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

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

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

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

**Health disparities in African-American communities**

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

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

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

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

**The Importance of Health Equity and Universal Coverage**

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

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

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

**The Role of Government**

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

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

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

**Frameworks for Health Care Coverage to Aid Communities of Color**

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

I want to leave you with two points:

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

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

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

Thank you Mr. Chairman.