Written Testimony for the Office of Affordable Health Care Annual Hearing

September 29, 2025

Daniel C. Bryant , M.D.

Thank you for this opportunity to testify. I am a retired physician, a supporter of the non-profit advocacy group Maine AllCare, a co-author of the original drafts of the two bills referenced below; and would like to focus my testimony on the challenge of controlling health care costs—all relating to the potential for publicly funded universal health care reform to do that—in three ways: 1) commenting on the Maine Bureau of Insurance's August 15 "Public Forum Regarding 2026 Proposed Health Insurance Rates for the Individual and Small Group Market," a version of which I am submitting to the Bangor Daily news with the help of Scholars Strategy Network; 2) responding to some of the excellent points Executive Director Meg Garratt-Reed made at the May 14, 2025, Health Care, Insurance and Financial Services Committee hearing in opposition to LDs 1883, An Act to Enact the All Maine Health Act and 1269, Resolve, to Study the Costs and Funding of a Universal Health Care Plan for Maine; and 3) citing my recent *Maine Policy Review* paper on the cost of health care in different coverage scenarios.

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1) At the Maine Bureau of Insurance's August 15 Forum, Maine's five health insurance companies (Anthem, Community Health Options, Taro/Mending, United Health Care, Harvard Pilgrim) discussed the cost drivers leading them to request increases in premium rates of up to 20 to 30% (18 to 24% approved September 2). Following their presentations, thirty-nine members of the public commented on their experiences with health insurance (133 had registered to do so), describing their difficulties paying for health care and suggesting ideas for controlling costs such as bringing stakeholders together, relying on high-deductible plans, and standardizing prices. Insurance Commissioner Carey argued for extending the premium tax credits that are due to expire in December, though those apply to only 4% of Maine's population.

What is needed to protect Mainers from increasing health care costs, however, is not tweaks to the commercial health care system that has evolved since the 1940s in response to market forces but an overhaul of the entire health care system. One such reform, at the state level, would be replacement of the current system with a publicly funded one that covers everyone and is still privately and publicly provided. An example of this in Maine is the recently introduced LD 1883, An Act to Enact the All Maine Health Act, based on a plan developed by Maine AllCare. Though for various reasons (which I have discussed elsewhere) the bill did not make it out of committee, it does contain provisions that would lead to control of six of the nine cost drivers identified by the insurers and bulleted below. Three of the drivers—inflation, reduced federal funding, and tariffs—would remain beyond the control of any state plan.

A. Increased provider (hospital, professional) charges reflecting their costs. Providers' billing costs make up a large part of their administrative costs and could be reduced by a third to a half in a simplified one-payer system. Staff and professional health benefits, bad debt, and charity

care would be eliminated. Professional prices and hospital global prices would be negotiated, and by one payer rather than five separate payers.

B. Increasing severity of illness and utilization of care. With universal coverage and no postponement of care due to cost, illnesses would be diagnosed and treated earlier, lessening their severity and cost. And those with illnesses would pay according to their income, not the illnesses they're unfortunate enough to get.

C. Increased drug costs. One evidence-based formulary would be established, simplifying providers' time dealing with drug lists of multiple plans and allowing negotiation of standardized prices.

D. Reduced ACA and MaineCare eligibility, shifting costs to commercial insurers. With a unified system, these separate groups would no longer exist; risk would be spread over nearly the entire population.

E. Reduced Maine Guaranteed Access Reinsurance Association payments. A revised, more comprehensive reinsurance plan could be developed.

F. Insurer administrative cost increases. Just as state administrative costs for MaineCare are less than commercial administrative costs (up to 20% of premiums charged), they would be less for a public plan. Though not mentioned specifically by the insurers, three of them are for-profit corporations obliged to maintain profit margins appealing to their investors. Public plans do not have profit margins, only responsibilities to patients, providers, and taxpayers.

Though the Forum was an excellent one, the take-away should not be just that a lot of Mainers won't be able to afford the requested premium increases. It should be that, given the cost drivers identified by the insurers, we, with the help of the Office of Affordable Health Care, should be able to reform the system to control those drivers. As argued above, comprehensive reform along the lines of the publicly funded universal health care model could do just that. Advocates of other reforms should make their cases as well, including their strategies for cost control, so that the Legislature can choose among them and act before it's too late.

2) Following are responses to six of the arguments Ms. Garratt-Reed made in opposition to LDs 1883 and 1269:

A. "… while some administrative savings may be available for public plans which remove insurer profit motive, reduce or eliminate the need for advertising and other administrative functions, and lessen provider administrative burden, those savings are likely to be more than offset by additional spending in a plan like the one contemplated in these bills, which includes

little or no utilization review, expands covered services, and increases provider reimbursement rates."

Though plan spending may be "likely" to exceed savings, this has not been demonstrated and should be before dismissing the proposal out of hand. As far as I know, the cost (to payers and providers) of extensive utilization review has not been proven to be less than the cost of denied care; the cost of expanded services (covering more of the population) may well be less than the savings from the putative reduced chronic care burden; professional provider reimbursement may be similar in toto, when reduced commercial rates are balanced against increased MaineCare rates in a setting of reduced provider costs as described in 1)A. above; and institutional provider reimbursement rates may be similar overall, and increases more controllable, if global budgets are implemented, again in a setting of reduced provider costs.

B. "… the proposed health plan would negotiate rates with providers and establish annual global budgets for hospitals, rather than setting rates administratively as Medicare and MaineCare currently do, removing one of the most significant sources of administrative efficiency within those programs."

Negotiating rates with providers based on their costs and the needs of most of the population, as opposed to setting rates for providers based on attitudes toward subgroups of the population, would allow rates to reflect actual, agreed upon costs of care, plus reasonable margins.

C. "Congress would need to pass legislation to drastically alter the authority of the Secretary in order to permit the kind of waiver process envisioned in this bill, as well as creating pathways for numerous other waivers of federal tax and commerce laws. The possibility of such action is highly unlikely in the current environment."

These legislative concerns are very real and are the reason why the 2022 universal health care bill (LD 1045) was severely amended to formation of a board and only if such federal action was taken. However, it is possible that increasing popular dissatisfaction with our current health care system and with some of the administrative and legislative restrictions on it, could lead to political change and passage of the State Based Universal Health Care Act or its ilk. In addition, as far as I know, no state has made applications for "the kind of waiver process envisioned in this bill," meaning we don't know for sure what the Secretary's response or what any legal fallout might be. In either case, were legislation like LD 1883, containing specific provisions and its own contingency clause, to be passed, having it on the books could be to the state's advantage.

D. "In light of these looming challenges, now is not the time to divert the limited resources of agency staff to the kind of collaboration on data access and subject matter expertise which would be necessary for our Office to fulfill the requirements of either of these bills."

It is understandable that the Office does not have the expertise, manpower, or funds to do the sort of fiscal analyses required by these bills but the Office is charged with "Monitor [ing] the adoption of alternative payment methods in this State and other states that foster innovative health care delivery and payment models to reduce health care cost growth and improve the quality of health care…." It would seem that money (estimated to be $400 to 500 thousand dollars) could be found in the Legislature or through private grants to contract for a project so consistent with the Office's charge and the state's needs.

E. "… As I've shared with this committee in the past, we have worked hard with our Advisory Council to identify policy priorities and begin developing ambitious but achievable solutions that can deliver results for Maine people…."

These priorities and solutions are often indeed reasonable in themselves, but in complex systems adjusting one component often affects other components (butterfly effect). For example, increasing eligibility for MaineCare was discussed in the 2/5/25 Advisory Council meeting. This reform (part of MECEP's recent fiscal analysis) would help some individuals but would not achieve significant administrative savings; would impose new costs on the federal government, commercial insurers, and Maine taxpayers; would further stress the primary care workforce; and would likely threaten finances of hospitals, which would be caring for increased proportions of poorly-reimbursed MaineCare patients. Only a unified, publicly funded system could coordinate all these inter-related components.

F. "… We would ask that you allow us to continue focus on making progress on those priorities, rather than requiring additional studies of a policy concept that has no realistic path to implementation and which would likely be outdated or irrelevant in the event that a future opportunity for greater collaboration with the federal government were to arise."

Only by doing "additional studies of a policy concept" (e.g. LD 1269) would we know whether, economically, there is a "realistic path to implementation" or not. Rather than waiting for the Godot of "a future opportunity for greater collaboration with the federal government" we should do all we can to pursue such collaboration now.

3) "The Cost of Health Care in Maine: "It All Depends"." *Maine Policy Review* 34.1 (2025), https://digitalcommons.library.umaine.edu/mpr/vol34/iss1/4.

Abstract: When policymakers consider reform of Maine's healthcare system to reduce costs for Maine residents, it is important for them to compare those residents' total costs in the reform proposed with their current total costs. The latter include both hidden costs, which I addressed in a previous commentary, and apparent costs, which I address here. Using the same example of a hypothetical 30-year-old Maine resident, I examine the total apparent costs that individual might bear for a range of healthcare expenses in six different healthcare coverage options: no insurance (self-pay), commercial insurance obtained through the Maine Health Insurance Marketplace, two instances of a workplace health benefit, and two of a state-based, publicly funded, universal

healthcare plan (single payer). I conclude that Mainers' healthcare costs vary greatly with the type of coverage they have and that when these costs exceed $1,500 to $2,000 a year, the single-payer model would cost this hypothetical Maine resident, and presumably many other Mainers, less than they pay now regardless of their current type of coverage.