Testimony for the Office of Affordable Healthcare annual hearing
September 29, 2025

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As most of you already know, Maine AllCare, established in 2010, has been tirelessly advocating for a publicly-funded healthcare system for everyone in Maine.

Mainers currently spend about $18.5 billion annually on health care spending, yet at least 6% are uninsured and many more forgo care due to cost, despite having health insurance. This situation is going to get much worse. Thousands of Maine people are losing Medicaid[1], thousands more are likely to become uninsured when premium subsidies end. Still more are facing eye-popping double digit increases in their insurance premiums, and many families may decide to go uninsured. Almost half of Maine households surveyed[2] incurred medical debt in the past two years. A large majority – two out of three – had health insurance at the time.This is a sad and dramatic illustration of the many thousands of Maine people who are UNDERINSURED: who struggle to afford the costs of their insurance premiums and the high out-of-pocket expenses for medical care and prescriptions even though they have health insurance.

I am a psychiatrist. I have practiced psychiatry in Maine for almost 40 years, in a variety of settings: hospital inpatient units, private practice, community health centers, crisis units, nursing homes. Here in Maine, most of my colleagues in private practice are unable or unwilling to accept insurance. This limits access and increases out of pocket costs for patients who need a psychiatrist, but can't find someone who accepts insurance. Many will go without treatment.

Here's a post on Quora from a psychiatrist colleague: "For traditional medication evaluations and follow ups, insurance companies reimburse about 1/3 to 1/2 the going rate. When I said that the rates didn't make sense for a thirty minute appointment, they told me to see five or six patients per hour to make up for it. I said I couldn't do that, and they said that was fine with them. So I asked them why I should sign up with them, and they had no idea, so I never did…Contracting with insurance companies is incredibly complex, no confidentiality, they only pay for a few psychotherapy sessions, and it involves non medical people taking part in the physician patient relationship. For all of my patients who have insurance, I provide a detailed receipt, which they file for reimbursement. I hope that helps explain why I'm not contracted with insurance companies. It's not a political statement, it just didn't make any sense for me or my patients."

My colleagues often spend hours each week, wasting valuable clinical time fighting with insurance companies for payments they are owed, or waiting for prior authorizations. All of these issues limit the time that they could otherwise spend doing clinical work. Both MaineCare and private insurance rates for individual practitioners are outpaced by the rising costs of running a

[1] https://healthcareuncovered.substack.com/p/when-washington-hands-out-lemons Copy appended to testimony
[2] https://mainecahc.org/advocacy/expanding-access-affordability.html

practice, costs that include not just rent and electricity bills, but the costs of maintenance of certification, licensure and liability insurance, and the costs of tracking down insurance company payments.

Here's an email I received just last week from a colleague of mine: "I have recently received recoupment requests from an insurance company, which I have never experienced before. They simply state that certain claims were paid at the "wrong rate" and they want to be paid back the entire amount. If I don't send them a check or an appeal, they will simply deduct what they think they are owed from future claims. I wonder if the insurance company has subcontracted with some company that uses AI to reject claims, because all of the claims in question were clean, valid and timely filed."

Also, many of my colleagues in solo private practice are facing problems with the cost of their own health insurance coverage. Here's a Facebook post from a Portland colleague from July: "Anyone else considering voluntarily foregoing health insurance this coming year? I thought about it the past two years, but this coming enrollment I'm seriously considering it again. I pay $20k in premiums before I then get to build up a $14k deductible to THEN get benefits. That's $34k a year paid BEFORE I actually get coverage for a healthy 8 year-old and myself before seeing any benefit. If I put that into a savings account, I'd have $100k in three years. I have tried to think about my insurance as a catastrophic plan insurance policy, but being trapped in this farce just feels increasingly ridiculous. AND premiums are going up…"

When incremental reforms are implemented, insurance companies, pharmacy benefit managers and large hospital entities will always find a way to work the system to their advantage. In 2024, Congress passed legislation to limit copays for 10 expensive drugs, including insulin. The costs for other drugs skyrocketed. A personal example: my husband's asthma inhaler co-pay increased from $40 to over $200. If their premium increases are limited, insurance companies respond by reducing coverage, and increasing co-pays, deductibles and out of pocket maximums. This happened last year with both my health insurance and my long term care insurance. Hospitals respond by reducing staffing levels and cutting or closing unprofitable programs. Maine AllCare has been keeping a list of closures in 2025. A list appears at the end of this testimony.

As if that is not bad enough, we are revisiting another moment where the biggest insurer and one of the biggest hospital systems in the state are at loggerheads, with the potential to disrupt healthcare for thousands more Mainers.

On behalf of Maine AllCare, I pose this question: why do we have healthcare networks at all?

The answer: Because healthcare networks are one way that insurers can limit the amount of money they pay out, to maximize profits. As for-profit corporations, this is what they are chartered to do. It is a failure of public policy that permits profit-driven companies to control so much of the healthcare system. The United States is the only developed country in the world to do so. It is time to rethink our priorities and our values. It's time to declare our decades-long experiment with market-driven, for-profit healthcare a failure.

This is why Maine AllCare and our many volunteers urge that we fundamentally change the rules of the game so that patients get high-quality care they can afford, physicians can focus on practicing medicine, and our state is not burdened by uncontrolled healthcare costs.

We at Maine AllCare advocate a universal program—everybody in, nobody out—for the whole state that would eliminate this kind of negotiation that puts Anthem's customers at risk. Everyone would be in the program, with no deductibles and no networks. We would all pay fees according to our incomes and receive care when we need it—the way other developed countries do with their humane and popular country-wide healthcare systems.

Maine AllCare has commissioned two recent analyses by the Maine Center for Economic Policy - in 2019[3] and in 2024[4]. Based on these studies, we at Maine AllCare KNOW that a universal, publicly-funded health care system remains fiscally feasible. The 2024 study showed that a universal system that expands coverage and benefits for all Mainers could cost between $17.8-19.3 billion, depending on the extent of coverage and benefits, while providing fiscal stability for health care providers through a streamlined payment system.

The money to fund a universal health care program in Maine is already in the system. It includes the taxes we already pay to fund Medicare, Medicaid and the VA, our taxes which pay for the health insurance for our teachers, and our state and municipal employees. It includes our costly private insurance premiums, and our often bank-breaking out-of-pocket payments.[5]

Unfortunately, the money we currently pay into our healthcare system is just not being used efficiently. Our publicly financed programs such as MaineCare and traditional Medicare are very efficient, with administrative overheads of between 3 and 6 percent compared to 17 percent for private insurance.

By eliminating administrative waste, eliminating administrative complexity and expense (think of billing and collections, advertising, doctors time wasted on prior authorizations, to name just a few), by negotiating ALL prescription drug prices for the entire state population, and by simplifying the payment system and eliminating the need for the for-profit middleman, **the money saved could be used to provide more and better care to all residents for about the same money we currently spend**.

Unfortunately the Health Coverage Insurance and Financial Services committee voted ONTP on a study of the cost of universal healthcare in Maine, although the HCIFS Committee did direct this office (OAHC) to "review prior studies and develop recommendations for potential policy options for the committee's consideration."

Maine must refuse to stand by while healthcare cuts, program and hospital closures, and higher healthcare insurance premiums push Mainers off of their healthcare and put Maine lives at risk.

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[3] MECEP fiscal study 2019: https://maineallcare.org/fiscal-study-2019/

[4]https://maineallcare.org/wp-content/uploads/2025/03/2024-MECEP-Report_Executive-Summary_March_-2025.pdf Copy appended to this testimony.

[5]https://www.kff.org/health-policy-101-health-care-costs-and-affordability/?entry=table-of-contents-introduction

Maine AllCare believes that it is critical that Maine leaders examine the cost drivers within their control[6] and move forward to implement universal healthcare now, providing comprehensive healthcare for all Mainers and securing our hospitals with a single payer.

*List of 2025 Medical Closures

Medical Center/Unit	Town	Month of Closure
Waldo Hospital Labor and Delivery Unit	Belfast	April
Houlton Regional Hospital Maternity Unit	Houlton	May
Inland Hospital (including labor and delivery)	Waterville	May
Community Clinical Services (school clinics, a pediatric dentist office, and psychiatric and counseling services)	Lewiston	May
Edmund N. Ervin Pediatric Center (EEPC) the only multidisciplinary diagnostic center north of Boston for children with developmental disabilities and complex behavioral health disorders	Augusta	May
MDI Hospital Birthing Unit	Bar Harbor	July
DFD Russell Medical Center, primary care	Bridgton	August
Northern Light Walk In Clinic	Bangor	September
Manchester Care (CMMC), primary care	Manchester	September
Aurora Healthcare, primary care	Fairfield	December

Appended to this testimony:

1. Executive Summary of the 2024 MECEP Fiscal Analysis on Universal Healthcare for Maine
2. An essay by Rachel Madley is appended to this testimony: When Washington Hands Out Lemons: How States Can Cushion Medicaid Cuts.
3. Maine AllCare responds to the reasons behind rising rates for health insurance premiums in Maine

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6 https://maineallcare.org/maine-allcare-responds-to-the-reasons-behind-rising-rates-for-health-insurance-premiums-in-maine/ Copy of statement appended to this testimony

Maine ALLCare

March 2025

A Fiscal Analysis on Universal Health Care for Maine: **Executive Summary**

Overview

This brief summarizes a study that analyzed the cost impact of implementing a universal health care system in Maine [see full report here].

Mainers currently pay $18.5 billion annually on health care spending, yet at least 6% are uninsured and many more forgo care due to cost. A universal system that expands coverage and benefits for all Mainers could cost between $17.8-19.3 billion, while providing fiscal stability for health care providers through a streamlined payment system.

Background

In 2018, Maine AllCare (MAC) contracted with the Maine Center for Economic Policy (MECEP) to conduct a study of the costs and economic impacts of a health care model that would cover all Maine residents through a state-level public plan. Published in 2019, the results showed that even with an ample benefits package which included eye, ear and dental care, total yearly healthcare spending could decrease, bringing significant benefits and stability to residents, towns and employers, and health care providers.

Since then, the Covid-19 pandemic demonstrated the shortfalls of our current fractured health care system, which left many without adequate access to care or with unaffordable insurance coverage. Despite increased access to Medicaid coverage, 90,000 Mainers went without health insurance in 2022, and thousands with health insurance reported having to delay or forgo medical visits due to high deductibles and co-payments. The assassination of a health insurance company executive in December 2024 sparked public outrage over systematic claims delays and denials by for-profit corporations.

In 2023, MAC once again commissioned MECEP to reassess the costs and impact of a universal healthcare system in Maine. Completed in August 2024, we summarize its findings here.

Core Principles of a Universal Health Plan

UNIVERSALITY: as far as practicable, all Mainers should be included in the public plan

EFFICIENCY: waste and complicated administration should be reduced

SIMPLICITY: the plan should be easy for Mainers to understand and use

Key Findings

ASSUMPTIONS

The new plan would cover all Mainers:

- It would be the primary source of coverage for those who currently have employer-based or individual plans (e.g., purchased on Maine's health insurance marketplace).
- It would fill coverage gaps for those on Medicare, Medicaid (MaineCare), the VA, Tricare and Indian Health.
- It would cover the uninsured.

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 coinsurance or deductibles and minimal, if any, co-pays.

The new plan would reimburse providers and hospitals at Medicare rates.

HOW MUCH WILL IT COST?

MECEP estimates that Maine's current total health spending (including administrative costs) is approximately $18.5 billion annually. The cost of a new insurance model ranges between $17.8 and $19.3 billion. This would include the expanded benefits without significant out-of-pocket payments. MECEP's analysis takes into consideration the likely increase in healthcare spending with increased demand based on better access and benefits, AND on the significant drop in administrative costs to be expected with the consolidation and efficiencies gained by having a single central payer.

HOW WOULD MAINE PAY FOR IT?

A significant portion of care is already covered by federal funds coming to Maine in the form of payments for Medicaid, Medicare, the VA, and as federal subsidies via the Affordable Care Act (ACA). Currently, these programs pay approximately $10.6 billion. To reduce the total cost of a universal state program, it would be advisable to make use of these existing federal programs, by maximizing federal pass-through dollars from the ACA, and by potentially augmenting the federal contribution to Maine Medicaid care by raising the income eligibility level to up to 321% of the poverty level for adults, and 424% for children. In Maine, the federal government pays for 72.2% of Medicaid costs. Increasing this eligibility could bring up to $ 1 billion additional dollars to fund the MECEP model.

The remaining state share to raise through revenues would be $8 billion. A large portion of this would come from recapturing the funds currently paid as premiums by individuals, families and employers. The goal in covering the remaining expenses would be to :

- Continue to share costs between individuals and businesses, while no longer tying insurance to a particular job
- Ask those individuals and businesses with the greatest means to pay the highest rates
- Leave most Mainers and businesses paying less than under the current system

CONCLUSION

The MECEP analysis and model would require broad changes in how healthcare coverage is provided in Maine, but demonstrates financial feasibility of a public plan providing significant benefits to families, municipalities and employers while curtailing the wasteful spending on managing a currently complex and inadequate system.
It provides fiscal stability to health facilities and practitioners and eliminates the difficult choices many Mainers have when they are unable to afford necessary care and services.

Health Spending Estimates for Maine, in millions, 2023
See full report for details (pp 11-13)

		Public Plan	
	Current System	Estimate 1	Estimate 2
Health Care Spending	$ 17,149	$ 18,687	$ 17,118
Medicare	$ 3,780	$ 3,780	Current spending adjusted for increased demand, but with administartive savings, and lower prices
Medicaid	$ 3,670	$ 6,660	
Private Insurance	$ 4,860	$ 49	
Other	$ 4,839	$ 938	
New Public Plan	$ -	$ 7,260	
Net Cost of Insurance	$ 1,150	$ -	$ -
Public Administration	$ 238	$ 637	$ 637
TOTAL	$ 18,537	$ 19,324	$ 17,755

REAL LIFE EXAMPLES

A lower middle-class family with one child, earning $50,000 a year, currently on insurance purchased through the ACA marketplace, would save between $1,000 and $15,000 per year depending on their out-of-pocket spending given their current deductibles.

A two-person household earning $75,000 a year, with employer insurance that pays 75% of the premium, would save an average of $1,100 per year.

An older couple on traditional Medicare living on their Social Security payments would save approximately $7,400 annually.

Key Findings

The MECEP model would raise the remaining revenue by:

- Assessing a premium on individuals/families on a sliding scale with a cap of 8.5% of their income
- A payroll tax on businesses based on the number of employees they have, ensuring that larger firms pay a larger share of their income towards the tax, and keeping the cost to small businesses manageable
- A more broad and modern Maine state sales tax
- An expansion of the state income tax for very high-income family units
- An assortment of possible other smaller taxes

Together, these revenues would cover the revenue needed to fund the plan.

Premium contribution scale

Household income level as share of federal poverty level	Income level for familiy of 3 in 2024	Required share of household income	Annual premium at maximum level
150% or less	$37,290	None	$0
200%	$49,720	2%	$994
250%	$62,150	4%	$2,486
300%	$74,850	6%	$4,491
400% & higher	$99,440	8.5%	$8,452

WHAT WOULD BE THE IMPACT OF SUCH A PUBLIC PLAN TO MAINERS?

INDIVIDUALS & FAMILIES

Most families (80%) would see a boost in disposable income by eliminating private insurance premiums and out-of-pocket costs, while gaining increased coverage and access to eye, ear, dental and primary care. Mainers currently covered by basic Medicare would receive wraparound coverage for medications and services currently covered by a supplemental plan. These benefits would also extend to those with VA, Tricare and Indian Health Service coverage.

CITIES & TOWNS

Many municipalities would see reduced health care costs, via lower payroll assessments (instead of health insurance premiums) and reduced workers' compensation costs. These savings could be used for education, town, services, or reduction in property taxes.

EMPLOYERS

Most employers would contribute the same or less than they do now. They would not need to spend time and money choosing and managing coverage plans. There would no longer exist the “job lock” hindering movement in the labor market.

HOSPITALS & HEALTH PRACTITIONERS

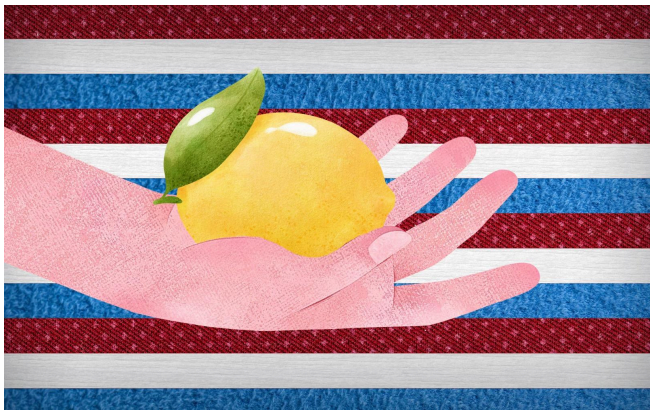
The MECEP public model would pay providers and hospitals promptly and directly. The payments would be at Medicare rates. Analysis of savings accrued by the elimination of bad debt and charity care, the increase of payments for Medicaid patients, the reduction of administrative costs associated with billing, and the savings on health insurance for employees indicates that providers would do as well or better financially.

When Washington Hands Out Lemons: How States Can Cushion Medicaid Cuts

Turning cuts into lemonade – states scramble to protect patients as Medicaid funding dries up.

Guest post by Rachel Madley, PhD for HEALTH CARE Un-covered, Substack, September 25, 2025

URL: https://rb.gy/fgjnl9



No family should have to worry about losing health care because of federal government cuts. Yet here we are, handed lemons we never asked for and states scramble to make lemonade to keep their residents alive and well.

The cuts to health care funding, like those we highlighted in the "One Big Beautiful Bill Act" and the probable expiration of enhanced subsidies for ACA premiums, are likely to precipitate a health care crisis in this country. If the subsidies are not extended, coupled with the OBBA changes, there will be 16 million more people without health insurance.

Additionally, the nearly $1 trillion cut in funding for Medicaid has put more than 300 rural hospitals nationwide at risk of closure and will leave states both red and blue with budget shortfalls. Louisiana will see a 20% cut in the federal funding it typically receives for Medicaid leaving a $27 billion gap over the next ten years while California will see a 17% cut and a $150 billion gap. This is a break glass moment for state governments who must use all tools in their emergency kits to protect patients. These tools include removing private insurance companies from their Medicaid programs, embracing global budgets for hospitals, and regaining control of their Medicaid pharmacy benefits.

The first tool states have to rescue their health care systems is to remove private insurance companies from their Medicaid programs. What many may not realize is that, even though Medicaid is a publicly-funded program, 40 states use private insurance companies such as UnitedHealthcare to act as "managed care organizations" to administer Medicaid benefits. Physicians for a National Health Program (PNHP) recently released a bombshell report showing that by moving away from private insurance companies and directly administering their Medicaid programs, states could save almost $34 billion every year. Over the ten year period of impending Medicaid cuts, that amounts to $340 billion, which is more than one-third of the funding cuts states will face.

This probably sounds too good to be true, but examining the high overhead costs of all programs that private insurance companies run demonstrates how these savings can be achieved. PNHP's report shows that states spend an average of 13% of their Medicaid budgets on overhead costs paid to the managed care organizations and that states moving away from using these private companies could decrease those overhead costs to just 4-6%. For those still skeptical, Connecticut conducted the experiment of deprivatizing its Medicaid program in 2012 and has saved $4 billion in taxpayer funding since then. The state also saw a 4.7%

increase in early cancer detection and 8% higher survival rates compared to New Jersey, which has maintained its privatized Medicaid model. If New Jersey de-privatized its Medicaid program it could save up to $11 billion over the next ten years, which is roughly 38% of the budget shortfall that state will experience from the OBBBA cuts.

Another tool states have to keep their health care systems afloat during this crisis is global budgeting for hospitals. Throughout decades of experiments to lower health care costs, global budgets have stood out for their ability to reduce costs and stabilize hospitals.

Under a global budget model, hospitals are paid a lump sum prospective payment for the coming year based on the populations they serve. This model creates dependable revenue for hospitals, which is especially important for hospitals in rural communities with a high percentage of Medicaid beneficiaries. Me. For example, the Pennsylvania Rural Health Model has demonstrated that by switching to global budgeting, crucial rural hospitals in the state have become more stable with positive operating margins in all cohorts in the model. The Maryland All-Payer Global Budget Model saved the federal government close to $1 billionduring its first implementation period from 2014-2018. This model combines global budgets with all-payer uniform pricing, increasing the ability for savings. The recently announced Rural Health Transformation Fund through the Centers for Medicare and Medicaid Services will provide funding to states that can be used to implement global budgets to support their hospitals that could be facing risks of closure due to the OBBBA funding cuts.

Pharmacy benefit managers (PBMs) present another opportunity for states to save on their health care costs while supporting rural and independent parts of the health system. It is well-documented that PBMs are forcing small pharmacies to close while driving the costs we pay for prescriptions to unprecedented levels. In Ohio, led by a Republican governor, state legislature, and attorney general, the Department of Medicaid stopped using Optum Rx, owned by UnitedHealth Group, and CVS Caremark as their PBMs and switched to its own PBM, which they work with directly. By doing this, Ohio was able to increase the dispensing fees paid to pharmacies by more than 1,200% and save $140 billion in just two years. Ohio proves that states can remove large insurer-owned PBMs from their Medicaid programs and not only save billions of dollars but also save critical independent pharmacies. In the aftermath of OBBBA, this is a key way for states to protect their health care systems.

In case it needs to be said, states should not be in the position of needing to backfill huge holes in their health care budgets. There is a lot wrong with our health care system, but cutting Medicaid funding for individuals rather than targeting the systemic abuses and profiteering by Big Insurance is not the way to fix it. That said, the above solutions have all been tested by a few model states and have shown that they hold the ability to save money, improve patient care, and support struggling rural hospitals and independent pharmacies.

***Rachel Madley, PhD**, is Director of Policy and Advocacy at the Center for Health & Democracy. She previously worked for Congresswoman Pramila Jayapal. She received her PhD from Columbia University and has written for publications including The New York Times.*

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August 22, 2025

Maine AllCare responds to the reasons behind rising rates for health insurance premiums in Maine

Maine must act now.

Last week Maine's Insurance Commissioner hosted an open forum with the five insurance companies requesting insurance premium rate increases of 20-30%. Maine people who testified described the rate increases as "catastrophic" and many speculated that they would not be able to afford healthcare thus putting lives at risk. The insurers shared eleven reasons behind the rate increases. Three of the reasons: inflation, reduced federal funding, and tariffs are outside of the control of Maine state leaders.

Maine AllCare believes that EITHER Maine can reform the system and control many of the health care costs, provide comprehensive healthcare for all Mainers and secure our hospitals with a single payer OR Maine can accept higher healthcare premiums that push Mainers off of their healthcare and put Maine lives at risk. Maine AllCare believes that it is critical that Maine leaders examine the cost drivers within their control and move forward to implement universal healthcare now.

1. High hospital and provider costs: A statewide plan could cut back on paperwork, allow drug price negotiations, reduce provider billing costs, and replace five different systems competing rules with one streamlined consistent system.
2. Income based premiums: Under a universal health care plan people under 65 would pay according to their income.
3. Increasing health issues: Maine people are getting sicker. If we had universal healthcare, people could receive healthcare when they need it rather than delay care and treatment because they cannot afford the cost of pills and providers.
4. Rising Drug costs: Drug prices are high and increasing with tariffs. With universal healthcare the state could negotiate the cost of medications with Big Pharma, and could explore partnerships with other states.
5. Eligibility: Fewer Mainers are eligible for the ACA and MaineCare leading to more Mainers who will transition to for-profit insurers with higher overhead. A single plan would decrease overhead and cut waste.

6. Coverage gaps: With the end of automatic enrollment in the ACA and MaineCare, people are more likely to disenroll. Maine could develop what is called “a reinsurance plan” with universal healthcare that prevents coverage gaps by automatically re-enrolling people annually.
7. Administrative Overhead: Up to 20% of premium cost is tied to administrative costs. As insurer administrative costs increase, so do premiums. MaineCare and traditional Medicare administrative costs are less and show that a public plan can reduce administrative costs.
8. Profits: For profit insurance must make a profit for their investors. Public insurance provides healthcare to the people and is responsible to patients, providers and the taxpayers rather than investors seeking to profit.

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About Maine AllCare: Founded in 2010, Maine AllCare promotes the establishment of publicly funded healthcare coverage for all Maine residents. This system must be efficient, financially sound, politically sustainable and must provide benefits fairly distributed to all. We advocate that healthcare, a basic necessity, be treated as a public good, since it is fundamental to our well-being as individuals and as a democratic nation

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