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Exploring Pathways to Affordable, Universal Health Coverage
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Chairman DeSaulnier, Ranking Member Allen, Chairman Scott, and members of the subcommittee, thank you for giving me the opportunity to address you today on the need for universal health care coverage.

I am Georges C. Benjamin, MD, executive director of the American Public Health Association. APHA is our nation's professional society that champions the health of all people and all communities. We are celebrating our 150th anniversary as an association this year and are celebrating our work to improve the health and well-being of our nation and the world.

I am a physician who is trained and certified in internal medicine. I spent the first half of my career as a clinician, practicing and teaching emergency medicine both in the private sector and in the military. I have also had the opportunity to serve my community in a variety of executive management positions to include: Chief of Emergency Medicine at the Walter Reed Army Medical Center; Chairman of the Department of Community Health and Ambulatory Care at the District of Columbia General Hospital; Acting Commissioner for Public Health for Washington, D.C.; Interim Director of the Emergency Ambulance Bureau of the D.C. Fire and EMS Department; and Health Secretary for the State of Maryland. I have served as the executive director of APHA for the last 19 1/2 years. I share my professional background with you here today to point out I have practiced and managed in almost every patient care component of our health and public health system. During my professional career, I have learned one thing: To receive quality, affordable health care, coverage matters.

The State of Coverage

Efforts around universal health care in the United States started in the early 1900s and have resurfaced on a regular basis.[1] President Franklin D. Roosevelt attempted twice in the 1940s to establish universal health care and was unsuccessful.[1] The U.S. Congress passed Medicare and Medicaid in the 1960s, and when the programs were signed into law, we expanded coverage for most seniors and some low-income individuals and families. The movement toward universal health care coverage was further advanced after the Patient Protection and Affordable Care Act was signed into law.[2] Expanding health insurance coverage has been surprisingly difficult. There also have been decades of political animosity toward health care reform in the United States, with failed attempts during the Nixon and Clinton administrations and numerous failed attempts to repeal and challenge the ACA. Today, the U.S. government remains the largest payer of health care in the United States, covering nearly 90 million Americans through Medicare, Medicaid, TRICARE, and the Children's Health Insurance Program.[3] However, this coverage is not universal, and many Americans remain uninsured[3] or underinsured.[4,5]

Health insurance is your membership card to our nation's health care system. While we do have a very large safety net system that includes public and private clinics, community health centers and emergency departments, health insurance coverage remains your best ticket to equitable care. Today, 90% of the civilian noninstitutionalized U.S. population has health insurance coverage.[4] Sixty-one percent have coverage through private coverage, and 38% through public coverage. This means that 9.7% of the population is uninsured. The percentage of individuals lacking insurance coverage is highly variable across states, with Texas being the highest at 17.7% to Massachusetts the lowest at 2.8%.[6] The lack of insurance coverage is also variable across race and ethnicity:

- of non-Hispanic Whites, being 7.8% lack coverage;
- of Asians 7.2% lack coverage;
- of non-Hispanic Blacks, 11.4% lack coverage;
- of Hispanics, 20% lack coverage;
- of American Indian/Alaska Natives, 21.7% lack coverage; and
- of Native Hawaiian/Pacific Islanders, 12.7% lack coverage.[7]

We know coverage disparities contribute to worse health outcomes. It is clear that until we achieve a health system with everyone in and no one out, we will continue to struggle to achieve

the best health for our population. In the United States today, the key to such a health system is affordable health insurance coverage.

The United States spends more on health care ($4.1 trillion, or 19.7% of GDP in 2020) than any other industrialized country yet has worse health outcomes.[3,8] Tragically, we have the most preventable deaths of any high-income nation but spend just 2.9% of that $4.1 trillion on public health.[8]

Our lack of universal coverage has been found to be one of the four factors that has contributed to the U.S. ranking last in health system performance when compared to 11 other high-income countries. One study found that there were four features that distinguished top performing countries from the United States: "1) they provide for universal coverage and remove cost barriers; 2) they invest in primary care systems to ensure that high-value services are equitably available in all communities to all people; 3) they reduce administrative burdens that divert time, efforts, and spending from health improvement efforts; and 4) they invest in social services, especially for children and working-age adults."[9]

Coverage Improves Health

Health insurance coverage impacts many things including access to health care, morbidity, mortality, the quality of care received, equity, and both individual and system economics.

Numerous studies have demonstrated the value of coverage. Since the passage of the Affordable Care Act and the 2012 Supreme Court decision National Federation of Independent Business et al. v. Kathleen Sebelius, Secretary of Health and Human Services, et al., which made Medicaid coverage optional for the states, the nation has undergone a natural experiment that has demonstrated the value of health insurance coverage. For example, having a personal doctor is known to be an important determinant of good access to care. More individuals in states that have expanded the Medicaid program have a personal physician than in states that have not expanded.[10] In addition, a series of studies found Medicaid coverage facilitated more people having a regular source of care; better access to preventative services, well child visits and early diagnosis and treatment; and improved access to behavioral health and treatment for substance use disorders.[11,12,13,14,15,16,17] All-cause mortality was reduced in the state of Massachusetts when

they expanded coverage.[18] In states that expanded Medicaid following the ACA's passage, several studies have shown that mortality decreased specifically with cardiovascular disease.[19]

Another national goal has been to optimize the utilization of care to the appropriate clinical setting. Coverage has been shown to reduce the utilization of emergency departments for non-emergent care.[20,21,22,23] If cost is a concern, which of course it is, keeping people out of emergency rooms except for emergency care is a major reason to provide universal coverage.

Universal health care can help increase access to care while decreasing disparities in health. Several factors point to decreased racial and ethnic disparities under a universal health care model. CHIP's creation in 1997 covered children in low-income families who did not qualify for Medicaid; this coverage is associated with increased access to care and reduced racial disparities.[24] Similarly, differences in diabetes and cardiovascular disease outcomes by race, ethnicity, and socioeconomic status decline among previously uninsured adults once they become eligible for Medicare coverage.[25] While universal access to medical care can reduce health disparities, it does not eliminate them; health inequity is a much larger systemic issue that society needs to address.

Still, universal health care better supports the needs of vulnerable groups. The estimated lifetime risk of need for long-term care and support services is about 52% among Americans 65 years or older.[26] Activities of daily living programs are not considered "medical care" and are not covered by Medicare or health plans. Medicaid buy-in programs for workers with disabilities exist in many states but have varying benefit levels and eligibility restrictions.[26] The United States can adopt strategies from existing models in other countries with long-term care policies already in place. For example, Germany offers mandatory long-term disability and illness coverage as part of its national social insurance system, operated since 2014 by 131 nonprofit sickness funds.[27] German citizens can receive an array of subsidized long-term care services without age restrictions.[27] In France, citizens 60 years and older receive long-term care support through an income-adjusted universal program.[28]

Universal health care can also decrease health disparities among individuals with mental illness. For instance, the ACA Medicaid expansion helped individuals with mental health concerns by improving access to care and effective mental health treatment.[29,30,31]

Health insurance coverage has been understood to improve the economic well-being of individuals, families, and health systems. Coverage reduces out of pocket costs as well as serves

as a buffer from catastrophic costs should an individual require a costly medical care.[30] In addition, the economic well-being of hospitals, particularly in rural communities, has been shown to be enhanced.[31,32]

Other societal benefits from Medicaid coverage have been job creation. In Montana, for example, Medicaid expansion has been credited with the expansion of 5,000 jobs between 2018 and 2020, and in Ohio expansion is linked to improving the ability to seek and maintain work.[31,34]

COVID-19 Pandemic Exposes Health System Shortfalls

The COVID-19 pandemic exacerbated underlying vulnerabilities in our current health care system and highlighted the urgent need for universal health care for all Americans.

Health care is inaccessible for many individuals in the United States. For many Americans, accessing health care remains cost prohibitive.[35] Coverage under employer-based insurance is vulnerable to fluctuations in the economy. Due to the COVID-19 pandemic, an estimated 20 million Americans had lost their employer-sponsored health insurance by September 2021 as a result of job loss.[36] Job losses were not distributed evenly and particularly affected those in low-paying, service-sector positions, thereby disproportionately affecting individuals of lower socioeconomic status.[37, 38] When uninsured or underinsured people refrain from seeking care, this may lead to delayed diagnosis and treatment. These delays can promote the spread of an infectious pathogen, reduce overall health, and, therefore, increase overall health care costs.

The ACA reformed health care by eliminating exclusions for preexisting conditions, requiring coverage of 10 standardized essential health care services, capping out-of-pocket expenses, and significantly increasing the number of insured Americans. However, many health services remain uncovered, and out-of-pocket costs can vary considerably. Those living with a disability or chronic illness are likely to use more health services and pay more. A recent survey conducted during the COVID-19 pandemic revealed that 38.2% of working adults and 59.6% of adults receiving unemployment benefits from the Coronavirus Aid, Relief, and Economic Security (CARES) Act could not afford a $400 expense, highlighting that the COVID-19 pandemic exacerbated lack of access to health care because of high out-of-pocket expenses.[37] In addition, the ACA did not cover optometry or dental services for adults, thereby limiting access to care even among the insured population.[39]

A 2019 study by the Commonwealth Fund[5] showed that after 10 years of implementation, 45% of adults ages 19 to 64 enrolled in the ACA were underinsured, defined as having out-of-pocket health care expenses of 10% or more of one's income (or 5% or more for those up to 200% above the federal poverty limit).

Our current health care system remains significantly stressed in its response to the COVID-19 pandemic to supply the level and quality of care our population expects and is entitled to. For the first time in our history, we implemented crisis standards of care on a broad basis, thereby triaging care for many individuals. The pandemic also reminded our nation of the vital role of the governmental public health system. The lack of an adequality structured and resourced federal, state, and local public health system is one major reason our nation performed as poorly as it did in responding to the COVID-19 pandemic.[40,41]

The U.S. public health system has a fragmented and antiquated data collection and disease surveillance systems. The COVID-19 pandemic response was plagued by inconsistent utilization of science-based public health strategies to mitigate the contagion, such as isolation, quarantine, masking, testing, and vaccination. Our system has been doubly challenged by historic under-investments in public health infrastructure and an inability to mount a coordinated national response linking our medical and public health data systems, messaging, and outreach.[40]

As in other economic downturns wherein people lost their employer-based insurance, more people enrolled in Medicaid during the pandemic. States' efforts to cover their population, such as expanding eligibility, allowing self-attestation of eligibility criteria, and simplifying the application process, also increased Medicaid enrollment numbers.[41] The federal "maintenance of eligibility" requirements further increased the number of people on Medicaid by postponing eligibility redeterminations. Resuming eligibility redeterminations will cause some to lose coverage. There is significant concern that when the public health emergency ends as many as 15 million people will be at risk of losing their coverage if their incomes are above traditional Medicaid thresholds.[42, 43]

An urgent need for coverage during the pandemic persists. Virginia's enrollment has increased by more than 40% since March 2020.[44] In Arizona, 78,000 people enrolled in Medicaid and CHIP in two months.[44] In New Mexico, where 42% of the population was already enrolled in Medicaid, 10,000 more people signed up in the first two weeks of April than expected before the pandemic.[45] Nearly 24 million people who lost their jobs during the pandemic could

be eligible for Medicaid.[45] Even in September 2021, the leisure and hospitality sector had a job shortfall of nearly 1.6 million relative to February 2020. The number of long-term unemployed (those jobless for 27 weeks or more) decreased by 496,000 in September to 2.7 million but was 1.6 million higher than in February 2020.[46]

While increasing Medicaid enrollment can cover individuals who otherwise cannot afford care, it further strains state budgets.[44] Medicaid spending represents a significant portion of states' budgets, making it a prime target for cuts. Ohio announced $210 million in cuts to Medicaid, a significant part of Colorado's $229 million in spending cuts came from Medicaid, Alaska cut $31 million in Medicaid, and Georgia anticipates 14% reductions overall in 2020. These cuts were in response to reduce revenues related to the pandemic.[44]

While Congress authorized a 6.2% increase in federal Medicaid matching during the pandemic, this increase was not permanently expanded (through 2021)[47] and is unlikely to sufficiently make up the gap caused by increased state spending and decreased revenue.[42] Given the severity and projected longevity of the pandemic's economic consequences, many people will remain enrolled in Medicaid throughout state and federal funding cuts. This piecemeal funding strategy is unsustainable and will strain Medicaid, making accessibility even more difficult for patients.

One way to expand health insurance coverage is to continue to build upon the Affordable Care Act. The House-passed Build Back Better Act includes significant investments for expanding and improving health coverage in the nation, moving us closer to the goal of achieving universal health coverage for all. The bill would close the current Medicaid coverage gap through 2025 by providing premium tax credits and cost-sharing subsidies for more than 2 million uninsured individuals who live below the poverty line. Importantly, the bill would also expand Medicare benefits by adding coverage for hearing services for millions of our nation's seniors. The bill would also extend the American Rescue Plan Act's enhanced premium tax credits for purchasing Affordable Care Act plans in the federal marketplace through 2025.

In addition, the measures in the legislation would provide important new investments to improve the health of our nation's children and their families. The bill would require 12 months of continuous Medicaid and the CHIP eligibility to postpartum women, implement interventions and research to address the nation's maternal mortality crisis, require 12 months of continuous

eligibility for children enrolled in Medicaid and CHIP and authorize permanent funding for CHIP.[48]

The pandemic continues to highlight the difficult truth that health disparities remain a significant problem in our current health system. Four reasons that have historically been thought to contribute to health inequities:

1. unequal access to health care, including, health insurance coverage;
2. differences in the quality of care received in the system;
3. differences in health seeking behavior; and
4. differences in access to goods and services communally known as the social determinants of health. These social determinants include structural racism and discrimination. During COVID-19 many of these factors became evident in the higher prevalence in COVID-19 hospitalizations and deaths in communities of color.[49]

The 1964 Civil Rights Act outlawed segregation of health care facilities receiving federal funding, and beginning in 2010, the ACA significantly benefited people of color. Yet racial and sexual minority disparities persist today in our health care system. For example, under a distribution formula set by the U.S. Department of Health and Human Services, hospitals reimbursed mostly by Medicaid and Medicare received far less federal funding from the March 2020 CARES Act and the Paycheck Protection Program and Health Care Enhancement Act than hospitals mostly reimbursed by private insurance.[50] Hospitals in the bottom 10% based on private insurance revenue received less than half of what hospitals in the top 10% received. Medicare reimburses hospitals, on average, at half the rate of private insurers. Therefore, hospitals that primarily serve low-income patients received a disproportionately smaller share of total federal funding.[50]

Additional barriers for these communities include fewer and more distant testing sites, longer wait times,[51] prohibitive costs, and lack of a usual source of care.[52] Black Americans diagnosed with COVID-19 are more likely than their White counterparts to live in lower-income zip codes, to receive tests in the emergency department or as inpatients, and to be hospitalized and require care in an intensive care unit.[53] Nationally, only 20% of U.S. counties are disproportionately Black, but these counties account for 52% of COVID-19 diagnoses and 58% of deaths.[54] The pre-pandemic racial gaps in health care catalyzed pandemic disparities and will

continue to widen them in the future. As of February 2022, disparities in COVID-19 vaccination rates among Hispanic, Black, Native American, and Asian/Pacific Islander individuals have improved substantially but remain below the rate among their White counterparts.[55]

Summary

The COVID-19 pandemic has brought a new urgency to the need for universal health care coverage in the United States. This is an unprecedented time, and indeed the pandemic has exacerbated many of the existing problems in our current patchwork health system. The COVID-19 pandemic represents a watershed moment where we can reconstruct a fractured health insurance system into a system of universal health care. As new data emerge about those most impacted by the pandemic, this is also a unique opportunity to expand benefits to address the needs of the underserved, the most vulnerable, and those historically denied or left out of health services. If we can drive to homebound people's houses to vaccinate them, we can reimagine boundaries to make home- and community-based disability services, dental care, vision services, prescription drugs, chiropractic care, mental health care, and telemedicine standard practice. We also recognize the essential role of ensuring that public health remains an integral part of any universal health system in order to advance population health.

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