Senator Claxton, Representative Meyer and the members of the Health and Human Services Committee. Thank you for the opportunity to testify on LD 1608. I am in full support of LD 1608. I support LD 1608 because it would lead to a single publicly-financed plan that would provide comprehensive healthcare (including dental, vision and mental health care) for everyone in Maine.

I am a psychiatrist. I have lived in Maine since 1987 with the exception of several times when I have lived and practiced in New Zealand, a single-payer country with comprehensive and equitable healthcare for all New Zealanders. I share with you my experiences and my insights that I have gathered in the course of my experience practicing medicine in Maine and in New Zealand, and from my years of advocacy for universal healthcare.

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 a 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. The US and in Maine, an estimated ONE of every THREE healthcare dollars goes to anything but care - this is money that is wasted.
8. Rural and racial disparities in healthcare are WORSENING.

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. It doesn't include dental costs and 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. 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.

This year, my husband was prescribed an inhaler, Breo Elipta, which costs five dollars for a three month prescription in New Zealand. That same inhaler retails for $491 per month in Maine, or a discounted price of $1080 for the same 3-month supply that cost $5 in New Zealand. In addition to excellent prescription drug coverage, New Zealanders are protected by a safety net 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.

A single publicly-funded state health plan would SAVE MONEY. In 2018, Maine AllCare contracted with the Maine Center for Economic Policy (MECEP) to conduct a study of the costs and economic impacts of a healthcare model that would cover all Maine residents through a state-level public plan, with no fee at the point of service. The results of the study showed that total yearly healthcare spending could 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. [Interestingly, this $1.5 billion estimate of savings is remarkably similar to a figure of $1.4 billion quoted late last year: the estimated shortfall that Maine's revenue forecasting committee anticipated over three budget years due to declining revenues from shuttering schools and businesses and ordering Mainers to stay at home.]

One issue not addressed explicitly in LD1608 that bears mention: The payment schedule for physicians would need to be overhauled in order to gain the support of physicians. Medicaid reimbursement is historically poor, and it has not kept up with inflation. In 1987 when I started in private practice in Maine, I treated many Medicaid patients. Although Medicaid paid only about 70% of the usual and customary charges for psychiatric services, the process for submitting claims was simple and I received payment very quickly. However Medicaid rates have not kept pace with inflation and the rising costs of overhead, malpractice, etc. and it is not financially viable for medical practices to treat exclusively Medicaid patients at the current rates.

Another problem with Mainecare reimbursement is particular to mental health services. Mainecare has two different payment rates for providers: one for agencies and one for individual providers. This has spawned a number of "agencies" that enable its providers to get a higher rate of payment. This is unfair for individual practitioners, who provide the same service yet

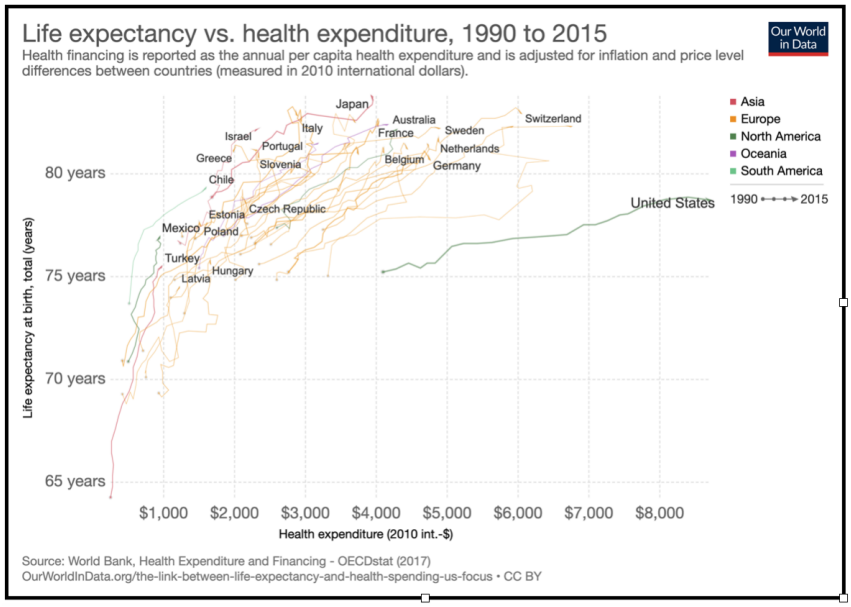
receive only a fraction of the agency payment. It also means that Medicaid dollars are also going to the agency administrators, when they could be going directly into patient care.

Maine Medicaid itself has also become more complicated, with differing eligibility requirements and multiple coverage plans within Medicaid. The process of becoming a Medicaid provider has also gotten more complicated. Although it has been years since I have had a private practice and registered as an independent provider, several colleagues tell me that it is not worth the time and expense to become credentialed as a Medicaid provider, given the low reimbursement received from Medicaid. This has led to a shortage of Medicaid providers within Medicaid. Thus, in the current Mainecare system, even if a patient receives Medicaid they may not be able to find a doctor that is able to see them.

However, these and other barriers are not insurmountable. We know the solutions. We know that a single, publicly-financed health plan such as Medicaid for Maine would save money. The majority of the people of Maine and indeed a majority of Maine physicians support universal healthcare.

Many legislators, past and present, including the co-sponsors of this bill and the co-sponsors of LD1045, have worked tirelessly for universal healthcare for many hours and many years. They are true champions for patients, for the people of Maine. It is time that the Legislature do 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.

References: Graph 1



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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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