

Testimony on LD 2196

An Act to Lower Health Insurance Costs, Reduce Barriers to Health Care and Ensure Fair Prices for Health Care

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Senator Ingwersen, Representative Meyer, members of the HHS Committee, my name is Daniel C. Bryant, M.D., of Cape Elizabeth and I am testifying neither for nor against LD 2196 and to express some thoughts about issues this bill raises. Although its title goals are laudable, I do not understand how the Part A cap figure of “200% of the Medicare rate for the same service in the same geographic area” was arrived at. According to national averages found by the Rand Corporation¹, in 2022 “employers and private insurers paid, on average, 254 percent of what Medicare would have paid for the same services at the same facilities.” That means that, should the bill become law, hospitals could face an approximately 21% reduction in payment by private insurers and employers, possibly forcing some of them to reduce the quality and/or quantity of the inpatient and outpatient care they are able to provide. “Exceptions” to this provision are made for a general hospital “determined to be financially distressed by the Office of Affordable Health Care,” but many hospitals have narrow margins as it is and performing annual detailed financial studies of multiple hospitals would put a huge burden on that office. As Katie Fullam Harris, chief government affairs officer for MaineHealth, has said (quoted in the February 25 Portland Press Herald): "Affordability is a serious problem. But this bill does not address the cost of health care." In addition, it is not clear how much premium payers would benefit from this squeeze on hospital finances.

For these reasons, I don't support or oppose LD 2196. I have, however, taken this opportunity to describe in an addendum what I think would be a more effective approach to achieving the bill's goals.

Thank you.

Daniel C. Bryant, M.D.

Addendum:

Though not trained in hospital finances, as chair of Maine AllCare's Legislative and Policy Committee I have looked into ways that hospital costs (that is, costs to the hospital of providing their services) could be reduced from within rather than capped from without. My conclusion is that implementation of a state-based, publicly funded, universal health care system could achieve that.

Unable to find in an internet search estimates of the percentage of total hospital costs that certain selected costs represent, I turned to ChatGPT. The figures this AI resource produced, listed in the following chart, may well not be accurate and would vary from hospital to hospital and year to

year, but specific hospitals could plug their own figures into the chart to estimate how their costs could be affected were they to operate in such a system as opposed to the present one.

Selected Hospital Costs Present System	% of Total Current Cost
Billing and Insurance Related (BIR) costs (total administrative costs 25%, of which approximately 82% ^a is due to BIR costs)	21
Benefits, largely health benefits	10
Bad debt	5
Charity care	2
Drug and device costs	15
Other (non-administrative labor, rent, supplies, etc.)	47
Total	100

^a Richman, Barak D; Kaplan, Robert S; Kohli, Japees; Purcell, Dennis; Shah, Mahek ; [et al.](#) Health Affairs; Chevy Chase Vol. 41, Iss. 8, (Aug 2022): 1098-25. DOI:10.1377/hlthaff.2022.00241

In a universal health care system, BIR costs have been estimated² to be about a quarter of current costs though half of current costs, or about 11%, would be a more conservative estimate. Benefits (employees covered in universal plan), Bad debt, and Charity care would be 0%. There is little evidence in the literature for what potential negotiated drug and device savings might be in a state, as opposed to a national, system though a recent Massachusetts study³ suggests those costs could be reduced 5%.

Selected Hospital Costs UHC System	% of Total Current Cost
Billing and Insurance Related costs	11
Benefits, largely health benefits	0
Bad debt	0
Charity care	0
Drug and device costs	14
Other	47
Total	72

That is, in a universal health care system, hospital costs could be reduced 28% without sacrificing care. I have not considered property, provider, and other taxes, and if hospitals were required to pay a payroll tax to help fund the system, that would reduce the effect of any savings.

From the patients' point of view, as commercial insurers can set premium rates at 118% of what they pay providers (1/0.85, given a medical loss ratio of 85%), patients so insured are paying premiums equivalent to 118% of hospital costs in the present system (plus any cost sharing). In a universal health care system, in which hospitals would bear just 72% of those costs, and the medical loss ratio would be closer to 95% because of simplified payer administrative costs, patients would pay premiums related to (reduced) hospital costs of only 76% of hospital costs

(1/0.95%, or 105%, of 72%). That's a reduction of 42% (118% - 76%) in what patients would pay for the hospital part of their premiums in a universal health care system.

¹ Whaley, Christopher M., Rose Kerber, Daniel Wang, Aaron Kofner, and Brian Briscoe, Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2024. https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html.

² Jiwani, A., Himmelstein, D., Woolhandler, S. *et al.* Billing and insurance-related administrative costs in United States' health care: synthesis of micro-costing evidence. *BMC Health Serv Res* **14**, 556 (2014). <https://doi.org/10.1186/s12913-014-0556-7>

³ Cote-L'Heureux, A, Friedman, G. Funding Universal Health Care in the Commonwealth of Massachusetts. 2026. <https://masscare.org/economic-analysis/>