Senator Sanborn, Representative Tepler and the members of the Health Coverage, Insurance and Financial Services Committee. Thank you for the opportunity to testify in support of LD 1045, which would create a single publicly-financed plan that would provide comprehensive healthcare (including dental, vision, hearing and mental health care) for everyone in Maine.

I am a psychiatrist. I live in Topsham. I have lived in Maine since 1987 with the exception of several times when I have lived and practiced medicine in New Zealand, a single-payer country with comprehensive and equitable healthcare for all New Zealanders. It is such a relief when we return to live and work in New Zealand, where we don't have to worry about healthcare and the health insurance hassles that we have in Maine. Not to mention its response to the Coronavirus - although Maine has done a very good job, the efforts of the New Zealand "team of 5 million" and the response of the healthcare system was nothing short of amazing.

In Maine, despite our best efforts, our current system is broken.

1. We spend more on healthcare per capita than almost any state in the country, and in almost anywhere in the world. Yet our outcomes are not good. We lag behind in life expectancy, and we have shocking rates of infant and maternal mortality, particularly in rural parts of the state.
2. Far too many Maine people remain uninsured and thousands more are under insured, meaning that they may have insurance but cannot afford necessary healthcare due to high co-pays and deductibles.
3. In 2019, MaineAllCare did a study that showed that 42.3% of Mainers (who were mostly insured) reported that they had put off medical treatment for themselves or family members because of the cost.
4. The Kaiser Family Foundation estimated the number of uninsured in Maine in 2019 at 105,000. This of course does not include those people who may have lost insurance during the pandemic. Using estimates from a March article by Gaffney, Himmelstein and Woolhandler, Maine is recording an estimated 127 to 378 excess deaths per year due to coverage losses. This is one death every 1-3 days in Maine due to lack of health insurance.
5. Healthcare in Maine and the US is tied to employment. This means that when people lose their jobs, they lose their healthcare, at a time when they may need it most. In addition, one in six people are currently in a job they want to leave but won't out of fear of losing health insurance benefits.
6. Healthcare providers face burnout from being unable to help patients due to insurance and financial limitations. Not to mention dealing with managed care, prior authorizations and paperwork. We spend hours on the telephone, only to receive denials, delays and unhelpful responses from insurance company clerks.
7. In the US and in Maine, an estimated ONE of every THREE healthcare dollars goes to anything but care - this is money that is wasted.

Rural and racial disparities in healthcare are WORSENING. A sampling of recent headlines:

- "Minority communities hit harder due to health care disparities"

- “As of February 11, almost one in ten Black Mainers had tested positive for COVID-19, a rate almost four times higher than the white population.”
- “Maine confronts wide race disparity in healthcare for expectant mothers”
- “Black women are three to four times more likely to die from pregnancy-related issues than white women, according to the CDC. And Indigenous women are more than twice as likely to die from complications than white women.”
- “Majority black communities are 67% more likely to have a shortage of primary care doctors”
- “For women with breast cancer, high-quality health coverage has been proven to erase nearly HALF of the racial disparities in detection, treatment and survival”
- “Maine’s rural hospitals are at risk. More than 90 rural hospitals have closed across the US since 2010.”
- “By 2015, life expectancy in rural areas was 3 YEARS LOWER than in metropolitan areas”
- “Rural residents have a 12.4 point higher mortality rate from diabetes”
- “In 2017, compared to urban areas, rural residents had higher rates for heart disease cancer, unintentional injury, chronic respiratory disease and strokes, with higher rates of potentially preventable deaths.”
- “One reason for higher infant mortality rates in rural areas is a lack of access to health care”
- “By 2014, seniors in rural areas were more likely to have lost all of their teeth than seniors in urban areas.”
- “Rural families spend a higher percentage of household income on insurance premiums and out-of-pocket medical expenses.”
- “Bad debt for rural hospitals has gone up about 50% since the passage of the Affordable Care Act”

LD 1045 would provide a lifeline to people of color and to people living in rural communities. It would improve health, save lives, reduce racial disparities and keep rural hospitals open.

- Everyone in Maine would have the same health plan, eliminating health coverage disparities. LD 1045 would cover all medically necessary care - including dental, vision and mental health care - without the burden of copays, deductibles or narrow provider networks. Uninsurance would be eliminated.
- Everyone would pay for healthcare based on their income, eliminating financial disparities.
- Health insurance, physician quality and physician access would no longer be tied to employment or socioeconomic level.
- LD 1045 would transform the way we fund hospitals: with annual global budgets based on regional and community health needs, not through a fee-for-service model that punishes small community hospitals.

This year my husband and I are paying $17,700 for a bronze plan on the exchange. The plan has a combined out of pocket pocket maximum of $16,000. There are limits on a variety of

services including physical therapy, for example. Our prescription costs remain outrageous. We are on the hook for $34,000 before our insurance company will pay even one penny. And that doesn't include our dental costs. In addition, we pay income and property taxes so that others in Maine, including legislators, teachers and those on Medicare and Medicaid receive good healthcare coverage.

In 2019 when I broke my arm, as a patient I spent more time on the phone with insurance companies than in my doctor and physical therapist's offices receiving treatment. In the end, because I had a high deductible plan, I was responsible for 100% the costs of the treatment for my broken arm. All of the charges went toward my deductible. My insurance paid nothing.

In my job in New Zealand, I spent ZERO minutes interacting with insurance companies. The administrative staff spent ZERO minutes interacting with insurance companies. They spent ZERO time on billing and collections. I dealt with ONE formulary. It took 1-2 minutes to obtain prior authorizations for prescriptions for patients, although most of the drugs on the NZ formulary do not require PA's. New Zealand patients do not need to know concepts such as co-pays, co-insurance, OOP Maximum, deductibles or in-network.

The NZ government has an agency called Pharmac that negotiates drug prices, and decides which drugs to subsidize (most are subsidized). The patient pays $5 per prescription up to a 3-month supply. New Zealanders simply cannot believe the stories about the high cost of insulin in the USA. A personal example: While in New Zealand, my husband was prescribed an inhaler, Breo Elipta, (and paid $5 for the three month prescription). That same inhaler retails for $491 per month in Maine, or a discounted price of $1080 for 3-months supply.

In addition to excellent prescription drug coverage, New Zealanders are protected by a safety net (Figure 1) which keeps out-of-pocket health spending to an average of just $506 per person per year. Now, you might think that New Zealanders pay a lot more than Mainers for these relatively generous healthcare benefits. But you would be wrong. The average annual per capita healthcare cost in New Zealand is about $4,000 or 9% of GDP, less than half of Maine.

We know the solutions. We know that a single, publicly-financed health plan would save money. The majority of the people of Maine and indeed a majority of Maine physicians support universal healthcare. If New Zealand can provide excellent healthcare to all of its citizens at a reasonable cost, Maine can do it too.

Many legislators, past and present, including the co-sponsors of this bill and the co-sponsors of LD1608, have worked tirelessly for universal healthcare for many years. They are true champions for patients, for the people of Maine. It is time that the Legislature does more than hold public hearings. **It is time to take action. All it takes is the political will. The health of Maine depends on each one of you.**

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FIGURE 1: New Zealand Typical Copayments and Safety Nets

TYPICAL PATIENT COPAYMENTS AND SAFETY NETS

SERVICE	FEES PER ENCOUNTER/SERVICE	MAXIMUM OUT-OF-POCKET COSTS PER YEAR (SAFETY NET)
Primary care visit	NZD 15–50 (USD 10–34) for adults under age 65	No copayments for children and youth under age 14 Reduced copayments of NZD 10–25 (USD 7–17) for: • High users (patients with >12 GP visits/year) who apply for high-use health card • Low-income adults who apply for community service card • Adults age 65 and older • New Zealanders in designated low-income areas
Specialist consultation	**Public hospitals:** None for outpatient consultations **Private practitioners:** Patients pay full cost; charges vary and are set by individual specialists	**Public hospitals:** N/A **Private hospitals:** None
Hospitalization (per day or visit) including pharmaceuticals	**Public hospitals:** None **Private hospitals:** Patients pay full cost; charges vary and are set by individual hospitals	**Public hospitals:** N/A **Private hospitals:** None
Prescription drugs (outpatient)	Drugs on national formulary: NZD 5.00 (USD 3.40) copayment Drugs not on formulary: full cost to patient (varies)	Cap on formulary drugs: after 20 prescriptions per family per year, no further copayments

Source: https://www.commonwealthfund.org/international-health-policy-center/countries/new-zealand

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This submission contains a few minor corrections and additions to the testimony submitted on 11 May. Apologies for any inconvenience.