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6 PROPOSALS TO ACHIEVE UNIVERSAL HEALTH

7 CARE COVERAGE

8 TUESDAY, DECEMBER 10, 2019

9 House of Representatives

10 Subcommittee on Health

11 Committee on Energy and Commerce

12 Washington, D.C.

13

14

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16 The subcommittee met, pursuant to call, at 10:30 a.m.,

17 in Room 2322 Rayburn House Office Building, Hon. Anna G.

18 Eshoo [chairwoman of the subcommittee] presiding.

19 Members present: Representatives Eshoo, Engel,

20 Butterfield, Matsui, Castor, Sarbanes, Lujan, Schrader,

21 Kennedy, Cardenas, Welch, Ruiz, Dingell, Kuster, Kelly,

22 Barragan, Blunt Rochester, Pallone (ex officio), Burgess,

23 Shimkus, Guthrie, Griffith, Bilirakis, Long, Brooks, Hudson,

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1 Carter, Gianforte, and Walden (ex officio).

2 Staff present: Jeff Carroll, Staff Director; Tiffany
3 Guarascio, Deputy Staff Director; Zach Kahan, Outreach and
4 Member Service Coordinator; Saha Khaterzai, Professional
5 Staff Member; Josh Krantz, Policy Analyst; Una Lee, Senior
6 Health Counsel; Aisling McDonough, Policy Coordinator; Meghan
7 Mullan, Staff Assistant; Kaitlyn Peel, Digital Director;
8 Alivia Roberts, Press Assistant; Samantha Satchell,
9 Professional Staff Member; Rebecca Tomilchik, Staff
10 Assistant; Rick Van Buren, Health Counsel; C.J. Young, Press
11 Secretary; Nolan Ahern, Minority Professional Staff, Health;
12 Margaret Tucker Fogarty, Minority Staff Assistant; Theresa
13 Gambo, Minority Human Resources/Office Administrator; Tyler
14 Greenberg, Minority Staff Assistant; Peter Kielty, Minority
15 General Counsel; Ryan Long, Minority Deputy Staff Director;
16 Kate O'Connor, Minority Chief Counsel, C&T; James
17 Paluskiewicz, Minority Chief Counsel, Health; Kristin Seum,
18 Minority Counsel, Health; and Kristen Shatynski, Minority
19 Professional Staff Member, Health.

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1 Ms. Eshoo. Good morning, everyone. The Subcommittee on
2 Health will now come to order. The chair now recognizes
3 herself for 5 minutes for an opening statement. And welcome
4 to our colleagues that are at the table and everyone that is
5 here in the hearing room.

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

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

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

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1 1997. It is why President Obama signed the Affordable Care
2 Act into law in 2010, which today provides health coverage to
3 more than 20 million Americans. But we know there is more
4 work to be done to achieve universality. During our second
5 panel today, we will hear the stories of fellow Americans who
6 live in daily fear that they will lose their health care
7 because of a decision by their employer, their insurer, or
8 this President.

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

19 Shortly before his death, Senator Ted Kennedy wrote a
20 letter to President Obama about health reform and what he
21 called "that great unfinished business of our society." He
22 wrote, "what we face is, above all, a moral issue that at
23 stake are not just the details of policy, but fundamental

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1 principles of social justice and the character of our
2 country." I think we all need to reflect on that moral issue
3 today.

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

6 [The prepared statement of Ms. Eshoo follows:]

7

8 *****INSERT 1*****

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

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

9 Ms. Eshoo. So ordered.

10 [The information follows:]

11

12 *****COMMITTEE INSERT*****

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

3 Ms. Eshoo. Thank you.

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

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

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

21 Medicare for All would eliminate private insurance,
22 employer-sponsored health insurance, Medicaid, the Children's
23 Health Insurance Program upon which many Americans depend. I

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1 am concerned about the consequences for existing Medicare
2 beneficiaries. The policy would raid the Medicare trust fund
3 which is already slated to go bankrupt in 2026; this will not
4 help. Our nation's seniors have been paying into and
5 depending upon the existence of Medicare for their healthcare
6 needs in retirement for, literally, their entire lives.

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

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

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1 order to pay for it, according to the Mercatus Center.

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

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

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1 it would reduce new drugs coming that we have all wanted
2 through innovation.

3 I support common sense, market-driven improvements to
4 our healthcare system. The goal should be to increase access
5 to health care services and drive down the costs for our
6 patients. These universal health care coverage bills are all
7 going in the wrong direction. In fact, I introduced H.R.
8 1510, the Premium Relief Act of 2019, which does include
9 reinsurance that is coupled with a structural reform of the
10 Affordable Care Act. This would give states more choice on
11 how to repair their markets that have been damaged by
12 previous legislative attempts. Even better, this legislation
13 is fully paid for by stopping bad actors from gaming the
14 system.

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

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1 completely in the dark. I yield back.

2 [The prepared statement of Mr. Burgess follows:]

3

4 *****INSERT 2*****

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

5 Mrs. Dingell. Thank you.

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

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

23 The Medicare for All of 2019 would provide coverage for

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

10 [The prepared statement of Mrs. Dingell follows:]

11

12 *****INSERT 3*****

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

4 The Chairman. Thank you, Madam Chair.

5 Since the passage of the Affordable Care Act, more than
6 20 million Americans have gained the peace of mind that comes
7 from knowing that they and their loved ones have health
8 insurance. This landmark law resulted in the highest insured
9 rate in our nation's history. It also expanded consumer
10 protections so that no matter where you live or work in the
11 U.S., your family would have access to affordable,
12 comprehensive health care.

13 The ACA ended debates of insurance companies' price
14 gouging older Americans, charging women more than men, and
15 discriminating against people with preexisting conditions.
16 It not only prevented health insurance companies from
17 discriminating against people with preexisting conditions, it
18 also required insurance companies to cover a set of essential
19 health benefits like hospitalization, emergency services,
20 maternity care, and substance use disorder services. It also
21 eliminated annual and lifetime limits on coverage that for
22 years had forced people with preexisting conditions into
23 bankruptcy. Thanks to the ACA, young Americans can stay on

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1 their parents' plan until they turn 26.

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

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

21 I firmly believe that today we would be very close to
22 universal coverage had it not been for the sabotage and for
23 the refusal of Republican governors to expand Medicaid. I

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1 also believe that had the final law included the public
2 option as supported by the majority of this committee and the
3 House at the time, that we would be even closer to universal
4 coverage. Now, unfortunately, that is not the case, and
5 millions of Americans remain uninsured particularly in states
6 that have refused to expand Medicaid.

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

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

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1 discussion and yield the balance of my time to the
2 gentlewoman from Illinois, Ms. Schakowsky.

3 [The prepared statement of The Chairman follows:]

4

5 *****INSERT 4*****

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

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

20 So we don't know exactly what path we are going to take,
21 but over the last 50 years we have seen some dramatic
22 changes. We have seen Medicare and Medicaid get passed, we
23 have seen the ACA, and these are examples of the dynamic

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1 changes that we can make and that we should be making. We
2 need to work together. Americans are asking us, begging us
3 to improve our healthcare system. They all want to be
4 covered. We can do this and we are going to hear about how
5 we can do this today. I thank the panel and I yield back.

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

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

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

11 The Chairman. Dreaming about a better world.

12 Ms. Eshoo. Lovely.

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

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

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

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

23 As you know, our committee has moved forward on maternal

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

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

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

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1 been fully funded for more than 5.

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

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

23 At the presidential debate in October, a top Democrat

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

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

19 Canada is facing a shortage of medical providers, and in
20 some provinces some hospitals have responded by actually
21 closing their emergency rooms 2 days a week. In British
22 Columbia, 300 patients died waiting for surgery between 2015
23 and 2016 because of a lack of anesthesiologists. And

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1 according to the British Columbia Anesthesiologists' Society,
2 they say that is a huge problem.

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

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

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

5 [The prepared statement of Mr. Walden follows:]

6

7 *****INSERT 5*****

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1 Ms. Eshoo. The gentleman yields back.

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

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

15 So beginning with Congresswoman Rosa DeLauro from my
16 home state where I was born and raised, Connecticut, welcome
17 to you; to Representative Jayapal from the state of
18 Washington, welcome to you; to Representative Higgins from
19 New York, thank you for making yourself available today; to
20 Representative Delgado from the state of New York; and
21 Representative Malinowski from New Jersey. Welcome to each
22 one of you. Thank you for the work that you have put into
23 the product that -- the legislation that you are going to

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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.

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

3
4 Ms. DeLauro. Thank you so much, Madam Chair.
5 Congressman Pallone, Congresswoman Eshoo, Ranking Members
6 Walden and Burgess, I am delighted to be here this morning.
7 It is an honor for me join with the members of this committee
8 and also to be with all of my colleagues here this morning on
9 what is a critical, critical, discussion on what are the
10 pathways that we can move forward to universal care.

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

20 Medicare for America moves every individual currently
21 enrolled on the individual exchanges and Medicare
22 beneficiaries on to the program. Individuals and children
23 enrolled in Medicaid and CHIP are transitioned on to Medicare

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1 for America, over time, to ensure that their care is not
2 disrupted as we transform our healthcare system. We made
3 this deliberate choice after working with members of the
4 disabilities community who know all too well about
5 disruptions in the face of budget cuts and other
6 complications.

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

20 Let me touch on something that I hear from most of my
21 constituents and that is cost. For individuals, seniors,
22 families living below 200 percent of the federal poverty
23 level, they will have no premiums and no cost sharing. There

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1 are never out-of-pocket costs for children under 21 and for
2 maternity services, for preventive and chronic services, for
3 long-term services and supports, and for prescription drugs.
4 There are also zero deductibles. Zero. Annual out-of-pocket
5 costs are no more than \$3,500 for individuals, \$5,000 for
6 families on a sliding scale, and premiums are capped no more
7 than eight percent of income for enrollees and are determined
8 on a sliding scale.

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

17 We are in a crisis. Families spend themselves into
18 poverty to get the care their aging loved ones need, hundreds
19 of thousands of individuals with developmental and
20 intellectual disabilities that wait years for services that
21 may never come, so Medicare for America establishes the gold
22 standard for long-term services and support. We partnered
23 with members of the disability community on the entire bill

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1 in order to ensure their needs. The resulting coverage: home
2 health aides, personal attendant care services, hospice, care
3 coordination, respite services, to name a few.

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

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

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1 continue. Patients deserve to be treated fairly to get the
2 care they need.

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

9 Ms. Eshoo. Rosa.

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

15 Ms. Eshoo. Amen.

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

17 [The prepared statement of Ms. DeLauro follows:]

18

19 *****INSERT 6*****

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1 Ms. Eshoo. Thank you, Congresswoman DeLauro. With all
2 the energy she always brings to everything that she does,
3 thank you.

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

7 Ms. Jayapal. Thank you.

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

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

3

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

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

18 And that is why I am so proud to have introduced, along
19 with my esteemed colleague, Representative Debbie Dingell,
20 H.R. 1384, the Medicare for All Act of 2019. Our 119
21 cosponsors, over half of the Democratic Caucus, many of you
22 on this committee, thank you for your input and your support
23 as we developed this bill. This is now the fourth historic

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1 hearing we have had on Medicare for All in the House of
2 Representatives and that would not be possible without an
3 enormous movement for Medicare for All.

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

13 Our nation's healthcare system is the most expensive in
14 the world. Contemplate that. This year, we will spend
15 almost \$3.9 trillion, or 18 percent of our GDP on healthcare
16 expenditures and that is almost double what every other
17 industrialized country in the world spends. Over the next
18 decade, our current healthcare system will cost America about
19 \$55 trillion. What does that astronomical spending get us?
20 The highest maternal and child mortality rates among our peer
21 countries and the lowest life expectancy. It gets us 500,000
22 Americans who every year are forced into bankruptcy because
23 of medical costs. It gets us 70 million people who still

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1 remain uninsured or underinsured and that is just a bad deal.

2 Why is America so far behind our peer countries? You
3 might ask that. Because profit-making motives are baked into
4 our system and our healthcare system incentivizes putting
5 profits over patients. For-profit insurance companies with
6 extremely high administrative waste stand between Americans
7 and good quality, affordable health care. Every American
8 knows someone, a loved one, a friend, a child, or a parent
9 who has suffered a healthcare crisis, and they know that the
10 system we have doesn't work.

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

20 Our bill, H.R. 1384, is a 125-plus page bill, a
21 comprehensive plan to lay out exactly how we get there and it
22 is the only plan that does all three of those things. Our
23 bill improves the successful Medicare program that we have,

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1 but it expands it to cover everyone with a guaranteed
2 government insurance plan including comprehensive benefits,
3 vision, hearing, dental, mental health, and of particular
4 importance long-term care for people with disabilities and
5 older Americans.

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

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

23 American families will pay 14 percent less than they

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1 currently pay in healthcare costs, and that is why over 250
2 economists sent a letter to Congress saying that Medicare for
3 All is the right plan for our economy. It is why former CMS
4 administrator under President Obama, Don Berwick, said that
5 after being the director of Medicare for some -- he now
6 believes it is time for Medicare for All, and it is why 30
7 unions for the first time -- don't listen to the arguments
8 that unions don't want this. For the first time, 30 unions
9 including the major unions in our country have supported this
10 bill.

11 Ms. Eshoo. Pramila?

12 Ms. Jayapal. Now it is up to us.

13 Ms. Eshoo. Pramila?

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

15 Ms. Eshoo. Wind up.

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

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

20 Ms. Eshoo. Yeah. Yeah.

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

22 Ms. Eshoo. Just wrap up.

23 Ms. Jayapal. -- that it is time for us to pass

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1 Medicare for All. Thank you, Madam Chair.

2 [The prepared statement of Ms. Jayapal follows:]

3

4 *****INSERT 7*****

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1 Ms. Eshoo. Thank you. Thank you very much for being
2 here today and testifying.

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

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

3
4 Mr. Higgins. Yeah, thank you very much, Chairwoman
5 Eshoo and Chairman Pallone and Ranking Member Burgess. I
6 just want to say that I was a proud supporter of the
7 Affordable Care Act which will be 10 years old this March.
8 But even the President, the Speaker, recognized that the
9 passage of the Affordable Care Act represented a start not a
10 finish and that it was highly imperfect in many ways
11 including the lack of a public option to be a real
12 countervailing force to private insurance, because I think by
13 and large private insurance screws people. They jack up
14 premiums. They jack up deductibles. They jack up copays.
15 And then when you go to use the insurance that you already
16 paid too much for, there is very little underlying insurance.

17 You know, before the Affordable Care Act, if you had a
18 kid that was stuck with childhood cancer, an insurance
19 company could deny you coverage because of a preexisting
20 condition. You can't do that anymore. It is against the
21 law. And the only federal law that protects people with
22 preexisting conditions is the Affordable Care Act. In 2010,
23 Democrats lost control of the House because of health care.

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1 2018, Republicans lost control of the House because of health
2 care. We are even. Let's move forward.

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

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

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

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1 specialist and all of the hospital institutions take Medicare
2 as well.

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

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

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1 Gold Plan on the individual market.

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

11 [The prepared statement of Mr. Higgins follows:]

12

13 *****INSERT 8*****

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

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

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1 STATEMENT OF HON. ANTONIO DELGADO, A REPRESENTATIVE IN

2 CONGRESS FROM THE STATE OF NEW YORK

3

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

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

21 We have got to achieve universal healthcare coverage,
22 and I believe we can get there with a public option. I
23 promised my constituents I would pursue this path and with

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1 that promise in mind, this spring, introduced the Medicare-X
2 Choice Act along with my colleagues including Representative
3 Higgins and Larsen. Medicare-X establishes a public option,
4 a government-run insurance plan available in the marketplace
5 for anyone to buy if they are uninsured or unhappy with their
6 current plan. The effect of a public competitor in the
7 private insurance marketplace will undoubtedly bring down the
8 skyrocketing costs of premiums and deductibles.

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

18 We start by, one, requiring Medicare to negotiate drug
19 prices; two, increasing federal support for those who need it
20 by eliminating the subsidy cliff for Americans above the 400
21 percent of the federal poverty line and increase in the tax
22 credit for those individuals below it; and three, authorizing
23 30 billion over 3 years for a national reinsurance program.

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1 Under this bill, a family of four with an income of \$101,000
2 would see their premiums cut in half. We do all that without
3 costing the federal government a dime.

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

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

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

20 [The prepared statement of Mr. Delgado follows:]

21

22 *****INSERT 9*****

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

10 Mr. Delgado. Thank you.

11 Ms. Eshoo. Now it is a pleasure to both welcome and
12 recognize Mr. Malinowski for your 5 minutes to talk about
13 your proposal which is H.R. 4527, the Expanding Health Care
14 Options for Early Retirees Act.

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

3
4 Mr. Malinowski. Thank you so much for those kind words,
5 Chairman Eshoo, Mr. Ranking Member Burgess. Thank you for
6 the opportunity to testify today alongside my colleagues,
7 each of whom have put together thoughtful proposals to get us
8 closer to that North Star of universal coverage. And
9 speaking of north stars, Mr. Burgess, Joni Mitchell is
10 Canadian which means she comes from a country with lower
11 healthcare costs and higher life expectancy. So I am hoping
12 you might have her for the next panel to answer some of Mr.
13 Walden's concerns. All right.

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

21 My bill, the Expanding Health Care Options for Early
22 Retirees Act, would allow retired first responders --
23 firefighters, police officers, EMTs -- to buy into Medicare

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1 beginning at age 50. Due in part to the physically demanding
2 nature of their work, first responders often retire earlier
3 than other workers and can experience gaps in coverage until
4 they become eligible for Medicare. This legislation would
5 close that gap. Coverage under this bill would be identical
6 to the coverage provided under the existing Medicare program.
7 Retirees would be eligible for tax credits, subsidies, and
8 tax advantage contributions from their former employers or
9 pension plan. Further, the bill specifically requires that
10 it be implemented in a way that will not harm the existing
11 Medicare program beneficiaries or trust fund.

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

20 And since introducing the bill in September, my office
21 has received dozens of phone calls and letters and messages
22 from people all across the United States describing how it
23 would help them or a family member. A person from Wilson

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1 County, Tennessee wrote to us, "This is a such a needed law.
2 More and more agencies are washing their hands of insuring
3 first responders when they retire. It is not a young
4 person's job. And when we retire, we are damaged physically
5 and emotionally and need the health care that eats up most of
6 our pension."

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

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

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

23 This is why we are here today, examining how to improve

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1 our healthcare system so that every American can spend more
2 time with our families and enjoy our lives so that we can
3 choose a profession we love and to change it when we please
4 without the crushing existential anxiety that comes from
5 being uninsured or underinsured, without the fear that an
6 accident or an illness could lead to bankruptcy.

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

15 Thank you so very much and I yield back.

16 [The prepared statement of Mr. Malinowski follows:]

17

18 *****INSERT 10*****

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

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

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

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

22 Mr. Burgess. Are you expecting a call?

23 Ms. Eshoo. No, I am not expecting a call, but people

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1 like to see what messages they have received.

2 [Pause.]

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

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

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

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

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

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

21 So I will now recognize Ms. Rosenbaum for your 5 minutes
22 of testimony, and you can begin. I think you all know what
23 the lighting system -- green. When you see the yellow light

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1 speed up, because on the heels of the yellow light comes the
2 red light. Welcome, and you may proceed.

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1 STATEMENTS OF SARA ROSENBAUM, J.D., HAROLD AND JANE HIRSCH
2 PROFESSOR OF HEALTH LAW AND POLICY, GEORGE WASHINGTON
3 UNIVERSITY MILKEN INSTITUTE SCHOOL OF PUBLIC HEALTH; PETER
4 MORLEY, PATIENT ADVOCATE; JEAN ROSS, R.N., PRESIDENT,
5 NATIONAL NURSES UNITED; DOUGLAS HOLTZ-EAKIN, Ph.D.,
6 PRESIDENT, AMERICAN ACTION FORUM; AND, SCOTT W. ATLAS, M.D.,
7 DAVID AND JOAN TRAITEL SENIOR FELLOW, HOOVER INSTITUTION,
8 STANFORD UNIVERSITY

9

10 STATEMENT OF SARA ROSENBAUM

11 Ms. Rosenbaum. Thank you, Madam Chair and Ranking
12 Member Burgess and members of the subcommittee for this
13 opportunity to --

14 Ms. Eshoo. Do you have your microphone on?

15 Ms. Rosenbaum. Yes, I do.

16 Ms. Eshoo. Get it close --

17 Ms. Rosenbaum. Yeah, closer.

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

20 Ms. Rosenbaum. Over the past half century, Congress has
21 pursued various solutions in its effort to insure all
22 Americans, as the limits of what could be achieved through a
23 voluntary employer insurance system became evident especially

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1 for the elderly, the poor and low-income people and people
2 with disabilities. We have embraced over many years a range
3 of solutions ranging from a single-payer solution in the case
4 of Medicare to efforts to strengthen public and private
5 insurance and expand our largest public health program,
6 Medicaid. Much work remains to be done and, of course, this
7 work takes place against a backdrop of the highest cost
8 health system among wealthy nations.

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

19 Preventive coverage has improved markedly and coverage
20 has improved for children and adults with disabilities.
21 People with serious health conditions have benefited from the
22 law's essential health benefit rules that broadened coverage
23 and limited out-of-pocket exposure while promoting actuarial

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1 value. Fifty-four million Americans have benefited from the
2 protection against preexisting condition exclusions and
3 discriminatory coverage practices. Medicare prescription
4 drug coverage has improved, 2.3 million young adults have
5 coverage through their parents' plans, and community health
6 centers have doubled their capacity.

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

16 Other administration initiatives are aiming to push
17 Medicaid enrollment still lower through block grants, work
18 experiments, and other administration strategies. The
19 administration has targeted the private insurance reforms
20 under the ACA in order to erode access to higher value
21 policies in favor of what experts call "junk insurance,"
22 while taking constant aim at the law's essential health
23 benefit and affordability provisions.

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

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

21 How broad should public coverage be? Should it subsume
22 long-term care? Should we use auto-enrollment to cut down on
23 churn? What is the best approach to financing reform? And

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1 in order to achieve true health equity, do we need to think
2 beyond coverage itself and also focus on community-level
3 investments in order to ensure accessible health care and a
4 broad continuum of health-promoting policies?

5 Thank you very much for this opportunity.

6 [The prepared statement of Ms. Rosenbaum follows:]

7

8 *****INSERT 11*****

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1 Ms. Eshoo. Thank you. It is so wonderful to have
2 people widen the lens.

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

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1 STATEMENT OF PETER MORLEY

2 Mr. Morley. Sorry, okay. Sorry.

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

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

17 In 2011, I survived kidney cancer and fought my way into
18 remission after losing part of my right kidney. In 2013, I
19 was diagnosed with lupus which causes me severe fatigue and
20 most days it is a struggle to get out of bed. I now manage
21 over ten preexisting conditions, take 38 different
22 medications, and receive 12 biologic infusions to slow the
23 progression of my disease. I live on the brink of financial

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1 ruin and only live modestly thanks to insurance and the fact
2 that I can't be discriminated against because of a
3 preexisting condition.

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

13 As someone who spends the majority of my waking hours in
14 doctors' offices, the ACA has meant focusing on healing not
15 bankruptcy. I did not ask to be chronically ill. I used to
16 be very private about my health, but once President Trump was
17 elected and set to repeal the ACA, I could no longer be
18 silent. In December 2016, I decided to foster awareness for
19 lupus and advocate for health care. My congresswoman,
20 Carolyn Maloney, has taken up my cause and those of people
21 like me. In the last 2-1/2 years, I have traveled to D.C. 27
22 times. I have collected the healthcare stories of thousands
23 of people who shared their personal stories and concerns with

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1 me. I have held over 350 meetings with Democratic and
2 Republican members of Congress alike. Many of you actually
3 sit here in front of me today.

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

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

19 I put my health at great risk to travel here and share
20 these stories. I never know if this is the last time I am
21 healthy enough to come to D.C. But I am here today to ask
22 you to protect the ACA so we can enhance it and move towards
23 universal health insurance for all Americans. Thank you for

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1 allowing me the opportunity to testify and I am happy to
2 answer your questions.

3 [The prepared statement of Mr. Morley follows:]

4

5 *****INSERT 12*****

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

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

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1 STATEMENT OF JEAN ROSS

2

3 Ms. Ross. Good morning and thank you, Chairwoman Eshoo,
4 Ranking Member Burgess, and members of the subcommittee for
5 inviting me to testify today. My name is Jean Ross. I have
6 been a registered nurse in Arizona for 45 years and I am
7 president of National Nurses United, the largest union
8 representing bedside nurses in the United States, with over
9 150,000 members.

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

22 Over many years, I cared for countless patients who
23 showed up in the ER with severe illnesses only because they

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1 could not afford preventive care. One patient always stands
2 out to me. He arrived in the ER in a hypertensive crisis.
3 We treated him for an imminent stroke. I learned he was
4 rationing his blood pressure medication. Instead of taking
5 it every day as prescribed, he was taking it every 2 days.
6 He knew he needed to take those pills daily, but he could not
7 afford the medication even with his private insurance plan.

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

17 My daughter is a single parent and she struggled to pay
18 the copays for my grandchildren's care. When my grandson,
19 Evan, was an infant, my daughter called me because he was
20 sick, she wanted my advice as a nurse. She didn't have the
21 money to take him to the doctor. I told her I would pay the
22 copay because I knew that Evan needed immediate attention,
23 medical attention, now. Indeed, he was suffering from

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1 encephalitis, which is an inflammation of the brain, which
2 can cause permanent brain damage and even death. I am so
3 grateful that I had the economic resources to help, because
4 if I hadn't, like so many other patients who don't have the
5 means, Evan would have been in severe trouble.

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

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

22 This brings me to my second point. Single-payer
23 Medicare for All is the only way we can guarantee health care

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1 while also reducing the amount of money we spend on health
2 care overall. Under Medicare for All, we will transform our
3 profit-driven health system, insurance system into a
4 healthcare system, one that prioritizes patient care.
5 Everyone will receive quality, comprehensive, therapeutic
6 care without any financial barriers. With Medicare for All,
7 doctors and nurses will be able to provide care based on our
8 professional judgment without insurance company interference.
9 We will have better patient outcomes and we will save money
10 too.

11 As you consider different options to improve our health
12 system, I encourage you to consider the following questions.
13 Will this proposal guarantee safe, therapeutic health care to
14 every person in the country regardless of their ability to
15 pay? Will it allow people to get health care independent of
16 where they work or if they have a job? Will it reduce
17 administrative complexity and waste in the system and control
18 costs? There is only one bill before the subcommittee today
19 that will achieve all of these things, H.R. 1384, the
20 Medicare for All Act of 2019, authored by Congresswoman
21 Jayapal and Dingell. The primary responsibility of a
22 registered nurse is to protect the health and well-being of
23 her patients. In my professional judgment, the only way we

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1 can put our patients first as we are ethically and morally
2 bound to do is through Medicare for All. I urge every member
3 of Congress to support H.R. 1384. Thank you.

4 [The prepared statement of Ms. Ross follows:]

5

6 *****INSERT 13*****

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1 Ms. Eshoo. Thank you, Ms. Ross.

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

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1 STATEMENT OF DOUGLAS HOLTZ-EAKIN

2

3 Mr. Holtz-Eakin. Chairwoman Eshoo, Ranking Member

4 Burgess, and members of the committee, thank you for the

5 privilege of being here today to discuss these proposals for

6 progress towards universal coverage which is, indeed, a very

7 important goal for the United States. The proposals fall

8 into two broad categories, as you have heard. Some are like

9 Medicare for All, sweeping single-payer reforms which would

10 cover everybody in the United States, and then a series of

11 more targeted reforms that take the character of Medicare

12 buy-ins, Medicaid buy-ins, and then public options, and I

13 want to discuss them in turn.

14 The proposal for Medicare for All is a truly, sweeping

15 reform unlike any single-payer elsewhere on the globe. Other

16 single-payers do not ban private insurance, indeed, often

17 supplement it; do not eliminate a role for regions and

18 states, but often rely on them to deliver their health care

19 and their insurance. They don't eliminate copays and other

20 incentives for individuals to utilize care effectively. And

21 in one case, Britain, they actually own and operate the

22 hospitals. In this case, that no such thing goes on.

23 So this is not something where you can say we are going

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1 to get something that looks like something elsewhere in the
2 world. This is like nothing else that has ever been proposed
3 and it has embodied in it, inevitably, some serious
4 tradeoffs. Among them will be the tradeoff between covering
5 folks in this manner and access to care and the quality of
6 that care.

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

15 In the extreme, one would worry that the reimbursements
16 would be so low that hospitals could not actually be able to
17 remain open and thus diminish access to care entirely, which
18 is obviously counter to the basic intention, but it is
19 something that needs to be dealt with in these proposals.
20 The easiest way to deal with it, of course, is to reimburse
21 at higher rates, but that is going to be extraordinarily
22 expensive. As proposed, the Medicare for All is on the order
23 of 30 trillion expense, or 32, 35, get in that ballpark. To

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1 give you a flavor for what that means as a matter of public
2 finances, if you were to finance that in the traditional
3 fashion of Medicare with a payroll tax, you would need to
4 have a 21-percentage point increase in the payroll tax
5 according to a Heritage Foundation study.

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

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

23 Some of the other approaches are more targeted. So, for

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1 example, there is a Medicare buy-in proposal that you heard
2 Congressman Higgins describe. We have taken a look at that
3 at the American Action Forum, the think tank that I run, and
4 in our estimate that bill would get about 293,000 Americans
5 to buy a Medicare buy-in the first year. By the end of 10
6 years, it will be down to about 170, 187,000 individuals.

7 To the extent that there are increases in coverage from
8 that bill, it comes from adding additional funding to the
9 existing ACA channels. But even with \$180 billion in
10 additional federal money, total coverage only rises by about
11 500,000 individuals. So we have these two approaches, a
12 sweeping turnover of the American healthcare system to little
13 gain, and some approaches that are targeted, but probably not
14 very effective.

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

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

20

21 *****INSERT 14*****

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1 Ms. Eshoo. Thank you for your testimony.

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

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1 STATEMENT OF SCOTT ATLAS

2

3 Dr. Atlas. Thank you, Chairwoman.

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

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

15 In England, the NHS constitution explicitly states, "you
16 have the right to receive NHS services free of charge,"
17 despite taxing citizens \$160 billion per year. The
18 opposition to single-payer care though should not focus only
19 on massive new taxes that will be required, but instead on
20 the well-documented half-century of its failure in the
21 medical literature to provide timely, quality medical care.
22 The truth is that single-payer systems, including in the
23 U.K., Canada, Sweden, and other European and Nordic

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1 countries, impose shockingly long waiting times for doctor
2 appointments, diagnostic procedures, drugs, and surgery that
3 are virtually never found in the United States specifically
4 as a means of rationing care.

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

14 The average Canadian woman, maybe not Joni Mitchell,
15 waits 5 months for her GP visit to her treatment by her
16 gynecologist. In the U.K.'s single-payer system, more than
17 19 percent of those referred for "urgent treatment for
18 cancer" wait more than 2 months for their first treatment.
19 In Canada, almost 8 months for brain surgery after seeing the
20 doctor. These long waits are the defining feature of all
21 single-payer systems and they stand in stark contrast to U.S.
22 health care.

23 Waiting lists are not a feature in the United States, as

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1 stated by the OECD and verified by numerous studies. Even
2 for low-priority checkups, U.S. wait times are far shorter
3 than for seriously ill patients in countries with single-
4 payer care. Single-payer systems also restrict the
5 availability of new drugs, including cancer drugs, sometimes
6 for years. Of the world's 54 new cancer drugs from 2013 to
7 2017, by 2018, 94 percent were available for Americans, for
8 Brits 70 percent, in Canada 53 percent, in France 43 percent,
9 in Australia 28 percent.

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

18 Governments in Finland, Ireland, Italy, the U.K., The
19 Netherlands, Norway, Spain, Sweden, Denmark, all with single-
20 payer care spend taxpayer money now, sometimes even outside
21 their own country, on private care to solve their
22 unconscionable failures. Americans should also wonder why
23 those with financial means spend even more money than their

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1 already high taxes for something that is "guaranteed and
2 free." Half of all Brits earning more than 50,000 pounds now
3 buy or plan to buy private insurance. Here is the reality.
4 Only the poor and lower middle class are stuck with
5 nationalized single-payer health care because only they
6 cannot afford to circumvent the system.

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

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

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1 afford to circumvent that.

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

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

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

23 [The prepared statement of Dr. Atlas follows:]

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1

2 *****INSERT 15*****

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1 Ms. Eshoo. Thank you.

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

5 Now we have, obviously, the whole span of what,
6 thinking, on public and private health insurance and that has
7 been expressed rather eloquently by each witness. I am taken
8 with the following and that is that the percentage of people
9 that still are not insured in our country. I don't
10 understand why people that are eligible are not enrolled. It
11 is such a loss because they are subjected to all of the
12 things that we know -- Mr. Morley, you spoke to them and that
13 they are not enrolled that is a whole other issue -- but at
14 6.8 million people in our country.

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

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

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1 the question. You may have --

2 Dr. Atlas. I will give it a shot.

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

8 Ms. Rosenbaum. Thank you very much.

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

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

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

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1 Ms. Rosenbaum. Right.

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

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

11 Whether you ever take the next step --

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

16 Mr. Morley?

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

20 Ms. Eshoo. Thank you for that.

21 Mr. Morley. You are so welcome. But I have very
22 limited opportunity to think proactively, but I take my cues
23 from Congresswoman Schakowsky, all of them. I support all of

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1 them. Anything that is going to get us access, to increased
2 access, I believe in all of them.

3 Ms. Eshoo. You are so beautiful.

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

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

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

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

14 Ms. Eshoo. Okay.

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

17 Ms. Eshoo. Thank you.

18 Dr. Holtz-Eakin?

19 Mr. Holtz-Eakin. Yeah, I would say two things. First,
20 I want to echo the importance of genuine delivery system
21 reforms to make whatever gains in coverage you achieve
22 sustainable, because they just won't stay unless we do that.
23 It is why I am very worried with the Medicare for All. That

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1 is going backwards to fee-for-service medicine, which this
2 committee with MACRA recognized was not the way to go.

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

7 Ms. Eshoo. Thank you very much.

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

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

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

22 And I should just announce that December 15th is the
23 deadline for enrollment, so whomever is listening in, if it

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1 is C-SPAN and everyone else, we are talking about insurance,
2 affordable coverage, everyone understand, December 15th.

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

7 Mr. Burgess. Thank you.

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

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

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

22 Mr. Burgess. Well, and I thank you for your
23 observations. I thank you for your testimony. It was some

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1 of the most interesting I have read in a while.

2 Dr. Holtz-Eakin, can you talk somewhat about the --
3 well, I guess the phenomenon is cross-subsidization.

4 Currently, the current Medicare system does not reimburse for
5 the cost of the care so that cost, that delta is covered by
6 generally employer-sponsored insurance or individual
7 insurance. Can you speak to that what would happen in a
8 world where there was no longer the ability for that cross-
9 subsidization?

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

19 The importance of that level of reimbursement for things
20 is brought home by some of the work the administration did on
21 international drug prices where the attention was that drugs
22 are cheaper elsewhere. But what was not caught in that
23 proposal was that of the 27 most expensive drugs that

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1 Medicare patients in the United States get and use, only 11
2 were available in all of the other sixteen countries that
3 were studied.

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

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

10 Mr. Holtz-Eakin. Congratulations.

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

19 Dr. Atlas, if you could, and you didn't mention it in
20 your oral testimony, but in your written testimony you talked
21 a little bit about the difference in infant mortality rates,
22 United States, other parts of the world, and I think the
23 statement that you have is about how in the United States the

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1 effort to save some of the most premature infants is
2 different from other parts of the world.

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

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

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1 So you can imagine in a fraction if you change the
2 denominator, you have a totally invalid statistic. This is
3 documented in the peer-reviewed medical literature. This is
4 not my assertion. Same thing with life expectancy, although
5 a little bit different. Most of the deaths in young people
6 in the United States are not even due to illness. Immediate
7 gunshot wound to the head in murder is not a reflection of
8 healthcare quality, okay. And when you look at, for
9 instance, lifestyle behavior is very different in the U.S.
10 than other countries. Forty percent of the difference in
11 life expectancy between the U.S. and other countries is due
12 to one lifestyle behavior, obesity.

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

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

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

20 Mr. Burgess. A lot of facts.

21 Ms. Eshoo. Yeah.

22 Mr. Burgess. But just before I yield back, I would like
23 to ask unanimous consent to add to the record a letter from

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1 the Texas Hospital Association and the American Hospital
2 Association.

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

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

7 The Chairman. Thank you, Chairwoman. I should thank
8 you for having this hearing. I was one of the drafters of
9 the ACA and obviously very proud of that fact and I do
10 believe that the ACA could have and still can achieve almost
11 universal coverage. I mean the idea was that, you know, 65-
12 some percent of the people get their insurance through the
13 employer, and then we had this large group of people who buy
14 insurance individually on the marketplace but can't afford
15 it, so the idea was to try to make it affordable and that is
16 where the subsidies came in. And the mandate, you know,
17 the idea of the mandate was that, you know, we will give them
18 enough of a subsidy so they will buy insurance rather than
19 paying a penalty to not buy it. But there was still two
20 groups that were still out there even with that scenario, one
21 where those who wouldn't be able to pay a premium and that is
22 why we wanted to expand Medicaid, and then the last group
23 were the uninsured. I mean, I am sorry, not the uninsured,

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1 the undocumented, which as far as I am concerned, you know,
2 we should have addressed and we had a debate but we couldn't
3 get the votes.

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

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

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

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

21 Ms. Rosenbaum. Yes.

22 The Chairman. And Congressman Veasey's bill that we are
23 considering today, the Incentivizing Medicaid Expansion Act,

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1 would make that offer even more generous, correct?

2 Ms. Rosenbaum. Yes.

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

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

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

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

19 The Chairman. Ideological, all right.

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

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1 think percentage-wise that would mean?

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

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

7 Ms. Rosenbaum. But undocumented --

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

9 Ms. Rosenbaum. Yes.

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

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

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

22 Ms. Rosenbaum. Yes. Yeah.

23 The Chairman. Okay. So, I mean I agree with you. It

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

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

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

20 Ms. Rosenbaum. Absolutely. And it is very difficult to
21 begin to quantify these kinds of shifts, but very important
22 to bring everybody in to deal with health problems before
23 they become serious enough to be high cost.

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1 The Chairman. All right, thank you so much. Thank you,
2 Madam Chair.

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

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

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

17 Mr. Holtz-Eakin. At that point it will be exhausted and
18 --

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

20 Mr. Holtz-Eakin. It means that the payments out to
21 hospitals will have cumulatively exceeded the payroll taxes
22 that go in, and at that point there will not be the legal
23 authority to reimburse for care.

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1 Mr. Shimkus. Can you say that again?

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

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

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

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

11 Mr. Holtz-Eakin. Yes.

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

19 Dr. Atlas. Yeah. What figure you are alluding to shows
20 that the number of workers funding per Medicare beneficiary
21 started out when the program started at 4.6 and now it is
22 about 2 point-something. And so when you have not enough
23 people working to fund the program at the same time as this

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1 explosion of an aging population and actually a positive of
2 people living longer, living longer also means incurring more
3 medical expenditures because older people have these --

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

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

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

19 Mr. Holtz-Eakin. It is not clear.

20 Mr. Shimkus. Okay. And we are talking about this too.
21 We have this big H.R. 3 drug debate about, well, maybe ten
22 new blockbuster drugs won't get to market, some estimates are
23 a hundred. If you are the patient who is looking for that

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1 lifesaving new drug you want to be able to get it. And it
2 is, I think, the countries that we have talked about who have
3 single-payer systems, their actuary, not actuary, but their
4 listing, it takes a long time for new products to come on the
5 market; is that correct?

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

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

12 Mr. Holtz-Eakin. It is gone.

13 Mr. Shimkus. It is gone.

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

17 Madam Chairman, I would like to submit two letters for
18 the record from the National Right to Life Committee, April
19 29, 2019 and the March for Life Action, and whenever you are
20 willing to do that and I know you may want to look at it.

21 But I want to read a statement. There are certain key
22 details of this legislation that would mean dramatic and
23 radical departure from longstanding abortion-related policy.

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1 The legislation would require government funding of abortion
2 without limitation and also likely would require unwilling
3 hospitals and doctors to perform abortion procedures. When
4 you go into a government system and you don't have choice,
5 you have to play by the rules.

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

10 Mr. Shimkus. Thank you.

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

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

19 The trend is reflected by the healthcare sector
20 consuming an increasing portion of our nation's GDP. In 2016
21 it has accounted for 18 percent of our GDP, but in 2026 it
22 will jump to 20 percent and that trend is unaffordable and
23 unsustainable. And every day, like my colleagues, I hear

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1 heartbreaking stories from my constituents about how families
2 are having to choose between paying for lifesaving health
3 care and other necessities such as groceries.

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

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

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

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1 Mr. Engel. Thank you.

2 Madam Chairwoman, I would like unanimous consent to
3 submit into the record a letter in support of H.R. 1384 from
4 253 leading economists discussing how this bill will reduce
5 healthcare costs while guaranteeing every American access to
6 comprehensive care.

7 Ms. Eshoo. So ordered.

8 [The information follows:]

9

10 *****COMMITTEE INSERT*****

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

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

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

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

6 Mr. Engel. Thank you.

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

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

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1 healthcare services?

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

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

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

19 Ms. Eshoo. The gentleman yields back.

20 I just want to add something to what the gentleman from
21 New York said relative to the ACA and the public option. The
22 House passed that. It was the Senate that fell short on --
23 we all feel strongly about it because we fought so hard and

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1 we achieved what we wanted to achieve in the House, but I
2 think it is important to have that as part of the record.

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

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

12 My daughter, she is 30 now, 25 years old she was
13 diagnosed with Hodgkin's lymphoma. She went through all of
14 the treatments and lost her hair, got her hair back and is
15 doing very good now, in fact, going to get married next
16 October. And I am wearing today my St. Jude's Children's
17 Research Center tie that I am very passionate about and have
18 been for over, well, close to 40 years now, I guess, but over
19 30 years.

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

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1 opportunity.

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

9 Dr. Atlas, first name Charles, middle name Charles, any?

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

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

14 Dr. Atlas. Okay.

15 Mr. Long. -- curious, but inquiring minds want to
16 know. But if you think back to 2013, with the rollout of
17 healthcare.gov and all the issues that they had getting the
18 website opening up and I think six people actually were able
19 to sign up that first day, it took months and months to get
20 it where it was fully functional and more than one-and-a-half
21 billion dollars over budget to get it up and going. In the
22 end, healthcare.gov website finally launched about 3-1/2
23 years after the passage of the Affordable Care Act. The

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1 Medicare for All bill is estimated to cost over \$30 trillion
2 and would fully transition from our current healthcare system
3 to a single-payer system in 2 years. So if the United States
4 Government couldn't build a functioning website in 3-1/2
5 years and went massively over budget trying, how can we
6 possibly expect the government to successfully transition to
7 a single-payer system in just 2 years and stay on budget?
8 Any comment?

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

20 I think the best way to get access is to reduce the cost
21 for everyone just like it is done -- that is why the
22 cellphone in your pocket, it is a super-computer, doesn't
23 cost \$20,000, from competition and empowering consumers who

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1 care about the price of what they are actually directly
2 buying.

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

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

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

22 And I have spoken of cancer patients, including my
23 daughter, here this morning to wait 2 full months. And when

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

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

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

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

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

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

23 Ms. Matsui. Thank you very much. And I want to thank

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1 the witnesses for all being here today and thank Chairwoman
2 Eshoo for having this hearing here today.

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

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

21 It is my hope that today we can have a productive
22 conversation about how to obtain universal coverage, increase
23 the role of federal government in lowering the cost of care,

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1 and maintain our role as the global leader in cutting-edge
2 treatments and health technology. Our path forward will say
3 a lot about who we are as a nation.

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

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

23 Ms. Rosenbaum. Yes. There are two kinds of subsidies

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1 under the ACA. There is a premium subsidy and then there is
2 a cost sharing subsidy. The premium subsidy begins at the
3 federal poverty level and it ends at 400 percent of poverty
4 and it essentially works by keeping down your cost of
5 coverage to a certain percentage of your income. Currently,
6 the subsidy has sort of a steep cliff and ends completely at
7 400 percent of poverty.

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

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

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

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

21 Ms. Rosenbaum. Estimates suggest that just those two
22 changes alone, probably along with, of course, something for
23 the Medicaid expansion states that have not expanded, would

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1 probably raise the insured levels by at least ten million
2 people, even more with auto-enrollment.

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

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

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

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

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

20 Ms. Matsui. Mr. Morley, I just want to make a comment.
21 Thank you for your testimony. We really do understand what
22 you have been going through and we really want to work on
23 behalf of you and many other patients such as yourself. And

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1 thank you for sharing your unique perspective with us. I am
2 equally concerned about the actions taken by the
3 administration to undermine Medicaid and the ACA protections
4 and that have increasingly exposed, you know, consumers to
5 coverage gaps. And, believe me, that is what we are trying
6 to do today, to ensure that we level the playing field and
7 understand how important it is. Thank you very much,
8 appreciate it.

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

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

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

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

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

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

22 So the concern as we go down this path is -- and we have
23 to -- it is not just a slogan that we can put on a bumper

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1 sticker or a T-shirt, it is, how is this going to affect the
2 healthcare system that Americans have. We can cure sickle
3 cell anemia. We -- cystic fibrosis is going to be a disease
4 that people can live with further. It is going to be a
5 maintenance disease. Artificial pancreases, available now.
6 Just the things that are coming out of this country and we
7 are subsidizing the rest of the world. And that is an issue
8 that we try to address in H.R. 19 on drugs is that we have a
9 U.S. trade negotiating or negotiate with other drugs.

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

20 Well, I will tell you, every rural hospital in Kentucky
21 today, an expanded state, would say if -- and we are making
22 it up, we are doing Medicaid expansion and DSH payments
23 because it just doesn't work -- they would all say they would

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1 close or have difficult -- particularly the smaller ones. I
2 won't say Owensboro or Bowling Green, but the smaller
3 hospitals would close, they tell me, if we didn't make up the
4 DSH payments when the policy was everybody be covered, but
5 the problem is the payments are so low even the people
6 covered, the hospitals can't make it up.

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

15 And so, what would you see with our --

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

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

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

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

21 Dr. Atlas. Well, we know that the CMS Actuary just now
22 said it that their warning in 2018, hospitals and nursing
23 facilities and in-home care are going out of business because

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1 they are losing money per patient. If you lose money per
2 patient, you don't make up for that in volume, as the old
3 joke goes.

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

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

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

12 Ms. Eshoo. The gentleman yields back.

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

23 So it is a pleasure to recognize the gentlewoman from

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1 Florida, Ms. Castor, for her 5 minutes.

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

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

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

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

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

21 Ms. Castor. So the protection, no longer can an
22 American be discriminated against for any preexisting
23 condition. It has been very meaningful for young people to

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1 stay on their parents' policies until they are age 26.

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

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

23 Chairwoman Eshoo, when you talk about this cohort of

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1 people who don't have health coverage, because of that
2 Florida, the fact they haven't expanded Medicaid, ten percent
3 of all working adult or all uninsured adult population comes
4 because of that coverage gap, so I appreciated Chairman
5 Pallone and Congresswoman Matsui highlighting this.

6 Dr. Rosenbaum, can we just -- we can look at Mr.
7 Veasey's legislation to increasing incentives, but I mean
8 \$13.8 billion, we would cover people, it would help our GDP,
9 we would be able to hire, we would be healthier, infant -- I
10 mean across the board. What else can we do? We have to just
11 go ahead and say we intended Medicaid to be expanded under
12 the Affordable Care Act. Do we have to craft that again and
13 pass it and would it withstand scrutiny of the Supreme Court?

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

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

23 Ms. Rosenbaum. Unfortunately, the Supreme, well, the

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

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

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

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

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

23 Ms. Castor. Thank you.

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1 Ms. Eshoo. I made the announcement, December 15th,
2 whomever is tuned in.

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

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

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

22 But an issue that it still plaguing our healthcare
23 system is cost. I held town hall meetings, I met with

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1 families, I met with small businesses in my state, and three
2 things kept coming up. For many, the out-of-pocket costs
3 were unaffordable. For some there were gaps in coverage or
4 they were underinsured. And, number three, health inequities
5 and disparities still persist, which is why we are still
6 talking about maternal mortality in this country.

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

20 Unaffordable, out-of-pocket healthcare costs aren't just
21 an issue in my state. The Commonwealth Fund has found that
22 about one in six Americans face healthcare costs they can't
23 afford, even with health insurance. Deductibles alone have

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1 tripled in the last decade. More than four in ten workers
2 enrolled in a high deductible plan reported that they don't
3 have enough savings to cover their deductible. In other
4 words, in the words of one of our previous witnesses, if you
5 can't afford it, you don't have it.

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

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

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

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1 minutes of questioning.

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

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

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

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

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

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

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

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

18 The real solution to drug prices is to figure out why
19 they are costing so much, because the cost of developing a
20 drug has exploded over the past decade to two and a half
21 billion dollars in 15 years and nobody is going to develop a
22 drug if they are not going to get that money back. So we as
23 a government, really, have added a lot of bureaucracy and a

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1 lot of hurdles and therefore cost to the development of new
2 drugs and that is where the attention should be focused.

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

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

9 Mr. Burgess. Yeah, who knew?

10 Ms. Eshoo. Who knew? That is right.

11 Mr. Carter. Excuse them.

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

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

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

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

19 Mr. Carter. Exactly. And again, I don't fault my
20 colleagues on the other side of the aisle. They want the
21 same thing I want. We all want the same thing, to bring the
22 prescription prices down and we can do that. And I see the
23 need for transparency so much because I know what is going on

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1 here and I know that there are middlemen who are bringing no
2 value whatsoever to the system but are taking profits out of
3 the system.

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

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

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

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

23 Ms. Ross. I am.

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

3 Ms. Ross. It does not.

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

9 Ms. Ross. I am aware of that.

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

15 Ms. Ross. I did hear that, yes.

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

20 Ms. Ross. I am aware.

21 Mr. Kennedy. Are you aware of the fact that about over
22 50 percent of the adults in this country in need of mental
23 behavioral illness will not get the access that they care

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1 today?

2 Ms. Ross. Yes.

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

5 Ms. Ross. Absolutely.

6 Mr. Kennedy. So I was at a regional hospital on my
7 district a little while ago -- keep in mind in a state with
8 98 percent, 98 percent of people covered with health
9 insurance, 98 -- there was a little boy that was waiting that
10 was being boarded. He had been waiting for over 150 hours
11 and counting, waiting for a bed. That they couldn't get the
12 stretchers down the hallways in the emergency room because
13 there are so many patients suffering from mental illness
14 waiting for a bed.

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

23 Ms. Ross. A lot.

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1 Mr. Kennedy. That sounds about right to me.

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

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

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

12 The challenge, where I would challenge you and challenge
13 others on this is that the focus of that system ends up being
14 on those who have access to it and not the drastic number of
15 Americans that don't. And the fact that even today in a
16 place like Massachusetts that is so proud of the healthcare
17 industry that we have invested in and that we have nurtured
18 that a story that ran in the Boston Globe about 8 months ago,
19 no, about a year ago, about an African American woman who
20 slipped and fell in a minority part of Boston, broke her
21 wrist, got in a cab and went to Boston Medical Center, the
22 old city hospital. She broke her wrists out in front of or
23 down the block from New England Baptist. It is where the

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1 Boston Celtics go to get an orthopedic surgery. She didn't
2 even know that the hospital was there. And even if she did,
3 it wouldn't have mattered because it is a private hospital
4 and they don't take Medicaid.

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

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

19 Mr. Kennedy. And so, my time is up here. I will just
20 say this. This is complex and this is complicated and there
21 are tradeoffs. But the core question here is that for a
22 system that every single one of us will draw on, whether you
23 are born into a system or whether you welcome a new child or

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1 watch a loved one pass through it, why would we not want to
2 make sure that it is a system that is there for everyone
3 else, the same system that we want for a loved one? And I
4 yield back.

5 Ms. Ross. Could I add one comment to that?

6 Mr. Kennedy. That is up to the chair.

7 Ms. Ross. Would I be allowed?

8 Ms. Eshoo. Well, I think we need to move along because
9 it is 24 minutes past -- or yeah, seconds past the
10 gentleman's time. I now would like to recognize the
11 gentleman from Virginia, Mr. Griffith, for his 5 minutes of
12 questions.

13 Mr. Griffith. Thank you, Madam Chair..

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

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

22 Mr. Griffith. Well, and I don't necessarily agree with
23 you on that and would take exception, but we try to be

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1 courteous on this committee and try to work together.

2 That being said, Dr. Atlas, today many rural hospitals
3 are closing because they cannot afford to stay in business,
4 leading to access problems for sick Americans. One of the
5 major reasons for these closures is that Medicare, and Mr.
6 Kennedy mentioned Medicaid, doesn't pay hospitals enough.
7 According to MedPAC, hospitals are unable to make money
8 caring for Medicare patients. If it wasn't for privately
9 insured patients, even more hospitals in rural communities
10 would close. Research by the consulting firm Navigant
11 predicts that a Medicare public option plan would put up to
12 55 percent of rural hospitals at high risk for closure.

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

20 Dr. Atlas. Well, absolutely, of course. Like I said
21 before, the CMS Actuary put out the statistic that and in
22 fact the statement that we expect access to Medicare
23 participating physicians to become a significant issue, quote

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1 unquote. And the reason is because Medicaid and Medicaid pay
2 not just lower than private insurance, but below the costs of
3 delivering the care. That is the point. And so it brings
4 you back to what I believe is the whole solution that should
5 be the focus which is to reducing the cost of care without
6 needing to limit or restrict the use of care. If you reduce
7 the cost of care, everybody gets access including those on
8 government programs.

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

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

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1 guarantee that those folks are actually going to have care?

2 It is not like getting in a cab and going to the next
3 hospital down the road. There is no hospital down the road.

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

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

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

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

17 Ms. Eshoo. The gentleman yields back. Actually, you
18 know, the GAO analyzed data and found that rural hospitals in
19 states that had expanded Medicaid as of April 2018 were less
20 likely to close compared with rural hospitals in states that
21 had not expanded Medicaid. So we deal with a lot of
22 complexities, but I think the facts need to be stated so
23 that, you know, that we build on the foundation of facts.

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1 And it seems to me that we are in an era where that
2 foundation continues to be eroded on a daily basis, so.

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

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

19 And I, myself, know what it is to grow up in a family, a
20 working family, where my parents faced the choice between
21 going to the doctor or having enough food to feed their
22 family, a choice that too many American families face today.
23 To say that the establishment of federally qualified health

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1 centers changed our lives is an understatement. For the
2 first time, we could get preventive care. We could go to the
3 doctor when we first started feeling sick instead of when it
4 was a dire emergency.

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

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

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1 Americans have access to health care today?

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

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

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

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

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

13 Mr. Cardenas. Okay. Okay, got it.

14 Dr. Atlas. And if I could --

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

18 The bottom line is this. In the United States of
19 America, we have -- a hundred percent of Americans have never
20 had truly access to health care. Just like I outlined in a
21 period of time in my family's history when I was growing up,
22 we truly didn't have access to health care, preventive care.
23 Excuse me. Today, Americans don't, before the Affordable

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1 Care Act we never were at a hundred percent. During the
2 Affordable Care Act, the new system, we are not at a hundred
3 percent. Hospitals have closed and opened, et cetera, over
4 the history of time in the United States of America.

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

19 So the main thing that I think this hearing is about
20 today is, how can we as elected members of Congress in the
21 House of Representatives, the people's house, how can we
22 advance some legislation that will bring us to a better
23 state, a better place where more Americans can appreciate the

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1 fact that they can live through a healthcare situation
2 instead of die because of nonaccess to health care? That is
3 at the core of what this hearing is about and I really do
4 appreciate all of you coming forward.

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

9 Ms. Eshoo. The gentleman yields back. The chair now
10 recognizes the gentleman from Florida, Mr. Bilirakis, for his
11 5 minutes of questions.

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

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

16 Mr. Holtz-Eakin. Yes.

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

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

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

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1 intervention and mandates?

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

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

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

17 Mr. Holtz-Eakin. The bill would eliminate Medicare,
18 Medicare Advantage included so that would be gone, so would
19 Medicaid. It would eliminate private insurance, so those
20 individuals would definitely be affected. The bill is silent
21 on financing the costs, which are substantial. I personally
22 believe having looked at a variety of these that it is
23 implausible to imagine that that taxpayer cost could be

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1 picked up by a small subset of affluent Americans. It is
2 simply too big of a number.

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

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

14 Mr. Bilirakis. Okay, thank you.

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

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

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1 Mr. Bilirakis. Okay.

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

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

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

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

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

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1 new technology and new drugs, the goods are not produced.

2 That is just a fact.

3 Mr. Bilirakis. Okay, thank you very much.

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

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

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

10 Ms. Eshoo. Put your microphone on, please.

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

15 Ms. Ross. Well, obviously we are not proponents of
16 denying care to people. We are proponents of making sure
17 that everybody gets them. There has been a lot of discussion
18 about the rural hospitals, very near and dear to our hearts
19 too. You are right. The main reason is the nonexpansion of
20 Medicaid, but the other is the for-profit motives of private
21 employers, hospital corporates that come in and they opt for
22 a model that will serve them better, make them more money, so
23 they close off services that people in those communities

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1 really need and they move them to other places so that our
2 patients cannot get the care that they need that they once
3 were able to. So Medicare for All actually has globalized
4 budgets and it has a budget for special projects which
5 ensures that those rural hospitals and others will be built
6 and opened.

7 Ms. Eshoo. Does the gentleman yield back?

8 Mr. Bilirakis. Yes.

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

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

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

23 Ms. Ross, you and I are made from the same fabric

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

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

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

23 So -- but, unfortunately, the ACA has not been fully

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

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

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

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1 control.

2 Mr. Ruiz. Well, you know, the thing we have to focus
3 here is that we need a preferential option. We need not just
4 any option, we need a preferential option. And when you look
5 at health insurance, you want to make sure that it is
6 expansive and protects you and will cover what you need to be
7 covered. And let's -- I am an emergency medicine doctor, so
8 there is nobody who is immune to accidents. Nobody is immune
9 to that unfortunate surprise diagnosis that you get that you
10 never thought you would ever get, like cancers and what not.

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

21 Ms. Eshoo. And the gentleman --

22 Mr. Ruiz. Yields back.

23 Ms. Eshoo. -- yields back. That is right. A pleasure

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1 to recognize the gentleman from North Carolina, Mr. Hudson,
2 for his 5 minutes of questions.

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

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

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

18 First, broadly speaking, the population we are trying to
19 help is roughly 28 million Americans who cannot afford
20 insurance or who have decided not to purchase insurance. By
21 comparison, 293 million Americans do have insurance, which is
22 a little more than nine out of every ten people in this
23 country are insured. Medicare is already going broke. The

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1 program currently covers roughly 44 million people in this
2 country. Under Medicare for All it would have to cover 327
3 million people. That is seven times the size it currently
4 covers. To think that we could add seven times more people
5 to the Medicare program without a cut in benefits defies
6 common sense.

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

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

22 Dr. Atlas. Yes. There is an increasing trend in
23 countries with single payers, specifically the U.K. is a

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1 florid example, but also all the other countries of Western
2 Europe that people with money opt out of the system, or not
3 opt out, they pay their taxes but they then supplement.
4 There is a significant increase in buying private insurance,
5 significant increase in paying out-of-pocket, and they all
6 avoid using their single-payer system of the people who are
7 affluent enough to do it.

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

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

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

21 Medicaid has worse outcomes from surgery, cancer, heart
22 procedures, lung transplants than the same patients with
23 private insurance because of the restrictive access to

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1 technology and drugs that Medicaid covers. My plan is to
2 make Medicaid money go for a bridge towards private
3 insurance. We want everybody in the country to have
4 excellence, to have access to the excellence of American
5 health care, not a separate parallel pathway for poor people.

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

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

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

22 Dr. Atlas. Because the single-payer coverage restricts
23 care. And as we see in the United States, we can expand

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1 Medicaid all we want, but Medicaid is not accepted by more
2 than half of doctors, including doctors who have signed
3 contracts to accept Medicaid, according to HHS data. So you
4 label someone as insured, but that is not the same as having
5 access to care.

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

8 Ms. Eshoo. The gentleman yields back.

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

11 Now we would like to --

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

14 Ms. Eshoo. Well.

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

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

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

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

22 The chair now would like to recognize the gentlewoman
23 from California, Ms. Barragan, for her 5 minutes of

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1 questions.

2 Ms. Barragan. I thank you. There was this conversation
3 about the one system for the wealthy and one for the poor.
4 Hello. Testing.

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

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

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1 really don't have coverage.

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

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

14 Ms. Ross. I think I would point to again what I talked
15 about with how it is administered, the globalized budgets.
16 There would be negotiations between the hospital and the
17 regional directors and you would look at what you would need
18 for the following year, looking at what you needed for the
19 year before, for one thing, and then you would project. So
20 if you knew you had rural hospitals, communities that are
21 underserved, and you needed more staff in those hospitals,
22 maybe you needed to build a hospital, those are the kinds of
23 things you would look at putting into the budget so that

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1 people who had previously been unserved and underserved would
2 be able to get care.

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

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

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1 Ms. Barragan. Thank you.

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

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

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

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1 want to see those protections removed.

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

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

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

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

20 Now some of my Democrat colleagues will claim Medicare
21 for All is a proposal out of a fringe, out-of-touch wing of
22 the Democrat Party, but the truth is it has taken over the
23 Democratic Party by storm. Many Democrats jockeying for the

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1 presidency in 2020 support Medicare for All and half of the
2 Democrats in the House have cosponsored Medicare for All.
3 Let's be clear. Medicare for All would gut Medicare and the
4 VA for our veterans and force 225,000 Montana seniors who
5 rely on Medicare to the back of the line. Montana seniors
6 have earned these benefits and lawmakers shouldn't undermine
7 Medicare and threaten healthcare coverage of Montana seniors.

8 Medicare for All would devastate rural health care, we
9 have heard that on the committee today, especially those in
10 Montana. They already face overwhelming challenges. Since
11 2010, more than a hundred rural hospitals have closed their
12 doors and nearly 40 percent of all rural hospitals operate on
13 a budget shortfall. Under Medicare for All, hospitals in
14 Montana would take a 40 percent payment reduction. Hospitals
15 in our rural areas would struggle further and patients would
16 lose access entirely to critical providers, like oncologists
17 and heart surgeons. Medicare for All will lead to worse
18 access to care in our rural communities.

19 In addition to gutting Medicare and eliminating access
20 to care in our rural communities, Medicare for All is a
21 fiscally irresponsible budget buster. Elizabeth Warren, a
22 frontrunner in the Democrat primary has proposed Medicare for
23 All that would cost 52 trillion dollars. With a straight

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1 face, she campaigns that her plan will not raise taxes on the
2 middle class. I don't believe that. It doesn't pass the
3 reasonability test. Medicare for All would terrify Americans
4 who rely on Medicare and who like their employer-sponsored
5 plans. Under Medicare for All, private insurance would be
6 banned.

7 Folks, this is a government takeover of health care,
8 plain and simple. We are not a socialist country. Medicare
9 for All will gut Medicare and the VA as we know it and put
10 Montana seniors at the back of the line. To force 225,000
11 Montanans who rely on Medicare to share their pool with
12 everyone isn't fair to Medicare seniors, Montana seniors. In
13 reality, Medicare for All is Medicare for none. Instead of a
14 reckless government takeover of our healthcare system, we
15 should take a bipartisan approach to fix our broken
16 healthcare system. We should protect patients with
17 preexisting conditions, increase transparency and choice,
18 preserve rural access to care, and lower costs. Let's get to
19 work on that and end this socialist charade. Now, Dr.
20 Atlas, as I said earlier, it seems like our rural providers
21 will struggle under a Medicare for All proposal. What do you
22 believe will happen to rural hospitals and other providers
23 under Medicare for All?

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1 Dr. Atlas. Well, under a single-payer system where
2 private insurance is banned, we already know that Medicare
3 pays less than the cost of delivering the care. These
4 hospitals survive because of the extra reimbursement they get
5 from the private insurers. So it is very naive to think that
6 oh, we are just going to wipe out private insurance and have
7 the Medicare payments support all these hospitals. The
8 hospitals will go out of business just like the CMS Actuary
9 said in 2018.

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

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

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

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

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

23 First of all, I want to push back pretty hard on the

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

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

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1 and so I think that it is just a matter of time before we get
2 to a place where we have a Medicare for All system.

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

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

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1 not a constructive contribution to the discussion.

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

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

19 Ms. Ross. I do, indeed. And I think we are lucky that
20 we have the example of Maryland because it has worked so well
21 there. For those who might not know, Maryland started their
22 what amounts to global budgeting in 2010 and they started
23 with rural hospitals, and it was so successful then they put

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1 it in the rest of their hospitals, private and public. And
2 what they found was -- I have got some figures. Their global
3 budget saved Medicare as a payer over 420 million in just 3
4 years. And, originally, their goal was to save 330 million
5 over 5 years, so it was a whopping success. And from a
6 nurse's perspective what it does for patients is wonderful,
7 because it reduced infection rates, it improved care, it
8 reduced readmission rates, and those are all things to look
9 at.

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

12 Mr. Sarbanes. Thanks very much.

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

18 So where is Mrs. Dingell? Is she here?

19 All right, I am going to call on Ms. Kelly from the
20 state of Illinois for her 5 minutes. And if Mrs. Dingell
21 comes back, I will take her, but then we are going to have to
22 close the hearing. So the gentlewoman from Illinois is
23 recognized for her 5 minutes.

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1 Ms. Kelly. Thank you all for your testimony today and
2 your patience. One thing I have to say, you know, we worked
3 hard on -- I wasn't here, but my colleagues worked hard on
4 the Affordable Care Act and I don't think there is a Democrat
5 that would say that was a perfect bill. But a lot of people
6 that didn't have coverage received coverage, but as we know
7 there is still about twenty-seven-and-a-half million people
8 that don't have the coverage.

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

17 I am the chair of the Congressional Black Caucus Health
18 Braintrust, so I am very concerned about the disparities in
19 health for minorities. We, when it comes to morbidity and
20 mortality, I mean we lead the cause. I had a bill, the
21 MOMMA's Act, that dealt with maternal mortality, and as some
22 of you know black women die at three to four times the rate
23 of white women. I had a bill that would take the Medicaid

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1 coverage to a year instead of 2 months, but I could not get
2 one Republican on that bill even though we talk about, you
3 know, we don't want two different healthcare systems for the
4 poor and for the rich, but then when we have the opportunity
5 we don't it. Now we got a bill out, but we had to water it
6 down.

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

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

19 I think it is very important to couple any health
20 coverage reform legislation with provisions that do the kinds
21 of things that the Braintrust has been such an advocate for,
22 which is bulking up public health, bringing healthcare
23 providers under sort of a broader public health umbrella,

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1 making sure that part of the healthcare experience is care
2 management to be able to get better access to the kinds of
3 services and interventions that we commonly call the social
4 determinants at this point, making sure that when you walk in
5 the door for health care you not only have good health care,
6 but you have access to nutrition to housing assistance to the
7 other things that make people healthy.

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

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

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

19 All right, I am going to place in the record the
20 following documents: an article from the Century Foundation,
21 Health Reforms North Star; report from the Century
22 Foundation, Road to Universal Coverage; coalition letter from
23 Advocates for Youth, et al.; a letter from NAACP, et al.,

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1 regarding Medicare for All; letter from the Fraternal Order
2 of Police in support of H.R. 4527; letter from the
3 International Association of Firefighters in support of H.R.
4 4527; letter from the Healthcare Leadership Council;
5 statement from the American Nurses Association; and the
6 statement from Representative Cedric Richmond; and a
7 statement from BCBS of California; as well as the documents
8 that Congressman Shimkus asked to be entered in the record.
9 Hearing no objections, so ordered.

10 [The information follows:]

11

12 *****COMMITTEE INSERT*****

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1 Ms. Eshoo. We will recognize the gentleman from
2 Virginia for his additions.

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

21 Thank you, Madam Chair.

22 Ms. Eshoo. So ordered.

23 [The information follows:]

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*****COMMITTEE INSERT*****

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1 Ms. Eshoo. All members, pursuant to committee rules,
2 have 10 business days to submit additional questions for the
3 record to be answered by the witnesses who have appeared
4 today, and I ask each witness to respond as promptly as
5 possible to any questions that are submitted to you.

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

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

21 So I thank all the advocates that have traveled to be
22 with us. Thank you for your passion, for your big dreams --
23 keep it up. And with that, the subcommittee is adjourned.

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1 [Whereupon, at 1:57 p.m., the subcommittee was
2 adjourned.]