September 24, 2024

Ms. Garratt-Reed:

My name is Tom Sterne, MD, M. Sc., and I am the Board Chair for Maine AllCare. What follows is my testimony for this year's annual meeting of the Office of Affordable Healthcare.

Several of my colleagues have submitted papers attesting to the gravity of the problem with our current system (if one can even call it a "system") of healthcare financing, and have suggested overarching plans to address the issues of access and affordability.

I fully agree with and support their approaches, but can likewise acknowledge the enormity of this task politically. I suggest in this paper that there may be a more incremental approach which would generate less opposition, but that still supports and can lead to eventual universal coverage in as close to possible a single public payer model, and that advances the mission of affordability.

Currently, many Mainers receive healthcare coverage in the marketplace via the benefits bestowed by the Affordable Care Act. While significant costs still remain in the form of premiums and deductibles, there exist substantial subsidies to decrease premiums through subsidy programs. These were augmented by the passage of the Inflation Reduction Act, which provides additional supports that will expire, barring the passage of renewed federal legislation, in 2025. Premium payments will by 2026 dramatically increase without Congressional passage of an extension of the ACA subsidy structure. Individuals and families earning greater than 400% of the federal poverty level (FPL) would see a doubling of their premiums, at least in the 12 states which use Healthcare.gov as their clearinghouse (estimates provided by the Kaiser Family Foundation). The KFF estimates that if enhanced benefits expire, families at 166% FPL would experience a 573% increase in premium payments, approximately $917 annually.
The additional federal cost of a subsidy extension is estimated by the CBO to cost $325 billion over the next 10 years. Moreover, we cannot know who will control the US Congress after the current election, and where their appetite for continued spending will reside.

A feasible approach to this problem would be for Maine to pass legislation changing the eligibility requirements for Maine Medicaid. As we know, Medicaid costs are shared between the State and the federal government, with the State responsible for about one third of the expense. Income eligibility varies from state to state; currently Washington, D.C. has a more generous program with eligibility up to 200% of FPL. for example. To the best of my knowledge, there are no legal barriers to the state for such an enactment, the cost for which would be disproportionately born at a federal level. The effect, depending on the level of eligibility chosen, would be to increase the population of covered individuals by 97,000 if increased to 200% FPL or 259,000 if up to 400%. Moreover, the administrative costs for administration of the Medicaid program in Maine are significantly lower than those of commercial insurers. I include a table compiled by the Maine Center for Economic Policy showing the impacts of expanding Medicaid for the State.

Table 1: Impacts of further expanding Medicaid for select populations	Total population	Currently enrolled	Additional enrollment at DC levels	Additional enrollment at higher eligibility level
Group				
Parents (21-64)	221,000	59,000	12,000	33,000
Nonparents (21-64)	507,000	92,000	40,000	77,000
Children (0-18)	266,000	118,000	28,000	39,000
Young adults (19-20)	32,000	1,600	16,000	13,000
Other eligibility groups	n/a	124,000	0	0
Total	1,025,000	395,000	97,000	162,000

Author's calculation using US Census Bureau, Current Population Survey, Annual Social and Economic Supplement for 2021 and 2022. Current enrollment numbers derived from Maine DHHS data for June 2023. "DC levels" represent eligibility at 221 percent of the federal poverty level for parents, 215 percent of FPL for nonparents, and 324 percent of FPL for children and young adults. "Higher eligibility level" represents eligibility at 321 percent FPL for parents, 315 percent of FPL for nonparents, and 424 percent FPL for children and young adults. "Other groups" includes those who qualify due to a disability, those over 65, and those who are eligible for partial coverage like those in the Medicare Savings Plan or Drugs for the Elderly program. Numbers may not sum due to rounding.

This change in coverage options would have the effect of putting aside concerns about changes in Federal ACA support, as mentioned above. Contributions from families with these higher incomes could be established on a progressive scale based on income, akin to the system in the ACA. Because there are no deductibles and minimal co-pays in the Medicaid system, out of pocket payments which currently serve as barriers to seeking early and up-front care would be eliminated, with significant down-stream positive effects on disease prevention.

Because providers would see a net loss in revenue with such an expansion, new rates would have to be set, perhaps at Medicare levels, to offset this decrease. The final cost to the State would have to be calculated, but lower costs for many individuals will surely be the outcome.

Medicaid is a popular, cost effective and long-standing program. The federal government bears much of its expense. Its benefits package is robust. Using it as a base for gradual movement towards universal publicly funded care can be a sound and feasible way of providing for all of us.

Thank you for your consideration.

Tom Sterne, MD