HealthCareforALLMaine

ADVOCATING FOR COMPREHENSIVE, HIGH-QUALITY AND AFFORDABLE HEALTH CARE FOR ALL MAINE PEOPLE

"Improving Health Care in Maine: What Can We Do?"

In February and March 2023, HealthCare for All Maine coordinated a series of six talks with Maine legislators: "Improving Health Care in Maine: What Can We Do?" This summary describes each of the talks, and includes all of the print materials and references that were distributed during the sessions.

1. **Complexity and Waste in our Healthcare System** - Physician and former state senator, Dr. Geoff Gratwick outlines the problems with our current healthcare system. The US healthcare system is focused on profit. It is expensive, wasteful, and confusing for everyone. Maine spends 23-25% of its total state economic product on health care, the US 18% and Canada and the E.U. 10-12%. Yet, the U.S. ranks somewhere between 21st and 35th in terms of population health. "The obstacles to change are political, not economic or medical," says Dr. Gratwick.
2. **Business impacts: a better model for healthcare in Maine** – Emergency physician Dr. Henk Goorhuis discusses how our healthcare system affects Maine businesses. He proposes a state coverage plan, "broadly imagined by coverage categories", citing examples of initiatives in Maine and in other states. A handout reviews ten years of legislative initiatives in Maine.
3. **Rural Health Care in Maine: Essential and At Risk** – Dr. Ted Sussman, Houlton internist, outlines the health care access problems facing rural Maine residents. Twenty-eight percent of rural Maine hospitals are at risk of closing, including four at immediate risk. Fifteen of sixteen Maine counties have health professional shortages in primary care, mental health, and dental health. "Having adequate health insurance is of little value if there is no Emergency Department, Laboratory facility or treatment capability available in a resident's community", says Dr. Sussman. Further references were also provided.
4. **Rural Health Inequities: Place Matters** – Dr. Caryl Heaton, family physician from Blue Hill, focuses on other critical rural health issues. She notes that rural Maine people have higher rates of poverty, unemployment and economic distress, as well as lower rates of health insurance coverage and poorer population health. In a separate handout, Dr. Heaton outlines strategies to attract healthcare providers to rural Maine areas. She also proposes a unified state healthcare program that includes global budgets for hospitals.
5. **Health Care: What Do People Need?** – Dr. Bill Clark, Brunswick internist, discusses the stress and confusion about medical billing, including what is covered or not covered by insurance, the devastating problems of high deductibles and denial of claims for care that is delivered. He states that what we really need is access to healthcare when we need it, the freedom to choose our healthcare providers, and the ability to make healthcare decisions with those providers without interference from insurance companies.
6. **Health Care: The Way Forward** – Les Fossel, small businessman and former GOP state legislator, proposes twelve possible steps to move Maine along the path to health care for everyone in Maine. He references a 2019 study by MECEP which showed that total yearly health care spending could decrease by $1.5 billion under a state-level universal plan in Maine.

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APPENDIX (with links to HealthCare for All Maine website):

1) Complexity and Waste in our Health Care System

2) Business Impacts of a Better Model for Healthcare in Maine

2b) A Summary of Maine Legislative Initiatives

3) Rural Health Care in Maine: Essential and At-Risk

3b) Additional Rural Health Care Resources

4) Rural Health Inequities in Maine: Place Matters

4b) Health Disparities in Maine: It's Where You Live and What You Do

5) Health Care: What Do Patients Need?

6) Health Care: The Way Forward

6b) The Way Forward: 12 Steps to a Unified Payer System for Maine

7) Economic Impacts of a Health Care Plan to Cover All Maine Residents: a Maine AllCare analysis of the Maine Center for Economic Policy 2019 Fiscal Study "Assessing the Costs and Impacts of a State-Level Universal Health Care System in Maine"

HealthCare for All Maine / healthcareforallmaine.org / info@healthcareforallmaine@gmail.com

Complexity and Waste in Our Health Care "System"

The current situation

Baffling medical bills that even insurance company representatives can't explain. Denials of the care we need and that our health care providers prescribe. The daunting process of assessing different health insurance plans with networks, tiers, premiums, deductibles, and so on.

The complexity and waste in our current system diverts money from other needs, hampers businesses and entrepreneurs, and leaves many people unable to access care without substantial financial burden. Maine municipalities and taxpayers pay for a system that costs too much without providing enough value.

You've probably seen the statistics: The U.S. spends more on health care than other developed nations, with similar or worse health outcomes.

Health care spending

% of GDP:
Maine: 27%
U.S.: 19.7%
Canada and the EU: 10-12%
Change in the U.S.: 6.9% in 1970 to 19.7% in 2020

Per capita:
Maine: $12,077
U.S.: $10,151
EU: $5,736
Change in the U.S.: $1,875 in 1970 to $12,531 in 2020

Sources: KFF 2020, 2022

Where does all the money go?

Waste in health care spending is often defined as anything that doesn't contribute to patient care or community well-being. It's been estimated that 25-35% of health care spending, or $760-960 billion, is wasted each year in the U.S.

The largest source of waste identified in a recent study was "Administrative complexity." Administrative costs for private insurers range from 15-30% of total spending, compared with 3-5% for Medicare. Why the big difference?

Our current "system" includes many payers, plans, and billing processes, plus spending on marketing and administrative staff tasked with deciding what services will be covered under which plans, for whom, and by which providers. And most private insurers are out to make profits for their executives and shareholders—in fact, they're chartered to do so.

Contrast that with Medicare, a publicly funded, single-payer system in which profit-making isn't part of the equation.

It doesn't have to be this way

No way around it, health care is complex, and expensive. Costs will continue to rise to unsustainable levels unless we do something different.

Most other countries in the world have some form of universal health care, ranging from government-run, to publicly funded single-payer, to tightly regulated private insurance. Common to all of these approaches is universal coverage, public investment in health care, and profit-making either strictly limited or nonexistent.

These systems are not perfect, but they save money, they are broadly popular, and they cover everyone.

Imagine:

Everyone has health care. Crippling **medical debt and medical bankruptcies disappear**. **Maine towns and cities** can apply funds, time, and other resources now spent on health insurance toward pressing needs such as infrastructure maintenance, economic development, and preparing for climate change impacts. **Businesses** can focus on innovation and investment rather than providing health insurance to their employees. **Workers** are free to choose employment based on their interests and skills rather than being locked in a job for health insurance. **Entrepreneurs** are free to create new businesses without worrying about how they'll provide health care for themselves, their families, and their employees. With a **simpler, more efficient system**, it's more feasible to **plan for and contain costs**.

The obstacles are not economic or medical, they're political

Many studies have shown that universal health care systems can save money and increase value. A Maine Center for Economic Policy study in 2019 outlined one model for how universal health care could work in Maine, finding that the state could save more than $1 billion and most people, by far, would pay less than they do now—and everyone would be covered. (Cai et al. 2020, MECEP 2019)

Questions? Thoughts? Ideas?
We want to hear from you!
healthcareforallmaine@gmail.com

Sources: Kaiser Family Foundation (KFF) Health System Tracker; Shrank et al. 2019, Journal of the American Medical Association (JAMA); Maine Center for Economic Policy (MECEP) 2019, Commonwealth Fund (2021); Organization for Economic Cooperation and Development (OECD) 2022); Healthcare NOW compilation of economic studies; Cai et al. 2020, PLoS Med; KFF 2020

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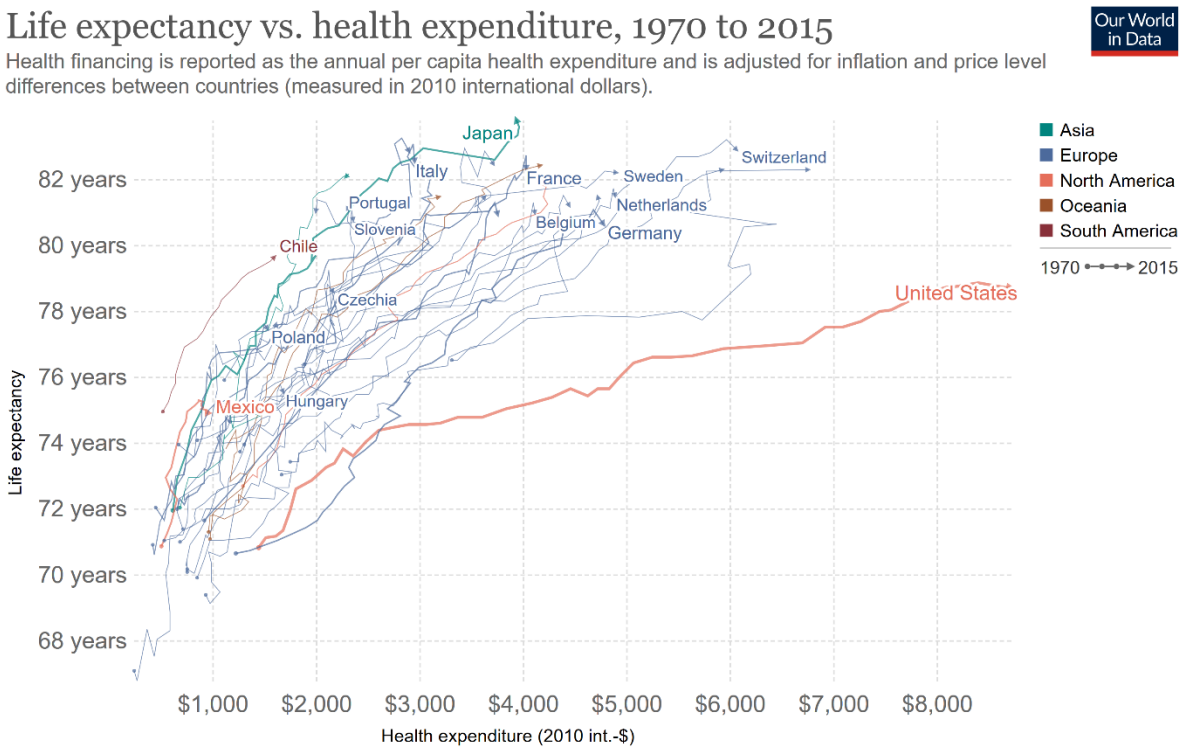
HealthCare for All Maine is the political and advocacy arm of Maine AllCare

A Better Model for Healthcare in Maine - Business Impacts

February 2023

Why reform the financing of healthcare in United States?

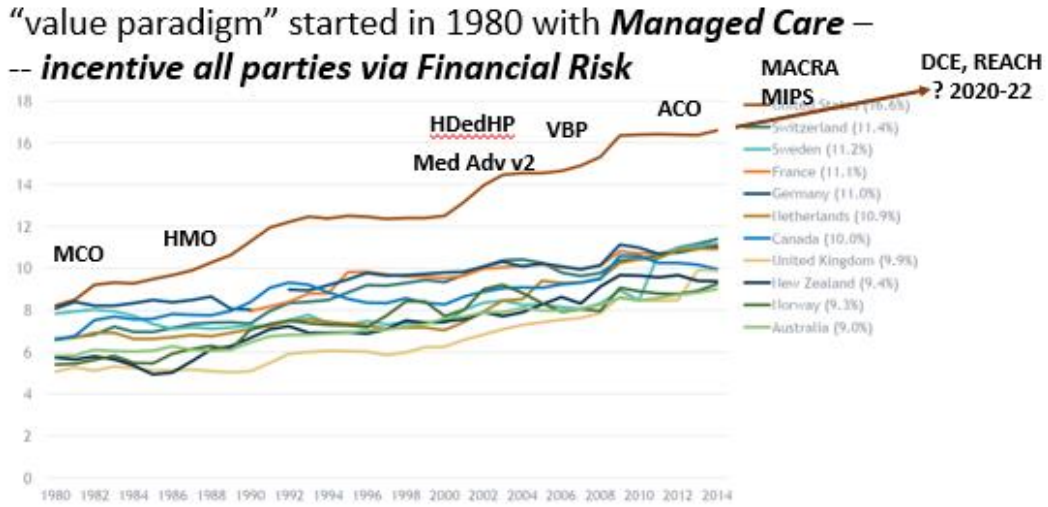


Source: Data compiled from multiple sources by World Bank; Health Expenditure and Financing - OECDstat (2017)
OurWorldInData.org/the-link-between-life-expectancy-and-health-spending-us-focus • CC BY

We underperform our peers.

Where are we loosing value?

Will continuing the current 40-year financial paradigm in healthcare be any different? More of the same?



-can we call this a failed cost control model?

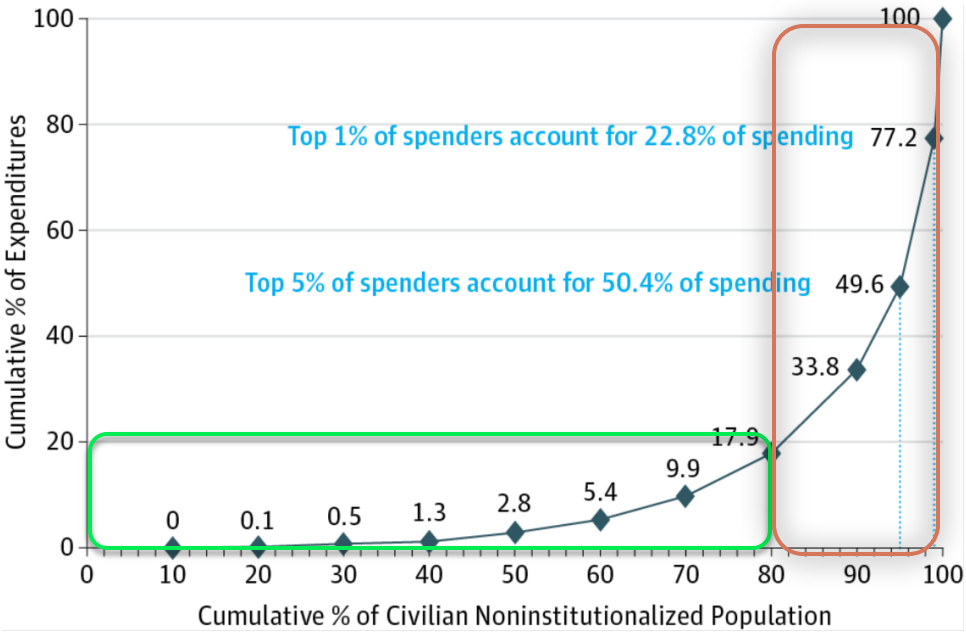
-and business would be expected to continue with the HR and administrative burden of seeking employee health insurance with its exaggerated costs?

Why the difference with our peer nations?

All the healthcare systems in peer nations include five basic characteristics – though each has their own nuances and history of development. They achieve global cost containment, universal coverage and spend less than we do, for similar, if not superior systemwide care. These five principles are:

1. One payer, that pays providers of care directly, with no sub-contracting of funding to competing risk-bearing entities (no complexity of the financial middlemen – so admin of 5%, not our current 20%).
2. Budgets for institutional providers of care, including hospitals, nursing homes, and community health care organizations.
3. A simplified, standardized fee schedule for individual (and mostly independent) providers.
4. Negotiated prices for drugs and durable medical equipment. (with a 40-50% discount versus USA)
5. Universal coverage without direct linkage of a person to employment.

Predictable Distribution of Healthcare Expenditures in a Population



2014 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Human illness is:

-unfortunate

-inevitable

-unavoidable

-predictable in a population

-and the healthy pay for the sick at an 80:20 ratio

-better viewed as a public good or public utility.

Why is employment and healthcare linked in the USA?

An accident from WWII during wage and price controls. Kaiser Steel looking for workers in 1942 offers health insurance.

Other countries use employment as collection point for assessments - BUT *do not* link healthcare coverage directly with employment.

Is there fiscal and administrative relief for business in HC reform?

Can we fund universal coverage, without the HR admin burden to employers, and at a better cost?

Could we also decrease workmen's comp premiums by 50% (via the healthcare component)?

Can we delink the direct involvement of employment and HC insurance?

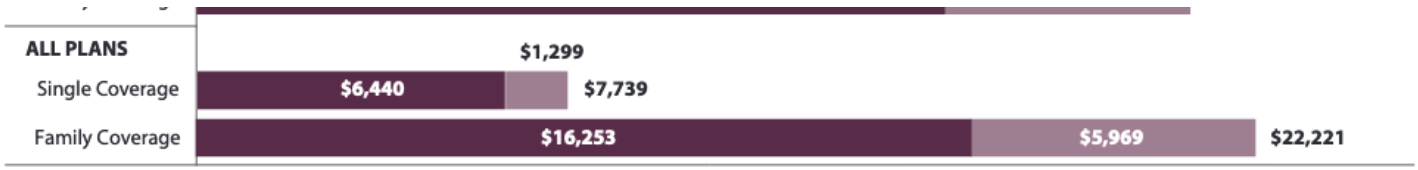
What would be effects across the spectrum of business in Maine?

Cases that we have seen or friends we know:

A small company – no benefits, three employees, all single, no coverage. 1) owner healthy. 2)employee A with Diabetes (owner's uncle). 3) employee B with asthma (owner's nephew). None qualify for Medicaid. Considered HDHP ACA. Rather pay OOP cash for medications.

A family of four – employed breadwinner with company HC benefits. One adult with Rheumatoid Arthritis on medications.

Typical plan parameters with costs for a 4-member family plan– Employer and Employee HC costs – KFF, Milliman Index



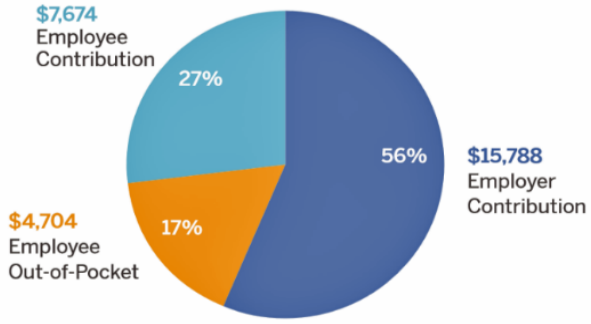
* Estimate is statistically different from All Plans estimate within coverage type (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2021

What would a small business pay for a tax for healthcare for themselves and their employees?

And does there need to be the high OOP costs?

Can we do better?



State Based plans modeled with funding options for business and employees

ColoradoCare - 2016 ballot initiative – a simple funding proposal

-a single percentage – 10%- assessment at wages/income

-Employer 6.67% (2/3) - Employee 3.33% (1/3)

-nonpayroll (1099) income tax of 10%

(Deductible from Federal tax, Exempts SSI, pensions, minimal copays)

ColoradoCare - 2016 Examples

-~$30,000/yr income – single worker @ Small Business – no benefits

CCare – Employer = $2000/yr, Employee = $1000/yr

With copays of only $5 for medical visits and Rx's for asthma and diabetes meds.

OR obtain on own, a HDHP plan via ACA at ~$200/mo (with the tax subsidized premium)

~$75,000/yr income – family of 4 – with benefits

CCare – Employer = $5000, Employee = $2500

With copays of only $5 for medical visits and Rx's for arthritis meds(?)

verses current HC benefits thru employer with HDHP

~150,000/yr combined employment income – two-person family – 2 jobs($100K,$50K)

CCare – Employers split = $10,000, Employees split = $5000/yr

Plus "other gains"on possible rentals, personal businesses, 1099 income, etc.

NY Health Act 2015

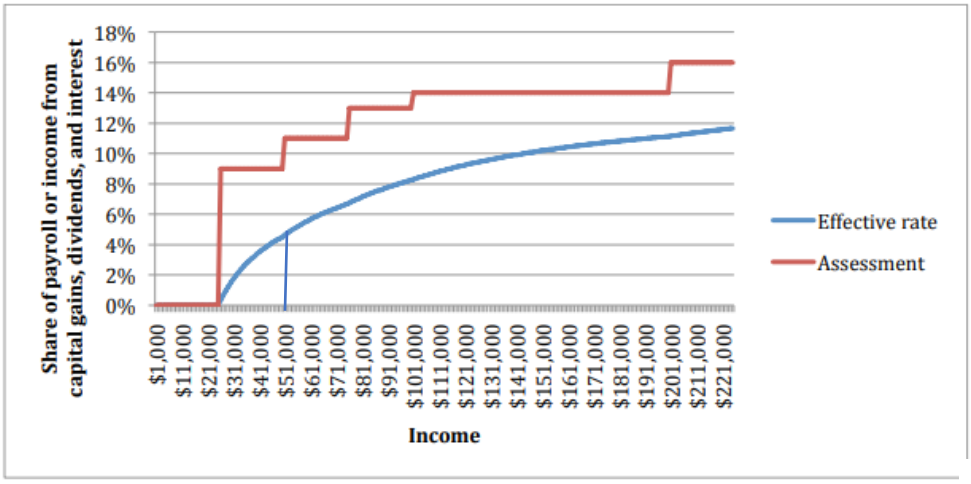


Figure 10. Assessment rate and average assessment as share of income.

80% employer, 20% employee split

initial $25K exempt

Example of$50,000 income with an effective rate ~4.5%

Total premium tax of $2,250

Employer 80 % - $1,800/yr (effective rate of 3.6%)

Employee 20% - $450/yr (rate of 0.9%)

http://www.infoshare.org/main/Economic_Analysis_New_York_Health_Act_-_GFriedman_-_April_2015.pdf

A Maine study from 2019

Sliding scale premiums would 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 599% of FPL – 6 to 7.5% of AGI
- Families above 600% of FPL – 7.5% of AGI (capped at full annual premium)

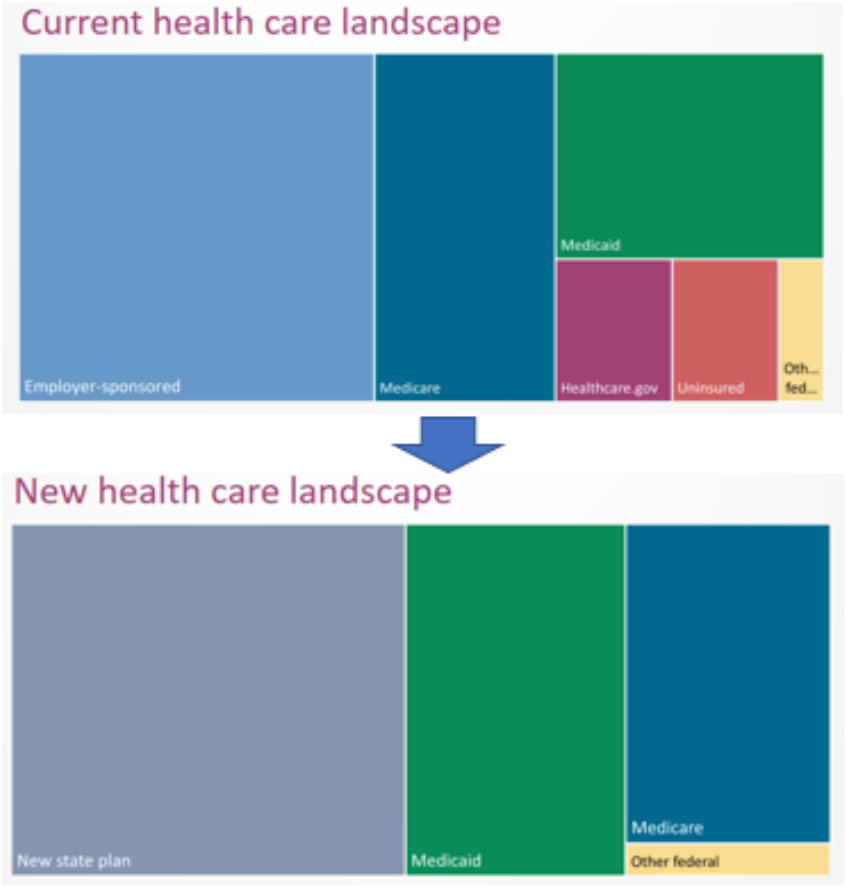
Full annual premium: $6000 per adult, $3500, per child, $3000 for 65+

Fee structure for employers:

- Fewer than 10 employees – 3% of payroll
- 10-99 employees – 4.5% of payroll
- 100+ employees – 10% of payroll

https://maineallcare.org/fiscal-study-2019/

A State Coverage Plan – Broadly imagined by coverage categories



A state entity offering HC coverage to all residents.

A public/governmental agency

It coalesces all available Federal funds and raises additional funds within state.

Then negotiates with and pays providers.

Is its own plan and ERISA compliant.

Workman's Comp's healthcare portion is included in coverage – so WC coverage costs could decrease by 50%.

Paying uniform and competitive rates (Medicare based)

Administering these areas of coverage paid at uniform rates

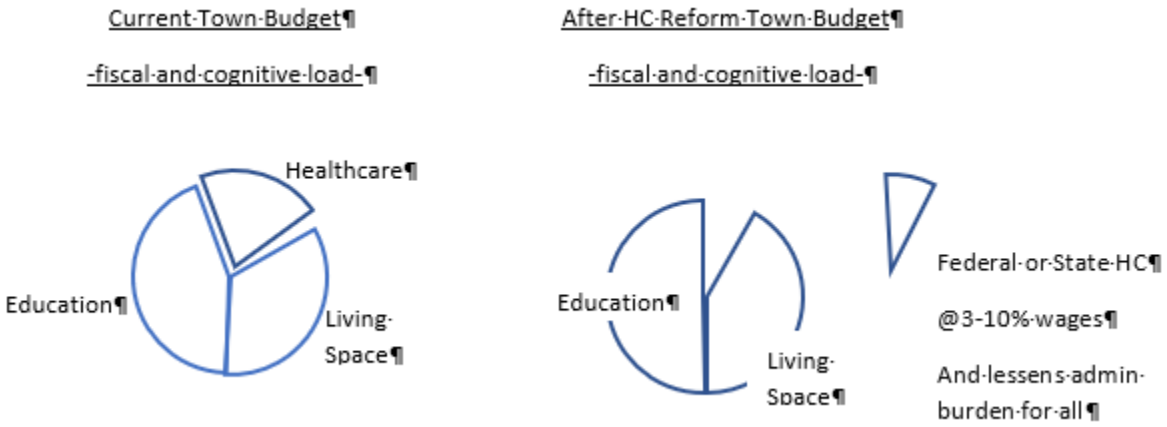
How would these changes effect the business community in Maine?

In Maine per SBA -> 117,000 list no employee 30,000 1-19 employees 3,300 20-499 employees 50 >500 employees

Per KFF -> 30% of business with < 50 employees provide HC insurance. 96% with HC coverage for businesses >50

Envisioning how a *certain type of business* could reset priorities and operate.

Imagine a new budget and priorities for a town in Maine



Rural Health Care in Maine: Essential and At Risk

The current situation

Almost two-thirds of Maine residents live in rural areas. Rural Maine counties tend to have higher rates of poverty, unemployment, and economic distress, and lower rates of health insurance coverage. Small rural hospitals and other rural providers face steep challenges in our current health care system, including workforce shortages and financial strain largely caused by underpayment and payment systems that don't meet their unique needs.

Small rural hospitals, along with Federally Qualified Health Centers (FQHC), provide most or all of the health care services in the communities they serve.

The health care services provided in rural areas also affect urban areas: farming and food production, recreational areas, resource extraction (mining, forestry), etc. are often located in rural areas.

Rural Living

61% of Maine residents live in rural areas

11 of Maine's 16 counties are rural

9 of Maine's rural counties experience economic and social distress

Maine's rural counties tend to have poorer population health and lower rates of health insurance

Source: NRBC 2022

"Having health insurance that pays fees for ER visits, laboratory tests, or treatments is of little value if there is no Emergency Department, laboratory, or treatment capability available in the community for the resident to use."

28% of rural Maine hospitals are at risk of closing, including four at immediate risk

It costs more to deliver health care services in rural areas, in part because rural hospitals and providers need to cover the costs of keeping facilities open and staff available when people need them, often called "standby capacity," as well as the costs of the services people use day to day and month to month.

Paying rural hospitals and providers adequately could also help attract more health professionals to rural areas. Fifteen Maine counties have health professional shortages in primary care, mental health, and dental health.

Potential solutions

- On a basic level, we need to pay rural hospitals and providers more to serve the health care needs of rural communities.
- This includes funding "standby capacity" so that rural hospitals and providers can cover the costs to keep necessary facilities open and providers available.
- According to leadership at one rural Maine Critical Access Hospital, being reimbursed at Maine Medicaid rates would be financially viable for them.
- **By reducing administrative complexity and costs, a publicly funded, universal health care system would also help to keep rural health care available and sustainable.**

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Questions? Thoughts? Ideas?
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Sources: Saving Rural Hospitals, Center for Healthcare Quality and Payment Reform (CHQPR); Maine Rural Health Research Center; Maine: A Health-Focused Landscape Analysis, Northern Border Regional Commission (NRBC), April 2022); Maine Center for Economic Policy (MECEP) 2019, Cai et al. 2020, PLoS Med

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HealthCare for All Maine
Lunch & Learn with Maine Legislators
2/16/23
Dr. Ted Sussman
Handout

Information and Data Sources:

Page 2-3:
Maine: A Health-Focused Landscape Analysis

A report by the Northern Border Regional Commission and Maine Rural Health Research Center

https://digitalcommons.usm.maine.edu/cgi/viewcontent.cgi?article=1029&context=population_health

Citation: Ahrens, K., Burgess, A., Milkowski, C., Munk, L., Jonk, Y., & Ziller, E. (2022). Maine: A Health-Focused Landscape Analysis. [Chartbook]. University of Southern Maine, Maine Rural Health Research Center.

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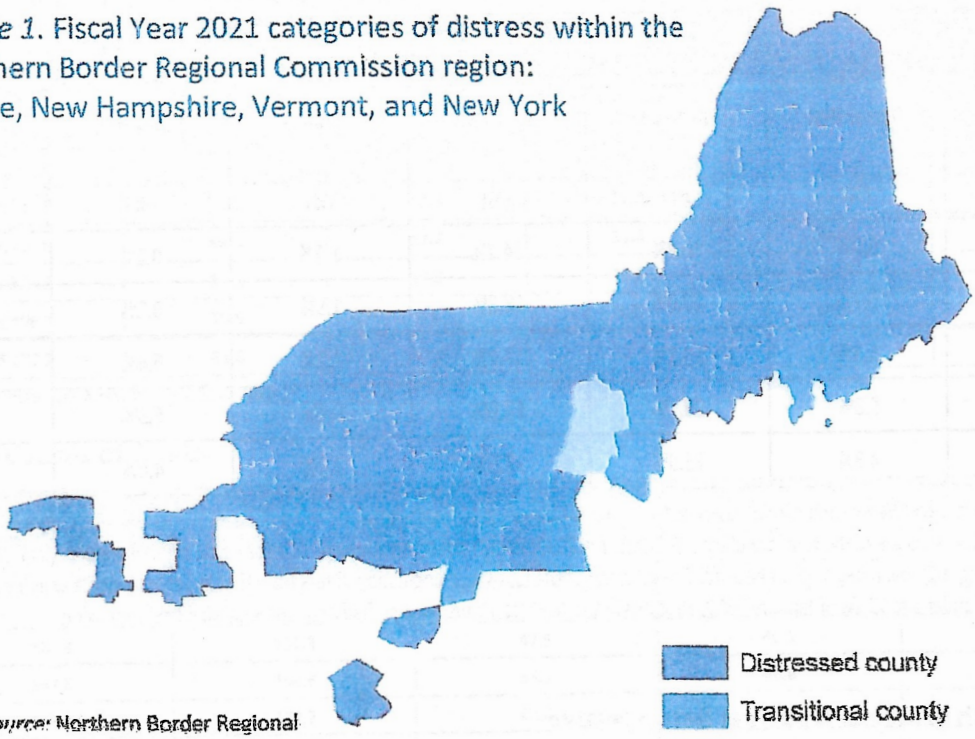
Page 4:
Rural Hospitals at Risk of Closing
A report by Saving Rural Hospitals,
Center for Healthcare Quality and Payment Reform
https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

https://ruralhospitals.chqpr.org

Figure 1. Fiscal Year 2021 categories of distress within the Northern Border Regional Commission region: Maine, New Hampshire, Vermont, and New York



Data source: Northern Border Regional Commission. *NBRC Annual Economic & Demographic Research for Fiscal Year 2021: To Determine Categories of Distress within the Northern Boarder Regional Commission Service Area.* March 2021.

SECTION I. Demographic Characteristics

Geography	Population	Rurality	Age		Sex	Race/ethnicity[1]						Language
		Living in a rural area	Below 18 years of age	Age 65 and older	Female	Non-Hispanic white	Non-Hispanic Black	Hispanic	American Indian & Alaska Native	Asian	Native Hawaiian/ Other Pacific Islander	Not proficient in English
	(N)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
United States	328,239,523	19.3%	22.3%	16.5%	50.8%	60.1%	12.5%	18.5%	1.3%	5.9%	0.2%	4.3%
Maine	1,344,212	61.3%	18.5%	21.2%	51.0%	93.0%	1.6%	1.8%	0.7%	1.3%	<0.1%	0.5%
New Hampshire	1,359,711	39.7%	18.8%	18.7%	50.4%	89.8%	1.5%	4.0%	0.3%	3.0%	<0.1%	1.0%
New York	19,453,561	12.1%	20.7%	16.9%	51.4%	55.3%	14.5%	19.3%	1.0%	9.0%	0.1%	6.9%
Vermont	623,989	61.1%	18.3%	20.0%	50.6%	92.6%	1.3%	2.0%	0.4%	1.9%	<0.1%	0.6%

Data sources: Census Population Estimates, 2010 and 2019; American Community Survey, 2015-2019 5-year estimates.
[1] Race/ethnicity data may not sum to 100% due to missing data.

SECTION II. Socioeconomic Characteristics

Geography	Employment			Income				Social support	Education	
	Employed full time, ages 16 to 64	Unemployed, ages 16 and older seeking work	Employed in healthcare and social assistance	Median household income	Population in poverty	Children in poverty	Children eligible for free or reduced-price lunch	Children in single-parent households	High school graduation rate	Adults with some college completion
	(%)	(%)	(%)	($)	(%)	(%)	(%)	(%)	(%)	(%)
United States	66.4%	3.7%	15.8%	65,712	12.3%	16.8%	52.2%	25.5%	85.0%	66.1%
Maine	63.1%	3.0%	21.7%	58,824	10.9%	13.8%	44.1%	20.6%	85.9%	68.3%
New Hampshire	65.4%	2.5%	15.4%	78,571	7.5%	8.1%	27.0%	19.1%	88.9%	70.8%
New York	66.4%	4.0%	19.9%	72,038	13.1%	18.2%	53.9%	27.0%	82.4%	68.7%
Vermont	62.2%	2.4%	19.0%	63,293	10.1%	10.8%	36.4%	21.2%	85.5%	68.7%

Data sources: American Community Survey, 2015-2019 5-year estimates; Bureau of Labor Statistics, 2019; Small Area Income and Poverty Estimates, 2019; National Center for Education Statistics, 2018-2019; EDFacts, 2017-2018.

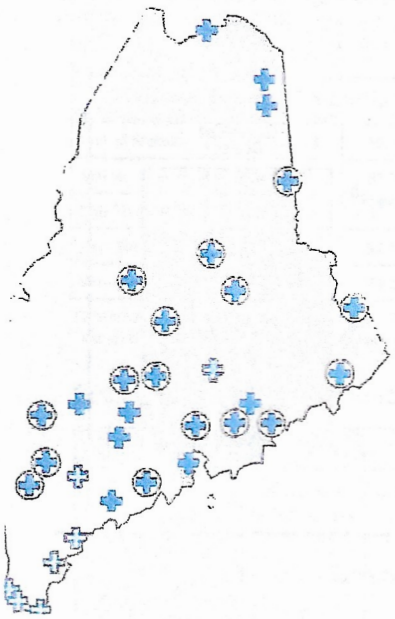
TION VII. Death Rates per 100,000 Population, Cause Specific

Geography	Length of life	Injury-related deaths	Injury-related death subcategories			
	Premature death (years of potential life lost before age 75, # per 100,000)	All injury deaths (# per 100,000)	Suicide deaths (# per 100,000)	Firearm deaths (# per 100,000)	Drug overdose deaths (# per 100,000)	Motor vehicle crash deaths (# per 100,000)
United States	6,906.6	72.3	13.8	11.9	21.2	11.4
Maine	7,020.8	93.0	17.7	11.4	28.4	11.5
New Hampshire	6,373.8	88.5	17.9	10.6	32.7	8.6
New York	5,406.3	50.5	8.1	4.2	19.1	5.7
Vermont	6,277.2	85.6	17.0	11.7	22.4	9.6

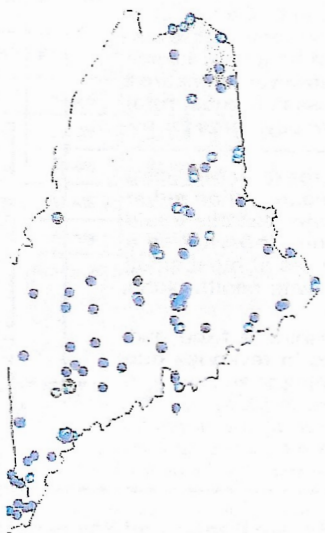
Data source: National Center for Health Statistics – Mortality Files, 2013-2019.

SECTION VIII. Top Five Causes of Death

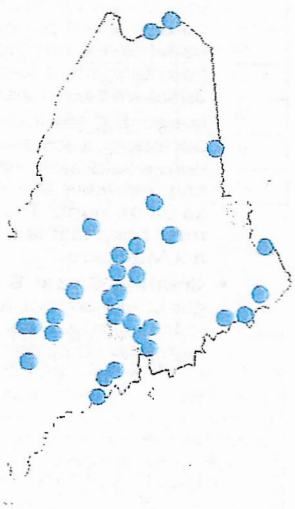
Geography	Top five causes of death (Age-adjusted rate of death per 100,000 population)				
	Heart disease	Cancer	Accidents (unintentional injuries)	Chronic lower respiratory diseases	Stroke (cerebrovascular diseases)
United States	164.8	152.3	47.5	40.2	37.3
Maine	147.8	168.6	63.3	48.6	33.9
New Hampshire	148.7	153.7	62.6	40.8	27.9
New York	173.7	141.5	33.7	28.6	24.9
Vermont	153.1	158.7	55.9	40.6	30.7



Hospitals



FQHCs



RHCs

The Causes of Rural Hospital Closures

Rural hospitals are being forced to close because they are not paid enough to cover the cost of delivering services in rural areas. Most of the hospitals that have closed had losses on patients with private health insurance as well as on Medicare, Medicaid, and uninsured charity care patients, and they did not have other sources of income sufficient to offset these losses.

It costs more to deliver essential services in rural communities because of the smaller number of patients served, not because rural hospitals are inefficient. For example, a small rural community will have fewer Emergency Department (ED) visits than a larger community simply because there are fewer residents, but the minimum cost of staffing the ED on a 24/7 basis will be the same, so the average cost per visit will be higher. A payment that is sufficient to cover the cost of ED visits at a large hospital may fall far short of the cost of visits at a small rural hospital.

A common myth about rural hospitals is that most of their patients are on Medicare and Medicaid. In fact, more than half of the services at the average rural hospital are delivered to patients with private insurance (including both employer-sponsored insurance and Medicare Advantage plans). Low margins or losses on patients with private insurance, combined with losses on Medicaid and uninsured patients, can force small rural hospitals to close.

Commonly Proposed "Solutions" Won't Prevent Most Closures

Several policies that have been developed or proposed to help rural hospitals would not solve their financial problems, and some would make them worse:

- **Creating "Rural Emergency Hospitals."** Requiring rural hospitals to eliminate inpatient services would increase their financial losses while reducing access to inpatient care for local residents. Residents of rural communities would have had even more difficulty finding a hospital bed during the pandemic if their hospital had been converted to a Rural Emergency Hospital.
- **Expanding Medicaid Eligibility.** Making more patients eligible for Medicaid would help low-income patients afford better care and it would reduce a portion of hospitals' losses on uninsured patients and bad debt. However, uninsured patients are not the primary cause of losses at most rural hospitals; most losses are caused by low payments for patients who have insurance.
- **Increasing Medicare payments.** An increase in Medicare payments, such as eliminating the 2% sequestration reduction, would be beneficial for rural hospitals, but this would only increase the margin at a typical rural hospital by a small amount. The biggest cause of losses at most small rural hospitals is low payments from private health plans, not Medicare.
- **Creating Global Budgets.** Giving a hospital a fixed budget could protect a hospital from losses in revenues due to lower service volume, but it does nothing to address the increases in costs that most hospitals are currently facing, and it would prevent hospitals from delivering new services their communities need.

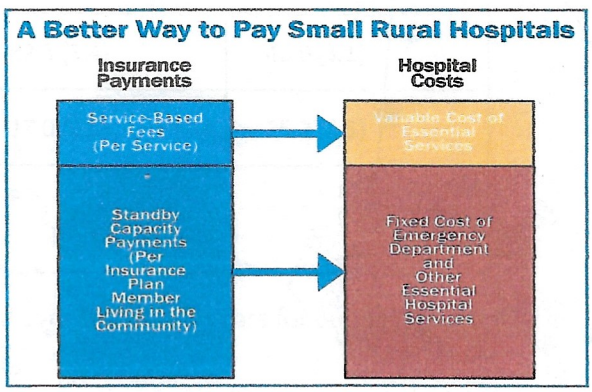
How to Prevent Rural Hospital Closures

The only way to prevent rural hospital closures is for health insurance plans to pay rural hospitals adequately to cover the cost of delivering essential services in their communities. Although most payers are underpaying small rural hospitals, the biggest cause of negative margins in most small rural hospitals in most states is low payments from private insurance plans and Medicare Advantage plans.

It would only cost about $3 billion per year to prevent closures of the at-risk hospitals and preserve access to rural healthcare services. This would represent an increase of only 1/10 of 1% in total national healthcare spending. Most of the increase in spending would support primary care and emergency care, not inpatient services, since the biggest causes of losses at most small rural hospitals are underpayments for primary care and emergency services. Spending would likely increase as much or more than this if hospitals close because reduced access to preventive care and failure to receive prompt treatment will cause residents of the rural communities to be sicker and need more services in the future.

The financial problems at small rural hospitals are caused not only by the inadequate *amounts* paid by private health insurance and Medicaid plans, but by the problematic *method* all payers use to pay for services. Small rural hospitals are not paid at all for what residents of a rural community would likely view as one of the most important services of all – the availability of physicians, nurses, and other staff to treat an injury or serious health problem quickly if the resident experiences an injury or problem. Having health insurance that pays fees for ED visits, laboratory tests, or treatments is of little value if there is no Emergency Department, laboratory, or treatment capability available in the community for the resident to use.

In order to preserve and strengthen essential hospital services in rural communities, small rural hospitals need to receive ***Standby Capacity Payments*** from both private and public payers in addition to being paid Service-Based Fees when individual services are delivered. The Standby Capacity Payment would support the fixed costs of essential services at the hospital, and Service-Based Fees would cover the variable costs of those services. More details on this approach are available at RuralHospitals.org.



Rural Health Inequities in Maine: Place Matters

Maine is the most rural state in the nation.
Almost two-thirds of Maine residents live in rural areas, and 11 of 16 Maine counties are considered rural. Rural areas tend to have higher rates of poverty, unemployment, and economic distress, lower rates of health insurance coverage, and poorer population health. Fifteen Maine counties have health professional shortages in primary care, mental health, and dental health.

Small rural hospitals, along with Federally Qualified Health Centers (FQHC), provide most or all of the health care services in the communities they serve.

Rural vs. Urban Health

50% more uninsured

76% higher enrollment in MaineCare

24% more overdose deaths

3 times the number of drug-affected births

19% higher death rate from all cancers

24% higher death rate from stroke

67% higher rates of COPD

Source: MSCHNA (2021)

Where you live makes a difference

Rural areas in Maine have higher death rates from cancer, cardiovascular disease, stroke, and diabetes-related illness than urban areas (see sidebar). People who live in rural Maine have higher rates of hospitalization for pneumonia, ER visits for asthma, and COPD than those who live in the urban parts of the state.

They also experience higher rates of many types of cancers including lung, bladder, and pancreatic cancer as well as leukemia. People in rural areas suffer more overdose deaths and births affected by drug use. Fifty percent more people in rural areas are uninsured, and 76 percent more are enrolled in MaineCare, including 70 percent more children.

28% of rural Maine hospitals are at risk of closing including four at immediate risk

Recognizing rural needs

It costs more to deliver health care services in rural areas, in part because rural hospitals and providers need to cover the costs of keeping facilities open and staff available when people need them, often called "standby capacity." Maine needs a payment system for rural hospitals that supports standby capacity as well as the services people use day to day and month to month, and adequately funds primary and emergency care.

Potential solutions

Health care for everyone—universal health care—means a healthier population.

By simplifying our system and reducing costs, a publicly funded, universal health care system would help to keep rural health care available and sustainable.

Providing people with a foundation of health care would take away one of the uncertainties and financial strains that can make it challenging to live and work in rural areas.

Paying rural hospitals and health centers adequately could help attract more health care professionals to rural areas. A simplified universal health care system would allow providers to focus on care rather than the unnecessary complexity of our current system.

Imagine:

Everyone has health care. Crippling **medical debt and medical bankruptcies disappear**. **Maine towns and cities** can apply funds, time, and other resources now spent on health insurance toward pressing needs such as infrastructure maintenance, economic development, and preparing for climate change impacts. **Businesses** can focus on innovation and investment rather than providing health insurance to their employees. **Workers** are free to choose employment based on their interests and skills rather than being locked in a job for health insurance. **Entrepreneurs** are free to create new businesses without worrying about how they'll provide health care for themselves, their families, and their employees. With a **simpler, more efficient system**, it's more feasible to **plan for and contain costs**.

The obstacles are not economic or medical, they're political

Many studies have shown that universal health care systems can save money and increase value. A Maine Center for Economic Policy study in 2019 outlined one model for how universal health care could work in Maine, finding that the state could save more than $1 billion, most people would pay less than they do now, and everyone would be covered.

Questions? Thoughts? Ideas?
We want to hear from you!
healthcareforallmaine@gmail.com

Sources: Maine: A Health-Focused Landscape Analysis, Northern Border Regional Commission (NRBC), April 2022; Maine Center for Economic Policy (MECEP) 2019; Maine Shared Community Health Needs Assessment (MSCHNA) 2021; Saving Rural Hospitals, Center for Healthcare Quality and Payment Reform (CHQPR); Maine Rural Health Research Center.

HealthCareforALLMaine

ADVOCATING FOR COMPREHENSIVE, HIGH-QUALITY AND AFFORDABLE HEALTH CARE FOR ALL MAINE PEOPLE

HealthCare for All Maine is the political and advocacy arm of Maine AllCare

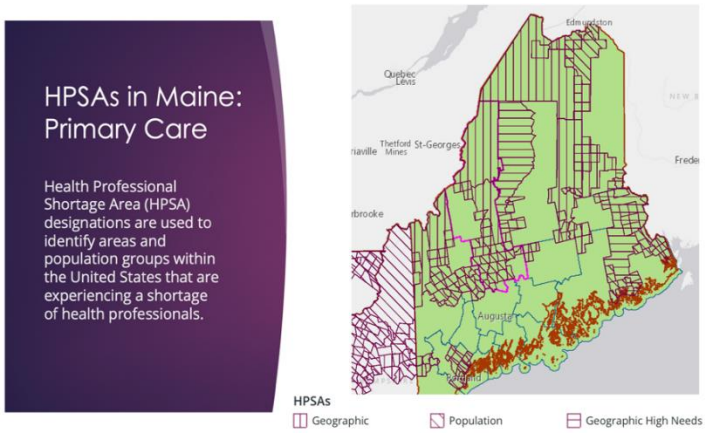
Health Disparities in Maine: "It's Where You Live and What You Do"

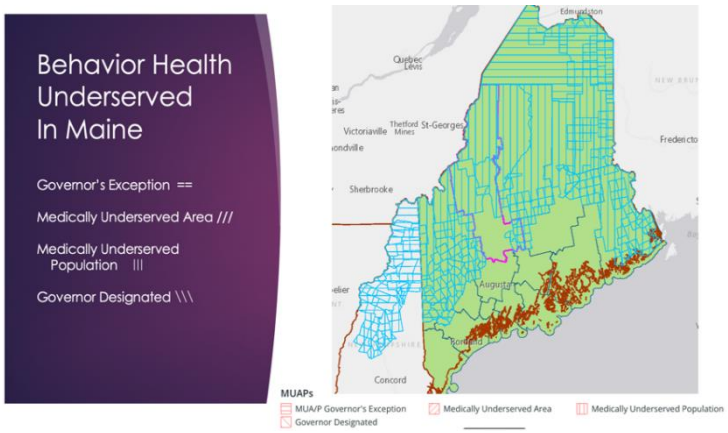
By far, most disparities in Maine health care exist between urban and rural communities.
--61% (66%) of Maine residents live in rural areas
--11 of Maine's 16 counties are rural
--Maine's rural counties tend to have lower education status, lower income, less insurance, and a longer distance to medical care.
-- Maine's rural residents tended to be older, with fewer under age 50 (43% versus 51%) and a greater proportion age 65 and older (26% versus 22%).[1]
--28% of rural Maine hospitals are at risk of closing, including four at immediate risk.

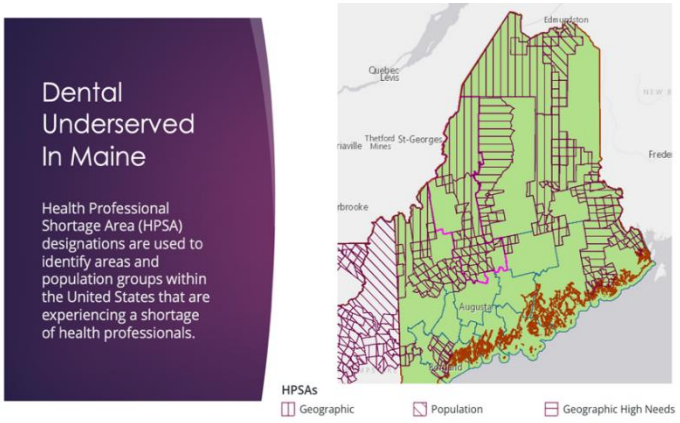
HPSAs[2] are health professions service areas designated by the federal government. Rural Maine doesn't have enough primary care physicians, dentists and behavioral health workers.

Maine people in rural areas are 50% more likely to be uninsured, and with fewer privately insured. The number of people who are underinsured is unknown. The disparities are less significant after 65 years old because of Medicare.

Maine is 15th in the US for spending on primary care – just 5.66% of health dollars are spent in primary care. With a broader definition of primary care, Maine is 19th, spending just 9.18%.







Rural Communities have:

--2 times the poverty
--50% more uninsured
--76% more enrolled in Maine Care
--70% more kids enrolled in MaineCare
--24% more overdose deaths
--3 times the number of drug-affected births
--55% higher rate of Lung Cancer
--44% higher rate of Esophageal Cancer
--30% higher rate of Bladder Cancer
--49% higher rate of Leukemia
--5% higher rate of Pancreatic Cancer
--20% higher rate of self-rated poor or fair health
--19% higher all cancer deaths
--20% higher lung cancer deaths
--16% higher coronary heart deaths
--46% higher stroke deaths
--52% higher rates of heart attack hospitalizations
--10% higher rates of diabetes related death
--33% higher rate of ER visits for asthma
--49% higher rates of COPD
--23% lower rate of Liver/Bile Duct Cancer--
--56% higher rate of Kidney Cancer [3][4]

[1] MEHAF https://mehaf.org/wp-content/uploads/2022_BRFSS-Rural-Brief_FINAL.pdf
[2] https://maps.healthlandscape.org/
[3] Health in Maine: Rurality
https://www.maine.gov/dhhs/mecdc/phdata/MaineCHNA/documents/Rurality%20HE%20Data%20Sheet%206.27.2022.pdf
[4] Based on a comparison of Washington, Aroostook, Piscataquis compared to York and Cumberland Counties in CHNA

How do we get a system that can address rural health inequities?

A unified state health care program provides better care to more people for less money, making the system more responsive to the patients it serves, without compromising provider payment. (Maine Center for Economic Policy fiscal study, 2019: maineallcare.org/fiscal-study-2019/)

- It is a public good; like schools, libraries, and fire departments.
- It is affordable because the middleman cut of money is taken out.
- It can pay a fair amount to hospitals, rural clinics, dental offices and drug treatment centers.
- It is responsible for quality and fairness.
- It can be innovative in reimbursement.
- It can be innovative in education and educational partnerships

How do we support hospitals in rural Maine?

Establish global budgets: A hospital global budget is a predetermined amount of money that a hospital is allocated to spend on its operations for a given period, usually a year. This budget covers all hospital services, including salaries, equipment, and supplies. The hospital is expected to operate within this budget and manage its resources efficiently to ensure that it can provide quality care to patients while staying within its financial means.

How do we get more providers in rural Maine?

1.) **Pay them:** fee-for-service, time-based model, FQHC look-alikes, rural health clinics, and hybrid models.

2.) **Grow them:** Develop In-State Programs to increase the number of primary care physicians in rural Maine.

James Herbert, PhD., president of University of New England testified to the Senate Committee on Health, Education, Labor, and Pensions (Feb 17, 2023), offering potential strategies to combat the shortage of health care workers:

1. **Increase the number of doctors, nurses, and other health care professionals we educate** by expanding partnerships between universities and community health care settings to develop additional training opportunities, revise out-of-date policies, provide targeted one-time adjustments to expand health care training infrastructure, and develop strategic scholarship and loan-repayment programs.
2. **Intentionally recruit more students who look like the communities we need to serve**, as individuals from underrepresented groups are more likely to seek out practitioners who share their identities and background.
3. **Use a variety of tools to encourage health care providers to practice in underserved areas**, including rural, tribal and medically underserved urban communities.
4. **Leverage the power of technology, including telehealth and digital medicine**, to reach underserved communities and integrate robust telehealth training for all of our health profession students in close partnership with our various training sites.

Take action:

- **Recognize that the current situation is unacceptable.**
- **Consider alternatives to incremental solutions**. (We all support lower insulin costs…but really?)
    - Begin the ground work NOW – **Access, Finance and Quality Exploratory Commissions for the State**
- **Don't put the fox in charge of the hen house**. *(For-profit companies have succeeded in transferring wealth to their shareholders, but little else.)*

Caryl Heaton, DO - March 23, 2023. Contact: carylheaton@gmail.com 207-669-0219

Health Disparities in Maine: "It's Where You Live and What You Do"

Caryl Heaton DO, March 23, 2022

Additional Charts and References:

Shared Maine Community Health Needs Assessment								
Cancer per 100,000 persons	Washington	Aroostook	Piscataquis	Average Rural	York	Cumberland	Average Urban	Ratio; Rural to Urban
Lung Cancer	153	128	158	146	109	79.3	94	1.55
Esophageal Cancer	18	10	14	14	11	8.5	10	1.44
Bladder Cancer	46	44	57	49	42	32.9	37	1.30
Kidney Cancer	31	31	32	31	22	18.6	20	1.56
Laryngeal Cancer	7	8	11	8	4	4.2	4	2.06
Leukemia all types	30	24	31	29	18	20.7	19	1.49
Pancreatic Cancer	20	21	20	20	22	17.3	19	1.05
Liver/Bile Duct Cancer	9	7	7	8	11	8.7	10	0.77

Maine Shared Community Health Needs Assessment Report 2022

https://www.maine.gov/dhhs/mecdc/phdata/MaineCHNA/documents/State%20Report%207.12.2022revision.pdf

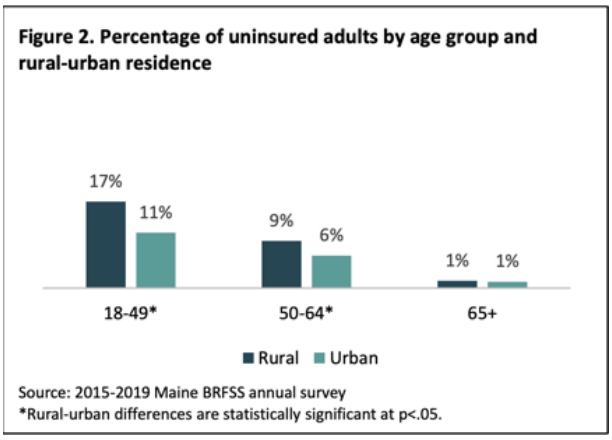
	Maine	Washington	Aroostook	Piscataquis	Oxford	Somerset	Average Rural	York	Cumberland	Average Urban	**Ratio; Rural to Urban**
Median Income	57,918	41,347	41,123	40,890	49,204	44,256	45,790	67,830	73,072	70,451	**1.54**
Unemployment	5.4	6.2	5.5	5.5	6.7	6.6	6.0	5.4	5.3	5.4	1.12
Uninsured	7.9	12.1	8.4	10.2	8.8	9.4	9.5	6.7	5.8	6.3	**1.51**
Individuals in Poverty	11.8	18.9	16.1	18.5	15.1	20.4	16.8	7.4	9	8.2	**2.05**
Children in Poverty <19 yrs.)	13.8	24.6	20.2	23.8	17.6	22.6	20.4	9.9	9.2	9.6	**2.14**
Persons with Disabilities	16	22.5	22.3	26.3	18.5	21.7	21.2	15	11.4	13.2	**1.61**
Veterans	9.6	11.8	11	12.6	10.2	10.6	11.0	10.2	7.2	8.7	**1.26**
Access to Broad Band	88.6	76.3		41.8	87.6	58.6	70.6	99.3	99.4	99.4	0.71
Ratio; Populations to PCP	1,332	2672	1481				1,828	1704	1018	1,361.0	**1.34**
Usual Prumary Care Provider	87.9	82.4	86.5*		89.1	90.7*	86.5	90.4	87.9	89.2	0.97
Percent over 30 miles to Visit	20	31.9	17.7	33.1	42.2	36	30.2	18.8	12.8	15.8	**1.91**
Visit to PCP last 12 months	87.9. 72.0 (2017)	82.4	74.1	71.8	73.2	75.2	75.3	73.1	89.5	81.3	0.93
Maine Care Total Enrollement	29.1	42.9	40.1	38.2	36.4	39.3	37.7	22	20.9	21.5	**1.76**
Maine Care Child Enrollement	43.8	62.6	56.2	61	56.3	56.8	56.1	34.7	31.5	33.1	**1.70**
Cost Barriers	10.6	13	12.9	11.2	11.6	8	11.2	8.6	9.1	8.9	**1.27**
Rate Seeking Mental Health Care in ER/100,000	181.5	195.5	193	188.2	199.3	183.5	190.2	152.7	160.7	156.7	1.21
Ratio; Population to Psychiatrist	12,985	60,664	64,856	NA	173,148	191,140	100,559	20,812	5,419	13,115.5	**7.67**
Percent HS students sad or hopeless for over 2 weeks	23.7	23.7	11.4	19.8	22.7	21.4	20.5	22.8	8.5	15.7	**1.31**
Overdose Deaths / 100,000	37.3	63.5	25.4	58.8	25.8	25.7*	42.2	35.4	32.5	34.0	1.24
Drug Affected Infants / 1,000	73.7	139.2	124.1	99.6	121.1	140.5	116.4	41	29.4	35.2	**3.31**
Binge Drinking (HS)	8.2	11.4	8.6	9.5	8.1	8.6	9.1	8.2	8.8	8.5	1.07
Alcohol Impared Death (Driving) /100,000	3.8	6.4	4.5	6.0*	10.3	4	5.8	1.4	1.7	1.6	**3.74**

https://www.maine.gov/dhhs/mecdc/phdata/MaineCHNA/final-CHNA-reports.shtml

These average rates and differences are weighted based on populations of 33.8% metro, 35.9% large rural, 24.3% small rural, and 6.0% isolated rural residents of Maine and come from the *Maine Shared Community Health Needs Assessment* www.mainechna.org

If you are interested in health disparities between the US and other first nations you can find them in the Commonwealth Fund report. *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes*

https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022



Rural vs Urban Uninsured

An Example of an In-State Program to increase the number of primary care physicians in rural Maine:

Thomas Jefferson University developed the PSAP in 1974. The Physician Shortage Area Program (PSAP) is an admissions and educational program designed to increase the supply and retention of physicians in rural areas and small towns, with a focus on Primary Care doctors for Pennsylvania and Delaware. The Program recruits, trains and supports medical students who have grown up or spent a substantial part of their lives in a rural area or small towns.

MEHAF https://mehaf.org/wp-content/uploads/2022_BRFSS-Rural-Brief_FINAL.pdf

https://maps.healthlandscape.org/

Health in Maine: Rurality
https://www.maine.gov/dhhs/mecdc/phdata/MaineCHNA/documents/Rurality%20HE%20Data%20Sheet%206.27.2022.pdf

Assessing the Costs and Impacts of a State-Level Universal Health Care System in Maine, by James Myall, Policy Analyst
www.maineallcare.org/fiscal-study-2019/

For more information about rural health, contact: carylheaton@gmail.com Phone: 207-669-0219

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www.healthcareforallmaine.org / www.maineallcare.org

Health Care: What Do People Need?

The simplest answer is, we all need health care at some point in our lives. It isn't optional, or a luxury, or a privilege.

What people experience all too often in our current system:

Stress and confusion about medical bills, what's covered and not covered, whether a doctor or hospital is in or out of network. Medical bills that drain savings and the ability to pay for other important things, and even cause bankruptcies. Not knowing how they will pay for care if something bad happens, even if they have insurance. Not knowing how much health insurance will cost from year to year. Ever-higher deductibles to make monthly premiums more affordable. Insurance companies denying claims for care that providers prescribe.

"*Eamon needed to be in the hospital after he was born, and we shouldn't have had this hanging over our heads. Why was this so stressful and confusing?*"

–Evelyn Roach, Portland Press Herald, Aug. 2022
Full article

BREAKING

Most Americans Worry About Accessing Health Care, Poll Finds

Full article

What people really need:

Access to health care when we need it. Freedom to choose providers, and to make health care decisions with those providers. Health care that's affordable. To be able to focus on care rather than medical bills, insurance plans, etc.

"...having a choice of health care providers matters more to people than having a choice of health plans."

–Jeanne Lambrew, Commonwealth Fund, 2005
Full article

In a survey of Maine residents conducted by Maine AllCare in 2019, more than 80% said they would strongly or slightly support “a national improved and expanded Medicare for All health care system.” A similar number (81%), said they would support “a publicly funded health care system that covered everyone in Maine” if the federal government was “unable to pass universal health care coverage.”

Maine AllCare Health Care Survey (2019)

“We need universal health care, now.”

Pam Gross
"A Community that Cares"
https://www.youtube.com/watch?v=oKA-VHp-eCU

Imagine:

Everyone has health care. Crippling **medical debt and medical bankruptcies disappear**. **Maine towns and cities** can apply funds, time, and other resources now spent on health insurance toward pressing needs such as infrastructure maintenance, economic development, and preparing for climate change impacts. **Businesses** can focus on innovation and investment rather than providing health insurance to their employees. **Workers** are free to choose employment based on their interests and skills rather than being locked in a job for health insurance. **Entrepreneurs** are free to create new businesses without worrying about how they’ll provide health care for themselves, their families, and their employees. With a **simpler, more efficient system**, it's more feasible to **plan for and contain costs**.

The obstacles are not economic or medical, they're political

Many studies have shown that universal health care systems can save money and increase value. A Maine Center for Economic Policy study in 2019 outlined one model for how universal health care could work in Maine, finding that the state could save more than $1 billion, most people, by far, would pay less than they do now, and everyone would be covered.

MECEP fiscal study

Questions? Thoughts? Ideas?
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Health Care: The Way Forward

Where we've been

We've tried...

Market-based health care solutions, for decades.

Many different arrangements for organizing, providing, and paying for health care (PPOs, HMOs, MCOs, ACOs, tiered networks, high-deductible health plans plus health savings accounts, and on and on).

Reining in the costs of prescription drugs (nationally and in Maine).

Making sure that children, the elderly, and those with certain health conditions have access to health care (Medicare and Medicaid).

Mandating that people have health insurance, often purchased through the existing health insurance industry (ACA).

Making health care pricing more transparent so that, in theory, people could shop for the care they need.

Where we are

We spend more on care and drugs yet have poorer health outcomes and don't cover everyone.

More than 100 million people in the U.S. have medical debt, and close to 40% of Americans say they have put off medical care due to cost.

Health care providers are burning out, hitting rural areas especially hard.

Costs continue to rise steeply, hurting individuals and families, municipalities, businesses, and society as a whole.

8.3% of Americans (5.7% in Maine) remain uninsured. Many more are underinsured and can't get the care they need.

> *"All around the world, you see heavy government involvement in health care. There's a reason for this. The market will not deliver universal, affordable health care on its own."*
>
> –Economist Mark Thoma, CBS MoneyWatch, 2017

Time for a different approach

A publicly funded, privately delivered, universal health care system that includes everyone.

This system would dramatically reduce complexity and administrative burden, and promote health care as a public good that's essential for a healthy democratic society—like schools, roads, and fire departments.

Will it be easy to implement fundamental change to our health care system? No.

But staying on our current path will not be easy, either.

Systemic change is possible, if we can find the political will and build the cultural momentum. And if we work together.

What can Maine legislators do?

- Pass LD 590 to establish a constitutional right to health care
- Create a Joint Select Committee on Health Care Costs as a step toward creating a new system
- Build a health care caucus (we're here to help!)

Imagine:

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MECEP fiscal study

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Sources: NPR (3/7/23); Gallup (1/17/23); Maine.gov (9/19/22); Peterson Foundation (11/17/22)

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The Way Forward: 12 Steps to a Unified Payer System for Maine

A presentation for Maine legislators, March 16, 2023, by Les Fossel, Alna, Maine

Les Fossel's Background

* Award winning contractor since 1975 with 15 employees with 160+ years of combined experience.
* Board Member, Lincoln Health.
* Board Chair, Eldercare Network of Lincoln County.
* Board Member, Lincoln County Dental.
* Health insurance underwriter & Heart Association Chapter Executive Director (before 1975).
* Legislative Service:
  - GOP Maine House Member 2008 to 2012.
  - Rated by MERI as one of the most fiscally conservative Legislators.
  - Health & Human Services, Government Oversight, Insurance & Financial Services, Judiciary Comms.
  - Joint Select Committee on Healthcare Reform (2010)

Twelve Steps

1. **Pass a Constitutional amendment making Healthcare a Right in Maine**.

This is what we believe, so let's say so. Our Constitution already comes close to considering it a right:

PREAMBLE.

Objects of government. *We the people of Maine, in order to establish justice, insure tranquility, provide for our mutual defense, promote our common welfare, and secure to ourselves and our posterity the blessings of liberty, acknowledging with grateful hearts the goodness of the Sovereign Ruler of the Universe in affording us an opportunity, so favorable to the design; and, imploring God's aid and direction in its accomplishment, do agree to form ourselves into a free and independent State, by the style and title of the State of Maine and do ordain and establish the following Constitution for the government of the same.*

Article I.

Declaration of Rights.

Section 1. Natural rights. *All people are born equally free and independent, and have certain natural, inherent and unalienable rights, among which are those of enjoying and defending life and liberty, acquiring, possessing and protecting property, and of pursuing and obtaining safety and happiness.*

2. **Accept that markets fail in healthcare because we do not choose providers on a cost basis.**

It is insanity to repeatedly do the same thing, get the same result, yet expect a different result.

3. **Create a Joint select Committee on Healthcare Costs**

The Legislature must set the agenda for the Office of Affordable Healthcare if we expect timely results.

4. **Standardize coverage, policy language, applications, claim forms, deductibles, payments, etc.**

We spend too much on overhead and too little on treatment. Colt standardized firearms 180 years ago. Ford standardized autos 110 years ago. We standardized almost all other forms of insurance decades ago. This lowered costs and improved quality, but none of these organizations were driven out of business.

5. **Develop a Unified Payer System**

This is what all other developed countries do. It clearly works, so we must consider it among our options.

6. **Limit combined overhead charges for healthcare providers and insurers to 20% (or less) of the total costs.** Mandate a reduction in overhead every hear. My business charges 15% for overhead & profit combined. Too much of our government and private entities spend 50% on overhead. This must stop if we are ever to earn the respect and meet the needs of our citizens.

7. **Get Mainecare to pay the real cost of care for hospitals, dentists, long term care homes, etc**.

We cost shift to insurance companies, private payers, and the uninsured. Mainecare doesn't come close to covering costs. Mainecare payments must match Medicare. The current situation is a hidden tax on Mainers.

8. **Fund public health**

Prevention is cheaper than treatment. Historically, prevention is primarily responsible for improvements in both the length and quality of life. Other developed countries spend an average of 2/3rds of their healthcare dollar on prevention, and their overall costs are 1/2 ours - yet their citizens live an average of 5 years longer. As Covid proved, many of our local healthcare systems are good at public health and want to do it.

9. **Require every worker be covered by Workers Comp & Unemployment Comp**

If you are unable to work because of a job-related injury and have neither WC nor UC, then you are at risk for bankruptcy. We have a huge number of "independent contractors" who have no insurance. I pay about 14% of my payroll for WC/UC. My "independent contractor" competitors pay nothing. When those workers get hurt or laid off, the rest of us pay for them.

10. **Use the MEMIC Worker's Comp model to for a more robust version of Community Health Options**

MEMIC has lowered costs and improved outcomes without government or politics - we can do the same for healthcare. Switzerland and Germany both have private health insurance carriers and 50% lower costs.

11. **Mandate Insurers pay interest at the highest allowable rate for late claims payments**

Insurance companies invest premium dollars. Delaying claim payments adds to their profits.

12. **Create tax incentives for medical trials in Maine**

This is a business incubator that can bring cutting edge treatments here 1st. There are treatments on the horizon that will lower healthcare costs. Maine should be 1st in line to benefit. With Jackson Labs, the Roux

Institute, proximity to Boston's medical infrastructure, hospitals rated the best in the US, the oldest population, and a very high quality of life, we are in a good position to attract such trials here.

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References

MAINE'S HEALTH COSTS:

* 3rd highest cost per capita in America (& the world) @ **$14,041**
* Largest share of the economy in the world @ **22%**,
* Increasing much faster than economic growth and inflation combined @ **5.8%.**

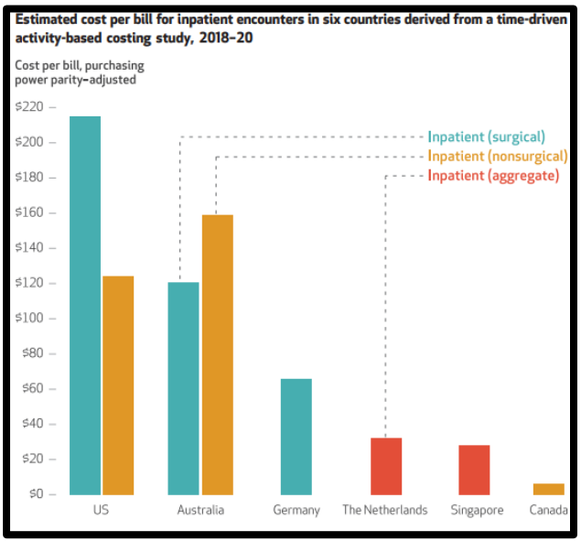
MAINE'S INCOME - *versus other states:*

* 30th in family income,
* 35th in per capita income,
* 44th in wage income.

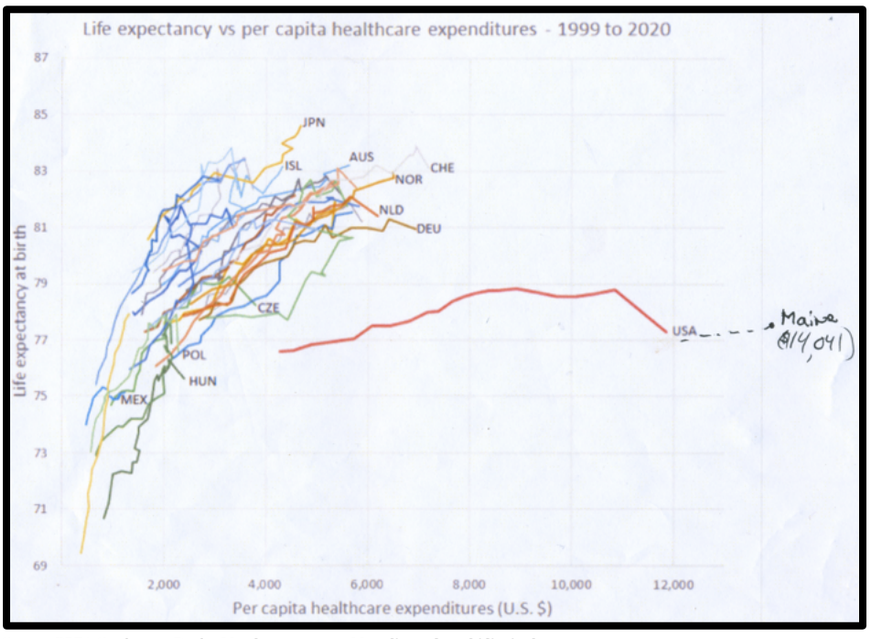
OUR COMPETITION – *the Swiss example:*

* A completely private healthcare system,
* A 5 year longer average lifespan,
* 1/2 Maine's costs - 11% of their economy,
* Rated the world's most competitive economy.

Sources: The Kaiser Family Foundation, Me. Dept. of HHS and *The Healing of America.*



Source: HEALTH AFFAIRS 41, NO. 8 (2022): 1098–1106



Source: BPEA Conference Drafts, March 23–24, 2017 Mortality and morbidity in the 21st century
Anne Case, Princeton University Angus Deaton, Princeton University

Maine ALLCare

December 2019

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

In 2018, 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-level public plan. The results of the study[i] show that total yearly health care 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 health care providers and hospitals.

How would a new public plan work?

MECEP 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.

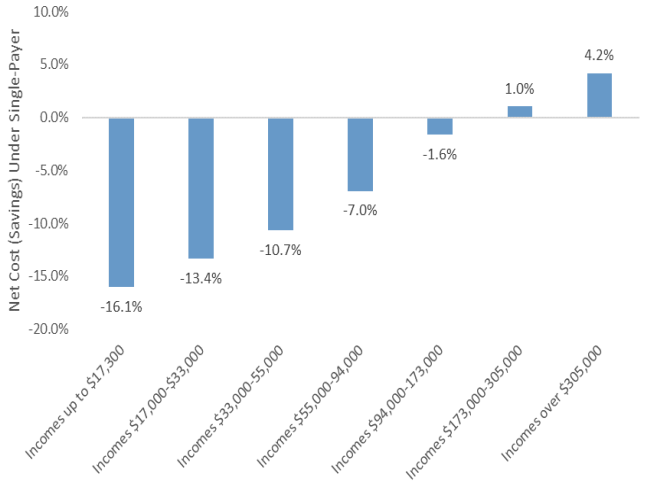
Impacts of a new public plan

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.

Most Maine residents would save money:

(See page 3 for real examples)



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% of FPL or above – 7.5% of AGI
- Families above $150,000 pay full premium

FPL: Federal Poverty Level ($12,490) AGI: Adjusted Gross Income
Full annual 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 over $214 million, or 8.4% of current property tax, equivalent to a property tax reduction of 1.5 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 they do now, 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 10 employees – 3% of payroll
- 10-99 employees – 4.5% of payroll
- 100-499 employees - 8% of 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 health insurance for employees; and simplified "billing and insurance" would offset reduced private insurance payments.

Jobs and economic impacts

MECEP estimates that under a public model for Maine, there would be 2,931 fewer administrative jobs in hospitals, doctors' offices, and businesses when administrative complexity is greatly simplified. Wage replacement and retraining costs are taken into consideration in the report. 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 2018, the average premium for an employee on an individual plan 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 an individual plan increased from $1,100 to $1,461.
- The average annual employer contribution for 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 fell from 73% to 61%.

Health care 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 2018 because of costs, compared to one in ten in 2006.

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 health care 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 administrative savings, including the elimination of private insurance administrative costs, marketing, and profit.

How do 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.

Conclusions

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

Real examples of health care costs drawn from a 2019 survey[ii] of Maine families:

Family Size	Income	Current costs	% of income	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%	$2,500	6.3%
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 (SS)	$3,200	12.3%	$1,250	4.3%

A single mother, 38, earning $10,000/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, for a total cost of 2% of annual income. Their net savings would be $1,040.

Lower-middle-class family with one child, earning $40,000/year from a 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, or 16% of annual income.

Under the public plan model, premiums are 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. The 3% payroll tax minus the reduced workman's compensation costs $1,000 a year. They would pay 6.2% of annual income with a net savings of $2,500.

Upper-middle-income family, earning $75,000/year, with employer insurance:

Two parents with one child are 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/year, 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/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/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, earning $25,000/year from Social Security:

Both are enrolled in Medicare and they purchase a Medigap 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 a Medigap 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. Net savings would be $1,950.

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[i] MECEP Fiscal Study Report (2019): https://maineallcare.org/fiscal-study-2019/

[ii] Maine AllCare Health Care Survey (2019): https://maineallcare.org/healthcare-survey-2019/

Maine ALLCare
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