LD 1397 - An Act To Establish a Single-payor Health Care System To Be Effective in 2017

Testimony - Insurance and Financial Services Committee - Public Hearing, May 3, 2011

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Senator Whittemore, Representative Richardson and members of the Insurance and Financial Services Committee, thank you for hearing my testimony today. I am a physician and a psychiatrist. I am here today on behalf my family, my friends, my colleagues in medicine, and myself. I have practiced in Maine since 1987, with the exception of 4 years when I worked as a psychiatrist in New Zealand, which is a single payer country.

Since coming to Maine, I have seen my own health insurance costs rise astronomically, I have seen increasing numbers of my patients becoming uninsured or underinsured, and I have found more and more of my time being consumed by unnecessary paperwork.

In this country, 33 cents out of every health care dollar goes to "anything but care". It's easy to see where some of this money goes: a hospital lobbyist makes more than a primary care physician. A primary care doctor in Maine earns about one tenth of the salary of the CEO of Maine Health. And an insurance company CEO earns several times more than the Maine Health CEO. In 1970 there were the same number of physicians as administrators. By 2008, there were 30 times (3000%) more administrators than physicians.

A national study of nearly 900 U.S. physicians and medical group administrators found that physicians spent on average 142 hours annually interacting with health plans, at an estimated annual cost to physician practices of $31 billion, or $68,274 on average per physician, per year. Indeed, since I started practice, my time doing non-clinical recordkeeping and paperwork has increased dramatically. I fill out several forms per day, doing prior authorizations, treatment plans, appealing denials of care, filling out patient assistance forms. I play "Mother, may I" with insurance clerks who have no medical training and no experience with direct patient care. I have to work with several different drug formularies, as the choice of medicines that I prescribe is determined more by a patient's insurance coverage than by their illness. I overheard a conversation on the street that went like this: "My doctor said the prescription would cost $80 for a month. When I got to the pharmacy they said it would be $155 - I can't afford that!" None of this has anything to do with the healing mission that I undertook when I entered medical school.

Every day at work I hop onto a productivity treadmill, hoping that my patients show up for their appointments so that my employer can bill one of multiple insurance companies for my services. I am scheduled to see and average 16 patients per day; this is considered a "luxury" by current standards. My patients are people who are sick; they have complex problems including serious and persistent mental illness, diabetes, heart disease, and high blood pressure. Many have co-occurring substance use problems. Some are stuck in bad jobs because they are afraid of losing their health care, some are uninsured because they became sick and unable to work, or because they lost their jobs and their health care. Some are underinsured and can't afford to see me often enough because their co-pays and deductibles are so high they might as well have no insurance at all. Some are afraid to go back to work, because they might make too much money and lose their Medicaid coverage. After seeing them and doing all of the paperwork mentioned above to try to get their care approved or their drugs covered by one insurance plan or assistance program or another, I have no time to consult with their primary care doctors, if they have them, or to make phone calls to case managers or other specialists. I leave my work at the end of the day, trying to balance my mission to deliver compassionate, high quality care with the insane demands of insurance companies. I am exhausted.

When I practiced in New Zealand, medical decisions were mine alone, and were not determined by a managed care reviewer sitting at a desk a hundred miles away. I had about one tenth the amount of paperwork. Hospital discharges were made when medically necessary, not when someone's insurance company mandated. Services were much better integrated, because we were all part of one system. I set my schedule based on my patients' needs. Whether a patient needed 5 minutes or 55 minutes of my time, if a case manager had an important question, if I needed to discuss my recommendations with a primary care doctor, or if I needed supervision from my colleagues or wanted to review my outcomes, I could set aside the time in my schedule. I rarely needed to see more than 10 patients each day, although I consulted on many more than that, because I functioned as part of a multidisciplinary team.

I know that the New Zealand system (or any other single payor system for that matter) is not utopia. There are waiting lists for elective procedures, hospital emergency rooms are sometimes crowded, and health care professionals stage industrial actions from time to time. However, no one delays necessary care because they cannot afford it, no one goes bankrupt due to medical expenses, everyone gets excellent, high quality, basic care regardless of their financial services, children have free dental care, and everyone receives prompt and highest quality treatment for serious illnesses such as cancer, heart disease and diabetes.

I close with a rather lengthy quote that I excerpted from a famous Republican who would have become an American hero if his vision for health care had become a reality. He said:

"Without adequate health care, no one can make full use of his or her talents and opportunities. …more and more Americans face staggering bills when they receive medical help today…For the average family, it is clear that without adequate insurance, even normal care can be a financial burden while a catastrophic illness can mean catastrophic debt….Americans who remain uninsured often need it the most and are most unlikely to obtain it. They include many who work in seasonal or transient occupations, high-risk cases, and those who are ineligible for Medicaid despite low incomes.

Second, those Americans who do carry health insurance often lack coverage that is balanced, comprehensive and fully protective…These gaps in health protection can have tragic consequences. They can cause people to delay seeking medical attention until it is too late. Then a medical crisis ensues, followed by huge medical bills--or worse. Delays in treatment can end in death or lifelong disability." Richard M. Nixon, 1974

I urge all of the members of this committee to become my heroes. Support LD 1397 and bring fair, affordable, high quality, comprehensive health care to all Maine people.