Testimony Before The Health Care, Insurance and Financial Services Committee
Maine Legislature LD 1045
May 12, 2021
by Philip Caper, M.D.

Good morning Senator Sanborn, Representative Tepler and members of the HHS Committee. I am Dr. Philip Caper. I am here to testify in support of LD 1405. I'm an internist, a nationally and internationally recognized health policy expert, and one of the founders of Maine AllCare. Today I am speaking as an individual. I am here to support LD 1045.

i'm also a long time critic of our current healthcare system and advocate for replacing it with a system that is truly affordable, high quality, accessible to everybody, is secure, and is truly designed to serve patients and to be much more friendly to doctors, nurses and other health care workers. I believe health care should be a public good as is the case in all other wealthy democracies, not a private commodity.

Despite having an abundance of some of the best medical technology and some of the most dedicated doctors and other healthcare workers in the world, America's for-profit health care system in which that technology and those health care professionals is embedded is badly flawed, and poorly serves patients, doctors, nurses and the general public in many important ways. We as doctors, nurses and other health care professionals want to provide provide and appropriate care to our patients. But the system we work in, with its excessive focus on money, fights us every step of the way

Here are a few examples:

- Our for-profit health care system is too expensive. Our costs are roughly double those in other wealthy democracies. Much of this spending (up to 30% of the over $3 billion we spend annually) has been classified as waste by the National Academy of Medicine. Much of that waste is caused by the administrative costs associated with the unproductive complexity of our health insurance system, and more unnecessary costs are produced by higher than necessary prices across the board in the system.

- Too many Americans cannot afford health insurance premiums. Even those with health insurance often cannot afford the out-of-pocket costs that usually come with it, and find the coverage inadequate when they most need it.
- Our system is too complex, and is fully understood by only a few policy wonks, navigators and expensive consultants. It is baffling to patients, and poorly or only partially understood by doctors and nurses, and much less by the general public
- It often focuses on the wrong things - we have too much expensive and lucrative high technology, such as invasive Cardiology, Imaging, Oncology and Orthopedics, and too little primary care such as Pediatrics, OB-Gyn, Family Medicine and Mental Health.
- Our investment in primary prevention and other public health measures is ridiculously under-appreciated and underfunded, a fact that has come back to bite us during the current COVID-19 pandemic. The recent catastrophic dismantling of the Federal government's pandemic response capability just prior to the arrival of COVID-19 is just the latest example of the health care system's failure.
- Despite our uniquely high level of spending on medical care, the United States, alone out of all wealthy countries in the world, is experiencing a rising mortality rate and falling life expectancy.
- The shortcomings of our heavy reliance on employment-based health insurance have become apparent to everybody during the pandemic, as millions of Americans lost their jobs, and with them their family's health care coverage..
- Over the past few years these facts have become widely understood by the American public. But they feel helpless to do anything about them.

The American health care system, despite being by far the most expensive in the world, leaves about 120,000 Mainers without health insurance, and another estimated 300,000 with unaffordable or inadequate, unstable insurance coverage dependent upon continued, stable employment. The health care system in America produces mediocre outcomes compared with other wealthy democracies. Despite the high costs of our system, it leaves many rural hospitals teetering on the edge of insolvency.

For the last forty or so years, America alone has been experimenting with heavy dependence on market forces to improve access to care, control health care costs and assure the quality of care. We have encouraged the growth of "consumer" choice of health plans, competition among hospitals, and has attempted to promote

price transparency in the health care industry so that patients can shop for care. It has encouraged the use of competing for-profit health insurance, pharmaceutical, medical device and health service delivery companies for the provision of services.

Many of these companies exist primarily to create wealth for their owners, not services for their customers. Even hospitals and hospital conglomerates that are nominally non-profit behave as though they are for-profit. For example, Maine General Hospital in Augusta (a non-profit) discontinued their diabetic clinic, eliminating a source of care for thousands of their diabetic patients - because it was "losing money".

Furthermore, our reliance on employment-based health insurance, a relic of WWII wage and price controls, is fatally flawed. The pandemic we are now experiencing clearly demonstrated that, as millions of Americans, and their families, lost their jobs, and with it lost their health insurance.

That now 40 year old experiment with market-based health care has failed. Americans now face out of control and rising costs for health care of all kinds, spotty and unstable coverage and poor quality for too many people.

Our for-profit healthcare system is unnecessarily complex, due largely to the huge administrative apparatus necessary to manage the large number of offerings. No other other wealthy country places such heavy reliance on for-profit unregulated entities to assure the health of their people , or the vagaries of the marketplace. The combination of complexity, focus on profits and interference in medical decision-making creates cognitive dissonance in doctors and other healthcare workers, and is a major cause of the professional burnout we are experiencing.

There is not a shred of evidence in the voluminous health policy literature that reliance on competition and market forces improves access to health care, controls costs or maintains quality.

To the contrary, there is persuasive evidence that markets, consumer choice competition among doctors or hospitals does not, cannot and will not result in any of these benefits.

60 years ago, Economist Kenneth Arrow warned against the use of market forces in health care because of a combination of the moral hazard of insurance and the lack of information and expertise by the consumers of health care goods and services.

In 2001, Economist George Akerlof won the Nobel Prize in economics for demonstrating that in markets where a large asymmetry of information exists between sellers and buyers (where sellers have much more information than do buyers) quality suffers and those markets eventually become corrupt.I can think of no fields that illustrate this principle better than health care.

It is time to terminate our 40 year old experiment in relying so heavily on market forces.

We must replace our present system with a system that focuses on patient welfare, not profits - a system that eliminates medical underwriting (insurance-speak for discriminating against those who are ill or likely to become ill) with the pooling of risk, where everybody shares in the risk.
By doing so, we would do away with the unpopular exclusion of coverage for pre-existing conditions, the contentious use of rating bands. and other unpopular and contentious practices. They, too, would be gone.

We must replace wasteful competition among health care providers with cooperation, regional planning and a sharing of expensive health care technology and services. Competition often results in duplication of expensive equipment and services, fueling increases in already too high levels of spending.

A single risk pool would permit placing hospitals on a budget based on medical need, not the profitability of individual procedures and tests. More emphasis could be placed on badly needed primary care and the prevention or illness.

LD 1045 would establish a structure within state government that could achieve these goals, and give it the flexibility to respond to changes in the political climate surrounding health care, including future changes in Federal policy.

At the request of Maine AllCare, The Maine Center for Economic Policy developed an economic model that would cover all Maine residents, save $1.5 BB in the first year of full implementation, effectively restrain total future costs of healthcare in Maine, improve the coverage by Medicare, Medicaid and other existing programs, and result in less spending than the current system for 80% of Maine residents.

Improved coverage would be paid for by partially eliminating spending the roughly $5 BB Mainers now spend on waste in health care every year.

These problems have been a long time in the making. The fight over universal health care goes back over a century in the United States.

Why is it so hard to change such a dysfunctional system?

In 2015, under the auspices of the National Academy of Social Insurance, I convened a panel of some of the leading health policy experts in the country at the National Press Club to try to identify some of the barriers to change of the American health care system. Many were cultural.

Their consensus was that the following were some of the root causes contributing to political gridlock on health care reform.

They included:

- Apathy and lack of empathy - “I’m OK. If somebody else isn’t, it’s not my problem”.

- Fear - of loss of income or profits, of loss of employment and of government incompetence.

- Anger - fear of other Americans - structural racism

- Ideology - growing reliance on free markets to control costs, assure access to care, and maintain quality. This reliance on market forces continues to be advocated by some, even in the face of glaring signs of market failure in health

care. We must move to a system that emphasizes cooperation among healthcare providers rather than competition.

- Ignorance - on the part of the public and many policymakers about how the system works

- Greed - The supremacy of shareholder value in American capitalism. There is no such thing as too much profit for a publicly-traded company Excess profits must be tamped down, and healthcare costs restrained, Markets alone can't do that in healthcare. This must be done

As Peter Arno and I recently wrote in a professional journal article, "The real struggle for a universal single-payer system in the US is not technical or economic but almost entirely political. Retaining the status quo (for example, the Affordable Care Act) is the least disruptive course for the existing medical- industrial complex, and therefore the politically easiest route. Unfortunately, the status quo is disruptive to the lives of most Americans and the least effective route in attacking the underlying pathology of the US health care system— corporatism run amok. Following that route will do little more than kick the can down the road, which will require repeatedly revisiting the deficiencies in our health care system outlined above until we get it right.

The US public and increasingly the business community are becoming acutely aware of the rising costs and inadequacies of our current system. It is the growing social movement, which rejects the false and misleading narratives, that will lead us to a universal single-payer system—truly the most effective way to reform our health care system for the benefit of the US people."

Many Maine political leaders voice support for "affordable, comprehensive, high quality health care care for all Mainers". But too few are willing to take the politically difficult steps that are necessary to bring that outcome about.

Real reform of our sick health care system is over-due.

Vote LD 1045 "OUGHT TO PASS"!

APPENDICES

The following Appendices are a press release, summary and the full 2019 report from the Maine Center for Economic Policy commissioned by Maine AllCare.

It creates an economic model that demonstrates how universal health care coverage could be accomplished that

- could be done without significant changes in federal law
- be affordable for all Mainers cost less than Mainers are now paying for health care resulting in a savings of $1.5 billion a year once fully implemented
- would result in slowing health care spending in the future with much less interference in clinical decision-making than the status quo
- would result in decreased costs to 80% of Mainers
- would eliminate medical underwriting, that now results in the exclusion of pre-existing conditions from coverage and discriminatory ratings bands due to experience rating
- would expand health care benefits for for many Mainers, including those now on Medicare and Mainecare.
- would eliminate dependence on employment (and its attendant health job lock) for coverage

This model is not the only way to get to universal health care in Maine, but illustrates the feasibility of one way that goal can be achieved within current parameters - once we have develop the political will to do so.

Appendix 1

PRESS RELEASE
New Fiscal Analysis: Maine can save money and implement universal healthcare

FOR IMMEDIATE RELEASE: December xx, 2019

Maine AllCare asked the Maine Center for Economic Policy to investigate and report on how a state-based healthcare plan providing universal coverage to all of Maine residents could be financed. This report, *Assessing the Costs and Impacts of a State-Level Single-Payer Health Care System in Maine,* has been released and presented at the recent Maine legislature's HCIFS healthcare taskforce meeting on December 16, 2019 The report outlines that all residents of Maine can be covered by health insurance, save significant system-wide funds, and improve the fiscal wellbeing of the majority of Maine's residents.

The very first question people ask when the subject of universal healthcare comes up is, "How are you going to pay for it?" *This report represents a 'fiscal plausibility model'"*, that mirrors(?) analyses that have been done previously for other state-based models. This fiscal analysis, of the costs and economic impact of moving to a **universal, publicly funded healthcare system that covers every Maine resident,** concludes that we can undertake such a move and potentially **save $1.5 billion over current spending**.

A key assumption is that by leaving federal programs intact and providing a state-run program to cover the remainder of the population (around 652,000 individuals), including those who are currently

uninsured, underinsured, and covered by private insurance, can we ensure success.

The MECEP team analyzed in some detail the impact of the new public plan on Maine families and individuals, cities and towns, employers, hospitals and providers, along with jobs and the overall economy of our state. Their conclusions:

Impacts of the new state-based public healthcare plan include:

– 80% of families and individuals would see a boost in income due to savings on insurance and out of pocket health costs. Importantly, all Mainers would have medical, vision, hearing and dental coverage.
– Municipalities, counties and school districts would see a net savings of $315 million, or 6% of current spending for employee health insurance, equivalent to 1.1 mils property tax reduction. – Most employers would pay the same or less than at present, based on a sliding scale: Fewer than 5 employees - no payment, 5-9 employees - 1% of payroll, 10-19 employees 2% of payroll, 20-99 employees - 4.5% of payroll, 100-499 employees - 9.5% and over 500 employees would pay 10% of payroll. Workers' Compensation would be cut in half and employers would eliminate the costs of choosing and managing coverage plans.

– Hospitals and providers would be paid promptly and directly at Medicare rates while uncompensated "charity" care would be eliminated. Most providers would see minimal, if any, net financial effects. All hospitals and doctors' offices would remain private.
–Due to a greatly simplified system; broader economic benefits would accrue from a healthier workforce, along with increased entrepreneurship when insurance is decoupled from employment. An estimated net 900 administrative jobs in healthcare would be lost and should be considered in any planning.

As an illustration of benefits to Maine citizens, the study also created seven healthcare cost scenarios based on family size and income, (ranging for $10,000 to $500,000) drawn from a survey of Maine families. Five out of the seven scenarios will save money with this new public

system. The proposed state-based public healthcare plan would provide significant benefits to Maine residents, municipalities and employers and bring fiscal stability to our healthcare providers and hospitals.

In conclusion the report states: “The fact that single-payer systems elsewhere in the world have delivered better outcomes at less cost than in Maine..., suggests that the pursuit of more cost-effective alternative is a worthwhile endeavor.” The report was intended to inform the Maine AllCare Board on the next steps toward achieving universal, high quality and affordable healthcare for the people of Maine. However, the report cautions, a more detailed analysis is needed before proceeding.

To that end, the Board of Directors, together with tens of thousands of Maine AllCare supporters will continue our advocacy and education to transform today’s broken healthcare system into a new, fair, cost-effective publicly funded system that serves every Maine resident.

For more details, including a four page summary provided by the Board of Maine AllCare, or the complete report, please visit maineallcare.org or contact us at info@maineallcare.org.

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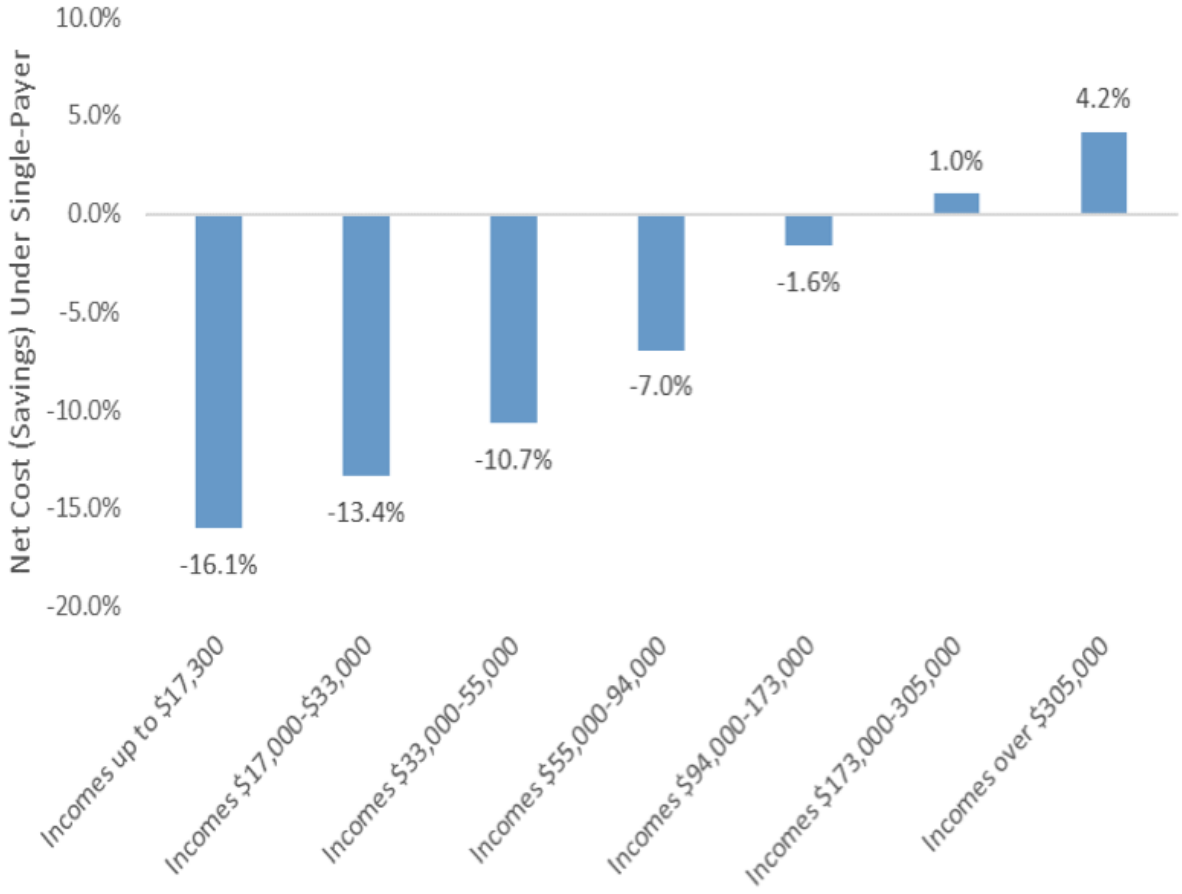
Appendix 2

Summary of MECEP Report

Most Maine residents will save money:

(See family surveys for real examples.)



Economic Impacts of a Health Care Plan to Cover All Maine Residents

Maine AllCare contracted with the Maine Center for Economic Policy (MECEP) to conduct study of the costs and economic impacts of a health care model that would cover all Maine residents through a state- based public plan.

The results of the study show that total yearly healthcare spending would decrease by $1.5 billion under a new public plan, delivering significant benefits to Maine residents, cities, towns and employers, along with fiscal stability for healthcare providers and hospitals.

How would a new public plan work?

The MECEP team based their model on the following assumptions:

- The new plan would be the primary source of coverage for those who currently have employer based and individual coverage. It would cover the uninsured, and fill coverage gaps for those on Medicare, MaineCare, VA, TRICARE and Indian Health.

- The new plan would provide all the benefits of Medicare or Medicaid and add dental, vision and hearing benefits.

- The new plan would have no co-pays, coinsurance or deductibles.

- The new plan would reimburse providers and hospitals at current Medicare rates.

  Impacts of a new public plan

  For Maine families and individuals

  Under a plan to cover everyone in Maine, 80% of families and individuals would see a boost in household income due to savings on insurance and out-of-pocket health costs. With lower spending on health care, Maine families would have more disposable income. Maine citizens would have medical, vision, hearing and dental coverage. In addition, increased access to primary care and prevention would promote early diagnosis, timely treatment and improved management of illness, including expensive chronic illness, which would improve health while reducing costs.

Sliding scale premiums ensure that all Maine residents contribute based on ability to pay.

• Below 138% of FPL – no premium
• 139% to 399% of FPL – 2 to 5% of AGI • 400% to 499% of FPL – 5 to 6% of AGI • 500% to 600% of FPL – 7.5% of AGI

• Above 600% of FPL – full premium
FPL = Federal Poverty Level ($12,490)
Full premium = $6000 per adult; $3500 per child; $3000 for 65+

For Maine cities and towns

Municipalities, counties and school districts would see a net savings of just under $315 million, or 6% of current spending for employee health insurance. This is equivalent to a property tax reduction of 1.1 mills. These savings could be used for education, town services and reduction in property taxes.

For Maine employers

Most employers would pay the same or less than at present, with their costs based on number of employees. Employers would eliminate the costs of choosing and managing coverage plans. Workman's compensation premiums would be cut in half. Improvements in access to care and in overall health would improve employee productivity. Coverage for everyone would lead to greater flexibility for employers and for workers.

Fee structure for employers:
• Fewer than 5 employees - no payment • 5-9 employees - 1% of payroll
• 10-19 employees - 2% of payroll

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- 20-99 employees - 4.5% of payroll

- 100-499 employees – 9.5% payroll

- More than 500 employees – 10% of payroll

  For Maine hospitals and providers

  A public plan would pay providers and hospitals promptly and directly. The state would not own hospitals or doctors' offices. Payments to hospitals, physicians and physicians' groups would be made at Medicare rates. Uncompensated "charity" care would be eliminated.

  Most providers would see minimal, if any, net financial effects. Higher Medicaid reimbursement levels; savings in bad debt, charity care, and employee health insurance; and simplified "billing and insurance" would offset reduced private insurance payments.

  Jobs and economic impacts

  MECEP estimates that under a public model for Maine, 1,400 administrative jobs would be lost in hospitals, doctors' offices, and businesses when administrative complexity is greatly simplified. These losses would be partially offset by an increase of 500 jobs to administer a state plan. Broader economic benefits would accrue from a healthier workforce, along with increased entrepreneurship when insurance is decoupled from employment.

  Maine health care costs keep rising and coverage keeps shrinking

- Between 2006 and 2017, the average premium for an employee on an individual plan went from $4,700 to $6,100. (*1l/2 times the increase in the cost of living over that period)*

- The average annual employee contribution for an individual plan increased from $1,100 to $1,300.

- The average annual employer contribution for an individual plan increased from $3,600 to $4,800.

- The average individual deductible for an employer-sponsored plan increased from $800 to $2,300.

- The share of Maine employees eligible for a plan through their employer fell from 73% to 61%.
  Healthcare spending was 17% of Maine's economy in 2001, 25% of in 2018 and projected to be 27% in 2026. The cost of health care is expected to reach $16,000 per person in Maine by 2026. There are 74,000 uninsured people in Maine and one in seven Mainers skipped care in 2016 because of costs, compared to one in ten in 2006.
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Primary sources of insurance in Maine in 2017: Employer-based (43%); Medicare (23%); MaineCare (20%); Affordable Care Act (6%); Uninsured (5.5%); VA/Tricare/Indian Health (2.5%)

How much would a public plan cost?

Maine spent $13.9 billion on healthcare in 2017. MECEP estimates that a public plan would decrease this to an equivalent of $12.4 billion. $0.6B of this decrease would come from lower reimbursement rates and $0.9B would come from net administra- tive savings, including the elimination of private insurance administrative costs, marketing and profit.

How would we pay for a new public plan?

The MECEP team estimates that the net cost for a plan to cover everyone in Maine would be just under $5 billion. This is after applying state savings as well as federal funds currently coming to the state for Medicaid reimbursement and Affordable Care Act subsidies. Approximately $4 billion would come from recapturing the funds now paid as premiums by individuals, families, and employers.
The remaining $1 billion could come from sources such as an additional income tax on individual incomes over $200,000, increases in restaurant and lodging taxes, eliminating some state tax subsidies, broadening the sales tax to

include certain services that are not currently taxed, restoring the estate tax, and increasing excise taxes on tobacco and alcohol.

Conclusion

A state-based public plan would require significant changes in the way health care coverage is paid for in Maine. A state plan would provide significant benefits to Maine residents, municipalities and employers as well as to bring fiscal stability to our healthcare providers and hospitals. Total health care spending could decline by $1.5 billion - $0.6 billion from price controls and $0.9 billion from administrative savings.

info@maineallcare.org

Maine ALLCare

Real examples of healthcare costs drawn from a survey of Maine families:

Family Size	Income	Current costs	% of incom e	Costs under new plan	% of income
Single mother, 2 children	$10,000	$1,200	12%	$160	2%
Family, 1 child	$40,000	$6,500	16%	$1,000	2.5%
Family, 1 child	$75,000	$7,100	9.5%	$4,050	5.4%
Family, 2 children	$120,000	$10,500	8.8%	$8,640	7.2%
Couple	$210,000	$9,900	4.7%	$12,990	6.2%
Couple	$500,000	$2,200	0.4%	$27,070	5.9%
Retired couple	$25,000(S S)	$3,200	12.3%	$1,250	4.3%

A single mother, 38, earning $10,000 a year, with two children, ages 9 and 4:
The family currently qualifies for MaineCare, with no monthly premiums. However, it's not uncommon for families like this to incur out-of-pocket expenses for services not covered. Perhaps the mother needs a tooth extracted, or one of the daughters needs to replace a pair of lost eyeglasses. These expenses could total $1,200 or 12% of annual income,

Under the public plan model, the range of services would be expanded to eliminate the need for additional out-of-pocket costs. Increased reimbursement rates could also increase provider options. Many low-income Mainers also suffer from unpredictability of income. Perhaps they work seasonal jobs, or jobs with varying schedules. This can make them eligible for MaineCare for a short period of time, before losing it as their income increases. A public plan model would bring increased stability to these families. Based on consumer expenditure patterns, increases to sales and excise taxes outlined in the public plan model would cost this family an additional $160 per year,

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for a total cost of 2% of annual income. Their net savings would be $1,040.

Lower middle class parents with one child, earning $40,000 a year from their small business: They purchase their insurance through the Affordable Care Act's online marketplace. Because of their relatively low income, annual premiums are capped at $2,500 per year. However, their plan has a high deductible, and total out-of-pocket expenses for the year are $4,000, costing a total of 16% of annual income.
Under a public plan model, the premium is capped at 2.8% of annual income ($1,120) with no deductibles or co-pays. The additional sales tax liability would be $280, and loss of itemized deductions increases state income tax liability by $100. Their small business has two employees, saving $500 in workers' compensation. Net cost is 2.5% of annual income and net savings would be $5,500.

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Upper-middle income family, earning $75,000, with employer insurance:
Two parents with one child. The family is insured through a plan offered by the

mother's employer. The employer covers about three-quarters of the cost of the premiums, but the family still contributes $3,600 a year. On top of that, they incur $3,500 in out-of-pocket expenses, for a total of $7,100 or 9.5% of annual income.

Under a public plan model, the baseline premium would be $15,500 ($6,000 for each adult, plus $3,500 for the child.) But based on their income, their cost is capped at 4.7% of annual income, or $3,525 per year. The additional sales and excise tax liability would be $450; loss of itemized deductions would increase their state income taxes by $75. Costs would go down to 5.4% of annual income and the family saves $3,950 per year.

Upper income family, earning $120,000, with employer-based insurance: The employer plan covers most of the premium cost for the parents and two children, leaving the family to pay $2,000 a year. Additionally, they incur $8,500 of out-of- pocket costs a year. Their total annual health care spending is $10,500, or 8.8% of their annual income.

Under a public plan model, their baseline cost is $19,000 ($6,000 per adult, plus $3,500 per child). Based on their income, their fee is capped at 6.0% of annual income, or $7,200 per year. Their additional annual sales tax liability would be $480. The end of itemized deductions increases their state income taxes by $960. Total cost of the public plan model for this family would be $8,640, or 7.2% of annual income. On net, the family saves $1,860 per year.

Wealthy couple, earning $210,000 a year, with individual insurance: The couple work as professionals with their own independent businesses and purchase a plan on the individual market. They pay $3,600 a year in premiums, and incur $6,300 in out-of-pocket costs, for a total of $9,900 annually, or 4.7% of income.

Under a public plan model, the baseline premium would be $12,000 ($6,000 per adult). As a high- income family, they are liable for the full cost. Their additional annual sales tax liability would be $630. The end of itemized deductions increases their income tax liability by $360. The creation of the new income tax bracket at $200,000 does not impact this family, after adjusting for deductions. The total cost would be 6.2% of annual income and the couple would pay an additional $3,090 under the new plan.

Wealthy couple, earning $550,000 a year:
One person runs their own business, the other works independently as a hedge fund manager. They are covered through an employer-sponsored plan, and currently pay $1,100 a year in premiums, plus an average of $1,100 out of pocket every year, for a total cost of $2,200 or 0.4% of annual income.

Under a public plan model, their base premium is $12,000 per year ($6,000 per adult). Their additional annual sales tax liability would be $5,500. The end of itemized deductions increases their income tax liability by $1,870. The creation of the new income tax brackets at $200,000 and $500,000 increases their state income tax liability by just under $9,900 a year. This couple pays 5.9% of income, or an additional $27,070 under a public plan model.

The business-owner currently offers a health insurance plan to some of her 40 employees, at a total cost of $60,000 a year to the business. Under the Maine AllCare plan, her business would instead pay a 5.5% payroll tax on her employee payroll of $975,000. Her total payroll tax liability is $53,625, a net saving of $6,375 compared to providing insurance under the status quo. Additionally, her workers' compensation premiums are reduced by $321 per worker per year, or $12,840. Total business savings are therefore $19,215. She could either pass these savings along to workers as higher wages, reinvest them in her business, or keep the savings as additional profit.

Senior retired couple, ages 73 and 69, earning $25,000 a year in Social Security payments: Both are enrolled in Medicare, with a Medicare Advantage plan. Currently they pay $1,300 in premiums and $1,900 out of pocket every year, or 12.3% of annual income.

Under a public plan model, they would no longer need to purchase a Medicare Advantage plan, and out-of-pocket copayments would be eliminated. They would also have access to services like dental and hearing care, which are not covered under basic Medicare. The premium would be capped at 4.2% of their annual income, or $1,050 a year. Based on consumer expenditure patterns, the increases to sales and excise taxes outlined in the new plan would cost this family an additional $200 a year for a total cost of 4.3% of annual income. Their net savings would be $1,950. Appendix 3

Appendix 3

Full MECEP Report

Assessing the Costs and Impacts of a State-Level Universal Health Care System in Maine

James Myall, Policy Analyst - Maine Center for Economic Policy

December 2019

Executive summary

In 2018, Maine AllCare contracted with the Maine Center for Economic Policy (MECEP) to conduct analysis related to the costs and economic effects of a state-based universal health care system that could cover all Maine residents. This report summarizes MECEP's findings regarding the structure, costs, and effects of a hypothetical proposal for a state-based universal system in Maine.

MECEP's findings provide a basic understanding of key factors to consider and are intended to inform Maine AllCare's exploration of next steps related to their health care advocacy. Any effort to proceed with the development of a Maine-specific universal plan would require more detailed policy development and analysis than could be delivered within the scope of this project.

Creating a single public plan that could cover all health care costs is difficult or even impossible at the state level, in part because many individuals are already covered by federally funded and administered health programs such as Medicare, the Veterans Health Administration, the Indian Health Service, and

TRICARE. Others are covered by the joint federally and state-funded Medicaid program. It is unlikely that the federal government would cede its authority over these programs and their associated funding to any state government.

MECEP is unaware of any current detailed proposals to enact a state-level universal system in Maine. Therefore, this report describes a hypothetical system devised by MECEP as one way to publicly-funded, universal coverage at the state level. MECEP has not endorsed the plan described in this report, but has provided analysis of the effects such a plan would have on health care and the economy in Maine.

The plan outlined in this report would leave federal programs intact and provide a state-run program to cover the remainder of the population, including those who are currently uninsured or covered by private insurance. It features the following characteristics, which undergird the figures and statistics found throughout this report:

- Mainers enrolled in existing public programs would keep their coverage. The state would fund initiatives to fill coverage gaps and eliminate out-of-pocket costs for this group.

- Mainers currently enrolled in private plans and those who are uninsured would be enrolled in a publicly funded program modeled on Medicaid. MECEP assumed

mandatory enrollment, to preserve cost-savings and capture greater efficiency in the

overall health care system.

- Enrollees in the publicly funded program would pay a coverage fee or tax that would be
  capped as a share of income. There would be no copays, coinsurance, or deductibles,

and care would be free at the point of service.

- Reimbursement rates for providers within the state program would increase to match
current Medicare rates.
Based on these assumptions, approximately 652,000 individuals, including 74,000 currently uninsured individuals, would obtain coverage through the new program. Net program costs are projected at $4.9 billion once federal subsidies and state-level savings are accounted for. Approximately 80 percent of these costs would be paid in the form of individual and employer taxes that would recapture funds currently being spent on premiums, deductibles, and out-of- pocket costs. The remainder — about $1 billion — would need to be paid for by raising taxes. In this report, MECEP has included several potential revenue sources.
Beyond the implications of a state-level universal plan for the state budget, MECEP attempted to model the effects of such a plan on family budgets, local governments, providers, and employment. Those effects can be summarized as follows:

- Family budgets: Most families, particularly those in the bottom 80 percent of households based on income, would experience a boost in household income as a result of this plan. For middle-income families, the average income gain would $3,500 per year (8 percent of annual income), because of savings on insurance and out-of- pocket health costs. Lower-income families would see proportionally bigger benefits.

- Providers: The net impact on health care providers would be neutral. Providers would see less patient revenue from patients who are currently privately insured and who would move to the new public insurance program with lower reimbursement rates. However, these losses would be offset by an increase in current Medicaid reimbursement rates, savings from reduced need to provide charitable care and write off bad debt, as well as business savings enjoyed by providers. Simplifying the insurance

system would reduce administrative costs for providers, and health care employers would see reduced costs from health care and workers' compensation insurance premiums versus the status quo.

- Local governments: Local governments could see a net savings of just over $214 million, which is roughly equivalent to a property tax reduction of 1.5 mils.

- Employment: The significant reduction in administrative costs for hospitals, providers, and businesses would result in a loss jobs in health care administration. These would be partially offset by job gains in health care administration in state government, for a net job loss of 2,931. There may be additional jobs created through the economic stimulus associated with additional federal funds flowing into the state, but these have not been calculated in this report.

Other impacts related to the economic gains associated with a healthier workforce and increased entrepreneurship resulting from decoupling insurance coverage from employment were beyond the scope of this study but are important to consider. So too are the gains associated with redirecting dollars being spent on health insurance and health care administration to other productive purposes.

It is important to note that the outcomes depicted here are calculated based on the implementation of a state-level universal plan that reflects the assumptions cited previously. One challenge in evaluating these impacts is that they are not modeled against the impacts of maintaining the status quo. While we know what the current system yields in terms of coverage, costs, and outcomes, the picture is likely to get worse absent significant change at the state or federal level, as costs continue increasing to unaffordable levels.

This report explores one potential path toward meeting the broad goals of a universal health care system at the state level. MECEP hopes it will contribute to the identification of comprehensive and effective solutions that benefit all Mainers.

Health care in Maine today

Health care spending in the United States continues to rise faster than the cost of living.[1] Between 2017 and 2026, Mainers are expected to spend almost $178 billion on health care. In 2026 alone, the cost of health care is expected to reach $16,000 per capita.[2]

Health care has gone from being 17 percent of Maine's economy as recently as 2001, to 25 percent today. By 2026, health care will comprise more than 27 percent of the state's economy.[3]

Increasing health care costs reduce Mainers' ability to spend money on other goods and services. Between 1997 and 2018, Mainers went from spending an average of 14 percent to 17 percent of their consumer expenditures on health care services.[4]

Mainers are increasingly faced with trying to decide between health care, and other necessities such as food and rent. Health care is a necessity for all Mainers, yet 125,000 Maine adults didn't get the care they needed promptly because they couldn't afford it in 2018.[5]

The inability of Mainers to get the care they need is widespread and worsening. In 2006, slightly more than 1 in 10 Mainers between the ages of 18 and 64 skipped care because of costs. By 2018, that proportion had risen to 1 in 7.[6]

Reliance on private insurance tied to employment is not working

Having private insurance coverage does not necessarily mean one is able to afford care. In addition to the millions of Americans with no health insurance coverage, an estimated one in

five non-elderly adults is *underinsured*, meaning they face significant out-of-pocket costs and deductibles.[7]

This means that even Mainers with insurance can't always afford the care they need. One in eight non-elderly adult Mainers with private insurance had to skip care because of cost in 2016, a 33 percent increase over 2006 levels.[8]

Since the 1940s, the United States has developed a health care system that, for the most part, relies on employer-sponsored private health insurance to meet the costs of health care. As the cost of health care and insurance has risen, the cost to businesses of providing insurance to their employees has also risen. In response, employers have offered less generous plans, allowing fewer employees to qualify for these plans, and asking those who do qualify to contribute more.

Between 2006 and 2018:

- The average cost to insure an employee on an individual plan in Maine increased from $4,663 to $6,866, one-and-a-half times the increase in the cost of living over that period.

- The average annual employee contribution for someone on an individual plan increased from $1,100 to $1,461.

- The average annual employer contribution for someone on an individual plan increased from $3,600 to $5,403.

- The average individual deductible for an employer-sponsored plan increased from $800 to $2,447.

- The share of Maine employees eligible for a plan through their employer has fallen from 73 percent to 61 percent. [9]

Maine employees and employers are paying more for insurance that offers them less value. While employers have, on average, taken on a greater share of the increase in insurance premiums, workers absorb the full cost of the increase in deductibles and copayments. The fact that premiums have increased much faster than wages also means that low-wage workers are spending a greater share of their income on their share of monthly premiums.

For Mainers working in businesses that pay low wages, the average monthly premium for an employer-sponsored plan covering a single individual represents 9 percent of their paycheck. For workers in the highest paying industries, the average employee contribution represents 2 percent of their paycheck.[10] For workers who need family plans, the burden for low-income workers is even higher. The average cost of a family plan for the lowest-wage workers is the equivalent of a fifth of their paycheck.[11]

Publicly funded health care has proven more cost-effective

The status quo is costly and delivers poor value for its high cost. Compared to other wealthy nations, the United States spends twice as much on health care per person for average results, as illustrated by life expectancy rates in Table 1.[12]

Given the higher-than-average health care spending per capita and the relative lack of racial and ethnic diversity, life expectancy at birth should be greater in Maine than the national average. However, outcomes are virtually the same as those for the rest of the country.

Table 1: Per capita health expenditures and life expectancy comparison

Personal health

expenditures per capita

Maine United States OECD $9,531 $8,015 $3,660

Life expectancy at birth 78.6 78.6 81.5

Source: MECEP analysis of Organization for Economic Co-operation and Development, 2017 data (health expenditures); Center for Medicaid Services National Health Expenditure data, 2014 (state health expenditures, adjusted for inflation to 2017 levels), Institute for Health Metrics and Evaluation (state life expectancy). Personal health expenditures exclude spending on investments, government administration, and public health preventative measures.

The disparity between health spending and outcomes in the US is partly because the provision of health care is inefficiently distributed within the country. Some people (especially the affluent and seniors), consume a lot of health care, while others (the less well-off) struggle to access basic services. Additionally, the price of care is significantly higher in the US than elsewhere.[13] Studies point to two major causes of this price inflation – the for-profit nature of parts of the health care sector, and the fragmentation within the United States' system, which creates administrative inefficiencies.[14]

The structural nature of these problems requires a structural solution. Many of the United States' peer countries deliver health care through a system that relies more heavily on publicly funded health care. The consolidation of funding into a single entity allows for greater efficiencies and administrative savings, while government oversight of the health care sector controls costs.

In recent years, several states have explored building similar universal health care systems, including California, Colorado, Michigan, Minnesota, New York, and Vermont. A national universal system (sometimes called "Medicare for All") has also been proposed at the federal level. This study draws from the experiences of those states.

Building a universal health care plan for Maine

A state-level universal health plan must account for existing federal health care programs in its development. Medicare, the Veterans Health Administration, the Indian Health Service, TRICARE, and the joint federally and state-funded Medicaid program cover almost half the

state's population. These programs have coverage gaps that would need to be addressed to ensure that participants do not face out-of-pocket costs. Maximizing enrollment in these programs while addressing coverage gaps is one pillar of an effective universal plan.

Another pillar of a comprehensive universal plan is the development of a state-level public program for non-Medicaid eligible uninsured individuals and individuals with private health coverage. Under the plan imagined in this analysis, such a plan would be modeled on the existing Medicaid (MaineCare) program. It would provide free care at point of service with no premiums, copays, or deductibles. In addition to the existing range of services, MECEP assumed in its analysis that this plan would also cover dental, vision, and hearing care for all enrollees. (MaineCare currently covers children's dental care only).

For this analysis, MECEP used Maine Department of Health and Human Services enrollment and cost data to calculate the baseline cost of care under the current MaineCare program. Estimates for the additional cost of dental, vision, and hearing care were based on estimates from the American Dental Association (for non-elderly adults)[15] and current spending through the Medicare part D program.[16]

As with MaineCare, the state would reimburse providers at fixed rates. MECEP assumes rates for the existing MaineCare program and the new public plan be set at Medicare reimbursement levels initially, with annual adjustments set by an independent board as necessary.[17]

According to the Maine Hospital Association, Medicare reimbursement levels represent 87 percent of the cost of delivering care in today's fragmented health

care system.[18] However, MECEP estimates that the bottom lines of hospitals and other providers would be largely unaffected relative to the status quo with a uniform Medicare reimbursement rate. Any losses suffered through reduced revenues from privately insured patients would be made up for by the elimination of charitable care and bad debt, the increase in rates for current Medicaid patients, and the reduction in providers' administrative overhead (see Table 6).

Summary of existing federal health care programs incorporated in a universal care plan

Medicare covers Mainers aged 65 and older, as well as Mainers with serious disabilities. The lowest-income Medicare enrollees receive free care, by also being eligible for Medicaid, which covers the cost of their premiums and co-pays. Under a universal care plan, Medicare recipients who currently pay premiums and out-of-pocket costs would receive a credit from the state to offset that cost. This includes costs associated with dental, vision, and hearing care, as well as prescription drugs (Medicare Part D).

Veterans' Administration health care is available for some former servicemembers. The extent of coverage and the out-of-pocket costs payable by the Administration depends on whether the covered individual has a service-connected disability and on the severity of their health needs. Under a universal care plan, Mainers using Veterans' Administration healthcare would be eligible for wrap-around coverage to pay for out-of-pocket costs.

TRICARE provides subsidized private insurance plans to active-duty military and their families. Like Medicare, a basic level of care is provided for free, but many families purchase supplemental coverage to cover extra costs. Under a universal care plan, TRICARE enrollees would be eligible for a credit to purchase this supplemental insurance at no cost.

Indian Health Service is run by the federal Bureau of Indian Affairs and provides free-at-point- of-delivery care to members of recognized Indian nations (residents of reservations, as well as tribal members living off-

reservation). The IHS has been underfunded for many years and provides only about half the care needed by tribal members. Under a universal care plan, the state would appropriate additional funds for Indian Health Service centers in the state to meet the unfunded need.

Medicaid is a joint state and federal program, known in Maine as MaineCare. MaineCare offers free care to low-income Mainers, Mainers with serious disabilities, and some Mainers with specific medical conditions, such as breast cancer or brain injuries. Under a universal care plan, all Mainers currently eligible for MaineCare, and its sister program, the Children's Health Insurance Program (CHIP), would be enrolled in the program. Maine would also apply to the federal government for permission to expand eligibility in CHIP to 312 percent of the federal poverty level and eligibility for parents to 200 percent of the federal poverty level. Under a universal care plan, the state would increase MaineCare reimbursement rates by 23 percent over current levels, to bring them to parity with Medicare payment rates.

Prescription drug pricing

The estimates in this analysis assume that Maine continues to control prescription drug costs using the same mechanism currently operating in the national Medicaid program. [19] Under this system, drug manufacturers rebate state governments a share of the total spending on drugs (on average, these rebates total 50 percent of prescription drug spending).[20] In exchange, Medicaid pledges to cover all FDA approved drugs by that manufacturer. The simplest mechanism would be for Maine to tie its rebates to the federal Medicaid program.

However, Maine could theoretically renegotiate prescription drug prices with manufacturers if it wished under the public plan. As a small state, Maine would inherently have less bargaining power in any price negotiations with pharmaceutical manufacturers than many jurisdictions. However, that does not mean that price regulation would be impossible in Maine. Internationally, many small counties regulate the price of prescription medicines. For example, all OECD counties have some form of price regulation, including Luxembourg

(population 300,000), Iceland (population 500,000) and Estonia (population 1,300,000).

Were Maine to pay full retail price for prescription medicines covered by the plan, the cost would increase by approximately $300 million.[21]

Based on current enrollment levels, more than 600,000 Mainers would continue to be covered by existing federal programs, including Medicaid. Further expanding Medicaid eligibility and automatic enrollment in this and other federal programs would mean that more than 700,000 Mainers would be enrolled in federal programs under the universal health care model. The remainder of those who are uninsured or have private insurance coverage would be automatically enrolled in the new public plan. Table 2 summarizes the primary source of coverage for Mainers under the status quo and a universal care scenario.

Table 2: Primary source of health insurance for Mainers under status quo and universal plan

Primary source of insurance Status Quo
Total Population 1,335,907 Employer 604,779 Healthcare.gov 81,212 Medicare 307,749 Medicaid 269,890 Veterans Adm. 15,698 TRICARE 13,792 Indian Health 2,103 Uninsured 74,196

Universal Plan 1,355,907

0

0 307,749 364,091 15,698 13,792 2,103 0

New State Plan 0 652,474

Note: For simplicity, populations are grouped by their primary source of insurance.[22] In reality, many Mainers have multiple sources

of insurance.

Source: MECEP analysis of US Census Bureau, American Community Survey, 2017 data.

Paying for a universal care plan in Maine

The universal care plan in Maine modeled in this analysis would carry a net state cost of almost $4.9 billion. This would require a significant increase in state spending through the General Fund, but it would also result in a significant reduction in health care spending compared to current levels. More Mainers would have access to care at a lower total cost. In effect, the cost to the state's general fund represents a shift from individual to collective costs.

Covering more people for less money

Total spending on health care in Maine would decrease under the universal care plan, from an estimated $13.9 billion in 2017 under the status quo, to an equivalent of $12.4 billion under the proposed universal care plan.[23] These savings are achieved by reining in the cost paid for services, and through reductions in administrative costs at the public (state) and private level.

Spending on core health care services would decrease by approximately $600 million, primarily through lower average provider reimbursement rates. By effectively setting all payment rates at Medicare rates, providers would see more revenue from some patients (those on Medicaid, the uninsured who qualify for charity care, and underinsured who accrue bad debt), and less revenue from privately-insured patients.

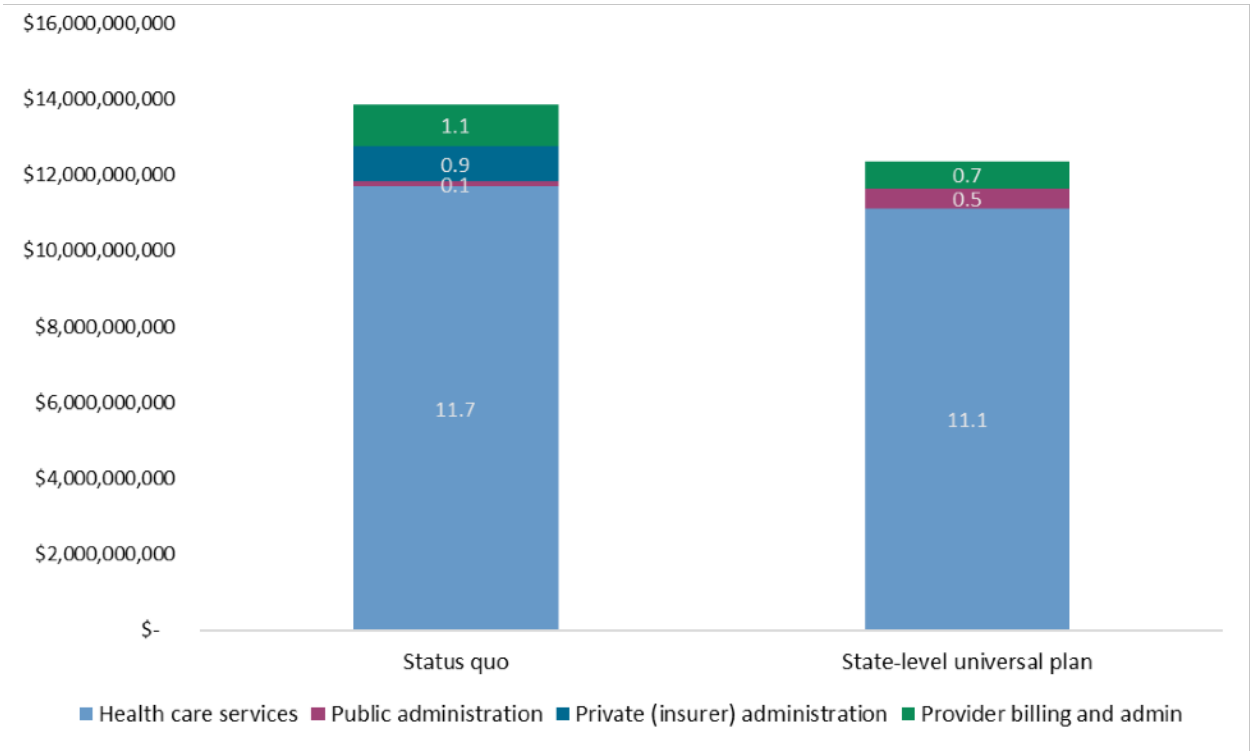
Overall administrative and overhead costs would decline significantly. Currently, approximately $2.2 billion is spent on these costs, including $0.9 billion on the net cost of private insurance (insurer administrative costs, marketing, and profit),[24] $1.1 billion on billing and insurance- related

administration in provider's offices,[25] and $0.1 billion to administer the MaineCare program.

Under the universal care proposal, total administrative spending would decrease to just under $1.3 billion, representing $0.8 billion in savings. This includes a 33 percent reduction in provider billing and insurance related administrative costs, plus the replacement of the net cost of private insurance with much lower administrative costs for a public plan.

Total health-related spending declines by $1.5 billion, of which $0.6 billion can be attributed to lower reimbursement, and $0.9 billion to administrative savings.

Chart 1: Total health care spending under the status quo and the universal care plan



Sources: MECEP analysis of US National Health Expenditure data, estimates of state spending; Maine Department of Health and Human Services budget data.

Table 3: Summary of costs

Baseline cost	Federal funds	State savings	Net cost to general fund
$6,274,617,482	-$1,143,859,844	-$263,886,203	$4,866,871,435

The baseline cost includes the full cost of health care and administration for additional enrollment and wraparound coverage for those enrolled in existing federal programs, plus full enrollment in the new universal care plan. This baseline estimate is inclusive of additional spending to fill in coverage gaps in existing programs, as well as raising the reimbursement rates for the MaineCare program. This figure also includes the cost of coverage for public employees currently covered by state health and dental insurance plans.

Federal funds would offset some of the cost of the Maine universal care plan. Maximizing Medicaid enrollment, and further expanding eligibility would draw down around $465 million in matching federal funds. The rate of federal match is assumed to be 65 percent for adults, and 75 percent for children.[26]

Additional federal funding estimated at $653 million is available in the form of pass- through money under the Affordable Care Act. Under the ACA, states can apply to the federal government to repurpose the funds that the federal government would normally spend to subsidize plans on the individual insurance market. With such a waiver, Maine could apply these funds to a state-run universal care plan. The estimate of $653 million assumes that Maine can enroll approximately 43,000 individuals who are currently uninsured but eligible for subsidies in the individual market.[27]

State savings represents the amount the state is currently spending on coverage for public employees, whose coverage under a potential universal care plan is already included in the baseline cost, as well as the state's existing workers' compensation insurance savings.[28]

Paying for the costs of a universal care plan would require new revenue, some of which would come from recapturing funds already being spent on health coverage by employers and individuals and directing them toward a universal care system. MECEP highlights one approach for securing the necessary revenue to pay for a universal care plan in Table 4.

Table 4: Summary of revenues

Individual premium recapture Employer premium recapture Income tax
Restaurant & lodging tax Excise taxes

Eliminating tax expenditures Sales tax for services
Estate tax
Total

Individual premium recapture

Currently individuals pay premiums,
universal care plan would eliminate these and replace them with a coverage fee or tax that would be capped as a share of income based on a family's relationship to the federal poverty level (i.e. household composition and income level). The federal poverty level for a family of four is $25,750 in 2019.[29]

Families would be assessed an annual premium depending on their family size, composition, and whether they have federal forms of insurance (see table 5). This "sticker price" would be capped at a share of family income, and most families would pay much less than the assessed premium.

Table 5: Baseline individual premiums

$ $ $ $ $ $ $ $ $

1,917,872,442 2,051,316,018 415,615,868 141,750,628 150,000,000

87,360,000 78,171,985 35,000,000

4,877,131,940

deductibles, and out-of-pocket costs for health care. The

Federal insurance type

Medicaid
Medicare
Veterans' Administration
Indian Health Service (under 18) Indian Health Service (18 and over)
TRICARE
None (under 21)
None (21 and over)

Baseline annual premium

$0 $3,000 $3,000 $1,500 $2,500 $900 $3,500 $6.000

The premium cap would be structured as follows:

• Families below 138 percent of FPL would pay nothing (same as current Medicaid recipients)

- Families between 138-399 percent FPL would pay between 2 and 5 percent of household income (under the ACA these families typically pay 4.7-9.5 percent of income for Healthcare.gov plans)

- Families between 400-499 percent FPL would pay between 5 and 6 percent of household income (currently ineligible for subsidies under the

ACA)

- Families between 500-599 FPL would pay between 6 and 7.5 percent of household income

- Families at or above 600 FPL would pay 7.5 percent of household income

  For example, a family of two adults and a child, with a family income of $60,000 is at 289 percent of the federal poverty level for their household size. They would make an annual payment or periodic payments capped at 3.8 percent of their family income, or $2,280/year, to cover health care costs. Such payment could be made when filing taxes or through a separate premium payment system established by the state.

  The individual premium recapture would raise just over $1.9 billion, or 39 percent of the total net cost to the state. This is significantly less than the $3 billion that Maine families currently spend on premiums and out-of-pocket costs.[30] The remaining cost would be covered by businesses, out-of-state visitors, summer residents, and the wealthiest Mainers.

  Employer premium recapture

  A further almost $2 billion would be raised through a coverage tax on employers' payrolls. This would take the place of the employer share of premiums currently paid toward health insurance.

  Private-sector employers would pay an estimated $1.8 billion through the new payroll tax,[31] somewhat less than the $2.1 billion they currently contribute to their workers' health insurance premiums.[32] (Public-sector employers, including the state and local governments, would contribute the remaining $238 million in payroll taxes).[33] In addition to saving on health insurance contributions, employers would also save from a 50 percent reduction in workers' compensation premiums,[34] estimated at just under $155 million.[35]

  Overall, Maine's private sector businesses would see net savings of just under $313 million.

  To account for the fact that small businesses are less likely under the status quo to offer insurance to their employees, the coverage fee would

vary depending on the size of the business. The fee structure used for this analysis follows:

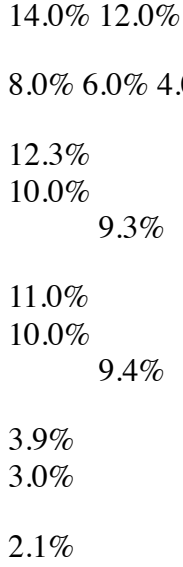
- Businesses with fewer than 10 employees would pay coverage fee equivalent to 3 percent of payroll

- Businesses with 10-99 employees would pay a coverage fee equivalent to 4.5 percent of payroll

• Businesses with more than 100 employees would pay a coverage fee equivalent to 10 percent of payroll

On average, businesses of all sizes would save money under this structure (see Chart 2). Private sector businesses would have to choose whether to pass these savings along to workers in the form of wages or other benefits or record them as additional profit. However, health insurance and workers' compensation insurance premiums are tax-deductible, so any savings booked as profit would be subject to state and federal income taxes.

Chart 2: Distribution effect for businesses



5.2%
4.5%

3.7%

<10 Current insurance costs

10 to 99 Projected new payroll tax

100 to 499
New payroll tax less workers comp savings

500 plus

Note: Chart does not include the impact on businesses of reducing tax expenditures for business incentives, though these are believed to disproportionately benefit large corporations.
Source: MECEP analysis of data from US Census Bureau, Annual Survey of Entrepreneurs, 2016. Employment and payroll estimates in the ASE were adjusted to 2018 levels using the Bureau of Labor Statistics, Quarterly Census of Employment and Wages data, 2018 annual average. Current employer insurance premiums were calculated using US Department of Health and Human Services, Medical Expenditure Panel Survey, 2018 data. Savings for reduced workers' compensation premiums were apportioned on a per-employee basis using mean costs for State of Maine employees derived from the Maine Open Checkbook.

Examples of effects on large corporations[36]

Just as family budgets and health expenses can vary dramatically, so too do businesses' health insurance expenses under the status quo. However, on average, MECEP estimates that most businesses would experience savings under the proposed universal care system and employer premium recapture model outlined above.

Ratio relative to employee payroll

In general, businesses who currently provide more comprehensive, more expensive plans, will save most under the universal care model. For example:

A big-box retailer with 1,000 employees which provides minimal health insurance to its employees currently spends $4.8 million on premiums every year.[37] With annual payroll of $40 million, their new tax liability at 10 percent is $4 million. The business saves $800,000 compared to the status quo.

A manufacturing business with 1,000 employees pays good insurance benefits to its workers. It currently spends $8.9 million annually on insurance premiums. [38] With an annual payroll of $50 million, their payroll tax liability at 10 percent is $5 million. The business saves $3.9 million compared to the status quo.

New coverage taxes

To cover the remaining balance of the costs to implement a universal care plan in Maine, the state would need to raise additional revenue by increasing existing taxes or instituting new ones. Below are tax increases identified for this analysis that would generate enough revenue to close the gap between total program costs and the amount generated from the individual and employer premium recaptures.

- Income taxes: Changes to the income tax code account for $416 million in new revenue. These include: Two new tax brackets – a 10.15 percent bracket for couples earning over $200,000, and a 12.15 percent bracket for couples earning over $500,000; elimination of obsolete state tax deductions for medical deductions, health savings accounts, and self-employed health insurance costs; elimination of all other itemized deductions on state income taxes; and counting retirement income as regular income for income tax purposes.[39]

- Restaurant and lodging taxes: $142 million from an increase to the restaurant tax from the current 8 percent to 12 percent and the lodging tax from the current 9 percent to 12 percent.[40]

- Excise taxes: $150 million from increases to tobacco and alcohol excise taxes. These increases would put Maine's excise taxes in line with other states with high tobacco and alcohol taxes.[41]

- Eliminating tax expenditures: $87 million from elimination of inefficient state subsidies for businesses that primarily benefit wealthy corporations

and do not promote job growth.[42]

- Broadening the sales tax: $78 million from broadening the sales tax to include certain services, particularly recreational services.[43]

- Restoring the estate tax: $35 million from rolling back the estate tax to pre-2012 rates. This would affect a few hundred of the wealthiest estates in Maine.[44]

Assessing the effects of a universal care plan in Maine

Implementation of a universal care plan would have far-reaching effects. For this analysis, MECEP attempted to evaluate the direct impacts on family budgets, providers, local government, and employment. These effects are summarized below and addressed in more detail in following sections.

- Family budgets: Most families, particularly those in the bottom 80 percent of households based on income, would experience a boost in household income as a result of this plan. For middle-income families, the income gain would be 8 percent, on average, from savings on insurance and out-of-pocket health costs, with average savings being even higher for the lowest-income families.

- Providers: The net effect on health care providers would be neutral. Providers would see less patient revenue from patients who are currently privately insured and who would move to the new public insurance program with lower reimbursement rates. However, these losses would be offset by an increase in current Medicaid reimbursement rates, savings from reduced need to provide charitable care and write off bad debt, as

well as business savings enjoyed by providers. Simplifying the insurance system would reduce administrative costs for providers, and health care employers would see reduced costs from health care and workers' compensation insurance premiums versus the status quo.

- Local governments: Local governments could see a net savings of just over $214 million, which is roughly equivalent to a property tax reduction of 1.5 mils.

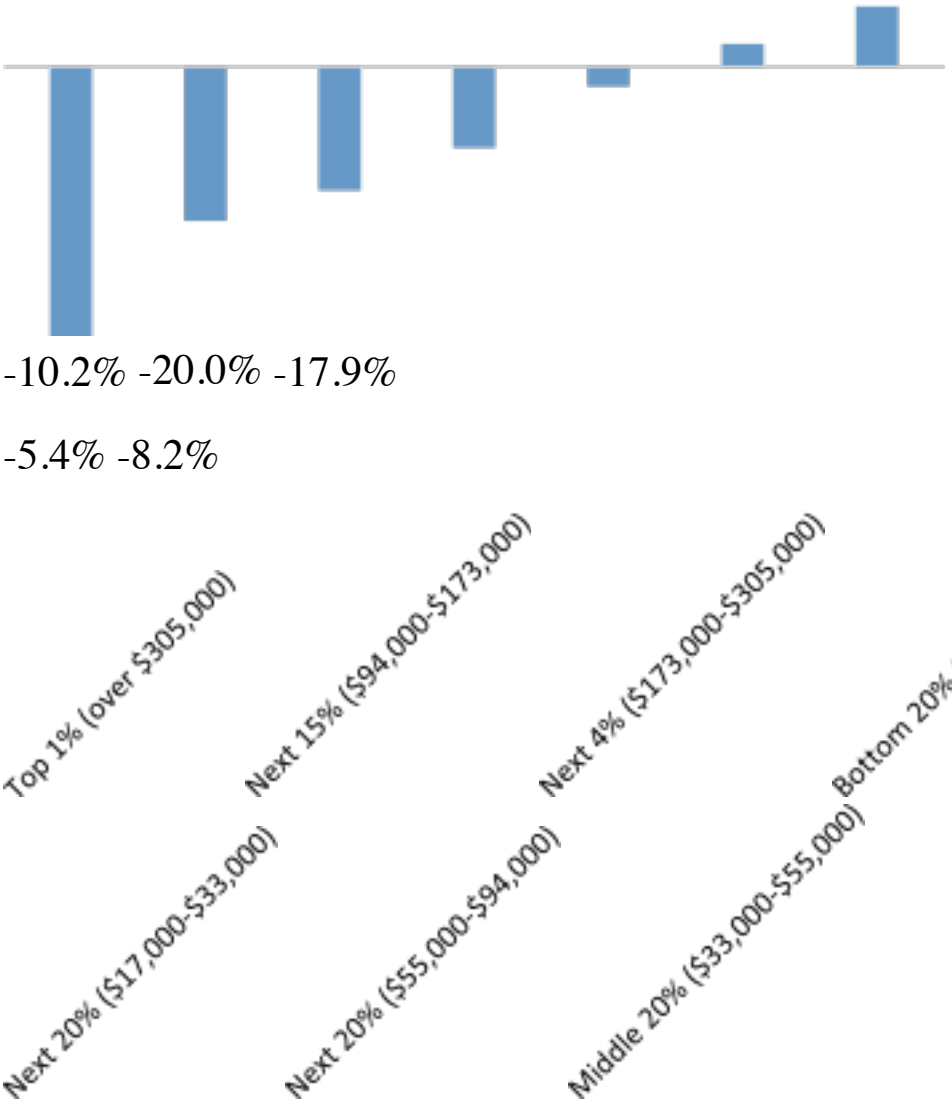
- Employment: The significant reduction in administrative costs for hospitals, providers, and businesses would result in a loss jobs in health care administration. These would be partially offset by job gains in health care administration in state government, for a net job loss of 2,931. There may be additional jobs created through the economic stimulus associated with additional federal funds flowing into the state but these have not been calculated in this report.
  Effect on family budgets
  The cost of the premium assessment and the revenue-raising measures contained in this report would be outweighed by the savings from no longer paying private insurance premiums and out of pocket health care costs. On average, the net result would be positive or neutral for Maine families in the bottom 95 percent of the income distribution (see chart 3).

Chart 3: Distribution effect for families

10.0% 5.0% 0.0% -5.0% -10.0% -15.0%

4.0% 1.5%

-1.3%



Note: Does not include impact of business effects on households of business-owners.
Source: MECEP analysis based on US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2011-2018 microdata via IPUMS. The impact of increases to sales and excise taxes were calculated using data from the Institution for Taxation and Economic Policy. Distributional effects of the end to itemized deductions were calculated using IRS Statistics of Income data, 2016.

Impacts based on family characteristics

The following examples are drawn from survey data.[45] Readers should bear in mind that individual experiences vary greatly, depending on health and insurance status. In general, individuals in good health currently spend much less of their income on health care costs than average, while the sickest individuals spend much more than average.

A single mother, 38, earning $10,000 a year living with her two daughters, 9 and 4: The family currently qualifies for MaineCare, with no monthly premiums. However, it's not uncommon for families like this to incur out-of-pocket expenses for services not covered. For example, the mother needs a tooth extracted, or one of the daughters needs to replace a pair of lost eyeglasses. These out-of-pocket expenses totaled $1,200, or 12 percent of the family's annual income.

Under the universal care plan, the range of MaineCare services would be expanded to eliminate the need for additional out-of-pocket costs. Increased reimbursement rates would

Net cost (benefit) of a state-level uinversal health care plan as share of family income

also help families who may have coverage for services like dental, but who cannot find a provider who takes MaineCare.

Many low-income Mainers also suffer from unpredictability of income. Perhaps they work seasonal jobs, or jobs with varying schedules. This can make them eligible for MaineCare for a short period of time, before losing it as their income increases. A universal care system will bring stability to these families.

Based on consumer expenditure patterns, the increases to sales and excise taxes would cost this family an additional $160 per year, for net savings of $1,040 per year (10 percent of annual income).

Senior retired couple, 73 and 69, with $25,000 a year in Social Security payments: Both are enrolled in Medicare, with a Medicare Advantage plan. Currently they pay $1,300 in premiums and $1,900 out-of-pocket every year, 12.3 percent of their income.

Under the universal care plan, they would no longer need to purchase a Medigap plan, and the out-of-pocket copayments would be eliminated. They would also have access to services like dental and hearing care which are not

covered under basic Medicare. Their universal care premium would be capped at 4.2 percent of their annual income, or $1,050 a year.

This couple would be unaffected by the changes to taxable retirement income, since their taxable income would still be zero after accounting for exemptions and the standard deduction.

Based on consumer expenditure patterns, the increases to sales and excise taxes would cost this family an additional $200 a year. Their net savings under the universal care plan would be $1,950 (8 percent of annual income).

Lower-middle class parents with one child, earning $40,000 a year from their small business:

They purchase their insurance through the Affordable Care Act's online marketplace. Because of their relatively low income, their annual premiums are capped at $2,500 per year (6 percent of income). However, their plan has a high deductible, and their total out-of-pocket expenses for the year are $4,000. All told, they spent 16 percent of their income on health care this year.

Under the universal care plan, their premium is capped at 2.8 percent of their income, or $1,120, with no deductibles or copays. Their additional sales tax liability would be $280, and the loss of itemized deductions increases their state income tax liability by $100.

Their small business has two employees and the 3 percent payroll tax increase costs them an additional $1,500 a year. They save $500 in reduced workers' compensation premiums.

The family saves $4,000 (11 percent of annual income) under the universal care plan.

Upper-middle income two parent family with one child, earning $75,000, with employer insurance: The family is insured through a plan offered by the mother's employer. The employer covers about three quarters of the cost of the premiums, but the family still

contributes $3,600 a year. On top of that, they incur $3,500 in out-of-pocket expenses, for a total of $7,100 (9.5 percent of annual income).

Under the universal care plan, their baseline premium would be $15,500 ($6,000 for each adult, plus $3,500 for the child), but based on their income, the premium would be capped at 4.7 percent of annual income, or $3,525 per year.

Their additional sales and excise tax liability would be $450 (0.6 percent of income); the loss of itemized deductions would increase their state income taxes by $75.

On net, the family saves $3,950 per year (5.3 percent of annual income)

Upper income two parent, two children family, earning $120,000, with employer insurance: The employer plan covers most of the premium cost for the parents and their two children, leaving the family to pay $2,000 a year. Additionally, they incur $8,500 of out-of-pocket costs a year. Their total annual health care spending is $10,500, or 8.8 percent of their annual income.

Under the universal care plan, their baseline premium would be $19,000 ($6,000 per adult, plus $3,500 per child). Based on their income, their premium is capped at 6.0 percent of annual income, or $7,200 per year.

Their additional annual sales tax liability would be $480 (0.4 percent of annual income). The end of itemized deductions increases their state income taxes by $960 (0.8 percent of annual income). Total cost of the universal care system for this family would therefore be $8,640.

On net, the family saves $1,860 per year (1.5 percent of annual income).

Wealthy couple, earning $210,000 a year, with individual insurance. The couple work as professionals with their own independent businesses and purchase a plan on the individual market. They currently pay $3,600 a year in premiums, and incur $6,300 in out-of-pocket costs, for a total of $9,900 annually (4.7 percent of income).

Under the universal care plan, the baseline premium would be $12,000 ($6,000 per adult). As a high-income family, they are liable for the full cost of the premium.

Their additional annual sales tax liability would be $630 (0.3 percent of annual income). The end of itemized deductions increases their income tax liability by $360 (0.17 percent of annual income).

The creation of the new income tax bracket at $200,000 does not impact this family, after adjusting for deductions.

This family pays an additional $3,090 under the universal care plan (1.5 percent of annual income).

Suppose the family receives a one-time inheritance worth $1.2 million. Under the modified estate tax, the family would have to pay $16,000 from this inheritance in taxes.

Very Wealthy Couple, with annual income of $550,000 a year. One person runs their own business, the other works independently as a hedge fund manager. They are covered through an employer-sponsored plan, and currently pay $5,000 a year in premiums, plus an average of $7,500 out of pocket every year, for a total cost of $12,500 each year (2 percent of annual income).

Under the universal care plan, their base premium is $12,000 per year ($6,000 per adult).

Their additional annual sales tax liability would be $5,500 (0.1 percent of annual income). The end of itemized deductions increases their income tax liability by $1,870 (0.34 percent of annual income).

The creation of the new income tax brackets at $200,000 and $500,000 increases their state income tax liability by just under $9,900 a year.

All told, this family pays an additional $16,770 under the universal care plan compared to the status quo (3.0 percent of annual income).

The business-owner currently offers a health insurance plan to some of her 40 employees, at a total cost of $90,000 a year to the business. Under the universal care plan, her business would instead pay a 4.5 percent payroll tax on her employee payroll of $1.5 million. Her total payroll tax liability is $67,500 a net saving of $22,500 compared to providing insurance under the status quo. Additionally, her workers' compensation premiums are reduced by $321 per worker per year, or $12,840. Total business savings are therefore $35,340. She could either pass these savings along to workers as higher wages, reinvest them in her business, or keep the savings as additional profit.

Effect on Maine's seniors

Approximately one in five Mainers is 65 years old or older.[46] While nearly every senior qualifies for coverage under Medicare,[47] that coverage is not comprehensive:

Part A covers hospital treatment, and most seniors are eligible at no monthly premium. However, there is a deductible for each hospital admission ($1,364 for 2019).

Part B covers outpatient services and doctors' visits. It requires a monthly premium ($135.50 in 2019 for those with incomes under $85,000). Enrollees are subject to an annual deductible ($185 in 2019) and 20 percent copays for each visit.

Part D covers prescription drugs. These plans are administered through private insurers and usually have annual deductibles, out-of-pocket costs, and co-pays for prescription drugs (which are capped at a share of prescription drug costs depending on your total annual drug spending).

In addition, many Medicare enrollees also purchase either a Medigap plan (to cover the deductibles and out-of-pocket costs in regular Medicare) or a Medicare Advantage plan (Part C). Both are offered through private insurers. Medicare Advantage plans cover

services not covered by regular Medicare, including dental, vision, and hearing, or medical equipment.

Low-income seniors qualify for financial help to cover some of these costs, through MaineCare (Medicaid). Most of these categories are subject to an asset test:[48]

Seniors with a qualifying disability or those below 100 percent of the federal poverty level (approximately $18,000 for a household of 2 in 2019) qualify for full-benefit MaineCare.

Seniors enrolled in Medicare with incomes below 175 percent of the federal poverty level can qualify for the Medicare Savings Program, providing some assistance for the Medicare out-of-pocket costs.

Seniors who need nursing care are covered through MaineCare if their income is below 300 percent of the federal poverty level. However, the state will recover long-term care costs from the patient's estate when they die.

Maine also has a Drugs for the Elderly and Disabled program for individuals with disabilities and those over the age of 62 if their income is below 175 percent of the federal poverty level.

Of the approximately 270,000 seniors in Maine, just under 60 percent have some sort of private coverage to supplement their Medicare plan (including Medigap, Medicare Advantage and Part D plans). Most of these individuals will be better off under the universal care plan.

The plan proposes to charge Medicare enrollees an annual premium of $3,000 per year, capped at a portion of their annual income. For those who are currently eligible for Medicaid, the premium will be $0.

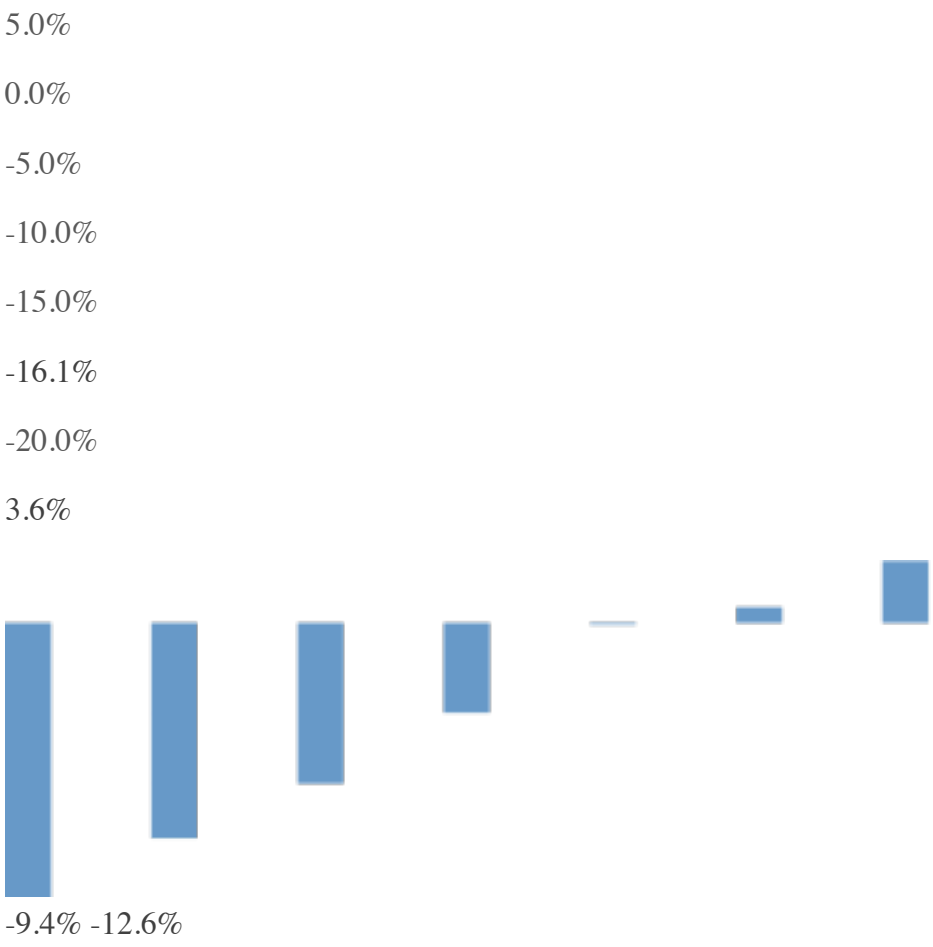
Maine's seniors will be affected by elimination of the pension tax deduction, and making Social Security income taxable. Together these will raise just over $194 million from seniors. However, the lowest-income seniors will be unaffected by the changes because their taxable income will still be zero, even after including their retirement income. For example, a married couple over 65 is currently entitled to a total of $35,400 in deductions and exemptions from

their taxable income under Maine's state income tax.[49] This far exceeds the median Social Security payment among Maine seniors, which is just $12,100 per person.[50]

Indeed, these changes will raise revenue from Mainers who currently draw substantial pensions and investment income in addition to their Social Security benefits.[51]

As a result, the distributional effects for seniors (see chart 3) are similar to those for all Mainers. On average, seniors in the bottom 80 of households by income will be better off under the universal care plan, even after accounting for new sources of revenue.

Chart 4: Net impact of the universal care plan on households with seniors



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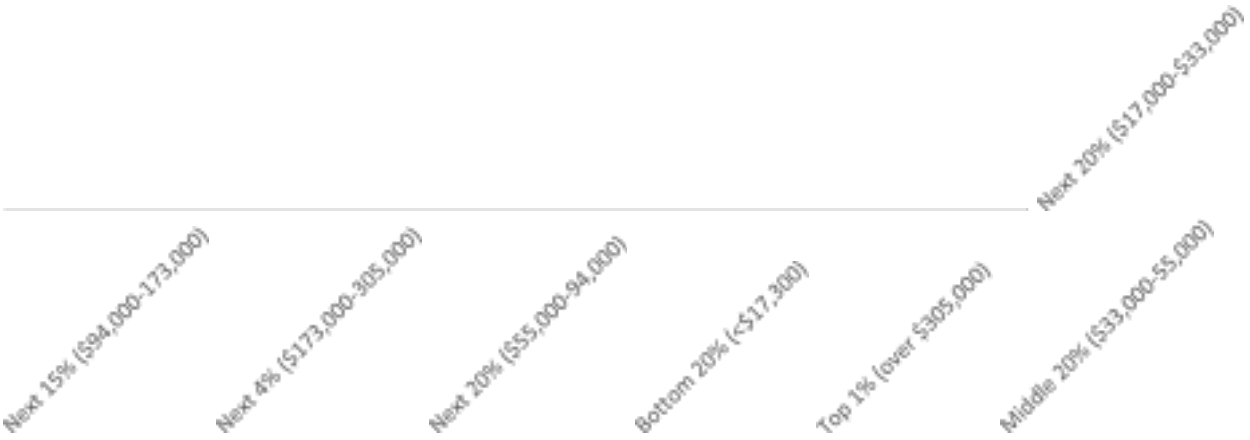

Note: Does not include impact of business effects on households of business-owners.
Source: MECEP Analysis of US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2011-2018 microdata via IPUMS. The impact of increases to sales and excise taxes were calculated using data from the Institution for Taxation and Economic Policy. Distributional effects of the end to itemized deductions were calculated using IRS Statistics of Income data, 2016.

Effect on providers

On net, providers' finances would be minimally impacted by the transition to a universal care plan.

Under the plan modeled for this analysis, provider revenue would decrease by just over $945 million, or 7 percent.[52] However, the reduction in revenue would be offset by savings, including a reduction in charitable care and bad debt; reduced costs to providers as employers; and reduction in administrative waste.

Comprehensive information for all health care providers in Maine is not available. The following analysis applies to Maine's hospitals, which report data annually to the Manie Health Data Organization. Hospitals accounted for 38 percent of all medical spending in Maine in 2014.[53] Their share of the anticipated loss of revenue would be just under $362 million annually.

By law, Maine hospitals must provide free (charity) care to uninsured low-income individuals. In 2017, Maine's hospitals gave free care worth $241 million.[54] Additionally, providers routinely write off bad debt that cannot be

recovered from individuals who were billed for services they cannot afford. In 2017, Maine hospitals wrote off $325 million of bad debt.[55] Based on the

experience of other states, Maine's hospitals are expected to see a 41 percent reduction in total annual uncompensated care costs,[56] leaving a remaining $334 million in billable services. Under a universal care plan, hospitals would receive just under $186 million for these services.

As with other employers, hospitals and other health care providers would no longer have to pay health insurance premiums for their employees. MECEP estimates Maine hospitals pay $228 million annually in insurance premiums,[57] and would save just over $15 million in workers' compensation premiums.[58]

Billing and insurance-related administration consumes 13 percent of revenues in physicians' offices and 8.5 percent of hospital revenues.[59] For Maine's hospitals, that's over $464 million.[60] Based on existing research, MECEP estimates a universal care system would reduce billing and insurance administrative costs by 33 percent, for a savings of $151 million annually.[61]

Hospitals and other providers would have to pay the new employer-side payroll tax. MECEP estimates Maine hospitals would be liable for just under $198 million in new payroll taxes.[62]

Under these assumptions, total net revenue for Maine hospitals would decline by roughly $21 million under the universal care plan.

Note that in the 2017 fiscal year, Maine's hospitals recorded surplus revenues of just under $239 million.[63]

The transition to a universal care system would impact different hospitals in dramatically different ways, depending on the profile of their patients. Under the universal care system, hospitals would receive significantly lower rates for patients who are currently insured through private providers but would receive higher rates for patients who are currently insured through Medicaid. In

general, well-resourced hospitals in Maine's more affluent regions would see the biggest decline in revenue.

For example, Maine Medical Center and its subsidiaries received 66 percent of its 2016 revenues through commercial insurers, [64] and ran a net surplus of $94 million. Calais Regional Hospital received roughly 33 percent of its 2018 revenues from commercial insurers,[65] and ran a net loss of $600,000 in that year.[66]

The hospitals which would see the biggest decline in revenues may also have significant reserves to draw upon in the short term. For example, Maine Medical Center and its subsidiaries held just under $933 million in unrestricted net assets in 2016.[67]

This analysis does not assume a significant increase in utilization of health care services. While some cost estimates of universal care plans have assumed that utilization rates will increase, academic studies of health care system expansions don't support this view. The recent experience of states with Medicaid expansion has shown changes in utilization patterns, but not necessarily increased overall use. Instead, patients are more likely to seek preventative

care, and less likely to use emergency care.[68] A recent study of 13 universal coverage expansions in wealthy nations over the course of 80 years confirmed that utilization rates do not necessarily surge following expansion of access to care.[69]

Table 6. Summary of provider cost-benefit analysis for hospitals

Lost patient revenue
Employer premium recapture Administrative savings
Reduction in uncompensated care Employee health insurance savings Workers' compensation savings

Total net savings

-$361,897,937 -$197,774,475 $151,386,888 $185,919,558 $262,504,544 $15,033,072

$55,201,650

Sources: Maine Health Data Organization, Hospital Financial Report, 2017; Centers for Medicaid and Medicare Services, National Health Expenditure Survey, 2014; US Census Bureau, American Community Survey, 2017; CMS, Medical Expenditure Panel Survey 2017

Effect on local governments

The employer payroll tax would be assessed on local government payroll. However, the state cannot impose payroll taxes on the federal government.[70]

On balance, local government units would save money through the implementation of a universal care system, even after paying the payroll tax. MECEP estimates local government tax liabilities would total just under $166 million.[71] But local governments would no longer be liable for health insurance, an estimated expense of just under $367 million (including education staff),[72] and would save an estimated $13 million through reduced workers' compensation premiums. [73]

The net impact would be savings of just over $214 million for local governments, equivalent to 8.4 percent of current property tax revenues.[74] This would be the equivalent of a property tax reduction of 1.5 mils.[75]

The impact on individual government units would vary depending on the number of employees and current expenditure levels.

Impact on employment

The complexity of the US health care system results in significant administrative waste. An estimated 8.5 percent of hospital revenue and 13 percent of revenue at physicians' offices goes to billing- and insurance-related administrative costs,[76] just over $1 billion annually in Maine.[77] A statewide universal care system would reduce this $1 billion in administrative costs by an

estimated 33 percent, [78] for a total of $151 million in Maine's hospitals, and $98 million in providers' offices.

However, achieving these savings would result in the loss of jobs in health care administration. A 33 percent reduction relative to 2017 levels would be 1,868 jobs in hospital administration,[79] and 1,513 in providers' offices.[80]

Maine businesses spend an estimated $39 million annually on administering health insurance benefits.[81] The implementation of a universal care plan is estimated to reduce these expenses by 10 percent, resulting in savings of just under $4 million annually. However, achieving these savings would result in the loss of 61 jobs.

Total estimated job loss in health care administration and the insurance industry is therefore 3,442 jobs.

There would be some additional job losses associated with a decline in demand for private health insurance. However, the number of job losses is difficult to estimate. The Bureau of Labor Statistics does not separately count the number of insurance workers who work in the health insurance industry. Additionally, there is no direct correlation between the number of insured lives in Maine and the number of Mainers employed in the health insurance industry.

The job losses in private sector health care administration would be somewhat offset by the increase in jobs in the Office of MaineCare services, estimated at 511.[82] Total net impact on jobs would therefore be a reduction of 2,931.

The impact of these job losses could be offset through wage replacement and retraining subsidies for laid-off workers. These supports could be structured in a variety of ways. [83] One example could include a year's worth of wages, plus a $10,000 retraining or relocation stipend, approximately $50,000 per displaced worker.[84] This would represent an additional one-time cost of $171 million for 3,422 displaced workers.

There would also be additional economic expansion and potential job creation as Maine families have more disposable income that is no longer being spent

on health care waste, and Mainers are more productive at work. These benefits are harder to quantify and are not included in this estimate.

Potential additional benefits

Implementing a state-wide universal care system would have several indirect benefits that have not been calculated for this analysis. The expansion of Medicaid eligibility in more than 30 states has allowed researchers to catalog many benefits to low-income Americans from the availability of public-run health care. These include:

- Better access to diagnostic and preventative services such as mammograms and smoking cessation programs;

- Improved treatment of mental health conditions, including substance use disorder;

- Improvements in self-reported health

- Significant reductions in mortality, especially among those aged 55-64

- Improved financial stability for families, with reduced unmet health needs, and less
  medical debt.[85]
  It seems likely that many of these benefits would also apply to the expansion of public health care to the remainder of the population. However, differences between the low-income population affected by Medicaid expansion, and the middle- and higher-income population who would be covered by a universal care plan make it impossible to estimate these impacts with certainty.
  Additionally, Maine spends approximately $126 million on public health initiatives,[86] ranging from tobacco cessation to drug education. The

dramatic increase in access to care under a universal care system would likely improve public health outcomes and reduce the need for state spending on these initiatives.

Increased access to preventative care results in less need for more expensive late-stage treatments. It is not necessarily true, however, that increased use of preventative care reduces *total* health care costs. Earlier health interventions increase life expectancy, which necessitates more spending on older residents.[87] This does not negate the case for preventative and early- stage health interventions. In fact, prolonging Mainers' lifespans and improving their quality of life will allow them to be more economically active, ultimately producing more revenue to fund health care services.

Poor health is a significant obstacle to work for many Mainers. In 2018, almost 71,000 Mainers weren't working because of a health problem or disability, including 31,000 prime-age workers (25-54 year-olds).[88] Improved access to health care should lead to a greater number of Mainers able to participate in the labor force, and greater productivity for those who are currently working, but struggling with physical or mental health limitations.

Maine families could also see reduced consumer costs in areas such as auto and home insurance. Currently, the cost of these insurance premiums is partly driven by the cost of medical care covered under these policies. Bodily injury claims, which accounted for nearly 40 percent of all auto insurance costs in Maine in 2015-16,[89] would be greatly reduced under a free-at-point-of-service health care system. Some early studies have shown that the Affordable Care Act reduces auto insurance rates for young Americans.[90]

Medical losses account for a much smaller portion (2 percent in 2017) of losses for homeowners' insurance policies,[91] but could also see a reduction under a universal care system.

While rising health insurance costs have been found to limit wage growth for American workers, there is much less evidence to show that lowering costs would lead employers to increase wages. In fact, the evidence from the 2017 Tax Cuts and Jobs Act, which drastically

reduced corporate tax liability, would suggest that employers are more likely to keep any savings as profits, rather than pass them along to workers in the form of higher wages.[92]

Implementation considerations

This analysis focuses on the costs and savings associated with implementing a state-level universal care health plan for Maine and how to pay for it. The details of transitioning to such a plan are beyond the main scope of this study. However, there are important considerations.

In transitioning to a universal care plan, there are strong arguments both for haste and caution. On the one hand, the more people enrolled in the plan, the bigger the administrative and efficiency savings could be. On the other hand, a shift of this magnitude has the potential to cause significant upheaval in the economy. It also requires a significant expansion of government services, and the hiring of many new employees, which would take time.

The easiest group to enroll in the new state plan are those Mainers eligible for subsidized individual insurance through the Affordable Care Act. The analysis in this study assumes that Maine applies for a federal waiver to redirect the individual market subsidies to fund the new state plan. Those who currently purchase individual insurance through the ACA marketplace would have only the new state plan available to them, although it should be noted the state plan premiums would be lower than those of plans on the ACA marketplace, and the benefits more comprehensive.

In implementing a universal care plan, policymakers would have to determine the extent to which coverage under the new plan is to be mandatory or voluntary.

Enrollment in the new public plan could be mandatory and automatic. Health care would effectively be provided as a government service, and the premiums would be assessed as a tax. For this analysis, MECEP assumed mandatory enrollment, which would be more cost- effective and would capture greater efficiencies by simplifying the payer mix.

Alternatively, enrollment in the new plan could be strongly encouraged through the creation of a state-level individual mandate to carry health insurance. In the wake of the federal government's decision to effectively eliminate its mandate in 2017, several states have already enacted such a mandate. Under this scenario, Mainers would have the option of purchasing private coverage instead, but the state plan would likely provide greater value.

Lastly, enrollment in the new plan could be entirely voluntary, and structured as a buy-in program. The risk with this approach is that sicker Mainers would be more inclined to buy into the program, and the costs would exceed the revenues to fund the plan. This risk could be mitigated by gradually extending the eligibility to buy into the plan to different demographic groups. For example, the plan could be offered to those aged 55-64 and children under 18 at first, with one very healthy pool of residents subsidizing the costs of a less healthy population.

Any implementation scheme would have to contend with the federal Employee Retirement Income Security Act (ERISA) which reserves authority over employer-sponsored insurance plans to the federal government. States do not have the legal authority to regulate employer plans. Maine could not, for example, compel employers to purchase a new public plan on behalf of their employees. Some experts even suggest that courts could take issue with any state plan which taxes businesses to pay for a public health care plan, on the basis that it creates an overwhelming financial incentive for employers to drop their own health insurance plans.[93] This legal question has not been tested in court, and could prove a significant challenge to creating a state-level universal health care plan.

Conclusion

Enacting a state-level universal health care for Maine has the potential to deliver significant benefits to the state and its people. However, it would require a significant change in the way Mainers currently pay for health coverage. While a state-level universal public plan could substantially decrease

overall health care costs in the state, it would require a significant increase in state revenue.

For this analysis conducted on behalf of Maine AllCare, MECEP attempted to provide information on the costs, benefits, and potential funding mechanism of a hypothetical health care reform plan that achieves the goals of a universal care system, while recognizing the need to accommodate the federal government's current role in Maine's health care system.

Any effort to proceed with the development of a Maine-specific universal health care plan would require more detailed policy development and analysis to address key implementation considerations and firm up cost estimates. The fact that public systems elsewhere in the world have delivered better outcomes at less cost than Maine or the United States health care system suggest that the pursuit of more cost-effective alternatives is a worthwhile endeavor.

Endnotes

[1] Between 2008 and 2018, the cost of medical care within the US Bureau of Labor Statistics Consumer Price Index grew by an average of 2.9 percent annually, compared to an average increase in the overall CPI of 1.6 percent annually. Median hourly wages increased by an average of 1.9 percent over the same period. US Bureau of Labor Statistics, Occupational Employment Survey data, 2008-2018.

[2] MECEP analysis using US Centers for Medicare and Medicaid Services, National Health Expenditure Survey data for 2014 (the final year of state-level data available). https://www.cms.gov/Research- Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.
Per-capita costs were inflated using US Centers for Medicaid and Medicare Services national projections through 2026. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and- Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

[3] Ibid.
[4] MECEP analysis of Bureau of Economic Analysis, Personal Consumer Expenditure Survey data, 1997- 2018. Retrieved by James Myall using BEA's Interactive Data Application. https://apps.bea.gov/itable/index.cfm (November 25, 2019).

[5] US Centers for Disease Control, Behavioral Risk Factors Surveillance Survey, 2018. Retrieved by James Myall using the Web Enabled Analysis Tool. https://nccd.cdc.gov/weat/ (November 25, 2019).
[6] Ibid.
[7] Collins, Sara et al., "How Well Does Insurance Coverage Protect Consumers from Health Care Costs?" *Commonwealth Fund*, Oct 2017. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_oct_collins_underinsured_biennial_ib.pdf
[8] MECEP analysis of US Centers for Disease Control, Behavioral Risk Factors Surveillance Survey data, 2006-2016. Retrieved by James Myall using the Web Enabled Analysis Tool. https://nccd.cdc.gov/weat/ (November 25, 2019).
MECEP analysis of US Census Bureau, American Community Survey data, 2010-2016. Retrieved by James Myall using American Factfinder. https://factfinder.census.gov/ (November 25, 2019).
MECEP analysis of US Census Bureau, Current Population Survey data (2006-2009). Retrieved by James Myall using the Current Population Survey Table Builder. https://www.census.gov/cps/data/cpstablecreator.html (November 25, 2019).
The BRFSS only reports affordability of cost by general health insurance coverage. Estimates of affordability for the privately insured population were generated by assuming that the unaffordability rate for Medicaid was 0 percent, and that 18- to 64-year-olds insured by the Veterans' Administration and Medicare had the same unaffordability rate as the senior population (which is almost entirely insured through Medicare). Estimates for the share of the population primarily insured through these public programs were obtained from the American Community Survey for years 2010-2016 and the Current Population Survey for years 2006-2009.
[9] MECEP analysis of US Department of Health and Human Services, Medical Expenditure Panel Survey data, 2006 and 2018. https://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables.jsp
[10] MECEP analysis of US Department of Health and Human Services Medical Expenditure Panel Survey, 2017 data. https://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables.jsp
US Census Bureau, County Business Patterns, 2017 data. Retrieved by James Myall using American Factfinder. https://factfinder.census.gov/ (November 25, 2019).

MEPS reports average employee contributions for health insurance premiums by the wage quartile of the employer. MEPS does not disclose the cutoff thresholds for wage quartiles, but the approximate bounds can be estimated using data from the Count Business Patterns survey. This dataset was also used to calculate the average wage within each quartile.

[11] Ibid.
[12] "Health at a Glance 2017: OECD Indicators," *Organization for Economic Co-operation and Development*, 2017. https://www.oecd.org/unitedstates/Health-at-a-Glance-2017-Key-Findings-UNITED-STATES.pdf
[13] Anderson, Gerard et al., "It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, And A Tribute to Uwe Reinhardt," *Health Affairs*, Vol 38, No. 1, Jan 2019. Available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144
[14] Kumar Sameer et al., "Examining quality and efficiency of the US healthcare system"
International Journal of Health Care Quality Assurance, Vol. 24, Issue 5, (2011): pp.366-88. https://www.ncbi.nlm.nih.gov/pubmed/21916090
[15] Yarborough, Cassandra et al., "Estimating the Cost of Introducing a Medicaid Adult Dental Benefit in 22 States," *American Dental Association*¸ March 2016. http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0316_1.ash
[16] "An Overview of the Medicare Part D Prescription Drug Benefit," *Kaiser Family Foundation*, Oct 12, 2018. https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug- benefit/
[17] "Taking the Financial Pulse of Maine's Hospitals: An Overview," *Maine Hospital Association,* 2017, pp. 6-7. http://www.themha.org/Finance/Publications/MHA-Financial-Report_22017.aspx
Maine's Medicaid program currently reimburses hospitals for 72 percent of their calculated cost of treatment, while Medicare reimburses 87 percent of the costs of care.
[18] Ibid, p6.
[19] For an overview, see Dolan, Rachel, "Understanding the Medicaid Prescription Drug Rebate Program," *Kaiser Family Foundation*, Nov 12, 2019. https://www.kff.org/medicaid/issue-brief/understanding-the- medicaid-prescription-drug-rebate-program/.

[20] "Medicaid Drug Spending Trends," *Medicaid and CHIP Payment and Access Commission*, Feb 2019. https://www.macpac.gov/publication/medicaid-drug-spending-trends/

[21] Nationally, the Medicaid program spent $64 billion on prescription drugs before rebates in federal fiscal year 2017. With 74 million enrollees, the average spending per enrollee was $865. Manufacturers' rebates cover approximately half this cost, or $433 per-person. Therefore, paying full price for the 652,000 enrollees in the new state plan would incur an additional cost of up to $282,195,005.

[22] Determining the "primary" source of insurance relied on the following hierarchy: Medicare > Medicaid > Veterans' Administration > Indian Health Service > Employer-Sponsored > TRICARE > Healthcare.gov. Those with none of the forgoing were identified as uninsured.

[23] MECEP calculations using US Centers for Disease Control, National Health Expenditures state-level estimates, 2014 data, adjusted for inflation.

[24] US Centers of Disease Control, National Health Expenditures, 2017 data. Calculated using net cost of private insurance as a share of total national private health spending. Net cost of insurance is excluded from NHE state-level estimates.

[25] Based on estimated billing and insurance related administrative costs of 8.5 percent of hospital revenues, 13 percent of revenues at physicians' offices, and 10 percent at other health service providers. Baseline revenues were derived from 2014 state-level National Health Expenditure data, adjusted to 2017 levels. For estimates of billing and insurance related costs, see Yong, P.L. et al (eds.), "Excess

administrative Costs," in "The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary," *Institute of Medicine (US) Roundtable on Evidence-Based Medicine* (Washington, DC: 2010). https://www.ncbi.nlm.nih.gov/books/NBK53942/

[26] Based on 2019 federal matching rates for adults and pre-ACA rates for CHIP.

[27] US Centers for Medicare and Medicaid Services, Healthcare.gov Effectuated Annual Enrollment data, February 2018.

US Census Bureau, American Community Survey, 2017 data. Retrieved by James Myall using American Factfinder. https://factfinder.census.gov/ (November 25, 2019). Mainers received $481,270,752 in After Premium Tax Credits for plans on Healthcare.gov in 2018. MECEP estimates an additional $172,425,716 would be available to 42,789 uninsured 21-64 year-olds with incomes between 138 and 399 percent of the federal poverty level.

[28] Existing state costs for health and dental insurance, as well as workers' compensation insurance were calculated using Maine Open Checkbook data for State Fiscal Year 2017. http://opencheckbook.maine.gov/transparency/index.html

[29] "Federal Poverty Guidelines for 2019," *US Department of Health and Human Services*. https://aspe.hhs.gov/2019-poverty-guidelines

[30] MECEP analysis of US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2011-2018 microdata. Analyzed by James Myall using the Integrated Public Use Microdata System. https://cps.ipums.org/cps/

[31] MECEP analysis of US Census Bureau, Annual Survey of Entrepreneurs, 2016 data. Retrieved by James Myall using American Factfinder. https://factfinder.census.gov/ (November 25, 2019).

MECP analysis of US Bureau of Labor Statistics, Quarterly Census of Employment and Wages, 2018 annual average. Analyzed by James Myall using the BLS data finder https://data.bls.gov/ (November 25, 2019).

[32] MECEP calculation based on US Department of Health and Human Services, Medical Expenditure Panel Survey, 2018. https://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables.jsp

[33] MECEP analysis of US Bureau of Labor Statistics, Quarterly Census of Employment and Wages, 2018 annual average. Analyzed by James Myall using the BLS data finder https://data.bls.gov/ (November 25, 2019).

Calculated as a 7 percent payroll tax on total state and local government payroll of $3.39 billion.

[34] Freund, Richard et al., "Annual Report on the Status of the Maine Workers' Compensation System," 2018, p. B1. https://www.maine.gov/wcb/Departments/administration/2018_TROIKA_Annual_Report_2018.pdf

50 percent of the expense of workers' compensation claims in Maine is due to medical costs. A free-at- point-of-service universal care system would eliminate this cost from Maine's Workers' Compensation system.

[35] Calculated using a mean per-employee savings of $321 for 482,014 Maine private-sector payroll employees reported in the Bureau of Labor Statistics, Quarterly Census of Employment and Wages, 2018. Analyzed by James Myall using the BLS data finder https://data.bls.gov/ (November 25, 2019).

[36] MECEP analysis of US Department of Health and Human Services, Medical Expenditure Panel Survey, 2018. https://www.meps.ahrq.gov/mepsweb/data_stats/

quick_tables.jsp
[37] Based on a per-employee cost of $11,000 per year, with the employer paying 66 percent of the premiums, and assuming 66 percent of employees sign up.
[38] Based on a per-employee cost of $11,000 per year, with the employer paying 90 percent of the premiums, and assuming 90 percent of employees sign up.

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[39] US Internal Revenue Services, Statistics of Income, 2016. State income tax data.

https://www.irs.gov/statistics/soi-tax-stats-historic-table-2

"Maine State Tax Expenditure Report 2020-2021 and Maine Tax Incidence Study," *Maine Revenue Services*, Feb 15, 2019. https://www.maine.gov/revenue/research/tax_expenditure_19.pdf
Estimated revenues include $164 million from the 10.15 percent bracket and $36 million from the 12.15 percent bracket, $10 million from the obsolete deduction for self-employed health insurance plans, $2 million from the obsolete deduction for medical expenses, $9 million from eliminating the remaining itemized deductions, $31 million from ending the pensions tax deduction, and $164 million from taxing Social Security as regular income.

[40] MECEP estimates using Maine Revenue Services, monthly taxable sales data, 2017. https://www.maine.gov/revenue/research/sales/homepage.html.
[41] MECEP estimate using Revenue Forecasting report, March 2018. http://legislature.maine.gov/ofpr/revenue-forecasting-committee/9302

[42] "Maine State Tax Expenditure Report 2020-2021 and Maine Tax Incidence Study," *Maine Revenue Services*, Feb 15, 2019. https://www.maine.gov/revenue/research/tax_expenditure_19.pdf
[43] "Governor Paul LePage 's 2018-2019 Biennial General Fund Budget Proposal," *Maine Bureau of the Budget*, part E, Jan 6, 2017. https://digitalmaine.com/cgi/viewcontent.cgi?article=1009&context=bob_docs [44] Maine Revenue Services estimate provided for LD 518 (129th legislature).

[45] MECEP analysis of US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2011-2018 public-use microdata. Analyzed by James Myall using the Integrated Public Use Microdata System. https://cps.ipums.org/cps/
[46] US Census Bureau, American Community Survey, 2018 1-year data. Retrieved by James Myall using data.census.gov (November 25, 2019).
[47] Undocumented immigrants are not eligible for Medicare. Those with a short work history can buy into the program.
[48] "MaineCare Eligibility Guide," *Consumers for Affordable Health Care & Maine Equal Justice Partners*, June 14, 2018. https://www.mejp.org/sites/default/files/MaineCare-Eligibility-Guide-June2018.pdf.
[49] "State of Maine – Individual Income Tax 2019 Rates," *Maine Revenue Services*, Oct 30, 2018. https://www.maine.gov/revenue/forms/1040/2019/1040_RateSched_2019.pdf.
The total deductible income includes two personal exemptions at $4,200 each, plus two additional exemptions of $1,300 for over-65s, and a standard deduction of $24,400 for married couples.
[50] MECEP analysis of US Census Bureau, American Community Survey data, 2017. Retrieved by James Myall using American Factfinder. https://factfinder.census.gov/ (November 25, 2019).
[51] Van de Water, Paul N., "Taxing Social Security Benefits Is Sound Policy," *Center on Budget and Policy Priorities*, Sept 6, 2019. https://www.cbpp.org/research/social-security/taxing-social-security-benefits-is- sound-policy
[52] MECEP analysis of US Centers for Medicare and Medicaid Services, National Health Expenditure Survey 2014 data for Maine, adjusted for inflation. Total spending on health care services (excluding capital expenditures, administration and non-patient revenues) in Maine is estimated at $12.8 billion in 2017. The total non-administrative cost of the universal care plan in this report would be $5.9 billion, a $1.4 billion reduction compared to current private-sector spending by Maine residents ($6.8 billion).
[53] Centers for Medicare and Medicaid Services, National Health Expenditure Survey, Spending by State of Provider, 2014.
"Hospital Financial Information, 2013-2017," *Maine Health Data Organization*. https://mhdo.maine.gov/_pdf/Report%201_2017_Final.pdf

Share calculated as a share of total personal health expenditures, less uncompensated care, non-patient hospital revenues and state hospital tax payments.

[54] "Hospital Financial Information, 2013-2017," *Maine Health Data Organization,* p.39. https://mhdo.maine.gov/_pdf/Report%201_2017_Final.pdf

[55] Ibid., p.38.

[56] Dranove, Daivd et al., "The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal," *The Commonwealth Fund*, May 3, 2017. https://www.commonwealthfund.org/publications/issue-briefs/2017/may/impact-acas-medicaid- expansion-hospitals-uncompensated-care

[57] MECEP analysis of US Census Bureau, American Community Survey, 2017 data. Retrieved by James Myall using American Factfinder. https://factfinder.census.gov/ (November 25, 2019).

MECEP analysis of US Department of Health and Human Services, Medical Expenditure Panel Survey, 2018. https://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables.jsp

The ACS estimates there are 46,832 hospital employees in Maine. Total cost was calculated using the MEPS data for provision, eligibility, take-up, cost, plan selection and employer cost-sharing of health insurance plans using the mean rates for employers with more than 500 employees in Maine.

[58] Calculated using a per-employee savings of $321, based on State of Maine data on workers' compensation premiums using Maine Open Checkbook.

[59] Yong, P.L. et al (eds.), "Excess administrative Costs," in "The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary," *Institute of Medicine (US) Roundtable on Evidence-Based Medicine* (Washington, DC: 2010). https://www.ncbi.nlm.nih.gov/books/NBK53942/

[60] Maine Health Data Organization, Hospital Financial Report, 2017, pp 36-37

[61] Liu, Jodi L., "An Assessment of the New York Health Act," *RAND Corporation*, 2018, pp.32-33. https://www.rand.org/pubs/research_reports/RR2424.html

[62] US Bureau of Labor Statistics, Quarterly Census of Employment and Wages, 2017 annual average. Analyzed by James Myall using the BLS data finder https://data.bls.gov/ (November 25, 2019).

Total wages for hospitals in Maine were just over $2 billion. Nearly all hospitals in Maine employ more than 500 employees and would pay the tax at the 10 percent rate.

[63] "Hospital Financial Information, 2013-2017," *Maine Health Data Organization,* p.10. https://mhdo.maine.gov/_pdf/Report%201_2017_Final.pdf
[64] "Maine Medical Center and Subsidiaries Independent Auditors' Report...Year Ended September 30, 2018," *KPMG*. Accessed by James Myall from the Federal Audit Clearinghouse, https://harvester.census.gov/facdissem/Main.aspx (Nov 25, 2019).
[65] "Calais Regional Hospital by the Numbers," May 2019. https://www.calaishospital.org/wp- content/uploads/2019/05/Community-Benefit-Report-05-2019.pdf
[66] Ibid.
[67] "Maine Medical Center and Subsidiaries Independent Auditors' Report...Year Ended September 30, 2018," *KPMG*. Accessed by James Myall from the Federal Audit Clearinghouse, https://harvester.census.gov/facdissem/Main.aspx (Nov 25, 2019).
[68] Antonisse, Larisa et al., "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review," *Kaiser Family Foundation*, Aug 15, 2019. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated- findings-from-a-literature-review-august-2019/

[69] Gafney, Adam et al., "The Effect of Large-scale Health Coverage Expansions in Wealthy Nations on Society-Wide Healthcare Utilization," *Journal of General Internal Medicine* (2019), pp1-12. https://doi.org/10.1007/s11606-019-05529-y
[70] This does create an issue in terms of providing coverage for federal workers. Since the state cannot assess a payroll tax, the state would need to identify a different mechanism for recouping costs associated with providing coverage for federal employees.

[71] US Bureau of Labor Statistics Quarterly Survey of Employment and Wages, 2018. Analyzed by James Myall using the BLS data finder https://data.bls.gov/ (November

25, 2019).
Total wages paid by local government equaled $2,367,949,104. Disaggregation of local government employment by size of employer is not available for Maine. Instead, an average 7 percent payroll tax rate (the average tax rate for private-sector businesses across all size classes) was assumed.

[72] US Bureau of Labor Statistics Quarterly Survey of Employment and Wages, 2018. Analyzed by James Myall using the BLS data finder https://data.bls.gov/ (November 25, 2019).
Maine Department of Education data. Analyzed by James Myall using the MDOE's data warehouse. https://www.maine.gov/doe/data-reporting/reporting/warehouse.

Local government employed 58,739 workers in 2018. Maine Department of Education data shows that 22,578 of these positions are partially funded through Maine's school funding formula, the Essential Programs and Services model. Total wages for non-education staff were just under $1.468 billion. Assuming that health insurance costs equivalent to 19 percent of wages, local government spent approximately $279 million on private health insurance in 2018 for non-education staff.

The total cost of health insurance for employees funded through EPS was calculated using Maine Department of Education data on teacher positions, salaries and benefit levels for state fiscal year 2018- 19. Overall, the state is liable for 55 percent of the costs, and local governments the remaining 45 percent, just under $88 million.
[73] Based on Workers' Compensation insurance savings of $321 per employee per year (using State of Maine employee data). Total savings include $321 per non-education local government employee (36,161), plus 45 percent of $321 per educational employee (22,578).
[74] "Municipal Valuation Return Statistical Summary," *Maine Revenue Services*, 2017. Total statewide property tax commitments equaled $2,549,487,648.
[75] "Municipal Valuation Return Statistical Summary," *Maine Revenue Services*, 2017. Total statewide taxable property valuation $159,381,711,584. The estimated average statewide taxation rate was therefore 16.0 mils.
[76] Yong, P.L. et al (eds.), "Excess administrative Costs," in "The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary," *Institute of Medicine (US) Roundtable on Evidence-Based Medicine* (Washington, DC: 2010). https://www.ncbi.nlm.nih.gov/books/NBK53942/
[77] MECEP estimate from National Health Expenditure Survey by state of provider, 2014.
Total spending for hospitals and physicians' offices, adjusted to 2017 dollars with a 3 percent annual rate of inflation.
[78] Liu, Jody et al., "National Health Spending Estimates Under Medicare for All,"

RAND Corporation, 2019. https://www.rand.org/pubs/research_reports/RR3106.html
[79] MECEP analysis of US Census Bureau, American Community Survey, 2017 Public Use Microdata. Analyzed by James Myall using the Integrated Public Use Microdata System. https://usa.ipums.org/cps/ Based on a 33 percent reduction in the total number of financial and administrative workers employed in hospitals in Maine.

[80] MECEP analysis of US Census Bureau, American Community Survey, 2017 Public Use Microdata. Analyzed by James Myall using the Integrated Public Use Microdata System. https://usa.ipums.org/cps/ Based on a 33 percent reduction in the total number of people employed as financial and administrative workers in the offices of physicians, offices of dentists, offices of chiropractors, offices of optometrists, outpatient offices, and offices of other health care providers.
[81] MECEP Analysis of US Bureau of Labor Statistics, Occupational Employment Survey 2017 data. Represents a 20 percent reduction in the total compensation of benefit managers and specialists, plus human resource managers, specialists, and assistants.
[82] Based on Maine Department of Health and Human Services data for FY 2016-17. Based on enrollment of 290,000 in the MaineCare program, with total staffing of 161 positions. This represents one staff position per 1,803 enrollees.
[83] For one example, see Pollin, Roberty, et. al., "Economic Analysis of Medicare for All," *University of Massachusetts, Amherst, Policy Economy Research Institute*, Nov 30, 2018, pp. 112-118. https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all
[84] MECEP analysis of US Census Bureau, American Community Survey, 2017 Public Use Microdata. Analyzed by James Myall using the Integrated Public Use Microdata System. https://usa.ipums.org/cps/ The mean wage earnings of administrative and financial workers in hospitals and providers offices in Maine was $39,553 in 2017.
[85] Antonisse, Larisa et al., "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review," *Kaiser Family Foundation*, Aug 15, 2019. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated- findings-from-a-literature-review-august-2019/
[86] "America's Health Rankings," *United Health Foundation*, 2018, Maine. https://www.americashealthrankings.org/explore/annual/measure/PH_funding/state/ME
[87] Goodall, S. et al., "Cost Savings and Cost-Effectiveness of Clinical Preventative

Care," *Robert Wood Johnson Foundation*, Sept 1, 2009. https://www.rwjf.org/en/library/research/2009/09/cost-savings-and- cost-effectiveness-of-clinical-preventive-care.html

[88] US Census Bureau, Current Population Survey monthly data, January-December 2018, 12-month average. Analyzed by James Myall using the Integrated Public Use Microdata System. https://cps.ipums.org/cps/

[89]"Auto Insurance Database Report,2015/16," *National Association of Insurance Commissioners*, 2018. https://www.naic.org/prod_serv/AUT-PB-15.pdf

[90] Kadiyala, Srikanth and Paul Heaton, "The Effect of Health Insurance Coverage Expansions on auto Liability Claims and costs," *RAND Justice Infrastructure and Environment/Institute for Civil Justice,* June 2017. https://www.rand.org/content/dam/rand/pubs/working_papers/WR1200/WR1214/RAND_WR1214.pdf

[91] "Facts + Statistics: Homeowners and renters insurance," *Insurance Information Institute*, (Accessed 25 November 2019). https://www.iii.org/fact-statistic/facts-statistics-homeowners-and-renters-insurance

[92] Gravelle, Jane and Donald Marples, "The Economic Effects of the 2017 Tax Revision: Preliminary Observations." *Congressional Budget Office*, May 22, 2019. https://www.everycrsreport.com/files/20190522_R45736_8a1214e903ee2b719e00731791d60f26d75d3 5f4.pdf

[93] Jodi Liu et al., "An Assessment of the New York Health Act: A Single-Payer Option for New York State," *RAND Corporation*, 2018, p18. https://www.rand.org/content/dam/rand/pubs/research_reports/RR2400/RR2424/RAND_RR2424.pdf