

**EXAMINING PATHWAYS TO UNIVERSAL  
HEALTH COVERAGE**

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**HEARING**  
BEFORE THE  
**COMMITTEE ON  
OVERSIGHT AND REFORM**  
**HOUSE OF REPRESENTATIVES**  
ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

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\* University of California - San Francisco Study on Single-Payer Proposals; submitted by Chairwoman Maloney.

\* Questions for the Record: to Ms. Grace Marie-Turner; submitted by Rep. Comer.

*The documents listed are available at: [docs.house.gov](https://docs.house.gov).*



## **EXAMINING PATHWAYS TO UNIVERSAL HEALTH COVERAGE**

**Tuesday, March 29, 2022**

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON OVERSIGHT AND REFORM,  
*Washington, D.C.*

The committee met, pursuant to notice, at 9:05 a.m., in room 2154, Rayburn House Office Building, and via Zoom; Hon. Carolyn B. Maloney [chairwoman of the committee] presiding.

Present: Representatives Maloney, Norton, Lynch, Connolly, Krishnamoorthi, Raskin, Khanna, Mfume, Ocasio-Cortez, Tlaib, Porter, Bush, Brown, Davis, Welch, Johnson, Sarbanes, Kelly, DeSaulnier, Gomez, Pressley, Comer, Jordan, Foxx, Hice, Grothman, Cloud, Sessions, Keller, Biggs, Clyde, LaTurner, Herrell, and Donalds.

Also present: Representatives Jayapal, Omar, Bowman, and Jones.

Chairwoman MALONEY. The Committee will come to order. I am told we need to restart the opening because of the stream was not there.

Today, I am convening the Committee on Oversight and Reform to examine a subject that touches the lives of every person in the United States, our Nation's healthcare system and Americans' access to affordable, high-quality medical care. Democrats in Congress have spent decades fighting, and succeeding, to expand access to healthcare in the United States.

In 2010, under the leadership of President Obama, we passed the Affordable Care Act, a landmark law that made affordable healthcare accessible to more than 30 million people across the United States. That includes 14 million people with lower incomes who finally received high-quality health insurance, thanks to the Affordable Care Act's Medicaid expansion. This also includes millions of people who had previously experienced obstacles to obtaining healthcare, including people with preexisting conditions, older Americans, and women.

Unfortunately, my colleagues on the other side of the aisle not only opposed this law, but over the last decade, they have voted more than 60 times to repeal it or weaken it. Republican Attorney Generals sued in Federal court, trying to strike it down, and the Trump administration refused to defend the ACA in court. Despite these relentless attacks and thanks to the tireless work of patients, caregivers, and community advocates, the ACA still stands.

Since President Biden took office, congressional Democrats have continued to strengthen and enhance the ACA to make healthcare

more affordable and accessible for every person in the United States. Last year, we passed President Biden's American Rescue Plan, sweeping legislation that expanded the ACA's financial assistance for patients and families working to make ends meet.

But our work is not done yet. Today, more than 27 million people in the United States remain uninsured, and even for some who do have insurance, it is not enough to insulate them from the significant cost of getting healthcare in this country. congressional Democrats have proposed and advanced many different reforms to close these coverage gaps and move our Nation toward universal health coverage. We have voted on legislation to close the coverage gap left by Republican States that failed to expand Medicaid under the ACA, as well as legislation to expand Medicare benefits for older Americans and to further reduce out-of-pocket costs for patients with commercial coverage.

And more than 100 of us have cosponsored the Medicare for All Act, as proposed by my colleague Congresswoman Pramila Jayapal and championed by numerous members on this committee. Medicare for All, a comprehensive proposal to transition our healthcare system to a national single-payer model, offers a bold vision for an America where no patient is denied necessary medical care because it is too expensive and no family has to decide between putting food on the table or paying their medical bills. This proposal fulfills a promise that I have long fought for, the promise that healthcare is a human right.

Medicare for All would contain skyrocketing costs across our healthcare system and provide a sustainable path to more equitable and accessible healthcare, especially for communities where access has historically been pushed out of reach. I have proudly supported Medicare for All since it was first introduced in Congress nearly two decades ago, and I will continue to push for this vision of the American healthcare system.

At the same time, my Democratic colleagues and I will continue to fight for every bit of progress we can make in moving our Nation toward universal coverage. While Republicans raise barriers to affordable healthcare, Democrats will continue working tirelessly to ensure that no person's financial circumstances keep them from obtaining quality healthcare.

Let me conclude by taking a moment to recognize the leadership of several of our committee members in bringing renewed energy and urgency to the fight for universal coverage. Congresswoman Cori Bush, Ayanna Pressley, Alexandria Ocasio-Cortez, and Rashida Tlaib, all members of this committee, have been some of the most powerful voices in Congress for an America where healthcare is a human right, and I am grateful to partner with them.

Before I recognize the distinguished Ranking Member for his opening remarks, I would like to recognize Congresswoman Bush for an opening Statement.

You are now recognized, Congresswoman Bush.

Ms. BUSH. St. Louis and I thank you, Chairwoman Maloney, for your partnership in convening this historic hearing on the urgent need for comprehensive and universal health coverage in the United States. The committee's exemplary leadership, tireless ad-

vocacy, and commitment to genuine health equity will rightfully bring this conversation back to the forefront of public health policy.

I must acknowledge the tremendous work and contribution of Senator Sanders and Rep. Jayapal for putting forth the boldest legislative proposal to date, the Medicare for All Act, and to my sisters in service on this committee for their partnership and steadfast leadership in our effort to protect healthcare as a human right.

Thank you to our seeing witnesses, a comprehensive range of patients and researchers, healthcare professionals, who have come together today to passionately advocate for universal healthcare.

Medicare for All is transformational policy change that would implement a national single-payer universal healthcare system that guarantees comprehensive healthcare coverage to every person in America and end the for-profit, privatized broken system we have in place now.

I have personally bore witness to the stark inequities faced by uninsured and underinsured patients during my tenure as a registered nurse. For some people, it is hard to imagine rationing expensive medication like insulin, skipping dialysis appointments, forgoing surgical procedures, or refusing medical care entirely. People are having to choose between their life or a lifetime of medical debt, and that is not OK.

And I know because I am one of those people. Until I was sworn in as a Member of Congress, I was uninsured for over a week, and actually, I have spent the better part of my adulthood lacking access to health coverage, overburdened by medical debt, and unable to receive regular preventive and routine medical care. It shouldn't have taken a job for me to be able to access affordable medical care. Healthcare is a human right, and we should guarantee it for everyone.

Providing every single person in the United States with healthcare is a powerful anti-poverty mechanism. Medicare for All would help low-income households save over \$38 billion annually on medical out-of-pocket expenses like deductibles, copays, co-insurance, and self-payments. Research has proven universal coverage will help reduce poverty rates by over 20 percent.

In St. Louis, our communities are facing systemic threats to their health from all angles—from poverty, substandard housing conditions, environmental destruction, overdose and mental health crises, pollution, to over policing. Lack of affordable healthcare has resulted in millions of preventable deaths before the pandemic, and the situation continues to rapidly deteriorate as COVID-19 claims over 1 million lives and counting.

While Democrats have a majority in the House, Senate, and the executive branch, it is imperative lawmakers seize this narrow opportunity now to enact transformational public health policy and poverty-reductive policies like Medicare for All. Taking strides toward universal healthcare coverage is the only path forward to reversing troubling trends in U.S. population health.

I urge my colleagues on both sides of the aisle to earnestly consider the lethal consequences of continuing to prioritize big pharma profits over human life and health.

Thank you, and I yield back.

Chairwoman MALONEY. The gentlelady yields back.

I now recognize the distinguished Ranking Member, Mr. Comer, for an opening Statement.

Mr. COMER. Thank you, Chairwoman Maloney, and I want to thank our witnesses for your testimony here today.

Keeping with the majority's pattern this Congress, today's hearing is not an oversight hearing. It is not a hearing that will bring transparency or accountability to the executive branch. It is not a hearing to find ways to save taxpayer dollars, especially as Americans toil under inflation.

Instead, today's hearing is an attempt to find more ways to spend taxpayer dollars and expand the reach of the Federal Government. It is a hearing to grow massive entitlement spending, this time by pushing for Government-run healthcare.

With inflation at a 40-year high, Americans are struggling to afford essential items like food and medicine. Since day one of this administration, President Biden's policies have crippled America's energy independence. Gas prices have skyrocketed. In California, gas prices are over \$6 a gallon.

Meanwhile, fentanyl is streaming across the Southern border unchecked. According to the Centers for Disease Control, fentanyl overdoses are now the leading cause of death for adults age 18 to 25. Children are also being hit hard by the fentanyl crisis with reports daily about accidental overdoses.

Yet my Democrat colleagues refuse to look into any of these issues. The mission of the Oversight Committee is to root out waste, fraud, abuse, and mismanagement in the Federal Government, but Democrats keep finding new ways to use the tools of the committee to spend even more taxpayer dollars.

Instead of looking for ways to expand Government, Oversight Committee Republicans have been conducting our own investigation in the healthcare space on Medicaid improper payments. And what we have found is very disturbing. Documents obtained during the investigation show that Democrat policies, such as Medicaid expansion and removing eligibility checks, have increased improper payment rates in the program.

In fact, improper payments are so rampant, the most recent data shows that more than 1 out of every 5 Medicaid payments are improper. That is about \$87 billion in taxpayer money being misused in one Fiscal Year alone. Why aren't we holding a hearing on that?

Instead, this hearing is about further expanding Obamacare and moving the United States closer to socialized medicine. Medicare for All will gut quality healthcare coverage in favor of waiting lines, rationed care, and stalled medical innovation. Medicare for All will cancel first-rate health plans for millions of workers, children, and seniors in favor of giving D.C. politicians unlimited control of your healthcare.

Evidence around the world shows socialized medicine causes long lines for treatment, decreased innovation, and empowers the Government to decide who lives and who dies. It also enables systems that benefit the rich who can afford private insurance to bypass Government waitlists.

Democrats have seen the polling and know the American people don't want Medicare for all. So Democrats have worked to hide their end goal from the American people, using terms like "Medi-



care for all who want it” and “public options,” when, in reality, these are just steppingstones to socialized medicine. But no amount of Washington spin can change the fact that socialized medicine is a bad deal for the American people.

Americans recognize the frightening attempts at Government takeover of healthcare for what they are, bans on good healthcare plans that work, eradicating Medicare for seniors as we know it, and doubling everyone’s taxes. And voters will reject it. When they do, Republicans stand committed to working together to improve the broken status quo and lower healthcare costs for families and small businesses.

Republicans, through the Healthy Future Task Force, are already working to develop common sense proposals to increase competition, encourage investment in new cures and therapies, protect access to care for all Americans, and ensure patients remain in control of their care. But Republicans know centralizing control in D.C. and continuing to limit access and choice for patients is an awfully bad starting point for Democrats.

Republicans will continue to fight Democrats’ takeover of healthcare through common sense solutions to increase the availability of affordable care for all Americans while ensuring we remain the global leader in healthcare innovation.

And with that, Madam Chair, I yield back.

Chairwoman MALONEY. The gentleman yields back.

We have very important witnesses today, and I want to focus on getting to their testimony. Let me briefly say that President Biden has unified our allies in Asia and Europe. He has restored trust in American leadership. He has swiftly acted to move against the aggression of Russia against the Ukraine. After the COVID crisis, he has taken steps to help our economy and has had record employment, the most ever in the history of our country.

I would like to place into the record a list of all the Federal hearings that we have had in Oversight and address the other attacks on the Biden administration and respond very simply to the claim that our hearing today is too expensive.

The truth is we cannot afford our current healthcare system. We pay more for healthcare than any other comparable nation, nearly 20 percent of our GDP and rising yearly. Americans go bankrupt because they don’t have health insurance, and that is a national disgrace. And studies show that the reforms we are discussing today would actually save money over time.

I would like to submit for the record a study from the University of California San Francisco, which analyzed 22 single-payer proposals and found that every single one would result in long-term financial savings.

Without objection.

Chairwoman MALONEY. If my Republican colleagues were really worried about inflation, they would support policies that bring down healthcare costs instead of voting 60 times against the Affordable Care healthcare plan that has expanded healthcare to 30 million Americans.

Finally, in terms of the deficit, I don’t hear my Republican colleagues complaining when President Trump pushed through \$1.9 trillion in tax cuts for the very well off. I invite my Republican col-

leagues to stop playing politics and let us work together on real solutions, all kinds of ideas that we will be discussing today, real solutions so that working families can get the healthcare they so justly deserve at an affordable price.

And before we move on, I would like to ask unanimous consent that Representatives Omar, Bowman, Jones, and Jayapal be allowed to participate in today's hearing.

Without objection, so ordered.

Now we are going to introduce our distinguished first panel of witnesses who are all patient advocates. The first panel will not be taking questions, but we welcome their experience, their perspective.

I now recognize Ms. Bush to introduce the first witness.

Ms. BUSH. I am proud to represent a witness in this hearing from St. Louis, Mr. Christopher Willcox, who will share his testimony as both an underinsured patient and a relentless advocate for Medicare for All.

Chris is currently the mutual aid and policy advocate at A Red Circle, where he helps connect St. Louis County residents with community resources. As a social worker who is passionate about healthcare, housing, and freedom from police violence, Chris has extensive experience helping patients navigate a fragmented healthcare system.

I am confident his testimony will lay bare the true human cost of the brutal for-profit healthcare industry.

Chairwoman MALONEY. Thank you.

Our next witness will be Nikki Lyons, who is a pre-med student from my district in New York.

After that, we will hear from Chris Briggs, who is a patient advocate from Woodburn, Virginia.

I now recognize Ms. Tlaib to introduce our next witness.

Ms. TLAIB. Thank you so much, Chairwoman Maloney, for your incredible courage in having this hearing and, of course, to all of my other sisters in service for helping us bring so many of our families into the halls of Congress as they express the dismay of our broken healthcare system.

I have the honor of introducing Bishop Walter Starghill from Inkster, strong in Thirteenth congressional District. The bishop has already had personal experiences himself, almost going blind because of our broken healthcare system, but he also serves in one of my amazing federally accredited clinics. He serves as the vice chair of an all-volunteer board of directors of Western Wayne Family Health Centers, whose goal is to provide high-quality, affordable care for all of our residents and our communities, regardless of insurance status.

I want to thank him so much for his courage and for him providing this testimony that is so critical. As the bishop will tell you, in our district, we are not about just surviving. We are also about thriving. And that is why we need to get closer to passing Medicare for All.

Thank you so much, Chairwoman. I yield.

Chairwoman MALONEY. I now recognize Ms. Pressley to introduce our final witness.

Ms. PRESSLEY. Thank you, Madam Chair, for your leadership and heeding our calls, working with my colleagues and I to hold this critically important, historic, and timely hearing. It has been a long time coming.

I thank Rep. Jayapal for being undeterred in this justice fight, and of course, I want to recognize my colleague and sister in service, Representative Bush, for spearheading this effort.

The fight to make Medicare for All a reality is intrinsically a fight to center people with disabilities once and for all, and that is why I am proud to introduce Leslie Templeton, constituent of the Massachusetts Seventh, a resident of Boston, who from a young age has navigated the world as a disabled person and uses her experiences to advocate for others.

Thank you, Leslie, for your tireless dedication to advancing disability justice in the Commonwealth and across the United States. You make the Massachusetts Seventh and the movement very proud.

Chairwoman MALONEY. The gentlelady yields back.

The witnesses will be unmuted so that we may swear them in. Please raise your right hands.

Do you swear or affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

[Response.]

Chairwoman MALONEY. Let the record show that the witnesses answered in the affirmative.

Thank you. And without objection, your written Statements will be made part of the record.

With that, Mr. Willcox, you are now recognized for your testimony. Mr. Willcox?

**STATEMENT OF CHRISTOPHER WILLCOX, MSW, ST. LOUIS,  
MISSOURI**

Mr. WILLCOX. Great. Thank you for the kind introduction and thank you for inviting me to speak.

My name is Chris Willcox. I'm an organizer with St. Louis Mutual Aid, and I work for A Red Circle, which is a nonprofit that serves North St. Louis County.

My history with healthcare systems in America comes from the perspective of those receiving services and from providing them. I was first diagnosed with anxiety and depression in college before I graduated in 2011 at the peak of the Great Recession. Getting treatment for depression suddenly made a lot of struggles in my life make sense.

The thing about depression is that the simplest things, such as getting out of bed, can feel incredibly difficult, and it can be hard to even imagine that there is anything worth getting up for. Adding to that, failing to overcome challenges makes it all the easier to gather what feels like a cumulative body of evidence of your own worthlessness.

We deal with arbitrary disruptions in healthcare because of our dependence on private health insurance companies and struggles with precarious employment. I've had to change therapists at least

three times because the ones I was working with was no longer in network.

When I was temporarily uninsured or had to start with a new insurer, I've had to go through withdrawals multiple times because of denials or delays, prior authorizations, or any other bureaucratic headaches we spend hours and hours of unpaid time dealing with.

In my experience working in social services, the limitations of existing public health insurance left many of my clients' needs unmet. Many agencies operate by churning as many billable services as possible from underpaid and poorly supported staff. Imagine being worried about making your numbers while trying to be present for a client that is telling you about their suicidal ideation.

One client I work with is particularly ill-served. She had to borrow money from her brother to get her medications while she waited on Medicaid to establish her coverage. I was advised to reschedule her appointments so that I could pick up others to get my numbers up because she would frequently have to reschedule. Understandable for someone needing treatment for serious mental health challenges.

The very day I was given this advice, this same client texted me a call for help as she was struggling with suicide. After I intervened, she went to the hospital for the second time for suicide before she was finally granted coverage by Medicaid. This was while I was having my own thoughts about suicide related to the conditions of my job, but I had put off seeing a therapist for several months because during that time, I was hired late in the year, and I would have to pay entirely out-of-pocket, have the deductible reset in January.

These problems exist simply because we choose not to make the commitment to care for every person who needs it. This may be even more the case in mental illness, which can be every bit as lethal. It takes courage and resolve just to seek treatment, as fear of being seen as weak or as making it up in your head only adds to the barriers we already put between people and care.

Without getting the care I needed, I might not even be alive today, let alone speaking to Congress about finally getting the support our people need and deserve. We know what we need to do to make sure that everyone gets the care that they need, Medicare for All now.

Thank you.

Chairwoman MALONEY. Thank you. The gentleman yields back.

Ms. Lyons, you are now recognized for your testimony. Ms. Lyons?

**STATEMENT OF NICOLE LYONS, NEW YORK CITY, NEW YORK**

Ms. LYONS. Hi. OK, thank you so much for giving me the opportunity to speak today, members of the House committee.

Just give me one second. I'm having a little technical difficulty right now.

So, as the speaker said, my name is Nikki Lyons. I'm here to speak today because the second time in my 20's, I am waiting for an organ transplant due to kidney failure.

This loss of control regarding so many aspects of my life and waiting for an organ transplant has had me thinking many times

about what I would say to you guys with the power to make changes in this place where decisions are made. Like so many Americans, Medicare for All would have changed the course of so many aspects of my life and provide comfort for my future.

The first time I found out I was sick, I was at a hospital in the middle of college midterms week and waking up from an emergency appendectomy. The diagnosis was not adequately explained, and there is no followup care that one would expect.

As a struggling college student, I didn't have the luxury to see a doctor anywhere besides the emergency room. Because of this, I didn't know how truly sick I was, and because of my illness, I ended up failing out of school, which further delayed my career and cost thousands and thousands of dollars.

Years later, I found out at that time I already should have been looking for a transplant because I was in the end stages of kidney failure, not told just to watch my sodium—or not just to watch my sodium, as I was told. Had I had regular access to healthcare, blood tests, anything like that, the extent of my organ failure could have been stalled or even prevented, had it been caught early enough.

While waiting for my first transplant, instead of resting and conserving the little energy I did have, I was working 50-plus hours a week on my feet at a bar and at a gym to afford my doctors' appointments and medication. For those who don't know, potential transplant patients are evaluated for stability as to not waste the gift of an organ. They look at your housing, your economic status, your compliance with doctors. Not being able to afford medication or appointments could have disqualified me for the organ I needed to live at any point.

Medicare for All would have meant not deciding if I needed to skip meals to qualify for a kidney. I wouldn't have had to work myself to the bone while incredibly sick.

I was lucky enough to receive a transplant in 2016, but I am again in organ failure. This round of organ failure I can say with 100 percent certainty would have been prevented by Medicare for All. I wasn't able to get regular transplant checkups because of the resources I had allotted for healthcare went toward mitigating the symptoms of long-term COVID. Because of the lack of care, I had no idea my body was rejecting my transplant as a complication of said long-term COVID.

I haven't been able to properly work or attend class adequately since winter of 2020. The COVID symptoms transitioned into kidney failure symptoms so seamlessly to the point I didn't realize what was happening. All I had needed was a simple blood test, and the rejection would have been caught earlier. When rejection is caught quickly, it is very treatable.

I, unfortunately, wasn't that lucky. It was amazing I was alive for the second time in my life. Since June, I have had six long-term hospital stays, with the longest being seven weeks; travel 12 hours a week 3 times—12 hours 3 times a week for dialysis for 3 1/2 hours; blood transfusions, chemicals similar to chemo to try and save the kidney and prevent anything from getting worse, and that just ends up making me feel significantly worse. I've had days I'm only able to be awake for four hours. There's no way for me to work, finish school, or thrive at all in this condition.

On top of this, I had no insurance when this first started until Medicare kicked in, which took six months from the time I applied. I was told their online system never got my application several times, and then after that, several times the local office had lost my paperwork and never filed it.

So, for those six months, I couldn't access care unless I went to an ER. I ended up going into heart failure as well during this time, which took four ERs to catch. But had I been able to see a cardiologist for something as simple as an ultrasound of the heart or an echo, it would have been spotted immediately.

I was also told peritoneal dialysis would have been a much better option than the standard hemodialysis that I had to endure because no surgeon would place the right catheter if I didn't have insurance to pay for said surgery. So I have spent the past six months getting the entirety of my blood taken out through a tube in my neck, cleaned, and returned to my body while often going into shock when there's a loss of fluids because it makes your heart unable to pump blood through the body, having horrible insomnia, deep pain, and fatigue.

Six months of suffering due to a lack of access to care for a medical situation that should have been prevented in the first place. Medicare eventually kicked in, and now 229 days after my first dialysis session, I am finally switched over to in-home peritoneal dialysis that I should have gotten in the first place. Two hundred twenty-nine days of my life were robbed from me for reasons out of my control, but preventable for the next person by the elected officials sitting in this room.

The experiences I briefly shared are but a drop in the bucket compared to my full story. I wanted to take the time to thank everybody for listening to me, and I implore you to take the time to fully absorb what the words I said meant.

This situation is happening across the country, and Medicare for All would prevent it. It is inhumane to present any human being in a situation where they must choose between eviction, a lack of food, or their healthcare.

Thank you.

Chairwoman MALONEY. Thank you.

Mr. Briggs, you are now recognized.

#### **STATEMENT OF CHRIS BRIGGS, WOODBURN, VIRGINIA**

Mr. BRIGGS. Chairwoman Maloney, Ranking Member Comer, members of the House Committee on Oversight and Reform, please allow me to thank you to testify before you today. And just a point of correction, I do, in fact, live in Northern Virginia, and I am a patient advocate, but I also am public affairs counsel for Independent Institute, which is a think tank in Oakland, California.

In November 2015, my wife got the most dreadful call a parent can get. The doctor knew why our daughter, Colette, then 2 1/2, hadn't been feeling well. Bloodwork had revealed leukemia, cancer. We raced Colette to Inova Fairfax Hospital, the only one in Northern Virginia, where we live, that treats pediatric cancer and got there just in time.

Thanks to Obamacare, we were already in difficult straits regarding healthcare. In 2014, that law had eliminated a plan we had had for years.

Before the ACA went into effect, the private marketplace consistently and reliably had offered us a wide variety of inexpensive plans that covered specialist care even out of State. After the ACA went into effect, however, all that was left were increasingly costly plans with fewer benefits, including fewer doctors and fewer hospitals.

Thanks to Obamacare, we were, and still are to this day, basically restricted to medical facilities within a short radius of our zip codes. Obamacare, in a word, has made us into medical serfs. We're tied to the land on which we live, unable to leave it, even to save a little girl dying from cancer. Which is why, when we tried to take Colette to Johns Hopkins, just up the road in Baltimore, we were denied. Under our pre-ACA plan, which didn't geofence sick children from the care they deserve, she would have been admitted.

Our predicament was made all the more painful by swelling premiums, as well as by skyrocketing deductible and maximum out-of-pocket expenses. They can go as high as \$16,500, as it has been for my family.

But things were about to get much worse than expensive for our family. In mid-2017, President Trump merely suggested the scrapping of the massive Obamacare payments to insurance giants, which were delivering worse care at ever greater cost. And in response—because Obamacare, for some reason, permits this—every insurer in Northern Virginia with a family plan, including the one we had, pulled out for the following year, 2018.

Except one. Cigna Connect, however, wouldn't cover my daughter at Inova Fairfax, the one hospital in Northern Virginia, as I say, with a pediatric cancer ward. So under Obamacare, our daughter was effectively without coverage for cancer. Not the common cold or a broken bone, but cancer.

We went through another terrifying event in 2020. In mid-March of that year, with COVID sweeping the country, Anthem, the plan we had for that year, announced suddenly that on April 1, it would no longer cover not the hospital this time, but the clinic where she received most of her doctor-administered chemotherapy. So we called the marketplace. Perhaps it would grant us a waiver to buy the Cigna plan still available for sale in our zip code. Not a chance, we were told.

The failure of the ACA to cover our daughter battling a terminal illness was not considered, we were told, a "qualifying event." So once again, thanks to the ACA, we were left without coverage for our daughter, recovering from cancer at the clinic, the only one she could go to in Northern Virginia.

Now in both cases of systems collapse, we were forced to turn to the author of these failures that is to the Government, to all of you. Specifically, we had called Senator Mark Warner for Virginia, one of our Senators, so he could bully a private company—Cigna in the first instance and Anthem in the second—into covering, respectively, the hospital and the clinic. And in both cases, the threats from the State drove the insurance giants back into the marketplace.

But I do hope all of you can see how these successes that I achieved were actually failures. Ad hoc exercises of Government power to ensure proper functioning of the ACA means we are not dealing, despite the rhetoric, with a marketplace, but rather with a closed web of insurance companies and medical providers at the mercy of the police powers of a complicit government.

Now perhaps to solve the instability of Obamacare, which is inherent to it, the Government could just take over all medical facilities. But everybody in the country at that point would be at the mercy of the same Government bureaucracy that has been brutalizing my daughter and her parents for years.

The high costs of Obamacare would go higher. The rationing of care that we've already experienced would be even more pronounced, and here is why. It's very simple. Bad ideas don't get better just because you make them bigger. They get worse.

Twice in a three-year period, the most important problem that we faced wasn't high costs, bad as they were, but the terrifying reality that high prices in a planned, closed economy always signify that we are on the way to scarcity. Twice in three years we found ourselves with no insurance product to buy for any amount of money that could save a little girl battling cancer.

And here's the thing that's the main point of what I want to say. Scarcity doesn't go away under universal coverage or single-payer, whatever word we want to use this week or next week to describe it. Under full Government control of the body, that is under full Government control of the body by all of you, scarcity wouldn't be, as it is in my case now, circumstantial. My family was effectively a canary in the coal mine.

Scarcity under such authoritarian medicine becomes policy, and by that, I mean this. Those long wait times that everyone can read about for cancer screenings in Great Britain or Canada, that is scarcity made institutional, universal, but in a very bad way. And if you want an example closer to home, try the Government-run hospitals of the Veterans Administration, where people die in line waiting for care.

In other words, if we unfortunately get more managed care from all of you, the Government, my daughter will be everyone's daughter. And every mother and father will experience what my wife and I have experienced. We watched our daughter battle cancer while the institutions of medicine, thanks to the ACA, colluded with the disease against her.

There is one correct long-term answer in my view. We must prohibit the Government, that is to say all of you, from further interfering in the acquisition by private citizens of their preferred medical care, and we do that by repeal of the ACA and placing back into the hands of Americans real, actuarially sound, automatically renewable insurance products curated to individual needs. That is the kind of universal coverage this country deserves because it's the only kind that works.

And now a word for my Republican friends. Obamacare, as you may know, has very little to do with actual insurance. It is essentially a giant scheme. Some would say, I would say a giant Ponzi scheme to pay for each other's medical bills. And since my daugh-



ter, thanks to the ACA, got very, very sick under a non-insurance regime, she is now permanently uninsurable.

If we ever come to our senses in this country and give back to the citizens real insurance, my daughter will never be able to have one, and here is the logic. You cannot buy auto insurance after the car accident. My daughter managed to get sick with cancer. She's had that accident. She is permanently uninsurable.

However, if I had been allowed to keep my pre-ACA plan, as President Obama promised, things would be very different. My daughter today would have insured, durable access to medical care. In essence, Obamacare turned an insurable illness, one as grave as cancer, into a permanent preexisting condition from which my daughter will never escape.

But my daughter is not alone. Millions of persons have gotten sick under Obamacare, and everybody in this room, in this entire country, will someday suffer a serious illness, such as we'll call it fate for the purposes of this discussion. And soon enough, the number of permanently uninsurable will be so large that you won't be able to repeal Obamacare.

Obamacare, in a word, is creating right now a nation of pre-existing conditions. The Democrats know this. All they have to do is wait, and we will be forced to go full State takeover of the body. So how about it? When you Republicans get into the majority, you win both houses and possibly get the presidency back, will you give us back our bodily autonomy and repeal this law?

Your doing so, however, won't help my daughter. For her, it is too late. She and the other victims of Obamacare will need Government healthcare for the rest of their lives. But the rest of us and for those yet unborn, it is not too late.

And to put this another way, and this may sting, but when you come back into power, please, for the love of God, no more Paul Ryan-style tax cuts, which the other side will just eliminate or destroy by inflation as they're doing now. The State takeover of the human person by authoritarian control of medicine is far more worthy of your attention than any tax cut, no matter how deep.

I thank both sides for the time given me to air my concerns.

Chairwoman MALONEY. Thank you.

Mr. Starghill, you are now recognized for your testimony.

**STATEMENT OF BISHOP WALTER STARGHILL, JR., DETROIT, MICHIGAN**

Mr. STARGHILL. Well, thank you for allowing me to be part of this testimony and this great information that needs to be given out.

I'm Bishop Walter L. Starghill, Jr., Eastern Michigan pastor of Face-to-Face Outreach Ministries. Thank God for Congresswoman Tlaib allowing me to be a part of the solution or the answer to bear witness what has happened to me.

One of the things back in 2009, I was uninsured, pastoring. During the great migration out of the Michigan area, my membership dwindled. So, therefore, we didn't have the proper funding to make sure that I had insurance. So, therefore, I was uninsured.

I had a condition which is called shingles that I didn't know I had, and at the time, I was feeling very bad. I went to actually one

of the major hospitals at about 1 or 2 in the morning, which was an emergency, and I told them I didn't have insurance.

They saw me, but they gave me the bare minimum. They checked my pulse. They checked my blood pressure and told me I may have shingles. But after that, they gave me a bill of \$800. Now I couldn't afford it. It took me almost 6 to 7, 8 months just to pay that money back.

But as a friend of mine told me that they had a clinic, which is the Western Wayne Family Health Center. It's a federally funded clinic, and could you possibly come up to them and see what they can do for you? So as I got worse and worse and as a person that didn't have insurance, you are very susceptible to just worry, worry, worry. And I was worried. So that made the condition even worse.

So I finally went up to the clinic and filled out all the paperwork that they had to do for me, and they gave me a \$20 copay. So as they were doing that, filling out my paperwork, I had—over the time from the emergency room to the actual clinic, I had rashes all over the right side of my face, all the way going down my nose, and my eye, my right eye started to close. I was like Worf from Star Trek. I was in a bad situation.

And as they gave me a shot, immediately that actual shot started to move everything back. So I thank God for that. And before that happened was, like I say, if I didn't have that clinic, I might have lost the sight in my eye. Yes, sight in my eye.

Again, I had a scenario as a pastor. We went to Niagara Falls with our church. Fifty-six people went there, and we enjoyed ourselves. The weather was quite hot that day, and on the way back, one of the mothers fell ill. So we called 911—we were in Canada—and they came, picked her up in the ambulance, took her to the hospital, and ran every test that they had to run. And as they were doing that, we started to wonder how much the bill was going to be.

And after they got her stabilized and everything up and running so she was able to travel back with us, I asked the doctor, well, how much is this going to be? The doctor said, as I was holding my breath, that it was \$70 Canadian, which was \$40 American. I quickly paid the \$40 and got back on the road.

Now, I don't know. America is the greatest country in the world. Yes, we do have some issues with affordable healthcare. Yes, we need to fix it. That's why we're here today.

But the bottom line is I am one of the 30 million people that was not insured. I'm not talking about underinsured, but actually had no insurance. Now I'm able to live life and go to the doctor, go to the dentist, go to specialists now. So, therefore, I can live a confident, great life, yes, myself. But the bottom line is that we got to look at doing things better for the people.

I thank you for this time, and I want you—I feel for the man that his daughter had these issues. But again, that's why we're here today is to talk about both sides where you can come with solutions that will help all of us obtain affordable healthcare.

Thank you for my time.

Chairwoman MALONEY. Thank you. The gentleman yields back.

And we now hear from Ms. Templeton. You are now recognized for your testimony. Ms. Templeton?

**STATEMENT OF LESLIE TEMPLETON, BOSTON,  
MASSACHUSETTS**

Ms. TEMPLETON. Good morning, everyone, and thank you for having me.

My name is Leslie Templeton, and it's a pleasure to be here. I am a 25-year-old disabled person, and some of my diagnoses include epilepsy, kidney disease, ADHD, familial hypercholesterolemia, and depression.

Being 25 and sick is extremely funny. While many of my friends are worried about their careers, finding life partners, and what they're doing next week, I have the added worry about what my future holds regarding my health. I wonder if I'll always be able to access my healthcare and treatments. If, heaven forbid, something goes wrong, and I don't have access to healthcare, what will happen to me?

Sitting before you, I'd be lying if I said there aren't nights I cry about this, scared of it all—of my diseases, of my future, of losing my healthcare. With Medicare for All, these wouldn't be concerns I'd have to live with every day of my life.

I'm fortunate enough to be able to access the lifesaving healthcare I need right now. That is a privilege that has given me the ability to be here today. Before I was able to access treatment, I struggled to do most things or fully participate in life.

I don't know if you'll understand how deeply I mean this, but having access to healthcare has allowed me to be a 25-year-old. My Wellbutrin, an antidepressant, has given me the ability to enjoy life. My kidney medication is slowing, if not preventing, further progression of my kidney diseases, ensuring I feel well enough to live my life the way I want to.

And there's so much more. I am fortunate enough to be able to afford these interventions currently due to my income level, a privilege not everyone has. Being sick is expensive, and that expense makes treatment inaccessible to so many people. Being able to access healthcare is not enough. It's being able to afford it, too.

As long as I can always have access to healthcare and I can afford it, I will be able to hopefully live a long life. I'll get married. I'll see my kids graduate from college. I'll grow old and watch my body age gracefully. Without Medicare for All, that outcome is not guaranteed, just as it's not guaranteed for millions of Americans right now.

What people don't talk about enough is the cost of staying alive. My ability to live is based on whether I can afford it or not, and that thought keeps me up at night. So many people are in a similar situation to me. Just look at GoFundMe. People shouldn't have to rely on charity to stay alive.

To put it bluntly, I don't want to die. I want to live a long life without constant worry of whether I will be able to afford my meds each month or I'll have insurance to cover my doctors' visits. Medicare for All would give every American that peace of mind, especially those who rely on the healthcare system the most in order to stay alive.

No one should go broke because they have a life-threatening illness. No mother should have to choose between getting her medication or her kids'. No child should have to watch their parents suffer through pain and ailments because they are not insured.

We Americans are counting on you to change this reality for us because, again, to put it bluntly, we don't want to die.

Thank you.

Chairwoman MALONEY. Thank you, and I would like to thank all of the witnesses for their powerful testimony today. You are now excused, and we will welcome our second panel. Thank you so much.

We will pause a moment as we make a transition.

[Pause.]

Chairwoman MALONEY. I would like to introduce our second panel of witnesses.

Our first witness today is Dr. Uché Blackstock, who is an emergency physician and is the founder and CEO of Advancing Health Equity.

Then we will hear from Dr. Sara Collins, who is the Vice President of Health Coverage and Access at the Commonwealth Fund.

Next we will hear from Grace-Marie Turner, who is the President of the Galen Institute.

Next we will hear from Dr. Jeffrey Sachs, who is the Director of Columbia University's Center for Sustainable Development and is the President of the United Nations Sustainable Development Solutions Network.

Next we will hear from Dr. Jamila Michener, who is an associate professor at Cornell University and is the Co-director of Cornell's Center for Health Equity.

Finally, we will hear from Ady Barkan, who is the founder of Be A Hero.

The witnesses will be unmuted so we can swear them in. Please raise your right hands.

Do you swear or affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

[Response.]

Chairwoman MALONEY. Let the record show that the witnesses answered in the affirmative.

Thank you. Without objection, your written Statements will be made part of the record.

With that, Dr. Blackstock, you are now recognized for your testimony. And please, let us all try to keep within our five minutes.

Dr. Blackstock, you are now recognized.

**STATEMENT OF UCHÉ BLACKSTOCK, M.D., EMERGENCY PHYSICIAN, FOUNDER AND CHIEF EXECUTIVE OFFICER, ADVANCING HEALTH EQUITY**

Dr. BLACKSTOCK. Hi, can you hear me? OK, hi, everyone.

Thank you, Chairwoman Maloney, Representatives Bush, Pressley, Tlaib, Ocasio-Cortez, and all of the members of the House Oversight Committee here today. It's an honor to be invited to testify during this very important hearing, a key step toward addressing racial health inequities in our country.

I'm Dr. Uché Blackstock, an emergency medicine physician with over 17 years of clinical experience, a second-generation black woman physician with lived experience with injustice, and the founder of an organization dedicated to advancing health equity. I have worked for years in communities where far too many of my patients were either uninsured or underinsured, mostly black and brown Americans who have sadly been disregarded by our country.

They are not only dealing with mental and physical health issues, but also with systemic afflictions like bias and racism, housing insecurity, economic instability, and lack of access to reliable transportation. These are what we call the social determinants of health, the factors which influence the health and health outcomes of communities and people.

Lack of access to healthcare is one of the primary social determinants of health. I've taken care of thousands of patients over the years, many I could never forget.

The 40-year-old black man with a history of high blood pressure who came into my ER unconscious on a stretcher after he collapsed at home in front of his family. The paramedics were performing CPR on him. The CAT scan of his head showed a brain bleed, a complication of untreated high blood pressure. He had been unable to afford to pay out-of-pocket for his blood pressure medication since he lost a job a year prior and, as a result, his health insurance.

The 55-year-old Latina woman who came into my ER complaining of bleeding and swelling from her left breast for several months. She explained that she did not have health insurance and did not have a primary care physician.

After we spoke, I examined her and found a foul-smelling mass protruding from her left breast. It was advanced breast cancer.

As Black people and people of color, just living in this country is an act of survival, let alone being able to access quality and culturally responsive health care. The ongoing COVID-19 pandemic and the country's presumed reckoning with racism has only exposed the deep preexisting fissures in our health care and public health system.

Despite advances in health care innovation and technology over the last 75 years, Black men still have the shortest life expectancy, Black women have the highest maternal mortality rates, and Black babies have the highest infant mortality rates.

Overall, Black Americans have a six-year life expectancy gap compared to white Americans, the widest gap since 1998 and widened even more by the pandemic. This pandemic should have been a wake-up call to help us understand the urgency of identifying a path toward making universal health care a reality, among other critical strategies to improve health equity.

I have had a front row seat to the tragic loss of Black and brown life from COVID-19 and racism. During the height of the pandemic in New York City, I noticed my patients' demographics quickly shifted to more racially and socioeconomically diverse patient population to mostly Black and brown patients.

They were essential workers, service workers. Some had underlying medical problems. Others were left with no choice but to use

public transportation and many live in crowded multi-generational housing.

I vividly remember an elderly Black man who came into my urgent care with shortness of breath and fever. He was in a wheelchair and his oxygen level was shockingly low. He lived alone.

I was very worried that he had COVID pneumonia and asked if I could call an ambulance to bring him from urgent care to the closest ER. He refused. He didn't want to die in the ER, he told me. He didn't think he would receive good care because he didn't have health insurance. He felt safer at home.

For many years, I worked in two ERs in New York City, Bellevue Hospital, the oldest public hospital in the country, and Tisch Hospital, a private institution that is part of NYU Langone Medical Center, among the wealthiest hospitals in the country that have gotten hundreds of millions of dollars richer after Federal bailouts.

At these two ERs that, literally, sit next door to each other, I experienced firsthand deep inequities in our health care system, one that is separate and unequal. Patients were divided up based on insurance and race.

Nationally, at private academic medical centers, Black patients are two to three times less likely than white patients to receive care, while uninsured patients overall are five times less likely than patients with insurance coverage to be treated.

In cities across this country the top-ranked hospitals do not treat as many patients of color as white patients, even when they are located in diverse communities.

This is the definition of systemic racism. People who look like me are living this every day. But it should not fall solely on us to always have to call out when something is wrong.

Now is the time to protect our most vulnerable and underserved communities and identify a pathway to ensuring universal health care for all Americans. We must work to break the cycles of trauma and injustice, to foster generational progress for more people, especially people of color because it is cruel to talk about an American dream when only a select few live to see it.

Thank you.

Chairwoman MALONEY. Thank you so much, Dr. Blackstock.

Now we will hear from Dr. Collins. You are now recognized for your testimony.

Dr. Collins?

**STATEMENT OF SARA R. COLLINS, PH.D., VICE PRESIDENT OF HEALTH COVERAGE AND ACCESS, THE COMMONWEALTH FUND**

Dr. COLLINS. Thank you, Chairwoman Maloney, Ranking Member Comer, and members of the committee for this invitation to testify on past universal coverage.

My comments will focus on gains in coverage since the passage of the Affordable Care Act, the effects of the pandemic and Federal relief efforts on coverage and policy options to cover the remaining uninsured, and lower consumer costs.

The ACA brought sweeping change to the U.S. health system, expanding comprehensive and affordable health insurance to millions

of lower and middle income Americans and making it possible for anyone with health problems to buy insurance.

The number of uninsured people fell by nearly half after the ACA became law, dropping from 49 million people to a low of 28 million in 2016. There has been a slight uptick since then.

Research shows that the ACA lowered financial barriers to care and improve people's ability to afford health insurance and get needed care. Despite expectations that the pandemic would leave millions uninsured, the latest Federal data indicate that the uninsured rate is actually declining. This decline is due in part to the ACA's coverage expansions which provided safety net coverage for those who lost insurance and Federal COVID-19 relief bills that provided enhanced marketplace subsidies and a requirement that States keep people in Medicaid continuously enrolled in exchange for enhanced Federal matching funds.

The result was record enrollment of nearly 15 million people in the marketplaces and nearly 84 million in Medicaid and the Children's Health Insurance Program.

There are four risk factors that could reverse these gains and limit the ability of Americans to afford their health care. The end of the Medicaid continuous enrollment requirement and the enhanced marketplace subsidies could trigger extensive enrollment losses in Medicaid as States redetermine enrollee eligibility and in the marketplaces as subsidies decline.

Twelve States have yet to expand eligibility for Medicaid. Millions of people are eligible for the ACA's coverage expansions but are not yet enrolled. Growth in health care costs is outstripping growth in median income, leaving millions of people under insured and with growing premium burdens.

There are several targeted policy options that might mitigate these risks including extending the marketplace subsidy enhancements at the end of the public health emergency; requiring States to conduct Medicaid eligibility redeterminations gradually; fill the Medicaid coverage gap; maintain aggressive, targeted, and consistent outreach enrollment efforts to reach the remaining uninsured and keep people covered; enable people to automatically enroll in coverage; address the high provider prices that drive most of the health spending growth in private insurance and, by extension, growth in worker premium contributions and deductibles, such as through a public option.

Allow more workers in expensive employer plans to access marketplace subsidies. Fix the family coverage glitch. Rein in deductibles and out-of-pocket costs and marketplace plans. Ban non-ACA compliant policies like short-term plans.

But how can the U.S. reach universal coverage? Can we get there by building on the ACA or will it take a single-payer approach? This question was debated during the 2020 Presidential election. The Urban Institute tackled it at the time by modeling reforms that built on the ACA in two versions of a single-payer approach.

The ACA approach included auto enrollment and a public option that lowered provider plant prices close to Medicare rates. Urban found that it was possible to reach near universal coverage with this ACA approach as well as with the two single-payer approaches.

They also found that the ACA approach and one of the single-payer approaches reduced national health expenditures, even though nearly everyone is covered. This is because both approaches reduce private insurance prices paid to providers closer to Medicare rates.

The debate at the time focused not on this fact but on the increase in Federal costs under a single-payer approach. But what commentators failed to point out was that this higher Federal cost was not because the single-payer approach was so much more expensive than our current system but that all of the responsibility for financing that spending shifted away from employers, households, and State governments to the Federal Government.

We need to have reasonable discussions as a country about how to share our healthcare spending responsibilities. But it is not just about who pays but also about how much we pay and why and what we are getting for our spending.

The U.S. has one of the most expensive health systems in the world and, yet we rank last among high income countries on most measures of health system performance, including access to care.

Prices paid to providers in private insurance is one of the primary reasons we spend so much more. As we consider strategies to expand health insurance coverage and lower consumer costs, and as we weigh the benefits of those strategies against their Federal costs, it is critical that the prices paid to providers in private insurance be part of the discussion. Thank you.

Chairwoman MALONEY. Thank you, Dr. Collins.

Ms. Turner, you are now recognized for your testimony.

**STATEMENT OF GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE**

Ms. TURNER. Thank you, Chairwoman Maloney, Ranking Member Comer, and members of the committee and Representative Jayapal—lovely to see you again—for your sponsorship of the legislation we are considering today.

So I would like to emphasize what I believe are widely shared goals for health reform and achieving universal access to care, coverage that is affordable, protecting the—protecting quality and choice, and especially providing a strong safety net for the most vulnerable.

There is no question that Americans are frustrated with our current health care system. Millions remain uninsured, and even for those who do have insurance, coverage and care cost too much. Many face deductibles that are so high that they say they might as well not be insured.

But the more government gets involved, the more that we see the health sector is forced to comply with countless rules and regulations rather than innovating to respond to more choices of more affordable care and coverage for patients.

Wharton Professor Mark Pauly, University of Pennsylvania, explains that the government exerts great control over our health sector with government affected spending, totally nearly 80 percent and part of that, of course, is actually the government direct spending, which is nearly 60 percent, on public programs. Medicare for All and its derivatives such as Medicare buy-in or a Federal public



option would take us further toward government control of our health sector with fewer choices and where, I believe, vulnerable patients, as we see in so many other countries, with the greatest health care needs would have to fight even harder to get access to the care that they need.

In proposing policy solutions, I believe it is important to begin by clearly defining the problem that we want to solve. The Congressional Budget Office reports that 29.8 million people were uninsured in 2019, two-thirds of whom were eligible for existing public or private coverage but were not enrolled. Most of the remaining one-third were not lawfully present in the United States, a problem for immigration and citizenship policy, rather than health policy.

Medicare for All also would mean that virtually everyone would lose the plans they have now and there would be no choice but the one government-run health plan for 173 million Americans who value their employer-based health insurance including millions of union workers and 64 million seniors with Medicare, including 26 million with private Medicare Advantage plans.

The CBO found that establishing a single-payer system would be a major undertaking that would be complicated, challenging, and potentially disruptive, and that the changes could significantly impact the overall U.S. economy.

Three States—Vermont, Colorado and, recently, California, as I describe in my testimony—came to similar conclusions in shelving their plans for single-payer.

So rather than dramatically expanding the role of government through new or expanded taxpayer-supported programs, I believe we need targeted approaches to address the specific needs of those who are uninsured, underinsured, and especially focusing on those of marginalized communities.

Uninsured rates continue to be higher in certain populations, as we have as we have heard other witnesses say, including Latinos, Blacks, those with incomes below the poverty level, and residents in States that have not expanded Medicaid.

Tragically, it is often the most vulnerable who are left behind when demand for services outpaces resources. Just five percent of the population accounts for more than half of U.S. health spending. Those who are the sickest with the greatest health care needs are most often disadvantaged, as political leaders inevitably have to balance then in between them and the great majority of healthier constituents.

Medicare for All will restrict access to new medicines and treatments, lead to dramatic increases in Federal spending, and really turn back the clock, I believe, on innovations in personalized care.

I concluded my written testimony and will conclude here describing the experience of Janet, a patient from Colorado with multiple health challenges. Janet received coverage under the ACA but said her access to care was far worse than the State-run high risk pool that she had participated in before, even though her premiums and co-payments were much higher.

I worked with a number of policy experts through the Health Policy Consensus Group to focus on policy recommendations for patient-centered reform and I also commend the Healthy Future

Taskforce that is underway here with a number of solutions to, again, move toward solutions but in a patient-centered way.

I would welcome the opportunity to work with you to achieve the goals of access to more affordable coverage for everyone, better protection for the vulnerable through targeted solutions.

And thank you for your invitation to testify. I look forward to questions.

Chairwoman MALONEY. Thank you, Ms. Turner.

Dr. Sachs, you are now recognized for your testimony, and I understand you are testifying from Berlin.

**STATEMENT OF JEFFREY D. SACHS, PH.D., DIRECTOR,  
COLUMBIA UNIVERSITY CENTER FOR SUSTAINABLE  
DEVELOPMENT, PRESIDENT, UNITED NATIONS SUSTAINABLE  
DEVELOPMENT SOLUTIONS NETWORK**

Dr. SACHS. I am, indeed, Chairwoman. We have multiple crises in the world and one of them, unfortunately, is nearby here.

Let me proceed expeditiously for you. Thank you for the hearings. If you could move to the next slide.

[Slide.]

Dr. SACHS. The U.S. system is completely broken. This is the main point. We are spending a fortune, unlike every other country, and we are getting worse outcomes. This is what needs to be understood beyond the ideology, beyond the anecdotes. We are going broke from a system out of control, and this is from the wonderful Commonwealth Fund report. I think you are going to have a witness from Commonwealth Fund. They do great work.

And what you see is the top line is the U.S. spending percent of GDP. This goes up to 2019, about 18 percent of GDP. Now we are almost 20 percent of GDP in the most recent data.

Look at all the rest of the countries, all of them. We are broken. If you move on, it is the same story. We are broken. Here, all of the other countries have higher life expectancy than the United States and the gap is widening dramatically. We are broken. We spend far more on health care, we get far less, because we don't even have a healthcare system. We have a hodgepodge of private overpriced monopolies, whether for profit or not for profit. I will say a word about that later on. But this is a broken, unfair, out of control costs system that doesn't deliver.

Next, please.

[Slide.]

Dr. SACHS. So I referred to the Commonwealth report. You could go on to the next slide.

[Slide.]

Dr. SACHS. We rank last—last—in our health system performance and we rank last in access to care, last in administrative efficiency, last in equity, last in health care outcomes.

Let us stop with the individual anecdotes and just look at our system compared to the rest.

Next slide, please.

[Slide.]

Dr. SACHS. This, again, we spend more—that is on the horizontal axis. On the vertical axis is performance. The U.S. is that little dot

on the bottom right, expensive and poorly performing. All the rest of the countries less expensive and better performing.

Next, please.

[Slide.]

Dr. SACHS. We spend a fortune in administrative costs. When you go into a doctor's office or a hospital, you spend hours, in the end, either before or during or after, filling out forms trying to get reimbursed, trying to figure out what is covered, who is in the network, who isn't in the network. I can tell you even with a physician and Master's of Public Health, Ph.D. degrees, it is almost impossible to navigate the U.S. system now and the result is administrative costs out of control, unlike any other country.

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[Slide.]

Dr. SACHS. Again, we are spending 10, 15, even 20 percent of outlays on administration, people that are working—hundreds of thousands of people employed to move between different accounts because it is private this, it is private that, who is going to reimburse this, who pays for that. It is unbelievable the amount of time we are burning in order to run this ramshackle nonsystem.

Next, please.

[Slide.]

Dr. SACHS. The expenditures continue to soar, and in 2020 we reached almost 20 percent of GDP, basically, twice what other high income countries are spending that are getting the same or better outcomes than in the United States.

This is what I would plead for the committee. Look at the rest of the world. Not at our own internal, ideological, bizarre discussion, but at the comparison with what is happening elsewhere because there are so many solutions abroad.

Next.

[Slide.]

Dr. SACHS. Life expectancy stopped rising a decade ago. It is falling in the United States. When will we understand we are falling apart in this country and our health system doesn't deliver? It doesn't deliver preventative health.

This tragic story of Dr. Blackstock of the patient who comes in with advanced breast cancer who couldn't afford to be seen beforehand, that is a system? That is the United States of America?

It is shocking and it shows up in the most basic measure of societal performance. No, not GDP, life expectancy, which is falling in the United States because we are becoming completely dysfunctional.

Next, please.

[Slide.]

Dr. SACHS. We are at the top of avoidable deaths. Again, from the Commonwealth Fund, if you look in detail at what the cause of deaths are, these are preventable deaths. But the United States has the most of them and it has the least reduction of them of all of our peer countries.

Next, please.

[Slide.]

Dr. SACHS. Costs for low income populations. Well, we have heard this repeatedly—out of control, unlike all of our peer coun-

tries. We are the country all the way to the right hand side. We look different from all of the rest of the countries.

Next, please.

[Slide.]

Dr. SACHS. We have, as you know, an epidemic even before COVID of deaths of despair. We have soaring deaths from suicide, from substance abuse, opioid overdoses, and so forth, for people who are battling economically as well, and so you see the biggest rises for the white population with no college degree. This is an absolute shocking epidemic in the United States of America without a health system to address it.

Next, please.

[Slide.]

Dr. SACHS. We have vast differences across the States. Typically, as is true in U.S. politics, the States farthest behind are the ones most defending the status quo. Very sad. But this is how our politics is absolutely upside down.

Instead of a system that could work, we have an opposition to State control, as if we have a functioning market system.

Next, please.

[Slide.]

Dr. SACHS. What we have is a scam going on. Please understand. We have the most high-priced high-cost system and we have a system that is filled with its sense of success because they are making a fortune.

This is what I clipped from the Wall Street Journal list of our CEOs of our pharmaceutical industry. What do you want, \$20 million salary? Twenty-five million a year salary? Thirty million a year salary? That is the game of the United States of America health care system.

Chairwoman MALONEY. Dr. Sachs—

Dr. SACHS. Yes?

Chairwoman MALONEY.—you are way over time. It is fascinating. Way over time.

Dr. SACHS. I am sorry. Can I come quickly to an end? I will come—just next slide. I will come very quickly to an end.

[Slide.]

Dr. SACHS. Our not for profit hospital administrators are making millions and millions of dollars.

Next, please.

[Slide.]

Dr. SACHS. I will just do—forgive me, Chairperson. I just want to make two more points.

Chairwoman MALONEY. Please—OK. All right.

Dr. SACHS. This is an incredibly profitable industry. That is where the high prices go.

Next slide.

[Slide.]

Dr. SACHS. This is the biggest lobbying industry. I don't have to say this in congressional testimony. Everybody knows it. This industry lobbies a fortune and makes a fortune. It is a scam, and we should compare with the rest of the world and see what we are getting. We are wasting a trillion dollars a year that is going into administrative costs—

Chairwoman MALONEY. Thank you.

Dr. SACHS [continuing]. High costs for products, for prices, for devices—

Chairwoman MALONEY. Thank you.

Dr. SACHS [continuing]. For hospital care. Thank you very much, Chairwoman.

Chairwoman MALONEY. Thank you. Thank you. The gentleman yields back.

And now, Dr. Michener, you are now recognized for your testimony.

**STATEMENT OF JAMILA MICHENER, PH.D., ASSOCIATE PROFESSOR, CORNELL UNIVERSITY DEPARTMENT OF GOVERNMENT, CO-DIRECTOR, CORNELL UNIVERSITY CENTER FOR HEALTH EQUITY**

Dr. MICHENER. Thank you, Chairwoman Maloney, and the members of the Oversight Committee and everyone who is here today.

My name is Jamila Michener. I am an Associate Professor of Government and Public Policy at Cornell and also co-director of Cornell Center for Health Equity. I am going to focus today in my comments on underscoring the role of universal health insurance coverage, particularly in addressing racial health inequities, but also in terms of strengthening our democracy.

So health equity has never been a reality for people of color in the United States. It has never been a reality for Black, Latinx, or indigenous people in the United States. Notwithstanding changes that have happened over time and some improvements that have occurred, we have seen persistent and continual disparities.

Consider just a few examples that are striking and contemporary. Black and indigenous Americans live for fewer years, on average. Black and indigenous Americans are more likely to die from treatable preventable conditions. They are more likely to die when there is no need for them to die on account of a lack of access to health coverage and health care.

Black people are at a higher risk for chronic health conditions like diabetes and hypertension. They are more likely to die from breast cancer and colon cancer. Importantly, this is particularly because of late stage diagnosis and differential treatment.

Black and indigenous women are more likely to die during or after pregnancy, to suffer serious pregnancy-related complications and they are more likely to lose children in infancy.

All of these things, of course, were exacerbated and became worse during the pandemic, and the few disparities that I just discussed are only the tip of a much, much larger iceberg, an iceberg that this country has been crushed under since before it was even the United States.

Crucially, these inequities are a product of systemic forces, not individual choices. This isn't about people being able to choose. In fact, it is about the lack of options, the lack of ability to have equitable access, and much of this lack is grounded in systemic racism.

Systems of racial stratification shape whether you live in a neighborhood that will promote your health, whether you have access to resources like health insurance to sustain your health, whether you have daily experiences with things like discrimination

that might undermine or threaten your health, and importantly—and I will address this shortly—whether you have influence over the political processes that can be activated to protect your health.

Inequitable health insurance is a key factor that contributes to this range of disparities. So the fact that people of color have lower access to health insurance is a significant, life-threatening, policy-altering problem. Unequal, unstable, unaffordable, and constrained access to health insurance contributes to people of color experiencing their healthcare system as profoundly discriminatory and difficult to navigate.

People of color are more likely to delay care or forego treatment. They are less likely to and struggle to adhere to prescribed medication and treatment regimes and, again, these disparities are not lessening. If anything, they are widening.

Access to health care is an ethical and human rights principle. It means that everyone has a fair—health equity, rather—it means that everyone has a fair and just opportunity to be as healthy as possible and, of course, access to health insurance is a critical determinant of whether health equity could be a reality.

I want to spend the last bit of my time here pointing something really important and often overlooked out. Over and above the noted material and health benefits of having access to health coverage, which we have heard quite a bit about today, that access would provide people who receive that coverage with a strengthened position in our democracy. It would reinforce their civic status and reinforce our promise as a country, as a polity, of full inclusion for all. This connection is not obvious.

But social scientists—political scientists, in particular—have established that health and health policy are crucial for democratic—full democratic participation. Medicaid is a perfect example. Medicaid expansion is associated with boost in voter turnout.

Disenrollment is associated with declines in rates of voting. Medicaid beneficiaries and their ability to participate in politics is a function of their experience with the program.

This is not about partisan politics or electioneering. It is about ensuring that people with the most at stake, with the most to lose here, many of the people we have been using in our anecdotes, that they actually have meaningful influence over the political processes that determine their ability to thrive and survive, and we know that that influence happens when, in fact, they have access to the resources that they need to allow them to be full and equal members of our democratic polity.

I want to end with words from a Medicaid beneficiary from systematic qualitative research that I did. This is a woman from Georgia named Lucy. She says, I think a lot of people on Medicaid and without insurance are scared that their voice is not going to be heard, at the end of the day, that no matter how much you protest or how much you call on those in higher upper seats, it is as if our voices don't matter. And people think, why should I even say anything? It is not going to change.

But in actuality, it might just be that one vote that pushes us to change everything. But to us sitting down here, looking at those up there, it is like our voice—what is my little voice going to do?

Lucy and other people who are fighting for health equity, especially racial health equity, in this country have voices that we ought to be responsive to. Universal health coverage is part and parcel of precisely that responsiveness.

Thank you.

Chairwoman MALONEY. Thank you, Dr. Michener.

And Mr. Barkan is our last panelist and you are now recognized for your testimony.

**STATEMENT OF ADY BARKAN, JD, FOUNDER, BE A HERO**

Mr. BARKAN. Good morning, Chairwoman Maloney, Representative Bush, and members of the committee. Thank you for holding this hearing and inviting me to testify.

My name is Ady Barkan and I am the co-executive director of Be A Hero, an organization whose mission is to win health justice in America.

As you can see, I am currently in bed. I live in California and it is rather early here, and because I am living with the neurological disease ALS, which has left me almost completely paralyzed, it takes me a very long time to get ready in the morning. So I am grateful for your grace in permitting me to participate from bed.

But I am even more grateful that it is my bed in my bedroom, in the home I share with my wife and our two young children. I am able to live at home because I have 24-hour home care. Without it I would be forced to live in a nursing home separated from the people I love.

I don't know if that would be a quality of life that I would be willing to tolerate. Home care is, literally, keeping me alive.

Three years ago, I came to the Capitol to testify in the Rules Committee as the first ever hearing about Medicare for All. I was emaciated, weighing about 100 pounds, down from 160. I had trouble breathing and was sweating even though the room was cold. Every month, my body deteriorated further. I felt like I was dying.

Later that year, I had to decide whether to get a tracheostomy, a procedure to implant a breathing tube into my windpipe to compensate for my failing diaphragm. But I didn't know how I would be able to pay for the care that would allow me to stay alive.

My insurance had already denied me a ventilator, stating that it was experimental, and then two weeks after that, they rejected access to an FDA-approved ALS drug. Even good health insurance, which I have, does not cover the long-term home care I need to survive. Paying out of pocket would have left my family bankrupt quickly.

And so for too long after my diagnosis, my wife, Rachel, and I tried to get by without homecare, which put the burden on her to care for both my young son and me.

We eventually secured 24-hour home care after suing my health insurance company in Federal court. Home care has been life changing, allowing me to participate in my family's life in ways I thought were no longer possible for me.

My daughter, Willow, was born six months after I gave my testimony and now I am a father to two beautiful wild children. But it shouldn't take a seasoned activist, a team of lawyers, and the

generosity of strangers and friends to get the health care you need to survive. The reliance on crowdfunding to afford healthcare is a uniquely American tragedy. My outcome is the exception. But the challenges we face fighting insurance companies for services we are rightfully owed are not.

We spend such absurd amounts on health care and we get such bad outcomes for our money. The high cost of care and infuriating bureaucracy burdens all of us, including nurses and doctors, working families and small businesses.

The only people who benefit from this absurd system are the corporate executives who profit off of our pain and spend inordinate amounts of money trying to stop you from making life much better for your constituents.

We have allowed greedy health care corporations to set the parameters of what we can expect of our health care system, and because of it, we have been forced to normalize the fate of bankruptcy, illness, and death.

It is shameful that in the richest country in the world we choose to inflict so much suffering. Since that first hearing about Medicare for All, our country has been through the worst public health crisis in a century.

The pandemic has revealed and exacerbated the existing inequalities in our profit-driven health care system. It has hit hardest on disabled people, poor people, Black, Latino, and indigenous people, and especially people who live at the intersections of these categories, and one out of three COVID-19 deaths in the U.S. are related to gaps in health insurance.

Nearly a million Americans have already died from the coronavirus. How much more is necessary to shock our legislators into action? When we lost 3,000 lives on September 11th, we responded by reorganizing our national security system, launching a global war on terror, and conducting two massive invasions and occupations.

Three hundred times more people have died in this pandemic but we have not marshaled our national energy to build a better health care system. It is a scandal and it is a shame.

But in the last two years, we have also seen glimmers of what is possible when our government takes action to prioritize people over profits and works to guarantee care for all.

Congress subsidized the Affordable Care Act marketplace plans, leading to unprecedented enrollment, and paid States to keep millions more people on Medicaid. As a result, more Americans have health insurance than ever before.

Taxpayers funded vaccine research and then our government made vaccines easily accessible to all at no cost, and recently, our government made rapid test kits available to all Americans who requested them free of charge.

These programs and many others are at risk of ending if Congress does not fund them and when the pandemic emergency policies expire. Instead of returning to the status quo, which fails all of us and especially our most vulnerable communities, we should build on the progress we have made during the pandemic.

The American people deserve so much more and so much better. Our seniors and disabled children and adults deserve to live at



home, not be warehoused in institutions. Working people deserve high quality care, regardless of their income or their employer marital status.

The people of rural America deserve good mental health care options, good community clinics, good accessible hospitals, and so do the residents of poor urban America and the people who live on Indian reservations. And seniors on Medicare deserve care also for the parts of their body above their necks, which means their teeth and eyes and ears and minds.

We can and must do better. We know what the solution is, a system that brings everyone in and abandons no one, where we are patients and people, not opportunities for profit. The road to reach the better world of our imagination may be long and there are many obstacles in our way.

But our North Star is clear. It is time for America to guarantee comprehensive, affordable health care to all. The best way to do that is by enacting Medicare for All. If each one of us continues to demand better, if, together, we build an even more powerful movement for health justice, then I know that someday we will get there. Thank you.

Chairwoman MALONEY. Thank you so much for your testimony. I now recognize myself for five minutes for questions.

In 2010, President Obama signed the Affordable Care Act into law, laying the groundwork for over 30 million people to achieve affordable and available health care. Republicans not only opposed this law, but in the past decade have voted over 60 times to repeal or weaken it.

Dr. Blackstock, you gave very moving examples of health care challenges. As an emergency physician who sees patients directly, how does access to health care coverage affect a person's health?

Dr. BLACKSTOCK. Thank you, Chairwoman. Well, I mean, access to health care coverage is key. Unfortunately, what I often see in the emergency department, especially working in the communities that I work in, are people who, because they do not have insurance, will come to the ER sometimes for treatment of chronic medical problems or come for issues like advanced cancer, as I described with the patient that I had, with preventable diseases that have essentially become chronic and even late stage.

And so they are at the point in their disease process where, you know, it is very costly for them to even be able to afford to pursue treatment. And so access to care, essentially, results in improved health for my patients and enables them to—

Chairwoman MALONEY. Thank you. Reclaiming my time—

Dr. BLACKSTOCK [continuing]. Utilize primary services.

Chairwoman MALONEY.—because I want to get to Dr. Michener. You have studied the relationship between access to coverage, health equity, and racial justice. How did coverage gains under the Affordable Care Act advance health justice in the United States?

Dr. MICHENER. Well, coverage gains advance health justice, in particular, in relationship to racial justice by allowing more Black and Latino people to have health coverage than had before and we see this in particular in Medicaid expansion States where the increases in terms of access to health insurance were most striking among Black and Latino Americans. And so that is a key factor.

Of course, it is more challenging in nonexpansion States. So that gives us like a kind of primary lens into the importance of access.

Chairwoman MALONEY. Thank you so much. And in this Congress, I was proud to join over a hundred of my colleagues in re-introducing Congresswoman Jayapal's Medicare for All Act, which would transition the United States to a national single-payer health care system.

So, Dr. Sachs, how would the Medicare for All Act expand access to health care while controlling skyrocketing costs that you pointed out in your testimony?

Dr. Sachs?

Dr. SACHS. Chairwoman, ACA expanded coverage but it did not control prices. We need Medicare for All to do both, to ensure coverage and to ensure a system in which highly concentrated highly monopolized service providers don't charge an arm and a leg—literally, don't charge prices that are twice what other countries pay.

For each procedure—diagnostic, medicines—we are out of control in price. So Medicare for All would ensure coverage, control prices, and, by my estimates, save about a trillion dollars a year for the U.S. economy.

In my world, a trillion dollars a year is not small change. We could use the savings.

Chairwoman MALONEY. Thank you so much. Let me conclude with you, Mr. Barkan, and thank you for your bold advocacy and for your powerful testimony before us today. You remind us all why we are all in this fight.

Why is it so crucial that we achieve universal coverage in the United States?

Mr. Barkan?

Voice. OK. Just a minute while he writes his answer.

[Pause.]

Voice. OK. He is writing.

Chairwoman MALONEY. He is writing it. It takes him a few minutes, if everybody understands.

Mr. BARKAN. We deserve dignity and health. Because we deserve dignity and health.

Chairwoman MALONEY. Thank you. Thank you for your Statement for equity in health. And, in conclusion, as we will hear today, Democrats have proposed a number of different policies to move us toward a universal coverage, including Medicare for All.

Our party has a diverse set of ideas on how to reach this goal. But we stand unified in pushing to make healthcare more affordable and available for every person in the United States.

I thank all of our witnesses for their testimony this morning. I yield back, and now I yield to the gentleman from Georgia, Mr. Hice.

Mr. Hice?

Mr. HICE. Thank you, Madam Chair. We all realize this is a complicated issue but the solution is not government takeover of the health care. It is returning power to the patients, not overwhelming doctors and hospitals with regulations. This is a disastrous pathway to go down.

Ms. Turner, I would like to begin with you, if I may. And I realize it is extremely difficult to try to take the cost issue out of the debate discussion, but I want to try. OK.

So if we were in some magical land where money was no object, in spite of that, are there still problems that exist with a government socialized healthcare system?

Ms. TURNER. Congressman, there will always be resource constraints. That is the world we live in. There are only so many physicians, so many hospitals. They have to be paid. The people that I worry about most in a system like that are the most vulnerable.

I had a father write to me after Medicaid was expanded in his State and he said that there is so many people now on Medicaid that it is almost impossible for him to find a urologist to treat his daughter with multiple health problems. He has to wait sometimes six months for an appointment.

So when you see the people who are most vulnerable having to struggle the most for care, it is because of resource constraints. The studies that have been done on Medicare for All, Congressional Budget Office said that we would likely see physicians paid 40 percent less, hospitals 30 percent less. Many of them wouldn't be able to keep their doors open.

The American Medical College says that they expect at least to have 120,000 fewer physicians. So when we think about putting everybody in the same system, the people who need care the most are the ones who have to fight the hardest for it because the resources are constrained.

Mr. HICE. And what would happen to those who currently have coverage that they like.

Ms. TURNER. I think that is really a major issue. We are a diverse country and your health—our health sector really represents that diversity. And as I said in my testimony, about 175 million people have employer coverage, either employees, retirees, or dependents, they value, including many union workers, 64 million people on Medicare, including about 26 million with Medicare Advantage plans that they have chosen, among many others.

So the disruption of having one single plan following the same set of rules, I think, would find—as diverse and often complicated as our current system is it is because people are responding to top-down rules rather than responding to patients and what they want and I think they want choice and control and diversity.

Mr. HICE. So there is a problem on both sides of the equation. So is it fair to say, in your opinion, that even those who would be—that those currently who need health care that they themselves through the long lines, the waiting periods, all these things—some of the things you mentioned a moment ago—would they be satisfied with a government-run socialized health care system?

Ms. TURNER. Well, you see in the Medicaid program today too many people are forced to go to hospitals—hospital emergency rooms for even routine care and that is because often physicians are paid so little for providing care for Medicaid patients.

I had a physician write to me one time and he said he had taken care of a patient with relatively complex pulmonary problems. When he got his check from Medicaid, after going through all the

paperwork, he got a check for \$0.06. He said, I can only see so many Medicaid patients.

Mr. HICE. Wow. OK. And there are problems with this type of system all around the world where it has been attempted. What about right here in America in Vermont? What went wrong with Vermont's attempt?

Ms. TURNER. So Vermont wanted so much to be able to be the first State to be able to produce the single-payer system and they invested an enormous amount of time, energy, and money in coming up with the—with a plan they thought could work for their State.

And, ultimately, it was rejected because they realized, as happened also in Colorado, that it was really going to tank the economy with the taxes and the resource-forced constraints and that people were going to have fewer choices than they do today.

Mr. HICE. And it will tank our economy if we go that path and provide fewer choices as well. So I thank you for your testimony. I appreciate it a great deal.

And with that, Madam Chair, I yield back.

Chairwoman MALONEY. The gentleman yields back.

The gentlelady from the District of Columbia, Ms. Norton, is now recognized.

Ms. NORTON. Thank you, Madam Chair. This is a very useful hearing. We are learning what the Affordable Health Care Act has achieved so that we can evaluate what more needs to be done to improve it until we get universal health care. This is, certainly, far less than what it is that we want in the long run.

When I look at last year, 11 million people used the ACA marketplace. Fourteen million people—and this one is particularly important—have enrolled in Medicaid as a result of the ACA's Medicaid expansion, and I think it is important to note that millions of people have benefited from the ACA's protections for people with preexisting conditions. So it has done a great deal.

But, Dr. Collins, let me ask you how the ACA has improved the economic security of families in the United States, particularly those who have historically struggled for access to health care.

Dr. COLLINS. Thank you very much, Congresswoman. Lots of research has shown that we have not only—the ACA has not only led to enhanced insurance coverage and dramatically reducing uninsured rates but it is also lowered financial barriers to care, reduced people's medical debt burdens, reduced out-of-pocket spending for a lot of people who have had preexisting conditions, for example, prior to the Affordable Care Act's reforms.

So this has been a substantial change both for coverage rates but also for reducing—for improving people's financial security.

Ms. NORTON. How much, Dr. Collins, have people in the United States saved in out-of-pocket healthcare costs since the passage of ACA?

Dr. COLLINS. It varies quite a bit by States and the type of coverage people have. But there has been a significant improvement in premiums, what people faced prior to the Affordable Care Act.

When you went to get coverage in the individual market you had to pay the full premium. You do not have to do pay the full pre-

mium anymore. There are subsidies to help you if your income is under 400 percent of poverty.

Medicaid expansion has been substantially important for people with very low incomes, reducing premium costs to zero, very low—very low out-of-pocket spending and cost exposure in those two expansions.

Ms. NORTON. Finally, Dr. Collins, you could help us a great deal. What steps can Congress take to build on the ACA and move where we want to go to universal coverage?

Dr. COLLINS. The Urban Institute has analyzed a set of proposals that shows that we can get to universal coverage by building on the Affordable Care Act: Medicaid expansion in every State, an auto-enrollment mechanism, public options addressing the high provider prices that I talked about in my testimony.

We can get to universal coverage by the building on the Affordable Care Act. It is critically important that we have a way of auto-enrolling or people have a way of auto-enrolling in coverage.

Keeping people on the Medicaid experience of the last—during the pandemic shows how much more enrollment you can get in Medicaid if people can stay on Medicaid rather than having to get on and off all the time. So but it is, certainly, possible to get there by building on the law.

Ms. NORTON. Well, we do know that if it weren't for the ACA millions more people would face catastrophic medical debt or the choice between paying for their medical care or, perhaps, for groceries.

But I do think it is time to build on the progress Democrats secured with the ACA by enacting policies that move us toward universal coverage. That is where we need to go.

Thank you very much, Madam Chair, for this hearing and I yield back.

Chairwoman MALONEY. The gentlelady yields back.

The gentleman from Wisconsin, Mr. Grothman, is recognized for five minutes.

Mr. GROTHMAN. Thank you. There, obviously, are many reasons for the high cost of health care in this country. But as the ranking member on the subcommittee dealing with Homeland and being on the border quite a bit, I always talk to the Border Patrol and they tell me at least one of the draws for people coming here illegally is promises to pick up their health care. Obviously, nothing is free.

Ms. Turner, maybe you could comment a little bit on the effect on health care costs in the private sector as more and more people come here illegally and who is paying for their health care?

And, again, I will remind you that the Border Patrol have told me that they feel that some people are coming into this country not just because the administration, obviously, has somewhat of an open door policy but because they feel they are getting free health care. Who is paying for that health care?

Ms. TURNER. A number of different programs are paying for their health care. They are disproportionate share hospital payments to hospitals that have more patients who cannot pay for their care. You actually see employer plans paying more for coverage because private—because public plans and uncompensated care drives up

the cost. So in many cases, it is taxpayers and it is also people with coverage and private plans.

Mr. GROTHMAN. Right. How many of these people are paid for by a government program and how many directly have to be eaten by the providers?

Ms. TURNER. You know, I was interested to see when I was looking at the CBO study on the uninsured that about half of the uninsured actually—of illegal immigrants actually have coverage. So I think there are different ways for people to get coverage than through—

Mr. GROTHMAN. Right. If somebody comes here and, I suppose, to get coverage from an employer, right?

Ms. TURNER. I would presume employer but they may have actually some private plans that they buy—short-term limited duration plans, other private plans.

Mr. GROTHMAN. OK. When people don't have plans and the number of illegal immigrants in this country—different people argue about 10 million, 20 million, we don't know.

Let us say there are 15 million people here illegally. Obviously, that is going up every month considerably and it is particularly going up in significance if the Border Patrol is right in telling me that some people come here specifically for the free insurance.

Does that cause private insurance or insofar as individual hospitals bill out their billing to go up to compensate for the people that they are—that they have to pay for health care that they are not being compensated on?

Ms. TURNER. Yes, and they—price negotiations are very opaque and complex among hospitals and plans and private payers.

Mr. GROTHMAN. Right, but somebody has got to eat it, right?

Ms. TURNER. Yes. Somebody pays for it.

Mr. GROTHMAN. At the end of the day, the hospital, to pay their mortgage, to pay their employees, if people are coming into that hospital and they don't have insurance but they have to have something being taken care of, and at least I am told that if they have a serious problem at the border we will deliver them to the local hospital and, of course, other people are being shipped all around the country. Those costs are being eaten by the private sector or the individuals who are being billed on an individual basis. Isn't that true?

Ms. TURNER. Correct.

Mr. GROTHMAN. Do you know—does that happen in other countries? Do you know—do you have any idea, like, in European countries where they have—

Ms. TURNER. Actually, other countries have very different ways. There is really no one way that you can say other countries deal with it. But that is—it is a problem everywhere and it rises cost—increases cost for those who do pay for those from those who don't pay or cannot pay.

Mr. GROTHMAN. OK. And I want to talk a little about pharmacy benefit managers. I am under the impression right now a lot of times there are rebates. A lot of times the pharmacy benefit managers wind up eating those rebates.

Could you comment on the fairness and the kind of who is getting the benefits and who is the intended beneficiaries of the rebates offered by the pharmaceutical companies?

Ms. TURNER. Yes. There are large rebates that go through the pharmaceutical benefit managers and they say that that reduces insurance costs across the board. But there are policy proposals that would have those rebates go directly to patients at the pharmacy to actually reduce their costs. I think that would be better policy.

Mr. GROTHMAN. I have a bill like that. So you think that would be a good idea if we care about the individual to make sure that the—and the rebates are intended to go to the consumer, right? Not the pharmacy benefit manager. Is that true?

Ms. TURNER. And we need more transparency so people understand that those rebates are going to the PBMs—and because of the transparency—lack of transparency we don't know where—rather than to the patient.

Mr. GROTHMAN. Thank you.

Chairwoman MALONEY. The gentleman yields back.

The gentleman from Maryland, Mr. Raskin, is now recognized for five minutes.

Mr. RASKIN. Madam Chair, thank you so much. This is an extraordinary and surpassingly important hearing and I hope it will be an historic one. I want to thank you and Representative Bush and Representative Tlaib for your leadership in bringing this forward.

Dr. Sachs' remarkable testimony shows that we are first in health care costs in America, first in administrative costs, first in CEO salaries, and last in access to care, last in equity, and last in health care outcomes, and our colleagues across the aisle just don't want to deal with any of these realities and are now trying to blame the systemic failures of our health care arrangements on undocumented immigrants, which is just an absurd and irrelevant distraction from the real nature of the problem.

Another sign of the sickness of our system is the staggering levels of medical debt that our constituents have, not just constituents of Democratic members but constituents of Republican members, too.

Americans, collectively, owe an astonishing \$195 billion in medical debt and this is a leading and, in many places, the foremost reason for bankruptcy that persons and families go into.

Dr. Collins, let me start with you. What are the leading factors that cause patients and their families to fall into this extraordinary abyss and quicksand of medical debt?

Dr. COLLINS. First, being uninsured is the primary risk factor. So people who are uninsured have the highest rates of medical bill and debt problems.

Second, being underinsured—having a health plan that face really high deductibles or maybe you have a non-ACA compliant policy that doesn't protect you from catastrophic health care costs. That is a second major source of medical debt. But we just have a lot of cost exposure in this—in our health system both through uninsurance and also through underinsurance.

Mr. RASKIN. Around one in five American families are struggling with serious levels of medical debt, and for many people with lower incomes their fear of coming under crushing medical debt becomes a major deterrent to their obtaining critical medical care or even just normal regular checkups.

How does medical debt pose a threat to the health as well as the economic security of families that are working to make ends meet?

Dr. COLLINS. Now, I do find that people who have faced high out-of-pocket costs whether or not they have medical debt or just face really high deductibles make decisions that are not in the best interest of their health.

So they tend to delay care, delay filling their prescriptions, just not getting care until it is—until it becomes very, very serious. And when they do get care they have—incur a lot of debt and have a lot of downstream financial problems like ruined credit ratings.

Mr. RASKIN. My family lived in France for a year, and just in our first month there our youngest daughter came down with just a piercing earache. She began to scream and we called some French friends and asked what to do. They told us to call a service that is connected to their national health care program.

In 20 minutes, somebody knocked on our door. It was a doctor. Came in, diagnosed Tabitha as having strep throat, wrote a prescription that we were able to fill downstairs. And asked if we were citizens. We said no. Asked if we were a member of the national health care plan. We said no.

They said they would have to charge us as strangers and that would be 20 euros that we had to pay. And they had a certain number of pediatricians assigned to each neighborhood that worked with us.

So when people talk to me about universal health coverage it sounds pretty good. But what are the statistics? What do they show about whether millions of people in France and other countries are facing crushing medical debt the way tens of millions of our people are facing crushing medical debt? Does that exist in countries with the dreaded universal health care, or what our colleagues are denouncing as socialized medicine?

Dr. COLLINS. No. People in other high income countries have—face much lower out-of-pocket costs. Just a striking difference between here and—there and the United States.

Mr. RASKIN. So, Dr. Sachs, let me ask you about this. You know, they called Social Security socialism. They called Medicare socialism. They called ACA socialism. So, of course, they are calling universal health coverage socialism. So but hasn't the progress of our system been about taking public responsibility, for making sure that everybody has access to health care?

Dr. SACHS. Every other high income country, Congressman, has found the solution to the problems that we are grappling with, and all of the stories that we hear avoid the most basic point, which is all the other countries have solved these problems. We have not.

The reason we have not is that we have a system that is geared toward not just private profits, massive profits of the hospital system, the pharmaceutical system, and massive waste of administrative costs unmatched by any other country in the world by far.



We are wasting hundreds of billions of dollars of billing time, of churning, of not in the network, in the network, can't cover this, dispute this. Nobody does this.

And I would say to Congressman Grothman we are spending \$4.1 trillion right now. How much is that—is undocumented aliens on the border? A pittance. It has nothing to do with that.

It has to do with prices that are out of control in the U.S. And with all the benefits of ACA, which brought people in, it did not create a system of cost control. We need a system of cost control.

And, Congressman, I have had the same experience—

Mr. RASKIN. And thank you so much, Dr. Sachs.

Thank you, Madam Chair. This system is irrational. It is costly. It is unjust. We should move forward with—

Mr. HICE. Madam Chair, his time has expired.

Chairwoman MALONEY. Thank you for your Statement. His time has expired.

The gentleman from Texas, Mr. Cloud, is now recognized.

Mr. CLOUD. Thank you. We keep saying we are having a national discussion on health care and the truth is over the last few years we haven't really had a national discussion on health care.

Too often health care and health insurance get conflated as if they are the same thing. Indeed, the chair, in her opening remarks, claimed that Obamacare expanded health care to 30 million people. That is not exactly true. You could maybe make the case that it expanded health insurance coverage to 30 million people.

But anytime you mandate something by law and say you are going to fine them if they don't have it, there is a probably good chance you are going to see an uptick in the usage of whatever that product is.

But that doesn't mean that it was better. We saw some people who were over insured who didn't need that much insurance. For most Americans, we saw over—a steady decline in what health insurance covers.

Meanwhile, premiums have gone up. Too many times families would even not be able to afford the health care because they are paying for mandated health insurance.

And so it is important for us to remember that health insurance is the middleman in the process and health insurance never—a middleman never decreases a cost. It always increases it. Now, in isolated incidences, it, certainly, should save money and everybody should have some sort of health insurance.

But when we are looking at systemic ways to save money, we probably need to go a different approach than what we have been doing, and what happens too often here in Congress is we, first, pass a program that breaks a system and then we come up behind it and try to be the solution to what we already broke. We definitely need a discussion but the discussion should center on how we provide actual care, how do we open access to care as opposed to mandating insurance for everybody.

Ms. Turner, I would like to ask you why are health care costs increasing in the United States?

Ms. TURNER [continuing]. That.

Mr. CLOUD. I am sure there is a few of them but if you could touch on—

Ms. TURNER. A lot of reasons for that. A lot of it has to do with the lack of transparency. Nobody has any idea how much somebody else is spending on their care and Americans, they want to know those questions.

But to—just to take the ACA as an example, the recent increase in subsidies through the American Rescue Plan put \$17,000—every newly insured person in the American Rescue Plan costs about \$17,000 for—in taxpayer dollars.

But many of those people are dropping private coverage because the subsidies are more attractive to go on the public—to go in the public plan. So I think that we need to look at what are the incentives in the system. Are there incentives for people to get better care, better coverage, more affordable care, get higher quality?

But we don't do that. We run it through rules and regulations, through Federal and State and local spending programs, rather than really trying to engage the same forces that work in the rest of the economy to give people more choices and more affordable products and services.

Mr. CLOUD. It is interesting. You mentioned—we talked about regulation in this committee hearing being a major driver of healthcare costs, but it is interesting you mentioned price transparency in the sense that for elective procedures, for example, we see technology being a driver and when costs are transparent and people are able to price compare, we actually see those procedures in the market actually decreasing over time, where we see, by and large, most of the industry increasing over time because, as you said, what makes capitalism work is the fact that you can shop. And then so we have removed that ability—that accountability metrics—from the system. And so I would agree that anything we could do to put accountability back in the system would help.

We talked about some of the ways that health care costs are increasing. What are some of the ways, maybe some technological breakthroughs, different ways that prices could be lowered in healthcare—that we could lower the costs and, thus, provide access to more people?

Ms. TURNER. I have reported in my testimony about several States that have used a provision in the Affordable Care Act called Section 1332 to be able to repurpose some of the money that is going through the ACA to be able to figure out how can we do a better job of taking care of the most expensive patients who need the most care but they are not able to see the physicians they need because of—everybody is a one-size-fits-all plan.

They make this a much more—a much more focused plan, doing a better job of taking care of the vulnerable. What that has done is reduced prices across the board for everybody else and that brings more people into the market, just as one example.

Ms. CLOUD. One other thing I would like to ask your opinion on in the short time I have left is what nation produces the most medical innovations?

Ms. TURNER. That would be the United States of America.

Mr. CLOUD. So we definitely have some issues we have to fix. But if we were to adopt the same system that does not lead to innovations, the world at large would really suffer.

Ms. TURNER. The world relies on us for innovation—for medical innovations.

Mr. CLOUD. OK. Thank you. I yield back.

Chairwoman MALONEY. The gentleman yields back.

The gentelady from Ohio, Ms. Brown, is now recognized for her questions.

Ms. BROWN. Thank you, Chairwoman Maloney and Ranking Member Comer, for holding this important hearing. Most—across the United States, most people of color are most likely to be uninsured and live in communities with higher rates of uninsurance or underinsurance.

As a result, people of color are more likely to be able to afford critical medical care and more likely to go into medical debt trying to pay for it.

Dr. Michener, let me begin with you. How does uninsurance and underinsurance put people of color at elevated risk for adverse health outcomes and what does this mean for health equity in the United States?

Dr. MICHENER. Yes. So uninsurance and underinsurance through many different mechanisms put people of color at risk. One mechanism is through delayed care, through inadequate care, because not only is care delayed but when you do receive care without insurance it is difficult to adhere to care protocol and regimens. It is difficult to get prescriptions and so on and so forth.

One of the things that I think is important to point out in some of the conversation that has emerged around things like choice and innovation is that when we are talking about disproportionately people of color and people who don't have insurance, in fact, they lack choice in a profound way, and to the extent that we are innovating they are the very people who are not benefiting from any of those innovations.

So if we can have the latest technology and the best procedures but you lack health insurance, you are not able to have access to those procedures or to have access to that technology, and those kinds of circumstances are disproportionately encountered by people of color.

And so when we are thinking about choice, innovation, and other things like that, the question is who will have the choice and who won't? Who will be excluded from that? Who will benefit from the innovation and who will not?

And I think that when we take equity into account it really, I think, undermines the overemphasis on some of these things and, at the very least, point out the importance of balancing that with an emphasis on equity so that we actually have full inclusion.

Ms. BROWN. Thank you very much. So achieving universal coverage is necessary to address those structural inequities in our current health care systems that have historically afflicted communities of color.

So, Dr. Blackstock, how would achieving universal coverage help ensure that patients of color receive high quality care before they become seriously ill?

Dr. BLACKSTOCK. Thank you so much for that question. You know, as I mentioned in my earlier testimony, there are other social determinants of health that are very key in influencing the

health of communities of color, but lack of access to health care is so incredibly important because we need our patients to be able to access primary and preventive health care services.

They need to be connected with primary care physicians and other types of health care providers so that initial diagnoses are made so that they are placed on the proper protocols and medications and so that they are really cared for and managed in a way so that they don't develop these significant chronic medical problems that will impair, really, their ability to live a full life.

Ms. BROWN. Thank you very much. It is clear throughout the testimony today that universal coverage will help eliminate the entrenched health inequities experienced by people of color in this country and, importantly, it will help eliminate many of the barriers to care for people of color that they so often face because of their employment or immigration status.

So universal coverage will create healthier communities so that every person in the United States can thrive and that is what excites me most.

And so with that, I yield back.

Chairwoman MALONEY. The gentlelady yields back.

The gentleman from Pennsylvania, Mr. Keller, is now recognized for his questions.

Mr. KELLER. Thank you, Madam Chair, thank you, Ranking Member Comer, and thank you to the witnesses for being here today.

Socialized medicine is not only the wrong approach, it would be detrimental to our healthcare system and the patients who rely on it. Americans are the ones who are best equipped to make health care decisions for themselves as well as for their families, not the government.

I want to talk a little bit about a personal experience. But before I do that, two names—Alfie Evans and Charlie Gard, a toddler and an infant in the U.K., whose doctors said they would not survive.

So the doctors took the parents to court and were forced to remove their children from life support. One child could have gone to Italy and one could have come to the United States for care. But their government didn't allow them to do it.

I want to talk about 1994 when my son had a brain injury, and he was life-flighted to Geisinger Medical Center, and they performed brain surgery and he came out of the surgery and the doctors told us—they said kids in his condition aren't a 50 percent mortality rate. It is not a 98 percent mortality rate. It is 100 percent mortality rate. And over the coming weeks, we were told to remove him from life support because he was not going to survive.

But we had control of our health care decisions, not the government, and because of that the following year it says Freddie Keller of Kramer is Geisinger's poster child for 1995 in northeastern and central Pennsylvania. He is now 31 years old and works for the health care industry in supply chain, because we had choices over his care, not the government.

So that is socialized medicine. That is universal health care. That is someone, a bureaucrat from the government, deciding what is best for you and your family, not you, and that should never happen in the United States of America. Never.

So I did want to just ask a question to Ms. Turner. Might these policies affect patient wait times for treatment in which patients would suffer most from the increased wait times?

Ms. TURNER. Very powerful story, Congressman. Thank you for sharing that.

We do have evidence of what happens when systems operate under a global budget in other countries and, as you say, you wind up with government making decisions about whose life matters and they do that in sometimes very subtle ways, something called quality adjusted life year, where they decide whether or not your life is worth getting a new medication that may be on the market.

So I think the choice and control issue is profoundly important because it also focuses the system on the patient rather than on bureaucrats making decisions about people's lives.

Mr. KELLER. Just another question. In addition to restricting choices and access to care, would a single-payer public health option truly lower health costs for Americans?

Ms. TURNER. My colleague, Merrill Matthews, from the Institute for Policy Innovation actually looked at the administrative cost savings, and when he made an apples to apples comparison, he said it is not going to save any money administratively because the government is still going to have to make sure that a procedure was provided.

The documentation will have to be there. The person will still have to be paid. There will still have to be all of the paperwork that we have now. It just runs through a different system.

So it is not clear to me to see how it would save, and Chuck Blahous from Mercatus Center says that it would actually cost \$32 trillion over 10 years.

Mr. KELLER. OK. Thank you. You know, this is something that I always say—changing who pays the bill does not make something affordable. All it does is remove choices from people.

Not only would socialized medicine offer patients fewer medical options, limited number of qualified medical personnel in the midst of a healthcare worker shortage, and discourage medical innovation, proposals like Medicare for All would cost the taxpayers an estimated \$32 trillion over 10 years. The cost of government-mandated universal health coverage is simply too huge.

And I tell you what, the cost of my son's life under a system like that that had to be endured by the parents of Charlie Gard and Alfie Evans, I don't want to see that happen to any family in America. The government should not be telling you whether or not your child can receive life-saving medical attention.

And thankfully, here in the United States of America, I didn't have to face that choice in 1994 when I was 28 years old, struggling to make ends meet, and my son is still alive today.

Thank you and I yield back.

Chairwoman MALONEY. The gentleman yields back. The gentleman from California, Mr. Khanna, is recognized for five minutes.

Mr. KHANNA. Thank you, Madam Chair. Thank you for your leadership on Medicare for All and holding this historic hearing.

Let us be very clear that private health care insurance is a crushing tax on working families in this country and on businesses. Working families have to pay a tax of almost \$12,000, if not more,

on the premiums that they pay to private health care insurance and on their out-of-pocket costs.

And businesses in this country are competing with one arm tied behind their back. What is the tax that private health insurance is putting on businesses? Sixteen thousand dollars for a family that businesses are having to pay. That is why they are having to compete in a total disadvantage to many companies and businesses and manufacturers overseas.

In fact, if you talk to CEOs they say the biggest burden on their payroll often is this tax that they are paying to private health insurance. On top of that—and I want to just talk about the economics here—on top of that you have over 23 million Americans in medical debt because of the tax that they are paying to private health insurance.

You have 78 million Americans not able to get the health care they need, not able to treat their kids for the medicine they need or get, in certain care, life-saving treatment—68,000 Americans every year dead because they aren't able to have health care that they need.

This is the current system, and what we are saying is have a tax cut for working families. Have a tax cut for businesses by eliminating the excessive profits of the insurance companies, of the pharmaceuticals, and off the hospital facility fees.

Let us get those deadweight costs out to cut taxes, cut the private insurance tax for working families at a time of inflation. Bring the costs down, bring the costs down for businesses. This would be actually deflationary and it would be one of the largest tax cuts in putting money back in the pockets of working families and businesses.

Dr. Sachs, let me ask you. You are an economist. Can you just explain from a commonsense perspective, if you take out of the system the excessive insurance costs, the excessive pharmaceutical costs, the excessive hospital facility fees, aren't you going to reduce the amount that ordinary Americans are paying and the American businesses are paying, from an economic perspective, into the system?

Dr. SACHS. Congressman, of course you are. It is just bizarre, this discussion that it would be too expensive to lower the health care costs through universal coverage. We just heard it would be an extra \$32 trillion.

This is phony numbers because it doesn't count the saving that comes from eliminating the private premiums, which, as you say, that is a tax on household income. It is all verbiage. The United States is paying twice what any other country pays for health care.

I wish there was some—I wish the opposition—the ranking members would ask me some questions, not just their witness some questions, so we could actually have a discussion.

We are paying nearly 20 percent of GDP. We are paying \$12,000 per person, more than twice what other countries are paying. Shame. It is just absurd. And where is that? It is procedure by procedure, it is hospital stays, it is doctor's appointments, it is devices, because our system is rigged.

From all the campaign contributors that make this the No. 1 lobbying sector in this country, it is rigged for an overpriced health

care system. We could save about a trillion dollars a year for our country to do other useful things.

Mr. KHANNA. Dr. Sachs, I totally appreciate that and, you know, this is why I strongly support Bernie Sanders' Medicare plan, which is a very reasonable plan.

I guess my last point is this. I am not a Ph.D. economist like you but I don't think you have to be a Ph.D. economist understand that if you are—if you have a system where everyone can go to any doctor they want because everyone now is in network under Medicare and you eliminate the middle people—you eliminate the people who are charging the insurance fees, you eliminate the pharmaceuticals who are making their profits in terms of having to negotiate with Medicare, and you eliminate hospitals from just being able to charge whatever they want because they have to negotiate with Medicare, that as a common sense perspective you are going to bring costs down because you are going to not have all those profits.

Am I missing something in that simple explanation?

Dr. SACHS. No. Not only are you not missing something, it is not even hypothetical. It is proven. It is proven in France, in Germany, in Norway, in Denmark, in Netherlands, in Sweden, in Finland. Go look at the data. I live in these countries. I see these countries day by day. It is the demonstrated daily reality.

So it is not theory. It is proven, and the United States is the single outlier because we are driven by greed and by a system of lobbying that imposes this completely overpriced system, which is not a system actually.

And what you said, Congressman, is exactly right. The hospitals charge whatever they want, and we all know that the pricing is a game, completely nontransparent. They charge what they can charge because they are discriminating monopolists. They charge what they can get away with where they can get away with it. There is no market here at all.

Mr. KHANNA. Thank you, Dr. Sachs.

Madam Chair, I yield back.

Chairwoman MALONEY. The gentleman yields back.

The gentlelady from North Carolina, Ms. Foxx, is now recognized for her questions.

Ms. FOXX. Thank you, Madam Chair, and I want to thank our witnesses for coming today.

I have to say that listening to this last interchange, there are some people on this committee and some of our witnesses who live in a Never Never Land—a Never Never Land.

Ms. Turner, today, we have heard a lot about government-run health care such as Medicare for All but we have not heard much about the quality of care. This is not surprising, though. I cannot think of one thing the government does that is both affordable and of high quality.

What would Medicare for All do to employer sponsored insurance and how would this affect the 155 million Americans currently enrolled in employer-sponsored coverage, something that Americans overwhelmingly support?

Ms. TURNER. Well, the Medicare for All would abolish employer-based health coverage and all other current health care programs

so that we would all be under one single plan. And you see—you know, you see employers trying so hard to innovate—providing wellness programs.

Wal-Mart, before the Affordable Care Act was implemented, had computer rooms to help their employees tailor a plan that worked best for them. That is the kind of innovation that we would lose, the kind of patient focus, the kind of energy from the private sector that leads to innovation.

Ms. FOXX. How would Medicare for All affect the nearly 64 million seniors who are currently on Medicare? Would they receive better coverage?

Ms. TURNER. Sixty-four million seniors and disabled patients on Medicare, 26 million of them have chosen Medicare Advantage private plans. That shows that they believe that there is more value to having a private plan that can manage their care. They can pick the plan that provides the best network in their area.

So they are—and some, we believe, could be focused care. If you have diabetes or heart disease, you will get the specialist in that care. So I think that there would be a lot of innovation lost and I don't think seniors would be nearly as happy as they are now.

Ms. FOXX. Yes. As I understand it, our friends on the other side of the aisle want to do away with Medicare Advantage and the kinds of things you have described.

Also, under Medicare for All or another universal health care system would Americans have wait times to seek care that are similar to those in Canada and the U.K.?

Ms. TURNER. Absolutely, because you—there are lots of different ways for people to pay for systems and one of them is in care that they don't get and, oftentimes, they don't even know the care that they are not getting.

I talked with a physician from the U.K. and he saw both private sector patients as well as those on the National Health Service Plan. And he said, I can't even tell my public patients about new medications that would be better for them because it is not covered under the system. Patients who are going to have to wait for two years to get a knee replacement surgery pay out of pocket, if they can, to go to the Mayo Clinic if they live in Canada or someplace else. So they—patients pay in other ways, especially those most in need of serious medical care.

Ms. FOXX. Thank you.

Ms. Turner, another question. The Mercatus Center calculated the costs of Medicare for All and found that under the best case scenario it would increase Federal budget commitments by \$32.6 trillion over the first 10 years of implementation.

Thirty-two point six trillion is triple what the Federal Government spends on our defense and domestic discretionary programs over 10 years. Even doubling the corporate income tax could not cover that.

Since our government is consistently overspending and running large deficits each year, is a massive new government spending program like Medicare for All financially feasible or sustainable?

Ms. TURNER. It is really hard to see how that could work. As I said in my testimony, that Colorado, Vermont, and, most recently,



California have tried to figure out how they could do just on a State basis a single-payer system.

In California—even California saw the price tag of \$450 billion a year and they said that is really not something we can afford.

Ms. FOXX. Thanks. And my last question—what lessons can we learn from the implementation of Affordable Care Act, or Obamacare, and how should that inform our expectations for further government involvement in health care?

Ms. TURNER. Running a top-down system is really difficult, especially from Washington, in a country as diverse as this one is, and one of the reasons there have been so many changes to the ACA is because some things worked for some States and others didn't work for other States, and for different sectors of the economy you need to have local control bottom-up decision, making not top-down decisionmaking that could have the same catastrophic effects as healthcare.gov did.

Ms. FOXX. Thank you, Ms. Turner.

I yield back.

Chairwoman MALONEY. The gentlelady yields back.

The gentlelady from Michigan, Ms. Tlaib, is recognized for her questions.

Ms. TLAIB. Thank you so much, Chairwoman, and thank you so much to my good colleague from St. Louis, Congresswoman Bush, for really leading us to making sure that we bring our residents to Congress and make sure that they are seen and heard.

As Bishop Starghill from my district said in his testimony, and it was very clear, lacking access to health insurance not only causes financial hardships but it puts millions of Americans' lives at serious risk every single day.

I represent the third poorest congressional district in the country. Very limited choices when folks talk about choices when it is convenient. But today, whether or not a person has access to high-quality medical care depends, largely, on whether they are insured or whether—what their income is, whether or not they are wealthy enough to pay for it.

Medicare for All will guarantee access to high-quality health care for every person in our country, regardless of their ability to pay, and we have heard a lot of misleading claims from my colleagues on the other side.

But Medicare for All—what we are talking about and what they are saying is simply not true. But what we are saying in regard to making sure it is accessible and making sure folks are covered is true. It simply says you don't have to be rich to have access to quality health care.

So my question to my good friend, Mr. Barkan—and, you know, thank you so much for being here today and getting up so early—your activism has helped put a face to so many people that really don't lack—lack the access to being here but also the fear that comes with being this vulnerable and talking about not being able to access health care.

So I want to hear from you and whether or not you believe we would have universal health care today if we didn't allow those who profit by our broken health care system to make political contributions.

[Pause.]

Voice. Mr. Barkan is writing.

Mr. BARKAN. I think it is crystal clear that we have a corporate corrupted system and it needs to change.

Ms. TLAIK. Thank you, Mr. Barkan. Do you believe in the work and the advocacy work that you are doing that our system is rigged? If yes, how have you seen it so clearly in your advocacy work?

Voice. One moment.

[Pause.]

Mr. BARKAN. Medicare for All boils down to the simple question of whether or not you believe that health care is a human right. Those against Medicare for All will call this policy various names to distract the public from the truth that you and me, nurses and small businesses, all of us, would fare far better under a system that guarantees comprehensive, high-quality, affordable health care to all.

The only people who benefit from our for profit system are the multimillionaire healthcare executives who profit off our illness, their corporate lobbyists, and the elected officials who take campaign contributions from health care corporations and, therefore, their policy views from them.

Ms. TLAIK. Thank you so much, again, for your courage and for helping, again, put a face to this broken health care system. I know I have said it over and over again, and Chairwoman, you have probably heard me, corporate greed does kill in our country and Medicare for All would address the disparity and reduce the health inequities associated with our current broken system while preserving patients' ability to make the best medical decisions for themselves and their families no matter their income.

So for those reasons, I am incredibly proud to support Medicare for All, and, again, thank you so much, Chairwoman Maloney, for your courage in having this hearing.

I yield back.

Chairwoman MALONEY. The gentlelady yields back.

The gentleman from Arizona, Mr. Biggs, is now recognized for his questions.

Mr. BIGGS. Thank you, Madam Chair.

You know, preventing individuals from making personal health care decisions, and then we have heard a lot about how important that is, and ceding those decisions to government bureaucrats is really the violation of fundamental human rights, and one must acknowledge that inherent in President Obama's Statement that if you like your health plan you can keep it was that recognition of that human right to make your personal choices. I mean, that is why he said that, because he knew that is what we want. We want to be able to choose our health plans.

But that was a lie and he told that lie because he wanted to get his Obamacare, ACA, whatever you want to call it plan out there. Which is interesting to me because repeatedly I have heard colleagues across the aisle say today the system is broken.

This is the system you designed. This is the ACA. We are all living under it now one way or the other. It is your system. Dr. Sachs

said it is broken. It is unfair. It is too expensive. There is too much administrative costs.

I agree with everything you said there. You are exactly right. But this is the system that my colleagues across the aisle made. Even in the private industrial sector—in the private plans, the administration costs are too high.

They are way too high, and part of that is because of the regulatory environment that mounted on the previous unworkable regulatory environment that was imposed through the ACA.

The good doctor repeatedly mentioned peer countries. But when you talk about single-payer systems or socialized systems, although we don't—apparently we are not supposed to call it that—there really isn't a peer to the United States. Just the size of the United States mediates against that.

The peer countries in population size or cost of health care and expenses paid are not comparable. There is no peer country on the charts that you were putting up there. Go back and take a look.

The scale of a Medicare for All plan will be unlike anything you have seen in the history of the world. And, you know, scalability is a problem but the inherent problems can be even in small States.

I mean, so when Vermont tried to implement its single-payer experiment that failed under the cost. Now, we all say, hey, yes, everybody should be able to have access to their health care. We want it to be affordable.

But Medicare for All would make our ability to buy private insurance even more difficult than it is to buy private insurance in Canada, and it wouldn't necessarily guarantee that you are going to reduce cost. I mean, let us take a look at Medicare and pharmaceutical costs. They are way up. They still remain high, even under Medicare.

So I think so much of what I have heard today is talking around the issue for political purposes. If you want to solve problems, I am willing to talk and let us solve problems.

But I am told today that all the other countries have solved their problems and I don't know that I believe that. There are lots of studies and science that indicates that is not true.

Dr. SACHS. Congressman, could I respond?

Mr. BIGGS. Let us take a look at one specific—let us take a look at one specific issue. And I don't know who is interrupting me.

Dr. SACHS. That was me, Professor Sachs. I was wondering whether I could respond.

Mr. BIGGS. Yes. Yes. I am not asking you a question, sir. I am not asking a question. Please don't interrupt me.

Dr. SACHS. OK.

Mr. BIGGS. In 2009, Medicare cut payments to independent cardiologists. This is what we call—this is what we call an unintended consequence, for people who don't understand economics.

2009, Medicare cut payments to independent cardiologists for common tests but left untouched their payment for cardiologists employed by hospitals. So what do you think what happened? Some imaging services Medicare paid hospitals nearly twice as much as they paid independent physicians for the same service.

The effects were predictable—were predictable. The percent of cardiologists employed by hospitals rocketed. People received many more cardiac imaging from hospital outpatient departments and less from freestanding physicians' offices. That is an unintended consequence.

So I will turn to you now, Ms. Turner. What effects would Medicare for All have on patients' ability to receive care in a timely, affordable fashion?

Ms. TURNER. I can't agree with you more about the comparison. The Swiss system works fine for Switzerland. It is the size of Massachusetts. That is not something that we can impose on this whole country.

We must have diversity, and I think people value not only diversity of places to get care but they also—they value diversity of how that care is going to be paid for and giving people more options than they have today.

As we see, fewer and fewer because so much of the spending is controlled by government—Federal and State government—rather than by patients and rather than seeing what innovations could come to provide people with more options of portable coverage that they own and take with them and that they can afford to keep with a strong safety net for the vulnerable.

Chairwoman MALONEY. The gentleman's time has expired.

Mr. BIGGS. Thank you.

Chairwoman MALONEY. Thank you. I now recognize the gentlelady from California, Ms. Porter. She is recognized for her questions.

Ms. PORTER. Dr. Collins, what percentage of revenue do private insurance companies spend on administrative costs?

Dr. COLLINS. Between—about 17 to 18 percent of spending in private insurance plans.

Ms. PORTER. So if I pay my insurance company \$100, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, \$17 go to administrative costs. What about Medicare? What do they spend on administrative costs?

Dr. COLLINS. That range is about, you know, 3 to 5—3 to 5 percent of Medicare spending.

Ms. PORTER. 3 to 5—3 to 5 percent. About 3 to 5 percent right here, and if we look at just billing costs, just billing in insurers' costs, Medicare is at one percent. Private companies spend 17 times more on administrative costs than Medicare?

What are private insurance companies spending on that Medicare is not? Does Medicare spend hundreds of millions of dollars on television advertisements like private insurance does?

Dr. Collins?

Dr. COLLINS. No.

Ms. PORTER. Does Medicare spend millions of dollars on stock buybacks to shareholders?

Dr. COLLINS. No.

Ms. PORTER. Does Medicare spend money on marketing? Private insurance likes to put its name on stadiums and PGA tournaments? Is there a Medicare Arena?

Dr. COLLINS. No.

Ms. PORTER. Does Medicare spend \$23 million on executive pay like private insurance companies do?

Dr. COLLINS. No.

Ms. PORTER. We know how much it costs to run a high-quality health insurance program—one dollar. Out of \$100, research shows that Medicare spends 1.1 percent on administrative costs.

We spend \$4 trillion on health care every year. We could save \$200 billion dollars on administrative costs with Medicare for All and those savings, they could go to expand Medicare. We could spend that money to let patients see dentists.

We could spend that money and let patients pay for hearing aids, to help older adults afford eyeglasses, to bring down the cost of prescription drugs, to finally pay mental health professionals for the work they do.

Instead, all this money is wasted. We are not talking about paying to keep the lights on in operating rooms or improving the quality of care. All this money is used to pay big insurance to push paper. It is death by 200 billion paper cuts.

Dr. Sachs, what is it about the U.S. market that leads to these sky-high administrative costs?

Dr. SACHS. Congresswoman, there is no market. These are local, concentrated providers that have tremendous power to set their prices and to set extraordinary salaries. We should contemplate that the so-called not for profits in this country pay their hospital directors \$5 million.

This is unbelievable, and so this is why these costs are—why the prices are so high. The administrative costs are so high because we don't have a system because we spend 20 percent of our spending just to funnel money between organizations, which is something that other countries don't spend. And I would like to say—I would like to—

Ms. PORTER. Dr. Sachs, I wanted to ask you—

Dr. SACHS. Sure.

Ms. PORTER. Reclaiming my time for one second, Dr. Sachs.

I wanted to ask you specifically about standardization and what role that might play in reducing some of this waste that we could reallocate to health care costs.

Dr. SACHS. Well, when you go in for billing there is no standardization on anything, on the information technology, on the systems, who is in, who is out, what is going to be reimbursable.

Everything is completely opaque. Everything is completely discriminatory depending on who is being involved. So standardization is a big part of all of this because when you lack standardization you put in resources to suck out whatever rents you can and we end up, as you counted those \$17 out of every \$100, basically, lost—basically, wasted.

Ms. PORTER. Reclaiming my time. Reclaiming my time, Dr. Sachs.

We heard today about the cost of Medicare for All but there is a cost to letting insurers paperwork patients and providers to death and that cost of inaction is \$200 billion on administrative costs.

Now, administrative costs waste money but they also waste health care workers' time. A recent study found that a majority of doctors—56 percent—support a single-payer health care program.

Why? Because today doctors spend only one quarter of their time with patients. What are they doing with the rest of their time? Paperwork.

Ninety—and I want to also—I want to add not only would 56 percent of doctors support Medicare for All but patients would have the most choice under Medicare for All. The health insurance coverage with the biggest network is Medicare. No private insurance comes close. Ninety-nine percent of pediatric—nonpediatric doctors participate in Medicare.

So I want to recap. Medicare for All would save money on administrative costs, \$200 billion a year. Medicare for All would give patients the most choices, 99 percent of nonpediatric providers, and Medicare would let doctors practice medicine.

Not surprisingly, given these three things, what do we get with Medicare for All? Better health outcomes, and that is why I support Medicare for All because they support patients over paperwork.

I yield back.

Chairwoman MALONEY. The gentlelady yields back. But before we continue, as mentioned at the beginning of the hearing, Dr. Sachs has a hard stop at 12 o'clock. We thank you for your participation, Dr. Sachs. You are excused. Thank you.

Dr. SACHS. Chairwoman?

Chairwoman MALONEY. Now the gentleman from Kansas, Mr. LaTurner, is recognized for five minutes.

Mr. LATURNER. Thank you, Madam Chair. I appreciate it. Dr. Sachs, I will give you—we don't agree on this but I will give you 30 seconds. I can see that you wanted to say something.

Dr. SACHS. Thank you very much. I want to say there is no economic cost to Medicare for All. It is pure saving. The \$32 trillion reference is about the increase of Federal finance.

But there is a larger decrease of private finance. The net is a large saving. We need to take that talking point out of the discussion so that we can solve the problems. We also need to understand we do have a peer. It is the European Union. Life expectancy is 81.3 years for their 440 million people.

Mr. LATURNER. I am going to have to reclaim my time.

Dr. SACHS. Congressman, thank you. Thank you very much for letting me say those words.

Mr. LATURNER. You are welcome. In the name of bipartisanship, Madam Chairwoman.

Dr. SACHS. I appreciate that very much. Thank you.

Mr. LATURNER. Yes. My questions are for Ms. Turner. Much of the money that Americans pay for health care is going toward its administrative costs, whether that is for hospitals, pharmacy benefit managers, or insurance companies.

Many proponents of Medicare for All strategies say that administrative savings would offset some of the costs of the government-sponsored health care program.

Do you agree that Medicare administrative costs are or would be significantly less burdensome than administrative costs for private

insurers? If not, where do you think that misconception comes from?

Ms. TURNER. Thank you, Congressman. I quoted in my written testimony a study by Dr. Merrill Matthews of the Institute for Policy Innovation in Texas, who is saying that when you compare apples to apples, when you compare the actual cost of making sure a procedure was performed, deciding who your—what your patient population is, making sure the doctor gets paid, all of the other procedures, you wind up with about equal cost.

One of the things that the Federal Government is able to do is to be able to shove the cost of collecting payments off to other agencies or not do the kind of due diligence that many of the private plans do to make sure that the revenues are connecting and premiums from the customers are able to be—are spent properly.

So you see much—you see less waste in private programs because they are spending some part of that administrative money on due diligence. We need to see more of that in the Federal Government.

Mr. LATURNER. I am going to stick with you, Ms. Turner.

Committee Republicans have discussed how the expansion of Medicaid and the elimination of eligibility checks have contributed to government waste through improper payments. According to CMS, total improper payments for Kansas in 2021 amounted to nearly \$290 million.

Can you provide any further insight into why 20 to 25 percent of all Medicaid payments are disbursed improperly and whether fixing these improper and wasteful payments would change how you feel about a Medicare for All policy?

Ms. TURNER. Well, I already don't think that a Medicare for All policy is the right approach for such a diverse country as this is that values innovation. If you wind up with standardization you get rid of a lot of the innovation.

My colleague, Brian Blase, who—with Paragon Health Institute, also a senior fellow at the Galen Institute, has done a deep dive into the study that you referenced about Medicaid waste, and he assumes—says that in one year Medicaid had improper spending of about \$100 billion that was, largely, for people who were on the program and weren't eligible.

There are a number of other ways in which people are taking advantage of the system and it is not being properly monitored. The inability of the Federal Government to be able to contain hundreds of billions of dollars in wasteful spending with a program that would cover 330 million Americans seems to me an in comprehensible task.

Mr. LATURNER. You highlight the burdensome Federal regulatory demands that providers must respond to. Often it is at the expense of their patients. Can you describe further how increased government involvement in the health care sector reaches a point of diminishing return when it comes to addressing patient needs specifically?

Ms. TURNER. Well, writing one more regulation to solve one more problem is when we are going to add more paperwork to a physician's backlog.

The former head of the Mayo Clinic one time looked up the—had his staff look up the number of regulations that the Mayo Clinic—had pages of regulations the Mayo Clinic had to comply with in order to treat Medicare patients. He said, we lost track at 100,000 pages, and that was two decades ago.

So the more regulatory compliance—and we are not going to get rid in this country of demands that taxpayer dollars are spent on this service that is promised. We are going to have to have paper-work trails. People are going to have to follow those trails.

That money is going to have to then go to the provider after it goes through other administrative checks. That—we are not going to get rid of that with Medicare for All. The only way we can get rid of that is through innovation, to give people more choices so that they are—the marketplace is responding to those needs rather than complying with all these hundreds of thousands of pages of rules and regulations.

Mr. LATURNER. Thank you, Ms. Turner.

Madam Chair, I yield back.

Chairwoman MALONEY. The gentleman yields back.

The gentlelady from Missouri, Ms. Bush, is now recognized for her questions.

Ms. BUSH. St. Louis and I thank you, Chairwoman Maloney, and to the committee for this—for convening this critically important hearing, which represents our steadfast commitment to achieving universal health care coverage in the United States.

For my colleagues on this committee, you have a choice in front of you today. It is a choice to save lives or a choice to let people die. Disproportionately low income people, Black people, brown, indigenous people, die. Because you are a human, you deserve health care. Because you are a human, you deserve health care.

In my community, Black mothers die at three to four times the rate of white women. In my community, Black babies are nearly twice as likely to die prematurely. I came to Congress because enacting Medicare for All, it is not a choice for me. It is a moral imperative.

When I worked as a nurse, I cared for uninsured and underinsured patients every single day. I am reminded of one patient with diabetes who was failed by our healthcare system because she could not afford all the aspects of her care.

Technically, she had primary—she had insurance and a primary care provider but she could not afford her insulin prescription, her needles, her test strips to track her blood sugar levels. The patient—this patient, she was forced to ration her insulin and she skipped appointments due to transportation, making it difficult to follow treatment plans. This patient ended up losing a limb and eventually she died.

One health condition, if left untreated, can be deadly. For me, after I turned 18 years old, I became an uninsured low wage worker. I could not afford to retain a primary doctor so I went to the emergency room for treatment for conditions like asthma, sinus infections, and tooth aches.

My asthma was exacerbated by environmental pollution and degradation and continued to worsen without proper medical care.



During the Ferguson uprising, toxic tear gas filled my lungs, leaving me gasping for air and it worsened my condition.

Even though I was working as a nurse, I was forced to pay a \$900 monthly premium, a \$4,600 deductible, and struggled to treat my asthma.

Dr. Michener, can you please describe the relationship between health care coverage—a healthcare coverage status and economic mobility in the United States? How would Medicare for All reduce poverty and stimulate economic growth in the United States?

Dr. MICHENER. Representative Bush, thank you for the question. I think this is a key dimension.

Oh, I thought it was on. Oh, OK.

Yes, I think this is a key dimension of the—of this discussion that we, I think that on some fronts has been willfully ignored, which is that there are gross inequities not just in our health system but in our economic and social and political systems, more broadly, and the inequities in the health system are exacerbating the inequities in other places.

So if we look at all of our anti-poverty programs that we have in this country, the largest effect on poverty—child poverty in particular but poverty more generally—comes from our Medicaid program. Addressing healthcare disproportionately addresses some of the other core and fundamental challenges we have around economic inequality in this country. And so what happens when you provide people with healthcare? We have seen it through Medicaid. They are less likely to be evicted. They are less likely to recidivate and go back to prison. They are more likely in the long term to have positive financial outcomes.

Ms. BUSH. Yes.

Dr. MICHENER. Less likely to be living in poverty, less likely to have medical debt, more likely to have positive educational outcomes, more likely to have employment. We want to say, “socialized medicine,” scare people away with the scary phrases, right? Oh, the government is going to be making the decisions.

Ms. BUSH. Right.

Dr. MICHENER. If the government is not making the decisions, who is? The market, and that is not democratically controlled.

Ms. BUSH. Thank you.

Dr. MICHENER. It is not something that people can influence.

Ms. BUSH. Thank you. If not three years into the pandemic, when will we actually address the fundamental flaws and structural inequities present in our healthcare system, in our privatized healthcare system? Dr. Blackstock, using your extensive experience as an emergency physician, can you please describe what the implementation of Medicare for All would look like for healthcare providers, particularly those who interact with insurance companies?

Dr. BLACKSTOCK. So what it will do is it will enable us as health providers caring for our patients to more efficiently care for our patients, to prioritize the primary and preventive services that we provide them. It will not result in more administrative effort and cost. In fact, it will do the reverse. And so it will help remove barriers for our patients to seek care, and doing so will enable us to buy the best care and to do so even more efficiently than we could that now.

Ms. BUSH. I will say “yes” to that as the nurse that actually worked the bedside. That is true. Thank you, and I yield back.

Chairwoman MALONEY. The gentlelady yields back.

The gentleman from Texas, Mr. Sessions, is now recognized for his questions.

Mr. SESSIONS. Madam Chairwoman, thank you very much. For those members that are here, I only see one other in the room that was here in 2008, 2009, 2010 as we went through this exact same type of hearing about how great the Affordable Care Act would be. And yet you notice no one Democrat that I see talks about how great the Affordable Care Act was because it wasn't. It took \$800 billion out of Medicare. Democrats actually took \$800 billion away from seniors to pay for this. Now we have Medicare for All like it is their newfound answer. Oh, by the way, I heard one of our persons just a minute ago giving testimony about how Medicaid works so well. I wonder why we are not doing Medicaid for All.

Well, ladies and gentlemen, the bottom line is that both the House bill and the Senate bill under Section 107, “Beginning on the effective date as in Section 106(a), it shall be unlawful for a private insurer to sell health insurance coverage that duplicates the benefits under this act, and it is unlawful for an employer to provide benefits.” Well, Mrs. Turner, I recall it took President Obama several election cycles before they could even tell us “what was in the bill.” And it took them a long, long time, only to discover that their drawings on a board did not equal success for patients. Why would they want everybody to go into this system that is designed for seniors? It is designed for seniors. It is not designed for children. It is not designed for disabled young adults. As a matter of fact, I have a disabled, at least one in my family, a Downs syndrome young man who is my son. They are trying to take all of America and make it to where we would be at the same place two years later of trying to say, my gosh, what did we do.

Ms. Turner, I know the gentleman, Dr. Merrill Matthews, well. I know the gentleman, Dr. John Goodman, well, and they have spoken about the excessive impact that this would have. Do you agree with me?

Ms. TURNER. I do, Congressman, and I also agree that we really have to figure out what the problem is we are trying to solve since two-thirds of people who are uninsured today have access to coverage. They are just not enrolled. So I think we need to look at specifically how do we help get people into the system who, for a number of different reasons, are not participating. And we also need to figure out how can we do a better job of delivering specialty care to people with special medical needs rather than a one-size-fits-all standardization, which is ultimately going to work for very few people.

Mr. SESSIONS. Yes. Mrs. Turner, when I came to Congress, I had spent 16 years at a small telecommunications company called AT&T. AT&T was prohibited by the law that was passed by Democrats and President Obama that said that they would not allow employers to deduct benefits, money spent on employer-provided healthcare to retirees. That is against the law. They wanted to move everybody off of an employer-provided model, which seemingly everybody was happy with, and to move to a Medicaid model.

The question I would ask you is, do you think that a system, let us say, American Airlines or AT&T, that that would be the model that we want everybody to move to just like employer-provided healthcare? Because as I read this, I am a political science major. When the government competes against somebody, free market that is called socialism. When the government dictates who can be in the marketplace that is communism. What do you think this is, given that as a choice?

Ms. TURNER. Well, I believe that Medicare for All definitely is a socialized healthcare system.

Mr. SESSIONS. Why is it socialized? It doesn't allow anybody to compete against it.

Ms. TURNER. Everybody would——

Mr. SESSIONS. Wouldn't that be communism? You may not have been a political science major.

Ms. TURNER. I don't have a term for it, but certainly it is a one-size-fits-all program.

Mr. SESSIONS. It outlaws anyone else from providing coverage.

Ms. TURNER. Right.

Mr. SESSIONS. That is communism. I thank the gentlewoman for being here, and I thank the chairman of the committee for this hearing today. Thank you.

Chairwoman MALONEY. The gentleman yields back.

The gentleman from Illinois, Mr. Davis, is now recognized for his questions.

Mr. DAVIS. Thank you, Madam Chairman, and thank you so much for calling this very important hearing. And I guess I would say one thing: Pete, I was in the room. I am a strong supporter of the Affordable Care Act. I was then. The 30 million people who got an opportunity to get healthcare coverage, I am sure they are all supportive of it as well.

I believe in a single-payer system of Medicare for All, and I have spent many years advocating for universal healthcare. As a matter of fact, I am pleased to know that I come from an area in Chicago Metropolitan where we have 120 clinic sites for federally qualified health center clinics. But also, we know that for many individuals living with less income, being uninsured and underinsured makes accessing healthcare untenable and unaffordable. People with less income or more likely to be uninsured in every State, but most especially in those States that have refused to expand Medicaid.

Dr. COLLINS, let me ask you, how has the failure of certain States to expand Medicaid under the ACA affected uninsurance rates in the United States?

Dr. COLLINS. Thank you, Congressman. That is a great question, and I agree that the Affordable care Act has put us on a path to universal coverage. And there are things that are preventing us from getting there right now, and one of them is the fact that 12 States haven't expanded eligibility for Medicaid. People are entitled to Medicaid by law, but States have chosen not to expand. About more than 2 million people are caught in the so-called coverage gap and unable to be enrolled in their State's Medicaid program or enroll in the marketplaces.

Mr. DAVIS. And people with low income or people who don't have the resources, for example, to purchase prescription drugs and pay

the rent, they may have a different opportunity. Dr. Blackstock, let me ask you. You are an emergency room physician. What differences have you observed in the health of patients who come to the hospital with health coverage and those who come without?

Dr. BLACKSTOCK. Thank you for that question, Congressman. I have worked in two different types of hospitals. I have worked in hospitals where people have insurance, and their health status and health outcomes are far more superior than patients I have cared for in public hospitals with patients who were uninsured and underinsured. I have seen patients who are uninsured coming in with uncontrolled chronic medical conditions that compromise their quality of life and that lead to an early mortality. And we don't see that in the same way in an insured population.

Mr. DAVIS. Thank you very much, and, Mr. Barkan, let me end with you. What can we do and how can we get rid of the barriers that people without resources have to being able to obtain healthcare for what their needs are?

Voice. OK. Ady is writing.

Mr. DAVIS. Yes, I think we are just waiting for Mr. Barkan.

Mr. BARKAN. We need to build the social movements to transform this reality. Thank you.

Mr. DAVIS. Thank you very much, Madam Chairman. Again, thanks to this very important hearing, and I certainly want to commend those who generated the enthusiasm and the need to hold it and to have it, and I yield back.

Ms. BUSH.

[Presiding.] The gentleman from Florida, Mr. Donalds, is recognized for five minutes.

Mr. DONALDS. Thank you, Madam Chair. To the witnesses, thanks for being here.

Look, here is the deal. We already run a single payer health system in the United States. It is called the VA system. The VA system has been plagued with backlogs. It has been plagued with long lines. It has been plagued with shortages of care. It has been plagued with overspending. It has been plagued with fraud and abuse. We have never fixed it. We choose not to fix it. But what we are going to say is, is that the VA system, which we know has not provided the best outcomes for the men and women who have served our country with honor and distinction, we are going to say instead of fixing that system, we are going to create a much larger system for every American where our own experience with the VA system has already proven what happens when you have universal coverage.

We have another system. It is called Medicare. By and large, it is one of the most popular systems that the Federal Government has in the United States. It goes insolvent in somewhere between 5 to 7 years. I was actually just in the Budget Committee, and director for Office of Management and Budget, in the President's own budget, which he just released yesterday, does not show any slowing down of benefits with respect to Medicare, but then also no proposals about how you are going to keep this situation going in Medicare because we are spending significant amounts of money, providing care to the elderly who paid in through payroll taxes over decades in the United States. But there are no reforms to actually

make sure that the benefits can be paid, which means that we are just going to have to dig into the pockets of every American to continue benefits when the money that was actually allocated for those benefits is not even enough to pay the burden going forward. But yet in his hearing, we are talking about universal healthcare.

I remember a video. It was a YouTube video from years and years ago. This was back when I was a fledgling political watcher, and it was from a member of our body who still serves here today, who talked about how the Affordable Care Act, effectively referred to as s Obamacare, was just the first step toward universal healthcare. What Obamacare has done, what the Affordable Care Act has done, however you want to call it, it has led to higher deductibles, and it has led to higher premiums in the United States bar none.

Of course I am a Member of Congress right now. I am on Obamacare. I have never paid higher insurance premiums than I am paying right now. I have never paid higher deductibles that I am paying right now. And everybody I know in my district and throughout the State of Florida, and, frankly, across the United States, their deductibles are higher. Their premiums are higher. Their access to care is actually less than it was before the Affordable Care Act. But the answer from the Democrats in our body is universal healthcare or Medicare for All, or whatever the amalgam is going to be.

Ms. Turner, you said in your opening testimony that undertaking universal healthcare in the United States, according to CBO, would be “complicated, challenging, and disruptive.” The complicated, challenging, and disruptive would apply to all Americans whether you are Black, or White, or Hispanic, whether you are rich or whether you are poor. You know, it doesn’t matter. When you unleash a system that is complicated, challenging, and disruptive, that affects everybody, and where are they going to go?

Ms. Turner, I have a question for you. Because of all these situations that we are talking about, can you provide some specific examples of potential stalled innovation in the medical field? What products will be most at risk if America adopted a single payer healthcare structure?

Ms. TURNER. What are the advantages today and what would be most adversely affected, Congressman?

Mr. DONALDS. Yes, ma’am.

Ms. TURNER. The world relies on the United States for medical innovation. We saw it in pharmaceutical research with the vaccines just last year. And when you see the Federal Government working together to support the private sector and the incredible resources it has in research and technology, innovation, flexibility, that is when you get results. When you have the Federal Government coming in and saying, this is how we are going to do it that is when you get the CDC with its failure to be able to come up with a test. We have to have the private sector if we are going to have innovation, and if we are going to have innovation, that is what leads to progress. That is what leads to the miracle cures that we see today, new surgeries that would have been impossible to envision 30 years ago.

So having private sector innovators who are rewarded, through ownership of patents oftentimes, but rewarded adequately for their investment in that research is what will solve these problems to give people more choices of more affordable care and coverage. The Surgery Center of Oklahoma is a perfect example. It doesn't rely on government funding to be able to provide the high-quality care it does. It relies on being able to make the procedures that they do as efficient as possible with the best procedure, with the best physicians, the best nurses, and the best outcomes. That is what we need more of.

Mr. DONALDS. Thank you so much, Ms. Turner. Madam Chair, I know I am over my time. The one thing I would say is this. I have long said to a lot of students across the country when I go and speak with them, if the Federal Government was in charge of the telecommunications industry, we would not have iPhones and Samsung Droid phones. We would still be on the Motorola StarTAC, and their response is, what is a Motorola StarTAC, and I am like that is my exact point. It is that funky phone that had the orange buttons and the orange screen. There is no innovation when it comes from the Federal Government. It only comes from private markets. This is the exact wrong way to go. And health outcomes in the United States would actually be worse, and if you don't believe me, look at the VA system. I yield back.

Ms. BUSH. The gentleman from Georgia, Mr. Johnson, is recognized for five minutes.

Mr. JOHNSON. Thank you, Madam Chair. For decades, Democrats have fought to protect and expand access to healthcare, and at every step, Republicans try to gut our efforts. Ms. Turner, do you believe that every American has a right to access America's healthcare system, or is access to healthcare just a privilege reserved only for those who can afford it?

Ms. TURNER. Congress decided in the early 1980's that anyone who needs care and shows up in a hospital emergency room is going to get care. Beyond that, we have just a plethora of government programs to offer coverage to people—

Mr. JOHNSON. But do you believe healthcare is a right or is it a privilege only for those who can afford it?

Ms. TURNER. I think we have a system that allows people who cannot afford it to be able to get care and coverage, but you don't have a right—

Mr. JOHNSON. OK. And you are fine with the system as it is now. I get it.

Ms. TURNER. No.

Mr. JOHNSON. You have been involved in the debate over healthcare reform since President Clinton proposed healthcare reform in 1995. Isn't that correct, Ms. Turner?

Ms. TURNER. That is correct. That was in 1992.

Mr. JOHNSON. And you opposed the Clinton healthcare legislation, correct?

Ms. TURNER. I did not believe then, nor do I now, that the government should be in charge of making all decisions in our health sector.

Mr. JOHNSON. And since 1995, you have headed up an outfit called the Galen Institute. Isn't that correct?

Ms. TURNER. That is correct, that I founded.

Mr. JOHNSON. And the Galen Institute is a right-wing operation funded by right-wing foundations and corporations opposed to healthcare system reform. Isn't that correct?

Ms. TURNER. We work closely with people from both sides of the aisle, and we advocate policies that put doctors and patients at the center of our health sector rather than bureaucrats.

Mr. JOHNSON. OK. Well, let me ask you this. How many times have you testified before Congress on the issue of healthcare reform?

Ms. TURNER. Oh, dozens.

Mr. JOHNSON. And each time you testified, that you spoke in opposition to healthcare reforms proposed by Democrats. Isn't that correct?

Ms. TURNER. Not always. I am sure that there were policies that—

Mr. JOHNSON. You have spoken in favor of some Democratic policy proposals? Is that what you are asking us to believe?

Ms. TURNER. There are some really interesting proposals, like cash for counseling, that were proposed by Democrats to give people in Medicaid the option to be able to get—

Mr. JOHNSON. OK. Well, let—

Ms. TURNER. Absolutely, we support it. We are not partisan.

Mr. JOHNSON. OK. All right. Well, let me ask you this, Ms. Turner. Let me ask you this. For 27 years, you have made a handsome living protecting corporate profits while opposing reforms that would make access to healthcare affordable for all. Isn't that correct?

Ms. TURNER. Our logo of the Galen Institute actually is designed to focus on those who are marginalized and left out, people who don't have access to public programs.

Mr. JOHNSON. And how do you propose for those people to gain access to the healthcare system?

Ms. TURNER. As I said in my testimony, we need targeted solutions. Who is uninsured?

Mr. JOHNSON. Tell me—

Ms. TURNER. Who is being left behind?

Mr. JOHNSON. Tell me your targeted solutions to enable people who can't—

Ms. TURNER. Not one government program.

Mr. JOHNSON. Tell me your solutions targeted toward those who cannot afford access to the healthcare system.

Ms. TURNER. I would like to see States be able to repurpose some of the ACA money to provide care for people who are not covered under Medicaid.

Mr. JOHNSON. So you are in favor of the ACA?

Ms. TURNER. And give people the option to use those resources—

Mr. JOHNSON. Are you in favor of the ACA?

Ms. TURNER. I am in favor of having no one who has coverage today losing it, but I believe many more people could get better coverage—

Mr. JOHNSON. OK. Well, what about those who don't have coverage? What about those who don't have coverage? That is what I am trying—

Ms. TURNER. What I am saying, if you—

Mr. JOHNSON [continuing]. Trying to get you to tell us about.

Ms. TURNER. Repurpose—

Mr. JOHNSON. What proposals do you have that would ensure that folks who cannot access to the healthcare system can have access to the healthcare system?

Ms. TURNER. If States had more flexibility, they would be able to use the existing resources—

Mr. JOHNSON. What about the Federal Government? What is the Federal Government role?

Ms. TURNER. As President Biden said recently, the Federal Government is really out of its element in dealing with something as local and private as healthcare.

Mr. JOHNSON. So you don't believe that the Federal Government should have any role in the delivery of healthcare, do you?

Ms. TURNER. That is not absolutely what I said. I believe that States could do a better job.

Mr. JOHNSON. But I am asking you, you don't believe that the Federal Government should be at all involved in helping poor people access the healthcare system. Isn't that true?

Ms. TURNER. That is not what I said. Absolutely not true. I believe that we need a strong safety net, and we need a strong safety net especially for the vulnerable who find it most difficult to get care and coverage in a system when they are competing with people who are dropping private coverage in order to get onto publicly supported programs. I oppose that.

Mr. JOHNSON. Well, you are not talking about poor people. You are talking people who are paying for insurance premiums. I think the public can see right through your testimony and can see that you support corporate profits over access to the healthcare system for all—

Ms. TURNER. Absolutely not true.

Mr. JOHNSON [continuing]. Including those who cannot afford it.

Ms. TURNER. That is not true.

Mr. JOHNSON. And with that, Madam Chair, I yield back.

Mr. COMER. Madam Chair, that is not what she said. He needs to be on one of Adam Schiff's committees if he is just going to make stuff up. That is not what she said. It is very disappointing—

Ms. BUSH. You are not recognized right now.

Mr. COMER [continuing]. That he would badger the witness like that.

Ms. BUSH. You are not recognized right now. The gentleman from Georgia, Mr. Clyde, is recognized for five minutes.

Mr. CLYDE. Thank you, Madam Chair, for holding this hearing regarding our Nation's disastrous healthcare system. It is long past time that we address this growing crisis, and I commend my Republican colleagues and the Healthy Future Task Force for working on solutions that prioritize innovation and competition to reduce costs and improve quality of healthcare for our constituents.

While many of my Democrat colleagues believe a Medicare for All Program would lower healthcare costs, unfortunately, that couldn't



be further from the truth. Reports estimate a Medicare for All Program would increase Federal budget commitments by another \$32.6 trillion. That is more than the total of our growing national debt. As the Nation faces continued inflation rates, which are now the highest we have seen in 40 years, one thing is clear: our current healthcare system is inadequate to meet the needs of Americans. One does not need to look long before realizing the Federal Government is ill-equipped to manage a large-scale healthcare program, as my friend from Florida, Mr. Donalds, pointed out.

It has been 12 years since the passage of the Affordable Care Act, and the Federal Government still fails to provide affordable quality coverage for millions of Americans in rural areas, leaving many communities with only one or two eligible insurers from which to choose. In fact, Obamacare was so disastrous that many States, including my home State of Georgia, filed Section 1332 waivers to exit the ACA marketplace. In addition, the Congressional Budget Office's outlook for major Federal trust funds indicates that the Medicare Hospital Insurance Fund could be exhausted by 2024, and that is in this particular document, the 2020 to 2034 report from September 2d, 2020, right here. If our government cannot even ensure the solvency of Medicare for our seniors and eligible participant recipients which comprise less than 20 percent of our population, there is no feasible way for the Federal Government to provide Medicare for All.

So, Ms. Turner, knowing the current State of the Medicare program, do you believe the Federal Government is equipped to manage a Medicare for All Program?

Ms. TURNER. No, Congressman, I do not. I believe that it has shown over and over that it is very good at spending money. It is not very good at spending money wisely, and it is not very good at all at innovating. When you see the Medicare program, 26 million seniors are voluntarily opting out of fee-for-service Medicare into private plans—

Mr. CLYDE. Wow.

Ms. TURNER [continuing]. Because they say this provides more and better coverage. People want choices. Innovation comes from the private sector and not from government.

Mr. CLYDE. Right.

Ms. TURNER. And that is what our health sector needs to be able to be more affordable and provide more people with coverage.

Mr. CLYDE. Thank you. As a followup, as you know, our rural communities already face problems with limited insurers and lack of access to quality care. In your opinion, would Medicare for All improve or worsen these struggles for patients in rural communities, like mine in Georgia 9?

Ms. TURNER. The CBO has actually shown that it would significantly reduce access to care because a Medicare for All Program would pay physicians and hospitals so much less than they do now, and you would not have the private sector, particularly employer-based plans, picking up the slack in order to be able to make these practices and hospitals solvent. So it is very hard to see how they could provide the same quality, the same access to care by the numbers that they are talking about, the savings that they purport to be able to achieve.

Mr. CLYDE. OK. Thank you. Not only is the Federal Government ill-suited to run a nationwide healthcare program as we just heard, but we must not forget that it is the poor policy decisions of lawmakers and executive officials that add to the problem by continuing to overburden our healthcare system, stifle innovative technologies, and raise prescription drug prices. While I am glad that we are holding this hearing to begin addressing our failing healthcare system, simply pointing out a problem is not enough. Our constituents need reliable solutions, not only to ensure the quality healthcare, but also to address the economic crisis, the hyperinflation crisis that is causing prices to currently surge. And I strongly urge my colleagues to abandon a universal healthcare proposal and work toward competitive market-based solutions that are truly in our constituents' best interest.

And in the few seconds I have remaining, Ms. Turner, would you like to respond to anything that my colleague from Georgia asked of you? Is there anything that you want to add to that as you were badgered?

Ms. TURNER. He is putting words in my mouth, things that I am not saying. Can I just make a comment?

Mr. CLYDE. Yes, ma'am.

Ms. TURNER. I really commend you in Georgia and Governor Kemp for the innovative proposal that you have offered to try to repurpose some Federal funds to do a better job of taking care of the vulnerable patients in the State and make care more affordable and efficient by giving them a wider choice of plans. So congratulations. I hope that the Biden administration allows that waiver request to go through.

Mr. CLYDE. Thank you, and I yield back.

Ms. BUSH. The gentlewoman from Illinois, Ms. Kelly, is recognized for five minutes.

Ms. KELLY. Thank you, Madam Chair. Thanks for holding this hearing. One thing I wanted to say really quickly, yes, when the Affordable Care Act was passed, I wasn't here, but it was just the beginning. It wasn't the end. And through the years I have been here, we have been trying to improve it but could not get cooperation from the other side. And the other side always talked about repealing the Affordable Care Act, and when they had a Republican President, Republican Senate, and a Republican House of Representatives, they did not get it done. So I digress.

Home-and community-based services give older Americans and people with disabilities a chance to live freely and independently in their homes and remain contributing members of their community. Mr. Barkan, I am just going to tell you my question, but I am going to move on to others to give you a chance to prepare to answer. But I wanted to know from you, I would love to hear about the ways in which home-based services have impacted your life, but I am going to move on and come back to you.

The Biden administration significantly expanded access to Medicaid home-and community-based services to the American Rescue Plan. The number of people in the U.S. will need home-and community-based services is projected to more than double by 2050. At the same time, direct care and home service workers are in increasingly short supply. Dr. Collins, what work force investments do we

need to make now to prepare for those projected increases in demand, and how can we make sure that these investments are equitable?

Dr. COLLINS. Thank you, Congresswoman. This is a huge burden for families, and everybody is experiencing it both with elderly parents and also with disabled children. It has come up repeatedly in this hearing today. We do need to improve the wages that people are paid who work in these jobs. These need to be living jobs that pay people well enough give people the care they want and the security that people and these families that need them so much need.

Ms. KELLY. Thank you. Dr. Blackstock, let me turn to you. Forty percent of family caregivers identify as Black, indigenous, or people of color. The higher prevalence of family caregiving occurs in Hispanic and Black families. We also know that it is much easier to establish trust with a provider that looks like you, and according to the National Academy of Medicine, this improves health outcomes. I am a person that has worked for the last six years on maternal mortality and morbidity and luckily got some bills passed. Why is it important that we consider health equity in expanding home-and community-based services in America?

Dr. BLACKSTOCK. As you mentioned, by having racial concordance in terms of who the caregiver is or who the healthcare provider is, we know that that will result in better health outcomes overall. So we need to make that investment in making sure that home caregivers receive the funding and support they need to do their jobs.

Ms. KELLY. Thank you. We need to build on the successes of the American Rescue Plan and provide a permanent expansion for home-and community-based services. That is why I support Rep. Debbie Dingell's Better Care, Better Jobs Act, which would invest \$150 billion into funding for home-and community-based services through Medicaid and the development of care infrastructure and labor force. Mr. Barkan, I will now conclude with you to respond to the earlier question.

Mr. BARKAN. Thank you for your question and for giving me time to prepare. I get to live a beautiful and full life because of home care. Home care saved my marriage as my wife, Rachel, and I got to be partners and co-parents again instead of patient and caregiver. It is the reason why I get to wake up every morning to my wife and two kids and be an active participant in their lives, but my reality is the exception. Home care is prohibitively expensive, and so when home care is not accessible, which is the reality for most, patients are forced into nursing homes.

Nursing homes are unsafe institutions where patients are merely warehoused and isolated from their loved ones. Since the pandemic began, over 150,000 disabled people have died in nursing homes due to the coronavirus. Many of these deaths could have been prevented if they had the opportunity to receive care safely at home. The loss of these lives are a moral failure and a direct result of the for-profit system of care that corporate lobbyists, like those hired by the nursing home industry, work hard to maintain. It is not exaggeration then to say that the difference between being able to receive care at home surrounded by the love of family and community and living at a nursing home is a matter of life and death.

Ms. KELLY. Thank you so very much for your response. Thank you for being here. Thank you to all the witnesses. Congress must act to ensure that older adults and the disability community are able to access high-quality care in an affordable and inclusive way. Thank you so much, and I yield back.

Ms. BUSH. The gentleman from Kentucky, Mr. Comer, is recognized for five minutes.

Mr. COMER. Thank you, Madam Chair, and, again, I want to thank our witnesses for being here.

Just to begin with, Ms. Turner, we talked about Medicaid, and it has been mentioned many times by those on our side of the aisle that Obamacare was supposed to be the solution for people that couldn't afford healthcare. It was supposed to be the great equalizer and solve all of our healthcare problems. So with Obamacare, many States had the option to expand Medicaid. My home State of Kentucky was one of those States that expanded Medicaid to the tune of about a third of the State is on Medicaid now.

Now, you talk to medical professionals and providers all over the State, and they will tell you they don't want to see Medicaid patients because the reimbursement rates are so low. That is because the slice of the pie is a certain size of what the States get for Medicaid. The more people that get on Medicaid, the thinner they slice the pie. They have more slices, so the reimbursement rates continue to go down, so a lot of people on Medicaid in Kentucky have trouble finding providers who will get them in. Would something like this happen with Medicare? If we greatly expand Medicare, which is already, as Representative Donalds pointed out, facing financial insolvency, would greatly expanding Medicare have the same negative impact on Medicare patients that expanding Medicaid has had on Medicaid patients?

Ms. TURNER. According to the CBO study, there would be a significant reduction in the number of physicians and hospitals that could afford to take those payment rates. Either they would have to cut back or some of them would even close their doors. So you would have fewer providers, which is the situation that too many people on Medicaid today face that they can't find a provider that can afford to take Medicaid's low payment rates. Many do so out of charity, but then they still have to go through all the ridiculous paperwork to get paid—

Mr. COMER. Right.

Ms. TURNER [continuing]. As I said earlier, six cents for a complicated pulmonary patient. Very few of them would be able to keep their doors open to do that, and I think it would be really a decimation of the medical profession.

Mr. COMER. I have to note I have 29 hospitals in my district. I would go out on a limb and say I have more hospitals than just about any Member of Congress. Every one of my hospital administrators will say the same thing, and these are, by the way, very rural hospitals for the most part. They say that they lose so much money on Medicaid. Anyone who goes in private pay or has private health insurance, they have to really spike the price up on them to cover the cost for Medicaid. So many of the arguments that my friends on the Democrat side have been making for Medicare for

All, I just don't buy because a lot of these policies were tried with Obamacare, and they have failed.

Representative Porter mentioned how efficient the government was in administrative work. That is a joke. The VA is a perfect example of government-run healthcare, and you can talk to my case workers in my office in Tompkinsville, Kentucky, about how inefficient and unresponsive the VA is to the VA patients. Very few VA patients in my district in Kentucky are satisfied with government-run healthcare of the VA. It was also mentioned by several Democrats about the numerous times that Republicans have tried to repeal Obamacare. Can you talk about any of the 60 or so times that Republicans have tried to repeal Obamacare?

Ms. TURNER. Thank you for that question, Congressman. We actually tried to track the number of changes that were being made to the ACA as it was happening, and we gave up, over at the Galen Institute, 70 changes, 43 of which were made by the Obama Administration, some with legal authority, some not. Twenty-four were passed by Congress and signed into law by President Obama, and three were made by the Supreme Court. So the allegation that Republicans have been trying for 60 to 70 times to repeal and replace Obamacare, the law didn't work, and it had to be changed even to marginally work, and still we see that it is not nearly serving the patient population that they had expected, and millions of people are having to pay such high premiums and such high deductibles, that they basically don't feel they are insured.

Mr. COMER. Other thing, and I will close by this, Madam Chair. Rho Khanna made a Statement that I actually agree with. He said we need to eliminate the middle people, and that is why Republicans, with respect to healthcare, we requested a hearing on PBMS—pharmacy benefit managers—that I feel like is an unnecessary level of bureaucracy in the healthcare system. This is something that I believe this committee should have a bipartisan hearing on. Republicans had a hearing. We published a report from our hearing, and I think that is a very good place to start looking if we are talking about trying to make prescription drugs more affordable to people, which is a significant cost of healthcare for people.

So I think the Republicans are serious on this committee about trying to solve the healthcare problems we have in America, but bigger government and government-run healthcare is not the solution to the problem. Madam Chair, my time has expired.

Ms. TURNER. Transparency would be very helpful.

Ms. BUSH. The gentleman from California, Vice Chair Gomez, is recognized for five minutes.

Mr. GOMEZ. Thank you, Chair. First, being uninsured in this country is daunting, and I know that because most of my life I was uninsured until I got a job after college as a child of working class immigrants who had no access to employer-sponsored health insurance, despite them working 4, 5, 6 jobs a week to make ends meet. It is something that it is not only daunting, but it takes a toll on the family. It takes a toll on the children. And when you are uninsured, preventative care is definitely out of the question. You only go to the doctor when it is the absolute last result resort, and that has devastating health and financial consequences that are dis-

proportionately borne by low-income individuals, particularly those of color.

In 2019, the uninsured rate for non-elderly Black Americans was 1.5 times higher than it was for white Americans. For Hispanics and Native Americans or Alaska Natives, it was nearly triple. When people don't have health coverage, they can't get regular checkups and screenings, which leads to preventable and tragic outcomes, such as Black women succumbing to breast cancer at a rate of 42 percent higher than white women, even though the incidence of breast cancer is higher in white women.

The Affordable Care Act helped narrow this coverage gap through premium tax credits that have allowed working families to purchase quality coverage through the marketplaces. The American Rescue Plan built on this key reform through provisions in the Health Care Affordability Act, which I introduced with Congresswoman Lauren Underwood. We expanded eligibility for premium tax credits, which has, on average, lowered existing premiums like 40 percent. Over one-third of the consumers who have taken advantage of the new lower rates provided by the American Rescue Plan have joined plans with monthly premiums of \$10 or less. Many individuals have seen their medium deductible fall as much as 90 percent.

Dr. Collins, how have the ACA premium tax credits helped individuals and families get covered, and how has the expansion of the premium tax credit in the American Rescue Plan enhanced the program?

Dr. COLLINS. We know from our survey data that affordability is the main reason people decide to take a coverage or not, and so the premium subsidies in the marketplace has helped millions of people gain coverage through a market that did not work for most people prior to the Affordable Care Act. The American Rescue Plan's subsidiaries have done what is needed and enhanced the affordability of those premiums by decreasing the amount of money people have to contribute to them.

Mr. GOMEZ. And since the American Rescue Plan has passed, since it has passed, more than 1.5 million Americans have enrolled in coverage, while an additional 2.5 million people who were previously enrolled in ACA Marketplace plans have seen their premiums fall by 40 percent on average. And despite this success, this relief is temporary and it will expire soon. Last year, I introduced the Choose Medicare Act with Senator Murphy and Merkley, which would give all Americans the choice of buying Medicare as their health insurance plan, and makes reforms to improve affordability, including expanding eligibility for the premium tax credit, while making it more general.

Dr. Collins, how would changes like these put us on the path to universal healthcare?

Dr. COLLINS. So I think that we can get to universal coverage by building on the Affordable Care Act. It has been modeled and demonstrated that we can do it even at lower cost, particularly if we add a public option to the marketplaces, and also, importantly, develop an auto enrollment mechanism to help people get easily enrolled. People who are not currently enrolled would have a much easier pathway to get covered.

Mr. GOMEZ. Thank you so much for that response, Dr. Collins. And as somebody who has been both uninsured and insured and seen my parents who were uninsured and insured, even in the best scenarios with individuals who have healthcare coverage navigating the healthcare system and ensuring that people who have language barriers who can't get necessarily access to certain types of care, we see that the disparities exist. And even under the current system, we need to work on making that disparity less and making sure that those who are left behind oftentimes by our healthcare system, our education system, and so many different systems, that we try to make changes that improve their health outcomes so that people of color or people who live in certain zip codes are not discriminated against because of where they live or the color of their skin.

So this is something that we need to work on. I believe that the ACA and the American Rescue Plan have given thousands of families a little peace of mind. I know that it is not permanent, but the more we work at improving coverage, the better people will be able to access quality healthcare.

So with that, I yield back. Thank you for the time, Madam Chair.

Ms. BUSH. The gentleman from California, Mr. DeSaulnier, is recognized for five minutes.

Mr. DESAULNIER. Thank you, Madam Chair. Nicely done on the pronunciation. And I want to thank the chair of the full committee for having this hearing.

For too many Americans in need of mental and behavioral health, they have been unable to access services for a variety of reasons. It was hard fought in the Affordable Care Act to make sure we had equity for behavioral health. We are learning so much about how the brain works, the impacts of stress, and trauma, poverty. That access is a real problem, and I wanted to ask a couple of questions about that, also just the capacity. I am told that there is a 75-percent increase in requests for behavioral health services by Americans since the ACA passed, but there are 25 percent fewer young people going into the field.

So access and getting universal healthcare for many medical conditions is extremely important, but also for behavioral health. This is personal for me. I am a survivor of suicide. On April 20th of this year will be 33 years since my father took his life, and largely because of that, myself, my family, my sons have access to great professionals. But it has been a challenge for us, so I can imagine what it is, particularly for poor people and people of color as they try to access healthcare for behavioral and mental health.

The Kaiser Family Foundation has studied and said that more than half of American adults coming out of COVID report experiencing symptoms of anxiety or depression disorder within the past two years. Dr. Collins, I want to ask you, how does our current coverage system present obstacles to people, particularly poor people, seeking mental and behavioral healthcare, especially for uninsured? Dr. Collins?

Dr. COLLINS. Yes. Particularly for uninsured, if you don't have health insurance coverage, it is very difficult to get care of any kind, including mental health, behavioral health, care for substance abuse problems, so that is one issue. Another, if you have

insurance, you can't access providers, so there is an increased demand that hasn't necessarily been met by the available capacity in the system, particularly in the wake of the COVID pandemic.

Mr. DESAULNIER. Thanks. How would, Dr. Collins, moving to universal healthcare help with that access, I think, for people who are uninsured and are completely without that access?

Dr. COLLINS. I think for people who are uninsured and are completely without access, particularly in States that haven't expanded Medicaid, expanding Medicaid expansion would clearly help address the problems in those States. Making coverage more affordable for people through the ARP subsidies have dramatically increased the affordability of marketplace plans. Mental health is part of the essential benefit package for marketplace coverage. But I think we also need to think about integrating different ways to increase capacity, integrating behavioral health and substance abuse into primary care, for example, expanding and diversifying the behavioral health work force by engaging a wider variety of providers to meet people's unique needs, and also thinking about leveraging current health technology to help improve access.

Mr. DESAULNIER. Dr. Michener, how about disadvantaged communities and communities of color? Clearly, as I said, my experience, although different than poor communities in my district and the Bay Area where I represent, have even larger challenges. So how would universal healthcare and getting at these disparities, even though the law says that it should be open and we should have equity for behavioral health, how might that help? And I will mention I have a bill that allows for money for primary care physicians because for people who commit suicide, over 60 percent of them see a primary care physician within a few months of them attempting to commit suicide or being successful at it. Doctor?

Dr. MICHENER. Yes. So I think there are few different pathways here. One is clearly through providing people who don't have insurance presently with insurance, and that means that they can see mental health specialists, but they can also see primary care providers. And I do think that primary care providers are an important sort of first stop, first base, and they can screen and, in many ways, direct people toward more specialized care that is appropriate for them given their mental health challenges and/or conditions. So I think that that is critical, and I think it is especially critical in communities of color where there are already stigmas around mental health and mental healthcare, and where people face systems and processes, like discrimination and racism, that create even more mental health stressors in their lives and in their communities. So I think that there are hardly any places where these problems are more acute and more imperative than in communities of color, and universal coverage is a primary pathway for getting there.

And I would reinforce this point about the healthcare work force. I think one of the places where we see the most potential and opportunity for growth in the healthcare work force is among people of color and communities of color. And I think investing in resources for education and training in those communities so that the very communities where these struggles exist can be equipped to participate in the work force to address them, a work force that can



only be robust under a system where the maximum number of people have health insurance.

Mr. DESAULNIER. Thank you, Doctor. I yield back.

Ms. BUSH. The gentlewoman from Massachusetts, Ms. Presley, is recognized for five minutes.

Ms. PRESSLEY. Thank you, Madam Chair, and thank you to all the witnesses who have shared their testimony today. I do want to just take a moment to offer special recognition for something that, at least to my knowledge, this is the first time in three years that it has occurred while I have been a Member of Congress. And I would like to acknowledge our ASL interpreters. I thank you for joining us today.

Mr. Barkan, my forever local progress brother and my sibling in the work of healthcare justice, I appreciate you so very much, and Rachel and your beautiful children, Carl and Willow, for all that you give to the movement. Like Leslie Templeton from my district, who testified on the previous panel of patients, you have highlighted how universal coverage and Medicare for All specifically is a healthcare justice issue and a disability justice issue.

The life and death consequences of our current healthcare system have been made tragically clear over the course of this pandemic, and it was the disability community, in fact, that sounded alarms early on, warning that this crisis would be a mass disabling event. With millions now suffering with the impacts along COVID, it is clear that they were right. There is simply no way we can return to the pre-COVID status quo normal because that normal was fundamentally unjust to begin with. Across the United States, folks with disabilities and chronic conditions, who are disproportionately people of color, are more likely to be uninsured and underinsured, creating a barrier to critical care. This, in part, is a result of how our current healthcare system frequently ties one's healthcare coverage to their employment status. For many disabled people, in particular, maintaining a full-time job with health insurance may not be feasible. And even if you have insurance, sky-high co-pays and out-of-pocket costs can keep people with disabilities in perpetual poverty.

Mr. Barkan, how does a system that ties health coverage to employment perpetuate deep inequities for people with disabilities, and how would Medicare for All help to address this?

Voice. He is writing.

Mr. BARKAN. Thank you. As of August 2021, 1 in 5 workers with disabilities lost employment during the pandemic, which does not include the 1.2 million newly disabled adults the coronavirus has created. For many in the United States, health insurance is tied to employment. If you change or lose your job, you are likely to lose your health insurance or have to start over again and build a new team of providers that exist in network. Patients who have medically complex conditions rely on continuity and their medical teams to monitor their health. The disruptions that result from our patchwork system not only inconvenience patients but endangers those of us who most need uninterrupted, high-quality care.

And as you heard from the patient panel this morning, critical health needs can make it difficult or impossible to work, leaving the people who need the care the most to either navigate being un-

insured or too often work in jobs that are inaccessible or damaging to their health. Additionally, despite the ability to and interest in working, disabled people are often employed at much lower rates than people without disabilities, in part because of discrimination. Barriers like ableism in hiring, inaccessible workplaces, and pay discrimination all contribute to the lower rates of employment for disabled people. By disconnecting healthcare from employment, disabled people, who are already burdened by ableism and discrimination, would not have to worry for their healthcare at the same time.

Ms. PRESSLEY. Thank you so much, Mr. Barkan. Congress must stop enabling a predatory health insurance system, one that repeatedly fails our most vulnerable communities. Today in America, if you are poor, Black, brown, indigenous, or disabled, your ability to live, to survive is jeopardized by a broken healthcare system that puts profit over people. We must stop allowing the greed of insurance companies to outweigh the health of our constituents, of our community members. We must ensure that every person has access to quality care when they need it and where they need it.

Babies with heart conditions ending up with parents in bankruptcy is not healthcare justice. A grandmother working the night shift so she can scrape together cash for insulin is not healthcare justice. These are moral failures and policy choices, violent ones. In fact, Coretta Scott King reminded us that, "Ignoring medical need is violence. Contempt for poverty is violence." Healthcare is a human right, and we need Medicare for All. Thank you, and I yield back.

Voice. Excuse me. I am sorry, Congresswoman Pressley, but Mr. Barkan was going to add a little more.

Ms. PRESSLEY. Oh yes.

Mr. BARKAN. One in 4 Americans live with a disability, and this number is growing exponentially due to those who have become recently disabled because of the long-term effects of the coronavirus. Only a single payer system can possess the scale and resources necessary to guarantee care for all, detached from employment. As one example, Medicare for All covers home-and community-based services for all who need it.

The Federal Government currently requires States to fund nursing home care for everyone eligible. This is not the case with regards to home-and community-based services. And because States manage their own home care programs through Medicaid eligibility requirements, the services available vary widely across States. It is by default and design that so many Americans who require care are forced into unsafe institutions like nursing homes. Patients overwhelmingly favor the option to receive care at home, but these services are prohibitively expensive and, therefore, inaccessible to most.

The government would actually save money covering the cost of home-and community-based services instead of covering nursing homes. Under a single-payer system like Medicare for All, home-and community-based services would be prioritized over institutional care, giving patients the safe and dignified care they prefer and deserve.

Voice. Thank you so much.

Ms. PRESSLEY. Thank you.

Ms. BUSH. The gentleman from New York, Mr. Jones, is recognized for five minutes.

Mr. JONES. Thank you, Madam Chair, for your leadership. I represent a district that people often think of as very affluent, and yet there are still too many people who cannot afford healthcare. I think of my grandmother, for example, who, like so many seniors throughout this country, worked well past the age of retirement just to pay for the high cost of prescription drugs, dental care, and other medical procedures that are not fully covered by Medicare as we know it today. Other of my constituents who lack healthcare coverage are working middle-class people who make too much money to qualify for Medicaid or other subsidies under the Affordable Care Act but not enough to afford the high cost of healthcare on their own.

The price of premiums and deductibles is simply too high for many families. Still others have experienced gaps in coverage at critical times due to job loss. In fact, we saw millions of Americans lose their jobs during the COVID-19 pandemic, and with that, their healthcare. The pandemic made it clear that the employer-based healthcare system just does not work in our modern economy.

Mr. Barkan, thank you for your testimony and for your dedication to making America a Nation that treats every person with dignity and with compassion. You are a leading voice in our push to finally realize universal healthcare coverage, our push for Medicare for All. We have heard a number of misleading claims from my colleagues on the other side of the aisle today, so now I would like to give you the opportunity to correct the record on what we have heard today.

Mr. BARKAN. Thank you for your comment and your leadership. There has been a lot of misleading information today about how Medicare for All would take away our freedom of choice, but the reality is our for-profit system does exactly this by inhibiting our ability to make choices for ourselves and by dictating and limiting our experience of care. As I told you this morning, my health insurance provider denied the ventilator that I needed to survive until I forced him to cover it.

Right now, multi-millionaire healthcare executives already make unilateral decisions about our health coverage. There is no freedom to be found in a system that tells us who we can or cannot see or which services we can or cannot access. Medicare for All would ensure that all of us have the freedom to choose our healthcare providers and hospitals without worrying about whether a provider is in network. It would mean that patients would have uninterrupted access to care and that we would be able to build long-term relationships with our providers. It would mean that seniors and disabled people have the option to live safely and with dignity at home instead of being warehoused in unsafe nursing homes. Medicare for All would mean that Americans would be free of medical debt. Health insurance companies and their multi-millionaire executives do not belong in the intimate decisions we make about our health. Medicare for All is a system designed to empower the peo-

ple by placing the power of choice back in the hands of patients and providers.

A single payer system is, in fact, the only system that would allow us the true freedom to make our own decisions about our lives. When it comes to waiting times, we already have incredibly long wait times for every element of our healthcare system. Even prior to the pandemic, which has deeply exacerbated this issue, the wait time for the ER takes hours. Wait times for specialists can take months or years, and that doesn't include the people who have to ration their own care because they cannot afford this. With a Medicare for All system, the system would expand. There would be more providers, and care would not need to be rationed in this way.

Mr. JONES. Thank you, Mr. Barkan, for your leadership. Madam Chair, I yield back.

Ms. BUSH. The gentlewoman from New York, Ms. Ocasio-Cortez, is recognized for five minutes.

Ms. OCASIO-CORTEZ. Thank you so much, Chairwoman Bush, and to all of our witnesses for being here today. But I have to underscore how grateful we are for Representative Bush's leadership and determination in securing such a historic and unprecedented hearing, not just for this committee, but for the country, so thank you.

We know that private insurance is the primary health coverage for two-thirds of Americans, with the majority of private insurance being employer sponsored. But what I think most people in the U.S., most working-class people need to contend with is the fact that the money employers spend on health benefits, and particularly for-profit private health insurance, comes from the money that they would have otherwise spent on our wages.

Dr. Collins, in 2020, the standard company-provided health insurance policy totaled over about \$7,000 a year for single coverage and over \$21,000 a year for family coverage. Is that correct?

Dr. COLLINS. Yes.

Ms. OCASIO-CORTEZ. And with employer-sponsored insurance, your employer pays a large portion, and you pay a smaller portion, correct?

Dr. COLLINS. Yes.

Ms. OCASIO-CORTEZ. So in the case of individual coverage, if the total cost is around \$7,400 and your employer pays, say, \$6,200, and you pay for around \$1,200, now that is thousands of dollars more that everyday people could be saving per year if it weren't going directly to insurance companies' private profits, correct?

Dr. COLLINS. Yes.

Ms. OCASIO-CORTEZ. Interesting. So one of the things that we are really seeing here is that the potential to moving to a Medicare for All system could actually give people a raise in many circumstances. Now, a common rebuttal to that and a common rebuttal to Medicare for All that you will hear from conservatives and the right is that we would merely just change the way in which that same premium is charged, and that those same dollars that are coming out of our paychecks now would then just be coming out in the form of taxes. But the truth is that Medicare for All actually lowers the overall cost of healthcare as well.

Dr. Collins, isn't it true that Medicare for All would also reduce the average total costs for lower-and middle-income families by eliminating more medical expenses than they would pay in taxes?

Dr. COLLINS. How it was structured is there is that possibility, particularly in terms of getting provider prices down which drive these cost that people are paying.

Ms. OCASIO-CORTEZ. Mm-hmm. Thank you. And you don't even have to take just our word for it. In fact, that conclusion has been confirmed via thorough research by the Center for a Responsible Federal Budget. We also know that Medicare for All is much cheaper than private insurance. Dr. Collins, public options like Medicare actually pay hospitals and service providers less than private insurance companies have to for the same service. So a single-payer public option would drive down costs additionally through its ability to negotiate on health services and drug prices. Isn't that right?

Dr. COLLINS. That is very true.

Ms. OCASIO-CORTEZ. And, in fact, I think the evidence for that isn't just theoretical, it isn't just calculated by think tanks, but we see it in everyday life. Another case in point right here comes from my district. Almost everywhere in the world, health outcomes are correlated with a person's income, but one of the only places in the world that that doesn't apply is in Queens, one of the handful of zip codes where your income does not determine the quality of healthcare that you have. And the reason for that is our crown jewel of the public hospital, Elmhurst Hospital in Queens.

Years ago, we as a community made a commitment that we would never turn anybody away based on their health insurance status, their documentation status, their housing, or their income. Every single person who enters Elmhurst Hospital gets treated regardless of their ability to afford care. And what we have found is that it is more affordable to treat everybody, it is possible to treat everybody, and people can get higher-quality care than they ever could under our current privatized for-profit system.

And with that, I yield back to the chairwoman. Thank you very much.

Ms. BUSH. The gentleman from Vermont, Mr. Welch, is recognized for five minutes.

Mr. WELCH. Thank you very much, Madam Chair. I appreciate it. I am a co-sponsor of Medicare for All as well, and the incredible challenge we have with healthcare, as many of my colleagues have said, it is too expensive. We pay the most and we get the least, and we still have 30 million folks who are uninsured, and it is unconscionable. It is unconscionable because it is not necessary. It is not as though we don't have the capacity to provide care, and it is not as though we don't have the capacity to save money. But we have a healthcare system that is so fragmented, both in the delivery system in the payment system that we end up paying the most and getting the least. And how we are not all shocked by that from a fiscal standpoint, but from a moral justice standpoint, is astonishing. It really is. So, Congressman Jayapal, I want to thank you for the carrying the torch on this.

The public option is something a lot of us advocate for. The Medicare for All is something we all advocate for. A major reason I do is that I think we do have to get the costs down, and what we have

seen in this pandemic is our frontline providers, folks hands-on like our nurses, they haven't been paid enough, and they are getting hammered with work responsibilities. On the other hand, you have private equity finding those seams in the healthcare system where they can take over an emergency room physician practice, and then, through double billing, make an immense amount of profit. And it is exploitation of the fragmentation of the healthcare system that is helping to lead to these high costs and low access. So that is just a little background.

The things we have done, I think, that are good is telehealth has really worked. That has been incredibly beneficial. We have got to bring down the cost of prescription drugs, and the House, of course, passed the legislation to do that. We have got to have mental health that has parity.

Just a couple of questions. Dr. Michener, I want to have you focus on rural communities because so much of my district is rural, but that is true for so much of America. What are the particular challenges that rural America has in accessing affordable, high-quality medical care?

Dr. MICHENER. Yes, this is an appropriate question given that I hail from UpState New York. So I think a lot about the rural communities there, and I am actually a part of a collaborative that focuses specifically on health equity in rural communities, and I think there are a range of challenges. So one is the basic challenge that we have been talking about today, which is access, and I think that because in rural communities we see higher rates of poverty and we see more difficulty and challenges around having health insurance, having just access to being insured, that is a primary and an initial barrier. And then I think there are some specific barriers that are particularly challenging in rural areas. Transportation is one.

Mr. WELCH. Right. Yes, very much.

Dr. MICHENER. And that that is an important problem and one that is, in part, addressed through a program like Medicaid, which has a transportation benefit. We don't see that same benefit available in the private sector, and we know that that benefit is correlated with all sorts of positive health outcomes.

Mr. WELCH. Thank you. Thank you. And I will ask Dr. Collins, how would universal coverage improve healthcare options in rural communities, and as we work to ensure that all in America can prosper, how would universal coverage foster economic growth in rural areas?

Dr. COLLINS. Well, I think we have seen in Medicaid non-expansion States, as a case in point, rural hospitals have closed. They just haven't had the financing that they need to serve people in their communities. And so having a universal financing mechanism to make it possible for these hospitals to stay in business would be one of the benefits of universal coverage in every State.

Mr. WELCH. You know, one final point I am going to make, and I will ask you, Dr. Collins, to just respond to it, if you have universal coverage, then the challenges that each of us faces in access to healthcare become the challenges that all of us face. It is not as though having Medicare for All necessarily solves all problems. It

just means we are all in it together to try to solve the problems we face. Does that make some sense to you?

Dr. COLLINS. That is right, and insurance is the most important and it is a necessary condition for people getting access to care, but it is not the only factor. And so we also need to work at making sure people have adequate provider networks, that providers are paid well enough to participate in the networks, and we have good transportation systems so people in hard-to-reach areas are able to get the healthcare that they need.

Mr. WELCH. I yield back. Thank you, Madam Chair.

Ms. BUSH. The gentleman from Maryland, Mr. Sarbanes, is recognized for five minutes.

Mr. SARBANES. Thank you very much, Madam Chair. I appreciate the opportunity to join the hearing today.

We know that the research shows very clearly that there is a correlation between uninsurance or underinsurance and poor patient outcomes, and we saw that during the coronavirus pandemic, in particular. More than 40 percent of Americans who contracted coronavirus in the first year of the pandemic were either uninsured or underinsured. And a recent study found that a 10-percent increase in the number of uninsured residents per county was associated with a 70-percent increase in coronavirus cases and a nearly 50 percent increase in deaths from the coronavirus. Dr. Blackstock, I would like to ask you, what inequities in our healthcare system could explain this correlation?

Dr. BLACKSTOCK. Yes. So, you know, we have to think about when people lack access to care, they are lacking access to primary and preventive services, mammograms, colonoscopy screenings, proState cancer screenings, and so that will cause an exacerbation of these inequities. And then with the pandemic, we saw that our systems were under even increased stress, so people, when they lost their jobs, they also lost their insurance and were not able to access care. We also have seen that, as our government has picked up the slack in terms of vaccines and testing, that those gaps actually in terms of COVID mortality rates have closed. So we see what happens when we are able to provide communities and people to services that they need.

Mr. SARBANES. You know, the threat from the pandemic, we spoke often and we continue to about how that combines with underlying conditions to pose a great risk to patients. And if underlying conditions are persisting and not being addressed in certain communities and populations that is obviously going to increase the risk. Can you talk about how universal coverage could have improved the experiences of patients during the coronavirus pandemic? Let's look at it from the positive side.

Dr. BLACKSTOCK. Right, absolutely. We know that people who carry a higher burden of chronic disease were more at risk for the more severe outcomes of COVID-19. So if people have access to care, if they have access to, you know, care that prevents their diabetes, and their high blood pressure, and their asthma from worsening, then that could ultimately improve their outcomes from COVID-19. So it is really about investing in health, investing in people from the beginning to prevent these worse outcomes later on.

Mr. SARBANES. Dr. Michener, I would love to get your perspective as well. How would universal coverage ensure more equitable outcomes in the case of a future public health crisis because we want to learn our lessons obviously, and adapt, and make clear-headed decisions going forward? So if you could speak to that that would be wonderful.

Dr. MICHENER. Yes, I think universal coverage, in addition to providing people with access to care, they get to go to the hospital. They get to go to the doctor. They get to get the treatments in the medications that they need. They don't have to delay. They don't have to forego care. The other thing to recognize is that uninsurance and underinsurance are concentrated in particular communities, that there are zip codes and there are neighborhoods that have disproportionately high levels of uninsurance and underinsurance. So when we address those problems, we don't just address them among individuals. We address them at the community level, which means that the solutions and the benefits can really amplify.

For example, we have research that shows that when you insure parents, they are more likely to take their children to well care visits. Even if the children were already insured, if the parents weren't, they weren't socialized into the habit of going to the doctor. And so you see families, and you see social networks, and you see communities, and the benefits of insurance ripple throughout these levels so that we can see amplified positive effects if we have universal insurance.

Mr. SARBANES. You know, there are so many connections here that aren't necessarily intuitive, but when it is brought to your attention, it makes perfect sense. So a lot of the adults with less income in our society experienced coronavirus-related job loss or pay cuts at the beginning of the pandemic, and then had consequential coverage laws that went with that. In Maryland, we saw 200,000 people enroll in healthcare coverage through our State-based health exchange during the special enrollment period that we extended during COVID-19, and nearly two-thirds of those people enrolled in Medicaid.

I am running out of time, but, Dr. Michener, what does it tell us about how Federal healthcare programs can support people and the ability to lift up communities during times of crisis and volatility?

Dr. MICHENER. I will quickly say, mindful of time, given all that has been said about the government, and Big Government, and government inefficiency, this is a really important point. There was a time before Medicare, there was a time before Medicaid, and it was a dark and dismal time where many more people had much worse outcomes. The private side of the market could not address the fundamental needs of the American people, and that is why we developed these public programs. And they are not perfect, but they are absolutely saving lives, and the science around that is quite incontrovertible.

Mr. SARBANES. Thank you, and I will just note as I yield back, their administrative costs tend to be much lower than what we see in the private sector and other arguments for the universal healthcare coverage that we are talking about today. Thank you, Madam Chair.



Ms. BUSH. The gentlewoman from Washington, Ms. Jayapal, is recognized for five minutes.

Ms. JAYAPAL. Thank you, Madam Chair, and thank you for your incredible leadership in making this hearing happen, and to all my sisters in service that were part of it, and to all the colleagues who have been talking about the various aspects of universal healthcare. Also, thank you for the powerful testimonies that we have heard.

My Medicare for All act would provide healthcare to everyone in the United States without the financial, racial, or demographic barriers that exist in our current system. My bill creates a comprehensive, universal single-payer healthcare system that provides all the medically necessary care that someone needs. Imagine that: a comprehensive care that includes dental, vision, and hearing, and for the first time when we introduced this bill two Congresses ago, long-term care, something that Mr. Barkan has spoken extensively on.

The bill eliminates insurance premiums, co-pays, deductibles, and all other out-of-pocket costs, and removes the for-profit insurance companies from the doctor-patient relationship, while controlling medical costs to bring down overall spending. That is a very important piece of this. And I think at the end of the day, I have heard people arguing against Medicare for All by saying it takes away choice. I would just argue that Medicare for All would actually allow people to make choices, like being able to go see a doctor or a hospital without worrying about out-of-network costs that come later when there are tens of thousands of dollars that people can't afford; or the choice to be able to have healthcare even when you lose your job instead of 27 million people losing healthcare because they lost their jobs during COVID; or the choice to start a small business because you don't have to worry about your healthcare, it is covered already; or, most importantly, the choice to live and not die.

Researchers have found that Medicare for All will save over 68,000 lives per year. That means 68,000 more birthdays, 68,000 more anniversaries, 68,000 more loved ones alive every year simply because we transitioned to a Medicare for All system. And under Medicare for All, those 68,000 lives saved would also see a drastic increase in quality of life.

Mr. Barkan, you have been an incredible patient advocate your entire life, and even now you are still. How would your life be different if Medicare for All were enacted? And I am going to give you a few moments because I know you have to get your answer prepared, and I will come back to you for your answer.

Dr. Blackstock, as a physician and expert in health inequities, you have seen firsthand who the winners and losers are in our for-profit healthcare system, and we often forget the crucial role that Medicare actually played in beginning the desegregation of hospitals. We sort of overlook that, but there is a lot more to do. So tell me, who do the 68,000 lives that Medicare for All would save, the lives that are lost in our current healthcare system, who do those lives belong to?

Dr. BLACKSTOCK. Thank you, Representative Jayapal, and thank you for mentioning that because I think we often forget that Medi-

care was probably one of the greatest civil rights achievements in terms of desegregating hospitals and providing or advancing health equity. But the 68,000 lives are people who matter, people who deserve humanity. They are mostly and disproportionately people of color. They are also low-income families. They are predominantly located in the Southern part and the Western part of this country. They are people who aren't able to afford the out-of-pocket costs, you know, to purchase medication or to access insurance. So this is giving people with families, low-income families with children, the opportunity to have a choice to access the care that they need.

Ms. JAYAPAL. Dr. Michener, you have spoken so eloquently about racial inequity. Tell us how a Medicare for All system would help alleviate those racial health inequities that people are facing right now.

Dr. MICHENER. One of the main benefits of a Medicare for All system is that it is not a tiered system. It is not a system that is rationed based on where you live. We know that rationing based on geography leads to racial inequities, so that people who live in the South or people who live in what we call hospital or our public health deserts, have less access. We don't have rationing based on income. We know that causes racial disproportionalities because people of color are more likely to be living in poverty. We don't have rationing based on a range of other factors that all bake in racial discrimination. Instead, we have access that is equally available to all.

Ms. JAYAPAL. Thank you so much. Let me go back to Mr. Barkan before my time expires and ask you for your answer. Mr. Barkan.

Mr. BARKAN. Thank you so much for your leadership. It is an honor to be in the struggle with you. I am not the only one whose life has been upended, first, by illness and then by the moral abomination that is our healthcare system. Right now, about 30 million people in this country are uninsured, and even more get necessary care denied every year by their insurance company. We are richest Nation in the history of the world, and yet Americans regularly go bankrupt from their medical bills and cut their pills in half because they can't afford the cost of prescription drugs. It reveals much about our country that we see spikes in cancer diagnoses for Americans aged 65 once they become eligible for Medicare. Too many go far too long without care because they cannot afford it.

By securing Medicare for All, we can save thousands of lives and free mourning families from the lingering pain of asking themselves, what if we had caught this sooner. Americans across the Nation and across the political spectrum have been harmed by corporate greed. I believe we can overturn our for-profit system because our power lies in our solidarity. Our movement for Medicare for All isn't slowing down any time soon. We intend to win our due rights, and we will continue to organize for our collective freedom until all of us are free from this corrupt system of corporate greed.

Ms. JAYAPAL. Thank you so much, Mr. Barkan. We are not giving up until we pass Medicare for All. Thank you, Madam Chair. I yield back.

Ms. BUSH. The gentleman from New York, Mr. Bowman, is recognized for five minutes.

Mr. BOWMAN. Thank you so much to Chairwoman Maloney and Rep. Bush for holding this historic hearing, and thank you to all the members of this committee for allowing me to join you today. Thank you also to Rep. Jayapal for her incredible leadership on this issue.

More than 27 million adults in the United States today are uninsured. Millions more are underinsured. As a Member of Congress, I am more than adequately covered. I can get a checkup any time I want. If something is wrong, I can get treated on the spot. Those of us who support Medicare for All believe that every single person who lives in this country should have that level of care. It is very simple. If people knew they had exemplary healthcare, they would go to the doctor more, but as it stands, millions of people often skip preventive and routine care, instead waiting until they are severely ill to seek treatment.

Dr. Blackstock, how do these delays in seeking care affect patients?

Dr. BLACKSTOCK. So delays in care result in late or misdiagnoses. They also result when a condition is diagnosed that is more difficult to treat, it results in higher mortality rates. We know that people who are uninsured have about a 40-percent higher age-specific mortality risk. And so, you know, access to care is equivalent to your mortality risk, so we need to give people access to care through health insurance so that we can reduce their risk and so they can lead full, healthy lives.

Mr. BOWMAN. Thank you, Dr. Blackstock. My next question is for Dr. Michener. As you have mentioned already today, people of color are more likely to be uninsured than white people. They are more likely to experience severe medical events or suffer from catastrophic medical debts. As a Black man, I am acutely aware of the specific care needs that Black men have in our society. It is well known, for example, that Black Americans have the highest rates of hypertension, and Black men are least likely to have their high blood pressure controlled. Lack of trust in our current healthcare system is one of the reasons they are not seeking treatment. Dr. Michener, how could we rebuild that trust under a Medicare for All system with universal access to comprehensive healthcare? How could Medicare for All strengthen communities of color generally and improve other social determinants of health?

Dr. MICHENER. I think that Medicare for All contributes to and can contribute to precisely this problem of lack of trust. We can think about lack of trust as sort of an individual attitude, right, but it is rooted in experiences with structures. So when you go to the doctor or you try to go to the doctor and you are not able to get access, or when you are worried about whether when you show up you will be able to see someone given your health insurance status, when you are worried about the cost, these are experiences that are disproportionately in communities of color, and they all erode trust.

Over and above that, Medicare for All, a universal coverage system, is going to strengthen the healthcare system more generally. It is going to allow us to make investments in the healthcare workforce. Again, this will increase access and increase access in ways that, if designed right, can disproportionately benefit the very com-

munities of colors that are disproportionately harmed by the current system. All of these things contribute to repairing what, frankly, is broken and has always been broken.

Mr. BOWMAN. Thank you so much for those responses. I want to briefly share a personal story. Just recently, maybe a month or so ago, I was feeling unwell in my office on the Capitol. I literally took a 10-minute walk to the healthcare unit on the Capitol, was seen immediately, treated immediately, and sent on my way to go home and take care of myself. It made me think of all the Black men, and people of color, and uninsured and underinsured people in this country who do not have that privilege and do not have that access. When they don't feel well at home, they have to just deal with it in whatever way they can using home remedies, which is OK. But imagine if they can walk right downstairs or take a 5-to 10-minute walk to a doctor right down the street, get seen on the spot, be treated on the spot, and be sent on their way with the medication or care that they needed, and also, by the way, have unlimited access for followup. I can call a doctor on the Capitol 24 hours a day and weekends to followup on the care that I received.

Everyone in this country deserves that level of care. Thank you, and I yield back.

Ms. BUSH. The gentlewoman from Minnesota, Ms. Omar, is recognized for five minutes.

[No response.]

Ms. BUSH. We can't hear you.

Ms. OMAR. My apologies. Thank you, Madam Chairwoman, for having me on your committee today, and thank you to all of our witnesses for your excellent testimonies.

When a person needs healthcare, they should not have to worry about whether their coverage status will be a barrier, but unfortunately, that is not the case for millions of marginalized gender identities in the in the United States. Across the United States, transgender people are uninsured at a greater rate than their cisgendered counterparts. When trans folks who are covered seek care, they experience denials of medically necessary services at higher rates.

Dr. Blackstock, can you speak to how these trends perpetuate stigma against trans folks and the broader LGBTQ+ communities in healthcare settings?

Dr. BLACKSTOCK. Yes. Yes, Representative Omar. So, you know, one thing that we know is that the healthcare system is not sensitive enough to the needs of the LGBTQ+ community, and that many of our healthcare providers are not trained in a way that is needed to provide the best care. But access is so incredibly important, especially for these communities, because we know that these health inequities exist, and they are perpetuated because people from these communities are unable to access care. So I think Medicare for All will provide an opportunity for members from stigmatized communities to engage in access with the healthcare system, and the healthcare system also needs to be equipped to provide the resources and services in a culturally sensitive way, in a culturally responsive way to these communities.

Ms. OMAR. Dr. Michener, what steps can Congress take to ensure that people of marginalized gender identities are able to access

medical that are necessary care and free of stigma and financial barriers?

Dr. MICHENER. I think the sorts of policies, the commitment to universal coverage that we have been talking about here today, is the first and critically important step. I think that there are barriers that are really concrete around simply being able to have access, and that is a sort of first point to address. Over and above this, though, I do think that we need to think about interventions that are sort of tailored to these uniquely marginalized populations. And so we need to be aware of what the unique challenges are in those populations, and I think part of what that means is talking to those folks, understanding better their perspectives and barriers, and connecting that information with the policy choices that we make going forward.

So I guess the broad point I am making is to really think about how we can improve voice in addition to access so that the people who are most affected, who have really unique stakes around these particular kinds of barriers, can really help us to understand how to engage and move forward in a way that is going to address their particular vulnerabilities.

Ms. OMAR. And I wanted to also ask you, you know, as someone who supports Medicare for All and serves as the vice chair of the Medicare for All Caucus, oftentimes we hear how universal access to care can lessen the quality of care that is available to people. Can you respond to that sort of critique as an advocate for universal access?

Dr. MICHENER. I appreciate the opportunity to address that. So one of the things that I always emphasize is that quality of care, just like access to care, is a choice. It is a political choice, and so many of the critiques that we have heard around quality to care—look at the VA and its weaknesses, or look at Medicare and its weaknesses—those are a reflection of political choices: choosing to under fund those services, choosing to create administrative burden and barriers, choosing to make life for people on those programs more difficult. And if we make different choices, we can have government programs that are just as well run, just as efficiently run, actually more so than private options, and the reason is because there is no profit motive.

We are not trying to maximize what we can gain in exchange for what we give in the context of a government program. We are trying to maximize what we can give in exchange for improving people's lives, saving their lives, and helping them to thrive. That is the best context for both efficient and effective programs that are going to help people. And to the extent that that is not what we have, it is because we are choosing not to put the pieces and the resources in place to achieve it.

Ms. OMAR. Thank you. Thank you so much for that response. I will just say as someone who has been fully insured for the first time in my life here in the United States, I know just how much my healthcare has improved, not just having the anxiety of worrying about whether I could access, you know, what Congressman Bowman was talking about, being able to pick up the phone, walk 10 steps to a medical professional to care for you. That is the kind of access that we want for everyone, and that is the kind of access

everyone deserves. So, again, thank you all for the opportunity to have this conversation.

Chairwoman, I yield back.

Ms. BUSH. Before we close, I want to offer the ranking member an opportunity to offer any closing remarks he may have. Ranking Member Comer, you are now recognized.

Mr. COMER. Well, thank you, Madam Chair, and I just want to reiterate the fact that the Oversight Committee's role is to determine waste, fraud, abuse, and mismanagement in the Federal Government and try to provide solutions to those problems with waste, fraud, and abuse. This hearing, like just about every other hearing this committee has had this year, hasn't touched upon that. In fact, not only does it not save money and reduce waste, fraud, and abuse, it increases the size of government significantly, and this is a pattern that we have seen with this committee.

We had an energy hearing where many of the members on the Democrat side asked the energy CEOs to pledge to decrease production. Now, think about that: decrease production. Now we have President Biden going to OPEC, Venezuela, and begging them to increase production. I say that because we don't believe that the government can efficiently run healthcare. We believe that the solution to healthcare problems is with innovation, is with competition, and that is where Republicans will continue to work to try to find solutions when we talk about healthcare.

Madam Chair, thank you for the time, and I yield back.

Ms. BUSH. Thank you. I now recognize myself.

The choice before the committee today, the choice is saving lives or increasing profits. It is the quality of life or the quantity of yachts. Medicare for All would guarantee high-quality healthcare to every person in America in the prioritizing of Big Pharma over human life and health, and, more importantly, it would save lives.

To the 30 million people in this country who are uninsured, to those who are underinsured, and to the Black, brown, indigenous, disabled, low-income, and trans people who are burdened under the various inequalities of our healthcare system, we see you, we know, and you matter. We are fighting for you. You deserve life. You deserve care.

I am grateful to Chairwoman Maloney and to our sisters in service for their partnership in this hearing. In closing, I want to thank our panelists for their remarks. I want to commend my colleagues for participating in this important conversation.

With that, without objection, all members will have five legislative days within which to submit extraneous materials and to submit additional written questions for the witnesses to the chair, which will be forwarded to the witnesses for their response. I ask our witnesses to please respond as promptly as you are able.

This hearing is adjourned.

[Whereupon, at 1:52 p.m., the committee was adjourned.]

