

Hearing on Pathways to Universal Health Coverage

HEARING
BEFORE THE
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HOUSE COMMITTEE ON WAYS & MEANS
CHAIRMAN RICHARD E. NEAL

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

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CONTACT: (202) 225-3625

Chairman Neal Announces a Hearing on Pathways to Universal Health Coverage

House Ways and Means Chairman Richard E. Neal announced today that the Committee will hold a hearing, entitled “Pathways to Universal Health Coverage” on Wednesday, June 12, at 10:00 a.m. in room 1100 Longworth House Office Building.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMdem.submission@mail.house.gov.

Please ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, by the close of business on Wednesday, June 26, 2019.

For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written

comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you require special accommodations, please call (202) 225-3625 in advance of the event (four business days' notice is requested). Questions regarding special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories are available [[here](#)].

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WITNESSES**Rebecca Wood**

Patient, Mother, and Health Consumer

[Witness Statement](#)

Tricia Neuman, Sc.D.

Senior Vice President and Director, Program on Medicare Policy at the Kaiser Family Foundation

[Witness Statement](#)

Donald Berwick, MD, MPP

President Emeritus and Senior Fellow, Institute for Healthcare Improvement

[Witness Statement](#)

Chiquita Brooks-LaSure

Managing Director, Manatt Health Strategies

[Witness Statement](#)

Pam MacEwan

Chief Executive Officer, Washington Health Benefit Exchange

[Witness Statement](#)

Grace-Marie Turner

President, Galen Institute

[Witness Statement](#)

Hearing on Caring for Aging Americans

U.S. House of Representatives
Committee on Ways and Means,
Washington, D.C

The Committee met, pursuant to notice, at 10:00 a.m., in Room 1100, Longworth House Office Building, Hon. Richard Neal, [Chairman of the Committee] presiding.

*Chairman Neal. The meeting will come to order.

And I hope our witnesses and guests will all take their seats.

So good morning and let me thank our witnesses and our guests for joining us today on the hearing this moment when we suggest that we want to examine pathways to universal health coverage.

Almost a decade ago, with some signature pride personally, the Affordable Care Act in this room was written, and it was signed into law. It provided an opportunity for more Americans, including those with preexisting conditions, to access affordable, high quality health care.

Developing the ACA was not an easy task. The drafting process spanned nearly a year, including hours of hearings, markups, and testimony, and I must tell you personally I am really proud that I was part of it.

While the ACA has helped millions gain coverage, there is more work to be done. Our Nation continues to have some of the best health care in the world, but unfortunately, many families still remain concerned about their ability to have access and to be able to

afford that care.

Today's hearing is part of our effort to build upon the progress we have made and explore opportunities to achieve affordable universal coverage. As we consider our options, I want to emphasize that it is also imperative to protect preexisting critical health care programs and to prevent discrimination against those with preexisting conditions, that would block changes, that would steer Americans to junk plans that provide no real coverage when it is really needed.

This committee is all too aware over the past several years there has been a steady stream of attempts to dismantle our existing health care law, while simultaneously having no viable replacement. Instead, there are half-baked proposals that will not bring down the cost, nor will it expand coverage.

This hearing is about exploring ideas that put patients first. My colleagues have introduced a number of bills that aim to improve affordability and get even more Americans covered. Today is an opportunity to learn more about those proposals, understand their tradeoffs, and examine how they would affect vulnerable populations.

We will hear about a range of ideas today, ways to strengthen existing law, the addition of a lower cost public option, Medicare, Medicaid buy-ins, Medicare for America, Medicare for All. All of these proposals would, indeed, help American families to see lower health care costs and increase the number of Americans with insurance coverage.

I want to recognize our guests today. They are here with us, and their unwavering commitment is really important, because upon their testimony and legislation that they have introduced.

For decades Democrats have fought to improve America's health care, understanding that we take great pride in the establishment of Medicare and Medicaid. We continue to fight for people right now, this morning. Yes, members of our party have put

forward different policy ideas, and that should be honored.

But what unites us as Democrats is our shared core belief that all Americans should have health care coverage and receive care that is not a financial burden.

As we discuss these proposals, I encourage my colleagues to think about how the approaches not only will affect individual patients, but also communities as a whole. Many of us have hospitals in our districts that are now among the largest employers in our State or region.

In particular, I think about how universal coverage would affect rural communities in States that may not have expanded Medicaid.

Ultimately, we want to have lower health care costs and see more people have access and enroll in programs that provide quality health care. Whatever path is taken, it is critical to address the important aspects like coverage, benefits, public insurance, and administration.

In addition, patient cost, provider payments, public financing, and other items like health information technology, patient data, and enrollment processes must also be considered.

The importance of this topic to millions of Americans is underscored by today's hearing. Members of many organizations have traveled long distances to show their support for a variety of proposals. Welcome, and thank you for joining us to hear more about the potential path we could pursue to help Americans have greater access to health care when they need it, at a price they can afford, and at a quality level they can count on.

This is the beginning of a process. Health care policy requires a thoughtful and detailed approach. Our witnesses today can provide insight into universal health care policy proposals.

I look forward to an open discussion about how we can expand access to health

care, ensure affordability of coverage, and improve the quality of life for all Americans.

And with that, let me recognize the ranking member, Mr. Brady, for an opening statement.

*Mr. Brady. Thank you, Mr. Chairman, for fulfilling your commitment to hold a hearing on the dangerous and controversial Medicare for All.

While our American health care system does have real problems, we should focus on improving what is working and to fix what is broken rather than starting over with a massive new socialized medicine scheme that will leave many families worse off.

Congress is facing another government shutdown this fall. The government shut down three times last year alone. So you have got to wonder. The Federal Government cannot even keep its doors open. Can you really trust Washington with your life and death health care decisions?

Make no mistake. Medicare for All guts quality health care in favor of delays and long waiting lines. It gives Washington politicians unlimited control over your health care. It cancels good quality health care plans for millions of workers, children and the elderly, and it is so costly, tens of trillions of dollars. It will bankrupt America.

Imagine a day in your life under Medicare for All. You wake up sick, and now you are worried because that great health care plan your union negotiated for you, the one that took care of you for so many years, it is gone, banned under Medicare for All.

Do not look to your spouse's health care plan, the one their company offered. It is gone, too. In fact, for the first time in America it is illegal for employers to offer health care to their workers.

Do not feel alone. You are one of 158 million American workers who Medicare for All canceled your good plans and forced you into one size fits all plan run by Washington politicians.

Your whole family is in the same boat. Your sister is a single mom whose child was covered under the popular Children's Health Insurance Program. That is eliminated under Medicare for All.

Your brother proudly serves his country in the military, willing to give his life to keep us free. His health care, TRICARE, that is wiped out, banned under Medicare for All. Thanks for your service, soldier.

And your parents who have scraped by for so many years to give you and your siblings a good life, the Medicare Advantage plan they and 22 million other seniors rely upon, well, that is ripped from them under Medicare for All.

So when you get down to it, under the Affordable Care Act, the big fib to the American people was if you like your health care, you can keep it. Under Medicare for All, the big truth is this. We are coming for your health care plan, and you are powerless to keep it.

You used to have good, dependable health care, and now you wait four weeks to see your doctor and get that test she says you need. And since doctors and the hospitals lose money on nearly every treatment they provide in Medicare, experts predict Medicare for All will cause a chronic shortage of doctors, and hospital overcrowding will be epidemic.

Maybe it will not matter because under Medicare for All, politicians and bureaucrats, not doctors, call the shots on your health care. That is not right. Individuals should control their health care decisions, not Washington politicians and bureaucrats.

To make matters worse, it is even more difficult to plan for an operation or a test because if you think getting a straight answer out of an insurance company is hard, just wait until you try to get a timely answer out of a Federal worker who could not care less.

Here is something else the politicians will not tell you. None of this is free. Your taxes and your spouse's and your business are doubled to pay for this free health care,

doubled. Smaller paychecks for your entire life does not make raising a family any easier.

When you pull the curtain back on Medicare for All, the truth is staring at you. Many Americans will pay more, wait longer for health care, and get worse care than you receive now.

You will hear today that none of this is true. This is all an exaggeration, just scare tactics. What is scary is that all of this is true. Private quality health care plans banned, true. One size fits all, true. Washington control, true. Tens of trillions of dollars in taxpayer cost that will hurt you and bankrupt America, also true.

And knowing the truth, can you really trust Washington with your life and death health care decisions? As Republicans, we are proud to be the party in Congress responsible for creating the Children's Health Insurance Program, Medicare Advantage for seniors, the lifesaving Medicare prescription drug program that Democrats opposed en masse, and every Democrat on this committee voted against at the time, and we are proud to have approved America's first law establishing protections for people with preexisting conditions.

We will not stand by and let Democrats seize your health care, seize your choices, and seize your control over life and death health care decisions under Medicare for All.

Thank you, Mr. Chairman.

*Chairman Neal. Thank you, Mr. Brady, for your opening statement.

And without objection, all members' opening statements will be made part of the official record.

I want to thank our distinguished witnesses for taking time to appear before us today to discuss this very important issue.

First, let me welcome Rebecca Wood and her daughter, Charlie. Ms. Wood is a patient advocate and mother who lives outside of Boston. We look forward to hearing her

story about how she has come to be a leading voice in the fight for affordable health care for all Americans.

Dr. Tricia Neuman is a Senior Vice President and Director of the Program on Medicare Policy at the Henry J. Kaiser Family Foundation, where she oversees the research and analysis of the foundation's work related to Medicare policy.

Dr. Donald Berwick is a former Administrator of the Centers for Medicare and Medicaid Services, CMS, where he helped implement the Affordable Care Act under the Obama administration and has been a source and very important leader in the fight for Medicare for All.

We have also Chiquita Brooks-LaSure, who is a Managing Director at the Manatt Health Strategies, where she examines State and Federal health reform policy and proposals, including the buy-in and public option opportunities.

Pan MacEwan is the Chief Executive Officer for the Washington State Health Benefit Exchange, in the State of Washington, where she has led efforts to implement the Affordable Care Act since 2012.

And finally, we will hear from Grace-Marie Turner, who is the President of the Galen Institute, which she founded in 1995 to promote free market health care reform solutions.

Each of your statements will be made part of the record in its entirety. I would ask that you summarize your testimony in 5 minutes or less, and to help you with that time, there is a timing light at the table. When you have 1 minute left, the light will switch from green to yellow and then finally to red when 5 minutes are up.

Ms. Wood, would you please begin?

STATEMENT OF REBECCA WOOD, PATIENT ADVOCATE AND MOTHER WHO
LIVES OUTSIDE OF BOSTON, MASSACHUSETTS

*Ms. Wood. Good morning. My name is Rebecca Wood. This is my daughter Charlie. She loves the color pink, princesses, bubbles, the outdoors, the band Dispatch, and Speaker Pelosi.

[Laughter.]

*Ms. Wood. Charlie is the reason I joined the health care fight in January of 2017. Prior to that, I had never been to Capitol Hill, nor had an interest in politics. But after all we have been through, I was not going to let bad policy steal her chance at a typical and independent adulthood.

Charlie's story begins in May of 2012. Due to severe preeclampsia, she was delivered via emergency C-section 10 hours into her 26th week of gestation. She weighed 1 pound, 12 ounces, and was the size of my hand.

My NICU bedside vigil began because I did not want her to die alone. It is the bravest I have ever been.

When Charlie was 3 months old, she was well enough to come home. Issues from her premature birth appeared one after another. Each one required treatments and therapies. Her birth is a preexisting condition, and she would have exceeded a lifetime cap before she came home for the first time.

Even with private insurance through my husband's employer, she relied on a Medicaid waiver for most of her care.

There were specialists, medications, injections, physical therapist, occupational therapists, speech therapists, specialty formula, formula thickeners, orthotics, eyeglasses, therapeutic equipment, attendant care, and later a feeding tube.

Charlie was in diapers years longer than most kids and needed adaptive cup, silverware and plates. The costs added up quickly.

Copays, deductibles, automatic denials, and exclusions drained our savings and financially devastated us over time. In addition, I had to and have to make impossible choices. Do I pay for her therapy or my overpriced asthma medication?

Choices like these really are not impossible. I choose to pay for hers and go without mine. One day I needed an expensive dental procedure. Unfortunately, it was at the same time a therapy payment was due. Charlie's speech was emerging. I was afraid we would miss a window of opportunity in her development if we cut her therapy.

I chose to make her therapy payment and put off my dental procedure. The decision cost me dearly. Due to the delay, an infection throughout my mouth and jaw. I went to the emergency department because the swelling in my mouth obstructed my airway. After a course of IV antibiotics, I was discharged.

The next day I had all of my teeth pulled, the infection drained, and part of my jaw scraped away in a 6-hour procedure under local anesthesia. I could not afford to have it done under general anesthesia. I sobbed the entire ride home afterwards.

I do not know what the worst part is, the excruciating pain I live with every day, how I worry whether I am drooling when I smile, how eating is awkward and challenging, or how I love jazz and I will never play the trumpet again.

Currently, I can only afford to seek medical care when I happen to be volunteering at a free clinic or when I am afraid an ailment will kill me. Forget preventative care. I am simply trying not to die.

While I juggle needs and problem solve, Charlie did and does her part, too. She survived the brutal beginning in which every breath was strenuous and touch was agony. She willed uncooperative muscles to move, pushed her sensory threshold to the limit,

gagged down food and feeding therapy, endured countless therapy sessions, and visited a multitude of doctors.

Charlie never quit. At the age of one, she was able to sit independently. At 20 months, with the assistance of orthotics, she took her first steps. Last September she learned to eat, and her feeding tube was removed. Currently she is hard at work on speech and motor issues, and Charlie celebrated her seventh birthday last month.

Today when people see Charlie, they call her a miracle. They say she is amazing or they tell me we are blessed, but there is nothing special about Charlie. She is merely an example of what is possible when kids get the health care they need.

I am lucky she survived. I am fortunate she thrived. However, it should not have cost me nearly everything. My story is one of profound policy failure. Every other nation in the world recognizes health care is a human right. It is time the United States of America does as well.

Her name is Charlie. I joined the ACA and Medicaid fights for her, but I joined the Medicare for All fight for me. I have to believe all of this happened for a reason.

Thank you.

*Chairman Neal. Thank you.

Dr. Neuman, I recognize you for testimony.

STATEMENT OF TRICIA NEUMAN, Sc.D., SENIOR VICE PRESIDENT AND
DIRECTOR OF THE PROGRAM ON MEDICARE POLICY AT THE HENRY J.
KAISER FAMILY FOUNDATION

*Dr. Neuman. Good morning, Chairman Neal and Ranking Member Brady and members of this committee. Thank you for inviting me to testify today.

I am Tricia Neuman of the Kaiser Family Foundation, a nonprofit, nonpartisan source of health policy analysis and journalism.

My testimony will describe a range of proposals that aim to broaden health coverage and make health care more affordable.

Health insurance helps people get the medical care they need when they need it, and it often leads to better health outcomes. The ACA contributed to a dramatic decline in the number of people without health insurance, but 30 million people in the United States remain uninsured, and even those with health insurance, including in employer plans, struggle to pay their medical bills, sometimes forego needed care, as we have just so eloquently heard.

Several recently introduced proposals aim to improve coverage and lower costs. Some would establish a public program or public plan option to help achieve these goals, and though they sound very similar, they differ in comprehensiveness and likely impact.

To help highlight these major differences, we have arrayed the proposals into five categories that I will talk through quickly.

The first and most far-reaching is Medicare for All, an approach that would cover all U.S. residents, ultimately replacing employer-based coverage, limiting private insurance, and ultimately incorporating Medicare and Medicaid. It would address affordability concerns and unmet need by providing comprehensive benefits, including

long-term care services and support and other services, with no premiums and no cost sharing.

Medicare for All would reduce costs paid by individuals, employers and States. It would eliminate inefficiencies derived from multiple payers and costs associated with insurer's profits.

It would also change how and how much providers are paid. It would shift costs away from other payers to the Federal Government and increase Federal spending and taxes, resulting in a major redistribution of the way health care is financed.

The second approach reflected in Medicare for America also establishes a Federal public program with an opt-out for people who choose qualified coverage. The public program would eventually replace Medicare, Medicaid and non-group insurance, but unlike Medicare for All, it would retain a role for employer-based coverage and for private insurers to offer Medicare Advantage for America plans.

The public program would also cover comprehensive benefits with no premiums and cost sharing for people with incomes below twice the poverty level.

This approach would also be a major step toward universal coverage and more affordable care, though it would also increase Federal spending and require new taxes.

A third and more incremental approach would establish a Federal public plan option offered in the marketplace alongside private insurance, and there are several proposals that would do this in a different and important ways that could affect their impact, for example, whether employers could buy into the plan and the extent to which they enhance subsidies.

The fourth approach would give people ages 50 to 60 an option to buy into Medicare without simply lowering the age of Medicare eligibility, a common misperception. This approach focuses on older adults who have high premiums in the marketplace, especially if they are ineligible for subsidies.

Many of these public programs and public plan proposals build on the popularity, strengths and actual name of the Medicare Program, and yet they differ from Medicare and implicitly draw attention to some of the gaps in Medicare.

Both Medicare for All and Medicare for America, for example, cover far more comprehensive benefits than Medicare does today.

A fifth and very different approach that involves a public plan would give States the option of establishing a buy-in. Because this would be optional for States, the impact on coverage would likely be uneven across the country.

In addition to proposals that involve public programs or plans, others would build on the ACA architecture to address affordability concerns by raising eligibility levels for premium tax credits and expanding cost-sharing subsidies.

These proposals, however, do not attack some of the more systemic issues addressed in the more comprehensive proposals.

And finally, as you will soon hear, some States are moving forward on their own to address these concerns.

Mr. Chairman, the wide range of proposals on the table vary in ways that are not trivial. These proposals reflect a number of very difficult policy choices that could have significant implications for the many stakeholders in the health care system, although CBO has yet to estimate their cost or the effect on their coverage.

This hearing provides a timely opportunity to educate the public about these various proposals, and I thank you for the opportunity to testify today.

*Chairman Neal. Thank you, Dr. Neuman.

Dr. Berwick, you can begin.

STATEMENT OF DONALD M. BERWICK, MD, MPP, PRESIDENT EMERITUS AND SENIOR FELLOW, INSTITUTE FOR HEALTHCARE IMPROVEMENT; FORMER ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES

*Dr. Berwick. Chairman Neal, Ranking Member Brady, and distinguished members of the committee, thank you very much.

My name is Don Berwick. I am a pediatrician. I am Senior Fellow at the Institute for Healthcare Improvement, and I served as Administrator, CMS, from July of 2010 to December of 2011.

So I led Medicare for some. My experience gives me confidence that Medicare for All would be a very wise choice for this country.

Medicare for All is not an end in itself though. It is a means to our goals, and I believe that every proposal for health care reform should be interrogated against our aims as a Nation, and our aims should be four:

First, to improve the quality of care for every individual;

Second, to improve the health of the population;

Third, to reduce costs by eliminating waste; and

Fourth, to cover everyone, to leave no one out.

By those four metrics, our Nation is lagging. It is lagging badly. Care remains far too often unsafe and unscientific. Underinvestment in addressing the social determinants of illness has left us 56th in the world in infant mortality and 43rd in life expectancy.

Our costs per capital are by far the highest in the world, and our waste levels exceed 30 percent of our total spend. And we are the only Western democracy that fails to insure everyone.

Twenty-two percent of Native American, 19 percent of Hispanic, 11 percent of

blacks, 7 percent of white individuals in this country still lack health insurance. No other developed nation on earth has that problem, none.

Administering Medicare and Medicaid, I got to work every day on achieving those four aims. They were my aims. We launched care improvement programs that reduced over-sedation for people in nursing homes by 33 percent.

We launched the largest patient safety effort in the history of the world, enrolling 4,000 hospitals. We saved 125,000 lives or more, prevented more than 3 million infections and injuries in hospitals. We reduced costs by \$26 billion.

We vastly expanded preventive care for tens of millions of elders. With CDC, we began a campaign to help prevent 1 million heart attacks and strokes within 5 years, and we worked really hard to overcome our horrific racial and economic disparities in care and in health.

We pioneered competitive bidding processes for medical equipment. We controlled our overhead costs. Medicare operates at about 2 percent overhead, while commercial insurance operates at 15 percent or more overhead.

No private insurer could or would do any of this at the scale that we achieved.

Now, critics of Medicare for All raise alarms. They say the system will explode our health care spending. It need not. On the contrary, it is the best option we have for sensibly containing costs by simplifying administration and paperwork; by using price setting authority and negotiation wisely; by improving the quality of care, which saves money; and by letting us invest against the upstream causes of illness and injury and disability.

In fact, I fear that without this change we are headed for true unaffordability.

They say that Medicare for All is a government takeover of health care. It is not. Not one single bill that I know of proposes that government should become the provider of

health care for all Americans. Medicare for All changes how we pay for care. It does not change who provides care.

They say that Medicare for All would underpay hospitals and clinicians. That is neither inevitable nor is it wise. In fact, Medicare for All would vastly reduce the hours that beleaguered medical professionals today spend on senseless complexity and endless paperwork.

Worst of all, critics say that it is unrealistic to make health care a human right in this country. I profoundly disagree. All other developed countries do that, and it seems to me that a Nation that is founded on an inalienable right to life, liberty, and the pursuit of happiness ought to promise to its people those forms of social policy and cohesion, including health care, that make life, liberty, and pursuit of happiness possible.

I am open to considering any policies that move us fast and well toward those four aims, towards better care, better health, less wastes, and leaving no one out. But compared with Medicare for All, I just do not see a better option.

Medicare works for some of us. It is immensely popular as a government program. Not one of you would dare touch it, and so let's go to work and make it work for all of us.

Thank you very much.

*Chairman Neal. Thank you, Dr. Berwick.

[Applause.]

*Chairman Neal. Ms. Books-LaSure, would you please offer your testimony?

STATEMENT OF CHIQUITA BROOKS-LaSURE, MANAGING DIRECTOR,
MANATT HEALTH STRATEGIES

*Ms. Brooks-LaSure. Chairman Neal, Ranking Member Brady, and esteemed members of the Ways and Means Committee, thank you so much for inviting me here today.

I am Chiquita Brooks-LaSure, a Managing Director with Manatt Health and also a former Obama administration official who worked on implementing the ACA.

The ACA made significant gain in reducing the number of uninsured and protecting people with preexisting conditions, but more work needs to be done. For example, 14 States have not expanded Medicaid, leaving 2.5 million Americans in the coverage gap.

And African American women, regardless of insurance status, are four times more likely to die in childbirth than white women.

This morning I will focus on a subset of proposals that endeavor to build on our current public program and also leave commercial insurance markets in place. There are a range of Federal and State buy-in and public option proposals in this category.

What these proposals have in common is the idea of leveraging in some way the administrative savings and the bargaining power of Federal or State programs to create more affordable coverage options for consumers. They could be offered through public-private partnerships similar to Medicare Advantage or Medicaid Managed Care or through a direct arrangement between the government and health care providers similar to traditional fee-for-service Medicare.

Tricia Neuman just went through several of the Federal models, including the public option aimed to improve competition and ensure an affordable, stable option is available across the country.

Another proposal, the Medicare buy-in, would allow a younger population who are currently ineligible for Medicare to purchase Medicare coverage while preserving the existing program.

Similar to a Medicare buy-in, a State buy-in model makes an existing program, such as Medicaid or the State employee health plan, available for purchase by consumers who are not otherwise eligible for them.

Several States are also considering versions of a State-sponsored public option that is structured like a qualified health plan and offered by a private insurer or insurers in the State's marketplace. These proposals may be structured to leverage Medicare rates and to operate like other plans on the marketplace.

Multiple States introduced legislation for coverage programs. Most recently Nevada joined New Mexico and Colorado as the third State this year to enact a bill to study potential models. In April, Washington became the first State to enact a State public option plan.

Some legislatures remain in session so more State action is possible this year.

States interested in implementing coverage proposals like these are considering a range of key design elements, such as defining targeted populations, determining provider rates and whether these plans are financed through consumer contributions, premium tax credits, general State funds, or some combination of these sources.

Under current rules, some of these State options may also require States to obtain Federal waivers for tax credit funding or plan design.

In conclusion, Federal-based options have some clear advantages, given the role of the Federal Government in subsidizing coverage under Medicare and the Affordable Care Act. And the fact that many savings are produced by reforms would actually accrue to the Federal Government.

State-based approaches also have advantages since States can move forward without Federal legislation and can tailor solutions to State-specific dynamics. State models could also serve as a testing ground for future national reforms, just as Massachusetts did for the Affordable Care Act.

But many States have limited resources and capacity to implement these proposals, and at least in the short term, a State-based approach is likely to increase the already widening variations in coverage access across States.

There is an opportunity for Federal legislation to support State-based innovations with additional authority, funding, or the ability to intersect with existing Federal programs.

Finally, each proposal has advantages and challenges. Therefore, input from stakeholders will be critical as Congress crafts policies to continue to build a better, more affordable health care system for all Americans.

Thank you.

*Chairman Neal. I thank the gentlelady.

Ms. MacEwan, you are invited to testify.

STATEMENT OF PAM MacEWAN, CHIEF EXECUTIVE OFFICER FOR THE
WASHINGTON HEALTH BENEFIT EXCHANGE IN THE STATE OF WASHINGTON

*Ms. MacEwan. Thank you, Chairman Neal, Ranking Member Brady, and members of the committee for the opportunity to testify today.

My name is Pam MacEwan. I am the Chief Executive Officer of the Washington Health Benefit Exchange. In prior roles, I have worked as an executive at a health insurance carrier in Washington for over 16 years and served on a governor-appointed commission to implement State-based universal health coverage.

The Exchange is a State-based marketplace, governed by a bipartisan board that connects one in every four Washingtonians to health coverage. Our State has made remarkable progress expanding coverage under the Affordable Care Act and will be implementing the first State-based public option in the Nation.

The Exchange is one of 12 State-based marketplaces. We each have different markets, stakeholders, political environments, and sizes, but all share a common commitment to providing high quality, affordable coverage for our States.

After the ACA passed, Washington State acted quickly in a bipartisan manner to fully implement the new law. This included establishing the Exchange and expanding Medicare. These efforts resulted in our uninsured rate decreasing by 60 percent, one of the largest decreases in the Nation. Over 800,000 residents gained coverage for the first time.

This resulted in a 30 percent drop in the number of people delaying care and tens of thousands of newly covered residents accessing treatment for cancer, opioid abuse, and substance disorder, and other life-threatening conditions.

Strong leadership at the State level has helped preserve our coverage gains and protect our consumers from recent Federal policy actions that have undermined the

integrity of the ACA. These actions include eliminating Federal funds for cost-sharing reduction payments, eliminating the penalty for the individual mandate, promoting short-term limited duration plans, terminating the Federal reinsurance program, reducing funding for marketing and outreach at the Federal level, and renewed threats to overturn the ACA.

In response Washington has taken strong steps to codify ACA consumer protections in State law, including protections for preexisting conditions, nondiscrimination protections, and prohibitions on annual and lifetime caps on care; limiting short-term limited duration insurance plans through straight rulemaking; and permitting insurance carriers to modify their Silver Plan premiums, a practice known as "Silver loading"; and extending the open enrollment period and securing State funding for marketing and outreach.

These protective measures have helped to stabilize our market. Since implementation, the premium increases our consumers have faced are less than half as much as those in Federal marketplace States, and for 2020, 13 health insurers filed a record low average proposed rate increase of less than 1 percent for our individual health insurance market.

While this is positive news for Exchange consumers, there is much more work to be done to reduce health care costs and achieve universal coverage. Everyone in our market and beyond would benefit from Congress working immediately to strengthen the ACA.

In Washington State, we have a strong base in which to build, and we are not waiting. Our State is moving forward with innovative strategies to tackle costs and continue moving forward to universal coverage.

In May, Governor Inslee signed into law comprehensive cascade care legislation to improve the affordability and quality of products in the individual market. The bill combines public purchasing with private delivery systems to create the Nation's first public

option for consumers regardless of income.

The bill directs the Washington State Health Care Authority, our State purchasing agency which buys on behalf of Medicaid and public employees, to work with the Exchange to contract with private carriers to offer lower cost, higher quality plans through the Exchange. These plans will offer standard benefits and cost sharing and must also meet additional quality and value requirements.

The public option plans are expected to have premiums of up to 10 percent lower than current offerings. Costs will be contained by paying providers no more than 160 percent of Medicare rates.

The bill also establishes special payment floors for primary care providers and rural hospitals to ensure patients across the State have access to the care that they need.

To further address consumer costs, the legislation also establishes standard plans. These plans will have coverage and cost sharing that is consistent across all carriers so consumers can more readily compare their options based on prices, provider access, quality, and customer service.

The bill also requires an implementation plan for a State premium subsidy program targeted to people at 500 percent of the Federal poverty level. Extending subsidies to middle income consumers receiving no financial help is critical to expanding coverage.

It is imperative for the Federal Government to take steps to help build on the progress we have made. We support the efforts that the House has made to protect and strengthen the affordable quality coverage.

Additional effective ways to help strengthen the individual market improved affordability include funding reinsurance programs. We hope the work that States like ours are doing to promote affordability and accessibility in our marketplace can serve as a roadmap for Federal policy both short and long term as Congress further explores the

pathways to universal coverage.

Thank you for the opportunity to testify.

*Chairman Neal. Thank you, Ms. MacEwan.

Ms. Turner, I recognize you to offer testimony.

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

*Ms. Turner. Thank you, Mr. Chairman. Thank you, Ranking Member Brady and members of the committee, for the opportunity to testify today.

I believe there are important shared goals in health reform and achieving universal access to coverage, to care that is affordable and that offers choices and protecting quality, especially for the most vulnerable.

Millions of American are frustrated with the current system, with the cost of care and premiums and with deductibles so high that many say they may as well be uninsured.

One dad in Virginia wrote that he faced premiums of \$4,000 a month in order to cover his family in an Obama Care plan.

People are hurting and they feel powerless against this system. But the more government gets involved, the more the health sector has to respond to legislative and regulatory demands rather than to patients who want more choices of more affordable care and coverage.

Wharton professor, Mark Pauly, explains in a new paper that the Federal Government already exerts great control over our health sector, with government-affected spending totaling nearly 80 percent.

Medicare for All and its derivatives, such as Medicare buy-in and the Federal public option, would, I believe, take us further down the road which is really a slippery slope toward government control of our health care, where vulnerable patients with the greatest health care needs would have to fight even harder for access to the care they need.

Today Medicare for All is center stage. It would mean virtually everyone would lose the plans they have now, and there would be no choice but the one government-run

plan. Employer coverage would end for 173 million Americans, including millions of union members.

Medicare, as 60 million seniors know it now, would end. Twenty million seniors who voluntarily have chosen Medicare Advantage plans would lose their coverage. Medicaid would end, as well as the Medicare prescription drug program, CHIP, Exchange coverage, et cetera.

The Congressional Budget Office found that establishing such a system would, quote, "be a major undertaking that would be complicated, challenging, and potentially disruptive, and that the changes could significantly affect the overall U.S. economy."

The experience of other countries with global budgets and centrally determined benefit structures leads to rationing, waiting lines, and lower quality of care. Tragically, it is often the most vulnerable who are left behind.

Just 5 percent of the population accounts for more than half of all U.S. health spending. Those who are sickest, with the greatest health needs, are most disadvantaged when political leaders inevitably have to balance spending between them and the greater majority of their more healthy constituents.

Medicare for All will restrict access to new medicines and treatment, lead to dramatic increases in Federal spending and taxes, and turn back the clock on the move toward personalized, coordinated care and other innovations.

So what would this mean for patients? There would be provider shortage if the Medicare for All program, as most of the plans recommend, pays at Medicare rates. That would mean 40 percent cuts for hospitals and 30 percent cuts for physician coverage, which would put most of them out of business, and that would exacerbate the coming physician shortage.

Access to new medicines and other new medical technologies would be limited as

we see physicians in other countries have access to only half of the newest drugs that Americans do.

And Federal spending would increase dramatically. Chuck Blahous from the Mercatus Center estimates that Federal spending would have to increase by \$32 trillion and that doubling individual and corporate taxes would not be sufficient to finance this spending increase.

The public option, we have recent experience with the public option, co-ops created under the ACA. Only a few of those remain, wasting billions in taxpayer dollars and leaving millions of people without coverage.

Some suggest a Medicare buy-in, but it is hard to see what problem that would solve because the cost, if people paid their own way, the cost would \$1,100 a month for Medicare buy-in, which is less than Exchange coverage.

Rather than dramatically expanding the role of government through Medicare for All or new taxpayer supported programs, I believe we need to target appropriate solutions and build on what works, and I look forward to working with you and the members of the committee on a bipartisan solution.

Thank you.

*Chairman Neal. Thank you, Ms. Turner.

We will now proceed to questioning under the 5-minute rule. Consistent with committee practice, let me first recognize those members present at the time the gavel came down in order of seniority.

Let me begin by recognizing myself.

Ms. Wood, in your testimony today, you remind all of us that the problems in our health care system have real world consequences. I thank you for your candor.

Your words are a powerful reminder that we need to use today's opportunity as a step forward in continuing to build in the work we have started with the Affordable Care Act a decade ago.

Charlie is lucky to have a mom like you who continues to fight for her.

It is our responsibility in Congress to continue to strengthen and build on the ACA so that the American family will not have to encounter the same health care and financial struggles you faced.

With that would you care to offer any additional testimony?

*Ms. Wood. Yes. So it was not merely just a failure of the private system or it was a combination of things.

I would like to add that we had just moved to Massachusetts. We lived in Virginia prior, and the Medicaid waiver system there is so tragically underfunded that Charlie was unable to get the waiver she was qualified for.

She was placed on a waiting list, and at the time it was 10 years long. Ten years is crucial for a developing kid, and that cost us more out of pocket.

Additionally, the waiting list recently, within the last few years, changed to being priority based. Charlie is never considered high priority. So she would never receive the services she qualified for.

It was the perfect storm of policy failures with underfunded Medicaid, private insurance. It was never one thing, and so I feel in order to address them all, Medicare for All would do an excellent job doing that.

*Chairman Neal. Dr. Berwick, last week you published an article in Health Affairs in which you argue that there are actions that Congress can take immediately to provide relief to Americans struggling for access and to afford quality health care while we continue to figure out the details of our vision for achieving universal coverage and affordability in our system. Without objection, I intend to include that article in the record.

[The information follows:]

[Chairman Richard E. Neal Submission for the Record](#)

*Chairman Neal. Dr. Berwick, today we have discussed a number of proposals that address universal coverage, and in your testimony, you stated that Medicare for All is, quote, "a mechanism to achieve goals."

It seems from your descriptions that you believe a multi-pronged approach is necessary for achieving universality of coverage. Would you further describe your position?

*Dr. Berwick. Yes. Well, first, as you said, as the Administrator of CMS, I was the first to implement the Affordable Care Act. From the time I was there, I was proud to have done that.

The Affordable Care Act made progress, covering 20 million people, adding prevention benefits, providing guarantees that our testimony has been given about. We can still improve that, and I think my argument is we should definitely work on the Affordable Care Act as a step of national progress, expanding Medicaid in all States.

I think that we need to increase the subsidies in the Affordable Care Act because there are people of marginal income that are not covered yet by the subsidies that could be included, and there are a bunch of ideas in that article.

So I do not see competition between the Medicare for All idea and the preservation and continuation of the Affordable Care Act en route to doing that. I see the Medicare for All as simply a much more powerful way to achieve those four aims that I talked about.

It gives this country far more leverage on cost. In a smart way, it allows us to work as a national policy on health care quality. It would allow us to work upstream against the causes of illness, especially racial and socioeconomic inequities, and it would allow us to make sure that everybody is in, which unfortunately with the Affordable Care Act as it currently is designed is not the case.

*Chairman Neal. And Dr. Neuman, as we think about universal coverage, it is

important to remember that we are all designing a system that needs to work for all members of the American family, and that means a system that is flexible, has generous coverage, does not discriminate against people with preexisting conditions, and protects our most vulnerable.

In your testimony, you spoke about the different types of democratic plans to expand coverage. As we continue to think these through as policy, how can we make sure that we are addressing the unique challenges that face children?

And I do take some satisfaction from the fact that 100 percent of the children in Massachusetts are covered with health insurance.

How do we ensure that these coverage expansions are tailored to the unique needs of the population groups?

*Dr. Neuman. That is a great question, Mr. Neal. Thank you for asking.

The Medicare for All and actually the Medicare for America proposals, both include a broad array of services that would be extremely helpful for people with disabilities and children with special needs, adaptive devices, EPSDT screening, services that are now covered by Medicaid; transportation services for people with disabilities.

So those proposals I would say have given a lot of thought to what types of services might be needed. I think an important consideration if they were to be enacted would be transitional, to be sure there are no gaps in coverage, to make sure that people who do have good coverage today through Medicaid, for example, would transition into the new program and maintain those services and get even more services.

The other proposals pretty much leave Medicaid intact, and Medicaid is the main payer of services for people with disabilities and children with special needs. So I think one of the approaches would be if Congress were to go down the path it would do a public plan option or even build in the architecture of the ACA, retaining Medicaid, maybe

expanding Medicaid so that it could continue to provide even wrap-around services for people with private insurance, would be very important.

Just one last thought, which is Medicare serves almost 10 million people who are under age 65 and have permanent disabilities. Perhaps more thought could be given to making the current Medicare program work better for people with disabilities.

*Chairman Neal. Thank you, Dr. Neuman.

Let me recognize the ranking member, Mr. Brady, to inquire.

*Mr. Brady. Chairman, thank you, again, for holding this hearing, and thank you to all of the witnesses. Very powerful testimony today.

I have letters from the American Hospital Association representing 5,000 of local hospitals adamantly opposed to Medicare for All.

Job Creators Network, representing 90 million workers, work for small businesses on Main Street; National Association of Health Underwriters, all opposed to Medicare for All.

I ask unanimous consent they be entered into the record.

*Chairman Neal. So ordered.

[The information follows:]

[American Hospital Association](#)

[Job Creators Network](#)

[National Association of Health Underwriters](#)

*Mr. Brady. Ms. Wood, thank you for your testimony. A real live person. It is frightening when your child undergoes that.

Chairman Neal and I launched an investigation last year focused on how more dangerous it is to give birth today than it was even 20 years ago. That is wrong.

We are only one of three countries in the world. I launched the investigation to address exactly those issues you raise. Thank you.

Secondly, you made it clear what you underwent was a failure of private insurance and was a failure of government health care plans.

Charlie was eligible for programs. Politicians did not fund it. That worries all of us.

And I want to tell you, Dr. Berwick, the rollout, I have to confess, the rollout for the Affordable Care Act was a disaster. It was so bad it frightened and upset so many of our constituents. Even Democrats were angry at the rollout.

I hope that never happens again in America.

Here is what frightens me as well. So I have got over 600,000 people in my district, just my little district that will have their health care plans ripped out from under them under Medicare for All, not canceled by private insurance; canceled by the government itself.

That is people who are at work and seniors who rely on Medicare Advantage. That does not even count those on children's health insurance or those military folks who are on TRICARE.

Those constituents of mine are frightened. They do not trust this government to make the life or death decisions about their health care.

Ms. Turner, H.R. 1384, that is the main in the House Medicare for All bill. You are very familiar with it. Twelve of the Democrats on this committee are cosponsors, over 100 in the House, and almost all the Democrat candidates running for President support it as

well.

So let's fact check a couple of things. Do you mind?

So I have made the case that under Medicare for All, H.R. 1384, the private quality health care plans are banned across America. Is that true?

*Ms. Turner. Correct.

*Mr. Brady. And people who are in Medicare Advantage, a lot of my seniors, the Children's Health Insurance Program, TRICARE for our military, that is canceled as well by the government; is that true?

*Ms. Turner. To be replaced by Medicare for All, yes.

*Mr. Brady. So let me ask you another fact check. So Medicare for All creates a one size fits all program where those decisions are really controlled by Washington politicians and bureaucrats.

Does that limit choices in control by the patients and families themselves?

*Ms. Turner. Washington would be deciding what benefits people are eligible to receive. It will be deciding how much providers will be paid. So, yes, it significantly limits choices of individuals.

And we see this, of course, in other countries as well.

*Mr. Brady. The cost is frightening. Estimates, as you mentioned, up to \$32 trillion. Almost everyone tells you the cost of this is just unbelievably high, which will require higher taxpayer dollars and will make it tougher to finance health care. Is that true?

*Ms. Turner. Yes.

*Mr. Brady. Under Medicare for All?

Final point, and you made this. This is scary as well. Will Medicare, as we know it today, end? Does it change significantly under Medicare for All?

*Ms. Turner. Medicare, current Medicare would be replaced by a very different

program under Medicare for All that makes a number of promises for free health care, access to all benefits, all doctors without any copayments, deductibles or premiums. So that is very different than the current Medicare.

*Mr. Brady. So seniors have no idea what is coming at them.

*Ms. Turner. Exactly.

*Mr. Brady. All they know is the Medicare they have today ends.

*Ms. Turner. And they would be competing with another what would be 260 million Americans for coverage under the Medicare Program.

*Mr. Brady. So wait. So they paid their whole life into Medicare out of their paychecks every two weeks. They paid for that care and so now all of a sudden that is shared with 200 million more Americans?

*Ms. Turner. That is gone, and also the 20 million seniors who have voluntarily selected private Medicare Advantage plans that they value would also end.

*Mr. Brady. Thank you. That is frightening, Ms. Turner. Thank you.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from Georgia to inquire, Mr. Lewis.

*Mr. Lewis. Mr. Chairman, thank you very much for holding this hear.

Mr. Chairman, I have said it before, and I will say it again. Health care is a right.

[Applause.]

*Mr. Lewis. Health care is --

*Chairman Neal. Excuse me. Will the gentleman postpone his comments for a second?

Everybody needs to be heard here. So let's proceed on that basis.

Let me recognize the gentleman from Georgia.

*Mr. Lewis. Health care is a fundamental human right that this country has yet to

realize. As long as I live, I will fight with every ounce of strength, every breath in my body to make this right a reality.

There is not a person in this country whose family has not known illness or injury. For too long they have struggled. They are fed up, tired of a health care system that is not right, not just, and not fair.

Access to care should not depend on the size of your wallet or the digits in your zip code. We must do more. We must do better, and we can, and we will.

In 1865, the 13th Amendment freed our ancestors from slavery. Almost 100 years later, those of us who took part in the Civil Rights Movement are still marching in the street, still fighting for equal rights.

We have come a long way, but we still have much work ahead.

Mr. Chairman, and members of the Ways and Means Committee, we play a special role. We need to stand up, fight for those who are not as healthy and not as wealthy.

We need to speak up for those who feel left out and left behind. We must ask ourselves what would these bills look like in 100 years. Does this move our cause far enough down that long road to justice?

Answering this question correctly is our most sacred duty.

Mr. Chairman, I ask for unanimous consent to submit a letter from the NAACP on this matter.

*Chairman Neal. So ordered.

[The information follows:]

[NAACP Letter in Support for H.R. 1384](#)

*Mr. Lewis. Dr. Berwick, thank you for your testimony, and thank each and every one of you for testifying.

Thank you, Ms. Wood for bringing your daughter to bear witness.

But, Dr. Berwick, what is your top recommendation to address disparities in minority and rural health

*Dr. Berwick. Well, first, Congressman Lewis, as always, it is an honor to be in the same room as you, and thank you for your service to this Nation.

What makes us sick in this country and selectively affects people of color and people of low income are social determinants of health. It is the nature of our communities.

Right now health care is a repair shop. We wait for people to get sick, and then they come into the system. Now, we have to have an absolute commitment to equity and justice in that system, and we are not equitable. There are things we need to do to make sure that no matter what your income or your race is, you can have access to the same quality care.

But unless we as a Nation begin to invest upstream on the social determinants, housing and transportation and the environment and violence in our streets and racism and its legacy, we will not be able to be a healthy country for any of us, let alone the disadvantaged among us.

And so we need a health care payment system which is sensitive to that and which is capable of distributing, redistributing health care resources toward actual causes. Otherwise we are always dealing with effects.

We have this terrible problem in this country with rising maternal mortality rates selectively affecting people of color and people of low income. We know what to do. It is empowering the communities in which those people live. It is broadening the support that

pregnant women get; supporting doulas; using the insights of the social determinants of health work and the Pathways for Community Health in Ohio. We know what to do.

No payer in this country is going to make those shifts unless it is a publicly accountable payer who knows where those resources should go.

We can do it, but someone has got to have the ball, and that is one of the reasons I favor a consolidated payment system in this country with accountability to the public.

*Mr. Lewis. Thank you very much.

Mr. Chairman, I yield back the balance of my time.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from Florida, Mr. Buchanan, to inquire.

*Mr. Buchanan. Thank you, Mr. Chairman, for this important hearing.

I want to thank all of our witnesses for being here today, especially you, Ms. Wood. We really appreciate your testimony, and we are all very sensitive about that.

Let me touch on a couple of things that I wanted to deal with. One is just looking at we are the committee that deals with Medicare. We are also the committee that is the pay-for committee. We had a couple of chairmen here the other day and a ranking member on Transportation. They come to this committee. So we have got to make sure it makes some sense.

Now, I will just say to you Medicare for All is expected to cost \$32 trillion over 10 years, according to the Urban Institute, a prominent left-wing Washington think tank. That is their number.

I do not know if many of you know how many dollars we take in in receipts per year, but it is about maybe \$3.5 trillion, somewhere in that neighborhood.

So what we are talking about spending on the pay-for committee, as much as we might have in total receipts -- over a period of time I am sure the receipts will be a little

higher because of inflation and other factors.

When I came to Congress, we were \$8.7 trillion in debt. Today we are \$22 trillion. So I kind of say we need a reality check when we look at these programs.

I hear what you are saying. It is broken. It costs too much. We have not bent the curve on health care costs. Someone said they were paying \$4,000 a month. I had someone last week and they are paying \$3,000 a month. So it clearly is broken.

But it is not broken for everybody. It is working for a lot of our folks. So when you look at the debt, at some point it not only ends badly, but it is going to completely bankrupt the country. We are going to bet the farm on this.

I look at a lot of young people back there. We are running up the debt on their credit card. So it is one thing to talk about policy, which I think a lot of you have got some good ideas. We also have to think about the cost. How are we going to pay for it?

So, Ms. Turner, I would ask you. You know, you mentioned in your testimony the thought is that it would double taxes on individuals and business and small business. Is that what you said to pay for this program?

And still on that basis, it would not cover the \$32 trillion.

*Ms. Turner. That is correct, Congressman.

Chuck Blahous, who has done one of the several estimates of the cost, says that \$32 trillion over 10 years would be a lower end estimate of the additional Federal spending.

All spending that currently is being paid by employers, for example, on health care, about \$1 trillion, would now go onto the Federal budget, and some of the proposals about how can you raise enough taxes to pay for this indicate that because doubling individual and corporate taxes would not be enough, where else do you go for taxes?

Well, you force employers to pay almost 100 percent of what they are currently paying for health coverage. You may have additional excise taxes, wealth taxes, a new tax

on a national sales tax and perhaps taxing longer --

*Mr. Buchanan. Let me just say that is one aspect. The other thing I wanted to mention, I am from Sarasota, Florida, and represent that region. Probably we are one of the top five with the most seniors. So I hear this back home.

Well, how is that going to impact them? They have paid in 40 years, not just them, but their employers have paid in as a part of their benefit package.

They are also worried about if this does not work, how does that impact their Social Security.

So it is a big factor back in my district where I would say 35, 40 percent are 55 and older, and I have got to say that a third of our seniors, a third to get 65, all they have is their Medicare and Social Security. They have paid in it for 40 years. They do not want to be put at risk.

So what impact, in your opinion, will this have on seniors? Will they be able to keep their current Medicare or are they going to go to a whole new version of what Medicare might be going forward?

*Ms. Turner. They will go into a whole new version of Medicare, and they will be in the same pool with more than 300 million Americans in trying to access providers and doctors.

And the biggest concern seniors should have is the dramatic cuts that Medicare for All would mean to hospital and physician --

*Mr. Buchanan. And let me just ask you about veterans. What is the impact of 88,000 veterans in our area? They are going to want to know the impact that this might have on them.

*Ms. Turner. Veterans, it depends on the version of the bill that you look at whether or not veterans --

*Mr. Buchanan. But they are going to be at risk, ideally?

*Ms. Turner. The ones who particularly have access to private physicians would be, again, competing for many other patients to get access to physicians and hospitals.

*Mr. Buchanan. Thank you.

And I yield back.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from Texas, Mr. Doggett, to inquire.

*Mr. Doggett. Thank you, Mr. Chairman.

I believe in better, stronger Medicare for more. Today's Republican condemnation of Medicare for All continues a great Republican tradition of opposing Medicare for anyone. They use the same --

[Applause.]

*Mr. Doggett. We have heard this morning that it would be about the worst thing to happen to the world since plague struck Egypt.

[Laughter.]

*Mr. Doggett. I find this to be though the same worn-out rhetoric they have used through the years. When Franklin Delano Roosevelt proposed Social Security, the Republican chairman of this committee as late as the 1950s was still saying that it was the lash of the dictator that would be felt.

Another Republican said it would enslave workers. Another said it would pull the pillars of the temple down upon the heads of our descendants.

And when Lyndon Johnson was able to get this Congress to set up Medicare, Ronald Reagan condemned it as socialism. Another Republican said it is not only socialism. It is brazen socialism.

When we attempted to get a children's health insurance program through this

Congress, now being relied upon by these folks, the Heritage Foundation said for Republicans socialism hitching a ride on the backs of children.

The Affordable Care Act was attacked by Republicans as the crown jewel of socialism, and of course, former Speaker Newt Gingrich, Mr. Let Medicare Wither on the Vine Gingrich, said you cannot get to universal coverage without a police state.

All of this simply masks a Republican Party that when it comes to health care is intellectually bankrupt and is offering only "nothing-care."

[Applause.]

*Mr. Doggett. Medicare remains the bright spot today in our health care system, despite Republican efforts to undermine it. It provides seniors with cost effective health coverage that they can always count on.

And I know many people around this country that would love to participate in Medicare. They are just not old enough. To be sure, Medicare has some gaps. That is why I have introduced separate legislation to expand, to include dental, vision and hearing, and legislation to make sure that Medigap plans cannot deny coverage to seniors with preexisting conditions.

And it is why I have focused on prescription price gouging. Medicare for All would resolve all of these issues. I support it not because it is perfect, not because it does not need further refinement, but because it represents real progress in presenting a bold idea to address the shortcomings in our system.

Democrats have offered, in fact, a number of good proposals. I salute Congresswoman Jayapal for her work on Medicare for All, the work of Congresswomen DeLauro and Schakowsky for Medicare for America and of our colleague Mr. Higgins on the Medicare buy-in proposal.

These are different approaches, but this will not be a program that gets implemented

overnight. As with any major reform, it will have to be phased in. It represents what we need to do to move our country forward for this basic right.

I am pleased that the Medicare for All and the Medicare for America bills incorporate verbatim the text of the Medicare Negotiation and Competitive Licensing Act that I have introduced to deal with prescription price gouging and monopoly prescription drugs.

I salute the efforts of Public Citizen who support Medicare for All, and would ask unanimous consent to include their statement in the record, Mr. Chairman.

*Chairman Neal. So ordered.

[The information follows:]

[Public Citizen](#)

*Mr. Doggett. And I would also honor the good work of the National Nurses United, particularly Jean Ross --

[Applause.]

*Chairman Neal. So ordered.

[The information follows:]

[National Nurses United](#)

*Mr. Doggett. Dr. Berwick, you have indicated that we need Medicare prescription drug negotiation, and you have heard reference this morning, and of course, Big Pharma always claims that if we make drugs affordable, innovation will be stifled, and Americans will not be able to access the drugs they need to cure the diseases we want cured.

What do you think of that argument?

*Dr. Berwick. Well, we need to defend the interest of patients, and the interest of patients includes the excessive cost of drugs today. We need a powerful negotiating advocate for patients on the other side of the table. We do not have that right now.

And so the drug prices are rising insanely, denying people access to drugs. We absolutely need to preserve innovation in this country. We need to invest in it.

A lot of the innovation is coming right now. The drug companies are exploiting public investment already from the National Institutes of Health. They spend more money on advertising than they do on research.

But I want a healthy research effort in the drug industry. We have to make sure that is preserved, but I do not believe it is preserved by having these confiscatory drug prices. We need negotiation on the other side of the table.

*Mr. Doggett. Thank you.

*Chairman Neal. I thank the gentleman.

Consistent with the rules of the House and the committee, manifestations of approval or disapproval really are not welcomed. We want to have a thorough discussion here today and to hear from a wide variety of members of the committee and our witnesses, and I think that the opportunity avails itself better if we refrain from demonstrating enthusiasm.

At the same time, everybody in the audience, you are more than welcome here.

So with that, let me recognize Mr. Smith from Nebraska.

*Mr. Smith of Nebraska. Thank you, Mr. Chairman, and certainly thank you to our witnesses for sharing your various perspectives, and certainly Ms. Wood for sharing your real life perspective as a health care consumer.

I think we should always be mindful of the impact on consumers themselves and the folks all across America, and I know that, you know, there has been some exchange here, and I think this is a healthy discussion that we need to have.

And I think it is healthy to also reflect on Medicare Part D, for example, a benefit offered seniors that met great opposition. In fact, I think there was unanimous opposition in this committee on the part of many when it was being discussed in 2003.

And I would actually ask unanimous consent to submit for the record a New York Times article from November 23, 2003.

*Chairman Neal. So ordered.

[The information follows:]

[New York Times article \(Nov 23., 2003\)](#)

*Mr. Smith of Nebraska. Thank you.

As the ranking member of the Tax Subcommittee here on Ways and Means, I hope that we can take a moment to put the cost of not only Medicare for All, but other costs that have been proposed as well.

To put that in the appropriate context, as we know that the efforts to raise taxes on all Americans, including middle class Americans, to pay for a new Federal benefit. As many of you know, we started in February with a proposal to increase the Social Security taxes. That proposal would increase the tax burden, for example, for a single mother making \$50,000 per year by \$1,200 annually.

And that was followed by a hearing on infrastructure needs that also proposed an increase in the gas tax.

After that we had a hearing on paid family leave, which would also raise that same single mom's taxes by about \$1,450 per year and provide a benefit that she would unlikely use if she would be running her own business.

The following week we had a hearing on climate change. That proposal would cost between 51 and 93 trillion over 10 years. Even at the most conservative estimate \$51 trillion works out to more than \$15,000 per American per year over the next decade.

And now we are meeting to discuss this proposal, Medicare for All, representing another tax increase of roughly \$10,000 per year that each American is going to have to pay.

As a representative of one of the most rural districts in America, I am very concerned about the impact that any proposal would have here out of Congress.

Now, we know that Medicare for All represents a \$32 trillion expenditure to the Federal budget, and it also represents an immense risk for rural providers. Under the proposal, a single unelected bureaucrat acting as regional director would be given broad

authority to negotiate payment amounts for all health care providers in its region.

These payments capped, an arbitrarily determined capacity to provide to care, would be prohibited from being used by hospitals for capital expenditures to improve patient care. These are very important topics across rural America, especially rural Nebraska.

Rural hospitals, as we know, are already struggling today, and we see uncompensated care because of high deductibles, high copays that are impacting so many.

Since 2010, more than 100 rural hospitals have closed their doors, and many rural hospitals are operating in the red. And yet one estimate regarding Medicare for All projects a 40 percent payment reduction for these hospitals that was discussed earlier.

This proposal would exacerbate the current health care provider shortage we see in rural communities, and I truly believe that rural America deserves better.

Ms. Turner, can you explain how a single payer system would impact rural Americans and the rural hospitals that serve them?

*Ms. Turner. I think rural hospitals would be much like vulnerable patients. They would be those who struggle the hardest. Most of them could not tolerate 40 percent cuts in their non-government compensation right now. Even more would close than are closing now.

And it would significantly impact the access to care. Also, physicians, finding it very hard to keep their doors open. People in rural communities have to drive 100 miles sometimes to see a doctor, a specialist in particular. I think those problems would be exacerbated as we lose more and more physicians.

*Mr. Smith of Nebraska. Right. Thank you.

And just in closing, I hope that we can have discussions about reducing the cost of health care before we actually implement drastic new changes to how we pay for health

care, and I think we can have a very, very thoughtful discussion and exchange of ideas as we might proceed.

Thank you. I yield back.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from California, Mr. Thompson.

*Mr. Thompson. Thank you, Mr. Chairman.

And thank you to all the excellent witnesses, and, Ms. Wood, thank you for your courage to share your powerful story with the committee.

Earlier this year, our committee held a hearing on the importance of protecting preexisting conditions. One of the witnesses that day was a constituent of mine, Andrew Blackshear. Andrew has a preexisting condition. He is one of 84,000 people in my district who gained health care coverage from the Affordable Care Act.

Eighty-four thousand people in my district alone, and after we passed the ACA, the uninsured rate in California dropped to less than 10 percent. By 2016, 91 percent of Californians had health insurance, the highest number ever.

Today we are here to talk about how we can close that final gap, how we can achieve near 100 percent coverage. As we have heard, there are a number of proposals out there that would do just that.

But unfortunately, while Democrats are debating different ways to achieve universal coverage, our Republican friends are hard at work trying to eliminate the progress that we have already made.

Republicans tried for 10 years to repeal the ACA with no replacement plan. So notwithstanding their promise that they were going to repeal and replace, they had no replacement plan.

When that failed, Republicans attacked it piece by piece, cutting funding,

expanding junk plans, eliminating the mandate, supporting lawsuits, doing everything they can to make sure the ACA fails. They are part of an effort to end the ACA in court, ending coverage for preexisting conditions on the people that we all represent.

Meanwhile Democrats are working to build on the success of the ACA, and that is where I would like to start with my questions. Ms. Brooks-LaSure, you mentioned that between 2016 and 2018, the number of Americans without health insurance increased by nearly 2 million people. You said this was due to recent policy changes that affected the individual market in Medicaid.

What policy changes are you referring to?

*Ms. Brooks-LaSure. Sure. So thank you for the question.

I think we have seen differences across the States. Some States, like California, have been very aggressive in making sure that people who are eligible for programs like Medicaid and marketplace coverage have access and get enrolled.

Across many States, they have not expanded the Medicaid program, which is a significant reason why we still have many uninsured, as well as diminished outreach efforts in some other States.

*Mr. Thompson. Thank you.

Ms. MacEwan, you talked about the positive impacts the ACA had in your State of Washington and how your State is working to improve on these gains.

My State has also taken action to strengthen the ACA, but not every State is as proactive as California and Washington. Can you talk about the impacts of the policies that Ms. Brooks-LaSure just described?

For instance, when the administration acted to expand junk plans or cut funding for outreach and navigators, what kind of impact does that have on uninsured rates and access to care?

*Ms. MacEwan. It has a tremendous impact. We, in our State, we have been able to regulate the short-term plans so that they are actually what they are supposed to be, which is short-term plans to serve a very special need, if someone needs insurance for just 2 or 3 months.

So those plans are not renewable, and we also have regulations that require that consumers be educated so that they understand that their preexisting condition can be excluded and that there will not be comprehensive coverage.

So many States have acted to take those actions. Other States, there is a huge difference and short-term plans can be renewed almost indefinitely, which makes them really not short-term plans.

In terms of outreach, having a healthy risk pool makes a big difference, and actually California has really led the way in research in this area and through your Exchange in California under Peter Lee's direction. And what we know is that consumers who are healthier or younger, lower income, are less likely to enroll, and outreach makes a very big difference in them taking up insurance, which improves the overall risk pool and lowers costs for everyone.

Cutting off the outreach, cutting off funding for navigators has made a real difference in enrollment, and you can see States that have kept up those efforts have higher enrollment and healthier risk pools.

*Mr. Thompson. Thank you very much.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from Texas, Mr. Marchant, to inquire.

*Mr. Marchant. Thank you, Mr. Chairman. And thank you for having this hearing today.

This bill, these proposals have created a lot of interest in my district, and it probably

has created more unrest about what this Congress may or may not do than any other proposal that has really been laid out before us.

So most of my constituents will be affected by any of the proposals that are being discussed today. After searching all the records that I have in my district, which is a district around the DFW Airport, a suburban district, we find that about 550,000 of my constituents are covered by private insurance. We find that about 20 to 30,000 are on Obamacare, as we call it, and under the Democratic plan, we cannot reach any other conclusion for those 550,000 people, is that they will have to be on another plan. They can no longer be on their employer's plan.

And I cannot give them any other explanation other than they were going to be on a different plan. I cannot tell them who will administrate that plan, but I can tell them that there will be a government official, several government officials that will be very, very involved in their insurance.

The seniors in my district, about 100,000 of my seniors are on Medicare, including me and my wife. They will be pushed out of the current system. After 3 years of navigating that system, I think that I now understand how Medicare works, but it is alarming to those 100,000 people that they may have to go through another learning curve on how to take advantage of a program that they have relied on during their entire working life.

And of that group there is another 30,000 that are on Medicare Advantage, and they have found plans that are crafted specifically to meet their needs, geographical needs, and the availability of the hospitals in their area, and again, they not only will have a jolt in their Medicare coverage, but they are going to have this underlying coverage that they depend on very heavily taken out from under them.

I do not know the number of veterans I have in my area, but it is many, and

probably the most distressing thing that I have heard today in this hearing is that there is uncertainty around TRICARE and the coverage for the veterans.

And this is not the time, in my opinion, for us to interject any kind of doubt or confusion about our veterans' coverage.

Americans want more, not fewer choices in health care coverage. Medicare for All will eliminate all choice and put them all in a single government program. With unelected officials making health care decisions for the people in the Texas 24, they will have even more choices than they have today.

A typical question that I get about this Medicare for All program, in my district it will be a mother of three. Her and her husband are both working for a major corporation. In many instances, they have relocated from somewhere in the United States because they have been offered a good job, and in many cases, a big part of their decision to relocate was the benefit package that that corporation or that company offered them so that they would make that kind of change.

And the questions that I am getting from this mother of three that is also working are: am I going to be able to keep my doctors? Am I going to have to completely look for new doctors? Are my children going to be able to get the care they need quickly or am I going to have to be put on a waiting list? Am I going to have to take time off from work to make sure they make their appointments?

So, Mr. Chairman, thank you for the opportunity. I yield back.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from Connecticut, Mr. Larson, to inquire.

*Mr. Larson. Thank you, Mr. Chairman.

And I want to thank you for this hearing this morning. I want to thank all of our witnesses. I cannot imagine anyone here on the dais or in the audience who did not listen

to Charlie and was not taken by that testimony.

But it is almost as though there are two alternate universes that exist up here, and it is as though -- and I want everybody in the listening audience to appreciate and understand what to do nothing means as well.

Now, people on either side can wax eloquent, but Daniel Patrick Moynihan warned a long time ago about semantical infiltration. What does that mean?

That means the repetition of a phrase over and over again so that the general public will begin to think that, well, any kind of universal health care coverage will only mean the sky is falling in. It is dangerous. Something horrible is going to happen.

We are a committee that is about solutions and the vitality of ideas, and when it comes to discussing these ideas, that is the kind of conversation that should ensue.

We hear about how we abandoned the other side on Part D, but what is left out of that discussion in 203 is because there were no negotiations for pharmaceutical drugs, no negotiations for pharmaceutical drugs --

[Applause.]

*Mr. Larson. -- and they continue to oppose that as well as preexisting conditions.

So forgive me because sometimes your blood pressure goes up a little bit when you hear this. But nonetheless, it is vitally important that we have this discussion on the vitality of ideas and where we need to go.

Now, what I would like to see here is Ms. Turner is also very eloquent in what she has to say, but I would ask her because we heard all about replace, repeal and replace.

What would you have replaced it with?

And can you cite us the Republican plan that they replaced the Affordable Care Act with?

[Applause.]

*Mr. Larson. No, please. The chairman has already admonished people, and really, truly, you know, this should be about getting to answers and solutions.

Ms. Turner, please.

*Ms. Turner. So, Mr. Larson, as you know, the House did pass the American Health Care Act and sent it over to the Senate. It did not make it through there, but there were a number of proposals, and a number of proposals in the policy community, and a number of proposals still today, but they do not have the --

*Mr. Larson. But as we stand, how many people have lost coverage over the last eight years because of the damaging effects and the hacking away at the Affordable Care Act?

Unlike Part D back in 2003 when we worked together to strengthen that and actually fix the doughnut hole that occurred with the Affordable Care Act, and yet given the same opportunity to help and move the country forward with respect to the Affordable Care Act, we got nothing.

*Ms. Turner. I do absolutely agree that health reform is most effective and strongest when it is done on a bipartisan basis.

But I think the committee's focus today on cost is primary because actually people have lost coverage in the individual and in the Exchange markets. They are not subsidized. They cannot afford that coverage. We would like to work on risk mitigation.

*Mr. Larson. Dr. Berwick, I saw you listening before, and as a number of our witnesses, I wonder how you would respond to Ms. Turner.

*Dr. Berwick. About the erosion of coverage in the Affordable Care Act?

*Mr. Larson. Yes.

*Dr. Berwick. Yes. I mean, there have been systematic activities now in this administration which have weakened the support to the Affordable Care Act. Millions of

people lost coverage through the zeroing out of the individual mandate. That has driven people out of coverage.

We have cutbacks in subsidies, and we can see the erosion happening right now. It probably is on the order of 6 to 7 million people who have lost their coverage, and these are very, very vulnerable people.

So I continue to believe improving the Affordable Care Act and getting it back into robust shape is a very important part of the agenda.

*Mr. Larson. Ms. Neuman, Brian Higgins on our committee has proposed, I think, a very thoughtful plan of having Medicare buy-in, starting at age 50 to 64. What would be the benefits of that?

*Dr. Neuman. Well, this is the population that faces extremely high premiums if they do not get subsidies in the marketplace. Premiums for a 62-year-old at a \$50,000 income could be over \$8,000. So that is something like 17 percent of an individual's income.

So this goes right to the heart of one of the biggest challenges and cost concerns, and the idea behind the Medicare buy-in would be to give people another option to buy into a Medicare program that would be more affordable, using Medicare rates to help bring down the premiums and costs.

*Mr. Larson. Thank you. I am out of time.

*Chairman Neal. I thank the gentleman.

With that, let me recognize the gentleman from Pennsylvania, Mr. Kelly, to inquire.

*Mr. Kelly. I thank the chairman for holding the meeting.

And thank you all for being here.

Ms. Wood, is Charlie's -- is that her real name or is it Charlotte?

*Ms. Wood. Charlie.

*Mr. Kelly. Okay. I have a daughter Charlotte, much bigger than your Charlie, but I have always called her Charlie. She said, "Dad, please do not call me Charlie. Call me Charlotte."

So thanks for being here, and your story is very relevant to being here today.

What I am really concerned with is that this is actually when we have these meetings and these hearings, it becomes a forum to actually give speeches to people, and I think that is fine. I have no problem with that.

I do know that we talked about Daniel Patrick Moynihan. I am a big fan of his. One of the things he also says you are entitled to your own opinion, but you are not entitled to your own facts.

I do not think there is anybody on this dais today that does not want to see Americans have health care. But I think the real question is: is it just having health care or is it having quality health care?

And so are we giving people a choice of what it is they want or are we giving them control over their own health care?

Very famously, and I think President Obama when he said it, he meant it. If you like the plan you are on, you can keep it. If you like the doctor you have, you can keep him or her. I think he thought that was actually part of what was in there.

But it was not. Now, as an employer, I do supply the people I work with every day for mutual success health care. Now, Ms. Turner, I just want to go to you.

So under this Medicare for All, a person like myself or many others, millions of people, in Pennsylvania, over half of Pennsylvanians are covered by an employer-sponsored health care program, including many of our brothers in the unions. They fought generations to get these coverages.

What would happen under Medicare for All? Would these options still be

available?

*Ms. Turner. Under most of the proposals, those plans would end. The employer would, therefore, be likely paying taxes to the Federal Government to support coverage for their employees, but they would also be paying higher taxes, higher corporate taxes, other taxes. So that coverage would end.

*Mr. Kelly. A lot of the district that I serve, Pennsylvania 16, we have rural hospitals. They tell me that part of their revenue for running their hospital comes from Medicare and Medicaid programs. They tell me they are underpaid for the services they provide.

Is that a true statement?

*Ms. Turner. Absolutely. My colleague, Doug Badger, wrote an extensive paper showing that employer-sponsored health insurance actually does support Medicare and Medicaid's underpayments to doctors and hospitals, and it is largely responsible for keeping the doors open.

*Mr. Kelly. Okay. So there is an old saying: what you do not make on the apples, you have to gain on the oranges that you sell.

So if you do not have that other source of revenue coming in, just from a business standpoint, how do these rural hospitals operate?

In fact, over half of the 16 hospitals in Pennsylvania's 16th Congressional District are operating in the red, which means they are losing money for those of you who do not follow that type of a philosophy.

So they would continue to lose money, and they would lose more money, and eventually, the way businesses work after a while you go out of business.

*Ms. Turner. That is right. They could not sustain a 40 percent cut in their revenues and still continue to keep their doors open from those private patients that they

treat.

*Mr. Kelly. Okay. And also the devil is in the details. What kind of paper would we be talking about? What kind of red tape would this new bureaucracy be creating for every single health care provider that is out there today?

*Ms. Turner. It does surprise me to think that people think that if the Federal Government is in control, there is going to be less bureaucracy and less paperwork. I do not think that is going to be the case.

Doctors, many of the same things that have to happen now will have to happen under Medicare for All. Doctors will have to document that they applied for coverage, that it was provided under the new rules and regulations.

There will be a global budget determining whether or not services and equipment are available to hospitals. Significant changes.

*Mr. Kelly. So as we all want, and I would rather be supplied by quality health care. So an organization that is running somewhere around \$22 trillion in the red, they are the people that are going to be advising our health care providers the way they should run their programs. It is bizarre. It is bizarre, but that is the way we think.

We often think that people on their own cannot decide what is good for them. They have to have some larger entity out there making those decisions. I think it is actually critical that we start to look at the cost of this.

Thirty-two trillion dollars is a lot of money. We cannot even comprehend what it is, but I think what it does mean is this Medicare for All means quality care for none.

This is a scary place that we are going right now. While it may sound good on the campaign trail, I would hate to see what happens.

[Disturbance in the hearing room.]

*Chairman Neal. Please, please, please. Will the gentleman please sit? Please,

please, please, please, please.

[Applause.]

*Mr. Kelly. Reclaiming my time, this does bring out the best and sometimes the worst in people.

There is an answer to where we are trying to go, and us --

[Disturbance in the hearing room.]

*Chairman Neal. Please let the gentleman finish his statement, please.

*Mr. Kelly. Thank you, Chairman.

I am glad there are more people here than the people at the panel.

But really, we can work together to get this done. As long as we make it about policy and not politics, there is opportunity for great things to be done.

Unfortunately, we are in an election cycle right now, especially in a primary cycle that does not allow us to do the things that we know are right for America.

So thank you all for being here. Mr. Chairman, thank you for having this hearing, and I look forward to making sure that Americans have quality health care. I just do not think this path we are going down right now is the right way to go.

Thank you, and I yield back.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from Oregon, Mr. Blumenauer, to inquire.

*Mr. Blumenauer. Thank you, Mr. Chairman.

Ms. Wood, I think you set down a marker. I hope that our deliberations going forward meet the Charlie test.

We ought to get real about this. I have had several forums in my community dealing with Medicare for All and having an opportunity for people to do a little deeper dive on this.

I am saddened that my Republican friends are continuing sort of a tired line of attack. It could have been and was used against Medicare, socialized medicine. Go back, and I appreciate some of my colleagues referencing that.

My friends talk about their concern about excess costs and paperwork and administrative detail and challenges. That is what we have now. That is why we pay almost twice as much as anybody else in the world for inferior results.

Some of us have access to some of the finest health care in the world, but not all of us, not many of us. We continue, and Dr. Berwick lined it out in his testimony. We die sooner. What, 43rd in the world with life expectancy? In those precious moments of childbirth, we are below many what we regard as Third World countries.

It is shameful that we pay so much and spin ourselves around the axle.

We made numerous compromises in the Affordable Care Act. They did not make it better. The notion that we could not use effectiveness to identify what medicines we were going to pay for; the fact that the United States Senate could not confirm the most well qualified person in America to be the permanent CMS Director, shameful, and that, I think, put us a little bit behind the eight ball.

Dr. Berwick, I deeply appreciate your work and your testimony, but I wonder if you could help us focus on one thing. You point out in your testimony that doctors pay now like \$70,000 a year, and that was a 10-year-old survey just complying with insurance companies; that insurance companies and the overhead is something like five times as much or perhaps more than the overhead that we have with Medicare now.

But I would like you to just focus if you could for a moment on the sustainability of what we have, the costs that we are going to face on the already \$3 trillion if we continue to have this haphazard, inefficient, expensive system that we have now.

*Dr. Berwick. Thank you, Congressman.

First, the rhetoric we are hearing about 40 percent cuts is not necessary. We can have sensible payment under an expanded Medicare system. That is rhetoric, not fact. That is in the design.

But the health care costs in this country continue to go up at a multiple of the rate of inflation. They are taking opportunities from everything else we want to do, housing and transportation and corporate profit and investment and worker take-home pay. Something has to be done.

Since we know that there are better designs for health care delivery, we need leadership to get health care into a place where it can deliver more to people but for less cost, and that is absolutely possible, but not under the current payment system.

The \$32 trillion that people keep referring to is not a new tax. It is a transfer of payment from the current channels that are absorbing the same \$32 trillion into a different and much more effective payment system, which would allow us to push back on costs that are not buying value.

The current fragmented system cannot articulate, cannot execute a plan for the true improvement of health care. An expanded Medicare program could do that. Cutting administrative cost is a major issue, and most people will tell you that the Medicare payment system is far more efficient than the commercial payment system.

*Mr. Blumenauer. Doctor, thank you.

I mean, I appreciate that. I urge everybody to read the testimony, but I, for one, like the gist of what we have had from our witnesses. I like the energy in the room. I like the fact that people were lined up down the hall, that we have our friends with the National Nurses United and a whole range of grassroots organizations that are keyed to try and have people look behind the screen at what we have and how we can do it better.

Thank you very much.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from North Carolina, Mr. Holding, to inquire.

*Mr. Holding. Thank you, Mr. Chairman. And I thank you for holding this hearing today to examine the impact and consequences of Medicare for All.

Roughly 600,000 of my constituents have private health insurance, and that is about 75 percent of the population in my district, and I am curious to know how they would fare under Medicare for All if it were enacted and their current coverage was banned.

So we all know that when bureaucrats are in charge we end up with winners and with losers, and we already know that providers would lose out under this proposal, but I am afraid that patients, my constituents, stand to be the biggest losers of all under Medicare for All.

A friend of mine from the United Kingdom was telling me a story, and they have a version of Medicare for All there, and it seems that if you have glaucoma in one eye in the United Kingdom they will not give you the medication because if you go blind in one eye, you still have another eye.

And I just thought, you know, in the civilized world that is pretty horrific.

So, Ms. Turner, I would like to hear more from you about the impact on patient choice and access to timely treatment or treatment at all, for that matter, under a Medicare for All system.

*Ms. Turner. Thank you, Mr. Holding.

We do find that other countries with government controlled, government run health care systems like the National Health Service in the U.K. operate under a form of global budget, and they restrict access to new treatments. People must find themselves in waiting lines for new surgeries.

Even going to an emergency room, hospitals do not want to have too long of a

waiting time. So ambulances will drive somebody around for 3 or 4 hours waiting for a slot to open in the emergency room, and then they may be warehoused in the hallway for hours if not days.

So you do see waiting lines. The Fraser Institute in Canada actually tracks waiting times to find that the average waiting time to see a specialist, if you get access to a primary care doctor, is 20 weeks, but it could be as much as 40 or 60 weeks or longer for more specialty surgeons.

*Mr. Holding. Wow. Now, to follow up on the access issue, in North Carolina in my district, we have a lot of cutting edge pharmaceutical innovation going on, and my constituents and all Americans should be able to access these first, kind of state-of-the-art technologies as soon as they come to market, whether gene and plasma therapies being developed, you know, right in my own backyard in North Carolina, and rare diseases are being cured right in my own backyard in North Carolina.

So, Ms. Turner, what would the development to consumer pipeline for these kinds of therapies look like under a Medicare for All system?

And how would patient preference play in the physician decision-making under a Medicare for All system?

*Ms. Turner. Americans have access to more than 95 percent of all new drugs. Patients in France and Great Britain and other countries with socialized health care systems have access to only half or less of the new drugs. Patients do not even know they are available.

And what happens when patients do not get the drugs, it dries up the pharmaceutical innovation. Europe used to be the medicine chest for the world. It is now the United States, and, yes, we do pay more than our share because other countries do not pay them, and I think that is a trade issue.

But it also has this vibrant industry that people rely on to not only create today's new medical miracles, but tomorrow's as well. And drawing up payment rates to them and limiting access would certainly curtail that.

*Mr. Holding. Ms. Turner, thank you very much.

Mr. Chairman, I yield back.

*Chairman Neal. I thank the gentleman.

Before we proceed to committee practice of now recognizing two inquiries for one, I want to recognize Mr. Blumenauer who would like to insert something into the record.

*Mr. Blumenauer. Thank you, Mr. Chairman.

I would like to submit for the record a letter from over 200 economists in support of the financial viability of Medicare for All.

*Chairman Neal. So ordered.

[The information follows:]

[Economist in Support of a Medicare for All Health Care System](#)

*Mr. Blumenauer. Thank you.

*Chairman Neal. Thank you.

With that let me recognize the gentleman from Wisconsin, Mr. Kind, to inquire.

*Mr. Kind. Thank you, Mr. Chairman. Thank you for holding this important hearing.

And I want to thank all of our witnesses for your excellent testimony here today.

And, Ms. Wood, I just want to especially thank you and Charlie for being here and offering your testimony because your words echo so loudly in my mind.

I had a similar family who reached out shortly after passage of the Affordable Care Act to thank me for my support and my vote on that bill, and the mother first though told me their story, that before the Affordable Care Act and before she delivered her little boy, Henry, he suffered a seizure in her womb and, therefore, the very first breath that he took in his life he was uninsurable because he had a preexisting condition.

And that young family was depleting their entire life savings and resources to make sure that that Henry was getting health care that he needed to stay alive, and they knew that with passage of the Affordable Care Act, that protection now was in place for her little boy, for that family, and they went out of the way to thank us.

And nothing was more heartbreaking than as a member of Congress about a year and a half ago when the other side was trying to push through their so-called health care reform bill that would have kicked 25 million Americans off from their health care system and would have given \$800 billion worth of tax cuts to the drug and insurance companies, than getting phone calls from families with young children who were scared out of their mind that the protection for preexisting condition was going to be taken away from their little daughter or their little boy.

And to field those phone calls and to hear that fear in their voices, and I am sure all

of us on this side of the dais at least will pledge to you today that we will do everything in our power to stop this Federal lawsuit in Texas from moving forward and taking away the guaranteed protection that little Charlie has today because of the passage of the Affordable Care Act.

We will not rest until that is defeated, and unfortunately, President Trump ordered his administration to be a party of that lawsuit to take those protections away from Americans today. It is outrageous.

Ms. Turner, I am sure you are familiar with the passage of the Part D prescription drug bill that happened about 2004. Could you tell us what revenue sources were used back then to pay for it, what taxes went up to pay for that legislation?

*Ms. Turner. I know that the cost was \$400 billion. I do not believe that there were new taxes raised to pay for that.

*Mr. Kind. Yes, it is amazing. We had the largest expansion of Medicare funding since the passage of the Medicare Act itself in 1965, and not one nickel was found to offset, not one penny was raised to pay for it.

So you can understand today that when we get a Republican witness and when we hear from our Republican colleagues the crocodile tears of, oh, this is going to be too expensive; how are we going to pay for it; taxes are going up, when they are so disingenuous on their side passing a major expansion of Medicare without paying for it at all.

And can you explain to us why it has been so difficult under that bill for the Federal Government to be able to negotiate better prescription drug prices for our patients as we do under the VA health care system?

*Ms. Turner. Well, as you know, this is one of the most popular programs in the country, and --

*Mr. Kind. Let me answer in case you are not familiar. The reason why we have not been more successful in negotiating is because they put language in that bill specifically prohibiting making it illegal for us to discuss price with the drug companies, let alone not paying for any of it.

So you can understand why some of us back then had a problem supporting that measure when it did come up for a vote on my ranking member.

Mr. Berwick, let me ask you. Let me turn to you because my time is very limited, but there was a recent article in the Washington Post, dated April 29th of this year, titled "Why Vermont's Single Payer Effort Failed and What Democrats Can Learn from It."

And, Mr. Chairman, I ask unanimous consent to have that included in the record.

*Chairman Neal. So ordered.

[The information follows:]

[Washington Post article \(Apr. 29, 2018\)](#)

*Mr. Kind. In that article, the then Governor Pete Shumlin was quoted as saying, and I quote, "What I have learned the hard way is it is not just about reforming the broken payment system. Public financing will not work until you get costs under control," end quote.

I would add to that statement that the private health care system is not going to work very well until we get costs under control.

Under the Affordable Care Act, we tried to throw a lot of cost containment measures in that. Can you tell us what has been successful and what more we need to be doing in order to bring these costs under control so whatever system we end up with will be affordable?

*Dr. Berwick. On the Affordable Care Act, you gave the CMS the authority to push back on hospitals on unnecessary cost increases. There were penalties attached to underperformance. You created rewards for safer care and penalties for less safe care.

You progressed, although this administration has stopped it, the lessons from the durable medical equipment bidding structure.

We have a proven experiment with durable medical equipment bidding which would have saved over a 10-year period \$27 billion to the Trust Fund and over \$10 billion for out-of-pocket payments for Medicare beneficiaries. That was well underway to a national expansion under the Affordable Care Act. This administration has stopped that.

*Mr. Kind. Thank you.

Thank you, Mr. Chairman.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from New Jersey, Mr. Pascrell, to inquire.

*Mr. Pascrell. Thank you, Mr. Chairman.

Thank you to all for your testimony. We deeply appreciate it.

I support every American having health care. It is a right and, as has been mentioned by Brother Lewis, should never be treated as a privilege.

So providing coverage, providing access, providing care to all 325 million Americans must be our ultimate outcome. My constituents in New Jersey and those across the country have waited long enough.

Americans should not be dying because they cannot pay for surgery. Families should not be reduced to pleading online to cover hospital bills with Go Fund Me.

Think about how we have come to accept this. A Nation that accepts begging to survive is itself sick.

So our urgency could not be better placed. I share that urgency. I want to get it, and I want to get it right. We need a system that lowers the cost of health care and a system that is sustainable.

When the Affordable Care Act came before us, we worked on it in a difficult way. We paid the price politically. Many of us have short memories of what happened. We paid the price politically because we stood up for what was right.

That is how this business works. I thought the ACA should have gone even further and, in my role in it, tried to do it as many on this dais did. The subsidies could have been greater, and we should have included a public option.

This side of the building did it. The other side of the building was asleep. Those two priorities for me must be on our agenda. Until we can create a system that would stand so much political disruption, we will never reach our goal. We need to build a citadel, not a sandcastle.

What I'm doing every day is working so that we could create a system that will withstand the inevitable political storms and protect every American, and I will not stop building until we have it. Health care coverage for every American, this must be our goal.

So my question, Ms. MacEwan, as the Chief Executive of the Washington Health Benefit Exchange, I am interested in your experience with the public option and other tools Washington has used to stabilize the individual market.

*Ms. MacEwan. Thank you for the question.

*Mr. Pascrell. I'm sorry?

*Ms. MacEwan. We have taken several actions to stabilize the market.

*Mr. Pascrell. I did not ask the question yet.

*Ms. MacEwan. Oh.

*Mr. Pascrell. Brilliant.

[Laughter.]

*Ms. MacEwan. Pardon me.

*Mr. Pascrell. I support State efforts to improve coverage for individuals and families, but what challenges do you envision in implementing the cascade care that could potentially be immense?

*Ms. MacEwan. If I had not listened to the whole question, I would have missed the challenges part. Very important.

So we have taken actions to stabilize the market through what we call Silver loading, allowing the cost sharing reductions to be footed on those plans, doing additional outreach and marketing and, you know, codifying the Affordable Care Act protections into our own laws, and then kind of pushing back on some of the short-term duration plan attacks on the Affordable Care Act.

*Mr. Pascrell. Do you think we would be at a different place if the other side, my brothers and sisters, I call them; would they have let the ACA be implemented in its form instead of now we reduce the funding for the Navigator Program, which educates people as to what is going on?

To heck with if the people know what is going on. We do not want that to happen, do we? So they took that money away.

The purposeful undermining of public confidence about the future of ACA when the President said, "It is dead." Well, obviously, he does not know a lot about many things. He certainly does not know a lot about the ACA. It is still the law of the land.

Third, numerous high-profile attempts to repeal and replace the ACA on the part of the other party. What plan? Which plan?

*Ms. MacEwan. Right.

*Mr. Pascrell. And fourth, the elimination of the ACA's individual mandate, which came from their think tanks before the ACA.

And finally, the decision in 2017 by this President in October to end the cost sharing reduction.

How are we ever going to get this right?

Thank you, Mr. Chairman.

*Chairman Neal. I thank the gentleman for his inquiry.

With that, let me recognize the gentleman from Missouri, Mr. Smith, to inquire.

*Mr. Smith of Missouri. Thank you, Mr. Chairman.

Democrats sold Obamacare by telling the American people the lie of 2013. If you like your health care plan, you can keep it. If they use the same line about the new health care plan today, I suspect it will be the lie of the century.

This is my second hearing on Washington mandated, one size fits all health care. In the Budget Committee, we heard from CBO to discuss the components of a single payer health care system.

I believe the more the American people understand what socialized health care gets them, the less they will like it. That is why it was no surprise to me that our Democrat

colleagues have not even requested a CBO score on their new health care plan.

CBO did confirm that socialized medicine leads to rationing, longer wait times, and bureaucrats dictating what procedures are best for you and when you can have them done.

I want to talk about two groups today who would be hurt by a government takeover of your health care, our seniors and our children. Congress has worked since 1965 to tailor the Medicare program to our seniors' unique health care needs, and it works.

How would socialized health care impact our seniors who have worked all their lives to earn their Medicare benefits? The Democrats' proposal would end Medicare as we know it. It would be government-run health care. It would force every American into a one size fits all health care plan, whether they want it or not.

Sixty million American seniors currently rely on Medicare. After a lifetime of work to earn their Medicare benefits, America's seniors would be forced into a one-size-fits-all government-run health care system no longer tailored to the needs of our older citizens, but one that rations care and limits their access.

Earlier this year the Medicare trustees projected hospital insurance to become insolvent in 7 years. That is without the massive government expansion.

There is no fiscally sound way to add over 250 million people to Medicare and maintain the program's quality and outcomes that our seniors enjoy today.

How would the Democrats' government takeover of our entire health care system impact our children? A one-size-fits-all health plan for Americans would eliminate the Children's Health Insurance Program, or CHIP, which 7 million American kids rely on today.

Now, I want to talk about a third group, patients who need an MRI to diagnose their illness. In Canada, where the other side points to as a successful single payer health care system, the median wait time to get an MRI is nearly 11 weeks, just to get an MRI in

Canada. It is 11 weeks. That is fast and efficient, but that is government control and take over your health care.

That is nearly 3 months of waiting, worrying, and worsening health conditions. Imagine being told by a doctor that there is something wrong with you or imagine being in excruciating pain every day, but they put you in line for 11 weeks to pinpoint what it is. That is Canada. That is government takeover of health care.

Increased wait times are inevitable in single payer systems. This is what Medicare for All gets you. Americans would have no choice but to pay more for waiting longer for lower quality care.

Ms. Neuman, Democrats like to pretend their plan is popular and in the mainstream. Kaiser does a lot of polling work on health care issues. Your polls find that 56 percent of respondents favor single payer health care, but 55 percent of them believe they would be able to keep their health care plan, which of course we know is not true.

Everyone would be forced out of the private and public plan they have, and like now, and would be moved into the new government program. When the tradeoff of higher taxes and eliminating private health care insurances were explained, support for single payer dropped to 37 percent.

*Chairman Neal. I will let the gentlelady finish the question if you get to it.

*Mr. Smith of Missouri. Okay. In your polls related to public opinion on single payer, have you found support from patients that they are willing to give up control of their health care and completely over to government?

*Dr. Neuman. We have not asked the question exactly that way.

[Disturbance in the hearing room.]

*Mr. Smith of Missouri. So you have not asked that question?

*Dr. Neuman. But you are correct in that we, based on our polling, we do agree

that there is a huge public education challenge that lies ahead and that the views of the public are malleable to arguments when they hear it one way or the other, put forward by proponents and opponents.

So when people say Medicare would be in trouble, support drops. When people say everyone will get coverage, support increases.

*Mr. Smith of Missouri. But you have not asked if they would be willing to give up

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*Chairman Neal. The gentleman's time has expired.

*Dr. Neuman. Not exactly.

*Mr. Smith of Missouri. Thank you.

*Chairman Neal. Thank you, Mr. Smith.

With that let me recognize the gentleman from Illinois to inquire, Mr. Davis.

*Mr. Davis. Thank you, Mr. Chairman. And I want to thank you for calling this very important hearing.

And I also want to thank all of our witnesses for sharing with us this morning. Especially I want to thank Ms. Wood and your daughter for the dedication and consistency of your efforts to bring to our attention some of the needs that exist, especially as we talk about health care.

You know, I have listened to the discussion this morning, and it reminds me of how contradictory some of us are. I am one of those individuals who believes, yes, that every citizen of this country, every individual in this country should have access to quality health services and health care.

But I also believe that if you want something, you have got to be willing to do what is necessary to get it. I do not come to this conclusion lightly. I happen to represent a district that has 24 hospitals in it. I have four outstanding medical schools. I have a

number of federally qualified health centers and other private health services.

And yet I have individuals with some of the poorest health status in Western civilization. You would think with all of these resources around them that they would have health status much greater.

We hear a great deal of conversation about cost and reducing the cost of health care. I have been chasing around health care now for more than 40 years, and I have not seen the cost reduced yet.

As a matter of fact, we talked about Medicare-Medicaid. I remember when there was no Medicare and Medicaid, and people went totally without. People where I lived and people in the community, they just simply knew they were going to die.

Yes, there was an alternative, and the alternative was the graveyard. You were going to die because you did not have any way to get to any of the care.

My one question is, Dr. Berwick, and at this time if we were to move from what I call a sickness care system, and I think we do a great job, sickness care, when you get sick, but health care prevention would seriously reduce the cost of health services and health needs in this country. How would you respond to that?

*Dr. Berwick. It would reduce health care costs dramatically. From the Chicago Loop to West Chicago, a distance, I guess, of 2 miles, there is a difference in life expectancy of 16 years.

*Mr. Davis. No doubt.

*Dr. Berwick. Your postal code is your future, and that is because of the social circumstances people find them in, and they are dying from the causes, upstream causes that cause our ill health, inequity, threats in the streets, nutrition, food insecurity, housing insecurity.

We need to begin to invest in that. That will reduce the demand on the health care

system, lower health care costs, and by the way, save lives and extend lives.

In Flint Michigan, the difference across town is 15 years of life expectancy. In New York City, between Midtown Manhattan and the South Bronx, there is a 10 to 12-year life expectancy difference.

We need to end this, and yes, sir, that would change. That would lower costs dramatically.

*Mr. Davis. It would lower the costs. We could make sure that everybody is covered, and we could have a health system everybody is in and nobody is out.

*Dr. Berwick. And justice, yes.

*Mr. Davis. Thank you.

And I yield back, Mr. Chairman.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentlelady from California, Ms. Sanchez, to inquire.

*Ms. Sanchez. Thank you, Mr. Chairman,

And I want to thank all of our witnesses for taking the time to be here with us today.

We have been fighting to protect access to health care for patients with preexisting conditions for so long that I am glad we finally can turn our efforts to proactive ways to achieve universal coverage and provide Americans with more access to care.

I have long been a supporter of universal coverage and helped lead the fight for a single payer option in the Affordable Care Act.

Now, Republicans love to knock the ACA but the fact remains that 20 million more people got health care coverage as a result of the passage of the ACA, and over a 10-year period with Republicans attacking the ACA at every turn, they have actually managed to reduce the number of people with health care coverage. So we are regressing as a result of the actions of the other side of the aisle.

But I know what we have to do now is we have to focus on those who still remain uninsured, and the ACA is a great base. It is not a perfect base, but it is a great base. But we still see Americans who cannot afford their prescriptions, Americans who choose not to take an ambulance to the emergency department because they are afraid of the bills, Americans who have to make hard decisions as it relates to their health and their finances, as Ms. Wood's testimony so eloquently underscored.

Those decisions are even more striking when you take into account the racial and ethnic disparities in our health care system. Latinos have higher rates of obesity and death due to diabetes than do their white counterparts, and compared to their black counterparts, Latinos are less likely to have received preventive screening, such as mammogram and PAP smears.

Latinos are more likely to forego necessary care simply because of the cost. So despite these gains that we have had in coverage through the ACA, there are still these massive disparities that affect Americans across this country.

I believe the answer is we have to have universal access, and I want to begin by asking Dr. Berwick. How would moving towards universal coverage help address the disparities and advance health equity?

And ultimately, how will that impact our economy?

*Dr. Berwick. I think the basic answer, by fixing responsibility for solving the problem. Right now the problem lies free floating, and certainly no insurance company owns the problem. No insurance company says, "We are going to solve disparities in this country."

We have a massive opioid epidemic taking 70,000 lives a year. Who has got the ball? You would hope that a purchaser of health care for this country would say, "We have a goal here. We are going to end the opioid epidemic. We are going to work on the

disparities you are talking about and invest," because they have the budget to invest in that.

We do not have a mechanism for that in this country. Medicare can do that and does do that for the wellbeing of elders. We could do it for everyone.

*Ms. Sanchez. So government has an outsized role that we need to take the rose by the thorn and make that happen.

*Dr. Berwick. I believe somebody has to have the responsibility, and that is to my mind why we have government.

*Ms. Sanchez. Thank you so much.

Ms. Wood, I really want to thank you for sharing your story. Your story is just, I mean, heartbreaking, and I am glad to hear that Charlie is doing well. I hope that her birthday was great.

I am a mom as well, and I agree with what you have said. Many times you choose to make decisions that benefit the health of your child over even your own health because that is what moms do.

You have heard a lot of questions from my colleagues today put to the panelists, and I think it is important not to lose the perspective of somebody who has been through the sort of meat grinder of our health care system.

I want to give you the chance to close in my time in questioning by asking what do you think is most important for us to keep in mind as we consider proposals aimed at achieving universal coverage?

*Ms. Wood. I have heard a lot of talk about cost, especially from this side. I have to point out that Charlie having health care young saved the government tons of money because she will have a typical, independent adulthood rather than a lifetime of disability. It is way more expensive to support somebody on disability than it is to provide health care for them when they are young.

Additionally, if I had my tooth treated when I first needed it, I would not have had to go to the ER which was additional expenses. I would not have had surgery. I would not have to order shakes now in order to eat.

So money is saved by providing health care now, and somehow they are losing sight of that.

*Ms. Sanchez. I really appreciate you underscoring that because that is what I call the leaky roof theory, that when your roof leaks, yeah, it costs money to fix it, but the money that you spend in fixing your roof prevents massive amounts of money that you are going to have to throw at it if you do not get it fixed.

So thank you again for your bravery in coming before this committee and I appreciate you being here.

*Ms. Wood. Of course. Thank you for having me.

*Ms. Sanchez. I yield back.

*Chairman Neal. Let me recognize the gentleman from Arizona, Mr. Schweikert, to inquire.

*Mr. Schweikert. Thank you, Mr. Chairman.

This is on a theme that I have shared with, you know, my brothers and sisters, Republicans and Democrats here. Every fiber of my being believes we are having absolutely the wrong discussion, the wrong argument.

Think about this. It is a simple thought experiment. ACA, it was who got to pay, who got subsidized, functionally in the financing side.

Our Republican alternative, which there was one which some of you actually helped me on my risk pool amendments and the laddering and then voted against me, but nevertheless, it was about who got subsidized and who gets to pay.

It is the wrong discussion right now. We are living in a time of disruption. There is

incredible technology that is about to crash the price of health care if this committee particularly is willing to challenge and do something it is incredibly uncomfortable for those of us in an elected office, and that is look incumbent providers, businesses, insurers, systems in the face and say, "It is time for the revolution."

And I have shown almost all of your things like the flu kazoo, you know, something you blow into. It tells you if you have a bacterial infection or a viral infection. The algorithm is incredibly accurate, and allowing that algorithm to order your antivirals and have them distributed, you just crashed the price of health care.

How about what is about to happen this November? Single shot cure for hemophilia. So if 5 percent of our brothers and sisters that are well over 50 percent of our health care spending, instead of having the debate on how to manage them or how to cut a corner here or cut a corner there, how about the revolutionary, the disruptive discussion of curing parts of that 5 percent of the population and the majority of our health care?

It is coming. Promise that single shot for hemophilia may be a million and a half dollars. We need to be having a finance discussion on what we are about to do to engage in the disruption of health care.

If we are going to continue this crazy loop of it is really a discussion of who gets to pay, who gets subsidized, I know everyone on this committee has actually read and I am sorry I have my dog-eared one still at home, the Medicare actuary report on what is going on. We are 6 and a half years away from the hospital portion of the Trust Fund being empty.

We have a math problem. So right now I do not know why this hearing is not about Medicare itself and protecting Medicare itself instead of nationalization of health care.

This is the math right now for someone who is going to retire in 2020. There, they have put in \$161,000, and they are going to take out almost \$500,000. This is the current

system.

No wonder so many people like Medicare. When you are getting \$3 to every 1 put in. We have already a massive distortion. We need to get our math right.

So our hearing right now should be about how do we save the current Medicare system because in 6 and a half years the hospital portion is empty. And according to this study right here, 13 to 18 years at the continued growth of just Medicare, it is going to blow our debt to GDP off the charts.

So defending the current system is absurd for all of us. It is time for an absolute disruption. Are we willing to talk to our hospitals, talk to our providers, talk to technology, talk to the FDA, and have the honest discussion that this is about to become your primary care physician?

We will be healthier because it is individualized to us instead of what is going on here in the discussion about collectivization of a system that is already pretty crappy.

And I am sorry, Mr. Chairman. I know we have our politics and we are sort of trapped into a mindset that is now decades old. I beg of all of us because this is not Republican or Democrat. We are on the cusp of a revolution that can crash the price of health care. It is like the Blockbuster video moment of one day all of a sudden it is gone because there is a new technology amongst us.

How do I drag a future hearing so we can talk about what we must do policy-wise to make these great things happen for all of us, and to actually save programs like Medicare itself?

Because if we are 6 and a half years from the Trust Fund being empty, we are engaged in an absurd conversation right now.

With that I yield back.

*Chairman Neal. I thank the gentleman.

I am informed that there is a procedural vote on the floor. We are anticipating and hoping that it is only one, but we are going to keep going here. What I am going to try to do is go over and vote and then come right back. Ms. Sewell will take the gavel, and I intend to keep the hearing proceeding as scheduled.

*Ms. Sewell. [Presiding] The chair recognizes Mr. Higgins.

*Mr. Higgins. Thank you.

The United States health care costs were \$3.65 trillion last year. It is over \$11,000 per person. Annual increases are 5.5 percent.

My colleagues on the other side have been emphatic in their support for protecting people with preexisting conditions, but prior to the Affordable Care Act, if you had a kid that was stuck with childhood cancer, an insurance company could deny you coverage because it is a preexisting condition.

You cannot do that anymore because it is against the law. And there is only one Federal law that provides protection for people with preexisting conditions, and it is the Affordable Care Act.

So if you vote to repeal it 70 times, you do not support protecting people with preexisting conditions. If you join a lawsuit to challenge the Affordable Care Act in a Texas appeals court to deem unconstitutional the preexisting conditions mandate, you do not support protecting people with preexisting conditions.

Rebecca Wood, you provided compelling and courageous testimony today. You said that when Charlie was 3 months old, she was well enough to come home. Issues from her premature birth appeared one after another. Each one required treatments and therapies.

Her birth, her birth was a preexisting condition. One hundred and thirty million Americans have preexisting conditions. Fifty-one percent of the non-elderly population

has at least one preexisting condition. Seventy-five percent of people between the ages of 45 and 54 have a preexisting condition. Eighty-four percent between the ages of 55 and 64 have a preexisting condition.

The good thing is those over the age of 65 do not have to worry about it because Medicare always covered preexisting conditions.

There are a lot of good proposals out there, but the bottom line here is we have an obligation on behalf of the American people to use the leverage in the quality of the Medicare program, virtually universal access.

You know, I often hear docs in hospitals bellyache about Medicare reimbursements, but they all take it. They all take it. Ninety percent of Democrats, Republicans and independents who have Medicare say it is a good quality system.

We have to find a way to expand this. If it is a Medicare buy-in, if it is a Medicare expansion, the reality is that many of us voted with great pride to support the Affordable Care Act, but we also understood that after 100 years of trying, that it was not a finish. It was a start, and that we would always have to improve on it.

And it was a good system from which we have to build on. Negotiations like this are always about leverage, and we have tremendous leverage in the Medicare program to drive down the cost of health care and drive up the quality.

An affordable health care insurance program does not do you any good if there is very little underlying insurance. You know, most people's problem with health insurance in this country starts when they need the insurance that they already paid too much for.

So I would ask Dr. Neuman, and I want to applaud the Henry J. Kaiser Family Foundation for the extraordinary work that they do in providing policy and economic analysis to help policy makers like us who are here.

Your thoughts on this and the general issue.

*Dr. Neuman. Well, you have raised so many questions. I will say in listening to the discussion about Medicare and lots of the issues about broadening Medicare, one of the advantages of Medicare that has not come up so far is that people in traditional Medicare have a broad choice of doctors and hospitals across the country.

So if they move because their family moves for a job or if they move because they want to live in Florida because it is warm, they have a choice of doctors all over the country, and that is very appealing to people who may -- you know, I do not know for sure -- but people may actually prefer to stay with their doctor or choose their doctor than an insurance plan.

So that is one thing that I think has been sort of missing and would be particularly valuable in the proposal that you have put forward as well.

*Mr. Schweikert. With that I yield back. Thank you.

Thank you.

*Ms. Sewell. The chair recognizes herself for 5 minutes.

I want to thank the witnesses and all of the advocates that are here today.

I want to be very clear. I believe that in this great country that we live in, this country of tremendous wealth and benefits, no America should not have health care coverage. I believe that it is a right for every American and not just the privileged few.

How we get there, how we get there I think is really the issue, and so I want to commend Chairman Neal for holding this hearing where we can talk about alternative ways that we can get universal coverage in health care for every American.

I am especially proud to sit on this committee and to hear from Americans such as yourself, Ms. Wood, because I know that in this great country no one should go bankrupt. No one should be worried about their child in order to get health care coverage and to get quality health care for themselves and their children.

Unfortunately, your story, although so inspiring, is the norm, is the norm for so many Americans. I think about my own district. My district is Alabama's 7th Congressional district.

I grew up in this district. It is a district that includes Birmingham and Tuscaloosa and Montgomery, but also my hometown of Selma, Alabama, where our colleague John Lewis shed a lot of blood in order for us to have civil rights that we have.

And I do believe that health care coverage, universal health care coverage is a civil rights issue of our day, and we have to be bold enough, brave enough to do something about it.

I am not sure that Medicare for All is the right answer. I have a lot of folks in my district. Fifty percent of the folks in my district have employer-based health care coverage, and they want to keep that.

But I also have in my district, and the State of Alabama was one of the 14 States that did not expand Medicaid. You were so accurate, Ms. Brooks, to talk about how expanding Medicaid, while everyone was supposed to be able to expand, every State was supposed to have to do that, the Supreme Court said the States could opt in or opt out.

Well, Alabama was one of the ones that opted out, but I think about all the folks in my district that I meet along the way. I met a young woman in Tuscaloosa earlier this year who is selling her house right now in order to afford the cost of her diabetes management, life or death. She has Type I diabetes, and it is life or death for her.

I think about the fact that the ACA did increase coverage in my State. Over 200,000 Alabamians receive premium assistance through the Affordable Care Act. I know that you are proud of that, Dr. Berwick.

For many it was the first time in their life that they had coverage. I think of Hank, an Alabama farmer who I have often spoken about right here in this hearing room.

He had never been able to afford coverage for his family. He was a second generation farmer in Alabama, and no one in his family had health care coverage the first generation, and he and his wife did not have coverage until the Affordable Care Act.

And Hank was so funny. He said to me, you know, "Congresswoman, had I known that it was Obamacare they were offering, I probably would not have gotten it. Because they said it was the Affordable Care Act and they gave me some subsidies to make it affordable, I got health care coverage for the first time."

And you know, later that year, after the first time of having health care coverage, his hand got stuck in a hay baler, and his coverage covered the majority of his medical costs. And not only did he get the Affordable Care Act help save his hand, it also helped save his farm.

So I want to talk about that gap that exists in my district, in my State, that gap. Fifty percent have employer base. Another 21 percent are covered by Medicaid in the State of Alabama. Sixteen percent are covered by Medicare. Six percent are covered by public or non-group insurance.

So there is 10 percent that is uninsured in my district, and I would like to know from you, Dr. Neuman, if you could talk about why Medicare expansion for everyone would be a good thing, and States like Alabama, how they can close that gap of the 10 percent that is uninsured.

*Dr. Neuman. Well, most simply Medicare and Medicare expansion, if it included every resident in the United States, would make sure that that 6 percent of people who live in Alabama would get coverage.

And it would also make sure that that coverage is affordable so that they would not only have health care, be able to afford it, and be able to go to the doctor when they get sick, when they need it, and presumably get the care that they need, you know, to take care

of themselves.

That is kind of straightforward.

*Ms. Sewell. Absolutely. I also wanted to ask you, whoever is in Washington, Ms. MacEwan? Yes.

Can you explain how Washington covered everyone, how the State of Washington did that?

I am thinking about my rural hospitals, and I have a lot of rural hospitals in Alabama that, because we did not expand Medicaid, because we have the lowest reimbursement for Medicaid in the country in Alabama, how was Washington State able to do that? And what do you think the benefits are in trying to get universal coverage?

*Ms. MacEwan. We are not at universal coverage yet. We are at about 95 percent coverage, which is good.

*Ms. Sewell. Very good.

*Ms. MacEwan. But we would like to be 100 percent.

I think the most important thing that we did was Medicare expansion, and that made a huge difference in our State. We had 800,000 new people come into coverage who had never had coverage before.

The second thing that is most important is affordability and doing everything we can to make coverage affordable. In addition to the subsidies, people need to know that the market that they are going to will have affordable rates, and that their deductibles will be affordable to them as well. So those are the most important things.

And then the third thing is the public option, which we just introduced, which we hope will start to pull us the rest of the way towards universal coverage.

*Ms. Sewell. I also would like to ask for unanimous consent and grant unanimous consent to submit for the record to this committee the remarks given by our colleagues,

Representative Donna Shalala, Representative Seth Moulton, and Representative Rosa DeLauro from hearings earlier this year in the Budget Committee and in the Rules Committee on this same topic.

And I unanimously accept those reports.

[The information follows:]

[Donna Shalala statement on the House Committee on Rules Hearing on Medicare for All Legislation](#)

[Rep. Rosa DeLauro Testimony](#)

[Budget Committee Hearing on Key Design Components and Considerations for Establishing a Single-Payer Health Care System: Seth Moulton](#)

*Ms. Sewell. I am going to ask the chair to recognize Ms. Walorski for her 5 minutes.

*Ms. Walorski. Thank you, Madam Chair, for holding this hearing.

I also want to thank all of our witnesses for your willingness to testify before this committee.

And, Ms. Wood, I think your daughter is a rock star, and I am glad you brought her today. Thanks so much.

Before I ever thought of running for Congress, my husband and I sold everything we owned, and we moved to Romania to serve as missionaries. Even though the Iron Curtain had fallen, the effects of communism could still be felt and seen all over the country during our 4 years living there.

We started working with organizations to help impoverished kids, some of whom lived in the sewers below ground and many of whom were victims of communist rule.

We helped set up a leadership training institute for young people to teach them the skills they needed to succeed, and we also got involved with providing medical supplies for children at the country's only burn unit.

One day my husband and I received a frantic call from a doctor, and he said, "The government just shut off the supply of antibiotics, and children in this burn unit are dying. I do not have the antibiotics. They are trying to make a point."

Fortunately, I knew somebody at Eli Lilly at my home State of Indiana, and they worked with us to get these lifesaving antibiotics where they were needed.

Years later, here I had the opportunity to serve on the House Veterans Affairs Committee for 4 years. During that time, we uncovered unbelievable real stories on long wait times, secret lists, and outdated IT systems not in Romania; right here in this country through the VA, a government-run health care program.

According to the 2015 VA OIG report, more than 300,000 American military veterans likely died while waiting for VA care, with some of their applications dating back nearly two decades.

In my own congressional office, veterans asking for help dealing with the VA continues to be our most common, number one constituent case work. We continually battle the bureaucrats at the VA to ensure that veterans get help in this country, the care they deserve and earned right now.

For impoverished children abroad to our brave veterans here at home, I have seen it firsthand. I have seen it, the damage government-run health care can do.

I have seen bureaucratic failures and top-down controls that prevent patients from getting the care they need. I have battled for them. I have battled to save their lives.

Forcing every American off their private or employer-sponsored insurance plans into a top-down, one size fits all system like Medicare for All would be a disaster. It would be especially harmful to patients with preexisting conditions who would bear the brunt of doctor shortages, wait lists, bureaucratic disfunction and budgetary cutbacks.

Promoting Medicare for All is easy to sell as a campaign slogan. I know it is, but it is a certain failure in practice. It is administratively and fiscally impossible to implement.

We still cannot handle our own veterans in this country, and it is a guaranteed path to preventing hardworking folks from getting the health care that they and their families need. That is not what the American people want.

What they want is a system that puts control back in their own hands and puts the needs of the patient first.

Ms. Turner, under the plans that we have seen proposed, services would be available to everyone with no cost sharing whatsoever, which is more extreme than any other country with a similar system. This increases demand for health services regardless

of their necessity, decreases supply of medical providers due to steep reimbursement cuts.

A government owned and operated system like this may not be able to address issues at all with chronically ill patients with multiple preexisting conditions.

Understanding the single payer system generally has wait lists for care, do you think that the most vulnerable patients stand to lose the most under this proposal?

*Ms. Turner. Absolutely, and the Congressional Budget Office agrees because it believes that the cuts in payments to even get to a \$32 trillion cost would lead to shortage of providers, longer wait times, changes in the quality of care, and they expect a substantial increase in patient demand, which further exacerbates the waiting lines, and much less investment in new technology and new equipment.

*Ms. Walorski. Thank you.

And I want to just say this in closing. I got a call one night from a young veteran woman whose husband was dying at a VA, lack of care. And I called the VA Secretary myself because I had his cell phone number.

And I said to him, "Mr. Secretary, if you do not save the life of this veteran from my district, I want to meet you at eight o'clock tomorrow morning in Indianapolis, and I am calling for your resignation."

And I took on that VA Secretary, and the gigantic bureaucracy that exists here that took the lives of so many fighters that fought for our freedoms.

I have been here. I have done it. I have lived through it, and I have saved their lives, and I cannot see doing this to all of our American people.

Thank you. I yield back, Mr. Chairman.

*Chairman Neal. [Presiding] I thank the gentlelady.

Let me recognize the gentlelady from Washington State, Ms. DelBene, to inquire.

*Ms. DelBene. Thank you, Mr. Chairman. And thank you for convening today's

hearing.

Thank you to all of our witnesses for being here and for your testimony. It is so important.

Absolutely, we should all agree that affordable, quality, universal health coverage should be a shared goal, a bipartisan, shared goal for members of the Ways and Means Committee and Congress broadly.

I want to thank Ms. MacEwan for your service overseeing the Washington Health Benefit Exchange and for your work to provide universal coverage. Like you said, 95 percent right now in the State of Washington.

The administration has definitely taken several actions to undermine the Affordable Care Act, to destabilize the individual market, to put barriers up in terms of access to coverage.

So I would like to ask you, Ms. MacEwan, how Washington State responded to some of these actions. First of all, in 2017, the administration ended cost sharing reduction subsidies that were intended to help the lowest income Americans pay for their copays and deductibles and keep premiums down for everyone.

What did Washington State do in response to those cuts?

*Ms. MacEwan. We allowed insurers to file two different rates, one if they were cut and one if they were not cut. So we were prepared, and when the withdrawal of the payments went through, we went to the second, which was a higher rate, but it loaded the expense of the cost sharing reductions onto the Silver plans where most of the people are who utilized those benefits, the low income, you know, under 200 percent of the Federal poverty line.

And so that kind of shielded people from the impact. It did have a negative impact on people who were not eligible for subsidies. It made the cost of those Silver plans go up

a lot for unsubsidized people.

*Ms. DelBene. Thank you.

Also, the best way to lower insurance premiums is to bring more people into the market and expand the risk, but unfortunately, in 2018 the administration slashed funding for ACA navigators and for marketing to let people know what was out there so they could sign up, and as a result we saw fewer people signing up for coverage, therefore a smaller risk pool and higher premiums.

So in response to those cuts to fund that marketing and those navigators, what actions did Washington State take?

*Ms. MacEwan. The withdrawal of the outreach in marketing from the Federal Government, we really missed it. That created a lot of understanding and knowledge that it was open enrollment and how the plans worked because it was national advertising on a very large scale.

In our State, we replaced it by funding a navigator network and funding communications, marketing, and outreach from the Exchange so we can continue to reach people.

I think it has made a big difference. There have been studies that show where there is that local outreach in marketing that has actually filled the gap from the Federal Government, although it has not completely replaced it.

We call it air cover. We still miss it, but it has made a big difference.

*Ms. DelBene. And then in 2018, the administration allowed short-term, limited duration plans to be renewed or extended for up to 3 years, and those plans were only intended to serve as a bridge between coverage because they do not have the protections of qualified ACA plans, like covering essential health benefits like maternity care, mental health or prescription drugs. They do not have out-of-pocket limits.

And we also know that they do not cover preexisting conditions, which has been a topic of much discussion because it is so important. That was a promise of the Affordable Care Act.

So what has Washington State done in response to these changes to short-term, limited duration plans, and allowing customers to sign up for these for long periods of time and getting less quality coverage?

*Ms. MacEwan. A few States outlawed them altogether. Our State stepped forward to continue to allow them, but to make them truly short-term, limited duration plans. They are not renewable. They are only for 3 months, and there is extensive communication required to consumers so they understand fully what it is that they are buying.

*Ms. DelBene. Thank you.

And I know that it has been a lot of work because as we work to extend coverage, we have been working to keep the coverage that has been there.

You talked about Washington State having 95 percent coverage. What do you think we can do to get to 100?

*Ms. MacEwan. I think the public option is really our best path right now for universal coverage. It is something we can do immediately, and we think the public option will make coverage more affordable for people, and right now, that is probably the most critical thing.

Right now premiums are very high particularly for unsubsidized, and we think affordability will make the difference. It will also be higher quality plans that will start to get at some of the cost trend issues and improved quality for consumers as well.

*Ms. DelBene. Thank you so much.

I yield back, Mr. Chairman.

*Chairman Neal. I thank the gentlelady.

Let me recognize the gentlelady from California, Ms. Chu, to inquire.

*Ms. Chu. Well, I would like to thank you, Ms. Wood, for sharing your story with us here today. No one should have to choose between their own health care and that of their child, not in the United States, one of the wealthiest countries in the entire world.

Every child should be able to have the medicines they need to survive. Every parent should be able to seek care when they need to so that they can get well and care for their children. It should not be just the wealthy that have access to health care, not in this country.

So, Ms. Wood, even though you and your family were covered by insurance through your husband's employer, in other words, you had employer-sponsored insurance, you had these experiences, and I actually read your written testimony, which had even more stories.

And what sticks out in your mind in terms of an example of a high, out-of-pocket cost that made health care nearly impossible for you to afford?

*Ms. Wood. In my written testimony, you will see I highlighted the fight we had to put up to get her formula covered when she was younger. We had private insurance. Her formula cost \$28 a day, and when we called to have it covered by our private insurer, we were told it is covered under your drug plan.

We called our drug plan. They said no. It is covered under your insurance. So we called our insurance again, and they said, "No, it is covered under Medicaid."

We called Medicaid. They said, "No, your primary insurance covers it first."

So we called back, and they told, you know, it is not covered. Fortunately, I did research and found out it is covered under the durable medical equipment portion of our policy, and when I pointed that out to them, they said, "Well, we need a letter of medical

necessity."

Well, first of all, it disturbed me that my own insurance provider did not know their own policy or they were misleading. Either way it is wrong.

And then when I did provide the letter of medical necessity, it required three copies. The first two were insufficient, yet they would not tell us what needed to be included.

Finally, the third time it was approved. This process took 2 months, and in 2 months I had to figure out how to get formula for her that cost \$28 a day.

This is health coverage I paid for. This is the service they were supposed to provide. Coverage does not equal access, which is probably one of the most frustrating lessons I learned since I learned through my daughter's birth and growth and development.

*Ms. Chu. Well, thank you for sharing your story.

I hear from my constituents every day about how health care is costing them dearly, even people with insurance are struggling with high deductibles and copays, and that is why I not only feel strongly about shoring up the ACA, but I am also a proud original cosponsor of the Medicare for All Act.

With a single payer system, no family would have to go through what Ms. Wood's family went through with her daughter. Medicare for All would cover primary care, hospital visits, prescription drugs, women's reproductive health services, including abortion, dental, vision, mental health, and even long-term care.

And in fact, I have a statement from a coalition of 35 reproductive rights groups and also a letter from the National Partnership for Women and Families supporting universal health care that covers the full range of reproductive services.

If I may submit it for the record.

Well, Medicare for All, of course, would have no out-of-pocket cost and no mother would have to make the impossible choices that you did.

And, Dr. Berwick, I would like to talk about two terrible situations we face in this country. One is surprise billing, which happens when a patient gets stuck between providers, hospitals, and insurance companies and can lead to exorbitant charges, like when a bike accident costs a patient in the ER \$20,000 or an ER visit for a migraine that cost \$10,000.

The other terrible situation is long-term care of which, of course, many people do not have long-term care programs, and many seniors spend down their life savings in order to afford it.

What would be different in a Medicare for All situation?

*Dr. Berwick. Well, with respect to surprise billing, there is the passing the buck problem that as you heard you say, it is not my job. It is someone else's job. When you have a single payer system or a single payment, there is one port of call. You go there and that is done.

Also we could forbid surprise billing. With a single payer system we could say this is the amount we will pay, end of story.

So I do not want to claim that it is simple. But working out rules that avoid this kind of nonsense would be possible in a consolidated payment system.

*Ms. Chu. Thank you.

*Chairman Neal. I thank the gentlelady.

Let me call on the gentleman from Kansas, Mr. Estes, to inquire.

*Mr. Estes. Thank you, Mr. Chairman.

And thank you to all of our panelists for joining us today.

You know, today we are discussing one of the most important topics facing America today. You know, for nearly a decade the health care industry has been in turmoil with rising prices, costs, choice has been reduced, and 30 million people still do not have

health insurance.

Unfortunately, instead of new approaches that would look at how do we increase competition, how do we provide more choices, how do we lower cost, we are looking at a one size fits all, kind of the same approach that we have been doing with government-run health care.

So we talked about a lot of these things earlier, but I want to repeat a few of them just because they are so important.

The Democrats' Medicare for All plan will double everybody's taxes and still doubling the taxes will not pay for it. It jeopardizes small hospitals and the benefits for the senior citizens who have worked all their lives to pay into the Medicare.

And finally, Medicare would also eliminate private employer insurance for 158 Americans. In Kansas that is 1.5 million people that would lose their private insurance, and in my district alone, there are 507,000 individuals on private insurance and 24,000 individuals who have a Medicare Advantage account, and their choice is to be taken away by Medicare for All.

There are also 137,000 senior citizens in my district who have paid into Medicare their entire lives, and they are eligible for it, and as it stands now, the Medicare Hospital Trust Fund is slated to be depleted in 2026.

What happens when this fund and the benefits they have worked for is depleted and when Medicare for All ends that access?

You know, one of the other things that we have talked about in this or has not really been talked about much is that Medicare for All would end the Hyde Amendment and the longstanding prohibition against Federal funds used for abortions.

I want to shift gears a little bit and talk about something that is really important in my State and a lot of other States. Kansas has one of the largest numbers of critical access

hospitals in the country at 83. As you know, these hospitals get reimbursed at 101 percent of their cost. Yet under the Democrats' plan, their reimbursement rate would be slashed to 40 percent below their actual current payment rates.

And given that the leading single payer plan in the house would make it illegal to negotiate that government set rate or to turn around patients, it would be inevitable that these vital rural hospitals would go under.

I could go on, but it is clear that the Medicare for All and other plans leading this one size fits all government health care are unstable, expensive, and do not address the problem of needing better health care at lower cost.

We have already seen how government health care works. You know, in Canada the median wait time is 19.8 weeks for patients to see a specialist after receiving a referral from a general practitioner.

Canadians also have a median of 4.3 weeks for a CT scan, 10.6 weeks for an MRI, 3.9 weeks for an ultrasound.

In Britain, one in five cancer patients have had to wait over 2 months for treatments after being referred from a general practitioner.

In the U.S., we need to look no farther than some of the problems that we have talked about about the VA and some of that issue that we have mistreated our veterans through that VA, government-run health care.

So instead of looking at a bigger government-run health care, let's look at some of the things that we can make work. You know, Ms. Turner, given that the Democrats' one size fits all plan would slash reimbursements to critical access hospitals, do you agree that critical access hospitals in rural America would be hit hardest of all in a single payer system?

And what does it mean for patients living in rural America that would be forced to

pay more than double their taxes only to watch their hospitals close in their community?

*Ms. Turner. I think that the rural hospitals would be among the most vulnerable because they often are relying even more now on Medicare and Medicaid payments and have fewer private people supporting them, which is really one of the reasons privately insured people tend getting care there, which is one of the reasons they cannot make their margins.

If you put all of them on these much lower government payment rates, it is very hard to see how most of them would be able to keep their doors open, and that is also validated by the CBO report.

*Mr. Estes. And part of that is because the private payers through insurance are covering those lack of coverage through the Medicare reimbursement for those providers.

*Ms. Turner. That is correct.

*Mr. Estes. So thank you.

And, Mr. Chairman, thank you for having this hearing, and I yield back the balance of my time.

*Ms. Sewell. [Presiding] The chair recognizes the gentlelady from Wisconsin, Ms. Moore, for 5 minutes.

*Ms. Moore. Thank you so much.

And I want to thank the chairman and thank all of our witnesses for sitting here for this great length of time.

I guess I wanted to start with you, Ms. MacEwan. You seem in the State of Washington to have taken a real strong initiative to stand up the Affordable Care Act, and as I was looking through your testimony, you identified, and I say that to say that I am sure that there are places like I am thinking of the State of Utah where all of the carriers left the marketplace, and people in Utah actually had no health insurance.

Many complaints you have heard here today about the high cost of the premiums under the Affordable Care Act, but I am wondering if you think that that is because of the undermining of the Affordable Care Act, things like not standing up the risk corridors.

And I notice from your testimony here that you talked about the elimination of payments for cost sharing reductions; the penalty for the individual mandate with no effective substitute; the promotion of the short-term duration health plans; termination of Federal reinsurance; reduction of marketing and outreach; and the renewed threat of ACA.

I just want to confirm with you that this is your testimony, and that the ACA really was on a trajectory of actually supporting our goals as you have experienced in the State of Washington, but for these disruptions.

*Ms. MacEwan. Yes, I agree. The market was really at a point where it had begun to really stabilize because we had had the year-over-year experience with the Affordable Care Act.

The actions that you described one by one drove up the premium cost. The cost sharing reductions alone was a 20 percent impact on premium cost in Washington State.

The withdrawal of, you know, reinsurance, not renewing Federal reinsurance had, I think, close to a 10 percent impact.

*Ms. Moore. And the reason I ask you these questions is because we are in a real fight here with regard to getting to universal health care, and I would not be surprised if everybody agreed with that.

But the ACA, you know, we could have just named it Romneycare and just everybody said okay with that, but we did not do that.

I want to talk for a second to Dr. Berwick. There seems to be a lot of testimony or questioning today about rationing health care versus cost containment. I want you to sort that out for us.

And I already want to point out that Charlie's mom has really pointed out that rationing of health care already occurs in our system.

So can you tell us the difference between cost containment and rationing health care that we have been told is going to occur if we go to single payer?

*Dr. Berwick. Well, first, right now we ration people. Some people can get it and some people not. That is unjust, and everyone here is saying that, and I agree with that.

The difference between rationing and cost containment is cost containment is working on waste. We have reports from the RAND Corporation, a massive report from the National Academies of Science, Engineering, and Medicine showing or estimating 25 or 30 percent of what we do in health care does not help --

*Ms. Moore. You would never consider the formula for Charlie as waste.

*Dr. Berwick. Absolutely not.

*Ms. Moore. As one of the ways to save money.

*Dr. Berwick. This country can afford and should afford and should invest in anything at all that helps people live long and well and is effective care, anything. And we can afford that.

We are spending twice as much as other countries. We are at \$3 trillion. We have that money.

One way to assure that is to stop doing things that make no sense at all, like requiring physicians to spend 2 hours a day on paperwork and having pricing of insulin go up every quarter, now denying people access to insulin.

*Ms. Moore. Okay. I want to talk a little bit about this \$32 trillion transfer, and, Dr. Berwick, you talked about this same money would be involved. It would be just different.

How would that work?

*Mr. Berwick. Well, I would look at --

*Ms. Moore. Thirty-two trillion. I am sorry.

*Dr. Berwick. Thirty-two trillion.

Look at a worker's paycheck. I do not think the worker cares when there is a deduction whether the deduction is going to a government payment system or a deduction that his employer is drawing out of his paycheck to pay for commercial insurance. They care about how much they take home.

And that money does not change. Indeed, I think under a Medicare for All system -

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*Ms. Moore. Well, do you get the money from the companies that they are kicking in?

*Dr. Berwick. You have to have the money that now goes to private insurers go to government sources, to the government payment system. It is the same money though, and probably less total.

So this \$32 million figure, it is a somewhat deceptive --

*Ms. Moore. In my seconds, this standing in line, waiting on services. How do you make sure that does not happen?

*Dr. Berwick. Well, I have worked in countries all over the world. This rhetoric about standing in line is just wrong. Some of the data quoted is wrong. You just ask those countries.

And if you ask the people that live in those countries if they are satisfied with their health care, almost every other Western democracy is more satisfied than we are.

And if we do not want lines, let's not have lines. Let's have a single payer system that supports hospitals and clinics enough that the lines are not there. It is a matter of design.

*Ms. Moore. Thank you for your indulgence, Madam Chair.

*Ms. Sewell. The chair now recognizes Mr. Kildee.

*Mr. Kildee. Thank you, Madam Chair.

I am just quickly commenting, picking up on this comment because we hear this issue about how other nations that have some form of universal health care, single payer, that there are these lines.

You know, there are people who never get a chance to get in any line. I think we need to point that out; that the problem we have is that in this country, the wealthiest country in the face of the earth, there is no amount of time that they have to wait in line because they never get to get in line. They are not in line. They do not get health care.

You know, we have a very wealthy country, the wealthiest Nation in the world, at the wealthiest moment in its history. The idea that we cannot find a way to provide health care to every American is because we choose not to, not because we cannot. It is because we choose not to do it.

And there is every excuse in the book. We have heard some of these forever, lines in Canada, whatever. The fact of the matter is one way or another we all pay a high price for either having or not having health care.

And, Ms. Wood, you pointed out very clearly that there is a very high price, but there is a price that sometimes is not measured in just dollars and cents. It is the price of pain. It is the price of loss. It is the fact that people can go through an entire life wondering if they are just going to be lucky and not happen to get sick.

And in the wealthiest country on earth, that is a crime.

Dr. Berwick, I want to thank you for mentioning my hometown earlier. I represent and am a son of Flint, Michigan, my community. And a lot of people know about my community because of what it has gone through recently with the water crisis, but that

crisis is just one manifestation of the shame that we carry in this country, and that is that we have allowed for far too long people living a few blocks from one another to have life expectancies that are as much as 15 years different. It is a shame.

So we have the haves and the have nots, and it is not just about what they have in terms of personal belongings or personal wealth. The haves and have nots in this country are unfortunately being defined with people who have access to care when they are sick and people who do not have access to care when they are sick. That is the haves and have nots.

So I thank you. I thank the panel for your testimony and for adding to this conversation and pushing back, many of you anyway, against this idea that there is some big, technical problem that keeps us from achieving our aspiration of having health care for every single American.

It is not a technical problem. It is a problem of will, and it is something that I am not going to sit idly by. So I am looking for every tool, and I am examining every tool available to get us to where we need to go so that every single American has access.

But one step that I just want to get a comment on, and maybe, Ms. Brooks-LaSure, you could comment on this. I, again, looking at every potential tool, but the one that gets mentioned occasionally is this notion of having an option for people age 50 to buy into Medicare, and I wonder if you might just comment a bit more on how you think that would have an impact on cost, how you think it would affect the sustainability of Medicare itself, and what effect it would have on access to care just generally.

*Ms. Brooks-LaSure. Sir, thank you for the question.

As has been mentioned before, I mean, Medicare is a very popular program. Many of the proposals that look to expand Medicare through a buy-in actually keeps the Medicare program dollars separate, so really do look to preserve the Medicare program as it is and

make sure it is sustainable.

I would say that this population, people who are right below the Medicare level, have access to coverage, but many of them are right above the subsidy level, as Tricia Neuman was talking about, really having the most difficulty affording premiums.

So having a stable option across the country would be helpful. I also think it would help the individual market. We have talked about the ACA marketplaces, stability, knowing what the risk pool is like, and one of these issues that we still need to continue to get to is making sure everyone is in the system, especially the young and healthy.

And so by bringing some of the older out of the marketplaces, it could potentially help younger people as well.

*Mr. Kildee. Again, I thank the panel for your testimony.

I yield back the balance of my time.

*Ms. Sewell. The chair recognizes Mr. Boyle.

*Mr. Boyle. Well, thank you, and I apologize in advance if I am out of breath. I just ran over here in record time from voting on the House floor.

Well, first I thank all of you for testifying, but I especially thank Charlie for being here. So please express my thanks.

So much of what we heard today from my friends on the other side is deja vu all over again because literally the same rhetoric was being said at this point 10 years ago as the Affordable Care Act was being debated: socialism, government takeover of health care. They have not gotten to death panels yet in this hearing at least, but that was one of the other phrases.

Rather ironic given that it was a proposal that had its infancy at the Heritage Foundation, and an idea of pooling people together through a series of taxes and tax credits and private insurers would negotiate for their business.

But, of course, even the rhetoric of a decade ago was not new. That was warmed over talking points from four decades prior when Medicare was being debated, and then the charges were socialism, government takeover of health care, Soviet style health care.

So it is, I guess, a sense of progress that some of our friends are now concerned about saving the Medicare program, a program they fought so hard against half a century ago, and --

*Mr. Brady. Will the gentleman yield?

*Mr. Boyle. No.

*Mr. Brady. I do have the vote totals for Medicare. Eighty-three Republics supported it, and the Chairman of the Ways and Means Committee --

*Mr. Boyle. I did not yield, by the way.

*Mr. Brady. -- and the chairman of the Ways and Means Committee, Wilbur Mills, opposed the Medicare plan for most of its debate.

*Mr. Boyle. So I had not yielded.

*Chairman Neal. [Presiding] Would the gentleman yield?

*Mr. Boyle. Yes.

*Chairman Neal. Wilbur Mills voted for the Medicare plan.

*Mr. Brady. After delaying it for concerns.

*Mr. Boyle. Well, if I could continue, I would point out that I would certainly welcome and appreciate the evolution from conservatives on now supporting a government-run health insurance system for seniors. The debate today is about how we expand health insurance for the remaining 30 million Americans who do not have health care.

It had reached a peak of 50 million before the ACA. The rate of uninsured was cut almost in half. So tremendous progress, but we obviously still have progress to go.

Now, I was especially interested for any one of you, but perhaps more so for Dr. Berwick. Since we hear a lot of the scare tactics about things that happen in Britain or Canada with their government-run systems, obviously every other industrialized country guarantees health insurance for its people without necessarily government-run hospitals or doctors as government employees.

If you could talk about that, the models that are used in Germany, France, Japan, I think that that would actually be helpful.

*Mr. Berwick. Every country is unique. No one is first proposing a British model here, which is that the government actually provides care.

*Mr. Boyle. Right.

*Dr. Berwick. We are not talking about Veterans Administration for all. We are talking about a government payment system for all.

All other countries, all of the Western democracies assure coverage. Some do it by having the government be the primary coverer of care, in those Nordic countries, for example. Others do it with a mixture of social insurance policies where the government is the payer, always the payer of last resort. You cannot get left out because government will be there for you.

No other country has a Medicare system exactly like ours so they do not have the opportunity to expand Medicare like we can. This is an American solution for an American context, and it is not a government takeover of health care. That is a complete misnomer.

The health care system we have and know and many people like a lot will remain in place. Now there is a payer that can make more sense to the people who need to be represented.

*Mr. Boyle. This would be actually a nice segue to the second part of what I

wanted to cover, and that is controlling costs. One of the kind of unsung successes of the Affordable Care Act is the way it has been able to reduce the projections of ten years ago in terms of increased cost.

Could any one of you speak to what exactly it was about the Affordable Care Act that enabled that achievement, and then how we could learn from that?

Because even with that success, we spend about 18 percent of our GDP on health care costs. Most projections have us soon going north of 20 percent. I think we can all agree that is simply unsustainable and will crowd out so much other spending. We need to find ways to bring that down.

*Dr. Neuman. As you may remember, the Affordable Care Act included significant reductions in payments to Medicare, and at the time there was a lot of concern about what the effect would be.

The truth is since 2010, Medicare spending has been growing at a very slow rate on a per capita and total basis and relative to private insurance. I say per capital because obviously people gained coverage outside of Medicare. So you would not want to look in the aggregate.

So what that shows is that it is possible and it is within Medicare's history to make changes over time, as could happen in a broader context, that would create incentives for more efficiency without necessarily creating, you know, terrible problems in access and quality, which we have not seen since 2010.

*Chairman Neal. I thank the gentleman.

With that let me recognize the gentleman from Texas, Mr. Arrington, to inquire.

*Mr. Arrington. Thank you, Mr. Chairman.

And thank you, panelists and especially Ms. Wood for your story, very personal, and your sweet daughter. Thanks for coming and sharing with us.

We do not want what you went through to happen. Nobody up here does. Do not believe anybody that tells you that Republicans or Democrats do not want access to the highest quality and affordable care for all families in this country.

The question is, how are we going to do that? What is the best way to go about that to achieve that desired outcome?

And I believe as a great Nation with the sacred words written in the Constitution "provide for the general welfare of the public," that it is our sacred responsibility as a great Nation to provide access to quality and affordable care. I want you to understand that, and I want everybody to know that.

And it is complicated. Okay? It is complicated, and when you are dealing with the health and wellbeing of people's families, that is a sacred, sacred issue, and those are special precious decisions that we guard jealously when we are talking about the health and wellbeing of our families.

So we have got to get it right, and I fundamentally, fundamentally do not believe that government controlled, socialized health care is the answer. I think it is a big part of the problem of the cost and lack of access that we are experiencing today.

And I think that if we have health care organizations and provider groups actually competing for our business and service as patients and we actually have transparency in the system, I think that we will actually get better quality, and I believe the cost will actually come down.

Now --

*Ms. Wood. May I say something?

*Mr. Arrington. The quality -- let me just finish please -- the quality of care in those countries that have adopted this socialized medicine system has actually decreased substantially in terms of wait times.

I have just seen, Ms. Turner, numbers like 2 months for MRIs, 10-month waiting for ultrasound, 5 months to see a specialist.

Are you familiar with these other countries and the systems that the Democrats have proposed to replicate in terms of the socialized medicine system of health care?

Are you familiar with the wait times and the lack of access that they are presenting the patients in those countries?

*Ms. Turner. Absolutely.

*Mr. Arrington. Would you elaborate on that?

*Ms. Turner. I recount a lot of that in my testimony about the waiting times for access to primary care, the waiting times for surgery, the waiting times to get into hospital emergency rooms, the lack of quality because the global budgets really force hospitals to decide should we keep our doors open even.

And there have been reports in Canada that if you have a surgery scheduled in December, you are probably not going to get it because the hospitals have run out of --

*Mr. Arrington. Are you familiar with patients in those countries who have serious or complicated medical issues seeking services in the United States because of the quality of care?

And I am recognizing that the cost is too high, that the current system is inadequate, but are you familiar with folks who are trying to get out of their system and into ours so that they can have some of these more serious procedures done?

*Ms. Turner. Yes, because access to private insurance is outlawed in Canada, for example, and so many Canadians will come to the Mayo Clinic, for example, across the border in Minnesota and get care.

In fact, it is not an insignificant part of their patient population, is people escaping the Canadian system because they desperately want care, quality care, and they come to the

United States.

*Mr. Arrington. The most comparable model in the U.S. that I can fathom that is akin to this Medicare for All is the single payer system that we have trapped our veterans in. I spent my first term on the VA Committee, and I was blown away by the lack of access.

They were just coming off these reports from Inspector Generals and the GAO whereby veterans were waiting in line for months getting sicker, some even dying. These are the folks that we call heroes. These are the people who risk their lives, and we stuck them in a system that is broken.

And the only way to fix that was not to throw more money at it, but it was a bipartisan effort to give them a ticket out of that government monopoly and that bureaucracy that was not serving them. And they got paid whether they served them or not.

And I just worry that we are trying to in one fell swoop push every American into that same model, and it would be an epic failure.

I yield back, Mr. Chairman.

*Chairman Neal. I thank the gentleman.

Let me call upon the gentleman from Virginia, Mr. Beyer, to inquire.

*Mr. Beyer. Mr. Chairman, thank you very much.

I think, Dr. Neuman, I direct this to you. We have been listening all morning to horror stories about the cost to taxpayers of Medicare for All or horror stories about how underpaid doctors are not going to want to go to med school, and therefore, what is going to happen is all of the rural hospitals are going to fail, or wait times.

I had extensive experience with the health care systems in Spain, Italy, and Switzerland, and I have never yet had to have a wait time as long as the typical visit in

Northern Virginia. Usually it is instant, and excellent care.

I am baffled about how the richest Nation in the history of mankind with low unemployment, a strong economy, virtually no government corruption cannot afford to do what every other developed nation in the world can do.

What is wrong with the United States that we cannot provide the basic level of care that every other country has figured out how to do, and especially when we are the champions of human rights, life, liberty, and the pursuit of happiness?

We are the ones, the first Nation in the history of mankind to elevate human rights, and now we are saying we are going to be the only one that does not say that health care is a human right.

*Dr. Neuman. People may disagree about how to do it. Not everybody supports Medicare for All. Not everybody supports the status quo, but that does not mean that there are not ways of getting to universal health care, health coverage, and making health care more affordable.

Really that is a matter of public will and policy intent. So those are political decisions that could be made, just have not been made.

We have come a long way in this country with Medicare and Medicaid and the ACA. The question is how to get across the finish line and what are the steps that it will take to do it in terms of both health insurance and making health care affordable.

Because what we have seen is it may be necessary to have coverage, but not sufficient. So there are two major goals that still need to be achieved.

*Mr. Beyer. I just want to push back a little bit, too. As a businessman, I just checked. We spent \$1.4 million, our little family business, last year as our share of the health insurance premiums. So I look and say those people competing against us overseas have an enormous advantage because that is not built into their cost structure.

*Dr. Neuman. Right.

*Mr. Beyer. And that was one of the big deals that put the Japanese ahead of Detroit for all those years in the 1970s, 1980s, and 1990s. They had a 2 to \$3,000 cost per car differential just in the health insurance costs.

*Dr. Neuman. Right, and the Medicare for All and the Medicare for America or Medicare for America would give employers the option to continue to provide coverage or make a contribution to the public plan, but the idea in both of those plans is it could free up dollars for employers to potentially increase wages or use funds in other ways.

*Mr. Beyer. Dr. Berwick, so you ran CMS. So I have listened all morning while people have said, "My constituents love Medicaid. My constituents love Medicare. My constituents love the VA. My constituents love Medicare Wrap-around, but do not take away any of those government-run programs and give us a new government-run program."

Why is a faceless bureaucrat in an insurance company motivated by maximizing profit going to give you a better decision than the faceless bureaucrat working for the government whose job is to make sure you get the proper health care?

*Dr. Berwick. They will not. I mean, running Medicare was the greatest privilege of my career, but the sense of accountability was there. Everything I did we had to do transparently. We were accountable to you, Congress. We were accountable to the public.

Private insurance companies are not. Their decisions about what to cover and what not are made behind closed doors, and I do not think those decisions are better than what we were able to make in Medicare.

And, by the way, with respect to Congressman Arrington's comment about competition, Medicare, a single payer, can induce competition because we can go to the market, and we are not taking over provision of care. We can actually take the position as single payer to increase competition among those that give care, which is exactly what we

did.

*Mr. Beyer. Which is one of the things when I look at Medicare for All, and it is not limited. Our family business almost inevitably leads to some restricted number of physicians who can provide these various services as opposed to Medicare for All where I can go to the best doctor I can find.

*Dr. Berwick. A prescription away, yes, and you as a business would end up paying less.

*Mr. Beyer. Yes. So one more question. The 17 percent of our GDP we spend on health care, what percent of that do you think represents private insurance company profits?

Well, it is an interesting question.

*Dr. Berwick. It is hard to say. We know that transaction costs of the private insurance, 15 percent of that bill on the commercial side is transaction cost being paid because of the complexity of the commercial insurance system. Medicare is 2 percent.

*Mr. Beyer. My doctors often complain about having to manage all of the different systems. Just simply having one system is going to save an enormous amount of money.

Mr. Chairman, I yield back.

*Chairman Neal. I thank the gentleman.

Let me call upon the gentleman from Pennsylvania, Mr. Evans, to inquire.

*Mr. Evans. Thank you, Mr. Chairman.

I want to follow a little bit on the State of Washington. I am very interested. I am interested to know what you have found to be the most beneficial in implementing universal health care in Washington State, and if there are any changes you think Congress should make to strengthen ACA.

The things that you consider because you have experience, evidential base. Talk a

little bit to me about what kind of recommendations you would make to us.

*Ms. MacEwan. This is for implementation of the public option?

*Mr. Evans. Either one, public option, ACA. You talk about your experience.

*Ms. MacEwan. Right. In Washington, we are fortunate in that people have worked together on health care for a long time. So we have some experience at it, and I think a balanced approach which focused on affordability, quality, and access, making those a value, stabilizing the market, doing the regulations with the consumer in mind are really important, and then being able to make the tough decisions about, for example, how we responded on cost sharing reductions, being able to do the Silver loading.

We did that. We made those decisions in a very transparent, open way, kind of keeping the consumer in mind all the way.

I think as we kind of go forward, I think we have long-term solutions that are in front of us, and then I think we have short-term things that we can do right now. And I do not think those things are incompatible at all.

I think working on reinsurance, allowing States to innovate through ways like the public option are incredibly important to help people who are hurting right this minute and having a hard time affording to pay for their health care.

*Mr. Evans. So if you were sitting here and knowing the way the situation is and understanding the policy divide and everything, the first thing you started off with is the people work together.

Suggest, throw us ideas.

*Ms. MacEwan. I am very encouraged by some of the proposals to shore up the Affordable Care Act, and I think I would really encourage you to continue to work on those, and I think this dialogue about the more long-range solutions is very important.

And it is hard. People disagree, but I think it is important to keep having the

dialogue and keep moving those proposals forward as well.

*Mr. Evans. Ms. Wood, thank you.

I am going to sort of ask you the same question in a different way. Obviously as a patient, if there is one thing or one idea, one ask that you need members to walk away with today, what would that be.

*Ms. Wood. The one idea I want you to walk away with is coverage does not equal access. I am priced out by copays and deductibles and even exclusions in policy.

Coverage does not equal access.

And also earlier I did not get to address Mr. Arrington when I wanted to, and I just want to point out that Medicare for All is not socialism.

Thank you.

*Mr. Evans. I yield back the balance of my time, Mr. Chairman.

*Chairman Neal. I thank the gentleman.

Let me call upon the gentleman from South Carolina, Mr. Rice, to inquire.

*Mr. Rice. Thank you, Mr. Chairman.

Ms. Wood, thank you so much for being here today, and thank you for sharing your story.

I did want to point out to you though that you were talking about the paperwork and the troubles that you had getting your insurance company to cover care for your daughter and yourself, and I just have to tell you that dealing with government health care, if you think the paperwork and the requirements are going to go away, then you really have not thought this through.

Dr. Berwick, I have to tell you that your assertion that this would not be a government takeover of providers, it would only be the payer, I can promise you that if there is only one payer and he tells that doctor what services that they will pay for and what

they will pay for those services, then absolutely the government will be the sole provider in the country. And so your assertion that that would not be the case is not very well thought through.

You know, our promise --

*Ms. Wood. May I respond?

*Mr. Rice. -- with the Affordable Care Act was that the primary focus of that, in addition to covering more people, was that we would bring costs down.

Now, let's look at what happened. We had 85 percent of the people in the country were covered before the Affordable Care Act, 60 percent by employer-provided insurance, and the others by private insurance, Medicare, and Medicaid.

After the Affordable Care Act, at the peak, three years after the Affordable Care Act, we moved to 91 percent. So we covered 6 percent more people.

Well, that is great. I am glad. I wish we could cover 100. We were at 91 percent, 6 percent more people.

What was the cost of that? The cost of that was that the average insurance premium, despite the President's promises that it would reduce the cost of the premium by \$2,400 a year per family, went from \$220 a month to \$470 a month in three years. It went up over 100 percent, 130 percent.

So that is the effect of all these government mandates on health care, and our response to that is, well, insurance is still too expensive, and despite the fact that we put government mandates on it and that made it more expensive, our answer, our solution to that is we want more government control and more government mandates because this time it will work. This time it will be cheaper.

And that is obviously misguided and ridiculous.

You know, when people ask me about Medicare for All, I say I have got two words

to respond to you, and those words are Veterans Administration.

We already have a government health care system. I have a guy named Barry Coates who lives in my district. He came to visit me -- I do not know -- my first year in Congress, and he had been fighting with the VA. He was having problems with his colon. He wanted a colonoscopy, and the VA did not have the resources or the doctors readily available. So they put him on a long waiting list, and the problems were getting worse.

He finally came to my office, and we got him sent to an outside provider, and sure enough, he had colon cancer. He had been trying to get a colonoscopy for a year and a half, and he died at 42 years old, a veteran, my district.

My district staff, I have seven people in my district. We have done an analysis. They spend 45 percent of their time dealing with the VA, 45 percent of their time.

Eighty veterans in Phoenix died because bureaucrats in the Federal Government lied on their forms to say that people had been treated who had not been treated, and these problems with the VA are not new. This has been going on for 100 years.

And I promise you if you put every American on a government-run health care system, it will be exactly the same thing.

Right now, you know, we are a model of innovation in the world. Pharmaceuticals, the pharmaceutical industry, the way it has evolved, all the innovation is coming out of our country, and I promise you when government gets involved and they say, "Look. We do not care what kind of cancer drug you come up with. We are going to pay you \$200 a pill," innovation will disappear.

So that is what scares me. I wish there was a magic wand. I wish there was a magic wand that I could wave and make health care free for everybody. I am reminded of the quote from Ronald Reagan who said you never know how expensive something can be until the government gives it to you for free.

I was recently in the Czech Republic, and they have a museum to communism, and I went through that museum. It talked about shortages of basic items when the government runs things, and there was a quote from Winston Churchill, and he said, you know, put the Commies in charge of the Sahara Desert and in 5 years there will be a shortage of sand.

I promise you with government-run health care there will be wait times. There will be less quality. There will be less care.

I yield back.

*Chairman Neal. I thank the gentleman.

Let me call upon the gentleman from Illinois, Mr. Schneider, to inquire.

*Mr. Schneider. Thank you, Mr. Chairman.

And I want to thank the chairman and the ranking member for holding this hearing today, and I want to thank all the witnesses for your time here, your perspective, your patience as we go through this issue which is critically important to all Americans.

In particular, Ms. Wood, you and Charlie, thank you for being here. Thank you for sharing your story. Thank you for having the courage to tell us your experience and helping us understand what the implications are when the system fails.

I cannot think of a better example of someone who did everything right and still got stuck in the endless stream of unreasonable medical bills. So I just want to personally thank you.

And I want to reiterate points that my colleagues have already made and something that is very clear. I think Congressman Lewis from Georgia said it very clearly. Health care is a right, and that Democrats, all Democrats are unified in the support of universal coverage.

That was the goal when Congress passed the Affordable Care Act, and it is still, without question, our goal today as we have this hearing.

At the same time, I think we all agree that our health care system is not working for the American people. The Affordable Care Act, while a step forward, still has many problems, some of which, many of which are the result of deliberate sabotage by this Trump administration and opponents of the law.

But that does not change the fact that there are nearly 30 million people in our country today who do not have insurance, and even those with comprehensive coverage, like Ms. Wood, find that their insurance is still unaffordable with the high premiums and skyrocketing deductibles.

So I am very happy that we are having this hearing today to examine this issue and study different proposals on how we achieve the goal of universal coverage. This Congress is working as it should through regular order.

And I want to use this hearing to understand the tradeoffs on these different proposals as we have had this discussion today. There are tradeoffs to keeping our current system and improving the ACA, pursuing the public options, and to broader reform like Medicare for America and Medicare for All.

That does not make these bad ideas, and it does not mean, as you mentioned, Dr. Berwick, the challenges are insurmountable. But only by understanding these programs and the tradeoffs within them can we make the decision on the best way to achieve our goal, which is, again, universal coverage for all Americans.

I have questions about all of the options, which I plan to submit for the record, but due to time today I want to focus on Medicare for All because that is the topic many of my constituents reach out to me the most.

Dr. Berwick, I want to give you the opportunity to respond to some of the concerns, many including myself, have about the proposal.

My biggest question at the moment is the lack of pay-fors in Medicare for All,

which I know you touched on in your testimony, Dr. Berwick, and it is something that I believe still needs to be fleshed out further, but I want to pivot to another question that has been raised.

My understanding with Medicare for All, as it is written, it would largely preserve our fee-for-service system, which at times can encourage overutilization, low quality and poor outcomes. The ACA intentionally moved away from fee-for-service payments and moving more to outcomes focus.

We are seeing some of the rewards from this shift already. How can the Medicare for All system encourage value?

And are there any changes you would like to see in the current proposal?

*Dr. Berwick. Well, I speak for myself. I am not a sponsor of a piece of legislation.

I think one of the reasons to have consolidated payment, Medicare for All, is that we could then change the payment system to migrate away from fee for service.

Fee for service drives everyone crazy. It keeps doctors on a gerbil cage. It keeps hospitals running machines that they do not really want to. It keeps beds full.

We need to stop that, and right now we are having a lot of trouble in this country migrating toward value-based payment really, where we are really going to begin to buy wellbeing and health and good experiences and proper outcomes.

We cannot do it in a very complex payment system, and it drives people crazy. In Medicare for All, we could. So I do not think Medicare for All should be a formula for preservation of fee for service at all. I think it should be used as leverage toward getting health care to pay for value and what physicians and hospitals really want to do for people, for keeping people at home instead of hospital beds.

So to me it is the potential for change that we cannot achieve in this crazy

pluralistic payment system.

*Mr. Schneider. Let's go on just because of time.

At its core, health care is local. One of the things I say is that everyone should have the care they need when they need it, where they are.

We have our neighborhood doctors, community hospitals. That means markets are very different across the U.S. We have challenges appropriately targeting payments under the current law. I hear from providers that Medicare does not cover their cost.

In an approved coast-to-coast system, how do we account for the regional differences while still containing cost?

*Dr. Berwick. That is a great question. I wish we could get into details of design --

*Mr. Schneider. You have 10 seconds.

*Dr. Berwick. -- as we should.

[Laughter.]

*Dr. Berwick. Medicare has a regional structure, but it is not exploited properly. When I was Administrator, I visited every region. The regions are fantastic. They are more in touch with the physicians and nurses. They know more about what is happening in the hospitals, and they are more in touch with the localities.

So if I could design Medicare for All, it would beef up regional autonomy in the Medicare system and let the texture of the administration and policies be more molded to what is actually happening in the localities.

I think that could be done.

*Mr. Schneider. Thank you.

I have gone over my time. I yield back.

*Chairman Neal. I thank the gentleman.

Let me call upon the gentleman from New York, Mr. Suozzi, to inquire.

*Mr. Suozzi. Thank you, Mr. Chairman.

This is such a complicated topic. We are obviously not going to solve it all today, but I want to thank all of you for the time that you have put in here today and the time you took to get here and to work on this.

People are so sick of us sniping with each other, you know, the Democrats and Republicans, and they are just sick of it. It is not like the Democrats are winning, the Republicans are. We are all losing.

People are sick of politicians. They are sick of us not just sitting down and working this stuff out.

And, Ms. Wood, what you talked about today, you know, you represent so many millions of people in America that you spoke for today because there are so many people suffering with so much anxiety and so much fear about what am I going to do to take care of my family; what am I going to do to take care of myself?

And that is what this is about. This is not a small, petty, cynical topic that politics is made out to be in today's world. This is life and death for people. This is serious business, and we really need to elevate the conversation.

I thank you so much for helping us to recognize that you are not alone and there are so many people that really you represent today. So we are so grateful for you and Charlie for being here today.

Dr. Neuman, I just want to clarify some facts. The numbers always jump around. I think you would be a good source to help with this.

Right now there are how many people in America that you would say get their insurance from their employer?

*Dr. Neuman. About 160.

*Mr. Schneider. Okay. I have always put 175 million. So we are close.

*Dr. Neuman. Million. Sorry.

*Mr. Schneider. One hundred sixty to 175 million.

And there are about 100 million people who get their insurance from Medicare and Medicaid, would you say?

*Dr. Neuman. About 120 million.

*Mr. Schneider. Oh, okay. And there are about 30 million people still uninsured in the country?

*Dr. Neuman. Correct.

*Mr. Schneider. And there are about 15 million people who get their insurance from the private marketplace, the individual marketplace?

*Dr. Neuman. Nine group markets, many of whom are in the marketplace.

*Mr. Schneider. And that is where we hear all of these horror stories about skyrocketing premiums, people pulling out of the market. That is that subset of 15 million people, which is really where we hear all of these awful stories about what is going on.

And I am going to ask you in a little bit, Ms. MacEwan, about some of the short-term fixes that we need to address what is going on in the individual marketplace.

So 330 million Americans, all different status as to what is going on with their insurance. So right now Kaiser, I think, has done polling on how many people like their insurance the way it is now. Is the number as high as 70 percent of the people in America like their insurance?

*Dr. Neuman. I have not looked at the number recently, but people tend to like their insurance. The issue comes about what happens when people are sick.

*Mr. Schneider. Right.

*Dr. Neuman. That is really the issue. Most people are satisfied with their coverage. People adore Medicare. You know, you cannot take people --

*Mr. Schneider. Well, one of the reasons there is a lot of demagoguing on different solutions is that people try and make people who like their insurance now have fear that you are going to take away what they like already. So that is one of the big challenges we face here, is when people demagogue instead of trying to work in good faith to actually try and figure out this issue because they create fear in people's lives.

So I do not think we are going to get to the long-term solution today that will address all of the things that Dr. Berwick said to try and improve everyone's care, improve everyone's health, reduce their cost and coverage for all. I think anybody of good faith, that is what everybody's objectives are.

Dr. Berwick, what you laid out, I think that is everyone's objective.

But, Ms. MacEwan, what are those short-term improvements you talked about so we can mend, not end, the ACA?

What do we need to do especially in that individual marketplace?

*Ms. MacEwan. I think reinsurance, which was reinsurance, which was a program that was in it about 3 years ago, is critically important. Our State looked into it a year ago, and we could not afford it.

Some States like Maryland and Minnesota have been able to go forward, but those States have the funds. Most States cannot afford to do that.

This is something where Federal help is absolutely --

*Mr. Schneider. So reinsurance is a big short-term fix. How about subsidies for people?

*Ms. MacEwan. Affordability is the most critical thing, and there is a cliff right now. When people hit 400 percent of FPL, they are cut off. They cannot access subsidies anymore, and there are a lot of middle class families that are being hurt very badly, and they are paying far higher percentage of their income than they should be for their health

care.

*Mr. Schneider. The short term, reinsurance, subsidies for the individual marketplace could make a big difference in a lot of people's lives that are freaking out right now.

Now, how about something more dramatic? I want to know from you, Dr. Berwick. How do you feel about the public option?

I know you are a Medicare for All pusher, but how do you feel about the public option?

*Dr. Berwick. Better than we have now. I wish we had one. I think we would be learning a lot if we had a public option about what it does to risk pools and so on.

I'm a little worried about the public option for a kind of technical reason. Insurance companies want to provide insurance to people that do not need it. That is how they make money. And so anything that can be done to game risk so that --

*Mr. Schneider. The public option would be used by all the people who really need the insurance the most.

*Dr. Berwick. Yes. Insurance companies would then try to find ways to have people who really need care go to the public option, which would be a good business case for them, and that is not good for the country.

*Mr. Schneider. Ms. Brooks, do you like the public option?

*Ms. Brooks-LaSure. I think there are a lot of the benefits that we are talking about that would be achieved through a public option.

As you know, the House thought about one in the ACA. I think it could go a long way to lowering premiums and making coverage more affordable today.

I also think having a stable option across the country is a very important measure.

*Mr. Schneider. Thank you so much.

Ms. Turner, I wanted to ask you about the public option, but I have run out of time. I am sorry.

*Chairman Neal. The gentleman's time has expired, but we thank him for his commentary.

With that let me recognize the gentleman from New York, Mr. Reed, to inquire.

*Mr. Reed. Well, thank you, Mr. Chairman.

And following up on my fellow New Yorker's comment to preface this, I agree. The American people are sick and tired of this rhetoric, and on this committee, we have prided ourselves for years to not engage in that type of rhetoric.

We have a passionate disagreement on a philosophical approach on how to solve problems, but at the end of the day we do not question the motives of the other side.

And what I will offer today is I am not questioning the motives of the folks that are putting forth the proposal of Medicare for All. They want to have a better health care opportunity for Americans.

As a Republican, I am offended that I get accused of not caring about Americans. I get offended that all I hear in Washington D.C. is I am here to feather my pockets and that all I care about is the almighty dollar.

When I was holding my mother, nine months to the day she got diagnosed with lymphoma and passed in my arms, I can assure you I worry about the American condition and the American individual as they face health care issues in America.

As I hold my 18-year-old son at 4 years of age when is diagnosed with diabetes in the emergency room, I know that experience. So do not question my motive about what I am trying to do here to fight for a new health care system in America.

I want a system that is better. I want a system that responds to the American voice that says these costs are killing us, literally.

So how can we get to a system that lowers cost I think is common ground, and that is not just cost of health insurance premiums. That is the overall issue of health care cost itself.

And so when we talk about government solution, such as what Medicare for All is at its heart fueled by, we had better go into this eyes wide open. You are talking about taking away the choice of an American who chooses to elect their private health insurance through their employer.

You are talking about turning over America's health care system to government bureaucracy. That is just the truth, and I will tell you I am opposed to that.

I am opposed to that because I have experienced the American government bureaucracy, and I think most Americans have, too. When you show up at the DMV, you show up at the Social Security Department where I am the Republican leader on Social Security, and it is 5 o'clock, the door is closed. If you are facing a health care crisis, who are you going to call in the government at two in the morning?

I know when I go to my pharmacist, when my mom needed her morphine drug, I called our local pharmacist guy. I knew him, and he met us down at the pharmacy at 2 o'clock in the morning to give her her pain medication. Who in the government is going to do that? Who in the government is going to do that?

So I appreciate the Utopic idea of what is being proposed by this panel, but I live in the real world, and what I am really interested in is finding a common ground on how we get these health care costs under control.

And how do we give folks in America, those individuals the opportunity to choose their health care rather than us in the ivory towers of Washington, D.C. to say to them, "We know what is better. We in the government will take care of you"?

So, Ms. Turner, could you comment? Am I missing the heart of Medicare for All in

regards to we are turning it over to American government-run system?

Is this somehow magically a private health system that is going to exist within the bureaucracy of the American government?

*Ms. Turner. Medicare already has several hundred thousand pages of rules and regulations. I cannot imagine that that would not be duplicated for Medicare for All.

So it will be a bureaucratic, government directed health care system in which choices would be determined in Washington, and people would have to appeal to political leaders in order to get the care they need.

*Mr. Reed. And those political leaders, now you raise a point here, Ms. Turner, that I am concerned about. For all of the people that are advocating for a government to have this power, those political leaders may not be the political leader that you voted for. Is that not true/

*Ms. Turner. That is correct.

*Mr. Reed. That could be a political leader that you are adamantly opposed to like many are adamantly opposed to the individual who sits in the White House as our President of the United States.

Do you want to give more power? So if we do this, we had better go eyes wide open that you are empowering those elected officials with this precious power over your health care life.

Am I missing something?

*Ms. Turner. No, that is so correct. People want more choices. They want to be in control of decisions. They want more transparency.

You do not have to sell health coverage if it is affordable. People want it. We have to figure out how to make health care and health coverage more affordable and induce the kinds of market mechanisms that we have seen in the rest of the economy in the health

sector.

*Mr. Reed. I appreciate it. Thank you.

I yield back.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from California, Mr. Panetta, to inquire.

*Mr. Panetta. Thank you, Mr. Chairman. I appreciate this opportunity, and to Ranking Member Brady, and specially the witnesses who have come here and are testifying based on their expertise, their knowledge, but also the preparation that you have done to be here. Thank you very much for that.

I appreciate this type of hearing because as a former prosecutor, it is about the evidence. Emotion is important. We understand that, but what it comes down to is about the evidence, about the facts. That is how you prove your case.

And what you have done today is allowed us to basically gather information, gather that evidence, gather these facts upon which we can continue to prove our case to expand coverage and hopefully, hopefully, reduce costs for all Americans.

Now, being from California, the central coast of California to be exact, we have done a pretty good job implementing the spirit and the letter of the Affordable Care Act, which has been to the benefit of millions of Californians, hands down.

But I think we know that we have got a long way to go. Do not get me wrong. The uninsured rate in California was reduced from 17.2 percent to 7.2 percent.

But I hear it from a lot of my constituents. They are worried about the cost of their insurance premiums, the out-of-pocket costs, and of course the drug prices. So clearly, we have a lot of more work to do.

But the problem is that there are certain counties, especially in my district that just are not getting a lot of the benefits, unfortunately. In Monterey County, which has a 9.9

percent uninsured rate, which is above the State's average, we basically have only one provider on the individual market.

A similar story can be told for San Benito County, another county in my district, which has an uninsured rate of 8.1 percent and has only one insurer on the individual marketplace.

And so the lack of competition in these two counties clearly, and I hear it over and over, has left my constituents unable to shop around on the individual market, and instead they are left with unaffordable health care plans and high premiums with high deductibles.

Now, it is a rural county, what I have. Agriculture is the number one industry, and so, Dr. Berwick, obviously one of the concerns I have, especially when it comes to single payer system, is the effect that it would have on rural hospitals.

Many facilities in my district and who I have spoken to, they run on thin margins and could likely face considerable financial difficulty if payments were reduced through a single payer.

Talk to us. Tell me what are some of the strategies how we can limit the negative impacts of a single payer system on these types of rural providers.

*Dr. Berwick. If we committed to the goals that I talked about, universal coverage, better care, better health, and lower cost, and we used the single payer system to do that, it does not mean that it is a one size fits all payment system. That payment system can be sensitive to local context.

In running Medicare, we took a lot of effort to understand and try to meet the needs of critical access hospitals, rural hospitals. We worked hard with safety net systems. You do not have to have a one size fits all payment policy. That is a misunderstanding of the function of the agency that would be in charge.

Congress would need to give guidance as to exactly what the texture of its intention

is in setting up such a single payer system. Do you want critical access hospitals to thrive? Then it becomes the job of that single payer to make sure that that happens. And that is the way I think about it.

The amount of data that one would have, by the way, the ability to consolidate information so you can meet needs that are local would be phenomenal in that kind of system as opposed to the opacity we have right now.

*Mr. Panetta. Great, great. Thank you. Thank you. Thank you for those facts.

Dr. Neuman, if I could, obviously, one of the things that also hurt my district and also hurt California has been the reduction of the individual mandate's effect on premium prices. In California, rates were increased between 2.6 and 6 percent in 2019 as a result of our government's actions to zero out the Federal individual mandate penalty.

What are some of the most important steps that we can take at the Federal level to help California, and obviously other States, who have seen these types of premium increases on the individual market?

How can we bring these premiums down?

*Dr. Neuman. Well, one of the things we have talked about is the fact that the navigators have been defunded essentially, and having navigators funded would help tell people more about health insurance so that people who left the marketplace because they did not think that the mandate would be enforced might then know that they could get coverage. They might be eligible for subsidies.

Many people who are now uninsured are actually eligible for subsidies but may not know it. So that would be a big thing that you could consider.

I also wanted to mention because you were talking about the fact that there was only one insurer in certain areas, some of the public plan proposals that are out there would sort of start the public plan in areas that currently do not have any competition.

So that might be something that would be helpful.

*Mr. Panetta. I appreciate that.

Once again, thanks to everybody.

I yield back, Mr. Chairman.

*Chairman Neal. I thank the gentleman.

Let me call upon the gentleman from California, Mr. Gomez, to inquire.

*Mr. Gomez. Thank you, Mr. Chairman.

For me health care has always been a personal issue just like millions of Americans. I grew up without health insurance almost my entire life, until I got out of college. I know what it is like when you get sick or you get injured and your parents have to worry what they are going to do with you.

Are they going to wait to see if you get better or are they going to rush you to an emergency room to get what bill that you cannot afford?

I have seen them make those decisions. When I was 7 years old, I ended up in the hospital with pneumonia, spent about a week in that hospital, and with the missed work shifts because my parents worked five to six jobs a week to make ends meet, with the new hospital bills, it almost bankrupted my family.

And I know that because siblings later that year told me that we were not getting presents for Christmas because of the hospital bills.

So this is an issue, right? This is before the Affordable Care Act, and since then we have had millions of Americans covered through Medicaid Expansion or Medi-Cal, as it is called in California. It covered California. The marketplaces have been established, and you have seen improvement.

But the improvements are not enough. I have a constituent, Janetta Costa, who passed away from cervical cancer, and she had private insurance. But when she tried to

make an appointment when she knew something was wrong, she could not get an appointment.

So where did she turn? She turned to Planned Parenthood, who got her in the door quickly, and once she got in through the door, they did the test. But unfortunately, that test showed that she was at Stage IV cervical cancer, and she would lose her battle with this disease.

Now, to say that everything is peachy keen and everybody has access is missing the point. And then at the same time, people say, "You know what? We are for providing health care. We care about these Americans."

But then why are you trying to repeal the Affordable Care Act, not, you know, once, twice, but almost 70 times trying to repeal the Affordable Care Act? That is, in my opinion, shameful.

So we are having discussions on how to make things better, and I know a lot of my colleagues have used over-the-top rhetoric to try to scare people, especially seniors.

Dr. Neuman, can you talk about how these proposals would actually expand benefits for seniors and people with disabilities?

*Dr. Neuman. Yes. Thank you for that question.

These proposals, the Medicare for All proposal, would absorb the current Medicare program, and people on Medicare would pay no premiums, no cost sharing, but it would also fill some of the significant gaps that result in very high out-of-pocket costs.

Dental, you have heard about the cost of dental and the problems of not having dental coverage. Vision, but the big one is long-term services and supports, which most people on Medicare really cannot afford.

Median savings for a person on Medicare is something like \$75,000. So if you have a nursing home expense or if you have multiple years of needing someone at home, people

cannot afford it.

And so what these proposals do is they fill these gaps so that people can afford the care that they need and reduce cost sharing requirements.

They also, by the way, would extend to other people protections that are in Medicare, like no surprise bills, right? Medicare protects people against that, a broad network of providers. So it does more for people on Medicare, but extends the Medicare protections that has made Medicare so popular to younger people as well.

*Mr. Gomez. So you think the criticisms and the rhetoric that have been used that seniors should not worry about their health care if these new proposals come forward?

*Dr. Neuman. I think under these proposals they would get a lot more. They may pay more in taxes, but they would certainly get more in benefits.

*Mr. Gomez. Thank you.

As I mentioned, health care is personal, but it is also personal for my district. I have 74 delivery sites for community health centers, 10 hospitals. These centers play a critical role.

Ms. Brooks-LaSure, how would the proposals we are discussing today impact community health centers?

*Ms. Brooks-LaSure. Thank you also for the question.

I think, you know, when we are talking about reimbursement and providers and access, something that people often forget about is that community health centers are actually better paid often through the Medicare program than they are in the commercial market.

And many of the proposals that are under discussion today certainly still have employer-sponsored insurance and private insurance companies operating. They just have more requirements to make sure they are covered.

One of the things that the ACA did was make sure that community health care centers would get funding and also be a part of the plans when people were enrolling in, and a lot of these proposals would continue to build on that and make sure that people could have access at community health centers.

*Mr. Gomez. Thank you so much.

My time is up. So I will yield back to the chair.

*Chairman Neal. I thank the gentleman.

With that let me call upon Mr. LaHood to be recognized.

*Mr. LaHood. Thank you, Chairman Neal and Ranking Member Brady, for having this hearing today.

And I want to thank all the witnesses today for your valuable testimony.

And, Ms. Wood, thank you for sharing your personal story with your daughter and your passion. I appreciate that very much. I think it is an important part of this debate.

And I have enjoyed this debate here today in looking at this proposal of Medicare for All and the different dynamics and how we as policy makers digest that and think about, you know, what we can do differently or how we can do things differently.

And as I listen to it, you know, I think about how are we going to pay for this, and that is the thing that foundationally keeps coming back. We are \$22 trillion in debt, and when I go back to my constituents in central and west central Illinois, hardworking people that play by the rules, but they fiscally ask, "Where are we coming up with the money to do this?"

And in fact, if we look over the last 10 years, we have gone from about 9 trillion to 22 trillion, the vast majority of that under the last administration. So we have not had a good track record of being fiscally responsible in Washington, D.C.

So to think about this proposal or a variation of these proposals, the government is

going to take over health care and how that is going to work. It is frustrating to try to digest that and go through that.

And so foundationally, I am not convinced, and I think there are a lot of people that are dubious and skeptical of how you do that, with a track record that has not worked with the government being involved. So I will just say that foundationally.

I want to pivot a little bit. This has come up throughout the hearing today. I represent a rural district, central, west central Illinois, and access to health care services are already a challenge in rural America.

The health needs of rural America are very different from those living in urban settings. We know that. The ability to travel to care or have access to specialty providers is very different for those living in rural areas compared to urban settings.

A one size fits all model does not allow for consideration of the unique needs of rural communities, and that will hurt rural America.

In my district, nine of the 11 hospitals I represent are either critical access or sole community hospitals. These hospitals fight every day to keep the doors open to patients, and without these hospitals, many of my constituents would be hours away from care.

One hospital in my district has 70 percent of their operation supported by the Medicare patients they serve. A transition to Medicare for All system would mean that they could not sustain operations, if they had to operate 100- percent on the one size fits all payment system without the support of the private market.

This would leave their communities without a sole community hospital. To add to this overarching concern of rural hospital closures, one provision of the leading single payer bill in the House that I want to point out would further harm the providers that could manage to stay open.

Under this Medicare for All bill, the government would control the hospitals, their

finances, and their ability to renovate and secure new technology. Funding would come from a capped global budget and no funding is guaranteed for capital expenditures. All funding must be approved by an unelected bureaucrat known as a regional director under the Secretary of HHS.

Institutional providers like hospitals would be prohibited from using any funds in a lump sum they receive from the federal government for capital expenditures, including renovations and facility upgrades necessary to improve patient care.

Instead they would have to apply for or plead their case to the government for approval of funds simply to renovate their facility to improve care for patients. So if my hospital does not qualify, according to whatever standards the Secretary of HHS decides to set or maybe it does not qualify, but the Secretary of HHS and its regional director denies the request for funding, a community will be left to perish with no way to renovate or expand their facility in order to make improvements and properly care for their patients, and that is a concern to me.

Ms. Turner, is it correct that under the Medicare for All health care providers and their local community of patients in need would be left to the mercy of Washington bureaucrats?

*Ms. Turner. As you say, in Congresswoman Jayapal's bill it does explicitly say that hospitals would have to petition Washington in order to be able to make capital improvements to their hospitals.

I think that is really indicative of the "Mother, may I" approach that people really want to move away from. They want to be empowered themselves, have efficiency. As Dr. Berwick said, it comes from the bottom. Efficiency comes from people on the ground knowing what is needed and being able to have the resources and allocate those resources appropriately and proper incentives to make sure efficiencies are gained in the system.

There is plenty of room to be gained in our health care system to wring out waste and inefficiency, but much of that is driven by people trying to follow the rules rather than trying to figure out what is right.

*Mr. LaHood. Thank you.

I yield back.

*Ms. Sewell. [Presiding] The chair now recognizes Mr. Horsford for 5 minutes.

*Mr. Horsford. Thank you, Madam Chairwoman, for giving us this opportunity to discuss efforts to achieve universal health care for all Americans.

This hearing started at 10:00 a.m. It is now 2:00 p.m. Over the last 4 hours since the start of this hearing, I have listened to my colleagues on the other side of the aisle. During that entire time, there has not been one policy proposal offered to provide universal health care coverage or a plan.

In fact, my colleagues spent their entire time arguing against Democratic proposals to increase coverage, protect preexisting conditions, and bring down the cost of health care.

I suspect the reason they spent their entire time attacking the Democratic plans is because they have no health care plan of their own. While our Republican counterparts argue that they support the protection of preexisting conditions, many of them support the Texas v. Azar lawsuit over the constitutionality of the individual mandate and the entire ACA.

This just does not add up. Either you are for health care and preexisting condition coverage or you are not. Republicans claim they support preexisting condition coverage. Yet they support the administration's lawsuit.

They claim they support preexisting condition coverage. Yet they have sabotaged funding to shore up the exchanges which have prevent the cost from being decreased, lowering premiums on our constituents.

Republicans claim they support preexisting coverage. Yet they support 17 States that continue to deny their constituents Medicaid expansion coverage.

Now, the Affordable Care Act is not perfect, but it has delivered. In my home State of Nevada, we have cut the uninsured rate from 23.5 percent to 11.4 percent. Prior to the Affordable Care Act, 20 percent of children in Nevada had no health coverage. Today only 8 percent lack coverage. Nearly 400,000 children in Nevada rely in Medicaid and the Children's Health Insurance Program, both programs that we have strengthened through the Affordable Care Act and other Democratic legislation.

The Affordable Care Act protects Nevada families from financial ruin. Women can receive free preventative care and wellness screenings. Thanks to the Affordable Care Act families with children under 26 are allowed to keep their children on their health insurance plans, and seniors are paying less for prescription drugs in Medicare coverage gaps.

Nevada's rural hospitals are losing less money providing medical services to uninsured Nevadans by spending less on uncompensated care.

If the Republicans had their way and the Texas v. Azar lawsuit eliminated the Affordable Care Act, that would mean the loss of coverage for over 200,000 Nevadans currently insured through our State's Medicare expansion and the elimination of other popular protections that serve our State.

Now, Ms. Brooks, I wanted to ask you. You shared in your written statement that the Nevada legislature just voted to study the feasibility of establishing a public health insurance program by allowing Nevadans to buy into the State public employees benefits program, joining New Mexico and Colorado as the third State this year to enact a bill to study potential models.

Can you and Ms. MacEwan please speak to the value of these fact-finding missions to establish public option programs at the State level?

*Ms. Brooks-LaSure. Thank you. Happy to.

I think States examining these on a State-by-State basis, these models, is incredibly value for two real reasons.

One, there are differences across the State in terms of how many actions, what their markets look like, how much competition they have today, and as States are moving in different ways, they are tailoring proposals that make sense for their States and targeting their populations.

I think it is also really important because States learn from each other, and the Federal Government, Congress also learns from States.

*Ms. MacEwan. I would agree. I think that States have to figure out what is best for them. I know Nevada is in the process of developing their own State Exchange and very responsive to their community.

What we did in Washington State was responding to our environment, our resources, and what was best for our community.

I encourage you to go forward. I think it is great.

*Mr. Horsford. Thank you very much. I appreciate the indulgence, Madam Chair, and I support universal health care. Health care is a right, not a privilege. I wish that my colleagues would join us in that endeavor so that we can actually provide coverage to the American people.

*Ms. Sewell. The chair recognizes Mr. Wenstrup from Ohio.

*Mr. Wenstrup. Mr. Chairman, Madam Chair.

Thank you all for being here.

You know, I just want to say right at the top, as a physician there is nothing about me that does not want every American to have access to quality care and affordable care, nothing about me. Yet we hear a lot of rhetoric here today and a lot of name calling, which

I do not think is constructive.

And, Ms. Wood, I appreciate you being here. I have a niece who was born with a neurological condition. She will never walk or talk. My sister when she was 26 years old got two forms of leukemia, was on death's bed, but survived because of a bone marrow transplant that we had to fight the insurance company over. They said it was experimental. She is alive today, has a family and two kids.

And I understand the anxiety that comes when people do not know if they are going to be covered or if they are going to be able to afford it.

And I would say candidly everyone here is in favor of coverage for preexisting conditions. We have supported it, all of us, both sides of the aisle, in one way or another have supported it, voted for it in one form or another.

I do not want people to be dropped from their insurance just because they are sick. That is a problem that we face, without a doubt.

But let's go through a few things. The majority of Americans are content with their plan. We know that. Medicare and Medicaid are the lowest payers. That makes it challenging in private practice if your payer mix looks like that. We are talking about rural areas.

So we are going to rely on Congress and the government to pay providers. Well, let me tell you what happened when I was in practice when Congress could not decide through Medicare how they were going to pay doctors. And so for 3 months while we treated Medicare patients, which of course we would, we got no pay.

We had to go to the bank to borrow money to keep our practice afloat. Now, if we did not have any private pay, we would have been shutting our doors.

So what I see proposed is it is illegal to have private pay. You know, some of the plans are going to cut payments to providers 40 percent, and again, it is illegal to have a

private plan.

How are you going to do this?

You know, I notice on the panel today there is nobody from private practice who is in the trenches taking care of people, either primary care or specialist, for us to hear from, to understand what actually takes place and the relationship between the patient and the doctor.

You talk about in this plan the Secretary will review the benefits. Well, that is just another way of saying rationing, I am afraid.

And instead of medical societies determining and setting guidelines and best practices, oh, the Secretary is going to do it. The government is going to do it.

I have already dealt with that since I have been in Congress where people who have no expertise are setting medical parameters for us.

Medicare, you say, government, oh, it is a good plan. Well, let me tell you I had patients on Medicare where I needed an MRI, and I could not get it because they were denying it.

And I said, "I cannot take care of this patient properly if you are going to deny it," and I could not get it. But in a private plan I had the same situation, and I got it because the patient was able to say, "We are going to drop you as our insurer."

They have some clout. When it is the other way around, you are stuck. And let's face it, a program like Medicare, least access to care, highest mortality and morbidity. That is not something to brag about.

I am sure the Affordable Care Act helped some people. I sure hope so with what it cost, but it did not help everybody. It hurt a lot of people.

When I was at Harvard before I was sworn in, they were talking about the ACA because it was voted on before I was here. They said, "Oh, well, you know, if you are old

enough, you will get this." They said, "Marcus Welby is done."

Well, I represent rural areas that want Marcus Welby and need Marcus Welby, and Marcus Welby is getting killed, and we are not doing anything about it. And Medicare for All will not solve that problem.

Now, I do propose that if you are in a rural area or where your cost of living is low and your payer mix is poor, then you should get paid more by Medicaid and Medicare. If you are in a place where your payer mix is really good, you should get paid less by Medicaid and Medicare, and level the playing field a little bit. I think that would be helpful, and I talk about that amongst this committee, especially those who represent rural areas.

Providers cut 40 percent. You know, we see these things happening, but Dr. Davis brought something up, and I know I am going to run out of time, which is a shame because I just want to talk about something quickly.

We should be devoting ourselves to focusing on health span of Americans, not just life span. How do we keep people healthier?

And I could go into a lot of ways, but I am going to run out of time. But think about this. We reward the surgeon who does the open-heart surgery and saves a life, and we should. But we do not reward the primary care doctor who works with their patient to prevent them from ever needing the open-heart surgery.

We have got to change our focus around, but have FQHCs and all of that does not matter if people do not have transportation to get there, and I was on our Board of Health in Cincinnati. We reached out. How do we get people into care? And there are ways of incentivizing that, but my time is up, but I would like to talk about it more because success should be based on keeping people healthy.

And I yield back.

*Chairman Neal. [Presiding] I thank the gentleman.

With that let me recognize the gentlelady from Florida, Ms. Murphy, to inquire.

*Ms. Murphy. Thank you, Mr. Chairman.

And thank you to the witnesses for your testimony.

Like nearly every American, I have had my own health scares and have lost family members and family and friends to illness. And I know that when you or someone you love is sick, you are at your most vulnerable, and I think the last thing you want to worry about is not having health insurance or having health insurance that does not cover the necessary treatment or health insurance that leaves your family with bills that they cannot afford to pay.

So I believe every American should have a health insurance plan, whether private or public, that enables them to obtain high quality doctor care, hospital care, and prescription drugs at an affordable cost.

But unfortunately, we are nowhere close to this outcome, and in Florida, we have one of the highest uninsured rates in the country at 13 percent. And in my district alone, there are over 60,000 people with no insurance at all.

And for those with insurance, they are unhappy. Many of them are unhappy, too, with the premiums, deductibles and other out-of-pocket costs that are too high.

My constituents and Americans across this country need their government to make things easier for them today, not years from now. And right now in my view, the best way to achieve universal coverage and to lower the cost of health care is to strengthen the four pillars of our existing health care system, and those pillars are Medicaid and CHIP for low income individuals; Medicare for the elderly and disabled, whether fee for service or Medicare Advantage; employer-sponsored health coverage in the health insurance marketplaces created by the Affordable Care Act where people buy private plans and lower

income people receive a Federal subsidy to do so.

So I want to focus on the best way to strengthen those pillars. Dr. Berwick, you ran CMS. So you are very familiar, and you know both Medicaid and Medicare well.

On Medicaid, Florida is one of only 14 States that have not expanded Medicaid to cover more people as the ACA authorized. So Florida residents essentially are paying Federal income taxes that pay for Medicaid expansion in other States, including a number of Red States, but these taxes are not being used to cover more low-income families in our own State.

Can you think of any good reason other than partisan politics why Florida's political leaders should not expand Medicaid?

Would you not think that that would put a big dent in lowering the number of uninsured people in our State?

*Dr. Berwick. I admit I do not understand it. Now, thanks to the unhappy experiment that some States expanded and some do not, we actually have the data. We have the facts, and we know that expansion is associated with better health and with cost reductions.

So it is just smart to do it, and I think it is time to do it.

*Ms. Murphy. I agree with you on that data, and that is why our office has been leading a piece of legislation that would require the economic and human impact of States that have not accepted Medicaid, and hopefully when we present them with those facts, these legislatures will make the right decision.

On Medicare, 20 percent of Florida's population is enrolled in that program. If Congress can make one immediate politically feasible change to the program, what do you think it should be?

And you can choose from Part A, B, C or D.

*Dr. Berwick. I think Congress should insist on more transparency in the Medicare program and so that the data that are available are much more available for local use so that people can use it to improve what they do.

I also think that we need to use Medicare more directly to lower the cost of prescription drugs and really be aggressive about that. It is hurting people terribly, what is happening now in that arena, and it is time to stop it. It is irresponsible behavior, and unfortunately, on the supplier side, Medicare should be used as a tool.

*Ms. Murphy. Dr. Neuman, did you want to respond?

*Dr. Neuman. I was just going to say on the issue of prescription drugs, this committee has worked on a bipartisan basis to at least propose or talk about putting a limit, a hard cap on Part D out-of-pocket spending, which would provide significant relief to more than million people on Medicare who take very high cost drugs for their conditions, and even though they have Part D, they are still paying a lot of money throughout the year. So that would provide a lot of help.

*Ms. Murphy. Thank you.

Ms. Brooks-LaSure, I looked at detailed data from my district, and over half of the 60,000 or so uninsured people in my district earn between 100 percent and 399 percent of the Federal poverty level, and most of them are between the ages of 19 and 44.

And it seemed to me that these folks are making a conscious decision not to buy a plan on Florida's marketplace which currently covers almost 2 million people and is the largest Exchange in the country.

Given that my colleagues on the other side of the aisle repealed the individual mandate, what do you think the best way is to get these younger, healthier folks to sign up for coverage?

*Ms. Brooks-LaSure. I think it is a couple-fold, and some have been mentioned. I

think outreach and enrollment is a key issue. What research finds is people need a lot of time to understand their coverage. That is an incredibly important piece.

I think also making sure people know that there are low premium options available. For those income levels, there are many low premium options available. Cost sharing is also an issue and something I think Congress can continue to work on in terms of lowering those costs.

*Ms. Murphy. Great. Thank you.

And I yield back.

*Chairman Neal. I thank the gentlelady.

I call upon Dr. Ferguson to inquire.

*Mr. Ferguson. Thank you, Mr. Chairman.

And thank you to each of the witnesses. Ms. Wood, especially thank you to you. I was a practicing dentist for 25 years. Part of your story touched me and certainly recognize that, have dealt with that many times in my practice in many different forms. So I am very sympathetic to your position there.

But one of the things that is just very striking in all of this to me, and my colleague from Ohio touched on this. I have listened to all of this. There are very few people in this room that have actually laid a hand on a patient and been down in the trenches every single day trying to find ways to make patients healthier, get them more convinced of preventive care, and drive down cost, the way we do that every single day, the way we did it in our practice.

And it is a real challenge when I hear people talk about a health care system in which they have never once been a part of, other than maybe as being a patient.

We can all talk about the sympathetic situations and the very tragic situations in many cases of our family members, our friends that have gone through these terrible

illnesses, and I think that we all recognize and we all want those with preexisting conditions and those that are the least among us and those that have the most catastrophic illnesses; we can as a Nation take care of those folks.

But to destroy the entire health care system is not the way to do that. Let me tell you something. If you look at this plan, the doctor-patient relationship, which has already been eroded, will be completely done away with. You would have unelected bureaucrats telling doctors what you can and cannot do with a patient.

As a matter of fact, the Federal Government would dictate the practice of medicine as the Democrats' leading single payer bill in the House requires the Secretary of HHS to establish a single national practice guideline for all patients and clinicians to follow.

That is tone deaf and it is irresponsible. All patients are different. Providers are different, and we need the flexibility to adapt health care to each and every single patient.

To think about treating hospitals all the same and having to, as my colleague from Illinois stated, basically ask permission from a bureaucrat to change a light bulb in a hospital, that makes absolutely no sense.

What is right in rural Georgia is probably different than what is right in Chicago. Both have needs, but this one size fits all policy will not work.

I can tell you there is nothing more frustrating to a patient than having their choice removed. I cannot tell you the number of times that I sat with a patient in my practice and had to tell them that there was a bureaucrat either in an insurance company or in a Federal Government office that was denying them care and coverage of care. Somebody without a health care license, a medical or dental license was telling me how to practice medicine and telling a patient what they could and could not receive.

The last time I checked I was the one in the room with the patient, along with my staff, talking to the patient about their unique circumstances to be able to make the right

decision for that patient.

That patient had choices. The patient was able to express their concerns. We were able to talk through it, what their fears were, what their needs were, what the potential outcomes could be.

What this will do is it will destroy that doctor-patient relationship, and it will destroy the patient's choice and freedom. To think that a single payer system is best for the patient is laughable, in my opinion. Okay?

Can we take care of our most vulnerable? Absolutely, we can and we have a desire to.

Can we to make sure that we keep the promises of Medicare to our seniors that have been made? Absolutely.

But we should be creating competition. We should be creating vitality within our health care systems. We should be doing everything that we can to drive the relationship back to the patient and the doctor and away from the bureaucrat because it is destroying health care in this country every single day.

And those that have never had the privilege of laying a hand on a patient to take care of them simply do not understand this. We understand it as patients when we cannot have those choices and we cannot get that care. But if you have not been a provider on that, you do not know the passion and the desire to take care of a patient. You are just completely missing the boat, and you are making this about a dollar sign and not a patient, and that is wrong.

And with that, Mr. Chairman, I will yield back.

*Chairman Neal. I thank the gentleman.

We will conclude our inquiry with the gentleman from California, Mr. Nunes.

*Mr. Nunes. Thank you, Mr. Chairman.

Single payer advocates often say things along the lines, "Well, we are already paying for health care through premiums and cost sharing. So even though a government takeover of health care adds 30-plus trillion to the Federal balance sheet, there is no new costs for patients."

These advocates are asserting something for which there is no evidence, that people are indifferent to whether they are spending under their own control or discretion or whether they are forced to pay taxes to the government.

A powerful example I have heard is suppose the Federal Government came to you and said, "You spend a lot of money on food and groceries and delivery. So why not take all of that money and give it to us in taxes, and we will buy your food for you? And, in fact, we will forcibly cut payments to the restaurants and grocery stores in an effort to save you money."

Would people be happy with that? I think the answer is no.

First of all, they would worry that the government dramatically cuts payments of their favorite restaurant, and they go out of business, and they would not be able to eat there anymore.

But beyond that, there is the principle of this. Even if I spend \$15,000 a year on food already, I do not want to pay a \$15,000 tax bill to the government to give me free food. I want to choose whether and how to pay that \$15,000, but once the government takes it over, I have no choice. I am forced to pay \$15,000, whether I want it or not.

Private and public spending are not the same because people have choice and control over one but not the other.

Ms. Turner, I want to turn to you and ask if you know of any other sectors in the Federal Government that are more efficient and better at delivering a product or service than the private sector.

*Ms. Turner. Hard to think of that, Mr. Nunes. Federal Government, actually, perhaps the Medicare Part D prescription drug benefit program, but it only works because it is delivered by private plans who work fiercely negotiating over drug prices with drug manufacturers and drug developers.

But that works because it is relying on the private sector, relying on competition, and relying on patient choice.

*Mr. Nunes. Well, I think the challenge with all of this where the Medicare falls is that you have a program that is going broke. I heard many of my colleagues talk about it earlier, and there is somewhere between trillions of dollars in unfunded liabilities.

Actually what do you think? I mean, you work on these issues every day. If you look at the Medicare recommendations and I think it is like 2023 that they are saying that Medicare begins a shortfall.

*Ms. Turner. 2026.

*Mr. Nunes. 2026. Do you agree with that figure, that range?

*Ms. Turner. I am not an actuary, but I certainly know that I believe the Medicare Trustees' reports, and they document why they believe that is, and there are extensive calculations.

*Mr. Nunes. And so how many trillions of dollars is this shortfall that we have in Medicare today if you look out over the next 20 years?

*Ms. Turner. Oh, I would have to look it up. I focus so much more on Medicare for All, and the \$32 trillion number that is most popularly discussed by Chuck Blahous, who is an economist from the Mercatus Center, says that is really the low-ball estimate, and this is an estimate from last year, much more like 39 trillion.

*Mr. Nunes. And the key to that is that that is just to keep Medicare as it is today.

*Ms. Turner. Right. This is the cost of Medicare for All, would be \$39 trillion.

But the cost that Medicare -- Dr. Berwick probably knows -- the deficit for Medicare now is very much in the trillions of dollars already without adding 2 million --

*Mr. Nunes. Right, without adding the 32 trillion.

*Ms. Turner. -- more Americans to it.

*Mr. Nunes. Right. Well, I want to thank the chairman for holding this hearing today. I hope it was enlightening for the public and for the members.

And I appreciate all of the witnesses being here and your indulgence, Mr. Chairman.

I yield back.

*Chairman Neal. I thank the gentleman.

There were, I think, many opportunities here today to express on the Democratic side that there are different options to a path to full coverage, and I thought the witnesses did an excellent job of explaining what those different paths could and would be.

I do not want to miss the opportunity though with our Republican colleagues to point out that there is a bipartisan opportunity to continue to work upon improving the ACA and, again, expanding the opportunities to lower out-of-pocket costs and improving the quality of care for all Americans.

I want to thank the witnesses for a very informative 4 and half hours, and I want to thank them, again, for the fact that even as we were moving back and forth between the floor, your perseverance was appreciated.

I am delighted that Charlie was here with us.

And please be advised that members will have 2 weeks to submit written questions to be answered later in writing. The questions and your answers will be made part of the formal hearing record.

With that the committee stands adjourned.

[Whereupon, at 2:28 p.m., the Committee was adjourned.]

Submissions for the Record follow:

[American Hospital Association](#)

[American Medical Association](#)

[United Philanthropy Forum](#)

[Johnathon S. Ross, MD MPH](#)

[National Association of Health Underwriters](#)

[National Nurses United](#)

[Rights & Democracy Project](#)

[Rebecca Cerese](#)

[Christine Ihde](#)

[Gaen McClendon](#)

[Medicare for All: LGBTQ Fact Sheet](#)

[Center for Fiscal Equity](#)

[Aviva](#)

[Lisa Peck, MD](#)

[Partnership for Employer-Sponsored Coverage](#)

[HealthCare for All WNC](#)

[Asian & Pacific Islander American Health Forum](#)

[Onja Bock](#)

[Whole Washington](#)

[Richard F. Averill/John S. Hughes](#)

[Lauren MacFarlane](#)

[Laborers' International Union of North America](#)

[National Nurses United](#)

[American Academy of Actuaries](#)

[Kentuckians for Single Payer Health Care](#)

[Nina Arshavsky](#)

[Jessica Schorr Saxe, MD](#)

[Will Rye](#)

[David Michels](#)

[Hope in the Midwest](#)

[Guttmacher Institute](#)

[Public Citizen](#)

[National Partnership for Women and Families](#)

[Health Care for All Colorado](#)

[Community Catalyst](#)

Questions for the Record follow:

[Rep. Brian Higgins Questions for the Record Directed to Tricia Neuman](#)

[Tricia Neuman Response to Questions for the Record](#)