Shumlin promoted the plan initially without explaining how to pay for it*** *… In 2014, Mr. Shumlin's office estimated* ***the plan would require an 11.5 percent payroll tax on employers and up to a 9.5 percent income tax on families.*** *Turns out the equivalent of a 21 percent income tax to finance "free" health care didn't have widespread political support. Go figure.* ***The effort was so unpopular that Mr. Shumlin almost lost his 2014 re-election.***

In a recent column, Peter Suderman, a columnist for *The New York Times*, drew similar conclusions and explains why Vermont's failure to implement a Medicare for All style system **"demonstrates why any similar project undertaken at a national scale is unlikely to succeed as well."**

> *… One reason the plan lacked strong* ***support was lawmakers were cagey about how to pay for it.*** *The* ***2011 proposal included no specific financing mechanism,*** *because Mr. Shumlin's team worried that might kill its chances … [B]y 2014, Mr. Shumlin's own estimates found that* ***employers would have to pay taxes equal to about 11.5 percent of payroll, while families would have to pay as much as 9.5 percent of their annual income*** *to make the financing work. The plan would have* ***nearly doubled the size of the state's budget. For both political and economic reasons, the cost was deemed too high.***
>
> *… And so, at the end of 2014, Mr. Shumlin admitted defeat. "I have learned that the limitations of state-based financing, the limitations of federal law, the limitations of our tax capacity and the sensitivity of our economy"* ***make single-payer "unwise and untenable at this time," he said. "The risk of economic***

> ***shock is too high."*** *The Vermont plan was done in by high taxes, distrust of government and lack of political support.* ***Any effort by a Sanders administration to enact a single-payer system at a national level would probably be doomed by similar problems.***
>
> *Like … Mr. Shumlin,* ***Mr. Sanders has so far declined to lay out a plan for fully financing his Medicare for All system*** *… But if it couldn't work in Vermont, with a determined governor, an accommodating legislature and progressive voters, Mr. Sanders will have a tough time explaining why it will somehow succeed on a vastly larger scale. Vermont represents a practical failure on friendly turf, and that is what makes it such a powerful counter to Mr. Sanders's proposal.*

The New York Times editorial board also acknowledged recently that "[i]n Vermont and Colorado, legislators dropped bids for a state-run single-payer system when it became clear that **people would not support the tax increases needed to sustain such a program."**

Much like Vermont's former Governor Peter Shumlin's single-payer campaign, national Medicare for All proponents have so-far refused to explain exactly how such a program would be financed. But when it comes to a national Medicare for All system, the nonpartisan Committee for a Responsible Federal Budget (CRFB) finds that even a low-end cost estimate of $30 trillion over a decade **"would mean increasing federal spending by about 60 percent (excluding interest)" and "require the equivalent of tripling payroll taxes or more than doubling all other taxes."** And the fact is, **"[t]here's no possible way to finance [Medicare for All] without big middle class tax increases,"** CRFB's Marc Goldwein explained to *The Washington Post* – a fact that even the bill's author acknowledged recently.

And while the bill's co-sponsors try to push the argument that the increase in taxes would be offset by savings, **"economists say that most taxpayers would pay more in taxes than they would save from having the federal government absorb the cost of health-care premiums,"** *The Washington Post* reports. *Bloomberg* adds that without taxing the middle class, the plan laid out by presidential candidate Senator Elizabeth Warren (D-MA) is **"$30 Trillion Short."**

> ***"Her taxes as they currently exist are not enough yet to cover fully replacing health insurance,"*** *University of California, Berkeley economics professor Emmanuel Saez, who advised the Warren campaign when developing the wealth tax …* ***Sanders acknowledged in Tuesday's debate that "taxes will go up,"*** *but neither of them have detailed how much or who those taxes would hit …* ***"She is offering a Medicare for All plan and not offering even close to enough to pay for it,"*** *said Kyle Pomerleau, the chief economist at the conservative Tax Foundation …* ***[T]here wouldn't be enough revenue from top earners and corporations to fund the estimated $30 trillion 10-year cost for Medicare for All.*** *She'd have* ***to find more revenue streams and that would***

> ***have to include increasing taxes on the middle class, according to public finance experts across the political spectrum.***

CRFB confirms this point, noting that the options laid out to finance the new government-controlled health insurance system **"would fall well short of raising the $30 trillion necessary to fully offset the plan,** and are **unlikely to cover much more than half of the cost of Medicare for All.** Though we have not formally estimated these new proposals, **it is clear that they would indeed leave a 'multi-trillion dollar hole.'"**

Meanwhile, the Kaiser Family Foundation finds that **60 percent oppose Medicare for All when they learn it would require most Americans to pay higher taxes.** And Voter Vitals – a new quarterly tracking poll conducted nationwide and in 2020 battleground states – finds that **a majority of Democratic voters are unwilling to pay any more in taxes for universal coverage** while a supermajority of Democrats (69 percent) support building and improving on what we have today over new government insurance systems.

PARTNERSHIP FOR AMERICA'S
HEALTH CARE FUTURE

About Us

OUR MISSION.

The Partnership for America's Health Care Future's (PAHCF) mission is to build on what's working in health care and fix what's not.

We want to work together to lower costs, protect patient choice, expand access, improve quality and foster innovation. And whether it's called Medicare for All, Medicare buy-in, or the public option, **one-size-fits-all health care will never allow us to achieve those goals.**

That's why we support building on the strength of employer-provided health coverage and preserving Medicare, Medicaid, and other proven solutions that hundreds of millions of Americans depend on – to expand access to affordable, high-quality coverage for every American.

WHO WE ARE.

Every American deserves access to affordable health coverage and high-quality care. Our health care system allows tens of millions of patients and families to receive world-class care delivered by world-class doctors and hospitals.

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

committed to working together to ensure every American has access to the affordable, high-quality coverage they deserve.

MEMBERS.

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PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

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PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

ICYMI: The Public Option 'Could Be Plenty Disruptive'

WASHINGTON – As some candidates and lawmakers try to paint **the public option** as a "moderate" alternative to Medicare for All, *The New York Times* explains that in reality, the new government-controlled health insurance system "**could be plenty disruptive" and "tilt in the same direction" as Medicare for All**.

They report that the public option "could shake up the private market and also **wind up erasing some current insurance arrangements** … There's also the possibility that **linking public-option coverage to Medicare could cause some doctors to stop accepting Medicare patients,** [Sherry Glied, the dean of the N.Y.U. Wagner Graduate School of Public Service, and a former health official in the Obama administration] said. That would be another form of **politically risky disruption.**" Further, they explain, the public option "**could have effects on employer insurance** … [T]he existence of a **public option might also induce some employers to abandon private coverage altogether** … If it took a lot of market share from private insurers, some might decide to stop selling certain lines of coverage. **Private insurance could disappear from some places,** or exist largely to fill certain niches, like high-deductible plans."

In a previous story headlined **"How a Medicare Buy-In or Public Option Could Threaten Obamacare,"** *The New York Times* reported that **"a public option may well threaten the A.C.A. in unexpected ways."**

*A government plan, even a Medicare buy-in, could **shrink the number of customers buying policies on the Obamacare markets**, making them less appealing for leading insurers, according to many health insurers, policy analysts and even some Democrats … [A] buy-in shift in insurance coverage **could profoundly unsettle the nation's private health sector, which makes up almost a fifth of the United States economy**. Depending on who is allowed to sign up for the plan, it **could also rock the employer-based system that now covers some 160 million Americans** … Siphoning off such a large group of customers **could also lead to a 10 percent increase in premiums for the remaining pool of insured people**, according to the Blue Cross analysis. More younger people with expensive medical conditions have enrolled than insurers expected, and insurers **would have to increase premiums** to cover their costs, Mr. Haltmeyer said. Tricia Neuman, a senior vice president at the Kaiser Family Foundation, which studies insurance markets, said a government buy-in*

*that attracted older Americans **could indeed raise premiums for those who remained in the A.C.A. markets**, especially if those consumers had high medical costs … Dr. David Blumenthal, the president of the Commonwealth Fund, a foundation that funds health care research, said a government plan that attracted people with expensive conditions **could prove costly**. "You might, as a taxpayer, become concerned that they would be more like high-risk pools," he said.*

As Dr. Scott Atlas of Stanford University explained in *The Wall Street Journal*, the **public option would raise costs for families and "mainly erode, or 'crowd out,' private insurance, rather than provide coverage to the uninsured."**

Meanwhile, a new study from FTI Consulting confirms that **the public option could eliminate consumer choice for millions of Americans and "eventually cause the elimination of all private plans in the individual market."** The study finds:

- After the first 10 years of the public option, **more than seven million current enrollees would no longer have private coverage through the marketplaces – with two million of those enrollees being forced off their private plans** as insurers exit the marketplaces altogether.

- The study also warns that **the public option could eventually cause the elimination of all private plans in the individual marketplaces, eliminating choice for millions of health care consumers**, even those with the resources or subsidies available to cover their preferred plan.

- In fact, the report finds that by 2050, **70 percent of state marketplaces (34 U.S. states) would no longer offer a single private insurance option.**

- **Rural families** – millions of whom already find their access to quality care at risk – would be **especially hard hit by the public option,** the study warns, and could find few if any options available to them.

Another study by KNG Health Consulting, LLC reveals that "Medicare for America," **a proposed new government-controlled health insurance system, could force one-third of American workers off of their current employer provided health care coverage,** also known as employer-sponsored insurance (ESI). And *The Wall Street Journal* reports that new government health insurance systems like **the public option, Medicare buy-in and 'Medicare for all who want it,' represent "stepping stones to single payer."**

Yet another study, conducted by Navigant for the Partnership for America's Health Care Future, finds that **the public option could put more than 1,000 rural U.S. hospitals in 46 states "at high risk of closure." These hospitals serve more than 60 million Americans,** and as *Kaiser Health News* and *NPR* report, **hospital closures can have "profound social, emotional and medical consequences,"** while *RevCycleIntelligence* also reports, **"[p]atient access to care**

suffers when a rural hospital closes its doors for good, and consequently, patient outcomes can deteriorate."

And the *Denver Business Journal* reports that another report found that an effort to implement **the public option** in Colorado, **"could imperil thousands of jobs in the health-care industry or take hundreds of millions of dollars out of the state's economy."**

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

ICYMI: Public Option Limits Patient Choice

WASHINGTON – With proponents of Medicare for All scrambling as support for their one-size-fits-all system continues to fall, attention is turning to so-called "moderate" fallback proposals like the public option. In a radio interview with KELA in Washington, Lauren Crawford Shaver, executive director of the Partnership for America's Health Care Future, points out that the falsely deemed more "moderate" **public option would "lead to the same one-size-fits-all government run care**," according to a new study:

*… The introduction of a **public option** which is the creation of a government-run separate plan and **system has a lot of questions** and what would it do? What would be the unintended consequences? … There are a lot of unanswered out there, but people are throwing it around as another plan, as another option. And really what it is, is it does **lead to the same one-size-fits-all government run care.** So, we released the study yesterday with our partner FTI Consulting and in it we found a few interesting things if you created a **public option.** One, you **would create a two tier health system** where employer sponsored insurance … would be through a different set of hospitals very different than those in the public program or public option. So, one thing that we pride ourselves in is that health care right now is something that once you have coverage, you have many choices in the system. This creates just a two-tier system.*

*Second, we found … that **would completely eliminate the private market over time.** It wouldn't be tomorrow, but over time the private market would not be able to compete with these government programs. So, what would that look like? By 2028, **20 percent of state marketplaces would not offer a single private insurance option as a result of the introduction of the public option.** … **Creating a public option actually eliminates options.** It means that the other plans can't compete and they're not going to be viable for people there. In the first year of the introduction of the public option, **130,000 Americans enrolled in the Affordable Care Act coverage or those marketplaces would be forced off of the existing health plan** because insurers would have to exit the marketplaces. Over a decade, 10 years from now, that would mean **two million people who get their coverage through the marketplace exchanges would lose their private coverage.** So, **it's a huge disrupter** and in fact, the goal is to continue to gain coverage, get people access to other plans, **you're actually disrupting the market so much that people would actually lose their employer-sponsored insurance.***

… I'll tell you that no matter what you call it, ***Medicare for All, Medicare buy-in or the public option, they do all lead to a one-size-fits-all government-run care …*** *So, whether it's something you choose now or something for a longer lead time,* ***it puts the government in the middle of making your coverage decisions rather than the patient or the individual.***

- To listen to Lauren Crawford Shaver's full interview, CLICK HERE.
- To read FTI Consulting's findings, CLICK HERE.

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

TO: Interested Parties
FROM: Partnership for America's Health Care Future
RE: Under Sanders's Medicare For All, Americans Would Pay More To Wait Longer For Worse Care
DATE: July 30, 2019

Overview

WASHINGTON – As Senator Bernie Sanders (I-Vt.) prepares to take the debate stage in Detroit this evening, Americans will be reminded that under his one-size-fits-all Medicare for all system, they would be forced to pay more and wait longer for lower-quality of care.

Higher Costs & Unaffordable Tax Hikes:

Sanders has repeatedly claimed that under Medicare for all, the "vast majority of the people in this country will be paying significantly less," as he recently declared on the debate stage. **But, as *Bloomberg* reports, "[f]or many Americans, though, that would not be true," and "higher taxes would exceed any savings."**

*Yet the **181 million taxpayers with employer-sponsored coverage could miss out on the benefits of the Sanders plan, and even those receiving Medicaid could pay more, according to health-care policy experts on both sides of the political spectrum** … Sanders has proposed a wealth tax, a bank levy and premiums paid by employers and employees. But that only raises about half of what is needed, meaning that **payroll taxes and income tax increases would necessarily have to be part of the plan. "There are likely to be a lot more losers than winners,"** Brian Riedl, a senior fellow at the right-leaning Manhattan Institute … **Many of the 181 million taxpayers with employer-sponsored coverage are likely to see their taxes go higher than their current health care spending**, because about 56% of their medical costs are covered by their company, according to the Milliman Medical Index, which tracks annual health care spending. For example, a person making $50,000 with employer-sponsored coverage spends about $5,250 annually on health care, meaning that **under Sanders's plan, her or his taxes would be nearly double the person's current health care costs** … **Those on Medicaid, the government-sponsored insurance program for the poor, are likely to see their tax burdens rise far beyond their current health spending**, Riedl said. A family of four earning $30,000 spends about $1,200 annually on health costs, according to the Kaiser Family Foundation estimates. Sanders' plan also assumes that health providers will be reimbursed at Medicare rates, about 40% below what they receive from private insurers. Health care experts question whether a cut this large is feasible, meaning that **the cost for Medicare for All could be even higher**.*

Tellingly, Sanders has "said his campaign purposefully didn't put out a detailed account of his payment plan because it would 'engender enormous debate.'" But, while pointing out **Sanders's "misleading" rhetoric**, fact-checkers for *The Washington Post* note that

"**[a]ccording to a study from the Urban Institute (and a follow-up paper), Medicare-for-all would still add $32.6 trillion to national health spending over 10 years**. The study goes on to state that **Sanders's proposed tax increase would be insufficient and that additional revenue would be needed**."

And *CNN* reports that "[t]ax experts … say that **you can't raise enough money from taxing the rich and that the levies on all Americans may exceed the savings for more people than Sanders expects. This may be particularly true of low-income folks** who get heavily subsidized coverage on the Obamacare exchanges … **'His plan still doesn't add up,'** [Marc] Goldwein [of the Committee for a Responsible Federal Budget (CRFB)] said … **'To generate the kind of revenue that Sanders is talking about to pay for something as big as his version of Medicare for All … would be vastly more expensive than any of the kinds of things he's talking about,'** said Howard Gleckman, senior fellow at the Urban-Brookings Tax Policy Center, a nonpartisan think tank. **'He's going to have to come up with more money from some place.'"** That place is the bank accounts of middle-class Americans: **"There's no possible way to finance [Medicare for all] without big middle class tax increases,"** CRFB's Goldwein explained to *The Washington Post*.

While many are just beginning to learn how a one-size-fits-all system would affect their health care, most Americans are well aware of the unaffordable tax hikes they'd be hit with. **"There's one thing Americans understand about Medicare-for-all: It would mean higher taxes** … Americans seem most familiar with the fact that Medicare-for-all would require **massively higher taxes,"** *The Washington Post* reports of a recent national poll by the Kaiser Family Foundation. As Kaiser writes of their findings, **"eight in 10 Americans (78%) are aware that taxes would increase for most people under such a plan."**

And while **Sanders insists that "a lot of people in the country would be delighted to pay more in taxes"** to bankroll his one-size-fits-all health care system**,** a previous national poll by Kaiser revealed that **60 percent oppose Medicare for all when they learn it would require most Americans to pay higher taxes.**

As both NBC News debate moderator Lester Holt and Senator Michael Bennet (D-CO) pointed out during the first round of Democratic presidential debates, Sanders witnessed this exact problem in his own home state, where **an effort to implement state-level Medicare for all in Vermont failed "when it became clear that people would not support the tax increases needed to sustain such a program,"** as *The New York Times* editorial board noted recently. *The Washington Post* reports that **the Vermont failure "offers sobering lessons for the current crop of Democrats running for president, including Vermont's own Sen. Bernie Sanders (I), most of whom embrace Medicare-for-all,"** adding: "**Then as now, many of the advocates shared 'a belief that borders on the theological' that such a system would save money**, as one analyst put it – **even though no one knew what it would cost** when it passed in Vermont. **That belief would prove naïve**."

Diminished Access To Quality Care:

It is telling that, appearing on CNN last week, **Senator Sanders "repeatedly dodged the question of whether Americans would be able to keep their doctor under his Medicare for All plan,"** and *The Washington Post's* fact-checkers note that "**providers warn [Medicare for all] could significantly hurt their ability to provide adequate, widespread care. A recent report from the Congressional Budget Office reinforces this concern**: 'Such a reduction in provider payment rates would probably reduce the amount of care supplied and could also reduce the quality of care.'"

The non-partisan CBO cautioned recently that under Medicare for All, "patients might face **increased wait times and reduced access to care**," and such a system "could also **reduce the quality of care**," while "[t]he number of hospitals and other health care facilities might also decline as a result of closures, and there might be less investment in new and existing facilities."

The New York Times reported recently that **experts are growing increasingly worried about the "violent upheaval" a Medicare for all system would cause hospitals**, cautioning: "**Some hospitals, especially struggling rural centers, would close virtually overnight**, according to policy experts. Others, they say, would try to offset the steep cuts by **laying off hundreds of thousands of workers** and **abandoning lower-paying services like mental health**."

This warning was echoed in a report by *POLITICO*, which notes that Medicare for all "would all but end private insurance and **regulate hospitals in a vastly different way, dramatically changing operators' business model and costing community hospitals as much as $151 billion a year**, according to one estimate published in JAMA**,"** all while **"slashing hospitals' pay rates and putting up to 1.5 million jobs at stake** … **It's a concern that's left Medicare for All advocates walking a fine line, arguing for a dramatic reshaping of the health system while trying to avoid a brawl with their hometown health systems."**

So-Called "Moderate" Fallbacks Will Lead To The Same Results:

And while often described as more "moderate" than Medicare for all, Sanders's fellow 2020 presidential hopefuls and others acknowledge that **new government insurance systems such as Medicare "buy-in" or the "public option" would ultimately lead down the same path to a one-size-fits-all government-run health care system** – with all the same unaffordable costs, tax increases, and threats to patients' choices, access and quality of care.

A new poll released by the Partnership for America's Health Care Future this week reveals that **voters prioritize improving our current health care system over offering a new government insurance system, often referred to as the "public option."** Voters across party lines prefer a presidential candidate focused on making those improvements over one who wants to expand government insurance systems, and majorities also "**believe that**

negative outcomes, such as increased taxes and fewer employer-based options, are more likely to occur than positive ones if a government health care program that people could choose were put into place – and most believe it would be unlikely to improve their health care or that of their family."

Meanwhile, the *Associated Press* reports this week that "**[g]overnment surveys show that about 90% of the population has coverage**, largely preserving gains from President Barack Obama's years. Independent experts estimate that **more than one-half of the roughly 30 million uninsured people in the country are eligible for health insurance through existing programs.**"

PARTNERSHIP FOR
EMPLOYER-SPONSORED COVERAGE

STATEMENT FOR
U.S. HOUSE OF REPRESENTATIVES
ENERGY AND COMMERCE HEALTH SUBCOMMITTEE
HEARING ON
PROPOSALS TO ACHIEVE TO UNIVERSAL HEALTH COVERAGE
DECEMBER 10, 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), employers tailor coverage to meet their workforce's specific needs across state lines, pay all health claims and bears the financial risk, and utilize 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 do 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.

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 a single-payer health care system 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?
- What are the financial implications to individual taxpayers and businesses if a single-payer health system were established? How would taxes increase on American workers and employers to pay for a system?

The Partnership for Employer-Sponsored Coverage opposes the establishment of a single-payer health care system. 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

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 for Human Resource Management

THE ETHICS & RELIGIOUS LIBERTY COMMISSION
OF THE SOUTHERN BAPTIST CONVENTION

Contact us:
202-547-8105
dc@erlc.com

The Medicare for All Act of 2019 Presents Grave Life, Conscience Protection, and Religious Liberty Concerns

The ERLC affirms that every human life is endowed by God with immeasurable dignity. Scripture illustrates the truth that every man, woman, and child is created in the image of God. We believe His knowledge of each person's life precedes the creative act of conception.

Abortion is not healthcare. If human dignity is given to each person when created in the womb, then abortion is not only an assault on the image of God but also irreparable harm on a vulnerable life. We believe abortion denies precious human lives both personhood and protection, and therefore cannot be considered as healthcare.

The federal government should not use taxpayer dollars to pay for abortions. Americans are divided over the issue of abortion, and many strongly object to their taxpayer dollars being used for what they believe to be a great moral wrong. The Medicare for All Act of 2019 would remove critical Hyde Amendment protections. For over forty years, the Hyde Amendment passed each Congress and prevented taxpayer dollars from funding abortions.

Medical professionals with conscience objections to performing abortions must be protected. The Medicare for All Act of 2019 would eliminate these foundational Constitutional protections. If a medical professional refused to perform an abortion, their employment could be at risk with the only medical provider left in the country—the state.

The Medicare for All Act of 2019 would also codify sexual orientation and gender identity in federal law. This legislation would require medical professionals to provide puberty blockers, transitioning hormones, and gender reassignment surgery even against their best medical judgement. This is harmful and unethical, especially in pediatric care.

The ERLC urges Congress not to adopt the Medicare for All Act of 2019. The legislation presents a grave threat to decades of conscience protection laws that ensured equal protection for millions of Americans, especially the most vulnerable. As ERLC president Russell Moore often notes, "A government that can pave over the consciences of some can steamroll over dissent everywhere."

December 9, 2019

Dear Representative,

As the Energy and Commerce Committee considers various proposals for federal health programs and spending, we urge members to oppose any legislation that fails to apply the principles of the Hyde Amendment to federal taxpayer-funded or taxpayer-subsidized programs. We are particularly concerned about the *Medicare for All* proposal and efforts to stabilize Obamacare.

For decades, the Hyde Amendment and other funding limitation amendments have prevented federal taxpayer funding for abortion or for health insurance plans that included abortion in federal programs such as Medicare, Medicaid and the Federal Employee Health Benefits Program. Only limited exceptions apply under the Hyde Amendment.

H.R. 1384, Rep. Pramila Jayapal's *"Medicare for All Act of 2019,"* would overturn decades of federal precedent and intent by funding elective abortion. The list of covered benefits contains "comprehensive reproductive… care," a euphemism that includes abortion-on-demand.

According to the Charlotte Lozier Institute, the Hyde Amendment has saved over 2.25 million lives through Medicaid alone since its enactment in 1976. Approximately one in every 150 of our fellow Americans is alive today because of this law. However, *Medicare for All* would eliminate Hyde and other lifesaving protections by creating a Universal Medicare Trust Fund to fund healthcare, and explicitly removing existing safeguards against federal abortion funding.

In a radical departure from the Hyde principle, the Affordable Care Act (Obamacare) uses accounting gimmicks to allow federal taxpayer funding for health insurance plans that include elective abortion. Any funding to stabilize Obamacare such as funding for cost-sharing reductions or reinsurance will further support this ongoing deviation from the principle of the Hyde Amendment.

Poll after poll has found that a majority of Americans oppose taxpayer funding of abortion. A 2019 Marist poll found that 54% of Americans oppose using tax dollars to pay for abortions, with just 39% in support.

Health care legislation that does not explicitly exclude coverage for elective abortion are historically interpreted to approve such coverage, directly or indirectly.

We are strongly opposed to any legislation that covers elective abortion in healthcare and urge you to oppose such bills unless amended so that such funds cannot be used for plans that include abortion.

Sincerely,

Marjorie Dannenfelser
President
Susan B. Anthony List

Weekly Checkup

Is a Medicare Buy-In Plan Viable?

CHRISTOPHER HOLT | NOVEMBER 15, 2019

This week, AAF's Center for Health and Economy (H&E) released modeling on the cost and coverage impacts of a Medicare buy-in plan—specifically H.R. 1346, "The Medicare Buy-in and Health Care Stabilization Act of 2019." As discussed in last week's Checkup, **the popularity of Medicare for All (M4A) is declining** as its details get parsed in the Democratic presidential primary. **Simultaneously, other proposals for expanding coverage—albeit ones that have not been as closely examined—have become much more popular. According to the Kaiser Family Foundation, 77 percent of Americans have a favorable opinion of extending a Medicare buy-in option to Americans aged 50 to 64.**

But what would the reality of Medicare buy-in look like? According to our modeling, the reality wouldn't live up to the hype.

H.R. 1346, like most Medicare buy-in proposals, is more of a public option/Medicare hybrid, and the bill does far more than just create a new insurance option. H.R. 1346 makes a number of changes to the Affordable Care Act (ACA) in addition to creating a "Medicare" plan that Americans age 50 to 64 can purchase. The major ACA changes include establishing a reinsurance program to protect insurers selling plans in the ACA marketplace against especially high-cost patients, and restarting and increasing cost sharing reduction (CSR) payments to marketplace insurers.

The buy-in plan itself would be sold in the individual market; the enrollees would be charged a premium set at the average annual per capita cost for benefits and administrative expenses under Medicare Parts A, B, and D. Additionally, if an individual purchasing the buy-in plan is eligible for premium tax credits or CSR payments through the ACA exchanges, those benefits can be applied to the buy-in plan.

Altogether, **H&E finds that the number of people insured under the package of policies in H.R. 1346 would increase by about 1 million initially, relative to H&E's baseline, but that increase would drop to less than 500,000 by 2029.** Just under 300,000 people would purchase the Medicare buy-in plan in the first year, and the number of buy-in enrollees would decrease over time to less than 200,000 by 2029. **Overall, H.R. 1346 would increase federal spending by $184 billion over 10 years.** Of note, H&E found that H.R. 1346 would lead to a decrease in premiums paid for catastrophic, Bronze, Silver, and Platinum marketplace plans of between 4 and 12 percent. That drop in premiums, however, is most directly the result of the reinsurance program, and not the Medicare buy-in plan. Additionally, premiums for the Medicare buy-in plan are expected to grow faster then marketplace plans of a similar actuarial value.

What do all of these figures mean? **This Medicare buy-in proposal would spend $186 billion over 10 years to reduce the uninsured population ultimately by less than 500,000, or 0.2 percent, with the introduction of the Medicare buy-in contributing little.** To put it another way, H&E projects that under current law about 29 million Americans will be uninsured at some point in 2020, but under H.R. 1346, after spending $186 billion, the country will still have roughly 33 million Americans uninsured for at least part of 2029.

Medicare buy-in is an increasingly attractive policy option for politicians. After all, it doesn't take away private insurance, any impacts to the individual market would likely be positive, and it can be framed as a

choice. **But what H&E's modeling has found is that Medicare buy-in would spend a lot of money to do very little.** Medicare buy-in is fools gold: It won't do much to address the uninsured, but it will increase federal spending.

CHART REVIEW

Jonathan Keisling, Health Care Policy Analyst

Many of the Medicare buy-in bills written in the last year and a half include far more than the introduction of a public option offered through the Affordable Care Act's (ACA) exchanges. Consider H.R. 1346, "The Medicare Buy-in and Health Care Stabilization Act of 2019": This bill allows individuals aged 50 to 64 to buy into Medicare using ACA premium tax credits and cost-sharing reduction subsidies (if they qualify), while also providing new funding for reinsurance. The AAF Center for Health and Economy's plan-choice model found that H.R. 1346's funding for reinsurance and increased cost-sharing reduction subsidies make up the bulk of its projected $184 billion of increased spending. Despite this increase in spending, net enrollment is only projected to increase by 500,000 by the year 2029, reducing the uninsured rate by 0.2 percent.

COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET

Choices for Financing Medicare for All

A Preliminary Analysis

October 28, 2019

Proposals to adopt single-payer health care in the United States have grown in popularity in recent years, as numerous lawmakers and presidential candidates have embraced Medicare for All. However, few have grappled with how to finance the new costs imposed on the federal government. By most estimates, Medicare for All would cost the federal government about $30 trillion over the next decade. How this cost is financed would have considerable distributional, economic, and policy implications.

In the coming months, the Committee for a Responsible Federal Budget will publish a detailed analysis describing numerous ways to finance Medicare for All and the consequences and trade-offs associated with each choice. This paper provides our *preliminary* estimates of the magnitude of each potential change and a brief discussion of the types of trade-offs policymakers will need to consider.

We find that Medicare for All could be financed with:

- **A 32 percent payroll tax**
- **A 25 percent income surtax**
- **A 42 percent value-added tax (VAT)**
- **A mandatory public premium averaging $7,500 per capita – the equivalent of $12,000 per individual not otherwise on public insurance**
- **More than doubling all individual and corporate income tax rates**
- **An 80 percent reduction in non-health federal spending**
- **A 108 percent of Gross Domestic Product (GDP) increase in the national debt**
- **Impossibly high taxes on high earners, corporations, and the financial sector**
- **A combination of approaches**

Each of these choices would have consequences for the distribution of income, growth in the economy, and ability to raise new revenue. Some of these consequences could be balanced against each other by adopting a combination approach that includes smaller versions of several of the options as well as additional policies.

Consequences could also be mitigated through aggressive efforts to lower per-person health care costs and/or by substantially scaling back the generosity or comprehensiveness of Medicare for All.

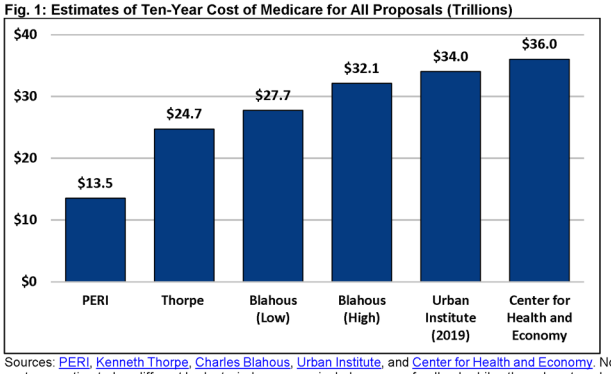
The Cost of Medicare for All

Though it is a somewhat amorphous term, the term Medicare for All has come to represent proposals that offer universal, single-payer health insurance coverage for virtually all health care services (including dental, vision, and long-term care) with no meaningful premiums, deductibles, copayments, or restrictive networks.

In theory, Medicare for All may increase or decrease national health expenditures, which is the total amount spent on health care by all private and public sources. Cost increases would come from covering those who are currently uninsured; expanding coverage to include services like dental, vision, and long-term care; and eliminating deductibles and copayments that currently help curb utilization. Cost reductions would come from lower administrative costs and significantly lower payments to medical providers and drug manufacturers.

Regardless of the impact on total national health expenditures, adopting Medicare for All would mean shifting virtually all private health costs to the federal government. Most independent estimates of Medicare for All find it would cost the federal government $25 trillion to $36 trillion over ten years (though not all incorporate long-term care coverage). Most recently, the Urban Institute estimated Medicare for All would cost $34 trillion over the next decade, or $32 trillion net of income tax effects. These estimates represent additional costs on top of the $16 trillion the federal government is already projected to spend on major health programs over the next decade.

Fig. 1: Estimates of Ten-Year Cost of Medicare for All Proposals (Trillions)



Sources: PERI, Kenneth Thorpe, Charles Blahous, Urban Institute, and Center for Health and Economy. Note: ten-year costs are estimated on different budget windows, some include revenue feedback while others do not, and some include long-term care while others do not.

The bulk of this expense represents the direct cost of eliminating premiums, copayments, and other out-of-pocket costs. That spending will total nearly $2 trillion this year alone. Replacing it will require significant new funds regardless of changes to national health expenditures.

Options for Financing Medicare for All

For the purpose of our analysis, we assume Medicare for All would cost $30 trillion over the next decade net of new revenue – roughly the midpoint of a variety of estimates. Though much of this cost represents savings to the private sector, it nonetheless needs to be financed through higher taxes, lower spending, more borrowing, or some combination of the three.

Our estimates are rough and preliminary, do not account for economic feedback, and may change modestly in our final analysis. Importantly, the options we present are illustrative rather than prescriptive. Their economic, distributional, and other consequences should be weighed relative to each other and against the effects of eliminating all premiums and out-of-pocket spending and providing comprehensive, universal health coverage through the federal government.

We estimate that policymakers could finance Medicare for All over the next decade in any of the following ways:[1]

- **Impose a 32 percent payroll tax**. Currently, most wage income is subject to a 15.3 percent payroll tax divided evenly between workers and employers to fund Social Security and Medicare. Wages above $133,000 are subject to either a 2.9 percent or 3.8 percent payroll tax to fund Medicare. We estimate a new 32 percent payroll tax, divided evenly between workers and employers, would raise roughly $30 trillion over a decade. This tax would apply to all wages, not just those below a taxable maximum. An equivalent amount of revenue could be raised with a 23 percent payroll tax on the employee side only or a 48 percent tax on the employer side.[2] A 32 percent payroll tax would raise the total payroll tax rate on most wage income to above 47 percent and the rate for high-wage earners to nearly 36 percent. It would apply to all earned income.

- **Establish a 25 percent income surtax on adjusted gross income (AGI) above the standard deduction.** Under current law, households pay taxes on their income under a progressive rate structure that ranges from 10 percent to 37 percent, with preferential rates for long-term capital gains and qualified dividends as well as deductions for mortgage interest, charitable giving, state and local taxes up to $10,000, pass-through business income, and other purposes. There is also a standard deduction of $12,200 for individuals and $24,400 for married couples. We estimate a 25 percent income surtax above the standard deduction threshold – which would apply to all AGI without deductions or

[1] These figures represent rough estimates generated by the Committee for a Responsible Federal Budget using our own models as well as a variety of sources, including the Open Source Policy Center's Tax Brain, the Congressional Budget Office, the Joint Committee on Taxation, the Centers for Medicare and Medicaid Services, and the Tax Policy Center. Estimates are from 2021 to 2030, exclude any macroeconomic effects, and include only modest behavioral effects. All estimates assume that the elimination of private health insurance premiums would lead to a significant increase in taxable wages.

[2] An employer-side payroll tax raises significantly less than an employee-side tax because higher employer contributions lead them to pay lower taxable wages. The result is lower revenue from current income and payroll taxes as well as from the newly imposed payroll tax itself.

preferences – would raise roughly $30 trillion over a decade.[3] This surtax would effectively increase the bottom income tax rate from 10 to 35 percent, the top income tax rate from 37 to 62 percent, and the top capital gains and dividends rate from 24 to 49 percent.

- **Enact a 42 percent value-added tax (VAT).** Whereas most developed countries raise a substantial share of their revenue through a tax on consumption – known as a VAT – the United States only taxes consumption broadly through state and local sales taxes. A VAT could be introduced at the federal level to finance Medicare for All. Based on estimates from the Congressional Budget Office (CBO), we project a broad-based VAT of 42 percent would raise about $30 trillion over a decade. The first-order effect of this VAT would be to increase the prices of most goods and services by 42 percent; the VAT would thus represent 30 percent of costs on a tax-inclusive basis, which is more comparable to an equivalent income or payroll tax rate increase. Importantly, a VAT can be designed in a number of different ways, and a different tax base would change the required tax rate.

- **Require a mandatory public premium averaging $7,500 per capita – the equivalent of $12,000 per individual not otherwise on public insurance.** Currently, most Americans are charged health insurance premiums – the majority of which are paid by employers on their behalf. Though current Medicare for All proposals call for ending premiums, policymakers could consider financing Medicare for All through mandatory fixed-dollar payments to the federal government. These payments would be a form of head tax but could resemble premiums in a number of ways. For example, they could vary based on household size and could be paid in part or in whole by employers. They could also be reduced or waived for some individuals, perhaps based on income. In 2021, we estimate those premiums would need to average about $7,500 per capita or $20,000 per household (including single-person households) and is the average applied to all individuals, including retirees, children, and low-income individuals. As an illustrative example, fully exempting everyone who would otherwise be on Medicare, Medicaid, or CHIP would increase the premiums by over 60 percent to more than $12,000 per individual.

- **More than double all individual and corporate income tax rates.** Under current law, ordinary income is taxed under a progressive rate structure with a bottom rate of 10 percent and a top rate of 37 percent, while long-term capital gains and qualified dividends are taxed at a top rate of 23.8 percent and corporate income at a rate of 21 percent. Assuming capital gains are taxed at death and pass-through income is no longer deductible,[4] we estimate that *doubling* all individual income tax rates would raise $20 trillion to $25 trillion over a decade, and doubling the corporate rate would raise about $2

[3] As part of this policy, we also assume all capital gains would be taxed at death and with this surtax. Absent that assumption, capital gains revenue would significantly *decline* under this surtax.
[4] Allowing households to deduct 20 percent of business income and step-up the basis of assets held at death would require much higher rates and would likely result in substantial tax avoidance. We therefore assume any reasonable policy to increase tax rates so dramatically would close off these and other avoidance techniques that could lead to large revenue losses.

trillion. Some additional revenue would be needed on top of these increases to reach $30 trillion in total revenue. This option differs from the income surtax in a number of ways, especially because it would represent a much smaller tax increase for lower-income taxpayers. Under this scenario, the bottom ordinary income tax rate would be raised to 20 percent, the top ordinary rate would be 74 percent, capital gains would be taxed at a top rate of 47.6 percent, and the corporate tax rate would be 42 percent.

- **Reduce non-health federal spending by 80 percent.** The federal government is projected to spend $60 trillion over the next decade, including $16 trillion on health care and $6 trillion on interest costs. Accounting roughly for the taxation of certain federal benefits, we estimate that financing the full cost of Medicare for All with spending cuts would require cutting the remaining federal budget by 80 percent.[5] Cuts of this magnitude are unrealistically large and certainly could not be imposed on a short timeline. For illustrative purposes, an 80 percent cut to Social Security would mean reducing the average new benefit from about $18,000 per year to $3,600 per year, and an 80 percent cut to the military would mean, among other things, reducing the number of soldiers and officers from about 1.3 million today to 270,000.

- **More than double the national debt to 205 percent of the economy.** Federal debt held by the public currently totals about $17 trillion, or 79 percent of GDP. Under current law, debt is projected to reach 97 percent of GDP by 2030. Assuming no changes in projected interest rates or economic growth, deficit-financing Medicare for All over the next decade would require about $34 trillion of new borrowing including interest, which is the equivalent of 108 percent of GDP by 2030. As a result, debt would rise above 205 percent of GDP, more than double its currently projected level. This would put debt in 2030 at almost five times its historic average of 42 percent and nearly twice the historic record of 106 percent (set after World War II). Under this scenario, debt would continue to grow rapidly beyond 2030.

- **Impose impossibly high taxes on high earners, corporations, and the financial sector.** There is not enough annual income available among higher earners to finance the full cost of Medicare for All. On a static basis, even increasing the top two income tax rates (applying to individuals making over $204,000 per year and couples making over $408,000 per year) to 100 percent would not raise $30 trillion over a decade. In reality, a tax increase that large would actually *lose* revenue because it would institute marginal tax rates above 100 percent when other taxes are incorporated – effectively requiring people to *pay* rather than be paid to work, earn business income, or sell capital assets. We previously found that an extremely aggressive package of tax hikes on high earners, corporations, and the financial sector might cover one-third of the $30 trillion cost of Medicare for All. Our very rough estimates showed that over the next decade raising the top two individual and pass-

[5] The replacement of Medicare, Medicaid, and most other federal health spending is already assumed in cost estimates of Medicare for All. If the cost of the new Medicare for All program were cut proportionally with the rest of the budget, the total size of the cut would fall to 45 percent.

through rates to 70 percent would raise about $2 trillion, phasing out most tax breaks for higher earners (assuming that 70 percent top rate) could very generously raise another $2 trillion, and doubling the corporate tax rate would raise $2 trillion. We also found that a wealth tax or "mark-to-market" capital gains taxation could raise $3 trillion, and the combination of a financial transaction tax and a tax on large financial institutions could raise about $1 trillion. Other taxes on high earners and the wealthy could raise some additional funds.

- **Enact a combination of approaches.** Rather than identify a single revenue source to finance Medicare for All, policymakers could combine several options. For example, one could combine a 16 percent employer-side payroll tax with a public premium averaging $3,000 per capita, $5 trillion of taxes on high earners and corporations, and $1 trillion of spending cuts. Other small options, such as a higher excise taxes on alcohol, tobacco, or sugary drinks, could also be included, as could policies to require or encourage state governments to contribute to offsetting the cost of Medicare for All. Adopting smaller versions of several policies may prove more viable than adopting any one policy in full.

While the financing options above are quite large in magnitude, they could be reduced significantly by reducing the cost of Medicare for All itself.

These cost reductions could be achieved in part by reforming or reducing provider payments, improving care coordination, and identifying policies to reduce excessive utilization of care. Our Budget Offsets Bank incudes numerous options to reduce the cost of traditional Medicare; some of these options would save much more if applied to a comprehensive Medicare for All program.

Cost reductions could also be achieved by scaling back the generosity of a Medicare for All program. For example, the Urban Institute recently estimated that a Medicare for All plan that required cost sharing to cover between 5 and 20 percent of medical costs (depending on income) and covered only core health benefits (not vision, dental, hearing, or long-term services and supports) would cost the federal government half as much per person as a comprehensive Medicare for All plan. A $15 trillion cost could be financed with a 15 percent payroll tax, as compared to the 32 percent payroll tax required to fund $30 trillion.

Choices and Trade-Offs in Financing Medicare for All

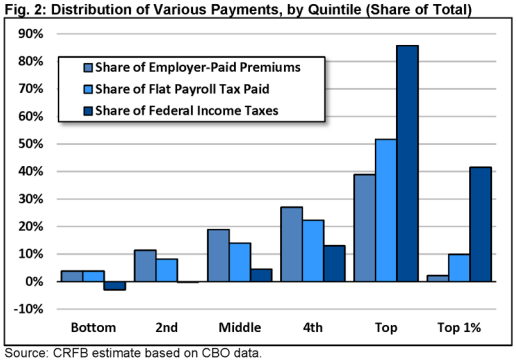
Deciding how to finance Medicare for All involves weighing significant trade-offs amongst options as well as relative to the current system. Indeed, the design of Medicare for All financing may have as much distributional, economic, and policy importance as the adoption of Medicare for All itself.

While many Americans are enrolled in heavily subsidized Medicare, Medicaid, or private insurance plans, the majority of Americans pay for their health care through premiums (especially employer-paid premiums), deductibles, copayments, and coinsurance.

While premiums and cost sharing are not a form of taxation, they do share some features in common with a "head tax" – a fixed-dollar tax imposed on every person. For those with employer-provided health insurance especially, premiums generally remain fixed regardless of changes in income. Like head taxes, insurance premiums would thus be regressive if measured relative to income among those who pay them (though many of the lowest earners on Medicaid or receiving exchange subsidies pay little or no premiums). Also like a head tax, premiums are economically efficient in the sense that they create very little economic distortion and do not generally disincentivize more work, investment, or productivity. Finally, because premiums and cost sharing don't affect marginal tax rates or returns to work and investment, they have little effect on the government's ability to raise revenue.

Any plan to replace current premiums and cost sharing must weigh how the new finance scheme will impact income distribution, economic output, and tax capacity. In the coming months, the Committee for a Responsible Federal Budget will release a full report evaluating the various effects of most of the options mentioned in this paper.

Fig. 2: Distribution of Various Payments, by Quintile (Share of Total)

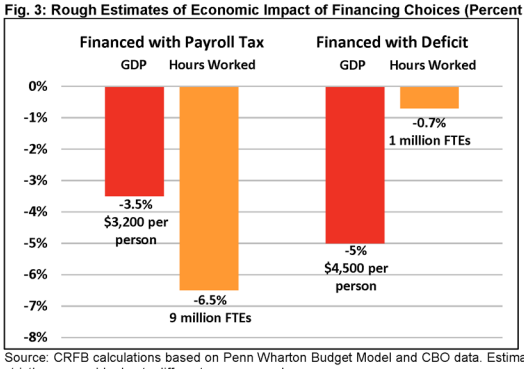


Source: CRFB estimate based on CBO data.

From a distributional standpoint, most of the options we put forward above would be more progressive on average than current law, though the impact would vary person to person and many of the options would represent a cost increase for lower-income individuals and families who currently benefit from Medicaid and exchange subsidies. Options would differ in their distributional impact. To get a broad sense of how distribution may differ, a recent CBO study shows that in 2016 the top income quintile (indirectly) paid less than 40 percent of employer-side health premiums, but they paid more than 85 percent of individual and corporate income taxes and would have paid over 50 percent of a new flat payroll tax. The top percentile paid about 2 percent of premiums, but they paid over 40 percent of income taxes and would have paid 10 percent of a new flat payroll tax.

At the same time, most of the options we present would shrink the economy compared to the current system. The 32 percent payroll tax hike, for example, would increase the effective marginal tax rate on labor by about 23 percent after accounting for various interactions. Penn Wharton Budget Model recently estimated that an 11.25 percent payroll tax increase used to pay for a Universal Basic Income (UBI) would reduce GDP by 1.7 percent.[6] This suggests that financing Medicare for All with a payroll tax would shrink the size of the economy by about 3.5 percent by 2030 – though the actual effect may differ. This economic impact would be the equivalent of a $3,200 reduction in per-person income and would result in a 6.5 percent reduction in hours worked – a 9 million person reduction in full-time equivalent (FTE) workers in 2030.

Fig. 3: Rough Estimates of Economic Impact of Financing Choices (Percent Change in 2030)



Source: CRFB calculations based on Penn Wharton Budget Model and CBO data. Estimates are very rough and not strictly comparable due to different sources used.

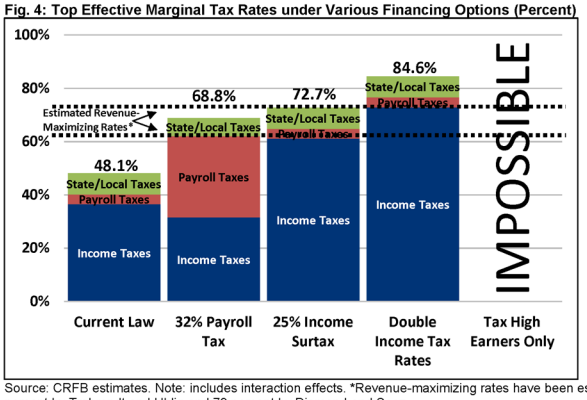
[6] A payroll-tax-financed UBI should be economically similar to a payroll tax financed Medicare for All, as both essentially raise the payroll tax to finance a lump-sum payment.

Deficit-financing Medicare for All would be far more damaging to the economy. Assuming that such a massive increase in the debt would not roil financial markets or lead to high inflation, we estimate that a 108 percent of GDP increase in the federal debt would shrink the size of the economy by roughly 5 percent in 2030 – the equivalent of a $4,500 reduction in per-person income – and far more in the following years. This is a low-end estimate of economic impact because it implicitly assumes few limits on the amount of foreign savings available to purchase Treasury bonds. Because deficit-financing would have little direct impact on the incentive to work, we estimate a 0.7 percent or 1 million FTE reduction in work hours by 2030.

An additional consideration is how much tax capacity any of these financing options might leave for future policymakers aiming to raise revenue to pay for new programs, fund existing ones, or reduce deficits. The best economic literature suggests a revenue-maximizing tax rate of between 63 and 73 percent,[7] after which further rate increases actually *lose* revenue. Tax rates approaching these high levels would reduce the ability of policymakers to raise revenue in the future.

Under current law, the top effective marginal tax rate (accounting for state and local taxes in a typical state) is about 48 percent. That rate would rise to 69 percent after a 32 percent payroll tax hike (the increase is smaller than the tax due to interactions with the tax base), 73 percent after a 25 percent income surtax, and 85 percent if income tax rates were doubled. In other words, each of these options would bring the top rate close to or above the revenue-maximizing rate.

Fig. 4: Top Effective Marginal Tax Rates under Various Financing Options (Percent)



Source: CRFB estimates. Note: includes interaction effects. *Revenue-maximizing rates have been estimated at 63 percent by Trabrandt and Uhlig and 73 percent by Diamond and Saez.

[7] Economists Mathias Trabandt and Harold Uhlig estimate a revenue-maximizing rate of 63 percent, while economists Peter Diamond and Emmanuel Saez estimate a revenue-maximizing rate of 73 percent.

Conclusion

Regardless of its impact on national health expenditures, Medicare for All would shift substantial costs from the private sector to the federal government. By most estimates, a comprehensive Medicare for All plan that expands coverage to every U.S. resident for nearly all medical services and eliminates premiums and cost sharing would cost the federal government roughly $30 trillion over a decade.

Policymakers have a number of options available to finance the $30 trillion cost of Medicare for All, but each option would come with its own set of trade-offs.

In this preliminary analysis, we estimate the cost could be covered with a 32 percent payroll tax, a 25 percent income surtax, a 42 percent value-added tax, or a public premium averaging $7,500 per capita or more than $12,000 per individual who wouldn't otherwise be enrolled in Medicare, Medicaid, or CHIP. Medicare for All could also be paid for by more than doubling individual and corporate income tax rates, reducing federal spending by 80 percent, or increasing the national debt by 108 percent of GDP. Tax increases on high earners, corporations, and the financial sector by themselves could not cover much more than one-third of the cost of Medicare for All.

Rather than adopting any one of the proposals above, policymakers could also consider a combination of approaches to finance Medicare for All. Reducing the cost, scope, or generosity of Medicare for All would also reduce the magnitude of needed financing.

In deciding how to finance Medicare for All, policymakers must consider the distributional, economic, and policy consequences of replacing premiums and cost sharing with various alternatives. Most of the options we put forward are more progressive on average than current law but would shrink economic output and bring the top tax rate up to its revenue-maximizing level – leaving little capacity for further taxes.

This paper will be followed by a more detailed analysis of the various consequences of different financing options.

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

MEMORANDUM

TO: Interested Parties
FROM: Lauren Crawford Shaver, The Partnership for America's Health Care Future
RE: VOTER VITALS II – A Health Care Tracking Poll
DATE: December 9, 2019

The second edition of Voter Vitals – a tracking poll conducted nationwide and in 2020 battleground states by Locust Street Group for the Partnership for America's Health Care Future – finds "that health care continues to grow in importance as the defining issue of the 2020 presidential election. However, **as voters learn more about new government-run health care proposals, support for them is declining with a majority of voters preferring to build on and improve what we have today rather than start over with Medicare for All or the public option."**

"Americans are clear that they are not willing to pay any more in taxes or give up their current health care coverage in favor of new government-controlled health insurance systems. Democratic, swing and Republican voters want policies that would lower costs and fix what we have today more than anything else," said Phillip Morris, Partner of Locust Street Group.

The first edition of Voter Vitals was conducted in August and can be viewed HERE.

Key findings of the survey, which is the second edition of Voter Vitals include:

- Lowering **COSTS** (71%) is the top health care priority for Democratic, Swing, and Republican voters.
- More voters support **FIXING** what we have today (**60% support, +3% since August 2019**) than the public option (41% support, -3% since August 2019), and Medicare for All (38% support, -2% since August 2019).
- **67%** of voters would rather **BUILD ON** our current health care system than replace it with something new.
- **65%** of voters believe **PRIVATE COVERAGE** should continue to exist and have a role in our health care system.
- **70%** of voters ages 18-64 with private coverage would rather **KEEP their coverage** than buy coverage through a public option.
- **65%** of voters would be **UNWILLING** to pay **ANY** more in taxes for universal coverage.

The second edition of Voter Vitals tracks closely with other recent national polling:

- A recent poll released by the Kaiser Family Foundation (KFF) finds **"support for a public option is slipping,"** *POLITICO* reports. The poll also finds that **Medicare for All "support wanes when voters hear trade-offs,"** *Becker's Hospital Review* adds.

- Kaiser Family Foundation (KFF) CEO Drew Altman wrote in *Axios* that **support for Medicare for All is "headed in the wrong direction" – meaning down – while "polling shows that support drops much further, and opposition rises, when people hear some of the most common arguments against Medicare for All."**
- A national poll from Quinnipiac University, finds that **"Medicare for All has grown increasingly unpopular among all American voters," with a majority saying it's a "bad idea." Medicare for All is "a real problem for … candidates. Not just because of the cost, but because few swing voters want to dump private health insurance,"** *Axios* adds.
- Another recent poll from Kaiser and the Cook Political Report finds that **nearly two-thirds (62 percent) of swing voters in the states of Michigan, Minnesota, Pennsylvania and Wisconsin rate Medicare for All as a "bad idea."**
- *POLITICO* has noted that polls show **"growing opposition to 'Medicare for All,'"** while national poll released by Kaiser in September "probes Democrats' views about the general approaches to expanding health coverage and lowering costs" and finds that **"[m]ost Democrats and Democratic-leaning independents (55%) say they prefer a candidate who would build on the Affordable Care Act to achieve those goals. Fewer (40%) prefer a candidate who would replace the ACA with a Medicare-for-all plan."**

Methodology:

- N=1,000 voters nationwide plus n=500-voter oversamples in Florida, Michigan, Pennsylvania, Wisconsin, Iowa and Ohio.
- Balanced to U.S. demographics by gender, age, race, income, political ideology and health coverage.
- Fielded online from November 19-25, 2019.
- National MOE: +/- 3%; State OS MOE: +/- 4 percent.

To read Locust Street's executive summary of the survey findings, CLICK HERE.
To read Locust Street's complete survey analysis, CLICK HERE.
To view the first edition of Voter Vitals, CLICK HERE.
To learn more about the Partnership for America's Health Care Future, CLICK HERE.

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

New Poll: Vast Majority Satisfied With Current Health Care Coverage

WASHINGTON – New polling out last week from Hart Research on behalf of "Get America Covered" finds that **"fully 84% of insured consumers say they are satisfied with their current health insurance plan overall,"** while **"many uninsured individuals intend to purchase health insurance in 2020."**

These findings track closely with previous public opinion research from Gallup. As *CNN* reported, **"82% of Democrats said the quality of health care they received was either good or excellent.** A large majority, **71%, believed their health care coverage was either good or excellent.** Even when it comes to health care costs, **61% of Democrats said were satisfied with what they paid in health care."** The same Gallup poll also notes that the **vast majority of all Americans are satisfied with the quality of their health care – rating it 'excellent' or 'good' (80 percent) – and their level of coverage (69 percent).**

The new polling data comes as some presidential candidates and lawmakers promote new government-controlled health insurance systems – like the public option, Medicare buy-in and Medicare for America – as "moderate" alternatives to Medicare for All. But a new study reveals millions of Americans would, in fact, be unable to keep their current coverage under such a proposal – and underscores that a new government insurance system would be a "stepping stone" to a one-size-fits-all system run by politicians.

Meanwhile, new data reveals the tremendous strides our current system has made in expanding access and strengthening the quality of care. Nearly a decade after its implementation, there is **"an emerging mosaic of evidence that … the ACA is making some Americans healthier – and less likely to die,"** *The Washington Post* reports. They write:

> ***With about 20 million Americans now covered through private health plans under the ACA's insurance marketplaces or Medicaid expansions,*** *researchers have been focusing on a question that was not an explicit goal of the law****: whether anyone is healthier as a result*** *… It is difficult to prove conclusively that the law has made a difference in people's health, but* ***strong evidence has emerged in the past few years.*** *Compared with similar people who have stable coverage through their jobs,* ***previously uninsured people who bought ACA health plans with federal subsidies had a big jump in detection of high blood pressure and in the number of***

> ***prescriptions they had filled,*** *according to a 2018 study in the journal Health Affairs. And* ***after the law allowed young adults to stay longer on their parents' insurance policies, fewer 19- to 25-year-olds with asthma failed to see a doctor because it cost too much,*** *according to an analysis of survey results published earlier this year by researchers at the Centers for Disease Control and Prevention.*

And an updated analysis from the Kaiser Family Foundation finds that, **"almost 54 million people – or 27% of all adults under 65 – have pre-existing health conditions that would likely have made them uninsurable in the individual markets that existed in most states before the Affordable Care Act."**

Today, thanks to the free market and public programs working together, **roughly 90 percent of Americans are covered, patients with pre-existing conditions are protected and young adults can stay on their parents' health plans until they are 26 years old.** That's why we should work together to build on what's working and fix what's broken – not start over with a one-size-fits-all government health insurance system we can't afford.

Pelosi: ObamaCare could ‘be path to Medicare for All’

Rachel Frazin – 12/6/19

House Speaker Nancy Pelosi (D-Calif.) on Thursday said that the Affordable Care Act could "be a path to Medicare for All" after previously expressing dislike of the health care proposal favored by progressives.

Asked her opinion during an appearance in a CNN town hall on presidential candidates who support replacing former President Obama's signature legislation with Medicare for All, Pelosi said, "I'm not for doing away with ObamaCare."

She did say, however, that the 2010 bill could be improved upon.

"There are improvements that can be made once you see the implementation of legislation, so I would rather call for health care for all Americans," she said. "As we improve the Affordable Care Act, it may lead to Medicare for All."

The top House Democrat proposed comparing proposals to see which is the best way to go.

"Put it all on the table, see what the benefits are to the consumer, to the patient, and when you do so, then compare it to what other options are," she said. "I think the Affordable Care Act can be a path."

"But whatever you want to eventually have, I don't think you should do away with the Affordable Care Act to get there," she added.

Progressive presidential candidates including Sens. Bernie Sanders (I-Vt.) and Elizabeth Warren (D-Mass.) have been vocal supporters of Medicare for All and getting rid of private insurance.

Other top contenders, like Vice President Joe Biden and South Bend, Ind., Mayor Pete Buttigieg have said they prefer a public insurance option in addition to private insurance.

Pelosi told Bloomberg last month that she's “not a big fan of Medicare for All,”

“I mean I welcome the debate, I think that we should have health care for all,” she added, particularly citing the cost of the plan and comfort some have with their current insurance.

The Hill

Biden and Buttigieg say you can keep your health-care plan. They're lying – just like Obama.

Marc A. Thiessen – 12/3/19

In 2009, President Barack Obama promised that under Obamacare, "If you like your health-care plan, you'll be able to keep your health-care plan, period. No one will take it away, no matter what." Millions of Americans believed him, and millions of Americans lost their health-care plans. Obama's promise was a lie and his administration knew it. As Obamacare architect Jonathan Gruber later explained, "the stupidity of the American voter … was really, really critical for the thing to pass."

Well, apparently some Democrats still think you are stupid. Because a decade later, they are at it again.

In the Democratic presidential primary, there is a major fight raging over health care among the four leading contenders. On one side are Sens. Bernie Sanders (I-Vt.) and Elizabeth Warren (D-Mass.) who support a single-payer Medicare-for-all plan. Unlike Obama, Sanders is refreshingly honest, admitting to voters that under his proposal they can't keep their health plans; Medicare-for-all will abolish most private insurance and replace it with mandatory government health care. Americans appreciate his candor, but they don't like his plan: A Quinnipiac poll shows that support for Medicare-for-all has plummeted from 51 percent in 2017 to just 36 percent today.

Sensing vulnerability, former vice president Joe Biden and South Bend, Ind., Mayor Pete Buttigieg have gone on the offensive. Their line of attack? Sanders and Warren are infringing on people's freedom to choose.

Biden and Buttigieg are pushing instead for a public option — what Buttigieg calls "Medicare for All Who Want It." They promise that we can have it both ways: The government can offer people the option of signing up for Medicare-like government coverage, but also protect the 160 million Americans — many of them union workers — who like their employer-provided insurance.

In other words: If you like your health-care plan, you'll be able to keep your health-care plan.

Biden's case for the public option uses almost the very same words that Obama used when he lied to the American people a decade earlier: "If you like your employer-based plan, you can keep it. If in fact you have private insurance, you can keep it," he says. In a new ad, Buttigieg also channels his inner Obama, declaring "If you prefer a public plan like Medicare, like I think most Americans will, you can choose it. But if you prefer to keep your private insurance, you can."

Just like Obama's false promise 10 years ago, the Biden-Buttigieg promise that you can keep your plan is a lie. As Seema Verma, head of the Centers for Medicare and Medicaid Services, has explained, "the public option is a Trojan horse with single-payer hiding inside." Verma points out that private insurance pays hospitals 75 percent more than Medicare for the same

services. In 2017, for example, Medicare underpaid hospitals by $54 billion. They make up the lost revenue by charging private insurers more — which means private plans are essentially subsidizing Medicare for seniors.

But if tens of millions of Americans under 65 sign up for a public option, the population requiring subsidies will expand dramatically, while the source of private revenue will dry up. To stay afloat, doctors and hospitals will have to charge even higher prices to private insurers, which in turn will force insurers to raise prices and reduce services — making it harder for them to compete with the government for customers. A death spiral for private insurance will ensue. The higher private insurance premiums go, the more people will be pushed into the public option — until eventually the private option all but disappears.

In other words, the end result of Medicare-for-all and "Medicare for All Who Want It" is exactly the same: the elimination of private insurance. It's only a question of whether it is eliminated instantly or dies a slow, painful death. Honest people on the left admit this. The New Republic's Libby Watson recently pointed out that Biden and Buttigieg are pushing "the big lie that by creating a public option, we can maintain private insurance" and asked "if the goal is to slowly smother private insurance, why promise that people can keep their plans that they like — plans that you intend to ultimately kill?" Good question. The answer is: Because if they are honest, the American people will reject their plan.

So, when you hear Democrats promising you can keep your health-care plan, they are lying — just like Obama was 10 years ago. As the saying goes, fool me once, shame on you; fool me twice, shame on me. If you buy the same lie a second time, you have no one to blame but yourself.

The Washington Post

By The Numbers | THE DEVASTATING COSTS OF DEMOCRATS' PROPOSED GOVERNMENT TAKEOVER OF YOUR HEALTHCARE

Congressional Democrats' so-called "Medicare-for-All" plan would eliminate your private health insurance, take away your choice, risk your job, and jeopardize your financial future.

(COUNTLESS): THE NUMBER OF LIES DEMOCRATS HAVE TOLD YOU ABOUT HEALTHCARE

- Once again, Democrats are selling you a complete lie about what their healthcare proposal will really do.
- Democrats repeatedly said you could keep your plan and your doctor under Obamacare and you would see your premiums fall. They repeated these lies countless times but they all proved to be false.

$32 TRILLION: THE PRICE TAG CONGRESSIONAL DEMOCRATS WANT YOU AND YOUR KIDS TO PAY

- Their government takeover of your healthcare would cost an astounding $32 trillion.
- This means massive taxes and more debt for you and your kids' future.

180 MILLION: THE NUMBER OF AMERICANS WHO WILL LOSE THEIR HEALTHCARE

- Around 180 million Americans like you will have their private health insurance ripped away.
- Congressional Democrats' radical proposal will take away your insurance whether you like it or not.

20+ MILLION: HOW MANY SENIORS WILL BE THROWN OFF MEDICARE ADVANTAGE

- More than 20 million seniors will have their Medicare advantage plans taken away.
- This means your senior loved ones may be thrown off plans that work for them.

540,000: HOW MANY HEALTH INSURANCE WORKERS WILL LOSE THEIR JOBS

- Congressional Democrats would end the private health insurance industry which employs 540,000 hardworking Americans like you.

- The economic destruction of their plan would likely go far beyond just those workers and could rob you of potential employment opportunities and hurt your community.

$17,000: HOW MUCH YOUR FAMILY'S INCOME WILL GO DOWN

- The Council of Economic Advisers (CEA) projects that a government takeover of your healthcare will decrease average household incomes by $17,000 annually.
- This would devastate your finances and hurt your ability to provide for your family.

53%: HOW MUCH THE FEDERAL BUDGET WOULD HAVE TO BE SLASHED

- In order to pay for their government takeover of your healthcare without raising taxes, CEA projects that the federal budget would have to be cut by 53% across the board.
- These impossible cuts to vital services like defense and social security make clear that Democrats are going to raise your taxes to fund their plan to take away your insurance.

9%: HOW MUCH THE ECONOMY WILL SHRINK

- The tax hikes Congressional Democrats would have to use to fund their radical plan would cause GDP to fall by 9 percent, according to CEA.
- This would devastate your local economy, decimate your retirement accounts, and take away job opportunities from you and your loved ones.

4: HOW MANY YEARS (AT MOST) UNTIL CONGRESSIONAL DEMOCRATS TAKE AWAY YOUR HEALTHCARE

- Congressional Democrats are proposing to completely overturn the healthcare system in just four years.
- This means you will have at most four years until you have your private health insurance plan taken away, even if you like it.

0: THE NUMBER OF CHOICES YOU WILL HAVE IN YOUR OWN HEALTH INSURANCE

- Congressional Democrats want to eliminate any say you have in your own health insurance.
- You will have no choice but a government run plan.

CONGRESSIONAL
PRO-LIFE CAUCUS

The Medicare for All Act of 2019

HR 1384

Groups Opposed: *National Right to Life, Susan B. Anthony List, March for Life, Family Research Council, Concerned Women for America*

LEGISLATIVE BACKGROUND

H.R. 1384 was introduced on February 28, 2019, by Reps. Pramila Jayapal (D-WA) and Debbie Dingell (D-MI) and has over 100 Democratic cosponsors. Its Senate companion, S.1129, was introduced by Sen. Bernie Sanders on April 10, 2019.

The bill states that it would establish a Medicare for All national health insurance program.

MEDICARE FOR ALL AND ABORTION

H.R. 1384 undermines the long-standing Hyde Amendment, which protects taxpayer funding from paying for abortion or insurance plans that cover abortion. It has historically been added by bipartisan agreement to LHHS appropriations bills since the mid-1970s. HR 1384 would ensure taxpayer-funded elective abortions for women and would eliminate previous laws that prevent federal healthcare spending from directly paying for abortions:

- The bill explicitly provides for federal funding of abortion: *"Individuals enrolled for benefits under this Act are entitled to have payment made by the Secretary to an eligible provider for…comprehensive reproductive, maternity, and newborn care"*

- The bill declares that the Hyde Amendment shall not apply: *"Any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health service shall not apply to monies in the Trust Fund"*

In response to an op-ed and tweet from Whip Steve Scalise (R-LA), Senator Sanders, the sponsor of Medicare for All in the Senate, admitted that the bill removes Hyde protections:

TALKING POINTS

- The Hyde Amendment is the major protection against taxpayer dollars being used to fund abortions through programs like Medicaid and has been in effect for 40 years.

- **Polling Consistently Shows Public Support for Prohibiting Taxpayer Funding for Abortion:** A Marist poll released January 2019 found that 54% of Americans oppose taxpayer funding of abortion. This finding is consistent with past poll results, including polls in 2018, 2017, 2016, and 2014

- **The Hyde Amendment *saves* lives**
    - Before the enactment of the Hyde Amendment in 1976, the federal Medicaid program was paying for nearly 300,000 abortions annually.

    - Recent analysis by the Charlotte Lozier Institute (CLI) found that at least 2 million Americans are alive today because of the Hyde Amendment. CLI estimates that one in every nine people born to a mother on Medicaid is alive because of the Hyde amendment.

    - Even the pro-abortion Guttmacher Institute acknowledges the Hyde Amendment's impact on reducing abortion, because a portion of Medicaid eligible women who may otherwise choose abortion choose life when the government does not incentivize abortion.

- The Hyde Amendment does not prohibit state funded or privately funded abortions; it simply prevents HHS from using federal taxpayer dollars to fund abortion or insurance plans that include abortion.

- **Abortion is NOT healthcare.** Abortion is a brutal procedure that ends the lives of unborn children through suction, dismemberment or chemical poisoning. Late abortions inflict excruciating pain and suffering on the child. This human rights abuse should not be paid for or encouraged by the U.S. government.

- **Women and children both deserve better than abortion. Our nation should invest in women's health, not abortion.** Post-abortive women, like the women in the "Silent No More Awareness Campaign," are courageously speaking up about the extraordinary harm they have endured from abortion. As the NGO Feminists for Life have reminded us, women deserve better than abortion.

FURTHER READING

DeSanctis, Alexandra. "Medicare for All Would Mandate Coverage for All Abortions." *National Review*. March 22, 2019.

"Reps. Scalise, Walden: The truth about 'Medicare for all' – Plan would make you pay for abortions" *Fox News* op-ed. May 21, 2019.

House Dem Campaign Chief On Medicare For All: "Hard To Conceive How That Would Work" & Price Tag "A Little Scary"

The Hill reports today that that "House Democrats' new campaign chief on Tuesday **poured cold water on the progressive Medicare for All plan**, dismissing it as just 'one idea' out there and warning that its estimated $33 trillion price tag was 'a little scary.'" In an interview with the paper, Representative Cheri Bustos (D-Ill.), the chairwoman of the Democratic Congressional Campaign Committee (DCCC), echoed the concerns of many Americans about the proposal's disruptions to existing coverage and massive price tag:

> *"What do we have – 130 million-something Americans who get their health insurance through their work?* ***The transition from what we have now to Medicare for all, it's just hard to conceive how that would work.*** *You have so many jobs attached to the health care industry" …* ***"I think the $33 trillion price tag for Medicare for all is a little scary,"*** *she said. Various projections have concluded that the bill, which is formally backed by 107 House Democrats, would cost the government $32 trillion to $33 trillion over 10 years …* ***"The vast majority of Democrats in the U.S. House of Representatives want to see us fix the Affordable Care Act and make it functional,"*** *she said, "so we can protect people with pre-existing conditions and so people have affordable health care."*

Notably, an analysis this week by CNN found that "[t]hough the single-payer idea is generating much more conversation than previously from prominent Democrats – including endorsements from several candidates seeking the party's 2020 presidential nomination – **it has attracted very little support from House members beyond the most reliably Democratic districts**…"

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

The Partnership for America's Health Care Future

The Partnership for America's Health Care Future's (PAHCF) mission is to build and improve upon what's working in health care and fix what's not.

We want to work together to lower costs, expand patient choice, improve access, enhance quality and foster innovation. And whether it's called Medicare for all, buy-in, or a public option, one-size-fits-all health care will never allow us to achieve those goals.

That's why we support building on the strength of employer-provided health coverage and preserving Medicare, Medicaid, and other proven solutions that hundreds of millions of Americans depend on – to create the health care future that every American deserves.

Let's work together to improve America's health care future. We're committed to solutions that:

- **Empower patients** with more options and control over their health care decisions
- **Keep the promise of Medicare** for our nation's seniors
- **Improve patient care by expanding access** to the world's best doctors, nurses, specialists, treatments, and technology
- **Provide access to affordable coverage for every American**, no matter where they live or how much they earn
- **Build on the strength of the employer-provided health coverage** that more than 180 million Americans rely on today

Critical Condition
CRFB: Medicare For All "Would Mean … Tripling Payroll Taxes Or More Than Doubling All Other Taxes"

As some Members of the U.S. House introduced Medicare for All legislation "without a price tag" last week, the Committee for a Responsible Federal Budget (CRFB) looked at the crucial issue of cost, and their findings are sobering. The bill "would replace nearly all current insurance with a government-run single-payer plan" that "would be far more generous than either Medicare or most private coverage," they note – and **"similar proposals have been estimated to cost the federal government roughly $28-32 trillion over a decade."**

So, how would American families be forced to pay for this massive, one-size-fits-all government-run health care system called Medicare for All?

"Enacting this type of Medicare for All would mean **increasing federal spending by about 60 percent (excluding interest)** and financing a $30 trillion program would require the equivalent of **tripling payroll taxes or more than doubling all other taxes,"** CFRB writes.

It's no wonder the bill's authors chose to leave these details out … because few Americans would support such a proposal if they were aware of the staggering costs it would place on their shoulders. A recent poll by the Kaiser Family Foundation found that **six in 10 respondents oppose Medicare for All once they learn it would force most Americans to pay more in taxes**.

Instead of eliminating our entire health care system, kicking every American off their coverage and starting from scratch with a one-size-fits-all government program that forces families to pay more – let's focus on protecting what works in American health care, while coming together to fix what's broken.

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

Exploring The Effects Of The Public Option On America's Health Care System

The Partnership for America's Health Care Future and FTI Consulting examined the impact the public option would have on American health care coverage with the release of a study, "Assessing the Impact of a Public Option on Market Stability and Consumer Choice."

The study found the public option would force up to two million Americans off their existing health care coverage over a 10-year period and leave close to eight million without a private coverage option through the health insurance marketplace over the same time span.

Some of the study's other findings include:

- Introducing the public option would create **a "two-tier" health system** where employer-based insurance provides access to a different set of hospitals or services than those available to enrollees in public insurance.
- The government would be expected to set premiums for the public option approximately **25 percent below market value for comparable private insurance plans**, squeezing out private competition and diminishing consumer choice. The significant discrepancy in premiums would cause the eventual elimination of all private plans in the individual market.
- By 2028, **20 percent of state marketplaces would not offer a single private insurance option** as a result of the introduction of the public option.
- In the first year following introduction of the public option, **over 130,000 Americans enrolled through the health insurance marketplace would be forced off their existing health plan** as private insurers exit the marketplaces.

Although some have tried to frame the public option as a moderate proposal, whether it's called Medicare for All, Medicare buy-in, or the public option, one-size-fits-all government-run health insurance systems will force Americans to pay more to wait longer for worse care. A copy of the full report can be found here and a link to all of the Partnership's resources can be found here.

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

Examining The Impact Of The Public Option On Rural Health Care

The Partnership for America's Health Care Future and Navigant Consulting examined the impact the public option would have on rural health care with the release of a study, "The Potential Impact of a Medicare Public Option on U.S. Rural Hospitals and Communities."

The public option would put as many as **1,037 rural American hospitals in 46 states at high risk of closure**. That's 55 percent of all rural hospitals closing their doors.

Since 2010, 108 American rural hospitals have closed, and the public option would further disrupt the care millions of Americans rely on every day. Some of the study's other findings include:

- The **1,037 hospitals** at risk represent more than **63,000 staffed beds and 420,000 employees**.
- To protect hospitals from the financial impact of the public option, Medicare would need to **increase reimbursement levels between 40 and 60 percent** above current rates, **costing between $4 billion and $25 billion annually**.
- Rural Americans **are nearly five times as likely** to live in a county with a primary care physician shortage compared to other citizens.
- When a rural community loses its hospital, **per capita income falls 4 percent and the unemployment rate rises by 1.6 percent**.

As candidates and policymakers continue to discuss government-run health insurance systems such as the public option, Medicare for All, and Medicare buy-in, it's important the conversation is informed by thoughtful data that illustrates these far reaching proposals' impact on some of America's most vulnerable communities. A copy of the full report can be found here and a link to all of the Partnership's resources can be found here.

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

Assessing Medicare for America

The Partnership for America's Health Care Future and KNG Consulting examined the impact Medicare for America would have on American health care coverage with the release of a study, "The Impact of Medicare for America on the Employer Market and Health Spending."

The study found Medicare for America could force one-third of American workers off of their current employer-sponsored insurance (ESI), while increasing health care spending.

Some of the study's findings include:

- Nearly **one of every four workers** who were previously offered ESI would lose access to insurance via their employer. This increases to about **one of every three workers** losing access to insurance through their employer by 2032.
- About **one-in-nine private-sector ESI enrollees** (16 million) would disenroll by 2023 and **one-in-four** (37 million) would disenroll by 2032.
- Medicare for America has a disproportionate impact on small employers (i.e. under 50 employees). Virtually all small employers would incur savings from dropping coverage under the proposal, incentivizing them to do so.
- Overall **health care spending would increase under Medicare for America** by three percent and 11 percent in 2023 and 2032, respectively. Most of this increase is driven by higher health care utilization.

This report adds to the growing chorus of research that shows one-size-fits-all government-run health insurance systems including Medicare for All, Medicare buy-in, Medicare for America, and the public option will hurt Americans' choice and control over their health care decisions. A copy of the full report can be found here and a link to all of the Partnership's resources can be found here.

PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

Understanding Medicare-X Choice

The Partnership for America's Health Care Future and KNG Consulting examined the impact Medicare-X Choice could have on the ability of hospitals and health systems to continue to provide access to high-quality care to their patients and communities with the release of a study, "The Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals."

The study found Medicare-X would lead to the largest cut to the hospitals Americans rely on, while covering less uninsured Americans compared to improvements under the current health care system. Some of the study's other findings include:

- The study projects **public plan enrollment of 40.7 million in 2024, with approximately 90 percent of enrollees coming from individuals currently insured** on the non-group market or through employer-sponsored insurance (ESI).
- Of the 29.0 million currently uninsured, **Medicare-X Choice would result in 5.5 million gaining coverage. By comparison, additional support of the Affordable Care Act would result in 9.1 million** uninsured persons gaining coverage.
- Nationally, health care spending would be reduced by **$1.2 trillion (7percent) over the 10-year period** from 2024 to 2033, **with spending for hospital services being cut by $774 billion** — accounting for almost two-thirds of the total spending reduction.
- The Medicare-X Choice reductions in health care spending and increases in coverage would be financed through reductions in provider payments, given that Medicare rates are significantly less than payments by commercial payers.

Whether it's called Medicare-X Choice, Medicare for All, Medicare buy-in, or the public option, one-size-fits-all government health insurance systems do nothing to address our top challenge: rising health care costs. These proposals would ultimately mean higher taxes, longer wait times, and lower quality of care for all Americans. We should lower costs, build on what's working, and fix what's broken to expand access to affordable, high-quality coverage for every American. A copy of the full report can be found here and a link to all of the Partnership's resources can be found here.

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

Employer-sponsored coverage has been the backbone of our nation's health system for nearly eight decades. Over 181 million American workers and their families rely on employer-sponsored coverage every day.

Benefits offerings and coverage plans in the employer-sponsored system are as diverse as employers and employees themselves. There is no one-size-fits-all employer plan.

- Self-insured (ERISA): employer can tailor coverage to meet their workforce's specific needs across state lines, employer pays all health claims and bears the financial risk, employer utilizes a third-party administrator (insurance carrier) for daily plan management.
- Fully-insured (state regulated): prescribed benefit insurance product sold in a state, coverage purchased from an insurance carrier, employer does not bear the full financial risk of claims.

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.

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.

Policy and Implementation Questions
Medicare for All & Medicare/Medicaid Buy-in Proposals

- 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?
- What are the financial implications to individual taxpayers and businesses if a single-payer health system were established? How would taxes increase on American workers and employers to pay for a system?

Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Proposals to Achieve Universal Health Care Coverage"
December 10, 2019

Sara Rosenbaum, J.D.
Harold and Jane Hirsh Professor, Health Law and Policy
Milken Institute School of Public Health
George Washington University

The Honorable Frank Pallone, Jr. (D-NJ)

Since the Affordable Care Act's passage, approximately 20 million Americans have gained health coverage through the law's various coverage protections. 9 million low and moderate-income Americans receive health insurance subsidies that help them pay for health care. The law also expanded Medicaid, which made health insurance available to millions of low-income Americans.

The Trump Administration has sabotaged the health insurance markets by cutting off cost-sharing reductions, gutting ACA marketplace enrollment periods and outreach, and allowing the sale of junk plans that don't provide adequate health care coverage or protections for families. These policies have caused three million people to lose coverage, and resulted in higher health care costs for American families

1. Can you describe how the actions by the Trump Administration have impacted access to affordable health care, particularly for Americans who are not eligible for the ACA's subsidies?

   In my view, the most harmful step the administration has taken for people with incomes that exceed premium subsidy eligibility has been to aggressively broaden the market for short-term limited duration health plans that drain younger, healthier customers away from the market for ACA-compliant plans offering a reasonably appropriate level of coverage. This movement of younger healthier people away from ACA-compliant plan has an incredibly damaging effect on those who remain, driving prices ever higher and effectively reducing the market for good quality health plans to high-risk pool status. As Larry Levitt and colleagues have noted,[1] the lower premiums experienced in this market can be

[1] Larry Levitt et al., Why Do Short-Term Health Insurance Plans Have Lower Premiums Than Plans That Comply with the ACA? (Kaiser Family Foundation, 2018) available at https://www.kff.org/health-reform/issue-brief/why-do-short-term-health-insurance-plans-have-lower-premiums-than-plans-that-comply-with-the-aca/

attributed to the fact that short term plans exclude an estimated 27 percent of all non-elderly adults. Even assuming that a consumer is able to secure coverage, benefits are excluded or severely limited, and at the first sign of health problem, policies are not renewed.

2. The uninsured rate has climbed since beginning of the Trump Administration. Can you briefly describe why the percentage of insured Americans has declined from its 2016 high?

Numerous factors account for the growing number of uninsured, as shown in a 2019 report from the United States Census Bureau showing that between 2016 and 2018 the number of uninsured Americans grew by 1.9.[2] An analysis conducted by the Kaiser Family Foundation[3] attributes the growth (a net growth of over 1 million between 2016 and 2018) to declining coverage in both Medicaid and the Marketplaces. Medicaid enrollment declined by over 2 million (3.1%) between December 2016 and December 2018, while Marketplace enrollment fell by over 900,000. Presumably some of the growth in coverage among the subsidized population has been the result of the administration's public charge rule, which has had a well-documented chilling effect on willingness of legal immigrants, entitled to public insurance, to enroll either themselves or their children.[4] Furthermore, anecdotal evidence from some states suggests that renewed pressure from the administration aimed at stopping what officials label Medicaid fraud has resulted in the wholesale elimination of eligible people (including tens of thousands of eligible children in at least one state).[5] Indeed, the serious, nationwide drop in Medicaid enrollment among children, as shown in the 2019 Census report, should be setting off nationwide alarm bells, not only for the children being lost to the system but for the deeper problems exemplified by this drop in coverage among a group that lacks any alternative.

3. Several studies have found that, under the Trump Administration, more than a million children have lost Medicaid or CHIP coverage. Do we know why all these children have lost coverage under the Trump Administration? This loss certainly cannot be ascribed to a surge in dependent coverage under employer sponsored plans; indeed, census data from the Bureau's most recent report show that enrollment of minor children in private coverage remained flat in 2017 and 2018 (Table2). The precipitous drop in public coverage likely can be laid at the feet of the well-documented chilling effect on children living in

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[2] Income, Poverty and Health Insurance Coverage in the United States: 2018, available at https://www.census.gov/newsroom/press-releases/2019/income-poverty.html

[3] Jennifer Tolbert et al., Key Facts about the Uninsured Population (Kaiser Family Foundation, 2019), available at https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

[4] Jeanne Batelova et al., Millions Will Feel Chilling Effects of U.S. Public-Charge Rule That Is Also Likely to Reshape Legal Immigration (Migration Policy Institute, 2019), available at https://www.migrationpolicy.org/news/chilling-effects-us-public-charge-rule-commentary

[5] Kansas City Star, Why is Missouri dropping thousands of children from its Medicaid rolls? (February 19, 2019).

immigrant families. It also may be caused by aggressive "fraud control" efforts, such as the one cited above, that removed tens of thousands of eligible children. Reduced outreach and a pullback from previous enrollment and renewal streamlining efforts, in the name of "program integrity," all are likely contributors.

The Honorable Tony Cardenas (D-CA)

1. Can you briefly describe some of the challenges with our current health care system?

   The ACA has made enormous contributions to access to the goal of universal, affordable health insurance. In my view, three important challenges remain. The first is to create a strong, universal-coverage public insurance program. Such a program could serve as an alternative to the employment-based system, which increasingly works well only for affluent Americans or those fortunate enough to be protected by strong collectively-bargained agreements. Meeting this challenge means building on the ACA's Medicaid and the Marketplace achievements by growing the two subsidy models into a seamless public option with the ability to automatically enroll and renew coverage for anyone without employer coverage or who chooses to forgo employer coverage in favor of stable public insurance without the burden of coverage interruption.

   Second, we need systemic cost control mechanisms. Accountability for the national cost of health care coupled with strategies for balancing valuable innovation against its cost is a basic feature of every health system maintained by wealthy industrialized nations except this one.

   Third, we need to invest in prevention, a commitment that takes many forms. From a health care point of view, it is an expanded commitment to high quality, accessible, and comprehensive clinical preventive and primary care. The expansion of community health centers represents, in my view, a real down payment toward this goal. But it also means community-wide investments: affordable housing; safe playgrounds and parks; investment in the arts; flourishing schools, high quality child care and strong early child development programs; elimination of food deserts; and safe streets and neighborhoods.

2. A few of the bills we are considered during the hearing would create a Federal public option to be offered on the ACA marketplace. The ACA's House version included a similar provision. Would a public option expand coverage to more Americans?

   By consolidating and streamlining Medicaid and marketplace subsidies into a unified public option offering comprehensive preventive, primary, acute, and long term care, it would, in my view, become easier to enroll in and maintain public coverage while, at the same time, preserving employer coverage for those who want it.

3. If Congress is to proceed with a public option, what kind of population should it aim to serve?

   A public option should be conceptualized as public – that is, it should be structured to serve the population on a universal basis, with individual contributions (enrollment fees, cost-sharing) discounted for those with lower incomes, as we now do with subsidized marketplace plans.

The Honorable Jan Schakowsky (D-IL)

1. We have a health care cost crisis in the United States. Do you believe that fighting for universal health care—so that your costs are not based on your race, your zip code, or your socioeconomic status—is the only comprehensive and lasting solution to this crisis?

   I do. We have real options for getting there, but universality can never stop being the goal.

2. Do you believe that we can ever achieve universal health care with bipartisan consensus? What might that look like?

   My career spans 45 years here in Washington D.C. I continue to have great faith in bipartisanship. In that vein – and having worked on so many initiatives on a bipartisan basis -- I believe that the answer lies in creating a new coverage pathway that: (a) merges into itself most of Medicaid along with the subsidized Marketplace system; (b) enrolls everyone who wants or needs coverage and regardless of whether they need financial assistance with premiums and cost sharing, and makes coverage affordable for all those who are enrolled; (c) offers a full range of preventive, primary, and long term benefits; (d) is reinsured by the federal government and administered by the states; (e) allows for adaptation to local practice conditions in terms of delivery and payment reform innovation without sacrificing universality or comprehensiveness; and (f) permits insurer administration, as we do with traditional Medicare and Medicare Advantage. If we are serious, we figure out how to move toward universality and comprehensiveness but using an administrative strategy that does not depend on direct federal administration.

Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Proposals to Achieve Universal Health Care Coverage"
December 10, 2019

Peter Morley
Patient Advocate

The Honorable Frank Pallone, Jr, (D-NJ)

Patient Advocacy

Thank you for your testimony to the Committee. It's admirable that you are advocating for millions of patients across the nation.

1. Can you describe your journey and how you came to be involved in advocacy?

   Dear Chairman Pallone,

   Thank you for your kind words. I will do my best to fully answer your questions. I just want you to know that it has been an honor to work with members of your committee. They have an incredible knowledge of health care and a deep compassion that is inspiring to me. That being said, having traveled to Washington, D.C., now thirty-one times, I get no pleasure out of these trips. They are incredible taxing on my physical and emotional well-being, but I persevere out of the hope that I am making a difference in my advocacy. I believe that the amplification of what this Administration is doing to constituents, sharing these stories with members of Congress and creating digital content, informing the American people, has informed, inspired, and motivated people to become more involved. As long as I positively affect the people, I will continue to return, and you might see me roaming the hallways of Congress. That being said, I can only travel as long as my body will physically allow me to, as someone who suffers with chronic illness that impedes me from enjoying an average, healthy life.

   My journey from healthy to patient began in 2007. I was permanently disabled from a fall off a ladder and unable to work, I was fortunate to be spared the entire cost of my medical bills because I had continuous insurance coverage. Since then, I have had 10 surgeries in 13 years, including 4 spinal surgeries (3 of which are failed spinal fusions; the last one caused irreversible nerve damage); I was subsequently diagnosed through an incidental finding with kidney cancer in 2011 and lost part of my right kidney, but I fought my way into

remission in 2016; I have had 2 neurosurgeries for benign pituitary tumors; 2 carpal tunnel surgeries; and one surgery to remove a malignant melanoma.

In addition, I have had diagnoses over the last 12 years that have catapulted me well-above 10 pre-existing conditions including but not limited to: Spinal Fusion Failure; Chronic Neuropathic Pain; Degenerative Disc Disease in both my cervical and lumbar spine; Renal Cell Carcinoma; BPH; Osteoporosis; Angiomyolipoma on my left kidney; Fibromyalgia; Sjogren's Syndrome; Raynaud's Phenomenon; Small Fiber Neuropathy; two brain surgeries to remove benign pituitary tumors; surgery to remove malignant melanoma (which I am in remission); Nodular Regenerative Hyperplasia (non-cirrhotic Liver Disease) w/Portal Hypertension and Obliterative Portal Venopathy; and Adhesive Arachnoiditis (which there is no cure or successful treatment, and I am progressively losing the function of my right leg as it becomes paralyzed).

In 2013, I was diagnosed with what has become my primary health concern to-date: Lupus, which is an autoimmune disease when activated, creates autoantibodies that attack not only an invading infection, but will turn and continue to destroy healthy cells and organs, thus causing inflammation known as a Lupus flare. Therefore, I must be checked frequently by my rheumatologist. Lupus has a multitude of side-effects, but for me, the most challenging is the chronic fatigue that I fight every day. It is a struggle and challenge to get out of bed every single day.

In December 2016, shortly after President Trump's election, I joined Twitter and created the handle @morethanmySLE with the goal of fostering awareness of men who have Lupus. My account gave me visibility that led me to work with my US Congresswoman, Carolyn Maloney to advocate for healthcare that is accessible and affordable to people with Lupus and other chronic illnesses.

I want you to know, Chairman Pallone that I was a very private person prior to the 2016 election, but once President Trump was elected, I realized I could no longer keep quiet. I had to in good conscience do something to promote healthcare advocacy and empowerment. I recognized that meant I had to share the very personal details of my own story on social media. There are people in my life that were not aware I had kidney cancer or Lupus and have found out through Twitter -- that's how guarded I was. But listening to President Trump's campaign rhetoric for 18 months caused me incredible stress and motivated me to speak my truth.

In the last 2 1/2 years, I have traveled to DC (as of 2/19/20) thirty-one times to advocate not only for myself, but for thousands of people who have reached out to me through Twitter and my website, morethanmySLE.com.

2. Can you also describe the medical care and services that you need?

I take 25 different medications daily, 38 yearly, and receive 12 lifesaving infusions yearly for my Lupus. Access to these medications medication are $15,000+ per month, sometimes more due to the fact that I take certain medications bi-annually.

As a cancer survivor my care and health must continue to be observed by physicians proactively and preventatively, which means I must see my doctors up to a quarterly basis. I also must see my rheumatologist four times per year to keep my Lupus in remission; I see my dermatologist four times per year for random biopsies to prevent recurrence of melanoma; I see a pain management doctor every six weeks to control chronic pain; I have annual check-ups as well such as but not limited to: annual check-up for kidney cancer; bi-annual scans of my esophagus for my liver disease; annual visit to neurologist to check on progression of neuropathy.

Without access to insurance, I could not afford to pay for these physician visits, radiology interventions, medications and would lose access to my team of doctors. As a result, my diseases would progress, and I would die.

Preexisting Conditions

In an unprecedented and nakedly political decision, the Trump Administration declined to defend the ACA in the Republican lawsuit that is seeking to declare the entire law invalid. If the district court's ruling is upheld, millions of Americans could lose their health care overnight.

1. You deserve and require stability and continuity in your care. How is the uncertainty from the district court's decision affecting you, and patients like you across the country?
2. Please describe how your access to treatment could be affected.

The stress has been unbearable at times, I personally have lost a lot of sleep worrying about the removal of protections for pre-existing conditions. Stress is extremely triggering for someone with multiple auto-immune diseases like myself. With Lupus specifically, it can and has triggered Lupus flares, in which my body becomes inflamed. These flares can be mild, moderate or severe and I could end up as an in-patient in a hospital setting to control the severity of it. I don't like to talk about my own personal suffering publicly because I prefer to focus on my advocacy, but I feel terrorized by this Administration. To be truthful with you, I don't know how to answer your second question and here's why: This Administration has attacked health care beyond the court case, through proposed rules, they are going after Social Security Disability, the President just announced proposed cuts to Medicare and Medicaid and over one trillion cuts to these programs. Personally, it extends beyond what is now the federal court case (as of this testimony) being referred to as California v. Texas. The uncertainty itself is cruel. And since there is no replacement plan announced, I have no idea what that would look like for myself, the ACA or any of these current programs.

I do worry about the thousands of people that have reached out to me who are also concerned about losing access to care; as a patient or caregiver. I thought it was best if I shared even a tiny fraction their stories directly with you. I am including their stories (with their permission):

1)

Sgt. Edward Corcoran
Veteran Advocate
1532 Crag Burn Lane
Raleigh, NC 27604

Sgt. Edward Corcoran, Disabled Veteran and Veteran Advocate

On March 27th, 2000, I raised my right hand and swore to defend this country, a county that I love. I enlisted as a medic in the Army Reserves. Six years later I was called to serve my country in Iraq. For 15 months, I was stationed at Air Base Balad. I split that time between being a field medic and working at our base aid station and hospital. I learned to heal battle wounds both visible and invisible. It was not just a job for me, it was a calling. It was my honor to serve alongside the brave men and women of our armed services; it was my duty to make sure they came home.

When I returned home, I was diagnosed with service-connected post-traumatic stress disorder, and that enabled me to be eligible for services through the VA for that condition. I was also very fortunate to secure a job that provided me with private insurance options. The fact that other veterans may not have that benefit has haunted me. What happens to those veterans who are not eligible for VA coverage and don't have a job that provides insurance? What happens to the veterans on the verge of poverty? All those faces I passed by in the hospital came back to me, what would happen to them? I needed to provide a voice to those that were fighting to merely survive.

This fight for my fellow veterans has led me to Washington seven times over the past three years. The first was a desperate office to office marathon begging to protect the Affordable Care Act to anyone who would listen. Time after time, I would return to plea for the continuation of pre-existing condition protections. I would explain how the ACA has a meaningful impact on the uninsured rate among veterans. I have attended hearings, much like the one today, to hear others share their stories and experiences with veteran health. Most importantly, I share the stories of other veterans. Veterans like my father, my brother, the generation I served with, and the generation that served before me. Veterans like myself who are dealing with specific health issues unique to our service. Issues like PTSD, TBI, artificial limbs, blindness, and toxic environmental exposure.

Veterans, as a population, have unique health concerns and considerations that would be considered pre-existing conditions. Pre-existing going back to our service, but not service connected. I have a pre-existing condition that is related to my service that is not recognized as service connected. I was exposed to toxic burn pits during my service in Balad, Iraq. The VA does not recognize the health-related issues I'm experiencing as service connected so treatment for those issues have fallen on the shoulders of my private insurance. What would happen if I

lose the pre-existing condition protections afforded to me by the ACA and then I switch insurers? Will I have my pre-existing conditions covered?

Health care coverage is important to me because it saved my life. I suffer from PTSD and without the services that I received through the VA and private health care system; I may not have been here to share these words. I could have been one of the twenty veteran suicides that occur on average a day. I think of the veterans that won't seek help because they can't afford insurance. I think of the veteran who has cancer from exposure to toxins overseas but won't be able to get insurance. I think of the veterans that will slip through the cracks. I think of the veterans that will die.

"Thank you for your service," is a catch phrase that we hear often. You, our elected representatives have the opportunity to not only thank us, you have the opportunity to save us.

Respectfully,

Sgt. Edward Corcoran

2)

Joseph Merlino
804 Brown Breeches
North Las Vegas, NV 89081

Medicaid saved my life after losing my company sponsored health insurance when I got cancer. I'm back to work but if my cancer comes back my fear is that Medicaid won't be there to help and that because I have a preexisting condition that I won't be able to get any insurance.

3)

Rachel Kucsulain
51197 Indian Pointe Drive
Macomb, MI 48042

I love the ACA! When the passed I had a primary doctor for the first time in 20 yrs. Now, as my income has increased, I pay less than $50 a month, which I am happy to do to continue seeing my primary care doctor.

4)

Dr. John Cavanaugh
3683 Preserve Crossing Blvd.
Columbus, OH 43230

On my 50th birthday, I promised my wife Lily, I would make an appointment for a full physical. On May 5, 2014, my primary physician, Dr. Troy Fate, MD scheduled a routine colonoscopy. I

had two polyps removed and one turned out to be cancerous with positive margins. After a consultation with Dr. Scott Brill, a Colon and Rectal Surgeon at Ohio Health in Columbus, we elected for surgery on June 6th (Lilly's birthday). Dr. Brill found no evidence of cancer in the section removed, but one lymph node out of 13 tested positive for cancer cells. One of the risks of my operation was the possibility of a leak. Unfortunately, that occurred, and I fell ill with sepsis which required a second emergency surgery. Luckily Dr. Brill is an Army Veteran with trauma experience, so he was able to save my life. I needed two additional procedures to install drains for fluid buildup near my lungs. My wife never left my side for a month and slept next to me on a recliner (Much like the scene where Robin Williams describes the meaning of love to Matt Damon on the park bench in Good Will Hunting).

After a several rounds of antibiotics, I recovered enough to be discharged from the hospital with a temporary ileostomy. After three weeks of intensive physical and occupational therapy at home, I was able to participate in our daughter's wedding ceremony. Then I endured several months of chemotherapy that made me look like the main character from "Unbroken". In December, right before my birthday and the Christmas holidays, Dr. Brill reversed the diversion and I spent much of 2015 recuperating. On May 5, 2015, Dr. Brill performed a colonoscopy which resulted in a normal finding. Later in December, I had a CT scan and received a clean bill of health. I continued to be followed closely by my oncologist with regular blood screening.

Many cancer screenings are now covered by law under the ACA. However, for those of us with "pre-existing conditions", the constant threats to repeal this life saving legislation compounded by the court challenges to remove it, create terrible uncertainty and anxiety for millions of families like mine. Will we lose our health insurance? Without the protections of this law will companies refuse to cover us? Please stop these inhumane and insensitive attacks and work on bipartisan solutions to build upon and expand coverage.

5)

Vicki Malone
17284 Malone Road
Athens, AL 35611

My daughter was 24 years old when she was diagnosed with endometrial cancer and had to have a hysterectomy, my husband and I had to come up with $3500 cash before they would schedule her for surgery, we weren't able to get her usual OB/GYN for the surgery, he wanted payment in full up front, so we had to settle for a doctor we weren't thrilled with. He did a decent job with the surgery, but he didn't do the standard follow up treatment with her type and stage of cancer, she should have had at least one round of chemo we found out several months later. To take her in to the oncologist, we had to come up with another $2000 for scans and tests, three months later it was another $1500. She tried for several years to get insurance but was denied because of her pre-existing condition, if not for ACA and its protections, she wouldn't be able to get coverage or be able to afford it. My husband and I sold or pawned anything of value, got title loans, whatever we had to do to come up with the money. Some family members gave what they could, we were about to the point of having to sell our home, it took us 7 years to pay off the title

loans, we were desperate to save our daughters life. Being disabled myself with a bone disease and two heart attacks, I felt helpless, I never want to go back to that time again, to have to beg and borrow, to be so desperate and afraid that being middle class, living paycheck to paycheck, to cost you your child's life. I'm covered by Medicare, I know they could make changes that could affect my insurance coverage, but my concern is my child, she has to have tests every year to make sure she is cancer free, we can't go in debit every year to insure that doesn't happen, we shouldn't have to. In the richest country in the world, in 2020, we shouldn't have to constantly be afraid that is what we may face, again.

The Honorable Jan Schakowsky (D-IL)

1. Peter, my friend, you are insured and have spent the past three years fighting to protect the health care coverage of other patients like you. In your advocacy, have you encountered patients who are insured but still struggling under the weight of enormous health care costs?

Congresswoman Schakowsky, it is an honor to know you, and to have partnered with you over the last few years to bring awareness to national events such as Open Enrollment. Your enthusiasm and optimism for the future of health care in the United States is, pardon the pun, infectious! I'm grateful to know you and have spread your hope as wide and far as possible every time we meet at in Washington, D.C.

Sadly, yes, there are so many Americans I have encountered who are insured that would have greatly benefited for fixes or enhancements to the ACA. It is heartbreaking when you hear or read people share with you that they must choose between buying insulin and groceries. I cannot fathom this experience, I have been fortunate to not experience this, so I can only, and heartbreakingly imagine. I have a few stories to highlight your question further from patients themselves:

1)

Nancy Albrycht
Florence, AL 35630

I moved to Alabama from New York in September 2018. I had great insurance in NY, which of course I lost when I moved. I had the United Healthcare Essential plan which I paid 20 dollars per month, 15 co-pay and 25 for specialists. There are no affordable plans here in Alabama. Why?! The cheapest plan I could find was 400 dollars per month, how do they expect you to pay one paycheck per month for healthcare, with a $5000 deductible before you can even use it! I'm 57 years old and I need routine exams, mammograms, colonoscopy and so on. How can they

NOT do better for people! Are they working on more affordable healthcare? I know way too many working people who are in the same situation.

2)

Gail Wilkins
P.O. Box 864
Clearlake Oaks, CA 95423

My life changed back in 2017. I had a heart attack & was flown out by helicopter because I live in a very rural part of CA. My worry is that I'm disabled now & my husband is my soul income. If he goes over a certain amount of money approximately 1840.00, a month, then I'm cut off Medicaid and can't afford insurance & also have a preexisting condition. The helicopter ride bill was $50,000.00! I fear now that if I have another attack, I will need a stent & won't live without it. I could afford ACA. Also, heart issues are genetic in my family so it's hard to get low premiums. I live on $13,000 a year. now and it's hard enough. Please pass Universal health care!

3)

Melody Rife
Punta Gorda, FL 33950

Approximately 8 years ago I started having serious health issues. My kids were young still and I qualified for Medicaid share of cost. I had to have neck surgery and had a disc replaced. I was diagnosed with degenerative disc disease, severe arthritis, COPD, and fibromyalgia. Twice a year I was getting pneumonia and being hospitalized. The medicines alone were $2000 a month. After 4 years of this my youngest daughter turned 17 or 18 and Medicaid promptly kicked me off. One month later I was hospitalized again for pneumonia but had no insurance. On the 2nd month after being kicked off Medicaid I had a pre-heart attack and had 1 stent put in. Again, no insurance. I was billed over $30,000. I found out I was born with 3 heart valves and not the normal 4 we are supposed to have.
Now move on to January 3rd, 2019. I had a major heart attack and had 3 stents installed. The bill was originally $233,000 but was discounted to $81,000 because I have no insurance. I found out that I still have a 70% blockage in one of my valves. They didn't take of it while I was in the hospital. I know it's because I have no insurance. The doctor told me a few weeks later he could easily add another stent to fix it but with no insurance that the hospital won't accept me. Basically, I'm going to wait to have another heart attack and hope I can survive it so that my last valve is fixed. My husband is out of work and I don't know how much longer the doctor will continue to see me without payment. Which means that the $20 worth of medicines I must be on to try to keep me from having another heart attack could stop being prescribed to me. I am fixing to be 55 years old. Even if I could afford insurance, which I can't, what good is a $6000 deductible normally. I feel like because I am poor that no one cares if I live or die. I live in pain

every day with no relief besides ice packs and heating pad. Sadly, millions in America are in extremely worse condition than I am.
ACA is too expensive; I was born with a pre-existing heart valve defect and now have several pre-existing conditions and now that I have no kids at home Medicaid is useless to me. And thanks to Rick Scott, Florida's ex-Governor and his Republican Administration, Florida didn't accept the Medicaid Expansion. Over 800,000 people I read a few years ago were affected by us not doing the Medicaid Expansion. I don't know if the expansion would have helped me, but it could have helped others. Too many rich people want to say poor people don't work hard.

My hubby is a construction laborer, he is getting too old to dig ditches and he has very high blood pressure and hasn't seen a doctor in decades. It's scary and sad to know he could die on me or could be unable to work. He has no skills other than hard labor. He has absolutely no computer skills and barely knows how to make phone calls on a modern cellphone. He is our only source of income.

A few last things, we are also both in dire need of dental care and eyeglasses. When we hit retirement age, if we make it, we will have nothing but Social Security to rely on. Assuming Congress doesn't take that away from us. We will have to get a divorce then just so we can get about $800 a month in Social Security.

2. What would it mean for patients like you to always know you would have access to health care—to know that you would never fall in between the cracks—under a universal coverage system?

Immediately what I think is: peace of mind, focusing on my own health, the huge burden of stress waiting for the next executive order from the Trump Administration, any Administration, or honestly, any Congress being lifted from my shoulders. I think it would exponentially increase hope and relief among millions of Americans. As far as prevention, there would be many people whose lives would be saved since they would have access to care and would see providers more frequently, instead of putting off a visit due to financial constraints. I feel based on my own personal experiences, people would be diagnosed sooner, and their conditions could be more under control, and in some cases healed. Millions of lives would be saved. I hope to see this happen in my lifetime and will continue to advocate with Congress to ensure I do everything I can to make this happen.

Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Proposals to Achieve Universal Health Care Coverage"
December 10, 2019

Douglas Holtz- Eakin, Ph.D.
President
American Action Forum

The Honorable Gus M. Bilirakis (R-FL)

1. Obamacare failed to make health care more affordable and more accessible through increased government intervention and mandates, so why double-down on failure with Medicare For All?

    a. Does cutting provider reimbursement rates under Medicare For All help increase the already short supply of doctors and nurses?

No. The best-case scenario is that every single medical provider is so mission-driven that the supply is unchanged. More realistically, the decline in potential earnings will make it unworkable for many to incur education and financing costs and the supply will diminish.

FRANK PALLONE, JR., NEW JERSEY
CHAIRMAN

GREG WALDEN, OREGON
RANKING MEMBER

ONE HUNDRED SIXTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115

Majority (202) 225–2927
Minority (202) 225–3641

February 4, 2020

Scott Atlas, M.D.
David and Joan Traitel Senior Fellow
Hoover Institution, Stanford University
434 Galvez Mall
Stanford, CA 94305

Dear Dr. Atlas:

Thank you for appearing before the Subcommittee on Health on December 10, 2019, at the hearing entitled "Proposals to Achieve Universal Health Care Coverage." I appreciate the time and effort you gave as a witness before the Committee on Energy and Commerce.

Pursuant to Rule 3 of the Committee on Energy and Commerce, members are permitted to submit additional questions to the witnesses for their responses, which will be included in the hearing record. Attached are questions directed to you from a member of the Committee. In preparing your answers to these questions, please address your response to the member who has submitted the questions using the Word document provided with this letter.

To facilitate the publication of the hearing record, please submit your responses to these questions by no later than the close of business on Wednesday, February 19, 2020. As previously noted, your responses to the questions in this letter will be included in the hearing record. Your written responses should be transmitted by email in the Word document provided to Meghan Mullon, Policy Analyst, at Meghan.Mullon@mail.house.gov. To help in maintaining the proper format for this hearing record, please use the document provided to complete your responses.

Thank you for your prompt attention to this request. If you need additional information or have other questions, please contact Ms. Mullon with the Committee staff at (202) 225-2927.

Sincerely,

Frank Pallone, Jr.
Chairman

Attachment

cc: Hon. Greg Walden, Ranking Member
Committee on Energy and Commerce

Hon. Anna G. Eshoo, Chairwoman
Subcommittee on Health

The Honorable Michael C. Burgess, Ranking Member
Subcommittee on Health

[Dr. Atlas did not answer submitted questions for the record by the time of publication.]

Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Proposals to Achieve Universal Health Care Coverage"
December 10, 2019

Scott Atlas, M.D.
David and Joan Traitel Senior Fellow
Hoover Institution, Stanford University

The Honorable Gus M. Bilirakis (R-FL)

1. Which groups would stand to be impacted the most by government rationing?