Michael Sylvester
Peaks Island

LD 1617

Senator Claxton and Representative Meyer, esteemed members of the Committee on Health and Human Services, my name is Rep. Mike Sylvester and I represent District 39, a part of Portland. Today it is my great honor to introduce LD 1608, An Act to Expand the MaineCare Program To Cover All Citizens of the State.

I introduced a similar version of this bill in the 129th Legislature and the concept was merged with two other bills to study health care and passed out of Committee OTP. That bill, in its final form, would have set up a Legislative committee to study whether a single payer system was possible. Like so many bills, it died in the Covid non-convening and I was left to wonder how different things might have been during the pandemic if the committee had finished its work. Then I realized that I didn't need to wonder because healthcare in the pandemic had proved the worth of a system in which profit was not the key driver. If you or a loved one feared exposure to Covid, you were tested for free whether you had insurance or not. If you wanted to be vaccinated, again, you were given the vaccine for free. Healthcare in the time of Covid has become a human right. The question is why hadn't it always been?

Colleagues, we are here today to ask a couple of questions. The first is whether or not our present system of health care is working. In the 129th, we brought dozens of people who utilized the current, for-profit healthcare system and who spent five hours telling there Health Insurance Committee the ways that the current system had failed them. It was not because any of the people who provide that care have failed. Our nurses, our CNAs and support staff, our physicians and physicians assistants, techs and custodians come to work every day with one thought; to make us well.

Rather the problem comes in the idea, some would say the obscene idea, that healthcare can not be provided without somebody making a profit. The idea that there would be shareholders in any part of the healthcare system would have been laughable for much of our healthcare history. It wasn't until the 1960's that hospital workers were considered workers. Before that, hospitals and healthcare facilities were considered charities. Yet times change. Now there are several layers of profit between patients and their care. Is that okay? Is that the way that we want our healthcare system to work or is there a better way. That is what LD 1608 and what we, therefore, are in this committee room today to discuss.

Now, I have put in this bill because I believe that our current healthcare system does not work. I could have filled this room again today but that's not what I wanted to do. You on this committee hear the tragedy of how people fall through the cracks every day. What I wanted to do was have a discussion with you about expanding Mainecare and let us come to our own conclusions. So to begin with, it probably makes sense to lay out how our healthcare system works today.

Right now, if you get sick, your options about how to make yourself well again are predetermined by a series of prior choices. Say that I break my leg in a bad fall. Who I can go to help take care of this injury is determined largely by what insurance coverage I have selected. Can I go see my doctor that I selected beforehand from a pre-approved list that my insurance agrees to pay for? Can I go to the emergency room or will that not be covered if my predetermined physician doesn't approve beforehand. Are there certain hospitals where I will pay more than others because they aren't on the list? What percentages of my x-rays, pain relief, cast, crutches and/or space that I take up in the hospital will my insurance cover and which will I be responsible for? Will I be responsible for it all because I haven't yet paid my deductible of one thousand, two thousand, five thousand or more on my catastrophic coverage? If they give me anti-biotics and some pain killers, does my coverage include pharmacy costs? What if I have to come back or when they take the cast off. What if the kind of treatment or cast that my doctor wants to give me isn't covered. I have a neighbor who had just such a situation and knew that he couldn't afford his deductable. He pushed his bone back in place against a rock and made his own cast out of duct tape and some resin he had laying around. It sounds like Maine ingenuity until you realize that he never walked correctly again and ended up losing half his

foot to infection. Thes tory ends with that infection eventually taking his life because he couldn't walk into a doctor to be treated without weighing his health against the cost.

So that's our current system. I pay a price to a for-profit insurance company. I get a rationed portion of coverage for that money. There will almost assuredly be additional costs above what I have already paid. Those costs are mine to figure out or to leave to my caregivers to figure out when I can't afford to pay it. Many people who don't like that system talk instead about the kind of single payer system that they have in every other industrialized country in the world.

So what is single payer? It's easiest to explain what it isn't first. It isn't a State Health System where the state hires doctors and nurses, etc. Single payer is a system where the government, in this case the state, pays the doctors and hospitals and pharmacies but they all remain private. The citizens/slash patients pay a tax in some form to the state either out of their pay or in combination with their employer. You go to the doctor and get an x-ray, some meds, a cast and a prescription. The state pays the hospital or the doctor, the pharmacy, etc. That's it. You, the patient, pay nothing more in a true single-payer system. You may say, that's crazy! Such a payment system couldn't work! Yet that's how it works for Medicare federally, for our military. There are a lot of models and, while everyone pays the taxes for our most needy, that is how MaineCare works. You are sick and you qualify for care and they pay. What I want to do is to improve Mainecare and expand Mainecare to make it accessible to every Mainer.

So how does LD 1608 intend to do this? Let's start with the how.

The bill authorizes the Department of Health and Human Services in consultation with other State Departments to design an expansion of Mainecare with the oversight of the MaineCare for All Implementation Task Force. The Task Force is created of nine Legislators, four from the Senate and Five from the House of Representatives. They are the voting members of the Task Force. While there are a number of named groups from which the task force can name consultants to be of assistance to the Task Force, it is the elected officials of the State of Maine who get a vote, who get to control the direction and matters of inquiry and get to shape the ultimate direction of the health care system that will serve us all. We have all seen or heard of Task forces where the seats are filled with people who, while nice, have vested interest outside of the people's. So this task force puts the steering wheel in the hands of the folks who are responsible, ultimately, to the people who voted us here.

It is tempting when writing such legislation to tell the Department and that Task Force exactly how this system should work and yet I used a broad stroke instead of narrow, prescriptive one. This is in part because we would be doing something somewhat groundbreaking and in part a check of humility on my part. I believe that you get the best people in a room and you let them work. I would rather have all roads open for the Task Force to drive down, then a single restrictive path to get to the goals of the bill. Yet while I don't tell the Task Force or the Department how to get there, I do provide a pretty clear map of the destination and the roads available.

The final system must cover these things:

Hospital services;
(2) Medical and other professional services furnished by participating providers;
(3) Laboratory tests and imaging procedures;
(4) Home health care for residents of the State requiring services performed by or under the supervision of professional or technical personnel, including, but not limited to, home health care for acute illness, personal care attendant services and the medical component of home health care for chronic illness;
(5) Rehabilitative services for residents of the State receiving therapeutic care;
(6) Prescription drugs and devices;
(7) Mental health services;
(8) Substance use disorder treatment;
(9) Primary and acute dental services;
(10) Vision appliances, including lenses, frames and contact lenses;

(11) Medical supplies, durable medical equipment and selected assistive devices;
33 and
(12) Hospice care

Some might ask, how would we create such a system? It sounds like some kind of utopia. Well, we already have such a system or darn close to it. It's called MaineCare and it is helpful to think of that system as the launch point for this program. Maine Care is an incredibly successful and popular program. It has wide access to services, an established protocol and is pretty popular with the people who use it. Yet it has issues particularly with amount and level of reimbursements and that is the type of thing that the task force will need to grapple with improving. Yet when you look at the fact that some hospitals charge an average of 170% of cost for private insurance costs to cover the .70 or so on the dollar plus indigent care losses, you can see that there is room to get to paying $1 on a $1 for care. In other words, paying what the care actually costs to deliver rather than monkeying the system to cover losses and make a profit.

How would the System roll out? Again, it is helpful to think of Maine Care and the recent expansion. This system would roll out in three waves or three expansions in 2023, 2025 and 2027 according to income. The first wave would be the next tier of people who are not presently covered by Maine Care and who fall into that next third of the remaining state population. This is important for a couple of reasons because of who this next group is. They are the uninsured and underinsured. They are young people, middle aged people and our elderly. They are heavy users and infrequent users. They are those who have coverage that they can't afford in the present system or those who have coverage that has such large deductibles that they can never meet it or such a small scope of what is covered that they can not use it. Even under the ACA, the plans that many people purchase leave them functionally uninsured no matter the catastrophic plan they pay for. In other words, by implementing in tiers, you balance the risk pool. Many programs like this seek to provide care for the heaviest users in the insurance gap which tilts the risk pool by age or health status. LD 1608 is proposing a more measured approach. As for the tiers that implement in 2024 and 2026, LD 1608 authorizes the Department to seek a waiver to allow those folks outside the first or second implementation to buy into the plan at what I would anticipate would be a much lower cost then private insurance if they so chose. That would also help balance the plan and the pool as cost would drive the market. Theoretically, we would be asking the Federal government to allow us to make this plan our public option.

How would you pay for it? Traditionally, such plans in nearly every other industrialized and some non-industrialized countries in the world pay for their citizens with a payroll tax on citizens, employers or a combination of both. We don't know what the Task Force will land upon but we can assume that they will study all of these models.

Oh, great, a new tax! No, that's the wrong way of thinking about it. Taxes already pay for 60% of US healthcare coverage in the form of pay outs and subsidized insurance according to Physicians for a National Health Plan. We are paying for a government system but we aren't getting it. By creating a plan that phases in but that everyone can purchase we would have a new way of paying for what we already pay out whether in employer contributions to insure their workers, employee contributions to fill the gap the employer can't, in deductibles, in co-pays, in miscellaneous out-of-pocket expenses that no one could know was part of their plan, in pharmaceutical costs that we pay for out of pocket and never have a right to negotiate, although programs like Maine Care get to negotiate them and in the cost to our society of our citizens who wait too long to get care, who are treated in the emergency room for things that could have been prevented with regular treatments or are denied or delayed by private insurance and pharmaceutical companies seeking to make a profit out of making sick people well. I don't have to tell anyone in this committee about the cost increases to private insurance that our businesses are reporting. In labor, we keep hearing 20% increases on our health care plans which don't cover what we need or cover what we

need at too much out of pocket to make it accessible.

Won't the hospitals go broke? Well, the hospitals are already going broke. Before Covid, we had two hospitals in the state in the black. Everyone else operating under this system is hemorrhaging money. Much of the time, that is put on low reimbursement rates of Medicare and Mainecare as well as unpaid and indigent care. Yet what would happen for hospitals and other providers if there was no unpaid care. What would happen if private insurance did not use delay, denial and obtuse rules as a business model for making a profit. We have all gone to receive care, found the form in our mail requesting "additional information" before the insurance company can pay, sat on the phone multiple times trying to get approval or fight a denial of payment. Heck, my dentist hires three people whose sole job is to help patients navigate the labyrinth of the insurance system. When I asked about that extra cost, she said that "the relief to (her) patients and his bottom line from getting through the insurance companies gaming of the system so (she) was paid in six months after providing the care instead of six years was worth every penny". If the hospitals were paid fairly for cost and on time, what would the effect of that be on a rural hospital who works on an annual basis and not the multi-year basis it takes some companies to pay claims. We pay for this system in our health and in the overpricing of care to compensate for the delays and non-payments. The hospitals pay for it in their ability to fully staff and provide care because the check is always in the mail.

Would having everyone on MaineCare ration care or have panels that make decisions about what care we can get? The answer is that, since this task Force will be designing the system and I've already stated what needs to be covered, unless yourself and your colleagues design such a system, which you wouldn't vote for, then no. Yet the truth is folks, we ration healthcare in this country right now but we do it by price rather than design. We already have panels deciding what care we get but they sit in cubicles with their bottom line rather than our health in mind. I have a lot to say about this but I won't belabor it. We all know the stories.

Lastly, the fear will be raised by opponents that people would overuse such a system. Initially that would be true because people who are priced out of the system now and go untreated would be able to see a doctor. Yet, I repeat, that we would no longer have indigent care or unpaid bills because everyone would be covered. We would not have a system that has 25% increases for marketing, review of claims when doctors prescribe care or who look for any reason to say no. The bare point is that we would return to a system where doctors and healthcare providers decide what care we get. People get care, tests and prescriptions, not because they demand them, but because a healthcare professional recommends them. If we have a system where the administration costs are much lower, healthcare professionals are driving care, insurance companies aren't increasing rates at 20 plus percent to cover the cost of new building and CEO salaries and pharmaceutical companies aren't raising prices 400% for an epi-pen and people are seeking preventative care rather then emergency care, my guess is that it will roughly even out. People are overusing the system now but they are overusing it either at the wrong end of the system for emergency or chronic treatment or they are going into bankruptcy to use the system.

Yet you don't have to take my guess. 20 plus years ago, this legislature authorized a study called the Mathematica study which some of you may be familiar with. What did that study say? In part, it said that Maine could implement such a system and could afford it. It says that there will be initial, upfront costs but that overtime the system would provide real savings. How? This conclusion was based on the then outrageous 8% annual increases that the study worried could not be sustained. Now we have 20% increases or more as a matter of course. That study can be reinstitute and I would suggest that it be explicitly put in the text of the bill but I wanted to leave that to the discretion of the committee.

We can do this, whether it is alone or because Federal money becomes available and we are able to say, looks here is what Maine has ready to go! We just need to think of the way healthcare should be rather than trying to manage the damage of what it is.

With that, I thank you for your service today and everyday to the people of Maine, I put my faith in you, my fellow legislators as this bill does and I am happy to answer any questions that I can.

In Solidarity,

Rep. Mike Sylvester
District 39, Portland

Mathematica Study
https://legislature.maine.gov/doc/2099

Maine All Care Study
https://legislature.maine.gov/doc/3626