



**Medicare for All Who Want It:
Putting Every American in Charge of Their Health Care with Affordable Choice for All**

Getting health care in America is too expensive, too complicated, and too frustrating. The soaring costs of care, the lack of coverage options, and the complexity of receiving even simple medical care almost always leave us feeling powerless. Navigating the bureaucracy and intransigence of insurance companies often leaves us feeling exploited rather than served. Going to the doctor can be worrying enough without the added concern of whether a biopsy will lead to a bankruptcy.

Every day, millions of Americans—both with and without insurance—struggle to afford health care, forcing families across the country to make impossible decisions. Seniors split pills to cut health costs so they can make rent. Young adults put off treating depression because they can't afford to pay \$150 to see a therapist. And parents avoid stepping inside emergency rooms when their child is sick, opting instead to wait in the parking lot in case things take a turn for the worse.¹ We pay, on average, over \$5,000 more for health care per person every year than other developed countries—and we don't have better health to show for it.² Last year, an elementary school teacher from Texas died after she balked at paying a \$116 copay for flu medication.³

While we're paying more for insurance, insurance companies are seemingly doing everything they can to make sure they don't provide the service that we are paying for—coverage of our health care costs. In 2017 alone, 121 leading health insurance companies denied more than 41 million claims.⁴ Only 0.5% of these denials were appealed, and only 0.07% of these denials were overturned on appeal.⁵ That same year, the state of California issued a multi-million dollar fine against Anthem Blue Cross for systematically denying patient claims.⁶ In one case, Anthem continuously denied a customer's claim to cover the cost of needed, already-approved surgery despite more than 22 phone calls made to Anthem to resolve this issue by the patient, his spouse, his doctors, and his insurance broker.

We're at this moment of crisis because of a failure of leadership. For years, Washington politicians have allowed the pharmaceutical industry, giant insurance companies, and powerful hospital systems to profit off of people when they are at their sickest and most vulnerable. It's why, for example, the federal government has failed to rein in predatory, surprise medical billing and unconscionable price increases on medicines.

¹ Kliff, Sarah. "[Am I a bad person? Why one mom didn't take her kid to the ER — even after poison control said to.](#)" Vox. May 10, 2019.

² Etehad, Melissa. "[The U.S. spends more on healthcare than any other country — but not with better health outcomes.](#)" Los Angeles Times. July 18, 2017.

³ Paul, Kari. "[Texas woman dies because \\$116 co-pay for flu medication was too expensive.](#)" Market Watch. February 2, 2018.

⁴ Pollitz, Karen, Cynthia Cox, and Rachel Fehr. "[Claims denials and appeals in ACA marketplaces.](#)" Kaiser Family Foundation. February 25, 2019.

⁵ Pollitz, Karen, Cynthia Cox, and Rachel Fehr. "[Claims denials and appeals in ACA marketplaces.](#)" Kaiser Family Foundation. February 25, 2019.

⁶ Helms, Liz. "[Has your insurer denied a medical claim? Stand up for your right.](#)" Stat News. May 17, 2019.



We don't have time to wait for the same Washington politicians to act—politicians who seem more interested in fighting each other than fighting to make people's lives better. It's time for a new era of leadership. Pete is committed to ushering in new solutions, guided by how they'll improve real people's lives, not by where those changes fall on some left-right spectrum devised in Washington.

For starters, everyone should have the option of getting coverage through a public insurance alternative. This way, if a private insurance plan from your employer or the marketplace isn't affordable, you can get a plan that is. It's what Pete calls Medicare for All Who Want It. Unlike many other proposals, you can choose whether to join a public alternative, so if you like your private insurance you can keep it. If corporate insurers are unable or unwilling to lower costs or offer plans that are dramatically better than what's available today, competition from this public insurance alternative will naturally lead to Medicare for All.

Pete's plan features even more ways to empower people. He will ban surprise medical billing, put a limit on out-of-pocket costs for seniors with Medicare, and ensure that health care providers, like hospitals, price their services fairly by capping out-of-network rates. Pete is also committed to bringing transparency to pricing and reducing wasteful administrative costs that ultimately get passed down to patients. These solutions will correct a system that has been stacked against Americans for too long.

Health care is a right, and the plan outlined here is an ambitious and enduring commitment to that basic truth. At the same time, it accounts for Americans' freedom to choose what's best for them and for the transition that individuals, families, businesses, and the economy will need to adjust to these changes. When the health of all Americans is the central force that drives our system, it will be Americans themselves who will move us in a better direction where health care is affordable and patients are healthier.

Pete's vision for Medicare for All Who Want It is part of the solution to driving down costs. But it's far from the only piece of his comprehensive strategy to make sure all Americans can live healthy lives. In the coming weeks, Pete will release a series of health care plans on drug pricing, innovation, equity in access to care and in health outcomes, and more.

We can come together as a nation to break with the past. We can create a health care system that puts power in the hands of each American. And we can create a healthier future for all.

Ensure that all Americans have affordable health care through Medicare for All Who Want It.

In our country, the more than 27 million people who are uninsured are either paying too much for care or not getting the care they need because it's too expensive.⁷ Uninsured individuals are less likely to access crucial preventive services—such as cancer screenings or cholesterol checks⁸—and more likely to forego

⁷ ["Key Facts about the Uninsured Population."](#) Kaiser Family Foundation. December 7, 2018.

⁸ Garfield, Rachel, Kendal Orgera, and Anthony Damico. ["The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act."](#) Kaiser Family Foundation. January 25, 2019.



care for chronic conditions, such as diabetes or heart disease. And 87 million are underinsured, which means they're also paying too much for care, in the form of high deductibles or out-of-pocket costs that make them more likely to struggle to pay for care or skip it altogether.⁹ We must ensure that everyone has an affordable option for health coverage that guarantees access to care when they need it.

Through Pete's Medicare for All Who Want It plan, anyone—whether you're currently uninsured, have employer insurance, are on Medicaid, or buy coverage on your own through the marketplace—will be able to opt in to an affordable, comprehensive public alternative. This affordable public plan will incentivize private insurers to compete on price and bring down costs. If private insurers are not able to offer something dramatically better, this public plan will create a natural glide-path to Medicare for All. The choice of a public plan empowers people to make their own decisions regarding the type of health care that makes sense for them by leveling the playing field between patient and the health care system. It gives the American people a choice and trusts them to set the pace at which our country moves in a better direction on health care.

Guarantee universal coverage through Medicare for All Who Want It.

Pete believes that health care is a human right, yet millions of Americans have no health insurance. This shameful reality has worsened under the current administration. Nearly 2 million fewer people, including 425,000 children, had health insurance in 2018 than during 2017.¹⁰ Today, about 1 in 10 people—more than 27 million—are uninsured.¹¹ People of color are less likely to be insured: about 1 in 5 Latinos and Native Americans, for example, lack health insurance.¹² To achieve universal coverage, Pete will:

- **Expand access to coverage through Medicare for All Who Want It.** The Medicare for All Who Want It public alternative will help America reach universal coverage by providing an affordable insurance option to the currently uninsured. First, individuals with lower incomes in states that have refused to expand Medicaid will be automatically enrolled in the public option. Pete will also end Medicaid work requirements that take health care away from people. Second, individuals who forgo coverage through their employer because it's too expensive will be able to enroll in the public option and receive access to income-based subsidies that help guarantee affordability. Third, middle-income individuals and families who were uninsured because they could not afford coverage will be eligible for subsidized coverage through the marketplace for either private insurance or the public option. The public alternative will provide the same essential health benefits as those currently available on the marketplaces and ensure that everyone has access to high-quality, comprehensive coverage.

⁹ Collins, Sarah R., Herman K. Bhupal, and Michelle M. Doty. "[Health Insurance Coverage Eight Years After the ACA.](#)" Commonwealth Fund. February 7, 2019.

¹⁰ Berchick, Edward et al. "[Health Insurance Coverage in the United States: 2018.](#)" U.S. Census Bureau. September 2019. Berchick, Edward R. and Mykyta, Laryssa. "[Uninsured Rate for Children Up to 5.5 Percent in 2018.](#)" U.S. Census Bureau. September 10, 2019

¹¹ Berchick, Edward et al. "[Health Insurance Coverage in the United States: 2018.](#)" U.S. Census Bureau. September 2019.

¹² Kaiser Family Foundation. "[Uninsured Rates for the Nonelderly by Race and Ethnicity: 2017.](#)" No date.



- **Automatically enroll individuals in affordable coverage if they are eligible for it.** Over half of people with no insurance are eligible for either free insurance or an affordable insurance option.¹³ Anyone eligible for free coverage in Medicaid or the public option will be automatically enrolled, and those eligible for subsidized coverage will have a simple enrollment option.¹⁴ Individuals could opt out of public coverage if they choose to enroll in another insurance plan.
- **Retroactively enroll those who fall through the cracks in the public option.** A backstop fund will reimburse health care providers for unpaid care to patients who are uninsured. Individuals with no coverage will be retroactively enrolled in the public option.

Make marketplace coverage dramatically more affordable for individuals and families.

Millions of Americans cannot afford the premiums on the marketplaces. Across Iowa, for example, a 60-year-old making \$50,000 could face a monthly premium of roughly \$1,000 for the most popular type of plan, amounting to a quarter of their annual income.¹⁵ The high cost of insurance keeps many Americans from enrolling through the marketplaces or drives them to short-term “skinny” plans that do not provide comprehensive coverage. To ensure that all individuals and families receiving coverage through the marketplace can afford quality insurance, Pete will:

- **Strengthen the marketplaces by rolling back the current administration’s attempts to undermine it.** Pete will restore and expand cost-sharing reduction payments to health plans to lower deductibles and other out-of-pocket costs for millions of people. His administration will reverse the Trump administration rules loosening restrictions on association health plans and short-term limited duration plans, which provide limited benefits and consumer protections.
- **Make marketplace coverage affordable for everyone by linking subsidies to higher-quality gold-level plans and capping premium payments at 8.5% of income.** Pete will make premium subsidies more generous for low-income people. Today, a family of three making \$31,000 a year pays about \$1,200 annually for “silver” coverage on the marketplace.¹⁶ Under Pete’s plan, they will pay a maximum of roughly \$600 a year for higher quality (i.e. gold-level) coverage. This plan will also extend the subsidies to more middle-income people by capping premium payments at 8.5 percent of income for everyone. That means that the 60-year-old in Iowa making \$50,000 and currently paying \$12,000 annually in premiums will now pay no more than \$4,250 annually for gold coverage. Pete will also lower out-of-pocket costs for consumers by increasing cost-sharing assistance.

¹³ Kendall, David, et al. [“Cost Caps and Coverage for All: How to Make Health Care Universally Affordable.”](#) Third Way. November 2018.

¹⁴ Kendall, David, et al. [“Cost Caps and Coverage for All: How to Make Health Care Universally Affordable.”](#) Third Way. November 2018.

¹⁵ Fehr, Rachel, et al. [“How affordable are 2019 ACA premiums for middle-income people?”](#) Kaiser Family Foundation. March 5, 2019.

¹⁶ Scott, Dylan. [“House Democrats new plan to strengthen Obamacare, explained.”](#) Vox. March 26, 2019.

Make health care affordable for seniors on Medicare by capping out-of-pocket costs.

Seniors on Medicare are among those struggling most with the high cost of care. One in four Medicare beneficiaries—15 million people—spend over 20 percent of their income on premiums and medical care.¹⁷ Low- and middle-income Medicare beneficiaries are most affected. Medicare beneficiaries spend an average of more than \$3,000 on coinsurance, deductibles, and other out-of-pocket costs each year.¹⁸ Costs run much higher for many, including those with chronic disease and disability.

Seniors enrolled in Medicare Advantage are protected from high out-of-pocket costs by an out-of-pocket limit. Once a beneficiary’s costs reach that amount, the insurer pays the full cost of care for the rest of the year. The traditional Medicare program, however, does not have a cap on out-of-pocket spending, putting seniors at risk of having medical or drug costs wipe out their savings. Pete believes that seniors in traditional Medicare deserve the same financial protection. To that end, he will improve affordability in Medicare by capping out-of-pocket costs, with lower caps for low-income seniors. Measures to improve the affordability of drugs purchased through Medicare Part D will be discussed in a forthcoming drug pricing plan.

End surprise billing by requiring all providers at in-network facilities to be in-network.

All too often, patients treated for injuries or illness suffer an additional misfortune: a surprise bill. Most commonly, unexpected bills arise when a patient receives care at an in-network hospital and, unbeknownst to them, is treated by an out-of-network physician.¹⁹ This mismatch isn’t the unintended consequence of skimpy provider networks or a lack of coordination—it’s a deliberate business strategy fueled by profit-driven firms in private equity.²⁰ Surprise bills are all too common. About one in five visits to the emergency room is likely to lead to a surprise bill. This phenomenon even impacts new mothers, 1 in 10 of whom experience a surprise bill.²¹

Surprise billing adds to families’ health care costs, can lead to medical debt, and may discourage people from seeking necessary care. The average surprise bill is \$628,²² a price tag 40 percent of Americans say they’d be unable to afford.²³ In the most extreme cases, patients have been slapped with five- or six-figure bills after emergency treatment for incidents like bike crashes or heart attacks.²⁴

¹⁷Schoen, Cathy, Karen Davis, and Amber Willinik. [“Medicare beneficiaries’ high out-of-pocket costs: costs burden by income and health status.”](#) The Commonwealth Fund. May 12, 2017.

¹⁸Schoen, Cathy, Karen Davis, and Amber Willinik. [“Medicare beneficiaries’ high out-of-pocket costs: costs burden by income and health status.”](#) The Commonwealth Fund. May 12, 2017.

¹⁹Lewis, David. [“The changing landscape of out-of-network reimbursement.”](#) Milliman White Paper. September 2018.

²⁰Kellett, Hunter, Alexander Spratt, and Mark Miller. [“Surprise billing: choosing patients over profits.”](#) Health Affairs. August 12, 2019.

²¹Chartock, Benjamin, et al. [“Consumers Responses to Surprise Medical Bills in Emergency Situations.”](#) Health Affairs, March 2019.

²²Sun, Eric, et al. [“Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals.”](#) JAMA Internal Medicine, August 2019.

²³[“Report on the Economic Well-Being of U.S. Households in 2017.”](#) Federal Reserve. May 2018.

²⁴Terhune, Chad. [“His \\$109K heart attack is now down to \\$332 after NPR told his story.”](#) National Public Radio. August, 31, 2018.



To protect patients from excessive and unexpected medical bills, Pete will require that bills related to in-network facilities be billed as in-network, including for services from physicians and laboratories that may not be in-network. Hospitals, not patients, should bear the responsibility of verifying that their providers are included in their insurance networks, whether for private plans or public programs. Pete will also place limits on what out-of-network providers, including ambulances and air ambulance services, can charge, as described in detail below.

Lower system-wide health care spending by ensuring that health providers price fairly and focus on patients, not profit.

The United States spends more than \$10,000 per person on health care, which comes to 18 percent of our GDP—more than twice as much what other high-income countries pay.²⁵ Despite spending more on health care per capita than any other country in the world, we don't have better health outcomes to show for it. Today, we are dying younger and are less healthy than we used to be.²⁶ Studies indicate that one of the main reasons why health care is so expensive in America is the industry's high price tag on everything—from insulin that is 10 times more expensive here than in Canada, to MRIs that are five times cheaper in Australia.²⁷ The millions of people with private insurance are increasingly being squeezed by the high cost of care²⁸ and have borne the brunt of hospital price increases.²⁹

To reorient our health system towards patient and community health and make health care more affordable, Pete will:

- **Ensure that hospitals serve their community by strengthening hospital community benefit requirements.** Nonprofit hospitals do not pay federal taxes under the assumption that they benefit their communities. Many benefit their communities in a number of ways, such as by providing free care to uninsured patients and offering medical training.³⁰ However, some non-profit hospitals are doing little to benefit their community—sometimes even harming their own patients through aggressive billing and predatory collection practices.³¹ Pete's plan will strengthen community benefit requirements to ensure that hospitals are investing in the health of their patients and communities. This will consist of defining standards for what spending counts

²⁵ ["CMS National Health Expenditure Accounts."](#) Centers for Medicare and Medicaid Services. December 11, 2018.

Johnson, Carolyn Y. ["The real reason the U.S. spends twice as much on health care as other wealthy countries."](#) The Washington Post. March 13, 2018.

²⁶ Laursen, Lucas. ["Drug Overdoses, Diabetes, and Suicide: Why Americans Are Dying Younger."](#) Fortune. November 29, 2018.

²⁷ Rauhala, Emily. ["As price of insulin soars, Americans caravan to Canada for lifesaving medicine."](#) Washington Post. July 31, 2019.

Kamal, Raban, and Cynthia Cox. ["How do health care prices and use in the U.S. compare to other countries?"](#) Peterson-Kaiser Health Systems Tracker. May 8, 2018.

²⁸ ["2018 Employer Health Benefits Survey."](#) Kaiser Family Foundation. October 3, 2018.

²⁹ White, Chapin, and Whaley, Christopher. ["Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely."](#) RAND Corporation. 2019

³⁰ Hostetter, Martha and Sarah Klein. ["In Focus: Hospitals Invest in Building Stronger, Healthier Communities."](#) Commonwealth Fund. September 23, 2016.

³¹ Beil, Laura. ["As patients struggle with bills, hospital sues thousands."](#) The New York Times. September 3, 2019.

Hancock, Jay and Elizabeth Lucas. ["UVA has ruined us": Health system sues thousands of patients, seizing patients and putting liens on home."](#) The Washington Post. September 9, 2019.

as meaningfully benefiting the community and setting a baseline expectation for the types of community benefits in which non-profit hospitals should be investing. This will also include supporting hospitals that are doing good work in their community and holding those falling short accountable.

- **Make premiums more affordable by prohibiting health care providers, including hospitals, from charging more than twice what Medicare would pay for the same service for out-of-network care.** Health providers often charge private insurers exorbitant fees. Some insurers, for example, pay hospitals four times what they are paid by Medicare—whose payments are designed to cover the cost of care at an efficient hospital—for the same service.³² As hospital prices for outpatient care increase at a rate four times faster than physician prices,³³ hospital profits have risen to their highest levels in decades.³⁴ As President, Pete will prohibit health care providers from pricing irresponsibly by capping their out-of-network rates at twice what Medicare pays. This will also provide insurers with leverage to demand lower rates for in-network care.³⁵ For Critical Access Hospitals and other providers treating patients in underserved areas, where the cap may jeopardize access to care, the cap will be looser to ensure that providers can cover their costs. As noted in our [rural health plan](#), for these providers, Pete’s administration will increase Medicare reimbursement rates and encourage states to increase Medicaid reimbursement rates.

Make it easier to afford and find care for mental health and substance use disorder by enforcing parity.

“Mental health parity” means that coverage and treatment for mental health and substance use disorder are provided on equal terms as treatment for physical conditions. If a health plan offers unlimited doctor visits for medical services, for example, it must do the same for mental health and addiction services.³⁶ Although the government requires many plans to maintain mental health parity, true parity remains out of reach for many.³⁷ This makes it difficult to find affordable mental health treatment in a timely manner. An office visit with a mental health clinician is five times more likely to be out-of-network—and therefore more expensive—than an office visit with a primary care clinician.³⁸ A hospital visit for a mental health condition, such as an anxiety disorder, is four times more likely to be out-of-network than one for a physical condition, like heart disease.³⁹

³² Chapin White and Christopher Whaley, “[Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely](#),” RAND Corporation, 2019.

³³ Rosenthal, Elizabeth. “[That beloved hospital? It’s driving up health costs](#),” The New York Times. September 1, 2019.

³⁴ Gee, Emily. “[The High Price of Hospital Care](#),” Center for American Progress. June 26, 2019.

³⁵ Chernew, Michael, et al. “[The case for market-based price caps](#),” Health Affairs. September 3, 2019.

³⁶ “[What Is Mental Health Parity?](#)” National Alliance on Mental Illness. 2019.

³⁷ Vuolo, Lindsey, Robyn Oster, and Ellen Weber. “[Evaluating the promise and potential of the parity act on its tenth anniversary](#),” Health Affairs. October 10, 2018.

³⁸ Melek, Stephen P., Perlman, Daniel, and Davenport, Stoddard. “[Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates](#),” Milliman. December 2017.

³⁹ Melek, Stephen P., Perlman, Daniel, and Davenport, Stoddard. “[Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates](#),” Milliman. December 2017.



To lower the cost of mental health and addiction care, Pete will:

- **Enforce parity for mental health and addiction treatment coverage across all payers by penalizing insurance plans that do not comply with parity.** Pete will enforce parity in several ways, including requiring health plans to annually report how they manage and meet parity. Health plans that violate this policy will face fines and statutory penalties, and those plans most often out of compliance will be publicly named.
- **Establish mental health parity in Medicare and Medicaid.** Medicare remains the only major health plan to not cover mental health and addiction equally. Pete’s administration will also remove the 190-day lifetime limit on inpatient psychiatric admissions. While Medicaid requires managed care services to have parity, fee-for-service procedures currently do not. As President, Pete will encourage states to require Medicaid parity.

Empower patients by increasing transparency of prices and the quality of health services.

It’s often impossible for patients to find reliable information about the cost or quality of a health care service. Although employers have offered “shopping tools” that claim to make it easy for patients to understand trade-offs between costs and quality, these tools are often deeply flawed.⁴⁰ Without making price and quality information more readily available to consumers and purchasers, the market for health care will continue to run inefficiently, and we will continue to pay more for lower quality care.

Pete’s plan will empower patients to move our health care system to deliver higher quality and more cost-effective plans by: pushing insurers to improve price transparency tools;⁴¹ encouraging price information in electronic health records so patients can discuss follow-up care options and prices with their doctor;⁴² and improving provider directories, drug formulary comparisons, and plan quality ratings. Pete will also establish a national All-Payer Claims Database that will improve the quality of research around health care costs and quality and make it easier for patients, providers, and insurers to reward high quality, cost-effective care.⁴³

Bring down the costs of health care in America by tackling high administrative costs.

Our health care system is the most costly in the world in part because it spends \$496 billion annually on administrative costs—more than any other system globally.⁴⁴ This is largely driven by the inefficiency that results from hundreds of private payers imposing their own separate, unique billing policies that must

⁴⁰ [“Shoppable Care Work Group Report.”](#) Commonwealth of Pennsylvania. September 2017

⁴¹ [“Shoppable Care Work Group Report.”](#) Commonwealth of Pennsylvania. September 2017

⁴² Susan Morse, [“Part D plans required to give drug pricing information through electronic prescribing or EHR.”](#) Healthcare Finance, May 20, 2019

⁴³ Calsyn, Maura. [“Policy options to encourage all-payer claims databases.”](#) Center for American Progress. April 20, 2018.

⁴⁴ Gee, Emily and Topher Spiro. [“Excess administrative costs burden the U.S. health care system.”](#) Center for American Progress. April 8, 2019.



be decoded by providers and patients.⁴⁵ To lower cost and improve quality, we must make our health care system more efficient.

Pete’s plan will do this by harmonizing standards for transactions, including for eligibility and benefit verification, prior authorization, claims attachment, and claim status inquiry. His administration will also hold insurance companies accountable for adopting them. It will simplify billing by creating a central clearinghouse for claims,⁴⁶ establish an All-Payer Claims Database that supports health care quality initiatives,⁴⁷ and require integration of electronic health records, billing, and reporting systems, so patients no longer have to chase down their own health information. All of these improvements will allow doctors to focus less time on paperwork and more time on patients. This could generate up to \$10 billion in savings a year.⁴⁸

Empower the federal government to challenge health care mergers that raise the cost of care without improving patient outcomes.

Health insurers, hospitals, pharmacy companies, and health care provider groups are all growing larger, but *bigger* has not been *better* for patients. Greater consolidation among providers and insurers results in higher prices for patients without improving quality.⁴⁹ In the health care sector, merger and acquisition activity continues to set records.⁵⁰ Despite this flurry of consolidation, the budgets for the federal agencies charged with reviewing mergers and ensuring that consumers are protected have remained flat.⁵¹

To ensure robust competition in health care markets and protect patients, Pete will increase funding for federal antitrust authorities to empower them to review more mergers and equip them to bring enforcement cases against activity that harms competition and hurts health care workers. He will also authorize the Federal Trade Commission to monitor the conduct of non-profit hospitals and take action against anti-competitive behavior.

Some of the transactions driving health care consolidation are too small to trigger review individually, yet collectively, they can add up to large increases in market power. For example, while hospitals are not subject to scrutiny when buying up small physician practices, those purchases can lead to monopolies in local markets. To address this, Pete will also lower reporting thresholds for mergers, requiring that more transactions be reviewed by antitrust enforcers.

⁴⁵ Gee, Emily and Topher Spiro. [“Excess administrative costs burden the U.S. health care system.”](#) Center for American Progress. April 8, 2019.

⁴⁶ Emanuel, Ezekiel. [“Democrats are having the wrong health care debate.”](#) The New York Times. August 2, 2019.

⁴⁷ Calsyn, Maura. [“Policy options to encourage all-payer claims databases.”](#) Center for American Progress. April 20, 2018.

⁴⁸ Cutler, David M. [“Reducing health care cost: Decreasing administrative spending.”](#) Testimony for Senate Committee on Health, Education, Labor and Pensions. July 31, 2018.

⁴⁹ [“Hospital consolidation: trends, impacts, and outlook.”](#) National Institute for Health Care Management. April 2019.

⁵⁰ Tracer, Zachary. [“Healthcare dealmaking just hit an all-time high of almost \\$400 billion — here are some of the year’s biggest mergers.”](#) Business Insider. November 20, 2018.

⁵¹ Slaughter, Rebecca Kelly. [“Remarks on antitrust and health care providers: policies to promote competition and protect patients.”](#) Federal Trade Commission. May 14, 2019.



Health care in America has been a source of frustration and fear for too long. By making care more affordable and available to everyone, we will finally put Americans back in charge of their own health care decisions and their own lives.