The subcommittee met, pursuant to call, at 10:30 a.m., in Room 2322 Rayburn House Office Building, Hon. Anna G. Eshoo [chairwoman of the subcommittee] presiding.

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

Staff present: Jeff Carroll, Staff Director; Tiffany Guarascio, Deputy Staff Director; Zach Kahan, Outreach and Member Service Coordinator; Saha Khaterzai, Professional Staff Member; Josh Krantz, Policy Analyst; Una Lee, Senior Health Counsel; Aisling McDonough, Policy Coordinator; Meghan Mullon, Staff Assistant; Kaitlyn Peel, Digital Director; Alivia Roberts, Press Assistant; Samantha Satchell, Professional Staff Member; Rebecca Tomilchik, Staff Assistant; Rick Van Buren, Health Counsel; C.J. Young, Press Secretary; Nolan Ahern, Minority Professional Staff, Health; Margaret Tucker Fogarty, Minority Staff Assistant; Theresa Gambo, Minority Human Resources/Office Administrator; Tyler Greenberg, Minority Staff Assistant; Peter Kielty, Minority General Counsel; Ryan Long, Minority Deputy Staff Director; Kate O'Connor, Minority Chief Counsel, C&T; James Paluskiewicz, Minority Chief Counsel, Health; Kristin Seum, Minority Counsel, Health; and Kristen Shatynski, Minority Professional Staff Member, Health.
Ms. Eshoo. Good morning, everyone. The Subcommittee on Health will now come to order. The chair now recognizes herself for 5 minutes for an opening statement. And welcome to our colleagues that are at the table and everyone that is here in the hearing room.

Today's hearing features House colleagues who will present their legislative proposals to advance what I have always called the "North Star" of the Democratic Party, and that is to achieve universal health care for the American people. Five members are or will be at the witness table. Two representatives, Mr. Lujan and Ms. Schakowsky, will speak from the committee seats and two others, Representative Cedric Richmond and Representative Veasey, are submitting written statements.

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

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

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

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

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

[The prepared statement of Ms. Eshoo follows:]

**********INSERT 1**********
Ms. Eshoo. Is she here? Not here? Pardon me? She is on her way. Well, we are going to move on because the chair is now going to recognize Dr. Burgess, the ranking member of the subcommittee, for his 5 minutes for an opening statement.

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

Ms. Eshoo. So ordered.

[The information follows:]

**********COMMITTEE INSERT**********
Mr. Burgess. And also, I am okay with you yielding your final minute and a half to Mrs. Dingell when she gets here.

Ms. Eshoo. Thank you.

Mr. Burgess. So, thank you for leading the hearing.

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

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

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

Medicare for All would eliminate private insurance, employer-sponsored health insurance, Medicaid, the Children's Health Insurance Program upon which many Americans depend. I
am concerned about the consequences for existing Medicare
beneficiaries. The policy would raid the Medicare trust fund
which is already slated to go bankrupt in 2026; this will not
help. Our nation's seniors have been paying into and
depending upon the existence of Medicare for their healthcare
needs in retirement for, literally, their entire lives.

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

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

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

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

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

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

[The prepared statement of Mr. Burgess follows:]

**********INSERT 2**********
Ms. Eshoo. The gentleman yields back. I now would like to yield the minute and a half that I want to yield to Congresswoman Dingell so that you can make use of the time that you asked for.

Mrs. Dingell. Thank you.

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

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

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

[The prepared statement of Mrs. Dingell follows:]

**********INSERT 3**********
Ms. Eshoo. The chair now recognizes the chairman of the full committee, Mr. Pallone, for his 5 minutes for an opening statement.

The Chairman. Thank you, Madam Chair.

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

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

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

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

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

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

The bills we are considering reflect Democrats' continued commitment to achieving universal coverage and making health care more affordable and accessible for all Americans. I believe that we must continue to build on the success of the ACA until health care is truly a right for all Americans, which it should be. I look forward to the
discussion and yield the balance of my time to the
gentlewoman from Illinois, Ms. Schakowsky.

[The prepared statement of The Chairman follows:]

**********INSERT 4**********
Ms. Schakowsky. Thank you so much. Today really does mark a landmark day to discuss ways that the United States of America can join the rest of the industrialized world in saying that health care is a right and not a privilege for all of our people. You know, we spend more than any other country on health care right now, yet millions of people don't have access to care. We have the highest rates of infant -- or maternal mortality, we have a shorter life span, and we can do better.

So I have been a cosponsor and a supporter of single-payer health care since a lot of you in the room were even born, but I also want to say that I am a cosponsor of every single bill that is going to improve health care in this country because we have to move forward. I am a cosponsor of a bicameral public option bill ever since the Affordable Care Act didn't include it. I am a cosponsor, and you will hear from Representative DeLauro on Medicare for America. I am a Medicare for All. I am a cosponsor of that and was there at its inception.

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

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

The Chairman. I am sorry. Yes, I yield back, Madam Chair.

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

The Chairman. Dreaming about a better world.

Ms. Eshoo. Lovely.

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

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

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

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

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

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

And Chairman Pallone and I are working together on legislation to stop surprise billing so consumers aren't ripped off when they go to the emergency room. One in five are getting a surprise bill today, that is wrong. We are on the cusp of dealing with that. And we fully funded Children's Health Insurance Program in the last Congress, when I chaired the committee, for 10 years. It had never
been fully funded for more than 5.

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

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

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

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

Canada is facing a shortage of medical providers, and in some provinces some hospitals have responded by actually closing their emergency rooms 2 days a week. In British Columbia, 300 patients died waiting for surgery between 2015 and 2016 because of a lack of anesthesiologists. And
1 according to the British Columbia Anesthesiologists' Society,  
2 they say that is a huge problem.  
3  
4 Canada has 16 CT scans for every million people. In  
5 America, we have 45 for every million people. That means  
6 that you can get access to care quicker here, get those  
7 scans. Delay and denial of care is how government-run  
8 healthcare systems control costs. You see what is going on  
9 in England right now with a young boy that was being treated,  
10 I think, in a hallway. They ration care. They delay care.  
11 If the government decides a treatment or drug you need is not  
12 cost effective, you are denied access. We had that debate in  
13 this committee. The data are clear about how long you wait  
14 to get access to miracle drugs in other countries. Upwards  
15 of 40 percent of the new drugs are not available. These are  
16 cancer drugs. These are new drugs on the market that would  
17 save lives, and do, in America.  
18  
19 We *got* have to deal with the issue of costs, certainly,  
20 but there is a way to do that. And by the way, most of these  
21 government-run systems prevent you from going around the  
22 government-run system. Some people do flee a country, come  
23 to another one, mainly America, to get access to care when  
24 their own government system fails them. It is not just a  
25 theory. It is what happens in some of these countries.
So I am not a fan of that complete government takeover. I am a fan of reform and of making sure we have the network in place. So, Madam Chair, thanks for having this hearing. I yield back.

[The prepared statement of Mr. Walden follows:]

**********INSERT 5***********
Ms. Eshoo. The gentleman yields back.

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

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

So beginning with Congresswoman Rosa DeLauro from my home state where I was born and raised, Connecticut, welcome to you; to Representative Jayapal from the state of Washington, welcome to you; to Representative Higgins from New York, thank you for making yourself available today; to Representative Delgado from the state of New York; and Representative Malinowski from New Jersey. Welcome to each one of you. Thank you for the work that you have put into the product that -- the legislation that you are going to
This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee’s website as soon as it is available.

1 explain to us today.
2 So we will start with Congresswoman DeLauro. You are
3 recognized for 5 minutes to speak to your legislation, 1384,
4 the Medicare for -- no, 2452, I am sorry, the Medicare for
5 America Act. You all know the light system, so I don't need
6 to explain that to anyone.
7 Welcome. Thank you, Rosa.
Ms. DeLauro. Thank you so much, Madam Chair.

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

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

Medicare for America moves every individual currently enrolled on the individual exchanges and Medicare beneficiaries on to the program. Individuals and children enrolled in Medicaid and CHIP are transitioned on to Medicare
for America, over time, to ensure that their care is not disrupted as we transform our healthcare system. We made this deliberate choice after working with members of the disabilities community who know all too well about disruptions in the face of budget cuts and other complications.

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

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

And, additionally, on the topic of the cost of the
program, our bill included pay-fors. I ask you to read it.
I won't enumerate all of them, but the pay-fors are there.
Let me discuss what is innovative about Medicare for America.
Today, healthcare benefits are too dependent on your ZIP
Code. Universal coverage must be universal, so Medicare for
America is explicit in the benefits covered especially with
respect to long-term services and supports.

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

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

Far too many individuals face roadblocks because reimbursement rates are too low. Far too many providers are weighed down or scared off because of mounting debt and choose only private insurance. So Medicare for America establishes all-payer rate setting. Private insurance pays the Medicare for America rate. It all comes back to getting patients the care they need. That is why we ban private contracting. Current law allows providers to cover individuals and private coverage. They also talk about paying out-of-pocket for care even if their insurance covers the benefit. It is a two-tiered system that must not
continue. Patients deserve to be treated fairly to get the care they need.

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

Ms. DeLauro. 1 second. At its core, Medicare for America is about ensuring that every American has health care and as we debate into the future on universal healthcare coverage, my view, Medicare for America is the best way forward in providing historic change.


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

[The prepared statement of Ms. DeLauro follows:]**********INSERT 6**********
Ms. Eshoo. Thank you, Congresswoman DeLauro. With all the energy she always brings to everything that she does, thank you.

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

Ms. Jayapal. Thank you.

Ms. Eshoo. And thank you again for being here today. I know that you have Judiciary as well, so away we go.
Ms. Jayapal. Thank you so much, Chairwoman Eshoo, Ranking Member Burgess and Chairman Pallone and Ranking Member Walden, and distinguished members of the Subcommittee on Health. Thank you for holding this historic hearing. This is a great day.

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

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

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

Our nation's healthcare system is the most expensive in the world. Contemplate that. This year, we will spend almost $3.9 trillion, or 18 percent of our GDP on healthcare expenditures and that is almost double what every other industrialized country in the world spends. Over the next decade, our current healthcare system will cost America about $55 trillion. What does that astronomical spending get us? The highest maternal and child mortality rates among our peer countries and the lowest life expectancy. It gets us 500,000 Americans who every year are forced into bankruptcy because of medical costs. It gets us 70 million people who still
remain uninsured or underinsured and that is just a bad deal. Why is America so far behind our peer countries? You might ask that. Because profit-making motives are baked into our system and our healthcare system incentivizes putting profits over patients. For-profit insurance companies with extremely high administrative waste stand between Americans and good quality, affordable health care. Every American knows someone, a loved one, a friend, a child, or a parent who has suffered a healthcare crisis, and they know that the system we have doesn't work.

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

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

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

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

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

Ms. Eshoo. Pramila?

Ms. Jayapal. Now it is up to us.

Ms. Eshoo. Pramila?

Ms. Jayapal. And it is time for us --

Ms. Eshoo. Wind up.

Ms. Jayapal. -- to pass Medicare for All.

I am just listening to my mentor, Rosa DeLauro, who took a minute more -- Mr. Shimkus. Regular order. Regular order.


Ms. Jayapal. -- to continue to say --

Ms. Eshoo. Just wrap up.

Ms. Jayapal. -- that it is time for us to pass
Medicare for All. Thank you, Madam Chair.

[The prepared statement of Ms. Jayapal follows:]

**********INSERT 7**********
Ms. Eshoo. Thank you. Thank you very much for being here today and testifying.

We will now call on Congressman Brian Higgins. Welcome, Brian. It is wonderful to see you here and you have 5 minutes to present your proposal.
STATEMENT OF HON. BRIAN HIGGINS, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF NEW YORK

Mr. Higgins. Yeah, thank you very much, Chairwoman Eshoo and Chairman Pallone and Ranking Member Burgess. I just want to say that I was a proud supporter of the Affordable Care Act which will be 10 years old this March. But even the President, the Speaker, recognized that the passage of the Affordable Care Act represented a start not a finish and that it was highly imperfect in many ways including the lack of a public option to be a real countervailing force to private insurance, because I think by and large private insurance screws people. They jack up premiums. They jack up deductibles. They jack up copays. And then when you go to use the insurance that you already paid too much for, there is very little underlying insurance. You know, before the Affordable Care Act, if you had a kid that was stuck with childhood cancer, an insurance company could deny you coverage because of a preexisting condition. You can't do that anymore. It is against the law. And the only federal law that protects people with preexisting conditions is the Affordable Care Act. In 2010, Democrats lost control of the House because of health care.
2018, Republicans lost control of the House because of health care. We are even. Let's move forward.

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

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

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

I have a bill that would allow people 50 to 65 to buy Medicare as a medical option. The Henry J. Kaiser Family Foundation that has done extraordinary work in this regard says that 77 percent of the American people support a Medicare buy-in 50 to 65. Why that age demographic? Because this age demographic, 50 to 65, is to this century what the traditional Medicare population was to the previous century, and that is that private insurance had every opportunity to write policies for people that were older and sicker but chose not to do it. And a good and generous nation responded by establishing the Medicare program, and then all the privates wanted in on it when it was deemed to be profitable and successful under the Medicare Advantage program.

This age demographic experiences very high preexisting conditions, about 50 percent. Their premiums are very high, their deductibles are very high, and their copays are very, very high. I will give you an example. A 60-year-old able to buy into Medicare at their own cost that will not adversely affect the Medicare Hospital Insurance Trust Fund, according to the Rand Corporation and the Henry J. Kaiser Family Foundation, would save 48 percent when compared to a
Gold Plan on the individual market. Now Rand also said that six million Americans would take advantage of that plan. That is almost 14,000 people per congressional district. And I would remind you that that age demographic also votes, so it is good on the politics. It is good on the substance. I think we have an obligation to much like we said 10 years ago, we need the next iteration, the next exciting iteration of Medicare expansion, and I believe that my bill should be in that conversation relative to that goal. Thank you very much.

[The prepared statement of Mr. Higgins follows:]

*********INSERT 8*********
Ms. Eshoo. Thank you very much. And thank you for being on time as well, on time with your conclusion using your 5 minutes.

It is a pleasure to welcome and thank Representative Delgado from New York to present his idea, his proposal, which is H.R. 2000, the Medicare-X Choice Act. So welcome and --
STATEMENT OF HON. ANTONIO DELGADO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

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

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

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

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

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

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

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

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

[The prepared statement of Mr. Delgado follows:]

**********INSERT 9**********
Ms. Eshoo. We thank the gentleman. It is a great source of pride to all of us that of the five that are speaking at the witness table this morning that Mr. Delgado and Malinowski are new members of Congress. This is their first term. And you are a source of pride to us and you more than hit the ground running with ideas. You are fresh off the campaign trail and it is always refreshing to see what new people bring to the Congress, so thank you as a combination with the others.

Mr. Delgado. Thank you.

Ms. Eshoo. Now it is a pleasure to both welcome and recognize Mr. Malinowski for your 5 minutes to talk about your proposal which is H.R. 4527, the Expanding Health Care Options for Early Retirees Act.
STATEMENT OF HON. TOM MALINOWSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

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

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

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

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

And since introducing the bill in September, my office
has received dozens of phone calls and letters and messages
from people all across the United States describing how it
would help them or a family member. A person from Wilson
County, Tennessee wrote to us, "This is a such a needed law. More and more agencies are washing their hands of insuring first responders when they retire. It is not a young person's job. And when we retire, we are damaged physically and emotionally and need the health care that eats up most of our pension."

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

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

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

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

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

Thank you so very much and I yield back.

[The prepared statement of Mr. Malinowski follows:]

**********INSERT 10**********
Ms. Eshoo. The gentleman yields back. And let me express on behalf of all of the members of the committee, both sides of the aisle, for not only accepting our invitation to be here today to describe your idea, your legislative proposal, but the clarity in which you have done so. We are legislators. We are lawmakers, and it is incumbent upon us to respect the thinking that goes into each person's proposal, and your thoughtfulness is on display this morning.

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

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

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

Mr. Burgess. Are you expecting a call?

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

[Pause.]

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

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

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

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

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

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

So I will now recognize Ms. Rosenbaum for your 5 minutes of testimony, and you can begin. I think you all know what the lighting system -- green. When you see the yellow light
speed up, because on the heels of the yellow light comes the red light. Welcome, and you may proceed.
Ms. Rosenbaum. Thank you, Madam Chair and Ranking Member Burgess and members of the subcommittee for this opportunity to --

Ms. Eshoo. Do you have your microphone on?

Ms. Rosenbaum. Yes, I do.

Ms. Eshoo. Get it close --

Ms. Rosenbaum. Yeah, closer.

Ms. Eshoo. -- so we all can hear you very well, every word.

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

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

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

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

Other administration initiatives are aiming to push Medicaid enrollment still lower through block grants, work experiments, and other administration strategies. The administration has targeted the private insurance reforms under the ACA in order to erode access to higher value policies in favor of what experts call "junk insurance," while taking constant aim at the law's essential health benefit and affordability provisions.
I think that we face two major challenges, one set in the near term and one set for longer term discussion and they are reflected in the amazing range of bills you have before you today and the deeper thinking that has gone on behind those bills. The first is to what I would call "stanch the flow." We need steps to redouble the effort to incentivize the Medicaid expansion where it has not happened, and people who depend on subsidized private insurance need more help. The ACA insurance market needs to be stabilized in order to promote affordable coverage. That is an immediate set of needs.

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

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

Thank you very much for this opportunity.

[The prepared statement of Ms. Rosenbaum follows:]

**********INSERT 11**********
Ms. Eshoo. Thank you. It is so wonderful to have people widen the lens.

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

Mr. Morley. Sorry, okay. Sorry.

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

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

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

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

As someone who spends the majority of my waking hours in
doctors' offices, the ACA has meant focusing on healing not
bankruptcy. I did not ask to be chronically ill. I used to
be very private about my health, but once President Trump was
elected and set to repeal the ACA, I could no longer be
silent. In December 2016, I decided to foster awareness for
lupus and advocate for health care. My congresswoman,
Carolyn Maloney, has taken up my cause and those of people
like me. In the last 2-1/2 years, I have traveled to D.C. 27
times. I have collected the healthcare stories of thousands
of people who shared their personal stories and concerns with
me. I have held over 350 meetings with Democratic and Republican members of Congress alike. Many of you actually sit here in front of me today.

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

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

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

[The prepared statement of Mr. Morley follows:]

**********INSERT 12**********
Ms. Eshoo. What an honor to have you here. Thank you for your courage and your tenacity. It really is an honor to have you here and we are going to do everything to help keep you healthy. And I will never forget your testimony and your words, just as you will never forget our late Elijah Cummings.

And now it is a pleasure to recognize Ms. Jean Ross, the president of the National Nurses United, for your 5 minutes of testimony. Thank you again for being here and for what you will say, so you are recognized.
Ms. Ross. Good morning and thank you, Chairwoman Eshoo, Ranking Member Burgess, and members of the subcommittee for inviting me to testify today. My name is Jean Ross. I have been a registered nurse in Arizona for 45 years and I am president of National Nurses United, the largest union representing bedside nurses in the United States, with over 150,000 members.

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

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

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

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

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

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

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

As you consider different options to improve our health system, I encourage you to consider the following questions. Will this proposal guarantee safe, therapeutic health care to every person in the country regardless of their ability to pay? Will it allow people to get health care independent of where they work or if they have a job? Will it reduce administrative complexity and waste in the system and control costs? There is only one bill before the subcommittee today that will achieve all of these things, H.R. 1384, the Medicare for All Act of 2019, authored by Congresswoman Jayapal and Dingell. The primary responsibility of a registered nurse is to protect the health and well-being of her patients. In my professional judgment, the only way we
can put our patients first as we are ethically and morally bound to do is through Medicare for All. I urge every member of Congress to support H.R. 1384. Thank you.

[The prepared statement of Ms. Ross follows:]

**********INSERT 13**********
Ms. Eshoo. Thank you, Ms. Ross.

It is now a pleasure to recognize Dr. Holtz-Eakin who is -- you are recognized for your 5 minutes of testimony and thank you again for joining us today.
Mr. Holtz-Eakin. Chairwoman Eshoo, Ranking Member Burgess, and members of the committee, thank you for the privilege of being here today to discuss these proposals for progress towards universal coverage which is, indeed, a very important goal for the United States. The proposals fall into two broad categories, as you have heard. Some are like Medicare for All, sweeping single-payer reforms which would cover everybody in the United States, and then a series of more targeted reforms that take the character of Medicare buy-ins, Medicaid buy-ins, and then public options, and I want to discuss them in turn.

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

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

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

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

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

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

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

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

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

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

**********INSERT 14**********
Ms. Eshoo. Thank you for your testimony.

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

Dr. Atlas. Thank you, Chairwoman.

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

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

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

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

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

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

These long waits have major consequences. In the medical literature, not anecdote, worse health outcomes than the U.S. system from cancer, heart disease, stroke, hypertension, diabetes. Why would Americans voluntarily move toward a system proven worse than current U.S. health care? Americans should also ask why the U.S. would move towards single-payer care when every other country with decades of that experience now use private care to solve their failures. Governments in Finland, Ireland, Italy, the U.K., The Netherlands, Norway, Spain, Sweden, Denmark, all with single-payer care spend taxpayer money now, sometimes even outside their own country, on private care to solve their unconscionable failures. Americans should also wonder why those with financial means spend even more money than their
already high taxes for something that is "guaranteed and free." Half of all Brits earning more than 50,000 pounds now buy or plan to buy private insurance. Here is the reality. Only the poor and lower middle class are stuck with nationalized single-payer health care because only they cannot afford to circumvent the system.

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

Why would beneficiaries need that if pure government insurance was so satisfactory? What is wrong with offering government insurance as an option? Because government insurance expansions only erode or crowd out private insurance. The public option is not a moderate or compromised proposal. It is simply a more insidious pathway to single-payer health care where only the affluent could
afford to circumvent that.

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

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

These reforms would permit all Americans, rich or poor, to access the same excellence of medical care that the affluent, including some of the most strident advocates for single-payer care for the rest of us, all use for their own personal health care. Thank you.

[The prepared statement of Dr. Atlas follows:]
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Ms. Eshoo. Thank you.

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

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

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

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

Dr. Atlas. I will give it a shot.

Ms. Eshoo. -- something that you like somewhere. But for each one of you, in terms of the thoughtful proposals that have been put forward by the nine members of Congress, what do you think will best help to achieve universal health care in our country? So I will start with Ms. Rosenbaum.

Ms. Rosenbaum. Thank you very much.

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

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

Ms. Eshoo. But what do you think? I mean my question is very specific.
Ms. Rosenbaum. Right.

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

Ms. Rosenbaum. Yes. I think because of the backdrop there has got to be some combination, and it may change over time, of a strong public insurance option coupled with potentially private insurance option for people who have good comprehensive coverage.

Whether you ever take the next step --

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

Mr. Morley?

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

Ms. Eshoo. Thank you for that.

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

Ms. Eshoo. You are so beautiful.

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

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

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

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

Ms. Eshoo. Okay.

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

Ms. Eshoo. Thank you.

Dr. Holtz-Eakin?

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

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

Ms. Eshoo. Thank you very much.

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

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

Ms. Eshoo. Yeah, I appreciate it and it reflects your
original testimony.

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

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

Mr. Burgess. Thank you.

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

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

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

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

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

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

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

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

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

Mr. Holtz-Eakin. Congratulations.

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

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

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

Dr. Atlas. Yes, I do. I think this is very important
vis-a-vis what has been said about both life expectancy and
infant mortality. These statistics are very coarse and
poorly calculated numbers and I will give you the specific
reason why. Infant mortality, for instance, is not a valid
indicator at all because when you look at the way it is
calculated, the European countries -- the United States
counts every live birth as a live birth with one heart rate,
one heartbeat, one respiration. That is WHO criteria. When
you look at countries in Western Europe who are so-called
pure nations, some of them don't count infants as having been
born unless they are a certain gestational age or unless they
survive 24 to 48 hours. They don't count the babies who died
as having been born if they don't live that long.
So you can imagine in a fraction if you change the denominator, you have a totally invalid statistic. This is documented in the peer-reviewed medical literature. This is not my assertion. Same thing with life expectancy, although a little bit different. Most of the deaths in young people in the United States are not even due to illness. Immediate gunshot wound to the head in murder is not a reflection of healthcare quality, okay. And when you look at, for instance, lifestyle behavior is very different in the U.S. than other countries. Forty percent of the difference in life expectancy between the U.S. and other countries is due to one lifestyle behavior, obesity.

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

Ms. Eshoo. It is hard for me to cut people off, but you are --

Dr. Atlas. I am sorry there is too many facts, but.

Mr. Burgess. A lot of facts.

Ms. Eshoo. Yeah.

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

Ms. Eshoo. So ordered, happy to place it in the record. Thank you. The gentleman yields back. Now it is a pleasure to recognize the chairman of the full committee, Mr. Pallone.

The Chairman. Thank you, Chairwoman. I should thank you for having this hearing. I was one of the drafters of the ACA and obviously very proud of that fact and I do believe that the ACA could have and still can achieve almost universal coverage. I mean the idea was that, you know, 65-

some percent of the people get their insurance through the employer, and then we had this large group of people who buy insurance individually on the marketplace but can't afford it, so the idea was to try to make it affordable and that is where the subsidies came in. And the mandate, you know, the idea of the mandate was that, you know, we will give them enough of a subsidy so they will buy insurance rather than paying a penalty to not buy it. But there was still two groups that were still out there even with that scenario, one where those who wouldn't be able to pay a premium and that is why we wanted to expand Medicaid, and then the last group were the uninsured. I mean, I am sorry, not the uninsured,
the undocumented, which as far as I am concerned, you know, we should have addressed and we had a debate but we couldn't get the votes.

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

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

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

The Chairman. Okay. And for those states that expanded Medicaid, you know, they got a pretty generous deal in terms of how much of that cost is paid for by the federal government, correct?

Ms. Rosenbaum. Yes.

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

Ms. Rosenbaum. Yes.

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

Ms. Rosenbaum. We are at about fifteen million now. It is roughly another two million people, a little more than two million people.

The Chairman. Okay. Now do you want to -- and not open-ended, because I want to get to the undocumented, but would you give me any sense of why you think these states are still rejecting the Medicaid expansion? Is it strictly ideology? What is it, do you think?

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

The Chairman. Ideological, all right.

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

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

The Chairman. Well, let me put it to you this way.

Ms. Rosenbaum. But undocumented --

The Chairman. Let's assume that everybody who was --

Ms. Rosenbaum. Yes.

The Chairman. -- legally here, documented, had insurance coverage. I think we -- would it be accurate to say we would still maybe be only at 95 percent because there would be another five percent that are undocumented? I mean I know that is a huge --

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

The Chairman. Okay. But would you agree, you know, even if everyone was covered who is legal, you would probably still have another five percent of the total population that is not covered because they are undocumented.

Ms. Rosenbaum. Yes. Yeah.

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

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

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

Ms. Rosenbaum. Absolutely. And it is very difficult to begin to quantify these kinds of shifts, but very important to bring everybody in to deal with health problems before they become serious enough to be high cost.
The Chairman. All right, thank you so much. Thank you, Madam Chair.

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

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

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

Mr. Holtz-Eakin. At that point it will be exhausted and --

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

Mr. Holtz-Eakin. It means that the payments out to hospitals will have cumulatively exceeded the payroll taxes that go in, and at that point there will not be the legal authority to reimburse for care.
Mr. Shimkus. Can you say that again?

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

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

Mr. Holtz-Eakin. It would not help solve. That would increase the outflow without raising the inflow.

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

Mr. Holtz-Eakin. Yes.

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

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

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

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

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

Mr. Holtz-Eakin. It is not clear.

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

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

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

Mr. Holtz-Eakin. It is gone.

Mr. Shimkus. It is gone.

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

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

But I want to read a statement. There are certain key details of this legislation that would mean dramatic and radical departure from longstanding abortion-related policy.
The legislation would require government funding of abortion without limitation and also likely would require unwilling hospitals and doctors to perform abortion procedures. When you go into a government system and you don't have choice, you have to play by the rules.

And, Madam Chairman, I would like to submit those two and I yield back my time. Ms. Eshoo. I will review them and advise the gentleman as to whether they will be placed in the record.

Mr. Shimkus. Thank you.

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

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

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

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

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

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

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

Ms. Eshoo. So ordered.

[The information follows:]

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

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

With that said, we must continue to build on the ACA's success, and two of the bills before us today introduced by New York, my colleagues in New York, Brian Higgins and Antonio Delgado, would create public options to help improve access to coverage. Let me ask Ms. Rosenbaum, how would a public option as envisioned by the bill as drafted by Congressman Higgins and Delgado help strengthen the ACA marketplaces?
Ms. Rosenbaum. What they would do is introduce a competitive alternative to private plans for especially vulnerable older Americans whose healthcare costs are quite expensive, relatively speaking. This would give them a more affordable way to buy care.

Mr. Engel. Thank you.

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

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

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

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

    Mr. Engel. Thank you. Thank you, Madam Chair.

    Ms. Eshoo. The gentleman yields back.

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

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

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

My daughter, she is 30 now, 25 years old she was diagnosed with Hodgkin's lymphoma. She went through all of the treatments and lost her hair, got her hair back and is doing very good now, in fact, going to get married next October. And I am wearing today my St. Jude's Children's Research Center tie that I am very passionate about and have been for over, well, close to 40 years now, I guess, but over 30 years.

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

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

Dr. Atlas, first name Charles, middle name Charles, any? Dr. Atlas. Not many people know who that was anymore, I don't think.

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

Dr. Atlas. Okay.

Mr. Long. -- curious, but inquiring minds want to know. But if you think back to 2013, with the rollout of healthcare.gov and all the issues that they had getting the website opening up and I think six people actually were able to sign up that first day, it took months and months to get it where it was fully functional and more than one-and-a-half billion dollars over budget to get it up and going. In the end, healthcare.gov website finally launched about 3-1/2 years after the passage of the Affordable Care Act. The
Medicare for All bill is estimated to cost over $30 trillion and would fully transition from our current healthcare system to a single-payer system in 2 years. So if the United States Government couldn't build a functioning website in 3-1/2 years and went massively over budget trying, how can we possibly expect the government to successfully transition to a single-payer system in just 2 years and stay on budget?

Any comment?

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

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

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

Dr. Atlas. Not in the government, no. The private sector would.

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

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

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

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

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

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

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

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

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

But that is why this moment presents a unique opportunity. The ACA improved the quality of basic care everyone receives. It unlocked access to care for Americans who have been historically shut out of or priced out of the system. It has expanded coverage to over 20 million Americans since it was signed into law. While acknowledging our successes, we must also recognize the need for improvement, the need to look up again at the North Star of universal coverage and ask ourselves what comes next.

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

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

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

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

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

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

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

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

Ms. Rosenbaum. Estimates suggest that just those two changes alone, probably along with, of course, something for the Medicaid expansion states that have not expanded, would
probably raise the insured levels by at least ten million
people, even more with auto-enrollment.

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

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

Ms. Rosenbaum. It is slightly more than two million
people.

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

Ms. Rosenbaum. Yes. They are disproportionately people
of color. They are disproportionately residents of southern
states.

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

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

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

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

What I kind of want to talk about with Dr. Atlas and Dr. Holtz-Eakin is, I think all of us here are wanting people to be covered with -- the question is that we get to when you look at Medicare for All, how does it change the healthcare system we have today?
We are currently in discussion this week about H.R. 3, which is setting a price for pharmaceuticals. We all want lower drug prices and there is a bipartisan bill to do that, but now we are going to where we are setting drug prices to the point where CBO says we will get less, eight to fifteen less drugs over the next 10 years. And people on this committee in that hearing said if we are going to lose miracle cures or -- they didn't say that. I won't put the words -- if we are going to lose some cures because we are going to have lower drug prices that is a tradeoff we are willing to pay.

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

So the concern as we go down this path is -- and we have to -- it is not just a slogan that we can put on a bumper
sticker or a T-shirt, it is, how is this going to affect the
healthcare system that Americans have. We can cure sickle
cell anemia. We -- cystic fibrosis is going to be a disease
that people can live with further. It is going to be a
maintenance disease. Artificial pancreases, available now.
Just the things that are coming out of this country and we
are subsidizing the rest of the world. And that is an issue
that we try to address in H.R. 19 on drugs is that we have a
U.S. trade negotiating or negotiate with other drugs.

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

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

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

And so, what would you see with our --

Dr. Atlas. Well, I will answer about the drug pricing issue that hasn't been brought up. You look at what a single-payer system does with drug pricing, we can look at the NHS. They have a budget impact test of 2017. They set a number and if the system is going to cost 20 million pounds or more for a drug, they are not going to have that drug available and they are going to "negotiate," and they give themselves 3 years.
If your wife has breast cancer and wants one of these new drugs, she is going to sit there for 3 years while the government, the NHS, negotiates that price down. It has been calculated by the NHS itself and the Alzheimer's Foundation in the U.K. that a drug for Alzheimer's would have to cost less than $4 a month to be approved because so many people need it. So if you look at this way, ironically, the more people that need the drug when you are capping the total expenditure, the more people that need the drug, the less likely it will be available. That is what the NHS Budget Impact Test does.

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

Mr. Guthrie. Well, this is what I want to point out is that we can't just sell that we are creating a whole new payment system and not affect the healthcare system we have. I think people are envisioning we are going to have exactly what we have and somebody else is paying for it and that is not what will happen, in my opinion.

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

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

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

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

Ms. Eshoo. The gentleman yields back.

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

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

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

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

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

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

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

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

And to Mr. Shimkus who was here, remember, the Affordable Care Act extended the life of the Medicare trust fund and it strengthened Medicare and it helped to close the doughnut hole. Now the Democrats this week are going to pass one of the missing links to allow Medicare to negotiate prices and drive down drug costs and then carry that over to private insurance, so that is going to be a great thing for families.

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

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

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

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

Ms. Castor. Can we just pass the law? Go back and --

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

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

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

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

Mr. Morley. It is Sunday. Go to healthcare.gov. That is the way that we keep enhancing the ACA. And just to add, when you talk about Medicaid expansion, a lot of people, I have heard for the majority of people in Texas and Florida, those are two major states that have not expanded Medicaid and I am very sympathetic and compassionate to that, so thank you for mentioning that.

Ms. Castor. Thank you.
Ms. Eshoo. I made the announcement, December 15th, whomever is tuned in.

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

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

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

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

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

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

So I would like to thank my colleagues for their leadership, who were on the first panel, and their work on the various pieces of legislation, and I would like to thank all of you who are on this panel. We all want our constituents to have quality health care and we all want our constituents to be able to afford it. With my plan, we can move towards affordable, universal coverage without starting from scratch or removing the 180 million Americans in employer-sponsored insurance from their existing plans. We can immediately get to the work by building on the current foundation of our nation's healthcare system to provide everyone with coverage that is affordable and universal.

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

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

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

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

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

Dr. Atlas. That is absolutely true. And since most new drugs are cancer drugs, people die because of that.
Mr. Carter. You cited some figures. I listened attentively to your opening statement about other countries and comparing us to what is available here in America as opposed to what is available in those other countries. Do you have that by chance again?

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

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

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

The real solution to drug prices is to figure out why they are costing so much, because the cost of developing a drug has exploded over the past decade to two and a half billion dollars in 15 years and nobody is going to develop a drug if they are not going to get that money back. So we as a government, really, have added a lot of bureaucracy and a
lot of hurdles and therefore cost to the development of new
drugs and that is where the attention should be focused.

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

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

Mr. Burgess. Yeah, who knew?

Ms. Eshoo. Who knew? That is right.

Mr. Carter. Excuse them.

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

Someone who was there at that time who saw people who came in
who were diagnosed with that disease and knew that they were
diagnosed that they were going to be dying soon, but now we
can treat them. That is phenomenal.
Now, you know, the thing that concerns me so much is that both sides, both Democrats and Republicans want the same thing. I get it. I understand that if a drug costs $85,000 and is not accessible to you, it does you no good whatsoever. I get the fact that we need to bring prescription drug prices down. But I also understand that there are other things that we can do aside from what is being posed in H.R. 3 that will lower drug prices without stifling innovation and that is what I am trying to get to here.

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

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

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

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

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

Mr. Kennedy. Thank you, Madam Chair. I want to thank my colleagues for, I think, unanimously, as this one, all agreeing how important this hearing is. Grateful to be here for it. I want to thank our witnesses for your courage, for your testimony, for your service, and for your perspective. It is important that we get this right.

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

Ms. Ross. I am.
Mr. Kennedy. And so does that seem like insulin is in fact readily available in the United States of America?

Ms. Ross. It does not.

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

Ms. Ross. I am aware of that.

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

Ms. Ross. I did hear that, yes.

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

Ms. Ross. I am aware.

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

Ms. Ross. Yes.

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

Ms. Ross. Absolutely.

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

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

Ms. Ross. A lot.
Mr. Kennedy. That sounds about right to me.

Mr. Holtz-Eakin, I think, would agree with a lot figure.

Fair enough?

Mr. Holtz-Eakin. It is a good estimate.

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

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

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

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

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

Ms. Ross. Could I add one comment to that?
Mr. Kennedy. That is up to the chair.
Ms. Ross. Would I be allowed?
Ms. Eshoo. Well, I think we need to move along because
it is 24 minutes past -- or yeah, seconds past the
gentleman's time. I now would like to recognize the
gentleman from Virginia, Mr. Griffith, for his 5 minutes of
questions.

Mr. Griffith. Thank you, Madam Chair.
Ms. Ross, we try to get along on this committee. If you
have something short, say it.
Ms. Ross. Thank you. It is very difficult for me to
hear the comparisons to other countries single-payers with
the constant comment that people are dying and denied care.
As long as the for-profit motive is present in this country
that is what is happening now. The only way for them to make
their profit is to deny care.

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

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

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

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

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

And the same is true when we closed down the Scott County Hospital. That meant a minimum of 45 minutes to an hour for many of the people in Scott County to get to the nearest hospital just for basic stuff, not even counting something that might be more complex. But how can we
guarantee that those folks are actually going to have care? It is not like getting in a cab and going to the next hospital down the road. There is no hospital down the road.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. Cardenas. Okay. Okay, got it.

Dr. Atlas. And if I could --

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

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

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

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

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

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

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

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

Mr. Holtz-Eakin. Yes.

Mr. Bilirakis. Okay. If so, why would Democrats now
support to repeal ObamaCare?

Mr. Holtz-Eakin. You will have to ask them. I don't
know.

Mr. Bilirakis. Okay. Could this be taken as an
admission of ObamaCare's failure to make health care more
affordable and more accessible through increased government
intervention and mandates?

Mr. Holtz-Eakin. Again, I would direct you to the authors.

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

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

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

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

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

Mr. Bilirakis. Okay, thank you.

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

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

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

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

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

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

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

Mr. Bilirakis. Okay, thank you very much.

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

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

Ms. Kelly. Thank you so much. I just wanted to --

Ms. Eshoo. Put your microphone on, please.

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

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

Ms. Eshoo. Does the gentleman yield back?

Mr. Bilirakis. Yes.

Ms. Eshoo. Thank you. The gentleman yields back.

Pleasure to recognize from California, Dr. Ruiz, for his 5 minutes of questions.

Mr. Ruiz. Thank you very much for having this hearing, this very, very important hearing, and I am so happy that we are now presenting a variety of different options that can move the healthcare system in America forward, because I truly believe, and I know many of us in this room believe that every American should get the care they need when they need it at an affordable low cost and that should be our goal. Our goal in order to achieve that should be universal coverage. Everybody should have coverage. And that is how we should, one, look at our efforts, and two, making sure that out-of-pocket costs are low for people, for patients.

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

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

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

So -- but, unfortunately, the ACA has not been fully
implemented. There has been a lot of changes since then to make it worse because the number one singular goal of the -- of, you know, the Republican Party since Obama passed this was to destroy it, to sabotage it, to then say, see it is not working, at the expense of the American people's health. And so, what are our next steps? You know, well, definitely we need to stabilize the market. We need to reduce overall healthcare costs. And then we have got to look at adding some provisions that would increase the ability for Americans to have coverage and therefore to eliminate the uninsured problem, health risks, of the American people here.

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

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

Mr. Ruiz. Well, you know, the thing we have to focus here is that we need a preferential option. We need not just any option, we need a preferential option. And when you look at health insurance, you want to make sure that it is expansive and protects you and will cover what you need to be covered. And let's -- I am an emergency medicine doctor, so there is nobody who is immune to accidents. Nobody is immune to that unfortunate surprise diagnosis that you get that you never thought you would ever get, like cancers and what not. So we need to make sure that it is affordable and that it can cover as many ailments that we need to protect patients. In addition to that we must address a couple of other issues and one is the provider shortage that we have in our country. We need to. We don't have enough nurses. We don't have enough doctors. And we need to also look at the delivery of our healthcare system and where we focus our resources for prevention and public health, not on expensive end-of-life kind of care, but the prevention and the public health at the beginning. Thank you.

Ms. Eshoo. And the gentleman --

Mr. Ruiz. Yields back.

Ms. Eshoo. -- yields back. That is right. A pleasure
to recognize the gentleman from North Carolina, Mr. Hudson, for his 5 minutes of questions.

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

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

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

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

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

Dr. Atlas, you spoke at length in your testimony about
the quality of care in this country compared to other
countries including wait times experienced by those patients.
Have you ever studied the private systems that exist
alongside the public system in those countries such as in
Canada or Great Britain and, if so, can you speak to who has
access to these private systems?

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

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

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

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

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

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

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

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

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

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

Ms. Eshoo. The gentleman yields back.

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

Now we would like to --

Dr. Atlas. Yeah. We are talking about data, not
individuals.

Ms. Eshoo. Well.

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

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

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

Ms. Eshoo. Yeah, we all are. And we have many Mr.
Morleys in our country.

The chair now would like to recognize the gentlewoman
from California, Ms. Barragan, for her 5 minutes of
Ms. Barragan. I thank you. There was this conversation about the one system for the wealthy and one for the poor.

Hello. Testing.

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

Everybody should have access to it.

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

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

   And I mentioned to you the district, the makeup of my district. Can you explain what the benefit would be to communities of color if we had Medicare for All and how the bill would reduce minority health disparities?

   Ms. Ross. I think I would point to again what I talked about with how it is administered, the globalized budgets. There would be negotiations between the hospital and the regional directors and you would look at what you would need for the following year, looking at what you needed for the year before, for one thing, and then you would project. So if you knew you had rural hospitals, communities that are underserved, and you needed more staff in those hospitals, maybe you needed to build a hospital, those are the kinds of things you would look at putting into the budget so that
people who had previously been unserved and underserved would
be able to get care.

Ms. Barragan. Great. Thank you. Ms. Ross, in addition
to being a registered nurse, you are also a national union
leader. As the president of the largest union of registered
nurses in the country, we often hear politicians telling us
that Medicare for All would be bad for union members and that
unions wouldn't support it. But your union does support
Medicare for All as do many national and local unions across
the country. Ms. Ross, can you tell us, why do unions
support this bill?

Ms. Ross. Well, right now, there is at least 9.3
million unions that represent New Yorkers that do want
Medicare for All. And I think if you look back at our
history, we are to the point now where we can't negotiate
anymore for better wages and working conditions, pension
benefits, because everything is taken up with bargaining for
health care. If you look at most of the strikes across the
country in the last several years, they have all been over
healthcare benefits. So I think we see the handwriting on
the wall. And also, I know union workers who might like to
switch jobs, but they are afraid to because they have got
their insurance tied to their employer.
Ms. Barragan. Thank you.

Mr. Morley, thank you for your advocacy. You are on the Hill all the time and you are very active on social media and you are telling your story and telling people about how important it is for us to fight on health care, something that I am proud Democrats have been doing and have been working on a bipartisan basis to make sure we find solutions as best we can under current conditions.

Mr. Morley, is there anything you want to share with us, any considerations you want to tell us about any of the bills before us today?

Mr. Morley. I just want to say I really think it is so important for -- I would love to see more of a bipartisan effort. There was no need to bring up anything about H.R. 3 today because this is not an H.R. 3 hearing, so that makes me kind of angry. So any and all bills that will get us towards coverage, increase our coverage towards all Americans, is what I am trying to achieve as a patient and for all the patients that have reached out to me through social media. That is all I have ever wanted. And to protect the protections for preexisting conditions that are already in place, the expanded Medicaid, the ways that the ACA has helped Medicare, that is all I have ever wanted and I don't
want to see those protections removed.

Ms. Barragan. Great. Thank you all for your work. I yield back.

Ms. Eshoo. The gentlewoman yields back. The chair now recognizes the gentleman from Montana, Mr. Gianforte.

Mr. Gianforte. Thank you, Madam Chair. This is a very important hearing for the future of our country. I appreciate the panelists being here.

Medicare is critical to Montana seniors. We should work to protect these benefits that they have earned. I believe the federal government must honor the commitment it made to our seniors, but Medicare for All will destroy Medicare as we know it. To a casual observer, Medicare for All sounds appealing on its face but it is really just a marketing gimmick. To dig deeper beyond the slick marketing efforts of a catchy name, Medicare for All is nothing more than a government-run, single-payer healthcare system. It would end Medicare as we know it and leave our seniors in the cold. Medicare for All in practice is Medicare for none.

Now some of my Democrat colleagues will claim Medicare for All is a proposal out of a fringe, out-of-touch wing of the Democrat Party, but the truth is it has taken over the Democratic Party by storm. Many Democrats jockeying for the
presidency in 2020 support Medicare for All and half of the Democrats in the House have cosponsored Medicare for All. Let's be clear. Medicare for All would gut Medicare and the VA for our veterans and force 225,000 Montana seniors who rely on Medicare to the back of the line. Montana seniors have earned these benefits and lawmakers shouldn't undermine Medicare and threaten healthcare coverage of Montana seniors.

Medicare for All would devastate rural health care, we have heard that on the committee today, especially those in Montana. They already face overwhelming challenges. Since 2010, more than a hundred rural hospitals have closed their doors and nearly 40 percent of all rural hospitals operate on a budget shortfall. Under Medicare for All, hospitals in Montana would take a 40 percent payment reduction. Hospitals in our rural areas would struggle further and patients would lose access entirely to critical providers, like oncologists and heart surgeons. Medicare for All will lead to worse access to care in our rural communities.

In addition to gutting Medicare and eliminating access to care in our rural communities, Medicare for All is a fiscally irresponsible budget buster. Elizabeth Warren, a frontrunner in the Democrat primary has proposed Medicare for All that would cost 52 trillion dollars. With a straight
face, she campaigns that her plan will not raise taxes on the
middle class. I don't believe that. It doesn't pass the
reasonability test. Medicare for All would terrify Americans
who rely on Medicare and who like their employer-sponsored
plans. Under Medicare for All, private insurance would be
banned.

Folks, this is a government takeover of health care, plain and simple. We are not a socialist country. Medicare for All will gut Medicare and the VA as we know it and put Montana seniors at the back of the line. To force 225,000 Montanans who rely on Medicare to share their pool with everyone isn't fair to Medicare seniors, Montana seniors. In reality, Medicare for All is Medicare for none. Instead of a reckless government takeover of our healthcare system, we should take a bipartisan approach to fix our broken healthcare system. We should protect patients with preexisting conditions, increase transparency and choice, preserve rural access to care, and lower costs. Let's get to work on that and end this socialist charade. Now, Dr. Atlas, as I said earlier, it seems like our rural providers will struggle under a Medicare for All proposal. What do you believe will happen to rural hospitals and other providers under Medicare for All?
Dr. Atlas. Well, under a single-payer system where private insurance is banned, we already know that Medicare pays less than the cost of delivering the care. These hospitals survive because of the extra reimbursement they get from the private insurers. So it is very naive to think that oh, we are just going to wipe out private insurance and have the Medicare payments support all these hospitals. The hospitals will go out of business just like the CMS Actuary said in 2018.

Mr. Gianforte. Okay. Dr. Atlas, would you agree that this legislation and bills like it would also require taxpayers to fund elective abortion with no limitation?

Dr. Atlas. I don't know the answer to that.

Mr. Gianforte. How would you rate -- well, with that, Madam Chair, I am glad we are having this hearing today. It is very important for the American people that we preserve access to quality care and get costs down, and with that I yield back.

Ms. Eshoo. The gentleman yields back. The gentleman from Maryland, Mr. Sarbanes, is recognized for 5 minutes.

Mr. Sarbanes. Thank you, Madam Chair. I want to thank the panel.

First of all, I want to push back pretty hard on the
doomsday scenario that is being painted by some of our colleagues on the other side of the aisle, which to me amounts to fearmongering. There is a lot of distortions of what the cost of the Medicare for All proposal would be, these scenarios about what would happen to hospitals, rural hospitals. The fact of the matter is that under the current Medicare and Medicaid programs there is a lot of investment and that is what it is that goes into those kinds of hospitals and delivery systems. And so, if you had a Medicare for All system, I think you would continue to see that kind of investment. It is not like we would just walk away from these critical parts of our delivery system, so that has to be accounted for when we are having this discussion.

The thing about the Medicare for All proposal, and there is many that have been presented, they all have different merits, is to me it is the most honest in the sense that I think that is where we are going to land, ultimately. The fact of the matter is Americans like Medicare, they like Medicaid, they like the veterans' healthcare system, they have basically already made a judgment that these systems that are delivered and led out of the public sector are ones that give them a sense of confidence about their health care,
and so I think that it is just a matter of time before we get to a place where we have a Medicare for All system.

As Representative Jayapal described it, it has got the three things you want. It has got universal coverage and access so everybody is covered. It has got a comprehensive set of benefits so people understand that when they need to see a doctor, they need to go to the hospital, they need to get care that that is going to be available to them. And it eliminates the wasteful overhead and the predatory practices of the health insurance industry which have inflicted a lot of suffering on people for decades now. So that is what Americans want. That is where we are going to be, ultimately.

The discussion that we are having we are seeing it play out even in the sort of the presidential sweepstakes is how do you transition? How quickly do you get there? I think there is an appetite to get there as quickly as we can and that is being discussed and it is part of what I think are very robust and meaningful and carefully executed analyses of the Medicare for All plan that have been put forward. So it doesn't help things to just engage in this kind of knee-jerk denigration of Medicare for All, pulling out of thin air some of these numbers, predictions, and fearmongering. That is
not a constructive contribution to the discussion.

Now I wanted to ask Ms. Ross -- the only thing, I only have a minute and a half left because I couldn't stop talking. But there is -- Maryland just -- there is just a report released by CMS about Maryland's all-payer model which includes global budgeting, and it did show that when you put global budgeting in place, in that instance you are reducing Medicare expenditures by 2.8 percent, hospital expenditures by 4.1 percent, reducing admissions and avoidable hospitalizations and I was just curious to get your perspective on kind of global budgeting.

Obviously, many of the proposals included here, Medicare for All as well, incorporates, conceptually, this idea of more global budgeting. And so, if you could speak to how that would promote transparency, potentially lower costs, and benefit patients in underserved and vulnerable communities, if you think that kind of approach would achieve those things.

Ms. Ross. I do, indeed. And I think we are lucky that we have the example of Maryland because it has worked so well there. For those who might not know, Maryland started their what amounts to global budgeting in 2010 and they started with rural hospitals, and it was so successful then they put
it in the rest of their hospitals, private and public. And
what they found was -- I have got some figures. Their global
budget saved Medicare as a payer over 420 million in just 3
years. And, originally, their goal was to save 330 million
over 5 years, so it was a whopping success. And from a
nurse's perspective what it does for patients is wonderful,
because it reduced infection rates, it improved care, it
reduced readmission rates, and those are all things to look
at.

Ms. Eshoo. I need to interrupt. The gentleman's time
has expired.

Mr. Sarbanes. Thanks very much.

Ms. Eshoo. And we have votes on the floor. I just want
to inform members that the members that are not part of the
subcommittee I don't think are going to have the opportunity.
I would stay were it not for the fact that we have votes on
the floor.

So where is Mrs. Dingell? Is she here?

All right, I am going to call on Ms. Kelly from the
state of Illinois for her 5 minutes. And if Mrs. Dingell
comes back, I will take her, but then we are going to have to
close the hearing. So the gentlewoman from Illinois is
recognized for her 5 minutes.
Ms. Kelly. Thank you all for your testimony today and your patience. One thing I have to say, you know, we worked hard on -- I wasn't here, but my colleagues worked hard on the Affordable Care Act and I don't think there is a Democrat that would say that was a perfect bill. But a lot of people that didn't have coverage received coverage, but as we know there is still about twenty-seven-and-a-half million people that don't have the coverage.

But when I came here, instead of spending time and time and time trying to repeal the bill, we should have been working on how we could make it better, but all we faced was a wall and I think we voted to repeal it 63-plus times. So, you know, let's be honest about, you know, what happened. And then there was the trifecta of Republican Senate, House, and the President and we still didn't improve health care in this nation.

I am the chair of the Congressional Black Caucus Health Braintrust, so I am very concerned about the disparities in health for minorities. We, when it comes to morbidity and mortality, I mean we lead the cause. I had a bill, the MOMMA's Act, that dealt with maternal mortality, and as some of you know black women die at three to four times the rate of white women. I had a bill that would take the Medicaid
coverage to a year instead of 2 months, but I could not get one Republican on that bill even though we talk about, you know, we don't want two different healthcare systems for the poor and for the rich, but then when we have the opportunity we don't it. Now we got a bill out, but we had to water it down.

Now, Ms. Rosenbaum, you mentioned the need for coordination across health care, public health education, and job development service systems. Could you expand upon this and explain what are the ways to address disparities and improve community health aside from increasing access to care which we all know is needed?

Ms. Rosenbaum. Yes. I would like to actually begin by disagreeing with Dr. Atlas. I think the infant mortality problem in the United States is very real. It is not simply a matter of numbers and how we count, and it is made all the more real by the terrible disparities on the basis of race and income.

I think it is very important to couple any health coverage reform legislation with provisions that do the kinds of things that the Braintrust has been such an advocate for, which is bulking up public health, bringing healthcare providers under sort of a broader public health umbrella,
making sure that part of the healthcare experience is care
management to be able to get better access to the kinds of
services and interventions that we commonly call the social
determinants at this point, making sure that when you walk in
the door for health care you not only have good health care,
but you have access to nutrition to housing assistance to the
other things that make people healthy.

The Affordable Care Act actually did a good job of
starting that process of bridging between health and health
care. The community health center expansion was, of course,
incredibly important. The Public Health Trust Fund was
important. And I think it is absolutely key that the Black
Caucus continue as it was, it was the leader on those kinds
of equity measures, that it continue to lead on these issues.

Ms. Kelly. Thank you. And because of time, I yield
back.

Ms. Eshoo. The gentlewoman yields back. And do we have
anyone else? Is -- Mrs. Dingell leave?

All right, I am going to place in the record the
following documents: an article from the Century Foundation,
Health Reforms North Star; report from the Century
Foundation, Road to Universal Coverage; coalition letter from
Advocates for Youth, et al.; a letter from NAACP, et al.,
regarding Medicare for All; letter from the Fraternal Order of Police in support of H.R. 4527; letter from the International Association of Firefighters in support of H.R. 4527; letter from the Healthcare Leadership Council; statement from the American Nurses Association; and the statement from Representative Cedric Richmond; and a statement from BCBS of California; as well as the documents that Congressman Shimkus asked to be entered in the record. Hearing no objections, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********
Ms. Eshoo. We will recognize the gentleman from Virginia for his additions.

Mr. Griffith. Thank you, Madam Chair. I ask unanimous consent to include the following into the record. I understand these documents have been shared previously with the majority. It would be statements from the American Hospital Association; America's Health Insurance Plans; Blue Cross Blue Shield Association; Chamber of Commerce; Partnership for America's Health Care; Future Partnership for Employer-Sponsored Coverage; Texas Hospital Association; March for Life letter; National Right to Life; Ethic and Religious Liberty Commission; Susan B. Anthony List; American Action Forum; American Hospital Association; Committee for a Responsible Federal Budget; Heritage Foundation; Mercatus Center; Partnership for America's Health Care Future; polling from Partnership for America's Health Care Future; news articles and op-eds from the Hill, the Washington Post; one-pagers from Blue Cross Blue Shield Association; Congressional Pro-Life Caucus; Partnership for America's Health Care Future; and Partnership for Employer-Sponsored Coverage.

Thank you, Madam Chair.

Ms. Eshoo. So ordered.

[The information follows:]
Ms. Eshoo. All members, pursuant to committee rules, have 10 business days to submit additional questions for the record to be answered by the witnesses who have appeared today, and I ask each witness to respond as promptly as possible to any questions that are submitted to you.

Before I gavel the adjournment of the subcommittee, I want to thank each one of you. You have taken a great deal of your time, put a great deal of effort into your written testimony. Each one of you has the passion that you have brought to the witness table. You have traveled to come to be with us. I thank each one of you.

At the beginning of this year as when my colleagues elected me the chairwoman, the question was asked, "Will you have a hearing on Medicare for All?" And I said that I would. No one had to twist my arm off for it. This subcommittee has been the most productive subcommittee of the Energy and Commerce Committee, so it may be December that we are having this hearing but we have taken up major legislation all year long. And that was appropriate and now this hearing.

So I thank all the advocates that have traveled to be with us. Thank you for your passion, for your big dreams -- keep it up. And with that, the subcommittee is adjourned.
Whereupon, at 1:57 p.m., the subcommittee was adjourned.