Committee on Rules
Original Jurisdiction Hearing: H.R. 1384 Medicare for All Act of 2019
April 30, 2019
10:00 am, H-313

Purpose
To discuss H.R. 1384, the Medicare for All Act of 2019.

Members Present
Chairman McGovern, Ranking Member Cole, Representatives Perlmutter, Raskin, Scanlon, Morelle, Shalala, DeSaulnier, Woodall, Burgess, Lesko

Witnesses
Mr. Ady Barkan, Health care activist and patient with ALS
Dr. Sara Collins, Vice President, The Commonwealth Fund
Dr. Doris Browne, President, National Medical Association
Mr. Charles Blahous, Senior Research Strategist, Mercatus Center
Dr. Dean Baker, Senior Economist, Center for Economic and Policy Research
Ms. Grace-Marie Turner, President, Galen Institute
Dr. Farzon Nahvi, Assistant Clinical Professor, Mount Sinai Health System

Opening Statements
Chairman McGovern said that this is the first time Congress has held a hearing on Medicare for All. Healthcare is a right for all, not a privilege for the lucky few, and Congress is putting that belief into action. ACA has saved lives, but it is not the last stop in healthcare reform. 29 million Americans still lack coverage and 44 million have insufficient coverage. Middlemen are unnecessarily jacking up costs and deciding who gets care. This bill would guarantee that those with disabilities have access to services they need to live with dignity. This bill deserves to move forward.

Ranking Member Cole said that out of the 120 bill test pages, the Rules committee has jurisdiction over precisely one of the pages. It is worth noting that Speaker Pelosi's personal committee is the first to take the swing at the ball while other committees can claim higher jurisdiction. Ranking Republicans of those committees will ask the chairs to take up this legislation in their respective committees. Democrats are proposing a change to the healthcare system for the worst. Americans would need to pay more, wait longer, and potentially receive worse care, putting current Medicare recipients at risk. Medicare and MA holders are satisfied with the care they receive. This radical bill puts Medicare itself at risk by enrolling millions of new recipients who haven't paid into the system. It would ban MA entirely. Medicare for All means Medicare for none. It is a socialist proposal threatening freedom of choice. Private health insurance would be completely ban. Every man, woman and child with private insurance would lose their plan. More than 150 million people will lose health plans they like and earned through hard work. A more basic version of this proposal would cost $33 trillion over the next few years. Everyone's taxes will have to more than double to pay for this program. The most egregious provision of this bill is the federal funding of abortion. Even ACA maintained limited conscience protections. This bill

requires comprehensive reproductive care, including elective abortions paid for by federal tax dollars. Longstanding life protections must be included as the bill is moved to the floor.

Testimony

Mr. Barkan said that healthcare is not treated as a human right in the US. Although his family has comparatively good private health insurance, ALS means paying out of pocket for in-home care, costing $9,000 each month. The alternative is moving into a nursing home by going on Medicare. This is an absurd way to run a healthcare system. GoFundMe is a terrible substitute for congressional action. There are simple reasons why Medicare for All is the only solution. First, it will deliver the high quality care Americans deserved; comprehensive primary care, dental, vision, reproductive and mental health care; the program will provide for long term services and supports allowing people with diseases like ALS to stay in their homes and communities. Second, Medicare for All will save enormous sums of money. There will be no premiums, deductibles or copays, which means Americans will no longer have to delay necessary care or starve to pay medical bills. Third, Medicare for All is the only way to make the healthcare system more efficient. The current system creates absurd amounts of administrative wastes every year in the form of billing disputes and price gouging. Medical professionals will now be able to deliver care, not paperwork. Cost-savings are only possible through a genuine Medicare for All system. Other proposals will not facilitate billing savings.

Mr. Blahous said that he is only presenting a cost projection, not passing judgement on the policy. The analysis is based off the Medicare for All proposal in 2017. Medicare for All would add 32.6 trillion and 32.8 trillion in federal budget costs over 10 years. The 32.6 trillion assumes every cost containment provision saves as much as possible. If things play out according to historical trends, it would be 32.8 trillion, which is 13 to 15 percent of GDP in 2031 being added to the federal ledger. There is no historical experience with government expansion of this size. Doubling corporate and individual federal income tax would be insufficient to finance the lower bound. This would be the net new costs above and beyond current federal health obligations. Total spending on Medicare for all would be 54.6 trillion and 54.7 trillion. The vast majority would arise from the government assuming spending that is currently being done by states and individuals. The biggest factor in increasing health spending would be its increased generosity of coverage. Additional benefits are also provided, such as dental, vision and hearing services. Medicare coverage would contain no copays or deductibles, increasing the demand for healthcare service. Under Medicare for All, the federal government would face significantly increased demand. Other provisions are expected to reduce costs, such as administrative cost savings and lower drug prices. Providers will be paid at Medicare rates, which are much lower. For hospitals, the payment reductions would be over 40 percent and for doctors it would start at 30 percent and grow to 42 percent over ten years. These reduced payment rates are substantially below providers' reported costs of providing services. If sudden provider payment cuts were implemented, quality of care cannot be ensured. Purely from an analytical standpoint, the provider payment cuts are larger than what has been historically considered reasonable. Medicare for All would increase health spending even above current projections.

Mr. Baker said that Medicare for All is affordable. First, the bulk of the payments come from shifting employer premiums to taxes. Secondly, the amount of additional revenue needed depends on the extent that input costs can be reduced. The third point is that lower costs can be associated with better care and better outcomes. From 2021 to 2030, $33.4 trillion will be incorporated into the government's budget. In a 2013 analysis, the administrative costs in providers are huge in order to deal with billing. Using that figure, the tab can be lowered to $25 trillion. There will be more utilization. 70 percent of healthcare costs come from 10 percent of the population, so only 30 percent of costs will really go up. $13.6 trillion will be left after $11.6 trillion in employer payment. Right now, there's no reason for Americans to be paying twice as much as other people around the world. CMS projects $6.6 trillion in prescription drug spending. The problem is that drugs are made expensive through government granted patent monopoly. Research can be funded in alternative ways to make drugs cheap. Opioid problems are largely the result of patent monopolies. Medicare must be fixed, including the standalone drug benefit, the overpaying of MA plans (roughly 13 percent each year), and limiting out-of-pocket costs. A very simple first step is lowering the Medicare age of eligibility to 64.

Ms. Grace-Marie Turner said that many Americans are simply priced out of the market, and those on public programs struggle to find specialists who can afford to take the low payment rates. People feel like helpless cogs in the $3.6 trillion system. It is hard to see how consumers can be empowered in this massive program. Even after the ACA, the nation is struggling. Medicare for All would mean much higher taxes and losing coverage, as evidenced by what happened in Colorado and Vermont. The growing presence of government in the health sector is a significant contributor to its dysfunction. Consumers should be the ones who determine the rules and regulations. Medicare for All's promise is virtually unprecedented and it is difficult to anticipate the repercussions. Paying doctors and hospitals at Medicare rates would worsen the existing physician shortage. Global budgets and centrally determined benefits structures lead to lower quality of care, rationing, and waiting lines. Many Americans would be severely disrupted when jobs-based health insurance get shut down. Employment-based health coverage produces nearly a 3 to 1 ratio in value to tax expenditures. Employer tax plans pay more to providers than Medicare, providing the margins need to keep doors open. Employers can advocate and educate their work forces. Americans want more, not fewer choices in healthcare. This bill will stifle innovation and result in a near doubling of the tax burden.

Ms. Collins said that the ACA brought sweeping change to the health system. The number of uninsured people has fallen by half and a decline in the number of people unable to afford costs. Three distinct problems remain: 27.9 million remain uninsured; 44 million are underinsured; and healthcare costs are growing faster than median income in most states. 17 states have not yet expanded Medicaid, and people with incomes just over the income subsidy have high premium costs, and congressional action on the marketplace have reduced enrollment, and cost-sharing is climbing in individual market and employer plans. Growth in healthcare costs are the primary drivers of premium and deductible growth. Prices paid to hospitals and providers explain the wide healthcare spending between Americans and the rest of the world. Democrats have introduced several bills that propose to expand the public dimension of the healthcare system. They are an amalgam of

provisions that have the potential to improve affordability and benefits, slow cost growth of prescription drugs and hospital care, and reduce the number of uninsured and underinsured people. Lifting the top income eligibility for marketplace tax credits could lower silver plan premiums by nearly three percent at a net federal cost of 10 billion. Allowing HHS to negotiate prescription drug costs could lower drug costs to almost 40 percent. Medicare for all could lower administrative costs to six percent to 3.5 percent of all spending from 14 percent. What has captured the most attention in this debate is the shift of financial responsibility. It raises important questions about financing sources. The range of national healthcare expenditures is that the increase in expenditures is often less than the demand in healthcare. Federal legislation is ultimately required for expanding coverage with cost saving provisions.

Ms. Browne said that the National Medical Association is disturbed by the obstacles experienced by people of color while seeking care. Research reveals that African Americans are more likely to experience health inequities. Given the disproportionate impact of chronic disease, Congress must find ways to make healthcare coverage affordable and of high quality for all. Healthcare is more than a provision of medical services: it is a multifocal, complex product that includes socioeconomic determinants. While the ACA made substantial improvements, it did not go far enough. In order to stem the high prevalence of chronic diseases, a comprehensive agenda must be developed around health equity. Healthcare must be provisioned to surpass socially defined circumstances. Universal health coverage is a pathway to achieving health equity. It can provide a more efficient and effective cost saving healthcare system for everyone. The government has maintained a track record for providing comprehensive healthcare through Tricare and other military sponsored programs. These programs have diligently worked to confirm affordable access for millions of citizens, adhering to evidence-based, high quality accessible care for their beneficiaries. The best framework for universal healthcare is through the engagement of diverse multisector partners and community involvement. Universal coverage must minimize administrative costs, it must allow patients to choose providers, and it must address the physician shortage and funding of safety net hospitals.

Mr. Nahvi said that there are countless stories of people who walk out against medical advice in the emergency room due to concerns with cost. 41 percent of Americans have skipped an ER visit due to concerns over cost. A week ago he encountered a patient with appendicitis who asked to be discharged with an antibiotics prescription because she was worried she could not afford treatment. One year ago he took care of a woman who overdosed on fish antibiotics, and his fiancée's mother died after failing to seek treatment for stomach cancer. This should not happen in the wealthiest country in the world.

Questions and Answers

Chairman McGovern asked Mr. Barkan which medical devices or services were denied by his insurance company. **Mr. Barkan** said that Healthnet ruled that the medicine provided by his neurologist was not necessary, as well as a brand new FDA approved medicine to treat ALS. He had to organize a protest at their headquarters, but no one should have to go through that. Insurance companies deny, delay and wait for patients to give up. Fundamentally the priority for healthcare insurance companies is to make a profit. **Dr. Nahvi** said that one patient had to be

admitted to the hospital after not being able to afford $300 for UTI antibiotics, which then resulted in a thousand dollar bill. Another example involved a patient whose insurance started denying her psych meds and had to be admitted to the hospital eventually. **Chairman McGovern** said that Medicare for All would cost only a little more than what is currently being paid. **Mr. Blahous** said yes. **Chairman McGovern** said that crushing out-of-pocket costs could be eliminated and services to the disabled and elderly can be improved, only at a slightly increased cost. **Dr. Baker** said that the ACA hasn't gotten as much credit as it should for reducing costs. The projections from CMS for 2017 were actually 1.5 percent of GDP higher than what was actually spent. **Dr. Collins** agreed. **Chairman McGovern** asked Dr. Browne what the difference is between a pre-pay system in the military and a post-pay system. **Dr. Browne** said that providers do not have to be concerned with whether patients can afford care. Healthcare should be based on medical need, not cost. **Dr. Nahvi** agreed. He has lose-lose conversations with patients who cannot afford treatment. **Chairman McGovern** asked Mr. Barkan how he could afford his care if he didn't have a social media following of his size. **Mr. Barkan** said he would have asked his parents to spend their retirement savings and then approach friends. No one should have to go to those measures.

Ranking Member Cole submitted to the record a letter from the American hospital association. **Ranking Member Cole** asked how many people would lose coverage under HR 1384. **Ms. Turner** said that everyone would lose current health coverage. 173 million Americans with job-based coverage in addition to those with CHIP and Medicare/Medicaid. The only ones with the option to keep their insurance are those with the VA or Indian Health System. **Ranking Member Cole** asked how HR 1384 would impact employers. **Ms. Turner** said that when Colorado tried to do a ballot initiative for a single-payer system, they wound up with serious pushback from people who would lose their private coverage. Employers have easier access to help their employees while balancing costs and benefits. Employer-based insurance helps support Medicare and Medicaid. The value of employer-sponsored health insurance was $991 billion in 2016 and there is a tax break worth about $350 billion to support employee health insurance. **Mr. Barkan** said that **Ranking Member Cole** asked how the bill will impact providers. **Ms. Turner** said that if hospitals and physicians were to see 40 percent payment cuts they would either dramatically curtail services or close their doors. **Dr. Blahouse** said that the effects are unpredictable. Simultaneous reductions in payment rates to providers during an increase in demand for healthcare would result in an unknown reaction. **Ranking Member Cole** said that rural hospitals would be the hardest hit. **Mr. Baker** said that rural hospitals already get paid at Medicare rates so it would not be as affected. **Dr. Browne** said that providers will not walk out on their patients due to decreased payment rates. **Dr. Blahous** said that Congress does not have a history of a willingness to impose steep reductions in payment quickly, but if this were to happen with HR 1384, the costs would be higher. **Ranking Member Cole** asked if two years is enough time for the transition. **Dr. Nahvi** said yes. **Dr. Blahous** said that a two-year transition increases the likelihood that the lower bound estimate is a gross underestimate of federal cost. **Ms. Turner** mentioned today's op-ed in the Washington Post about how Vermont providers like Green Mount Care failed to figure out providers would be paid and how taxes would be collected. The plug was pulled after implementation was found to be too disruptive.

Chairman McGovern said that the effects of job loss are amplified with employer-provided insurance. People will not lose their healthcare with Medicare for All, the only difference is not dealing with insurance companies.

Rep. Perlmutter asked Mr. Barkan to expand on how HR 1384 will help consumers. **Mr. Barkan** said that fighting with insurance companies is a huge strain financially and emotionally, but time is the most precious. Americans should not fight to be treated with dignity. He also asked Dr. Baker and Dr. Collins how the US compares to other industrialized countries in healthcare spending. **Dr. Baker** said that the US can finance the whole health system of the UK with what is currently just spent on the public healthcare sector. The US pays twice as much for all the inputs (e.g., drugs, doctors, etc.), which speaks to the enormous potential savings. **Dr. Collins** said that the US does not enjoy commensurate outcomes with countries that spend far less. **Rep. Perlmutter** asked Dr. Blahous what the potential savings are with Medicare for All. **Dr. Blahous** said that the federal government would also be assuming costs borne by the state government in addition to the private sector. The total national cost increase would be less than the utilization increase, and this additional cost may not be sufficiently offset by the cuts to provider payment. **Rep. Perlmutter** said there is a lot of demand not being met right now because people are afraid of costs. Healthcare costs are a huge part of bankruptcy. **Rep. Perlmutter** asked how providers could manage increased demand. **Dr. Browne** said that medicine would be practiced in a better way through education and prevention initiatives that reduce ICU visits. **Dr. Nahvi** said that primary care will be more efficient. The EMTALA Act makes it so that anyone can come to an ER when they need to and the taxpayer or hospital foots the bill. People will utilize care in the right places under Medicare for All. **Rep. Perlmutter** asked if Medicare for all would reduce paperwork. **Dr. Nahvi** and **Dr. Browne** agreed. **Rep. Perlmutter** said he voted against the Medicare for All legislation in Colorado because it needs to be national in scope. **Ms. Turner** said that Vermont assumed there would be a larger pot of money with federal funds and they still couldn't make it work. People in Colorado were nervous about the taxes that would be required to support it.

Rep. Woodall said that $32 trillion over 10 years is the best case scenario for additional federal obligation for Medicare for All. **Dr. Blahous** said that the $40 trillion upper estimate is not a worst case scenario since the administrative costs will bring down total cost to $38 trillion. **Rep. Woodall** asked what the per-American cost is. **Dr. Blahous** said about $10,000 per capita. **Rep. Woodall** said that the question should be whether taxpayers are getting the most bang for their buck. **Dr. Collins** said that 17 states haven't expanded Medicaid and there were changes to the cost-sharing reduction subsidies that have bumped up premiums on silver plans. Subsidies could be extended for marketplace tax credits. **Rep. Woodall** asked how ER visits would be reduced under Medicare for All. **Dr. Nahvi** said that patients are already incentivized to go to their primary care doctor, not the ER, but they don't know where else to go when doctors' visits feel out of reach. **Rep. Woodall** asked why union healthcare systems and DoD healthcare systems need to be abolished in order to serve the underserved. **Ms. Turner** said that the current system should be fixed instead of blown up by trying to apply a Medicare fee-for-service system in a span of two years. **Rep. Woodall** asked if it is necessary to abolish the system in place for military members to achieve Medicare for All. **Dr. Browne** said that Medicare for All can be a duplicate of the existing government plans in the DoD and VA. **Mr. Barkan** said that Congress never worries about where to find funding when it's war, only when it's healthcare. **Rep.**

Woodall replied that he disagrees; the pithy one-liners make it difficult for productive conversation. **Dr. Nahvi** said that the VA actually provides a good reason for why there should be Medicare for All: if it's good enough for the men in uniform, it's good enough for Americans.

Chairman McGovern asked how Medicare rates would be affected under Medicare for All. **Dr. Collins** said Medicare rates would go up. Outside of the issue of surprise billing, people have high deductibles, which then contributes to the underinsurance issue.

Rep. Raskin submitted to the record an article supporting Medicare for All's ability to lower drug prices. **Rep. Raskin** described his experience with treating stage 3 colon cancer. People should not be unable to receive medical treatment if they love the wrong person or lose their job. Healthcare access cannot be denied in the richest country. **Rep. Raskin** asked if it is true that tying employment to insurance was started during World War II to incentivize workers. **Mr. Baker** confirmed that is accurate. But employers are busy, they don't want to deal with managing their workers' insurance. **Rep. Raskin** said that Medicare for All would liberate small business owners. **Mr. Baker** said yes. **Rep. Raskin** said that other industrialized nations have arrived at universal health care. He asked whether the principal value they are seeking is justice, efficiency or public health. **Ms. Collins** said all three. Universal coverage promotes a more efficient health care system. **Dr. Browne** said yes. A healthier workforce leads to cost savings for businesses. **Rep. Raskin** described how the individual mandate compromise for the ACA become politicized and reviled by Republicans. He asked whether it will be possible for Congress to move from the ACA to a Medicare for All system. **Dr. Nahvi** said that it would not be too complicated. ACA expansions do not cut it. **Rep. Raskin** said that there is the misconception that Medicare for All is only for the uninsured, but it's really for the Americans with useless health insurance plans. He asked if it is the case that the proposed system would be unaffordable. **Dr. Nahvi** said that there are other countries who do have universal healthcare and have been able to finance it.

Chairman McGovern submitted to the record a Washington Post article about the GOP budget that cuts Medicare and Medicaid funding.

Rep. Burgess said that it is ironic that the hearing is criticizing employer-sponsored insurance when the ACA had an employer mandate built in. Normally, healthcare policy would come through one of the authorizing committees, which would then hold one of these hearings over several iterations. This hearing in the Rules Committee is somewhat unusual. Two primary hearings were held when Republicans were in the majority but they were on things outside of the normal realm of the authorizing committee. This committee is 9 to 4. Chairman McGovern will never lose a vote in this committee. Mr. Rayburn set up the ratio in 1961 to facilitate the agenda of an activist president. Additionally, the cost of bureaucracy will never go away, especially when more is tasked to the Department of Health and Human Services. **Rep. Burgess** asked if CMS has to account for the cost of capital. **Ms. Turner** said no. She cited a study where it was found that the administrative costs for Medicare and private insurance were roughly equal. However, it is an apples to oranges comparison. **Rep. Burgess** submitted to the record an article documenting the struggles of a mother in Nova Scotia to obtain sufficient cancer care. **Ms. Turner** said that the Fraser Institute found that the wait time for specialty care in Canada is five

months. In the UK ambulances have to drive around for hours waiting for an ER to open and patients die in ER waiting rooms.

Chairman McGovern asked how Medicare for All will affect coverage. **Dr. Collins** said that everyone will move into a new system with more comprehensive benefits. It is not true that people would lose insurance coverage. Clearly the US is rationing care right now, so it's all a matter of how that term is used. The US has wait times consistent with the rest of the world. Countries with single-payer that have wait time issues have addressed it. **Chairman McGovern** said that hearings should not be viewed as unusual or undesirable. **Dr. Nahvi** said that rationing is already happening with the insured. A third of Americans that have insurance but don't go to the ER are imposing self-rationing.

Rep. Scanlon said that Americans should not have to resort to GoFundMes to pay for medical care. Her constituents do have concerns over Medicare for All, and that concern stems from fear of rising costs, changes to existing to employer or union based insurance, and the impact on their jobs. **Rep. Scanlon** asked Mr. Baker and Ms. Collins how to address the cost of rising premiums, copays and deductibles. **Dr. Baker** said that Medicare for All would make those costs go away. Money that would have gone towards copays would instead go to taxes. The question is how to do that in a way that is least disruptive and most efficient. **Rep. Scanlon** asked whether there is analysis of tax burden versus savings. **Dr. Baker** said it depends on how the tax is structured. Cutting costs down will definitely happen since the insurance industry would be gone. Other countries pay half per person on average compared to the US. A typical person will pay much less in taxes than what they pay for healthcare. **Dr. Collins** said that there are lots of ways to improve cost sharing. For people with employer-based coverage, there are lots of hidden costs like wage concessions and high premiums and increasingly higher deductibles. Medicare for All would do away with the employer-based system and taxes would rise to finance that, but for many people there would be a net decrease in health insurance cost. Vermont really did come down to legislatures not being able to explain this change in financing to their constituents. **Rep. Scanlon** asked how Medicare for All deals with an aging population that needs long-term care. **Dr. Baker** said that HR 1384 does cover long-term care and home health services in a way that makes sense. **Dr. Collins** said that under Medicare for All bills, Medicare benefits would actually improve substantially, especially with the addition of home health services. **Rep. Scanlon** asked how a transition would occur for those whose livelihood depend on the insurance industry. **Dr. Baker** said that it depends on what Congress decides. **Mr. Barkan** said that it is important to emphasize that the administrative and billing savings are only possible through a genuine Medicare for All system. **Dr. Baker** said that the most glaring gaps in Medicare are the lack of an out-of-pocket cap and the separate drug benefit. So if the gaps are fixed and people can elect to buy into Medicare, then many providers may move towards only accepting Medicare. This in and of itself would lower administrative costs significantly. **Dr. Collins** said that the critical design issues with the bill are the proposed provider payment rates. A public plan option based on Medicare could be rolled out in certain parts of the country where there are few insurance companies to test how to set the price.

Rep. Lesko said that bipartisan collaboration is vital, but this is a very partisan bill that the Senate will not end up hearing because the Republicans do not support it. Several reputable studies have said that the cost of a one-size-fits-all healthcare system will cost over $30 trillion

over 10 years. Even the Bernie Sanders constituents in Vermont turned down this system after seeing the tax increases. The Medicare Advantage program would be taken away by this bill. MA enrollment has almost tripled from 1999 to 2018 and is growing, as indicated by the 2019 report released by the Medicare trustees. Taking MA away would only confuse beneficiaries. **Rep. Lesko** asked if seniors would be happy to lose MA. **Ms. Turner** said that MA provides an integrated plan that covers vision, dental and drugs. Seniors highly value coordinated care. **Rep. Lesko** asked if HR 1384 protects Americans from astronomical wait times. **Ms. Turner** said no. It is difficult to see the promises of universal coverage being fulfilled without wait times increasing. **Rep. Lesko** asked if this bill increases patient choice. **Ms. Turner** said that the fact that people would have a difficult time finding a private option is concerning. **Rep. Lesko** asked Dr. Blahouse if the bill would provide care for illegal immigrants. **Dr. Blahouse** said that it is up to the HHS Secretary to define what a resident is. There is nothing that excludes undocumented immigrants from receiving benefits. **Rep. Lesko** said that the majority of citizens would not be happy to pay for free healthcare for illegals. **Dr. Nahvi** said that the EMTALE Law already enables undocumented immigrants to seek care from ERs, which is fiscally irresponsible. **Rep. Lesko** responded that no one will voluntarily pay for healthcare for illegal immigrants.

Chairman McGovern submitted to the record a letter from the Washington Community Action Network and the story submitted by Rebecca Wood supporting the bill.

Rep. Morelle said that this issue is deeply personal, citing the death of his daughter from breast cancer. The Administration cut funding for the ACA, pushing Americans into junk STLDI plans, shortened enrollment periods, enacted barriers to reproductive care, and created Medicaid coverage burdens. Trump does not have a plan to address healthcare beyond stripping away protection for those with preexisting conditions or the underinsured. There are some concerns with cost containment measures and financing. $3.5 trillion is spent per year on healthcare by payers, public and private insurers. Even a 3.5 percent increase in CPI in healthcare would mean $41 trillion in healthcare spending over 10 years. **Rep. Morelle** asked the witnesses about financing. **Dr. Baker** said that there are large administrative savings right off the bat. The private health industry spends about 25 percent of what it pays out on in benefits administrative costs whereas it's less than two percent for the traditional Medicare system. A payroll tax has to be part of the picture. Healthcare premiums paid by employers are already similar to a payroll tax now. Payments to providers must be reduced. **Dr. Collins** said that research does not support the cost-shift argument. Higher payment rates did not finance lower Medicare rates, as evidenced in one case in Colorado. Prices drive costs in the healthcare market. **Rep. Morelle** asked what a neurosurgeon would be compensated in Canada or the UK. **Dr. Baker** said that they would be compensated considerably lower. Doctors in other countries do not pay for their education as they do in the US. **Rep. Morelle** said he is not sure how there are incentives for coordinated care in a fee-for-service system proposed in the bill. **Dr. Browne** said that the plan will introduce patient-provider coordinators. **Rep. Morelle** said that he is not convinced. **Dr. Browne** said that incentives are built into the program. **Mr. Barkan** said that global billing should replace fee-for-service.

Ranking Member Cole asked if Ms. Turner supports abandoning reforming the ACA in favor of Medicare for All. **Ms. Turner** said ACA should be fixed first. **Dr. Nahvi** said that it is a false choice. **Dr. Browne** said universal coverage is one way to fix the ACA. **Dr. Collins** said even

small fixes to the system can help millions of people. **Mr. Barkan** said both are needed. **Dr. Baker** said he does not see small fixes moving the system forward. **Ranking Member Cole** asked if Medicare going broke now. **Dr. Blahous** said the Medicare Hospital Insurance trust fund is projected to be insolvent in 2026. The other half of Medicare cannot go insolvent by statutory construction but it does have financing issues. **Dr. Baker** said that the ACA is projected to go broke by 2019.

Rep. Woodall submitted to the record a letter from the Partnership for Employer Sponsored Coverage. **Rep. Woodall** asked whether under Medicare for All, risk is indemnified through first-dollar coverage. **Dr. Blahous** said yes. **Rep. Woodall** asked what the order of magnitude is for the increase in individual citizen contribution. **Dr. Blahous** said $10,000 per capita. There is a substantial financing shortfall in the current Medicare system, which is a much more manageable financing problem than Medicare for All.

Rep. Shalala said that she supports universal care. Healthcare costs have been contained with very crude measures. Throughout all of that, Medicare has been a star. There are already existing platforms like Tricare. **Rep. Shalala** asked Dr. Collins why the private sector has been less effective than the public sector in controlling costs. **Dr. Collins** said that prices are set through private negotiations through providers and insurers. Providers in concentrated markets have leverage to increase prices. Employers have a higher premium due to insurers negotiating with providers, so then there's higher deductibles. **Dr. Blahous** said he is unable to explain. **Rep. Shalala** asked whether Medicare may be driving costs. **Dr. Collins** said that Medicaid has been a leader in lowering costs. Neither Medicaid nor Medicare has a lot of fat. **Rep. Shalala** asked about the military healthcare system. **Dr. Browne** said VA and Tricare are integrated systems with differing outcomes. **Rep. Shalala** said MA costs 13 percent more for some integration, which is where the system breaks down. She asked Mr. Barkan how many interactions he has had with his private health insurance system in a month. **Mr. Barkan** said five or 10.

Rep. Lesko said that unions sometimes trade health plans for higher salaries. She asked whether HR 1384 would take away the current plans negotiated by the teachers unions. **Ms. Turner** said yes. An issue is the compensation that union members passed up in order to get generous health benefits.

Rep. Burgess asked what would happen if expenditures exceed the budget. **Dr. Baker** said cutting the excess would be necessary. **Rep. Burgess** asked if that would result in a rationing of care. **Dr. Blahous** said that studies have demonstrated that demand goes up significantly when costs are lowered for healthcare. This would be combined with the constriction of supply due to the decreased provider payment rates. **Rep. Burgess** asked Ms. Turner whether patients will have to wait to the new budget cycle if there's a new CAR T-therapy or sickle cell treatment. **Ms. Turner** said yes. Restricted access already occurs in countries like Singapore and France. In Europe, innovation is crippled by payment policies. **Rep. Burgess** asked if Medicare level payment rates would affect access. **Ms. Turner** said yes. Physicians' offices would close from operating in the red. **Rep. Burgess** said that the bill is frightening to read. He asked what can prevent a black market healthcare system from developing private care. **Ms. Turner** said that could certainly happen on places like the Indian reservations.

Chairman McGovern said that there is a quarterly global budget review written into the bill. There is alarmist discussion happening analogous to what happened during the ACA hearing. **Chairman McGovern** asked whether the US has worst outcomes compared to the UK. **Dr. Collins** said the UK and other industrialized countries with universal health systems actually have better outcomes with less money spent. **Dr. Nahvi** said that there is already rationing happening with antiplatelet drugs and antibiotics.

Rep. DeSaulnier said that many small businesses face staggering costs in paying for their employees' healthcare costs. **Rep. DeSaulnier** asked about the consequences of handling care for indigent persons. **Dr. Nahvi** said the hospitals that primarily care for indigent persons would benefit with universal coverage since they would be receiving rates higher than Medicare payment rates. **Rep. DeSaulnier** asked how acute behavioral health costs are subsidized. **Dr. Nahvi** said that hospitals pay for the people who end up in the ER and cannot be reimbursed. **Dr. Collins** said that people are making decisions based on their deductibles for their health care.

Ranking Member Cole said that Medicare for All will take plans away from 173 million Americans and give them something they may or may not be willing to pay for. Medicare for All would cost $32 trillion over 10 years, which would make the annual budget $7.7 trillion dollars. The legislation has proposed no way to pay for this, but even doubling the income tax and corporate tax would be insufficient. Dr. Baker offered many ways to pay for this in his written testimony, but the industry would not accept the level of cuts to input costs. If such costs become law, Medicare for All would become nothing but a program that provides minimal care in exchange for astronomical costs and wait times. Medicare for All would force doctors and hospitals to take lower payments, thus making it impossible for current Medicare beneficiaries to receive care. Rural hospitals rely on the higher payment rates, which if lowered, would force additional closures. Congress should focus on building on Medicare, which is proven to work. It is skeptical that a new one-size-fits-all system will achieve its objectives.

Chairman McGovern said that Medicare for All is possible. Patients should not have to battle with their insurance companies or forego care due to unaffordability.

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