

State of Rhode Island Office of the Health Insurance Commissioner  
Health Insurance Advisory Council  
Meeting Minutes  
October 17, 2017, 4:30 P.M. to 6:00 P.M.  
Portsmouth Town Hall  
2200 East Main Road  
Portsmouth, RI 02871

**Attendance**

**Members**

Co-Chair Commissioner Marie Ganim, Co-Chair Stephen Boyle, Al Charbonneau, Teresa Paiva Weed, Ruth Feder, David Katseff, Sam Salganik, Howard Dulude

**Issuers**

Carolyn Rush, Neighborhood Health Plan of RI  
Shawn Donahue, Blue Cross Blue Shield of RI

**State of Rhode Island Office of the Health Insurance Commissioner Staff**

Cory King

**Not in Attendance**

Gregory Allen, Hub Brennan, Bill Schmiedeknecht, David Feeney, Tammy Lederer, Vivian Weisman, Karl Brother, Lisa Tomasso

**Minutes**

**1. Welcome and Review of September Meeting Minutes**

Commissioner Ganim called the meeting to order and welcomed all Health Insurance Advisory Council (HIAC) members and others in attendance.

The minutes from the September 19, 2017 HIAC meeting were accepted unanimously with no changes.

**2. Introduction of Council Members and OHIC Staff**

This HIAC meeting served as the Office's Quarterly Public Comment session. For the benefit of the members of the public in attendance, council members and OHIC staff each introduced themselves and gave a brief description of their role.

Following introductions, Commissioner Ganim acknowledged and thanked the following elected officials for their attendance: State Senators James Seveney, Lou DiPalma, and Dawn Euer and State Representative Kenneth Mendonca. She also thanked the Newport County Chamber of Commerce and their Executive Director, Erin Donovan-Boyle, for helping to host the event.

### **3. Overview of OHIC's Mission, Duties and Responsibilities**

Cory King and Mark Gray gave a presentation to the public on the mission, duties, and responsibilities of the Office of the Health Insurance Commissioner. The presentation was introductory in nature, focusing on OHIC's four major areas of work: consumer protection; laws, regulations and enforcement; health plan form and rate review; and healthcare reform and policy.

### **4. RIREACH Consumer Update**

Sam Salganik from RIREACH explained that RIREACH, a program of the nonprofit Rhode Island Parent Information Network (RIPIN), is OHIC's consumer assistance partner. The RIREACH call center assists approximately 3000 consumers each year. In September 2017, RIREACH helped 264 new clients and handled a total of 2,618 phone calls.

RIREACH is able to help consumers with issues relating to both commercial and public insurance. Top consumer issues recently include helping with Medicaid enrollment, helping consumers navigate the appeals process for coverage denials, and helping consumers facing surprise medical bills from providers that they did not know were outside of their health plan's network.

### **5. Action: Review of the OHIC/HIAC 2016-17 Annual Report**

HIAC members were presented with an outline of the Annual Report currently in development. Commissioner Ganim asked the Council to review the outline and submit their input to Mark Gray. Mark also shared sample designs for the layout of the annual report.

A brief discussion regarding several recent healthcare policy changes at the federal level took place. Initially, the November HIAC meeting was to be canceled due its proximity to the Thanksgiving holiday; however, Council members asked that a November meeting take place in light of the many issues arising due to actions in Washington.

### **6. Public Comment**

Note: This HIAC meeting also served as OHIC's quarterly public input session and therefore had more time allotted for public comment. A lightly edited transcript of the public comment portion of the meeting is attached to these minutes.

### **Next Meeting**

The next meeting of the Health Insurance Advisory Council will be Tuesday, November 28, 2017 from 4:00 P.M. to 5:00 P.M. at the State of Rhode Island Department of Labor and Training, 1511 Pontiac Avenue, Building 73-1, Cranston, RI 02920-4407.

## Transcript of Public Comment

### Health Insurance Advisory Council / OHIC Quarterly Public Meeting

**Dr. J. Mark Ryan, Physicians for a National Health Program RI:** I'd like to thank Commissioner Ganim and the Health Insurance Advisory Council for having this hearing and for giving us so much information as to the chaos you are currently facing in the health care system. I am glad you are doing it and not me. I think we have been very fortunate over the last few years in having diligent, perceptive people such as Commissioner Ganim, Commissioner Hittner before her, and Commissioner Koller before her... [indecipherable] ...they have gone to great lengths to protect the people of this state from the out of control costs of our healthcare system. Unfortunately, there's only so much you folks can do when the system in which you must operate is so completely broken.

I think a great summary of what's wrong with health care in this country was made by Kim Holland who is the Blue Cross and Blue Shield Association director of state affairs at an ACA conference for health insurance exchanges in 2015. She [indecipherable] there are unrealistic pressures on insurers to keep premiums down. You cannot have every doctor in your network, very low co-pays, broad benefits and low costs – it just can't work that way. And while it is true that our system of multiple private health insurers can't work that way, that is precisely how every other industrialized country with national health insurance does work.

America spends roughly twice what other countries do per capita on health care despite having health care quality measures that rank only 19<sup>th</sup> [indecipherable]. Our maternal mortality rate is 8 times higher than Australia's, which has a single payer national health insurance program. Our life expectancy now ranks 26<sup>th</sup> in the industrialized world and in our country, there is now a 15 year difference in life expectancy between the very richest and the very poorest.

Blue Cross, we've heard, will be raising their rates in the individual market by 12% next year, primarily in anticipation of President Trump's threatened cuts to funding to the ACA – which, as we've heard, he has now done by cutting CSR payments. But although next year's increases can be explained that way, they point out the inherent instability of private insurance which must receive government subsidies in order to offer people affordable insurance plans that actually cover their needs. And even with subsidies, costs are not being contained. Health insurance premiums in the US have been outpacing inflation by a factor of four for the past 40 years, to the point that the Congressional Budget Office predicts that the average employer-based health insurance plan for a family of four will equal 50% of that family's income by 2025. Some analysts say that by 2032 it will equal 100% of their income.

If all the money we're spending does not buy us better care, where does it go? Well, there are some cost increases in delivery of care, but an awful lot of it goes into excessive pharmaceutical costs and the administrative waste caused by our system of multiple insurers. In the past 40 years, the number of doctors has increased less than 2%. Over that same period of time, the number of people involved in processing billing and claims has risen three thousand percent. I've been a doctor for 30 years – I guarantee you I am not working three thousand percent harder than I was 30 years ago. So what are these people doing?

Massachusetts General in Boston – large hospital, well known hospital – has 350 people doing their billing. Toronto General, in single-payer Canada, roughly the same size with roughly the same number of people served has three people doing their billing. I was paying \$180 for my Advair inhaler from my insurance from a local pharmacy. I get it from Canada for \$20. I'm actually handing out the website information to my patients, because most of them can't afford inhalers with a price punitively high. It is estimate that if the US were to change next year to a national Medicare-for-all system such as the Canadian system, we would be saving \$500 billion annually.

The effects of the huge costs of this wasteful system are manifold. Health insurance costs are the most common cause of labor disputes in this country and are a major disincentive to companies to hire new workers. And when they do, they frequently hire them part time to avoid having to underwrite their health insurance – or, as Wal-Mart does, frequently let them go to Medicaid. So we're paying for their benefits.

I am currently on the Town Council in Portsmouth, and a large concern of our budget is OPEB – other post-employment benefits, which primarily consists of town retiree health insurance premiums. With a single payer health insurance system, OPEB largely goes away. Fewer arguments for us. I know that's selfish, but I am selfish. We recognize that health care is not like other commodities in that we tend to regulate the cost of health insurance to keep it affordable for everyone. People who make cars are not required to ask the government when they raise their prices. And if they were to continue to raise prices, they'd eventually have no customers and they'd go out of business. But people do not necessarily die when they cannot afford a car. And contrary to what Raul Labrador in Idaho said a few months ago, people do die when they are denied access to health care.

If the health insurance industry must continue to raise its prices, perhaps it ought to be allowed to go out of business. Maybe we should finally consider the efficient, equitable, and affordable alternative that every other industrialized country on earth has settled on – some form of national health insurance. Most of them, single payer – the government is the health insurance provider. There are bills in congress that would create such a system, which three quarters of our Congressional delegation have now signed on as sponsors. Senator Reed says he endorses it but has not signed on as a sponsor yet. It seems unlikely that they'll pass any time soon. And if they do, I'm sure somebody is going to veto them.

As the province of Saskatchewan with a million people, roughly the size of Rhode Island, pioneered single payer health insurance for Canada, Rhode Island could do the same in our country. There are bills in our Rhode Island legislature, in our House and Senate - the latter sponsored by our own Senator Seveney, who had to leave for a meeting – which would set up a state single payer health plan similar to that that started Canada on the road to reform. It is time to consider an effective solution to rising health insurance prices and provide relief to Rhode Island's overburdened businesses, struggling municipalities, and underserved citizens. Thank you.

**Linda Ujifusa, Physicians for a National Health Program RI:** Thank you, Commission, for allowing us to address you. My name is Linda Ujifusa, I'm also on the town council, and I'm the secretary of the Rhode Island chapter of Physicians for a National Health Program. Dr. Ryan would be the chair of that

organization. Despite the fact that the ACA greatly benefitted our state by allowing us to increase health insurance coverage, approximately 47,000 Rhode Islanders remain uninsured in 2016, and full implemented, the ACA would still leave 42,000 Rhode Islanders uninsured and likely many more underinsured. And that means approximately 100 Rhode Islanders will die each year due to being uninsured or underinsured. Between 1991 and 2014 health care spending in Rhode Island per person rose over 250%, rising much faster than income and greatly reducing disposable income and inflicting higher premiums, deductibles and co-pays as well as restrictive provider networks, limited coverage, and high out-of-network charges.

The reason that our congressional delegation and Governor Raimondo support single payer is that skyrocketing health insurance costs cripple small businesses, cause wage theft from workers and families, and saddle our state with serious liabilities. These elected officials recognize that a Medicare-for-all, single payer program will put money into our pockets and take away the fear that we are just one illness or one accident away from bankruptcy. I realize that part of your mission is to protect the solvency of private insurance companies, but we also hope that the commission can also help, can also look at single payer. Because, as Dr. Ryan pointed out, we are the only industrialized nation who does not have such a system. And although you are fighting valiantly to keep this system afloat, we absolutely have to start considering an option – and that would be Medicare for all.

A study by economics professor Gerald Friedman at UMASS Amherst shows that a single payer program only in Rhode Island would save Rhode Islanders approximately \$4,000 per resident per year by 2024. That savings puts more money in Rhode Island's economy and also single payer in Rhode Island alone would reduce administrative costs by \$1 billion in the first year. That study is located at [www.rihealthcare.org](http://www.rihealthcare.org). And I encourage you to look at it. Some argue that single payer will increase taxes too much, but in fact the premiums, deductibles and co-pays we now pay take more out of our wallets than a tax increase to cover single payer would. And not only to we pay directly to insurance, we pay indirectly as our tax dollars are used to prop up private health insurance companies.

Although a federal program would be best, Washington continues to defund important federal programs like Medicare and the ACA, and it seems unlikely that we will get federal Medicare for all. So I urge OHIC to support a Rhode Island study commission about implementing single payer. I urge everyone to go to the website I identified for more information about Rhode Island single payer legislation that was introduced – and will be again introduced in 2018. If Washington will not protect us, we must protect ourselves at the state level. Thank you.

**Carol Ryan:** I'm actually Mark's sister. He pretty much said what I wanted to say. I'm a retired physician, I actually worked for the Veteran's Administration. I actually wanted to make a couple comments about Cory's little plan here. He at one point said he was going to make the physicians accountable for the total cost of care of the patients. Well, there actually was an article in the New England Journal of Medicine several years ago. Great Britain did that with their national health system, they said that the doctors would be responsible for how much they spent per patient. So what happened was, the doctors just dumped their most expensive patients. Now, with the VA, they've done the same thing and I'm sorry to say that a similar thing happened. So, when you make the doctors accountable for the cost of a

patient, the doctors try to get rid of these patients because they're being affected financially. It's not really a good way to try to cut costs because it just doesn't work well for the patients. At the VA, what happens is, all of our wages were frozen – I retired in December – but our wages were frozen for about a decade. The only way we would get extra money was if we met certain goals like hemoglobin, A1C, which is an average of 90 days, blood sugar, and stuff like that. So the patients are non-compliant, many of them. They don't adhere to their diet, they don't take their meds even though, many times, they're free. And many times, nurses will set up meds for people. It's amazing how non-compliant patients can be. So, what some of the physicians at the VA did was take their name off the patient's chart so they wouldn't get dinged for it. Or they'd tell the patient to go sign up with somebody else. That's what would happen if you do that. And the other thing is you can't really make physicians accountable for the outcomes of their patients because unless you take a patient home and feed them chicken and vegetables, you cannot stop them from eating lasagna and brownies, you know what I mean? So, you might want to actually have some physicians that you talk to, to sort of give you a clue as to what the realities of the system is. The other point I wanted to make is that head of Kaiser, a few years ago, very famously said that they had tried everything to save money, and there wasn't anything they could do. At any rate, this is sort of an aside but everything my brother said I definitely am in favor of, because what happens is, if you don't have something like single payer, studies have shown repeatedly that the more copays you have, the higher they go, the less people seek care. We didn't have that problem at the VA – people go sick, they either walked in, which, they were supposed to call, but many just walked in, and we took care of them. Or they called for an appointment. If you have a co-pay in the private sector, they don't call. They get sicker and sicker and then they end up in the emergency room and they end up costing people more, the insurers more, and they might have a bad outcome as a result. Studies have repeatedly shown the higher the copay, the less they seek care, and the sicker people get. The other problem is, when you sign up for health insurance, many times you don't know what you have signed up for until you get a very serious disease, and then you discover that your copays are astronomical, or you can't afford the medications, or you can't go to the physician you want. Some of the insurance plans restrict where you can go. We've had many patients, and I've known a number of people who've had rare diseases, they get a certain health plan, and they had to drop their doctor in Boston because they could only get health care in Rhode Island. One person who had a very rare genetic disease ended up being cared for by a guy who's specialty was prostate cancer, essentially. That shouldn't have happened. But with national health care, she could have gone wherever she wanted to go, she could have continued to see the physician who actually specialized in that disease. So those are the sorts of things that having private insurance really results in. If you have national health care, if you have the government being the health insurer, then people have access to any system, they can go to any doctor, and they're not hobbled by copays and out of pocket expenses. Anecdotally, I had a patient who came to the VA in the 90s – his wife got breast cancer, he had to re-mortgage his house to pay for her care, she died, and he had to go back to work. Fortunately, he could get his health care through the VA for free. But those sorts of things are what happens when you get sick. 75% of the bankruptcies in the United States are due to an inability to pay health care costs. We're the richest country on the planet – why do we have this system? We need national health care, we need Medicare for all, and we need to take care of our citizens appropriately. You guys are all doing a great job, the complexities of the system are absolutely astounding, but it's a system that's broken.

**Terri Cortvriend, Portsmouth School Committee, Local business owner:** You answered quite a few of my questions. I'm a small business owner, and I just wonder, do you think that you're going to stay with the age rate model? Do you see that staying in place? As opposed to, before the ACA, we had more where everybody paid the same amount for a group policy.

**Commissioner Ganim:** So the Affordable Care Act does require that the only variables – age is one of the few variables that can be used in setting rates, and that is the one that we use.

**Terri:** So I guess, if the ACA implodes, you think Rhode Island will stay with the mandates of the ACA, as parameters for small group?

**Commissioner:** Our statutes right now I believe do limit variability in the small group market to age, and, I believe, family size also. Other than that I don't think even our state law is very different than the Affordable Care Act.

**Terri:** Well, I would echo the sentiments you've heard without repeating them all. As a small business owner, I would love to be able to decouple from health care and not have to make that decision on behalf of my employees and their families. While I don't mind making a contribution to it, having to decide what plan, how big of a deductible we have, is it better to keep prices level for them and for us, or, you know, all those decisions, I think, are very difficult for small businesses. I would just let you be aware that that's...

**Commissioner:** So, you're endorsing...?

**Terri:** I would be endorsing us looking into it, I would endorse a study commission, absolutely, so that we can see what kind of effect that would have and if that would be helpful to small businesses, because there's so many small businesses in Rhode Island and this is one of those big expenses annually for small businesses that strive to provide for their employees. Thank you.

**David Katseff, HIAC member:** Excuse me, Commissioner? Can I please interject? Just one item. The small business health care act did allow for averaging of lots of different factors before ACA took over. And, to my knowledge, the small business health care act in Rhode Island has not changed. It was superseded by the ACA, and therefore the ACA took over and set it by age and only by age. But before that, the healthcare insurance providers could give any business a package that averaged lots of factors. And I would expect that if ACA is not here tomorrow, it would go back to the small business health care act in Rhode Island, which did not specify that before ACA.

**Howard Dulude, HIAC member:** I think one of the concerns with that – and I'm not advocating either way on this – was that age rating was really intended to get more younger people into the coverage because they were really good risk and helped to sort of spread the risk. There's all different sides of all the fees, and, anyway, it's complicated. We're having lots of young people say they're not going to get coverage because it's too expensive. And when you do a composite rate, it's more expensive for younger people. It's sort of six in one hand, half a dozen the other.

**Theresa Paiva Weed, HIAC member:** Just to echo the small business... what was said if you, as an employer, paying for everyone's insurance, you have a 58 year old woman versus a 26 year old woman, you're giving them both single coverage, you're paying \$3,000 maybe for one and \$10,000 for the other. They become a line item by virtue of their age under small group [indecipherable].

[cross talk, audience member speaking]

**Unknown commenter:** I just had a comment directly related to that. I've always worked for small businesses. I'm an engineer, and I used to work for a small company that had ten engineers before the ACA. I was not in charge of deciding on the health plan, but for my boss, with this cost averaging, it was more expensive for him to hire a young, child-bearing-age woman than it was for him to hire a young male engineer, which...

**Theresa Paiva Weed:** That [has been changed] in Rhode Island state law, just so you know.

**Unknown commenter:** What's that?

**Teresa Pavia Weed:** That has been changed, that was changed, that's a different variable. And it's been changed by both the ACA and the state law.

**State Senator Lou DiPalma:** Thank you very much madam Commissioner, madam president, good to see you on the other side. I have a comment, I have a question, and I have a suggestion. The comment that Sam made earlier regarding RIREACH, I use the analogy, I refer many people to RIREACH as "a dog with a bone." They will work to solve the problem until its done – doesn't care how many hours it takes, how many minutes it takes, how many days it takes, they're going to take a problem from beginning to end. I have confidence any time I send a constituent to RIREACH that it's going to get done. That's the comment.

The question – and I apologize for being on the phone for work – but you have chart number nine that talked about increasing investments in primary care, transforming payment and the delivery system. With the recent proposal that was put out last week by the executive branch with regards to PCMH kids, looking to remove the \$450,000 out of the budget of general revenue, which is really in the neighborhood of about \$1 million out of the budget for the remainder of 2017 – it's going to fly in the face of working to address improving primary care. So, I'd ask the Commissioner to look at, the Council, how to affect restoring that \$450,000. I know I'm working on my end to do that, the more people we can get to provide that feedback, provide thoughts to the executive branch... I'm a firm believer there's strength in numbers. I think it's critical to do this. The question I've asked when it was first brought up about this cut, was, can the efficacy of the program be challenged? The answer was categorically "no." Meaning they were both efficient and effective with what it's doing. Given that, if something's efficient and effective, and achieving the efficacy of what we set out to do, it's something that should remain. So I'd ask whatever you can do to have it restored, I'm a firm believer that until something's done, it's never done. And I'm not going to take no for an answer – not from you folks, I'm not asking you to say yes – but I'm not going to take no for an answer until it gets restored. And I think it's about 18 months we've have the PCMH kids home, patient-centered medical home, in place. For adults we've had it for

about 8 years now – 6 or 8 years – there are some real results, real benefits that have happened and whatever the advisory group can do with regards to this would be beneficial, and appreciated - on my part and, I think, on the part of the work that it will do for primary care physicians as it relates to kids. That's the request, or the concern I have.

The last piece, and I'll finish briefly: with regards to, I think Dr. Ganim mentioned regarding the challenge with the CSR and the APTC, and whether some of those folks will move from a silver plan to a higher-level plan, and work on the tax credit, what that's going to do to the system, I don't know. I'm interested to see what those numbers look like and the possibility of what could occur and the probability of how many people actually do that and what that will do the system. With all that said, [indecipherable] whether we extend open enrollment to seek to address that, given the turmoil that has been put in place. Today's the 17<sup>th</sup> of October, less than two weeks, right? November 1<sup>st</sup> open enrollment begins. Extend it, and I don't what the right time to extend it is, or delay. One or both.... Consider that, whether that's possible and take that back to HSRI and Director Sherman, through the executive branch, of course, and Secretary Eric Beane in the Executive Office of Health and Human Services, on what the possibility/probability of that could do given this turmoil that just happened Friday afternoon. Thank you very much and thank you for what you're doing.

**Michelle McGaw:** Thank you for coming out to Portsmouth. I am excited to see you all here. I hope this is the right forum for my question. I have a consumer question for you and its – what recourse does a consumer have in regards to a consumer health plan when there are questions or concerns about the benefit design of the plan?

So, I'm going to tell you my circumstances. I'm a pharmacist. I work for a pharmacy provider in the state of Rhode Island. Our benefit plan has a very significant deductible and even though it is a pharmacy provider, our prescriptions are not covered until we reach that significant deductible. So it was presented to us because it would allow us to meet our deductible that much faster. That being said, the only in-network provider is that pharmacy provider that I work for. What that means is that I cannot shop around for a better price for my prescriptions. We talked about the fact of prescription prices and how significant that is to health care costs. But when I shop around, I learn that I can get the prescriptions that I have to get through this provider in order for it to be applied to my deductible, I have to pay three times as much from that provider as I can get by shopping around at other pharmacies. To me, that is a significant design flaw. If I am required, in order for it to go to my deductible, to pay three times as much by going to that very pharmacy provider, I think that is a significant conflict of interest. And so, this is something that I have been battling. I have been going through their network, through their benefits provider, they told me where I could appeal to, but then I was told that I could only appeal as to what drugs were covered and what drugs were not. I have yet to be able to come across how you can appeal the benefit design and address conflict of interest. And so I'm coming to you asking for some help and some recourse as to what can a consumer do when there's a concern about a benefit design, especially when it presents something like a conflict of interest?

**Sam Salganik:** It's a great question. It sounds like you work for a large national company?

**Michelle:** That's right.

**Sam Salganik:** Probably it's a self-insured group. There's two different ways for employers to buy insurance. One is sort of what we all think of as "normal" insurance – the employer pays a monthly premium to the insurance company every month, people get sick, the insurance company pays the bills. That's called "fully insured."

But actually, a lot of very large employers don't do it that way. Instead, they set aside a reserve of their own funds and then they hire an insurance company just to provide administrative services – provide a network and process claims. But the claims themselves are paid out of the employers funds, and that's a "self insured" design. Under federal law, self-insured plans are immune from state regulation or state law. So OHIC would have no jurisdiction at all over a plan like that. The federal Department of Labor, they have an Employee Benefits Security Administration – EBSA – they're good when there are legal violations that are happening, they're very accessible. Ah, the conflict of interest issue is an interesting one. I don't know if that's prohibited under federal law. My guess is that it's not. But the place to call would be EBSA. But if you're going to be here after we can talk?

**Michelle:** That would be terrific.

**Sam Salganik, HIAC member:** Is that a satisfactory, non-satisfactory – not happy answer, but an answer at least?

**Michelle:** It makes sense based upon the information, or the lack of information that I have been able to get, despite my battling this for the past year, and really getting nowhere. I think what it does do, is, once again, supports the need for single payer. On top of that, from a plan design perspective, and I get that this is sort of related to it but not fully related to that – something you may want to think about when you are reviewing these plans when they come through, from a consumer protection perspective – it also requires that if it's a maintenance medication, what they determine to be a maintenance medication, you have to buy a 90 day supply. If you have a 100% copay, and they're telling you you have to buy a 90 day supply that you may not be able to afford, you're option is to not buy that medication and not get the care that you need.

Based on all those things, I love what Dr. Ryan is saying about single payer health care. Thank you.

**Ruth Feder, HIAC member:** I have a question, based on your comments – which, that's just a horrible story. And if a pharmacist is grappling with this, imagine just the average person who is not as well versed in these intricacies as you are. With respect to the study commission that's been mentioned, are you proposing a state study commission to look at single payer to be implement within Rhode Island?

**Dr. Ryan [and others in audience]:** Yes.

**Ruth:** Has that ever – I know there's been legislation repeatedly introduced, but has there ever been legislation for a study commission? I know to have single payer, but not for a study commission?

**Dr. Ryan:** Not approved – there have been study commissions for other things but not for single payer. The study we asked Professor Friedman to do, he did out of the goodness of his heart. I don't think "goodness of heart" has state jurisdiction.

[laughter]

**Unknown Audience Member:** Senator Calkin will be introducing a resolution for a study commission in 2018, and probably Representative Regunberg as well, on the House side.

**Unidentified Commenter:** Can I add my name? To testify, please?

**Stephen Boyle:** Sure.

**Unidentified Commenter:** Ok. I apologize, I ran over here from my five-year-old's parent-teacher conference, so I was a little late. I'm gonna wing this, because I did testify at a Senate hearing in support of single payer because... My mother passed away in May. A year and a half before that she was diagnosed with ALS. My father and I were her primary caregivers. And healthcare was a big deal in my family for a long time – dealing with nurses and doctors and hospitals nonstop. Going through this whole process is when I first realized two-thirds of our bankruptcies are due to medical bills. The same thing that my family went through, I can see how easily that could happen. But we were lucky. We were lucky because my mom became eligible for Medicare three months before her official diagnosis. Before that, she had been on an Obamacare plan that my dad bought for her. And they had already reached their \$7,000 yearly maximum in five months of tests and exams. He paid a \$700 premium every month. When my mom was diagnosed we had to sit down and decided how we were going to manage it, as a family. We had two young kids, their grandkids, working and paying these premiums. I don't know how we would have made ends meet without Medicare. So Medicare was a godsend for my family. It saved us from bankruptcy and I truly believe that.

I'm not a healthcare expert, I'm just a healthcare user – and we used it a lot. I'm pretty sure my family would have been bankrupt if she hadn't become eligible for Medicare. In hindsight, I've been told, "Oh no, don't complain so much! She had ALS. ALS makes her eligible for disability." But no, not quite. Because my mom was Brazilian and although she was married to an American citizen for 25 years, she only lived in the US for ten years and became an American citizen seven years ago. Which means she didn't work here long enough to be eligible for any other benefits, except for Medicare once my dad became eligible. So I think that just illustrates the issue here. Health care is too complicated. There's too many different scenarios. We can't try to legislate every single one of them. We can't answer all these questions. The fact of the matter is, we all need health care. We all use it. The only way to affordably cover everybody and make sure we don't let anybody fall through the cracks is to have a system like single payer – to make sure everybody's covered, no questions asked.

I also just read the news this week that the Visiting Nurses Association of Rhode Island is shutting down. My family owes a huge debt of gratitude to a different visiting nurse establishment, but still, that's where money needs to be. We need to help people stay in their homes. We need to increase preventative care. We need to make our healthcare system less expensive, not more expensive. And you

all read the news, you know everything that's going on. It's not going to happen from Washington, DC. It's not going to happen from a federal level. As a state, we need to acknowledge this and we need to have a study commission, we need to look at solutions and steps that we can take to make the system better so that we can include everybody and cover everyone and not let people go bankrupt because they can't cover their medical bills.

[applause]

**Stephen Boyle:** Thank you.

**Ruth Feder:** First of all, you have my condolences. Second of all, well, two questions: How was the process of getting her on Medicare? Was it difficult, was it user friendly? And the same question applies to once she was on Medicare, how was it navigating the system?

**Unidentified Commenter:** So much easier. She was older than my father, so she didn't actually become eligible for Medicare until she was 69 because she had to wait until my father turned 65. And then when he became eligible, then she got spousal privileges. But as soon as she had it, it was easy, from what I heard. It was just a matter of getting her the card. They also moved from Minnesota from Rhode Island so they could be closer to family – so that was more of a difficult than anything else. But as far as dealing with illness and coverage it was a lot simpler with Medicare. There were a lot less questions. They did have to get the supplement plan for prescription and whatnot, and I confess, I don't know all the details. But there wasn't that constant worry of what was going to be covered or not. I know my mother was originally diagnosed at the University of Minnesota when they were still on private insurance, and she was told by a neurologist, "I think you have ALS? But I don't really know for sure, because there's no test for it." But Dad had reached the \$7,000 maximum, and his private insurance didn't even allow them to go get a second opinion on what, essentially, was a death sentence. And he had to wait until she was eligible for Medicare, and then Medicare allowed her to go to the Mayo Clinic in Minnesota and get a second opinion so that you can actually move forward from there. So, comparatively, a lot easier.

**Dr. Michael Gottfried, Chiropractic Society of Rhode Island:** I really wasn't expecting to speak... Dr. Ryan's information, also, people need to know that, if it wasn't already said, 50% of bankruptcies are medically related and many of those 50% have insurance, but either they max it out or they don't have coverage. We see it every day in our office. We have a dedicated person, we're a small chiropractic office and yet we have one dedicated person to handle insurance. Certainly, not cost effective. Somebody calls up, multiple plans these days, it's not like one person has Blue Cross Blue Shield and we know exactly what their coverage is. Instead, there's 50 different plans and we have no way of knowing fully, we try to find out in advance but, a lot of times, you can't find out in advance. We don't always get the same information that the patient gets. And so all we can do is say to the patient is, "you have to make the call to find out what your coverage is." Sometimes they're not covered, and we know we can give them more cost effective treatment, especially when it comes to pain management, which is certainly an issue as Dr. Ganim knows. We try to offer an alternative to the opioid related problem that we have in this state, and yet a lot of times, people don't have the coverage. Especially on the lower end from the standpoint of Medicaid at this point in time. Again, I would echo what Dr. Ryan said, we

probably need a one payer system. Hopefully, to reduce some of the inequalities and some of the problems that we have in this country and this state can certainly, hopefully, lead by example rather than wait for things to continue to crumble. Thank you.

[applause]

*End of public comment.*