1

TESTIMONY SIGN-UP SHEET

Task Force on Health Care Coverage for All of Maine

Jan. 22, 2018 Meeting

Public Comment After Lunch

	NAME	AFFLIATION/ORGANIZATION	
✓	Martha Morrison	MedHelp Maine	med Health M-a-
✓	Dr Jeffrey Graham	Bangor Maine AllCare	
✓	Dr Bill Clark	Mid Coast Main Cll Care	
✓	Dr. Phil Caper	Maine All Care	
✓	Poppy Alford	Right Care Alliance (RCA)	
✓	Marilyn McWilliams	Maine AllCare	
✓	Henk Goorhuis	Maine All Care	
?	Sonny Starbird	Maine Allcare	
✓	FREDERICK LANCASTER	MAINE ALL CARE	
✓	Wendy Flaschner	Midcoast Maine All Care	
✓	John Brewer, DO.	Maine AllCare	
✓	BRUCE GERRITY	MADA/ MHA/ PCI/ Dirigo Re	
✓	LYNN CHENEY	ACA NAVIGATOR, MAINE ALLCARE	
✓	MICHAEL KELLY	WHY NOT THE BEST	
✓	Elizabeth Torraca	—	
✓	Art Shea	Maine Allcare	
✓	Melissa Dunn	Southern Maine Workers Center	
	Nicole Clegg	Planned Parenthood	

Good afternoon. My name is Martha Morrison. I am founder and director of MedHelp Maine, a non-profit dedicated to increasing Mainers' access to unaffordable medicines. Generally referred by 2-1-1, patients frequently call me with stories such as the following:

1. A 17-year-old boy with Type I diabetes whose family can't afford his insulin and insulin pump supplies. The family's medical insurance ended when the father lost his previous job, and coverage with his new employer won't begin for another two months.

2. A man called because his 62-year-old disabled friend's MaineCare was terminated because annual renewal documents weren't returned by deadline. Cognitive impairment from a recent stroke, however, have made this man increasingly unable to attend to such matters.

3. A 50-year-old woman called following her second psychiatric hospitalization because she couldn't afford the meds needed to keep her out of the hospital. A hospital free care patient, she said she had been re-hospitalized because she couldn't obtain her meds after her first discharge.

4. A woman with multiple chronic medical diseases and mental health conditions, unemployed and with no source of income, was reportedly denied MaineCare because she is over-income.

5. A 73-year-old man is in the Medicare donut hole. The out-of-pocket cost for just one drug prescribed by his cardiologist for atrial fibrillation is $800 per month.

A system of universal and uninterrupted access to medical care would help each of these individuals stay well, while also preventing the need for costly acute care resulting from these gaps in coverage.

As you evaluate options for universal coverage for all Mainers, please consider how each will prevent the health- and even life-threatening interruptions in care experienced by state residents such as these.

Martha Morrison
41 Elm Street
West Newfield ME 04095
(207) 793-4462

January 22, 2018

Healthcare Task Force Testimony
January 22, 2018

Good Afternoon. I am Dr. Jeffrey Graham and I appreciate the opportunity to testify today. I am a consulting physician and work at CA Dean Hospital in Greenville Maine. Some of you have already heard me speak a few months ago in support of *Bill 1274*.

At that time I described how providing healthcare for all would not only assure meaningful primary medical care to all Mainers, but would prevent treatable diseases from progressing to emergencies or incurable states. It would also assure that healthcare providers, clinics, and hospitals would get paid for their services and remain solvent. These same hospitals, be they large or small, are also commonly the biggest employers in any given town or region. The rural hospitals, like the one at which I work, are usually the hardest hit economically from having to see patients who require care, but are unable to pay for it.

One of the biggest reasons to provide care for all is that in one year (2009) over 922,000 people or families in the US went bankrupt from medical bills. The scariest thing is that 78% of them HAD health insurance!

There is no question that wading through the details of implementing such a plan is a tremendous task, but I would like to provide an impetus towards that goal, and I would start with 7 simple words:
EVERY OTHER DEVELOPED NATION IN THE WORLD

Every other developed nation has found a way to provide basic health care to ALL of its citizens. This includes newly industrialized nations like Singapore who accomplished this in 1994, 24 years ago. It includes what we would consider capitalist nations like Switzerland (also 1994). This includes small nations where it is more akin to providing healthcare at the state level here in the US (Iceland did this in 1990). Canada initiated universal healthcare in 1966 starting with one province, Saskatchewan. A

Healthcare Task Force Testimony
January 22, 2018

single person, Tommy Douglas, led this effort in Saskatchewan and he was subsequently voted "The Greatest Canadian" in 2004.

This can and has been done in every developed nation. These healthcare systems vary widely but, in general, have a few things in common:
-Everyone is in, no one is out
-Everyone pays into the system and everyone receives care
-All costs are negotiated from the cost of a doctor's visit or procedure to the price of medications (this last one being a huge component of the high cost of medical care in the US)
-The basic health plan, if provided by independent insurance companies, is not for profit. Only premium supplemental plans (paying for such things as a private hospital room) can be sold for profit

Not only is healthcare provided more equitably in these countries, but their healthcare statistics are better than in the US, things like: life expectancy, neonatal death rate, and "healthy years" after the age of 60. So, once again, there is no state, province or nation too big or too small not to benefit from healthcare for all.

Please remember:
EVERY OTHER DEVELOPED NATION IN THE WORLD

Thank you for your time.

Jeffrey Graham MD
Glenburn ME 04401
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1-20-18 Testimony/ comments LD 1274 Study Group/Task Force

William D. Clark, M.D. Brunswick. wdclark@gwi.net; 207-844-8310

I am an internist with an interest in health policy since medical school. My patient care experience and policy issues both demand that I advocate for universal coverage in a publicly funded system for all Mainers.

At the health policy level, health care equity is a stubbornly difficult issue. Indeed, decades of experience confirm that policy tweaks and political compromises never achieve the common good of health care justice and equality. Look around you--healthcare disparity is literally killing Mainers, provoking financial ruin and, perhaps worst of all, fostering and enhancing divisiveness in our body politic. Policymakers should not tolerate this!

Speaking from experience, when caring for patients I was saddened and angry that they could not count on getting needed care when accidents, heart attacks or cancers crashed in. How ridiculous that they focused on "How will I pay for this?" instead of focusing on recovery! Now, I am really outraged, as tweaks to our commodity-based system leave 106,000 Mainers uninsured and an estimated 200,000 underinsured.

In practice, after spending 10 years in medical school, advanced training and the US Public Health Service learning to treat disease, I was ill-prepared for wasting time running a business whose rules changed rapidly. When a hospital purchased my practice, management hassles were not eliminated, just transferred to the hospital with the mountains of ridiculously costly paperwork. I'll leave discussion about effects on the Maine economy, businesses and entrepreneurs to another speaker!

If Maine creates a system with features adapted from those that deliver high quality medical outcomes, cost far less than we pay, are politically sustainable and fully functional in the other 34 OECD countries, all Mainers would receive medically necessary care from birth to death, would not delay care and get sicker because of upfront payments, and would not pay at the time of service.

We must first agree on a simple goal - namely, to create an equitable system where every Mainer receives healthcare, and every Mainer helps pay for it. Once we agree on our aspirations, we can engage experts to work out practical issues, such as what to cover, how much to pay providers, and equitable funding. On a positive note, in 1965 we implemented a publicly funded system for everyone over 65. It's imperfect, but every day 10.000 people gratefully transition to comprehensive coverage, and I'm certain you know people who just cannot wait to turn 65- how crazy is *that*?.

I am reminded this month that the Rev. Dr. Martin Luther King Jr. once said 'The time is always right to do what's right.' NOW is the right time for Maine to do this for everyone!

BANGOR DAILY NEWS

Do we need health insurance?

By Philip Caper, Special to the BDN - published December 15, 2011

Do Americans need health insurance? The short answer is no — at least not in the form it currently exists in America.

It is true that in many wealthy countries private insurance companies are used in the financing of universal health care systems. But they are nothing like American companies. They are regulated public utilities and are told by their governments who to insure, what to cover and how much and when to pay. Most are prohibited from making a profit and are required to pay any willing provider. Not exactly the American model.

The purpose of health care financing systems should be — and is in all other wealthy countries — to facilitate the delivery of health care services, to protect individuals and families against huge medical care expenses and to avoid breaking the national bank while they do so. But in America, our private insurance system actually interferes with the delivery of health care and is rapidly becoming too expensive.

Last month I argued for adopting a universal health care system on moral, ethical and economic grounds. It is not only more humane but cheaper to cover everybody. We have moved in fits and starts toward that goal since the enactment of Medicare in 1965.

The recent federal health reform law took a few steps forward. But we are now taking a couple steps back, especially in Maine. Last week Gov. Paul LePage proposed disqualifying 65,000 beneficiaries of MaineCare. Earlier this year, the Legislature enacted PL90 that rolls back regulations intended to spread the financial risks of illness and improve access to health care for those most in need of it.

A little history may be informative. Private employment-based health insurance in America was not a planned system, but grew out of World War II wage and price controls. It was one of the few ways employers could attract and retain employees in a tight labor market. The spread of these benefits received a boost when the federal government exempted them from federal taxes.

Private health insurance was dominated by nonprofit Blue Cross and Blue Shield plans until about 1990. That changed when Blue Cross plans across the country began to convert to for-profit status, arguing that it would improve their efficiency. Maine Blue Cross made that transition in 2000 when it changed from a company whose mission was facilitating health care to one whose mission was maximizing shareholder wealth.

The business model of for-profit insurance companies is pretty simple. The creation of wealth for shareholders, including many of their executives, depends upon profitability. To maximize profitability they must charge premiums as high as the market will bear, offer skimpy policies that limit coverage, impose high deductibles and minimize what they must pay out for the services they do cover.

Maximizing premiums, imposing high deductibles and limiting the scope of coverage are pretty straightforward. Minimizing payouts for services they do cover is a little more complicated. Four techniques are used. First companies try to avoid insuring people likely to require health care, such as those with a history of illness or who are elderly or in dangerous occupations.

Second, they dispute the need for health care that is recommended or has already been provided to their customers by micromanaging the decisions of doctors and patients and denying as many claims as they can. This is a very expensive and contentious process that often damages the quality of care.

Third, they bargain down the prices health care providers charge as much as possible, shifting costs to other payers. This has created the curious and uniquely American situation where uninsured people pay the highest prices for health care products and services.

Fourth, many companies try to find a reason to retroactively dump sick customers who have filed claims by asserting that they have failed to accurately state their health care history, therefore defrauding the insurance company.

These people end up on public insurance or on the roles of the uninsured. This practice, called “rescission,” is particularly unfair but nevertheless appears to have become widespread. It has been banned by the new federal health care reform act.

What is the problem with this picture? It is not that for-profit insurance companies are failing in their mission. In fact, they are doing a very good job of exactly what their mission demands, maximizing the wealth of shareholders. The problem is that their mission fundamentally conflicts with the mission of a decent health care system.

What can we do to fix this problem? The obvious first step — but not the last — is to replace for-profit insurance companies. They are like a camel entered into the Kentucky Derby. No matter how much it is trained, how hard it tries, how hard it is whipped or who the jockey is, it never wins. It just wasn't designed for the job.

Although insurance companies could play a role in a redesigned system by becoming public utilities, that is not the most efficient way to finance a system that includes everybody. For example, private insurance companies are currently fighting the new federal health care law's requirement that they keep their overhead below 20 percent. Medicare, financed through publicly mandated premiums and taxes, spends less than 5 percent on overhead and interferes with health care decisions much less than private carriers.

Maybe it's time to replace that camel with a racehorse. While we're at it, why not go for a thoroughbred? An improved Medicare-like system for all Mainers could provide better coverage while spending less. What's not to like about that?

Physician Philip Caper of Brooklin is a founding board member of Maine AllCare, a nonpartisan, nonprofit group committed to making health care in Maine universal, accessible and affordable for all. He can be reached at pcpcaper21@gmail.com.

http://bangordailynews.com/2011/12/15/health/do-we-need-health-insurance/
printed on December 16, 2011

BANGOR DAILY NEWS

The "no free health care" tax: We all pay when the 'undeserving' have to grovel for treatment

by Dr. Philip Caper, Special to the BDN

Posted Feb. 20, 2014, at 12:55 p.m.

How much tax would you be willing to pay to make sure somebody who can't afford health care has to grovel to get it?

I have watched the fight about whether to expand Maine's Medicaid program (sometimes referred to as "welfare") going on in Augusta during the past year or so with increasing bewilderment. Many Mainers, including Gov. LePage, seem to be really angry at the idea that "those people" (you know who they are) may get something they don't "deserve" at taxpayer expense. Yet these angry people seem unwilling to take the step that would really save money by just letting those who can't pay for medical care die.

Why? I suspect it's because the overwhelming majority of us still value human life. But they don't seem to mind making "undeserving welfare takers" grovel.

We all end up paying the bill for their care one way or another anyway, in higher health insurance premiums and hospital and doctors' charges. That bill is much higher than it needs to be.

Adding it all up, the price of unnecessary administration, avoidable illness, and lack of more effective control of costs that are avoided in the Medicare-for-all-like systems in other countries easily amount to 20 percent of our total health-care spending.

Many people are unwilling to believe you can cover everybody for less than the cost of covering just some, and probably can't be persuaded otherwise. But it's still worth trying.

Deciding who is or is not "worthy" of dignified health care turns out to be very expensive. It's been persuasively shown in dozens of other countries that it costs far less to cover everybody than to spend lots of money, energy and political capital deciding who the "undeserving" are, and then figuring out how not to cover them.

For example, doctors in Maine, required to deal with scores of health insurance plans, spend about three times as much on administration as Canadian doctors with their much simpler single-payer financing system.

Hospitals spend even more, requiring large billing departments, often with hundreds of employees. Insurance companies have large underwriting departments in order to create dozens or hundreds of "risk pools."

Credible estimates of the money wasted on such unnecessary administration run to about $1,500 per year for every person in the state.

Then there's the cost of avoidable illness. It's a well-known fact that people without health insurance often delay seeing a doctor if they think they can't afford it. This results in many delayed diagnoses that then end up requiring treatments that are far more difficult and expensive than need be.

Uninsured people tend to use emergency rooms that do their best to stabilize patients, but cannot prevent illnesses and injuries from happening in the first place and are not required or equipped to provide adequate follow-up care. Such pent-up demand is most likely what underlies the recent finding that the use of ERs surged

among newly insured Medicaid enrollees, who are less likely to have a regular doctor. I expect that it will level off as they begin to receive regular care.

A single pool of funds is much easier to control than our current fragmented system of financing health care. Constraining the flow of money into our current system is like trying to control the flow of a river by building a dam in its delta rather than upstream.

As governments and employers try to restrain their payments into the health-care system, the latest rivulet to expand is direct out-of-pocket payments (co-pays and deductibles) by patients. They too will soon become a flood.

Out-of-control health care costs are eroding our ability to do lots of other important things in both public and private sectors. The complexity of the Affordable Care Act will only make these unnecessary administrative costs grow even more. The tax just went up.

Is it really worth $1,500 every year and rising — to you and every member of your family — to make sure some "undeserving" person doesn't get "free" medical care?

That's something worth thinking about.

Physician Philip Caper of Brooklin is a founding board member of Maine AllCare, a nonpartisan, nonprofit group committed to making health care in Maine universal, accessible and affordable for all. He can be reached at pcpcaper21@gmail.com.

http://bangordailynews.com/2014/02/20/health/the-no-free-health-care-tax-we-all-pay-when-the-undeserving-have-to-grovel-for-treatment/ printed on February 20, 2014

BANGOR DAILY NEWS

Health care spending: A 21st century gold rush

Posted Feb. 14, 2013, at 11:38 a.m.

Winston Churchill once remarked, "Americans will always do the right thing, once they've exhausted all alternatives." His observation, at least the second half of it, is proving itself as we continue to struggle with our health care system, especially its out-of-control costs that are crippling the budgets of businesses and government alike.

There is a lot of money in our health care system, and no enforceable budget. That leads to carelessness when it comes to spending that money.

What are some of the reasons health care costs continue to rise? Here are a few examples.

For at least the past 40 years, I've heard colleagues say, "We'd better get our fees and charges up now, because next year they're really going to crack down on us." It has never happened, yet. The problem is intensifying as outpatient "providers" have morphed from being real people into being corporations.

The Los Angeles Times reported on a case where a teacher's group health plan was billed $87,500 by an "out of network" provider for a knee procedure that normally costs $3,000. Her health plan was willing to pay it. Outraged, the teacher ratted on the orthopedic surgicenter to California's attorney general. After the press got involved, the charge was "reduced" to only $15,000. Not a bad pricing strategy, from the surgicenter's point of view.

The New York Times reported an incident where a student who needed emergency gallbladder surgery ended up with a couple of "out-of-network" surgeons through no fault of his own. He was billed $60,000. His insurance company was willing to pay only $2,000. He was left to deal with the rest of the bill on his own.

There are many more examples. Privately insured patients are not the only ones affected. Governors around the country are continuing to struggle with how to pay for their Medicaid programs. In Oregon, Democratic Gov. John Kitzhaber is trying to find ways to impose a fixed budget on Oregon's Medicaid program without adversely affecting Medicaid beneficiaries. But, he acknowledges, disciplining Medicaid alone will not do the job. He hopes his approach will be adopted by most other health insurance programs.

In Maine, Republican Gov. Paul LePage is struggling not only with how to keep up with burgeoning current Medicaid costs, but also how to pay the state's almost $500 million past-due Medicaid debt to hospitals. He has proposed lowering liquor prices to boost sales, and mortgaging Maine's future liquor revenues to secure bonds to pay the debt. His Republican colleagues in the Legislature have described this idea as "creative."

One of the central features of Obamacare is the creation of "health insurance exchanges," or online marketplaces. But the law has recognized that many people will need help making the right choices. So it has created an army of "navigators" to help them. A recent Washington Post story points out that a huge number of such experts will be necessary (California alone plans to certify 21,000 of them). Their cost will be reflected in higher health insurance premiums and has sparked opposition from insurance brokers who view them as competition. That will be an expensive fight, without increasing the amount going to actual health care by a single dollar.

Then there is the purchase of politicians by powerful corporate interests. When the Medicare prescription drug

benefit was enacted in 2003, it was prohibited from negotiating lower drug prices, even though the veterans health system and many Medicaid programs are permitted to do so. The lead congressman pushing that provision retired from Congress soon after it was passed to take a lucrative job with the pharmaceutical industry. This has become [illegible] in Washington.

And don't forget the [illegible] paid to the executives of nonprofit hospitals.

Meanwhile in Massachusetts, where Obamacare was born, health care costs are expected to rise six to 12 percent next year. Last year, their legislature passed a law capping increases in total private and public spending statewide, limiting them to the rate of growth of the Massachusetts economy. But the job of figuring out how to actually get it done was turfed to an "expert panel" of "stakeholders." My bet is that such cost control will be difficult or impossible to achieve unless we simplify and centralize the way we finance health care.

Why does this financial abuse of taxpayers and patients continue? Because we let it. Americans often react to structural problems by simply throwing more money at them. We seem to be unable to say "no more."

Maybe it's time to revisit the part of Churchill's comment about Americans always doing the right thing — by emulating the policies of most other wealthy countries. They have health care systems that are more popular than ours, provide better access to care, get better results, and are far less expensive.

Maybe it's time to put everybody into a single, nonprofit system we can all support, within a budget acceptable to the majority of people. That arrangement would eliminate the political fights among people in different health insurance programs, each questioning change by asking, "How does it benefit me?"

Such a system would be best if done at a national level. But it could work initially at the level of individual states, such as Maine. That's how the Canadians did it — one province at a time. If Maine could be one of the first states to do that, the people of Maine could truly say "Dirigo, I lead."

Physician Philip Caper of Brooklin is a founding board member of Maine AllCare, a nonpartisan, nonprofit group committed to making health care in Maine universal, accessible and affordable for all. He can be reached at pcpcaper21@gmail.com.

[illegible] printed on February 14, 2013

Public Comment of Marilyn McWilliams
For Maine State Legislative Task Force on Health Care meeting on Jan. 22, 2018
(Submitted for the Public record on Jan. 22.,2018)

Dear members of the Maine Legislative Task Force on Health Care,

I disclose that I am a Board member of Maine AllCare, a non-partisan, non-profit organization that seeks to educate Maine residents about the advantages of a universal, single-payer health care system for all Maine residents.

I was born in Brunswick, ME in 1950. I have resided in Brunswick, Topsham, Dixfield, Auburn, Calais, Houlton, Orono, Old Town, Carmel, Brewer, South Portland, Westbrook, Gorham, and Portland, ME. My father was a manager of W.T. Grant Co., and we, as a family, moved a lot, in conjunction with his transfers as a manager to these Maine towns, as well as Newport, RI, and Georgetown and Newbury, MA. My Dad was a hard working family man, who was very well-respected and loved as a business man who cared deeply for his family and for his employees and their families. These employees said they'd follow him anywhere because of his sense of fairness. I luckily recognized these qualities and made them my own. My Mom, likewise, was a strong supporter of the family, the community, and was lauded for her sense of fairness and her vision and sense of humor as she worked in church Religious Education programs and wrote weekly columns for local newspapers.

I retired as an insurance broker in 2015 from Mass. employers- Northwestern and Digital Employee Benefits - as a group insurance broker for employers. I started my insurance career at UNUM (then Union Mutual) in 1975, and worked for UNUM for over 20 years before becoming a broker. That all adds up to 40 years of employment in the insurance industry.

I am proud of my contributions to this industry - working long and hard hours to represent fairness and decency and integrity (taught by my parents) for employers and their employees and families.

Then in 2008 or thereabout, something changed as I became more ensconced and aware of the realities I worked in EVERY day.

To quote, Rebecca Solnit as she wrote in The Faraway Nearby: "The moment when mortality… suffering, or the possibility of change arrives can split a life in two. Facts and ideas we might have heard a thousand times assume a vivid, felt, urgent reality. We knew them then, but they matter now. They are like guests who suddenly speak up and make demands upon us; sometimes they appear as guides, sometimes they just wreck what came before or shove us out the door. We answer them, when we answer, with how we lead our lives…. Most of us don't change until we have to, and crisis is often what obliges us to do so. Crises are often resolved only through a new identity and new purpose, whether it's that of a nation or a single human being."

I helped more than my share of employers through ridiculous annual health renewals, where the CEOs, CFOs, HR professionals agonized over deteriorating benefits in conjunction with increased costs. I helped hundreds (if not thousands) of employees with denied claims by insurance companies. The CEOs, CFOs, and HR folks I worked with came to be my allies in

seeing the failure of our current system, and said to me: 'let me just run my company and get this health insurance monkey OFF my back!' Go for it, Marilyn - we are behind you!

Think of it: Businesses in Maine thrive by saving money on insurance premiums, are more competitive than their neighboring states, and employers want to be in Maine so they can save money and concentrate on their business objectives and also be more competitive with other states and with other countries. Businesses want to be in Maine.

.. And so do individuals, who want to innovate and start new businesses, without having to worry about costs for employee health coverage. Plus — they can feel good that their employees will be healthy and won't have to worry about their family members' health - since the state of Maine had enough foresight to lead the country to what other countries are already doing - at a MUCH lower cost per capita.

Thank you to my parents for their caring for people, and for helping me want to envision a better world for all of us in Maine!

Marilyn McWilliams
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Jan. 22, 2018
Task Force on
HealthCare
Coverage
State House

Thank you for the opportunity to testify to you today.

Henk Goorhuis, a physician from Auburn, Maine.
207-783-5973 henk@maineallcare.org

I am speaking in support of this Task Force asking the question:
"Imagining what Maine's Healthcare System will look like in 5 years?"

I will present 6 facts and ideas in 3 minutes, information I hope you will consider when struggling with your task.
I will present them in graphic form:

1st -- The 20:80 Rule – The healthy pay for the sick – predictable, unavoidable, and inevitable.

2nd -- Income distribution among your citizens – all your decisions will affect these "Quintiles" differently.

3rd -- You won't get far with the behavioral solutions - the "Market Based 1-3%" options.

4th -- Make costs predictable for governments and business in Maine, by Broadening the Base, Lowering the Rate.

5th -- Big savings, and saving healthcare in Maine, will only come with big solutions - <u>big administrative and fiscal solutions.</u>

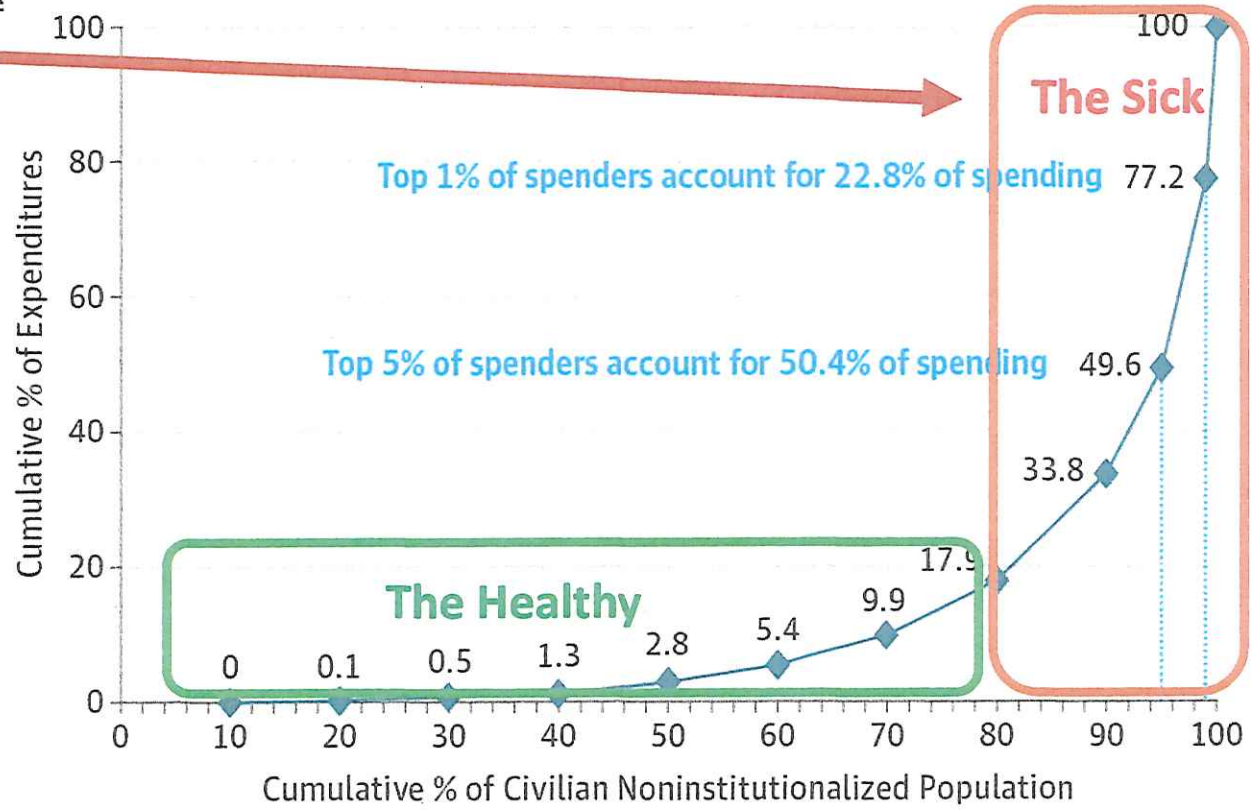
6th -- a one page review of what got you here, LD 1274. Summary done by Maine AllCare.

Best wishes to you as this Task Force makes recommendations to the 129th Maine Legislature on:
"Health Care Coverage for <u>ALL</u> of Maine".

-The 20:80 Reality- - of the Costs of Illness in the Population -

The Healthy 80%
Pay for the Sick
20%

-predictable
-unavoidable
-inevitable



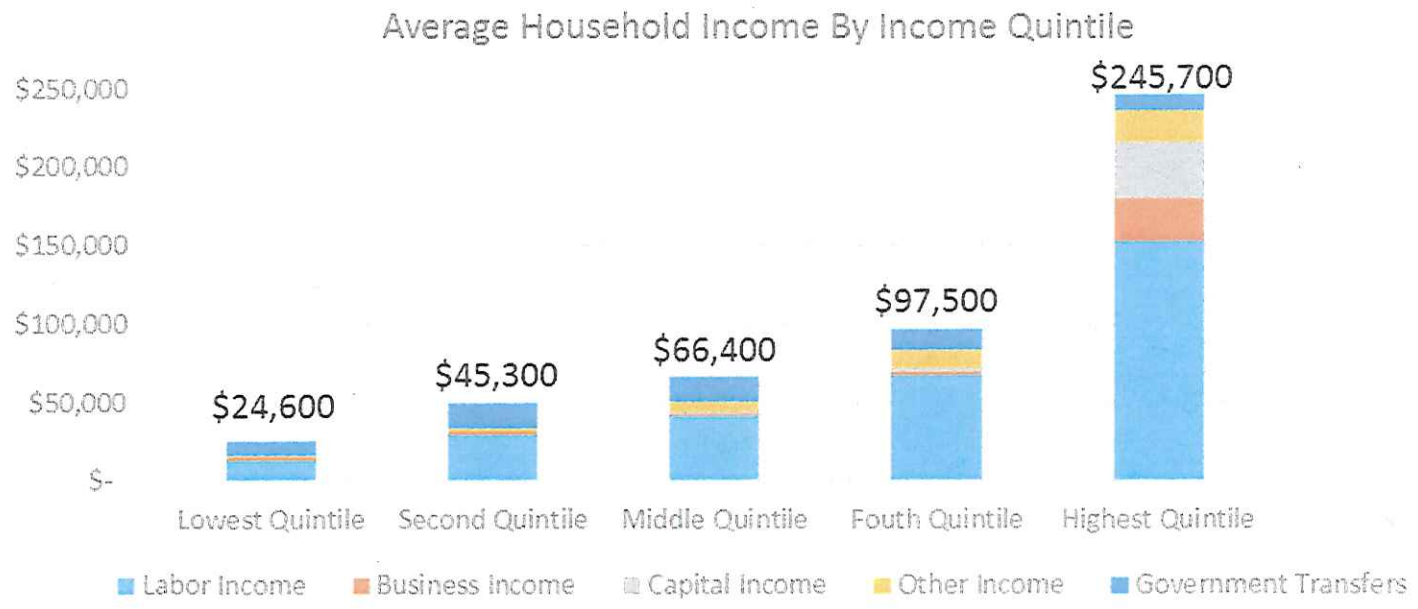
The Sick
-To be shed
to the public
system, i.e.

-Medicare
-Medicaid
-high-risk pools
-ACA cost-sharing

-Where can a "market" can make a positive margin?
-In the Healthy.

2014 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Income Distribution in the USA
~250,000 Mainers live in each these 5 quintiles



How will "consumer choice plans" effect each of these groups? CBO 2011

-Higher Deductibles and Copays?

-Loss of rural hospitals, services and travel costs?

-Increasing drug costs?

How will your decisions impact each of these groups?

Modifying behavior with "Market based" efforts? Has not moved Uncle Bob far.

"Uncle Bob"

Yet . . .

<u>Experience so far shows only small savings</u>

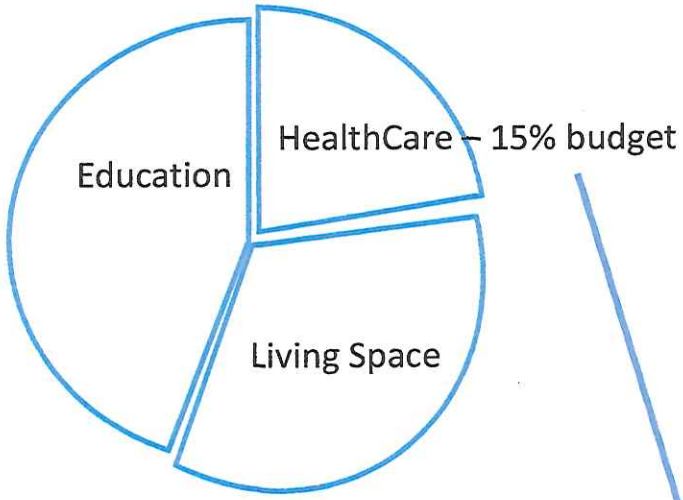
-How does "Bob" modify his behavior?
or
-How does a provider modify his behavior?

-Who to place at financial risk?

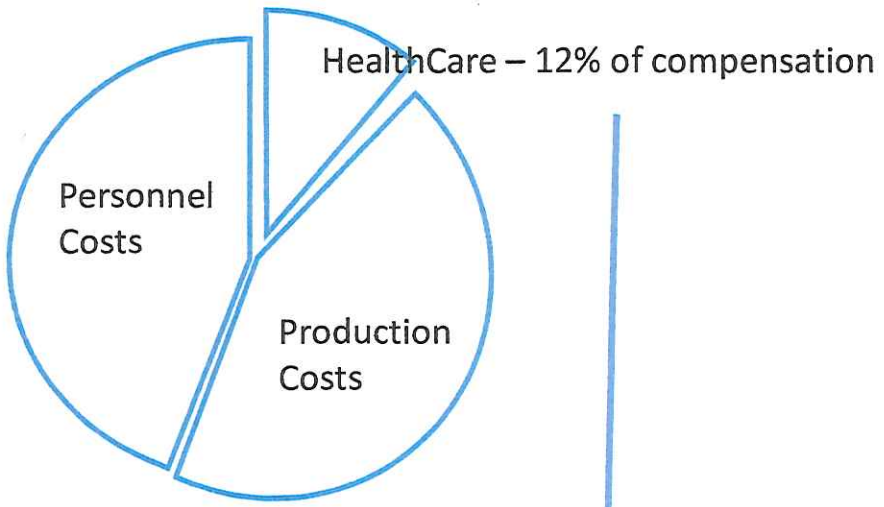
-How to place him (or providers) at increased $ risk?

Broaden the Base, Lower the Rate
Simplify the Financial Administration of Healthcare

Current Town/City Budgets



Current Business Healthcare Costs



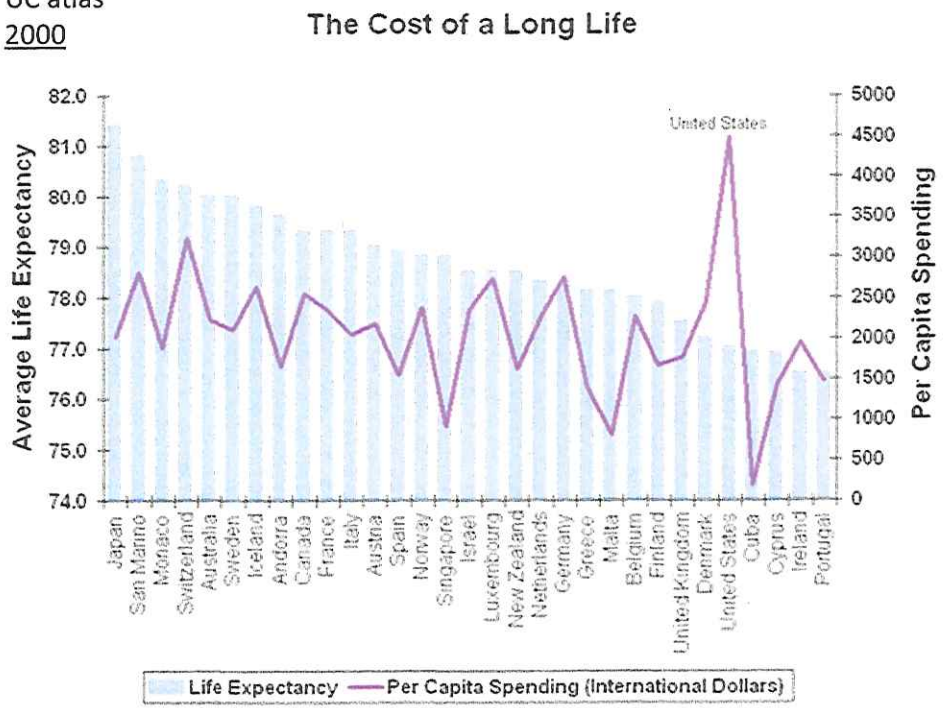
Imagine a State sponsored HealthCare System
–with a premium of 3% employee,7% employer of wages

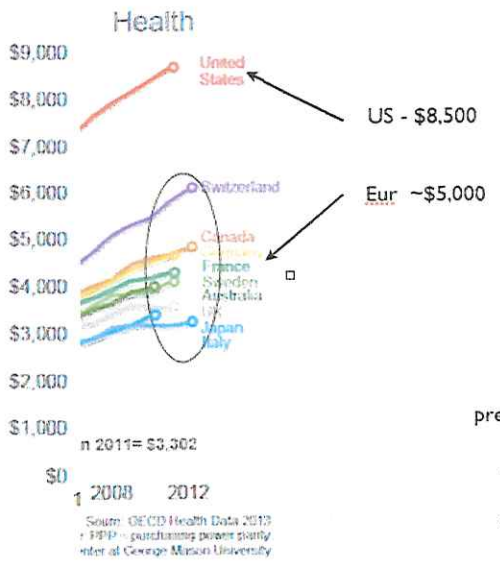
With Lower rates, predictable rates,
Savings at all levels that,
Lessens the administrative burden for all

Major Structural Changes Needed

-to fix this mess, you will have to think big for any real administrative and fiscal solutions-

UC atlas
2000





OECD 2013
-authors averages

What constitutes the $3,500 difference?

USA vs Others

administrative burden - $? **$1,500 vs $400**

non-negotiated drug costs - $? **$1,000 vs $600**

over utilization - $?

premium for more capacity in US - $?

overpricing in general in US -$?

costs shifted to healthcare from other societal issues - $?

better outcomes - $?

LD 1274

An Act to Promote Universal Health Care, Including Dental Vision and Hearing Care

Part A

§7502 Beneficiary – primary residence is Maine

§7503 Establishes legal entity of "Healthy Maine" as a "public instrumentality of the State" to finance healthcare services for all residents of Maine.

§7504 Establishes Healthy Maine Board(HMB) – duties to include entire operations of HM

HMB - establish procedures for ensuring financial(s) . . . negotiating drugs prices, adjusting payments and benefits, audits, etc.

"administer all state funds for healthcare services"

§7505 Covered services listed are broad, but not specific - to be finalized by HMB

Deductibles prohibited, copayments allowed as per HMB

Beneficiaries choose own PCP

§7506 HM can be a supplemental plan for Medicare, HM as secondary payor, subrogation rights defined

§7507 Begins July 1, 2020

Part B

Sec B-1: DHHS will assist in transition. Obtain Federal waivers (i.e. ACA §1332).

Sec B-2: Joint standing committees of HHS and IFS will work jointly in 2017 on further enabling legislation and submit to 128th Second regular session, legislation that:

-includes procedures to: "1. Fund the operation of Healthy Maine;"

-and transfer Federal, state, W Comp funds to HM

-determine process for selecting or electing the HM board members

-effectuate a smooth and efficient transfer . . . to assist HM in the assumption of its duties.

Major point analysis by

Maine AllCare

May 9, 2017 for

IFS work session LD 1274

Universal Healthcare Now!

My story is very common and not dramatic. For 30 years while working and raising our two children in Maine, my husband and I had terrific healthcare insurance with his job. I could work part-time while caring for the children and not think about insurance. We were healthy, middle class and owned our home.

Then, out of nowhere, my husband got a rare auto-immune disease called anklospondilitis. He required a hospital bed for 7 months in our home and many doctor visits in and out of the state to figure out how to get his inflammation down. He lost his job and our health insurance. We paid expensive cobra fees until he got disability and Medicare. I was only 59 years old and kept my part-time job but did not have options to buy insurance unless I worked full time. I could not work full time due to the nature of my position at a community mental health center while taking care of my husband. The only option for me was Community Health Options for which I could not get a subsidy if I kept my job. The monthly premium was half my take home paycheck. This did not include the $5,000 deductible which I had to save in case something happened to me. My husband's medication is $43,000 a year for which Medicare pays all by $4,000. Of note is that if I quit my job, I could get the subsidy. If I kept my job, my premiums went up to $700 per month. Those 6 years before I turned 65 were very stressful and scary. Fortunately, I turned 65 last year and the expensive drug Humira has helped my husband tremendously. We are the lucky ones.

My clients often had to leave mental health treatment because they lost their insurance. Many of my clients were children and/or single women.

We cover our cars and homes, but there are no affordable plans for ourselves.

Thank you for your attention.

Wendy Flaschner, retired school psychologist, Brunswick, Maine
flaschnerwendy@gmail.com

cell – 207-530-0590

Task Force on Healthcare Coverage For All of Maine

Meeting Jan 22 , 2018

Honorable task Force Members . Thank you for your work to address the critical issue of access to healthcare for Mainers, and allowing me to address the Panel today . My name is John Brewer, and I am a recently retired Primary Care Physician in Gorham , Maine. I was proud to serve that community for 30 years and being "in the trenches" as we say, feel that I am qualified to make a few statements regarding the healthcare needs of our citizens .

I became involved with the Maine AllCare organization last year and was impressed with it's mission advocating an improved "Medicare for all" theme for Maine. That is, the idea of a plan that mimics Medicare for senior citizens but would be available to **ALL** Maine residents from birth to grave. Presently, with the 10s of thousands of Mainers who go uncovered by any insurance for their health needs , and equally appalling numbers who have deficient insurance coverage, this plan would correct that void. Since an insured person is more likely to seek preventative care from a primary provider , they are probably more likely to stay healthier with better follow up and rely on the PCP (Primary Care Provider) for acute care needs. And by doing so, the burden and costs to our Emergency Rooms and Hospitals can be reduced.

So many times in my practice, follow up care was not maintained due to the patient not having adequate insurance or losing the insurance they had. Add to that, many could not afford the high cost of medications to maximize their treatment plans. Numerous times I was approached by the patient with the words, " I can't afford that med". Regularly I was confronted with the question " I have $100 at the end of this month, Doc, which of the 5 meds is the most important as I can only pay for one". Well, the answer was obvious , all are important , but this forced me to manipulate their care, adding extra time to problem solving and creative medicine , and always feeling the futility of not being able to do the best for my patient . And ultimately, I had several patients that could not come back for care as they were dropped from their coverage. How sad that has to happen on our watch.

The reluctance of a patient to be seen was also detrimental to best care outcomes. This was in many cases due to poor insurance coverage with high deductibles . Without adequate follow up, it was difficult to formulate a plan and to adjust care needs. This is turn can lead to poor outcomes , adding more strain to the medical community translating to higher costs to the public. And, by the way,lest we forget , the patient also suffers.

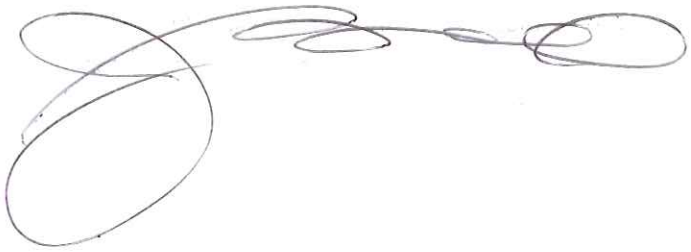
Since I started to practice medicine , it was always my philosophy that healthcare should be run by a central organization, not driven by an insurance company or for profit organization, and available to all. Essentially, paralleling the Canadian System , it was a way I could do my job more effectively and serve more folks as they would have better access to seek care, and be less likely to avoid help when needed. Putting out the small fires instead of having to deal with the inferno. At that time the concept of a "universal" or "single –payer" system was an unpopular idea with folks and especially some of my peers. But now with the ever increasing need for full coverage for **ALL** souls , but prohibited by the growing trend of monumental costs, new energy has been injected to this cause.

I urge the Panel to use this growing momentum to come together with a request proposal for 2019. I know the devil is in the details, but let us all agree, all citizens , and especially Maine citizens , require and need a system that can improve our overall health, redistribute the costs equally, and allow our State to prosper as it should. It is the right thing to do. **All in, No one out.**

Thankyou for your time and efforts to right the ship.

Sincerely,

John C Brewer, DO (ret)
100 Hicks St
Portland , Maine 04103



Testimony of Lynn E. Cheney in re: SP 592 Task Force on Healthcare Coverage for All Maine on January 22, 2018.

Senator Whittemore, Representative Sanborne, members of the Committee, thank you for hearing this testimony.

I am a volunteer ACA Navigator in Blue Hill and have worked with hundreds of residents on the peninsula. I have helped many obtain access to good, affordable, subsidized healthcare. Particularly satisfying are the ones who were able to leave dead end jobs with benefits and start their own businesses – something they would have not been able to do without affordable healthcare coverage.

However, this year I am seeing an increasing number of people who don't qualify for subsidies and are simply not able to afford health insurance. As an example, earlier this month, I worked with a 62 year old registered nurse and home health care giver earning just over $50,000/yr. The least expensive plan available to her was a bronze level ACA plan costing $1,118/mo with a deductible of $5,500 and max-out-of-pocket of $7,350.

The ACA deems healthcare coverage affordable if it costs less than 9.56% of a person's income. In other words, this woman would have to earn over $140,000/yr to afford just the premiums ... and that doesn't take into account her potential out-of-pocket expense. She concluded she couldn't afford 2018 coverage and will be going without health insurance for the first time in her life. She told me she was frightened. The irony is that if she decided to not work for a few weeks this year, she could get that same policy for $0/month. She knows this, but decided that her patients needed her and she couldn't let them down.

It is widely assumed that the repeal of the individual mandate will lead to a further increase in premiums, driving even more people out of the insurance market. Clearly there is a great need for a fundamental overhaul of healthcare if we want to control costs and cover everyone. While currently there is little hope for a federal solution, there are now 22 states working towards publicly funded, privately delivered healthcare systems covering all residents. I hope that Maine will be a leader in this movement.

At the December 20th meeting of this task force, you agreed to work toward proposals that ensure that all Mainers have access to and coverage for affordable, quality healthcare. Please keep this woman in mind as you proceed.

Lynn Cheney, Blue Hill Maine

The elephant in the room when considering healthcare options for Maine

Testimony for the Maine legislature Task Force Force on Healthcare coverage for All of Maine

January 15, 2018

By: Art Shea, Co-chair Waldo County chapter of Maine Allcare
44 McTaggart St., Brooks, ME 04921
artshea46@yahoo.com

Thank you senators and representatives and task force members for time to address you.

My name is Art Shea, I am retired from a healthcare profession, prosthetics and orthotics, and have been a long time advocate for "single payer healthcare" (since the 1980's).

I am here to talk about the "elephant in the room". Do you see it?

"Profit in Healthcare"

Without eliminating the huge profit motive, it will be impossible to find a solution to providing everyone in Maine with quality comprehensive universal healthcare.

My investment adviser tells me to be happy with about 6% yearly increase in my retirement "nest egg". You might get 8% if you go into riskier investments.

In a 2017 New York Times article(1), it stated: if you invested $100 in the S&P500 in 2010, it would be worth $136. If you invested the same $100 in United Health, it would be worth $580. For the average healthcare insurance companies, it would have been worth $300.

I don't consider health insurance investments to be risky nor are they a "free market" like cell phones,

Insurance companies are allowed to collude.

The 1945 McCarren-Ferguson Act, was set up to encourage formation of insurance companies after WWII. This act made them exempt from federal antitrust laws and still exists.

States were given rights to set limits on their activities of sharing information but those have not prevented the evolution of insurance companies from becoming such profit monsters.

Profit motive rationing.

I remember the frustrations fighting for patients to get authorization to pay even for a prosthetic limb so the patient could start walking after amputation and becoming independent in their life. There was one patient that needed an expensive prosthetic limb so we had to do very extensive documentation of the patient's needs, enlisting input from therapists and doctors. It was denied and I spent countless hours to appeal it multiple times - over 15 months. The final appeal was to be decided outside the insurance company. That company then decided to drop that patient's coverage.

It is time to disturb the status quo of allowing insurance companies to set whatever double digit rate increases they want and rationing what they will or will not cover, regardless of the patient's needs.

Single payer is the least expensive answer to providing a healthcare system for Maine that is universal (covers all Mainers), and comprehensive (includes eyes, ears, and dental care).

And: **Yes**, if you have to use that four letter word, "Tax", to replace all those health care premiums, copays, deductibles, paperwork and confusion caused by the paperwork, it would be worth it!

1) New York Times, 3/18/2017, "Gripes about Obamacare aside, health insurers are in a profit spiral"

Southern Maine Workers' Center's Testimony on LD1274
January 22nd, 2018

My name is Melissa Dunn, resident of Lewiston. I am the Healthcare is a Human Right Statewide Campaign Organizer for Southern Maine Workers' Center. The SMWC is a nonprofit, membership-led human rights organization committed to creating a grassroots, people-powered movement. Through member-led efforts we improve the lives, working conditions, and terms of employment for Maine's working class and poor people.

When I graduated from high school, my goals were simple. I wanted to work in my community and to change downtown Lewiston for better. I wanted to help solve some of the problems I saw around me. Instead, I found myself dealing with some difficult problems of my own stemming from past childhood trauma robbing me of *living* life. I lived imprisoned by Post Traumatic Stress Disorder and countless Suicide attempts which prevented me from continuing working my full-time job. Seeking help with the healthcare I had at the time was non-existent due to high-deductibles, co-pays, and terms in regards to how many visits I was allowed to have and even what medication would be covered. Despite working hard, putting in 40-80 hours a week I became sicker with each passing day.

For 3 years until I received healthcare, I was battling a system that treated health care as a commodity, instead of a right. I experienced homelessness, inability to feed or care for myself, and hopelessness.

Healthcare played a vital role in my life and proves the very resources in place to help those in need do work. Eventually I was able to get the help I needed, and my life improved. Within 3 years of being a recipient of healthcare I began working again, doing exactly what I dreamed of doing since I graduated from high school. I believe my dream could not be a possibility without healthcare that people in need across the nation like myself, depend on. In the work, I heard stories similar to my own and saw how healthcare intersected with every aspects of our lives.

Southern Maine Workers' Center volunteers, organizers, and allies gathered more than 1,300 surveys between February 2013 and March 2016 in 13 counties throughout Maine. We held community events and coffee shop talks, knocked on doors, and had face to face conversations with Maine People. We heard values and beliefs of universal and publicly financed health care. Through our research we've also found the healthcare crisis has touched most people and they are eager to share their stories. What we found is that almost 96% of survey respondents believe that healthcare is a human right and the majority of people (83%) liked the idea of a universal health care system. The results of our study are in our report Enough for All: A People's Report on Health Care.

We support LD1274, a bill "To Promote Universal Health Care, Including Dental, Vision and Hearing Care" because it aligns with the results of our survey: Maine people want universal health care and support the idea of a publically funded health care system. Maine people's lives are on the line and we are ready for health care system that truly meets the basic dignity and care of our human rights.

We are happy to meet with you to talk you through our findings and our recommendations. Thank you for giving me the opportunity to speak today.

Melissa J. Dunn, Statewide Campaign Organizer - Southern Maine Workers' Center
Residence: 254 Blake Street, Lewiston | Work Address: 56 North Street, Portland
p: (207) 402-0671 | e: melissa@maineworkers.org

January 23, 2018
To members of the Task Force on Health Care Coverage for All of Maine,

In follow up to my comments at yesterday's public hearing, below is a summary of some issues women uniquely face within the health care system. This list is not comprehensive but is intended to highlight the reasons specific attention should be paid to the health care needs of women.

While the Affordable Care Act and actions taken by the state legislature have greatly improved coverage opportunities for women, the system remains deeply flawed and the health care needs of women continue to be sidelined or segregated from the conversation.

There are several canaries in the coal mine that indicate that women's health is falling short in Maine:

- **Maine's maternal health serves as a clear illustration of the discrepancy between health outcomes and levels of investment in women's health, all too often leading to dire outcomes.** Women's maternal mortality rates are on the rise and while the numbers are small in Maine, this trend is concerning.[1] Over 60% of these deaths are preventable with many women surviving if they had better access to preventive care to manage high blood pressure, weight or diabetes. By treating women before they even consider becoming pregnant, real progress could be made to improve outcomes for the woman and the baby, but without investment and attention to the issue that's unlikely to happen.[2]
- **Despite our progress in reducing unintended pregnancy, Maine still has a long way to go.** In 2010, 48% of all pregnancies in Maine were unintended, higher than the national average, and the number continues to rise. This number jumps to *nearly 75%* when examining publicly funded pregnancies, compared to 68% nationally.[3] An extensive body of research links births resulting from unintended pregnancy to adverse maternal and child health outcomes and myriad social and economic challenges.[4] As we dig

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[1] Maine Maternal, Fetal and Infant Mortality Review Panel, 2016 http://www.maine.gov/dhhs/mecdc/population-health/mch/documents/2016-MFIMR-Legislative-Report.pdf.
[2] Report from Maternal Mortality Review Committees, https://www.cdcfoundation.org/sites/default/files/upload/pdf/MMRIAReport.pdf.
[3] State Facts about unintended pregnancy: Maine, https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy-maine.
[4] The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children, https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children.

deeper into these numbers, you begin to clearly see major disparities for women of low-income, women living in rural communities and women of color.

- **Chronic conditions are on the rise for women of reproductive age.**[5] These rates spike for women in rural areas and women of low-income, and yet there is a failure of the health system to adequately integrate reproductive health care in redesigns. Rather, women are pushed towards a general practitioner approach, sacrificing the expertise they desire for reproductive health. This strategy fails to acknowledge the different ways women access the health care system in comparison to men. For instance, nearly all women want the choice to see an OB/GYN as their primary care provider, but system reformers routinely redirect women who have trusted relationships with their OB/GYN/women's health providers to general practitioners who don't have the relationship or expertise to best care for them. Indeed, OB/GYN and other women's health providers can be blocked from patient centered medical home designations.
- **These health issues coupled with a shortage of providers present real problems for women in accessing the care they need, especially in rural areas of the state.** We are experiencing a shortage of OB/GYN practitioners, which is expected to continue to expand through 2020.[6] From 2004 to 2014, 9% of all rural counties in the country lost access to hospital obstetric services, and more than half of all rural counties are now without a single local hospital where women can get prenatal care and deliver babies.[7] As we can see in the example of Calais Regional Hospital's decision to close its obstetric and gynecological unit, meaning that women in northern Washington County must now drive more than an hour to Machias for prenatal care and delivery. When the system is reconfiguring to meet strong cost pressures, it is essential that there is a multi-pronged approached to ensure that essential care, like women's health care, is prioritized and not taken out of communities.
- **Key health programs like Title X (federal family planning funding), Medicaid, Medicare and the Affordable Care Act all disproportionally serve and benefit women and have been subjected to significant funding constraints with women paying the price.** Publicly supported family planning and women's health care providers in Maine meet approximately 33% of the need, leaving more than 52,000 women in need of the reproductive health care with limited or no access.[8] For the women served, these health centers are often their only entry point to the health care system.

As demonstrated by the creation of this task force, Maine is at a crossroads when it comes to modernizing the health care system, and I encourage you in your work to think of ways to

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[5] Increasing Chronic Conditions putting more moms, babies at risk, https://www.sciencedaily.com/releases/2017/11/171107180045.htm.
[6] A Shortage in the Nation's Maternal Health Care, http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/08/15/a-shortage-in-the-nations-maternal-health-care
[7] Access to Obstetric Services in Rural Counties Still Declining, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0338.
[8] Contraceptive Needs and Services, 2014, https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.

embed women's health care into transforming the system. Women's health care all too often is overlooked or marginalized. You have an incredible opportunity to center women's health in delivery systems, payment policies and infrastructure investments, ensuring value is placed on these critical services and everyone's need to access them.

I look forward to this conversation as it unfolds and am happy to make myself available for any questions or requests for additional information.

Thank you,
Nicole Clegg
Vice President, Public Policy