

132nd LEGISLATURE
JOINT STANDING COMMITTEE ON HEALTH
COVERAGE, INSURANCE AND FINANCIAL SERVICES

Interim Committee Meeting Agenda

November 6, 2025

10:00 am

- 10:00 am** Welcome and Commission members and staff introductions
Committee Chairs, Sen. Donna Bailey and Rep. Kristi Mathieson
- 10:00 am** Briefing on impact of expiring subsidies on Maine Health Insurance Marketplace plans and enrollment for 2026 Plan Year
*Hilary Schneider, Director,
Office of the Health Insurance Marketplace, DHHS*
- 11:00 am** Presentation on prior reports and policy recommendations to address health coverage accessibility and affordability
*Meg Garratt-Reed, Executive Director,
Office of Affordable Health Care*
- 12:00 pm** Break
- 12:30 pm** Briefing on provider contracting relating to Anthem and Northern Light Health
Representatives of Anthem and Northern Light Health
- 1:00 pm** Public Comment
- *Comment from interested parties and members of public*
 - *Approx. 3 minutes each*
- 1:30 pm** Update on Interim Activities on Committee's Carry Over Bills
- 1:45 pm** Potential Work Sessions on the following Carry Over Bills:
- LD 910, An Act to Collect Data to Better Understand the Consumer's Health Insurance Experience
 - LD 961, An Act to Address Maine's Health Care Workforce Shortage and Improve Access to Care
 - Other bills TBD?
- 3:00 pm** Adjourn

Times are approximate and may be adjusted as necessary by the committee chairs

Public access also available through the Maine Legislature's livestream:

<https://legislature.maine.gov/Audio/#220>

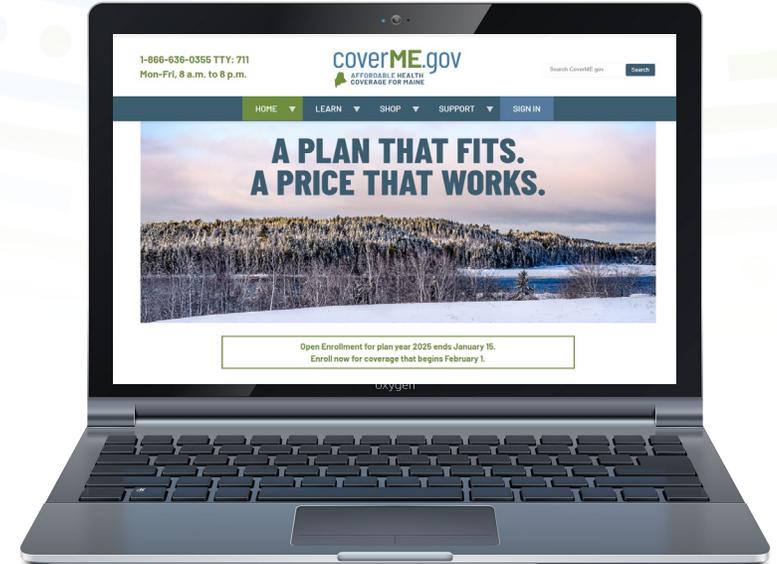


THE OFFICE OF HEALTH INSURANCE MARKETPLACE (OHIM)

NOVEMBER 2025

COVERME.GOV: MAINE'S HEALTH INSURANCE MARKETPLACE

- Single, secure and trusted **online marketplace** for **health and dental insurance**
 - **More easily shop** for and **compare** plans across private companies (Anthem, Community Health Options, Delta Dental, Harvard Pilgrim, & Mending)
- **Fills gap** between employer-provided insurance and government programs (i.e., MaineCare, Medicare or VA/TRICARE)
- **Only place** to access federal **financial savings**:
 - Advance Premium Tax Credits (APTC) which lower premiums
 - Cost Sharing Reductions (CSR) which lower out-of-pocket costs
- **“No wrong door”** – preliminary assessment for MaineCare – transfer likely eligible consumers to OFI for eligibility determination



Eligibility Requirements

- Live in Maine
- US Citizen or lawfully present
- Not incarcerated
- Not eligible for Medicare

**Not eligible for financial savings if eligible for other “affordable” coverage*

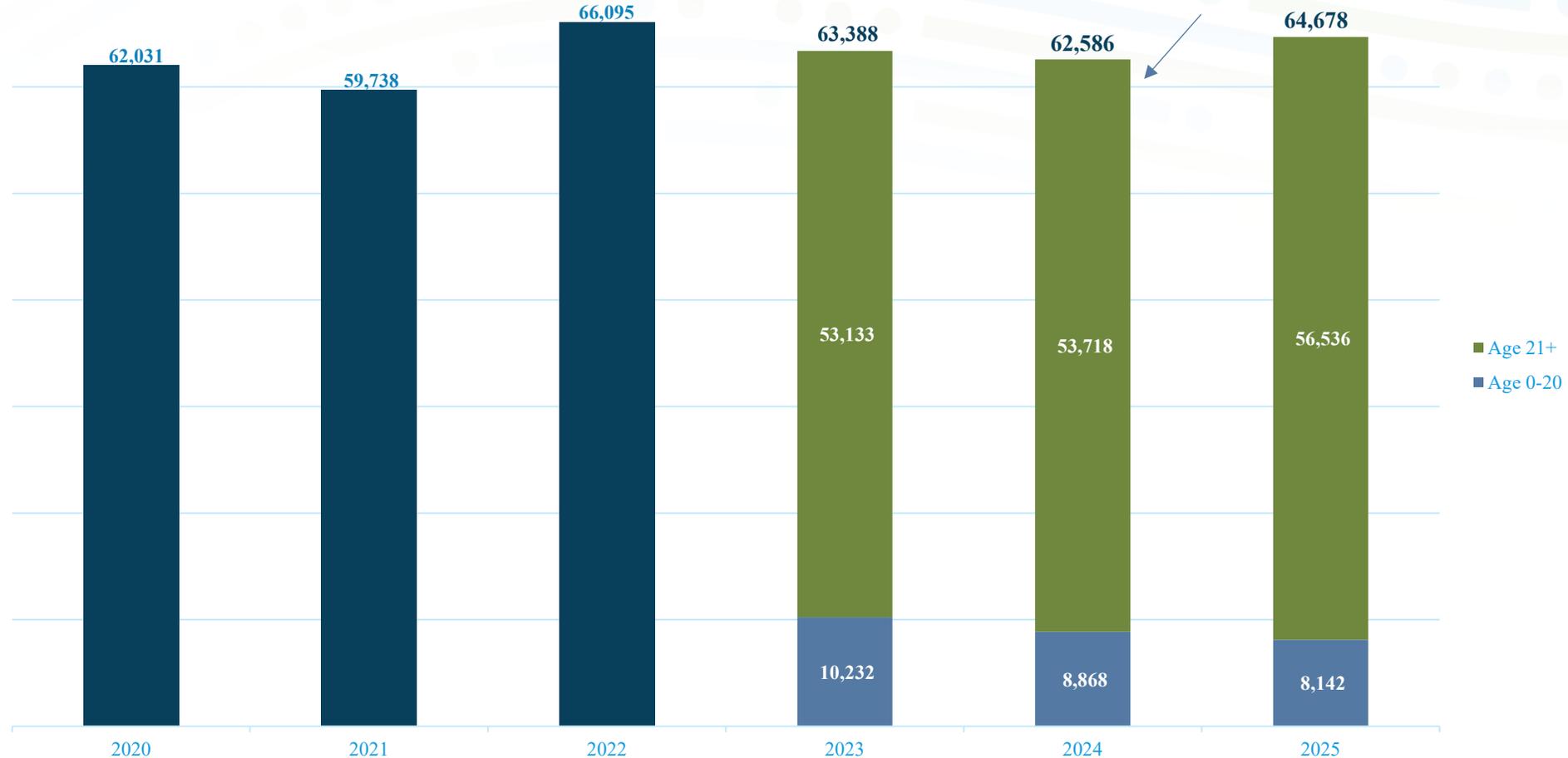
QUALITY PLANS WITH PREVENTATIVE SERVICES

- The following ten essential health benefits must be included in all health insurance plans sold on CoverME.gov:
 - Ambulatory patient services
 - Emergency services
 - Hospitalization
 - Laboratory services
 - Maternity & newborn care
 - Prescription drugs
 - Mental health & substance use disorders
 - Pediatric services
 - Preventive, wellness services, & chronic disease management
 - Rehabilitative & habilitative services/devices
- Individuals do not pay co-pays, coinsurance or deductibles for certain [preventive health services](#) that are provided by network providers, including routine immunizations, routine physical exams, recommended health care screenings.
- Most plans have significant pre-deductible coverage (e.g., office visits, prescription drugs, urgent care).
- As a state-based marketplace, CoverME.gov has the flexibility to offer enrollees tailored resources and communications to help Mainers take full advantage of their comprehensive coverage.



ENROLLMENT DURING OPEN ENROLLMENT PERIOD*

Implementation of expansion of MaineCare eligibility for children
(one month prior to start of OE 2024)

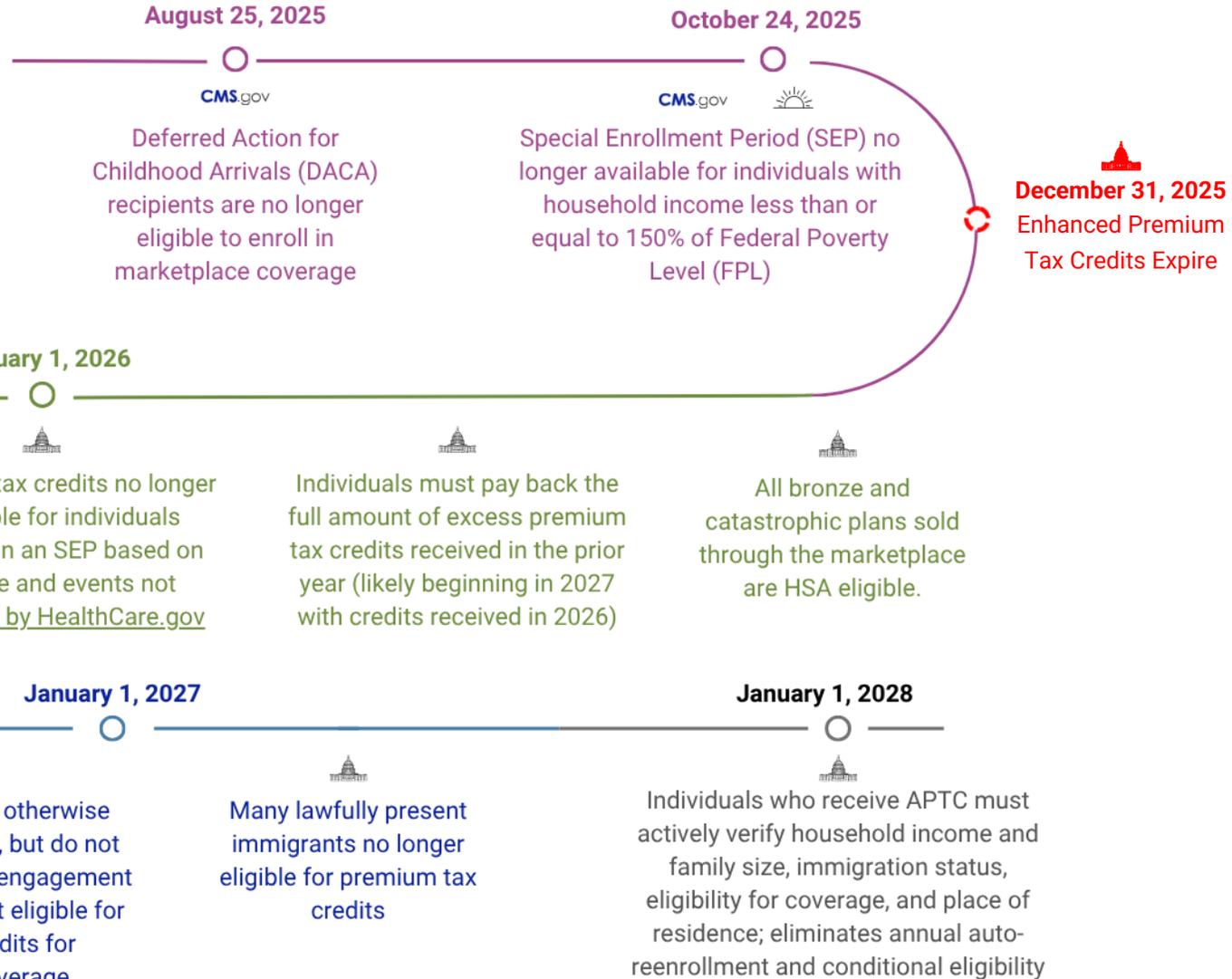


Recent Federal Changes to Maine's Health Insurance Marketplace

Key:

- 2025 Implementation
- 2026 Implementation
- 2027 Implementation
- 2028 Implementation

-  **Provision in CMS Marketplace Integrity and Affordability Final Rule**
-  **Provision in HR 1 (2025 Federal Budget Reconciliation Act)**
-  **Provision sunsets December 31, 2026**
-  **Enhanced Premium Tax Credits Expire**



* = Provision is stayed pending resolution of City of Columbus v Kennedy

2025 PLAN YEAR CHANGES (CURRENT PLANS)

Effective 8/25/25

- **DACA recipients no longer eligible** for health coverage on the marketplace
- **Loss of coverage due to underpayment:** Change to rules that allowed enrollees to maintain coverage if they hadn't paid their full premium
 - Carriers must use net percentage-based method (95% or higher)
 - Gross-premium and fixed-dollar threshold method no longer allowed

Effective 10/24/25

- **Income-based SEPs prohibited:** “Household income at or below 150% FPL” Special Enrollment Period eliminated
- Eliminates ability for households with a projected income $\leq 150\%$ federal poverty level to enroll in marketplace coverage at any time during the year
- Often utilized by:
 - Adults w/o children just above MaineCare cutoff
 - Legal immigrants experiencing waiting period for MaineCare eligibility due to citizenship status

2026 PLAN YEAR CHANGES

Effective Plan Year 2026

- **Lawfully present immigrants <100% FPL not eligible for APTC:**
 - Immigrant households with incomes less than 100% FPL no longer eligible for Advance Premium Tax Credits
 - Includes those waiting for Medicaid eligibility due to immigration status
- **APTC repayment limits eliminated:**
 - Households with incomes higher than anticipated will have to repay entire amount of any excess APTC received
 - Prior to this change, many protected by repayment cap
 - <138% FPL remain protected by repayment cap
- **Expansion of HSAs:** All bronze and catastrophic plans are HSA-eligible even if have pre-deductible coverage
- **EPTC Expiration:** Enhanced Premium Tax Credits (EPTC) set to *expire* December 31, 2025

These are the plans people are shopping for during Open Enrollment (started November 1, 2025)

2027 PLAN YEAR & BEYOND

Effective Plan Year 2027

- **Shortened Open Enrollment Period:** no longer than 9 weeks
 - Beginning no earlier than November 1
 - Ending no later than December 31
- **MaineCare eligible that do not meet “work requirements” not eligible for APTC**
- **Many lawfully present immigrant groups no longer eligible for financial assistance**

Effective Plan Year 2028

- **Auto-enrollment no longer accepted**
 - Consumers must actively verify application information to remain covered

RECONCILIATION & CMS RULE – OPERATIONAL IMPACTS

Time and Staffing Constraints

- Implementation to-date: hundreds of hours of staff time on changes/updates:
 - Consumer, broker, and assister communications
 - Internal operational guidelines
 - Eligibility and enrollment system changes or manual work-arounds
- To-date changes are small percentage of all newly required changes
- New eligibility and verification requirements require investments in people and technology:
 - Extensive system updates and testing
 - Increased casework and document verification
 - Updating operational guidelines
 - Communication with consumers, brokers, enrollment assisters, and partners
 - Coordination with OFI/OMS
- Inadequate timelines for system and technology changes: typical timeline 9-12 months v. 2-3 months for 2025 & 2026 implementation deadlines

RECONCILIATION & CMS RULE – OPERATIONAL IMPACTS (CONTINUED)

Vendor contracts

- Contract renewals (or contract amendments) with technology, call center, and outreach vendors will likely require increased investments, at least in the short term for:
 - Increased number of platform changes in a shortened time period
 - Projected increased consumer contacts inbound call and chat volume and outbound communication campaigns
 - Increased consumer confusion and enrollment support

Legal challenges

(result in ever-changing requirements)

- City of Columbus v Kennedy: court stayed all marketplace enforcement of removing eligibility for advance premium tax credits for consumers who have failed to reconcile in prior tax years
 - Additional manual workarounds and increased staff time necessary to maintain compliance with changing Failure To Reconcile (FTR) guidelines

EXPIRING EPTC: FINANCIAL SAVINGS BASICS

Premium Tax Credits (PTCs)

- Federal tax credit that lowers monthly premiums for marketplace health insurance
- Can be taken in advance of filing federal income taxes (called APTC)
- **PY 2025: nearly 85% received APTC; PY 2026: nearly 70% receive APTC**
- When you apply, you enter your estimated expected household income for the year to see if you qualify for the tax credit
- If you qualify, you can use any amount of the credit in advance to lower your monthly payments.
- Alternatively, you can take the tax credit at the end of the year when you file your federal income taxes.
- Tax credit reconciled when file federal income taxes – limit on underpayment penalty for those under 400% FPL*

Cost Sharing Reductions (CSRs)

- Additional savings on out-of-pocket costs like deductibles or copays, available to a smaller number of people than qualify for APTCs.
- Requires enrolling in a Silver category plan to get the extra savings.



Case Study

Family of three in Caribou with annual household income of \$81,500 enrolled in a Silver plan

- Full cost: **\$1,869/month**
- APTC: **\$1,215/month**
- Premium paid: **\$654/month**

Deductible: \$5,000 individual/ \$10,000 family

* HR 1 removed repayment limit starting in 2026 plan year, so all underpayments will need to be repaid when households file federal income taxes.

EXPIRING EPTC: CONSUMER IMPACT

Enhanced premium tax credits (EPTC)

- Authorized in American Rescue Plan Act of 2021 (ARPA); extended in Inflation Reduction Act (IRA)
- Temporarily increased amount of premium tax credits and expanded eligibility
- Eliminated premium “cliff” for thousands of Mainers
- **EPTC expires 12/31/25 unless Congress takes action to extend**
- If EPTC expires, premiums will increase for all who receive APTC with greatest impacts for older, rural adults, households with children
- **If EPTC expires, average premium increase for CoverME.gov households will be 77% in 2026**

Income Ranges for:			% of Income Expected to Contribute to Premium of “Benchmark” Plan	
Single Individual	Family of 2	Family of 4	With EPTC	After EPTC Expires
<\$23,475	<\$31,725	<\$48,225	0%*	2.10%-4.19%
\$23,475-<\$31,300	\$31,725 - <\$42,300	\$48,225 - <\$64,300	0%*-2%	4.19%-6.60%
\$31,300-<\$39,125	\$42,300- <\$52,875	\$64,300 - <\$80,375	2%-4%	6.60%-8.44%
\$39,125 - <\$46,950	\$52,875 - <\$63,450	\$80,375 - <\$96,450	4%-6%	8.44%-9.96%
\$46,950 - <\$62,600	\$63,450 - <\$84,600	\$96,450 - <\$128,600	6%-8.5%	9.96%
\$62,600+	\$84,600+	\$128,600	8.5%	N/A – do not qualify

*Maine households in this category pay a nominal monthly premium to cover benefits that are required to be covered by state law that go beyond the “benchmark” plan.

EXPIRATION OF EPTC – CONSUMER CASE STUDIES

Case Study: Kittery



Family of four (ages 40, 38, 8, 5) in Kittery with annual household income of \$100,000 enrolled in a Silver plan

- Premium(with EPTC): **\$6,280/year**
- Premium (without EPTC): **\$9,960/year**
- Increase in Premium: **59% increase**

Case Study: Penobscot



Family of three in Penobscot (ages 63, 60, 25) with annual household income of \$107,000 enrolled in a Silver plan

- Premium (with EPTC): **\$9,177/year**
- Premium(without EPTC): **\$47,300/year**
- Premium Difference: **415% increase**

Case Study: Bangor



Family of two in Bangor with annual household income of \$50,000 enrolled in a Silver plan

- Premium(with EPTC): **\$1,730/year**
- Premium (without EPTC): **\$3,370/year**
- Increase in Premium: **95% increase**

EXPIRATION OF EPTC – CONSUMERS’ OWN WORDS

Without EPTC, my monthly premium would double in cost, and I would not be able to afford health insurance that my life relies on. I will likely die without health insurance.



Holly, Hope, ME
Home Care Supervisor

Because of the current cost of living and cost of health care in Maine, I will not have an option to live here anymore if the enhanced premium tax credits do not continue.



Scott, North Yarmouth, ME
Golf Course Superintendent

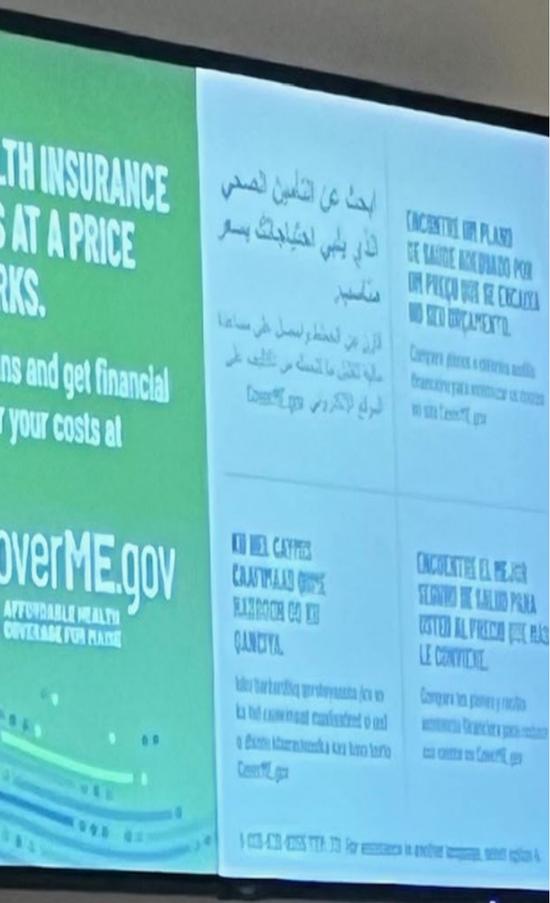
Affordable health insurance, and the EPTC that make it possible, allow families like mine to survive, and live with dignity.



Stephanie, Fairfield, ME
Hair Salon Owner

ADVANTAGES OF STATE-BASED MARKETPLACE

- Program Integrity
 - OHIM verifies all brokers' standing with the BOI
 - Consumers must consent to a broker or MEA acting on their behalf
 - Consumers undergo verification processes to ensure they have eligible residency, income, immigration and citizenship statuses for coverage and financial savings, when applicable
 - Local relationships support program integrity
- Certain provisions of new federal rule do not apply to SBMs:
 - For PY 2026, the FFM is newly required to conduct pre-enrollment eligibility verification for special enrollment periods for at least 75% of enrollees
 - The FFM, beginning for PY 2027 will have open enrollment run from Nov 1 – Dec 15. SBMs can run OE for an additional two weeks, until Dec 31
- Control of marketing and outreach funding
 - Messaging and images reflect Maine
 - Meet Mainers where they get their information
- Control and oversight of navigator funding
 - Coordination and collaboration with marketplace outreach
 - Coordinated messaging
- Close partnerships with:
 - Brokers
 - Maine Enrollment Assistors
 - Health and Dental Plans
 - Bureau of Insurance
 - DHHS – MaineCare
 - Other relevant state agencies
- Transparency and Tone



EARLY DAYS OF OPEN ENROLLMENT 2026

- Fewer new consumers enrolled during first few days
- Call center inbound call volume extremely high on first two weekdays of OE
 - On Monday, Nov 3, during first two hours, handled more calls than a “typical” day
 - By 3 pm , more calls than received on 1st day of Open Enrollment last year
 - Call volume on first Tuesday was also higher than last year

(Note: Call center typically open 8 am - 8 pm on weekdays during Open Enrollment – open some Saturdays and extended hours on deadline weeks)

- Social media channels are very active with consumer comments – most focused on significant increases in premiums

RECAP – RECONCILIATION IMPACTS

Program Overview

~64,000 Mainers enrolled; state-based exchange

Reconciliation & Other Federal Action Impacts

Elimination of enhanced subsidies and decreased state flexibility

Complex new eligibility verification requirements

Increased costs for consumers for health insurance coverage

Operational & Fiscal Implications

Technology: Major system updates to align with new federal eligibility verification requirements.

People: Additional staff and contractor resources to implement system changes and conduct consumer outreach to prevent coverage losses.

QUESTIONS





Maine State Legislature
OFFICE OF POLICY AND LEGAL ANALYSIS
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(207) 287-1670

MEMORANDUM

TO: Members, Joint Standing Committee on Health Coverage, Insurance and Financial Services

FROM: Colleen McCarthy Reid, Principal Analyst

DATE: November 6, 2025

RE: History of Legislative Studies and State Agency Reports on Health Care Reform Issues

During the committee's discussion of LD 1269, Resolve, to Study the Costs and Funding of a Universal Health Care Plan for Maine in the First Session, committee members asked for more information about prior legislative studies and reports on health care reform issues. In response to that request, attached are the following documents:

1. Chart outlining the task forces, commissions, boards and study groups established to study health care reform issues from 1970 to the present; and
2. Chart outlining studies required to be completed by State agencies on health care reform issues between 2005 and 2025.

Links are included to find copies of the legislative studies. Please let me know if you would like copies of the State agency reports described in the 2nd chart.

Health Care Studies, Boards, Task Forces, Committees and Commissions – 1970 to Present

Name of Organization, Board or Study Group	Enacting Legislation	Description	Link to Reports
107th Legislature (1975-1976)			
Committee on Health and Institutional Services Study of the Subject Matter of L.D. 1230: An Act Creating the Maine Health Maintenance Organization Act	Joint Order H.P. 1541 (1975)	Study the subject matter of LD 1230 and determine whether or not the best interests of the state would be served by enactment of such legislation.	http://ldc.mainelegislature.org/Open/Rpts/kf1184_h4m35_1975.pdf
108th Legislature (1977-1978)			
Health Facilities Cost Review Board	P.L. 1977, c. 691 Repealed 7/1/1982	Establish uniform systems for reporting financial and other health service data; review hospital budgets; conduct studies and analyses relating to health care costs and other related matters ; prepare an annual report for transmission to the Legislature and the Governor; apply for and receive grants, gifts and other payments from any governmental agency, private entity or other person; contract with 3rd parties for services necessary to carry out the activities of the board; approve voluntary budget review organizations and develop performance standards to evaluate the effects of any approved voluntary budget review organization on the costs of health care services rendered by hospitals participating in the organization.	Not available (hard copies of reports available from Law Library)
Committee on Health and Institutional Services Study of the Administration of Medication	Joint Order H.P. 2357 (1977)	Study the administration of medication to various types of persons including, but not limited to, those who live in correctional facilities and in facilities such as nursing, boarding and foster homes and determine who can safely administer medication and what type of, under what circumstances and to whom medication can be safely administered.	http://ldc.mainelegislature.org/Open/Rpts/kf3827_d8m35_1977.pdf
Joint Standing Committee on Performance Audit: A Study of Maine's Medicaid Program	Joint Order H.P. 1809 (1978)	Study Maine's Medicaid program and make recommendations for legislation.	http://ldc.mainelegislature.org/Open/Rpts/hd7102_u42m2_1978.pdf
109th Legislature (1979-1980)			
Governor's Task Force on Maternal and Child Health	Executive Order 5 (10/2/1979)	Examine and make recommendations regarding approaches for improving the quality, availability and coordination of maternal and child health services in Maine.	Not available (hard copies of reports available from Law Library)
Joint Subcommittee Studying the Provision of Emergency Medical Services	Study Order H.P. 1435 (1980)	Study the present operations and programs of Medical Care Development, Inc., the feasibility of restructuring the present law relating to the licensing of emergency medical service and testing of ambulance service and personnel to eliminate the	http://ldc.mainelegislature.org/Open/Rpts/kf3826_e5m35_1980.pdf

Health Care Studies, Boards, Task Forces, Committees and Commissions – 1970 to Present

Name of Organization, Board or Study Group	Enacting Legislation	Description	Link to Reports
		uncertainty and confusion that results from constantly changing standards and study the necessity and propriety of delegating responsibility in this area to private sector entities or persons, including findings, recommendations and suggested legislation.	
110th Legislature (1981-1982)			
Committee Studying the Certificate of Need Process	Approved by Legislative Council in June, 1981	Amend Maine's certificate of need legislation in certain areas, as a condition of receipt of federal funding.	http://lldc.mainelegislature.org/Open/Rpts/kf3825_5_z99m229_1982.pdf
111th Legislature (1983-1984)			
Maine Health Care Finance Commission	P.L. 1983, c. 579 Repealed by P.L. 1995, c. 653, sec. B4	Establish uniform systems for health care facilities to report financial and health care information; establish advisory committees: Professional, Hospital and Payor; establish and approve revenue limits and apportionment methods for individual hospitals; conduct studies and analyses relating to health care costs, the financial status of any facility subject to this chapter and any other related matters it deems appropriate and submit annual report to Governor and Legislature of its operations and activities during the previous year.	Not available (hard copies of reports available from Law Library and Maine State Library)
112th Legislature (1985-1986)			
Study of the Effect of Medical Costs in Maine's Workers' Compensation System	P.L. 1985, c. 372	Directs subcommittee of the Labor Committee to determine if rising medical costs are a contributing factor to rising workers' compensation costs as a whole, and if so, what specific aspects of treatment or fees are responsible for that increase.	http://lldc.mainelegislature.org/Open/Rpts/kf3615_z99m279_1986.pdf
Joint Standing Committee on Business and Commerce Study on Alternative Methods of Payment for Health Care in Maine	1986 (legislation not specified)	Study impact of alternate health care delivery systems, mandated benefits and licensing allied health professionals on health care costs, health insurance costs, quality of care and availability of care including proposed legislation.	http://lldc.mainelegislature.org/Open/Rpts/ra413_5_u6m26_1986.pdf
Joint Select Committee to Study Insurance Pools for High Risk Groups Seeking Health & Life Insurance	Created by Legislative Council in 1986	Examine the feasibility of establishing a state health insurance pool to help provide health insurance for individuals who, for medical reasons, are categorized as being in a high-risk group and who are often unable to obtain insurance or may only obtain insurance with significant exclusions.	http://lldc.mainelegislature.org/Open/Rpts/hg9397_5_m2m34_1986.pdf
113th Legislature (1987-1988)			
Blue Ribbon Commission on the Regulation of Health Care Expenditures	P.L. 1987, c. 440	An evaluation of the current and anticipated market for health care services, the current methods and impending trends	https://digitalcommons.usm.maine.edu/me_collection/117/

Health Care Studies, Boards, Task Forces, Committees and Commissions – 1970 to Present

Name of Organization, Board or Study Group	Enacting Legislation	Description	Link to Reports
		in the financing and delivery of health care, the current and anticipated environment for health care delivery systems and various methods of regulating health care and health care expenditures, including, but not limited to, the present regulatory system under the Maine Health Care Finance Commission	
Maine Health Policy Advisory Council	P.L. 1987, c. 542, secs. C2 and C3 Repealed by P.L. 1991, c. 622, sec. 20	Advise and be available for consultation to the Governor, Commissioner of Human Services, Commissioner of Mental Health and Mental Retardation, other executive branch agencies, the Legislature and the Maine congressional delegation on health policy issues related to health status, health promotion and health care delivery that the council believes to be significant and that it has the resources to address.	Not available (hard copies of reports available from Law Library)
Joint Select Committee to Study of the Necessity and Feasibility of Establishing a Health Information Recording System	P.&S. L. 1987, c. 138	Evaluate other states' centralized health data collection systems, and receive and analyze information from insurers, health care providers, a private health information collection agency and various state agencies to study the feasibility of establishing a health information recording system.	http://ldc.mainelegislature.org/Open/Rpts/ra410_54_m2m358_1988.pdf
Commission to Study Health Services in Public Schools	Resolve 1987, c. 66	Study existing adolescent health needs and concerns including, but not limited to: pregnancy, parenting, suicide, mental health, substance abuse, and sexuality, identify existing health services for adolescents and recommend appropriate educational programs and health services which may be provided through the public schools	http://ldc.mainelegislature.org/Open/Rpts/lb3409_u6m2_1988.pdf
114th Legislature (1989-1990)			
Maine Health Program Advisory Committee	P.L. 1989, c. 588, sec. A43 Repealed by P.L. 1999, c. 668, sec. 100	Advise the Department of Human Services on an ongoing basis with respect to the development and administration of the Maine Health Program, which is designed to meet the health care needs of uninsured, financially needy Maine residents.	Not available
115th Legislature (1991-1992)			
Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program	Authorized by Legislative Council on 8/22/1991; original legislation (LD 1727) vetoed by Governor 1/7/1992 and veto sustained)	Study and make recommendations on the establishment of a statewide health insurance program.	Interim report: http://ldc.mainelegislature.org/Open/Rpts/hg9383_m354_1992.pdf Final report: http://ldc.mainelegislature.org/Open/Rpts/hg9383_m3541_1992.pdf

Health Care Studies, Boards, Task Forces, Committees and Commissions – 1970 to Present

Name of Organization, Board or Study Group	Enacting Legislation	Description	Link to Reports
Medicaid Cost Containment: Issues and Options	Authorized by Legislative Council in April 1992	OPLA study of cost containment in the Medicaid program.	http://ldc.mainelegislature.org/Open/Rpts/kf3605_s3_1992.pdf
116th Legislature (1993-1994)			
Health & Social Services Transition Team	Resolve 1993, c. 36	Develop all of the legislation necessary to abolish the Department of Human Services and the Department of Mental Health and Mental Retardation and create two new departments: The Department of Children and Families and the Department of Health and make policy recommendations in a number of specific areas, including homelessness, juvenile corrections, regional planning and advisory boards.	http://ldc.mainelegislature.org/Open/Rpts/hv98_m2m326_1994.pdf
Maine Health Care Reform Commission	P.L. 1993, c. 707, Part AA	Develop 3 required models for health care reform, including a multi-payor model that provides health insurance coverage for all citizens of the State, a single-payor model that provides universal coverage for all citizens of the State and a model based on the present health care system that incorporates managed care and other mechanisms to control costs and to improve access for uninsured citizens of the State and a proposal for implementation of a uniform data collection system.	http://ldc.mainelegislature.org/Open/Rpts/ra395_a4m388_1995.pdf (Hard copies of other reports available from Law Library)
117th Legislature (1995-1996)			
Task Force to Monitor Hospital Deregulation	P.L. 1995, c. 368, sec. W12	Monitor the impact of deregulation on health care providers and consumers, propose recommendations concerning data collection and financial analysis and recommend statutory changes to carry out the elimination of regulatory functions of the Maine Health Care Finance Commission.	http://ldc.mainelegislature.org/Open/Rpts/kf3825_z99m25_1996.pdf
118th Legislature (1997-1998)			
Maine Commission on Children's Health Care	P.L. 1997, c. 560, Part B	Consider the problem of uninsured children in Maine and options to increase the number who are insured.	http://ldc.mainelegislature.org/Open/Rpts/hd7102_u42m26_2_1998.pdf
Certificate of Need Advisory Committee	P.L. 1997, c. 689 Repealed by P.L. 2001, c. 664, sec. 1	Review proposed rules, criteria, standards and procedures for the certificate of need process and the state health plan prior to their adoption, review the annual certificate of need report prepared by the department and advise the commissioner with regard to certificate of need.	Not available
Consumer Health Care Division Advisory Council	P.L. 1997, c. 792, sec. 3 Repealed by P.L. 2005, c. 294, sec. 24	Consult with and advise the Director of the Consumer Health Care Division of the Bureau of Insurance concerning the division's performance of the duties under this subchapter and to make	Not available

Health Care Studies, Boards, Task Forces, Committees and Commissions – 1970 to Present

Name of Organization, Board or Study Group	Enacting Legislation	Description	Link to Reports
		recommendations to the superintendent on issues concerning the protection of consumer interests and rights under health care plans.	
Task Force to Study the Feasibility of a Single Claims Processing System for 3 rd -Party Payers of Health Care Benefits	Resolve 1997, c. 63	Explore the feasibility of a single claims processing system for third-party payors of health care benefits and the feasibility of streamlining the current claims processing systems used by payors.	http://lldc.mainelegislature.org/Open/Rpts/hg9397_5_m2m37_1998.pdf
Commission to Study the Certificate of Need Laws	Resolve 1997, c. 82	Study the effectiveness of the certificate of need laws in ensuring access to health care and in controlling costs, the need for modifications to address the changing health care system and alternative methods of meeting the goals of the laws.	http://lldc.mainelegislature.org/Open/Rpts/kf3825_5_z99m247_1998.pdf
Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine	Resolve 1997, c. 85	Study the effects of government regulation and health insurance costs on small businesses throughout the State.	http://www.state.me.us/legis/pla/bluerpt.htm
119th Legislature (1999-2000)			
Year 2000 Blue Ribbon Commission on Health Care	Executive Order 2 (2/1/2000)	Identify the cost elements of Maine's health care system, considering the demographics of the State, determine the current allocation of costs and cost shifting among participants in the health care delivery system, recommend potential strategies for stabilizing overall health care costs and identify payment options for health care services, including the impact of such options on costs and utilization.	Not available (hard copies of reports available from Law Library)
Joint Select Committee to Study the Creation of Public/Private Purchasing Alliance to Ensure Access to Health Care for all Maine Citizens	Joint Order H.P. 1857 (2000)	Examine the public policy, regulatory and legislative issues related to creating a public/private purchasing alliance and the possibility of creating a pilot project for a community-based health plan.	http://www.state.me.us/legis/pla/alliance.PDF
Joint Select Committee on School-Based Health Care Services	Joint Order H.P. 1864 (2000)	Review the current funding sources for school-based health care services and recommending strategies for funding school-based health services, including public funding and third-party reimbursement.	http://www.state.me.us/legis/pla/schoolhl.PDF
120th Legislature (2001-2002)			
Health Care System and Health Security Board	P.L. 2001, chapter 439, Part ZZZ (amended by Resolve 2005, c. 119)	Develop recommendations to provide universal access to health care coverage for all Maine citizens after assessing the feasibility and cost of implementing a single-payer health care system in Maine	Preliminary report: http://lldc.mainelegislature.org/Open/Rpts/ra410_54_m2m3_2003.PDF Final report: http://lldc.mainelegislature.org/Open/Rpts/ra410_54_m2m3_12_2006.pdf

Health Care Studies, Boards, Task Forces, Committees and Commissions – 1970 to Present

Name of Organization, Board or Study Group	Enacting Legislation	Description	Link to Reports
Feasibility of a Single-Payer Health Plan Model for the State of Maine	P.L. 2001, chapter 439, Part ZZZ	Health Care System and Health Security Board contracts with a Mathematica Policy Research, Inc. to study the feasibility of establishing a single-payor health plan in the State.	http://lfdc.mainelegislature.org/Open/Rpts/ra395_a4m269_2002.pdf
121st Legislature (2003-2004)			
Commission to Study Maine's Hospitals	P.L. 2003, c. 469	Study Maine's community hospitals focusing on quality, access and costs.	http://lfdc.mainelegislature.org/Open/Rpts/ra981_m2c66_2005.pdf
Advisory Council on Health Systems Development	P.L. 2003, c. 469, Part B (2 MRSA §104) Repealed by P.L. 2011, c. 90, Part E, sec. 3	Advises the Governor in developing the State Health Plan by collecting and coordinating data on health systems development in the state, synthesizing relevant research, conducting review of cost drivers in state's health care system, collecting and reporting on health care cost indicators and conducting at least 2 public hearings on the plan and the capital investment fund each biennium	Not available
Commission to Study Public Health	Resolve 2003, c. 95	Study obesity in the State and methods to decrease the cost of health care and improve the public health.	http://lfdc.mainelegislature.org/Open/Rpts/ra395_a4m244_2005.pdf
Governor's Council on Physical Fitness, Sports, Health and Wellness	Executive Order 9 (2/14/2003)	Advise the Governor of means to foster a healthy citizenry, as well as offer viable solutions to the health challenges that face the State by proposing strategies to increase the level of citizen involvement in recreational and sporting activities, identifying and providing guidance on health-related issues that may be appropriately addressed through legislative and administrative action, serving as a liaison for national organizations and interest groups and generally planning methods to carry out the foregoing responsibilities.	Not available (hard copies of reports available from Law Library)
122nd Legislature (2005-2006)			
Blue Ribbon Commission on the Future of MaineCare	Resolve 2005, c. 117	Study the MaineCare program and make recommendations on how to improve the quality, adequacy, effectiveness and delivery of services under the program in the most cost-effective manner.	http://lfdc.mainelegislature.org/Open/Rpts/ra412_45_m2m33_2006.pdf
Blue Ribbon Commission on Dirigo Health	Executive Order 14 (5/24/2006)	Review and make recommendations for alternatives for funding the Dirigo Health Program and its subsidies, which may include the savings offset payment and review and make recommendations on methods proven effective in reducing and controlling health care costs and create savings in Maine's health care market, including how such methods may be incorporated in the DirigoChoice health insurance product.	http://www.dirigohealth.maine.gov/Documents/BRC%20Final%20Report.pdf

Health Care Studies, Boards, Task Forces, Committees and Commissions – 1970 to Present

Name of Organization, Board or Study Group	Enacting Legislation	Description	Link to Reports
123rd Legislature (2007-2008)			
Health and Human Services Committee Study of MaineCare	Joint Order S.P. 720 (2007)	Receive information regarding and review the MaineCare program.	Not available
Health and Human Services Committee Review of Eligibility for and Transitioning of the MaineCare Program	Joint Order S.P. 724 (2007)	Review eligibility for and transitioning of the MaineCare program.	Not available
Commission to Study Primary Care Medical Practice	Joint Order S.P. 732 (2007)	Identify the causes of the loss of independent ownership of primary care medical practices and the effect of this on health care costs and access to medical treatment.	http://lfdc.mainelegislature.org/Open/Rpts/ra427_9_m35_2007.pdf
Blue Ribbon Commission to Study the Regulation of Health Care Expenditures	P.L. 2007, c. 441	Undertake a study of the health care system and health care regulation and recommend the most appropriate form of health care regulation necessary to ensure the provision of quality care, the accessibility and the affordability of care.	Not available
Health and Human Services Committee Review of the Fund for a Healthy Maine	P.L. 2007, c. 629, Part H	Consider the structure, accountability and level of legislative and independent oversight of the Fund for a Healthy Maine.	https://www.maine.gov/legis/opla/fundforhealthymrpt.pdf
Updated Study of the Feasibility of Establishing a Single-Payor Health Care System	Resolve 2007, c. 216	Update 2002 feasibility study of a single-payor health plan model for the State of Maine.	Not available
124th Legislature (2009-2010)			
Updated Study of the Feasibility of Establishing a Single-Payor Health Care System in the State and the Impact of Any Federal Health Care Reform	Resolve 2009, c. 135	Contract with a qualified consultant to update a 2002 study of the feasibility of establishing a single-payor health plan in the State.	Not available
Governor's Health Information Technology Steering Committee	Executive Order 9 (4/6/2010)	Advise the Office of the State Coordinator for Health Information Technology in developing the vision, goals, and prioritization areas for advancing health information technology and health information exchange across Maine and to develop appropriate governance, oversight, and accountability mechanisms to assure success and present a draft state health information technology plan for approval by the Director of the Office of the State Coordinator for Health Information Technology.	Not available
Health Reform Implementation Steering Committee	Executive Order 12 (4/22/2010)	Advise the Governor and provide coordination and leadership for implementation of federal health reform across all departments and agencies of the executive branch; assure ongoing information sharing and coordination of efforts with Legislative Joint Select	Not available

Health Care Studies, Boards, Task Forces, Committees and Commissions – 1970 to Present

Name of Organization, Board or Study Group	Enacting Legislation	Description	Link to Reports
		Committee on Health Care Reform Opportunities and Implementation; assure broad stakeholder engagement by consulting the Advisory Council on Health Systems Development to ensure open dialogue and to further the success of health reform implementation and ensure the State Health Plan is consistent with ongoing implementation efforts, which must include a chapter outlining issues and options for National Health Reform implementation.	
Joint Select Committee on Health Care Reform Opportunities and Implementation	Joint Order H.P. 1262 (2010)	Study any federal health care reform legislation enacted by the U.S. Congress and determine the State's opportunities for health care reform and the State's role in implementation of federal legislation.	http://lldc.mainelegislature.org/Open/Rpts/kf6276_58_a2m2_2010.pdf
125th Legislature (2011-2012)			
Commission to Study Allocations of the Fund for a Healthy Maine	Resolve 2011, c. 112	Review the alignment of allocations from the Fund for a Healthy Maine and report findings and recommendations, including suggested legislation, to the Appropriations and Financial Affairs and Health and Human Services Committees.	http://lldc.mainelegislature.org/Open/Rpts/kf1297_t63m4_2011.pdf
126th Legislature (2013-2014)			
Maine Health Exchange Advisory Committee	Joint Order H.P. 1136 (2013)	Advise the Legislature regarding the interests of individuals and employers with respect to any health benefit exchange that may be created for the State pursuant to the federal Patient Protection and Affordable Care Act; serve as liaison between any exchange and those enrolled in it; and evaluate implementation and operation of any exchange.	Preliminary report: http://lldc.mainelegislature.org/Open/Rpts/hd7102_u42m245_2013.pdf Final report: http://lldc.mainelegislature.org/Open/Rpts/hd7102_u42m246_2014.pdf
Commission to Study Transparency, Costs and Accountability of Health Care System Financing	Joint Order H.P. 1123 (2013)	Review and evaluate the current data reported by hospitals and other health care facilities relating to charges, costs of providing services, revenue and financial data and make recommendations for standardizing financial reporting to enhance transparency to the public of health care costs.	http://lldc.mainelegislature.org/Open/Rpts/ra395_a4m34_2013.pdf
127th Legislature (2015-2016)			
Health and Human Services Committee Study of Allocations of the Fund for a Healthy Maine	Resolve 2015, c. 47	Review the alignment of allocations from the Fund for a Healthy Maine with the State's current public health care and preventive health priorities and goals.	http://lldc.mainelegislature.org/Open/Rpts/kf1297_t63m43_2015.pdf
128th Legislature (2017-2018)			
Task Force on Health Care Coverage for All of Maine	Joint Order S.P. 592, as amended by	Study the design and implementation of options for different health care plans	https://legislature.maine.gov/doc/2509

Health Care Studies, Boards, Task Forces, Committees and Commissions – 1970 to Present

Name of Organization, Board or Study Group	Enacting Legislation	Description	Link to Reports
	House Amendment “A” (2018)	providing coverage for all residents of the State.	
129th Legislature (2019 -2020)			
No related studies were conducted during this Legislature.			
130th Legislature (2021 -2022)			
No related studies were conducted during this Legislature.			
131st Legislature (2023 - 2024)			
Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities	Resolve 2023, c. 100	Evaluate funding models and structures that allow for the sustained investment in the health and prosperity of youth and families in the State, including identifying sources of sustained funding for reducing tobacco use, improving public health, preventing chronic illness, reducing health disparities across demographic and geographic populations and improving the community conditions that support good health and wellness.	https://legislature.maine.gov/doc/10642
Task Force to Evaluate the Impact of Facility Fees on Patients	Public Law 2023, chapter 410	Evaluate the impact on patients of paying facility fees charged by health care providers.	https://legislature.maine.gov/doc/10648
132nd Legislature (2025 – 2026)			
Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions that Impact the Delivery of Health Care Services in the State	Resolve 2025, c. 160	Evaluate the scope of regulatory review and oversight over health care transactions that impact the delivery of health care services in the State.	Report not due until December 10, 2025
Commission to Expand Access to Oral Health Care by Studying Alternative Pathways for Obtaining a License to Practice Dentistry	Resolve 2025, c. 107	Study integrating foreign-trained dentists and out-of-state dentists into the dental care workforce to expand access to oral health care in the State.	Report not due until December 10, 2025

Health Care Reform Studies by State Agencies (2005 – 2025)

State Agency	Enacting Legislation	Description	Year Report Published
Department of Health and Human Services	P.L. 2003, c. 20, sec. K-15	Report, including proposed legislation, on the restructuring cost-sharing in the MaineCare program.	2005
Dirigo Health Board of Directors	24-A §6971, sub-§3 <i>Repealed in 2007</i>	Report on high-risk pools, including disease management protocols, procedures and delivery mechanisms used to provide services to plan enrollees.	2005
Superintendent of Insurance	P.L. 2003, c. 469, Part E, sec. 21	Report on decisions by the Superintendent of Insurance to allow health carriers to offer health plans under Title 24-A, section 4303, sub-§1, par. A.	2005
Department of Health and Human Services	Resolve 2005, c. 9, sec. 1	Report regarding the Private Health Insurance Premium Program under MaineCare.	2006
Health Care Administrative Streamlining Work Group	P.L. 2005, c. 394, sec. 7	Report on the administrative streamlining of information from multiple insurers.	2006
Health Care System and Health Security Board	Resolve 2005, c. 119, sec. 2	Report and suggested legislation regarding the feasibility of a single-payor health plan to provide health care coverage to all citizens of this State	2006
State Employee Health Commission, in consultation with Dirigo Health	Resolve 2007, c. 112	Report on the feasibility of enrolling the Legislature as an employer group in the Dirigo Health Program.	2007
Superintendent of Insurance	P.L. 2003, c. 469, Part E, sec. 21	Report on decisions by the Superintendent of Insurance to allow health carriers to offer health plans under Title 24-A, section 4303, sub-§1, par. A.	2007
Dirigo Health Board of Directors	24-A §6971, sub-§4	Evaluation of the impact of Dirigo Health in Maine in comparison to states with high-risks pools.	2008
Advisory Council on Health Systems Development	PL 2009, c. 350, §A-3	Report on payment reform.	2010
Department of Health and Human Services and State Budget Officer	PL 2007, c. 539, §UU-1	Report on the department's progress towards the new organizational structure for MaineCare and any transferred amounts of money.	2010
Department of Health and Human Services	PL 2009, c. 213, §CC-10	Report on the impact of increased MaineCare physician reimbursement rates on access to and use of preventive and primary care services by MaineCare members.	2010
Department of Health and Human Services	PL 2009, c. 213, §CC-12	Report on the feasibility and advisability of reimbursing critical access hospitals on a diagnosis-related group system for inpatient MaineCare services and on ambulatory payment classifications for outpatient MaineCare services.	2010
Maine Quality Forum	Resolve 2009, c. 106	Report from the advisory group of health care related agencies convened to develop a plan to implement a program for shared decision-making as a strategy to improve the quality of health care.	2010

Health Care Reform Studies by State Agencies (2005 – 2025)

State Agency	Enacting Legislation	Description	Year Report Published
Governor's Office of Health Policy and Finance	P.L. 2009, c. 387, §4	Report on the statewide Health Info Net demonstration project.	2011
Maine Quality Forum	Resolve 2009, c. 106	Report from the advisory group of health care related agencies convened to develop a plan to implement a program for shared decision-making as a strategy to improve the quality of health care.	2011
Mental Health and Substance Abuse Services Working Group	P.L. 2009, c. 571, Part PPP	Report on the stakeholder work group established to examine: Service delivery; MaineCare reimbursable services and the reimbursement process; hospital and nonhospital providers; payment systems and rates; the effect of the switch to ADC reimbursement; and the outcomes, quality of services and administrative costs.	2011
Bureau of Insurance	P.L. 2011, c. 364, sec. 36	Report on the proposed transitional reinsurance program and risk adjustment program established under 24-A section 4320-E and information related to the risk corridors program established in the federal Affordable Care Act.	2012
Board of Trustees, Dirigo Health: Executive Director, Dirigo Health	P.L. 2011, c. 380, Part BBB-3	Health insurance exchange implementation report.	2012
Department of Health and Human Services	P.L. 2011, c. 424, sec. C-2	Report on the department's review of ways to improve the certificate of need process and a review of the rules that implement certificate of need laws, including any recommendations for changes in laws and rules.	2012
Department of Health and Human Services	Resolve 2011, c.109, sec. 6	Report with recommendations from the working group established to examine changes to the state's all-payor claims database system to improve the availability of and access to health care data, including any recommended implementing legislation.	2012
State-Designated Statewide Health Information Exchange	P.L. 2011, c. 373, sec. 5	Report on the progress of the state-designated statewide health information exchange, including the projected implementation for the secure website required under Title 22, section 1711-C.	2012
Department of Health and Human Services	P.L. 2013, c. 368, sec. MMMM-1	Report, with findings and recommendations, including suggested legislation, regarding amending MaineCare rules to achieve payment parity between hospital-compensated and non-hospital-compensated physicians.	2013
Department of Health and Human Services	Resolve 2015, c. 47	Report on the review of the alignment of allocations from the Fund for a Healthy Maine with the State's current public health care and preventive health priorities and goals, including findings, recommendations and suggested legislation.	2015
Health Exchange Advisory Committee	JSO, SP 533 as amended by H-501, sec. 11	Final report on the Health Exchange Advisory Committee's activities.	2016

Health Care Reform Studies by State Agencies (2005 – 2025)

State Agency	Enacting Legislation	Description	Year Report Published
Bureau of Insurance	P.L. 2015, c. 488, sec. 38	Report on the Bureau's evaluation of the effect of opioid medication prescription limits on the claims paid by insurance carriers and the out-of-pocket costs, including copayments, coinsurance and deductibles, paid by individual and group health insurance policyholders.	2018
Health insurance carriers and Maine Association of Health Plans	P.L. 2019, c. 273, §5	Report on efforts to develop standards for secure electronic transmission of prior authorization requests that meet the requirements of HIPPA.	2020
Superintendent of Insurance	Resolve 2019, c. 72, §2 and §3	Report on an assessment to determine the compliance of health insurance carriers in this State with state and federal mental health parity laws.	2020
Department of Health and Human Services	Resolve 2019, c. 114	Report on the review of state's public health infrastructure, including findings and recommendations.	2021
Maine Health Data Organization	P.L. 2021, c. 423, sec B-4	Submittal of a plan for the implementation of a multipayor provider database, including recommendations for suggested legislation.	2022
Bureau of Insurance	P.L. 2021, c. 73, §3	Report on the status of compliance by carriers of the adoption and usage of electronic transmission by health care providers when requesting prior authorization for prescription drugs from carriers.	2023
Office of Affordable Health Care	P.L. 2021, c. 518, sec. 3	Report on the effects of policies aimed at improving health care affordability and coverage, including the effects on the affordability of premiums and cost-sharing in the individual and small group health insurance markets, and the effects of the policies on enrollment in comprehensive health coverage.	2023
Superintendent of Insurance	P.L. 2021, c. 655, sec. 3	Report on the difference in premium rates between plan year 2023 and the approved premium rates for plan year 2024 in each geographic rating area used by a health insurance carrier in Maine.	2023
Office of Affordable Health Care	P.L. 2021, c. 518, sec. 3, as amended by Resolve 2023, c. 87	Report on the effects of policies aimed at improving health care affordability and coverage, including the effects on the affordability of premiums and cost-sharing in the individual and small group health insurance markets, and the effects of the policies on enrollment in comprehensive health coverage, as well as considering the creation of a public option health benefit plan that takes the form of either a buy-in to the MaineCare program or a fully publicly administered plan that may be eligible for advanced premium tax credits through the Maine Health Insurance Marketplace.	2024

Health Care Reform Studies by State Agencies (2005 – 2025)

State Agency	Enacting Legislation	Description	Year Report Published
Office of Affordable Health Care	P.L. 2021, c. 518, sec. 3, as amended by Resolve 2023, c. 87	Report on the effects of policies aimed at improving health care affordability and coverage, including the effects on the affordability of premiums and cost-sharing in the individual and small group health insurance markets and the effects of the policies on enrollment in comprehensive health coverage. The report must also discuss the creation of a public option health benefit plan that takes the form of either a buy-in to the MaineCare program or a fully publicly administered plan that may be eligible for advanced premium tax credits through the Maine Health Insurance Marketplace.	2025
Superintendent of Insurance	Resolve 2023, c. 177	Report, with findings and recommendations, regarding the placement of generic drugs and biosimilars on health insurance carriers' formularies, along with a summarization of the data on prescription drug coverage of generic drugs and biosimilars collected from health insurance carriers.	2025



Office of Affordable Health Care

Presentation to the Joint Standing
Committee on Health Coverage,
Insurance, and Financial Services

November 6th, 2025



Improving Health Care for Maine People



Brief Summary of Legislative Actions on Universal Health Care

Body	Charge/Focus	Brief Summary of Outcomes
Maine Health Care System and Health Security Board (2001-2004)	Develop recommendations for universal health care coverage in Maine and to study the feasibility of a single-payer system.	With a grant from the Maine Health Access Foundation, the Board contracted with Mathematica Policy Research to conduct a feasibility study . Due to the implementation of Dirigo Health, the Board recommended the legislature permit it to continue its work.
Task Force on Health Care Coverage for All of Maine (2017 – 2018)	Tasked with proposing at least three design options, including implementation plans for creating a system of health care that ensures all residents of the State have access to and coverage for affordable, quality health care.	The Task Force did not make specific design or implementation recommendations for a universal coverage plan. In its recommendations, it suggested extending the Task Force, and also made other recommendations including improving oversight of PBMs and changes to MHDO’s structure, funding, and capacity for the reporting and analysis of health care costs and quality.
An Act To Support Universal Health Care, LD 1045 (2021)	Established a Maine Health Care Board to create the Maine Health Care Plan to provide for all medically necessary health care services for all residents of the State. The bill's provisions do not take effect unless Federal law is enacted that authorizes a state to obtain a waiver to establish a state-based universal health care plan.	To date, no federal legislation has been enacted to authorize a state to obtain the type of waiver detailed in this bill.

OAHC Areas of Policy Focus

Provider Market Oversight and Competition: Private equity (PE) investment in health care has grown dramatically in the U.S. over the last 10 years, and early evidence suggests that PE ownership of health care providers can lead to higher prices, staff reductions, and in some cases lower quality of care. While Maine has seen less PE activity in the health care sector than other parts of the country, protective action could be warranted given the significant impacts to access and quality experienced in other states.

Regulating Commercial Prices for Health Services: Increasing commercial prices for health care services are a driver of higher insurance premiums and out-of-pocket costs, which are widely cited by consumers as a barrier to accessing care and a growing financial burden on households and employers. Meanwhile, providers cite difficulty in financing key services, particularly primary care and behavioral health care, and recruiting and retaining physicians, nurses, and other staff.

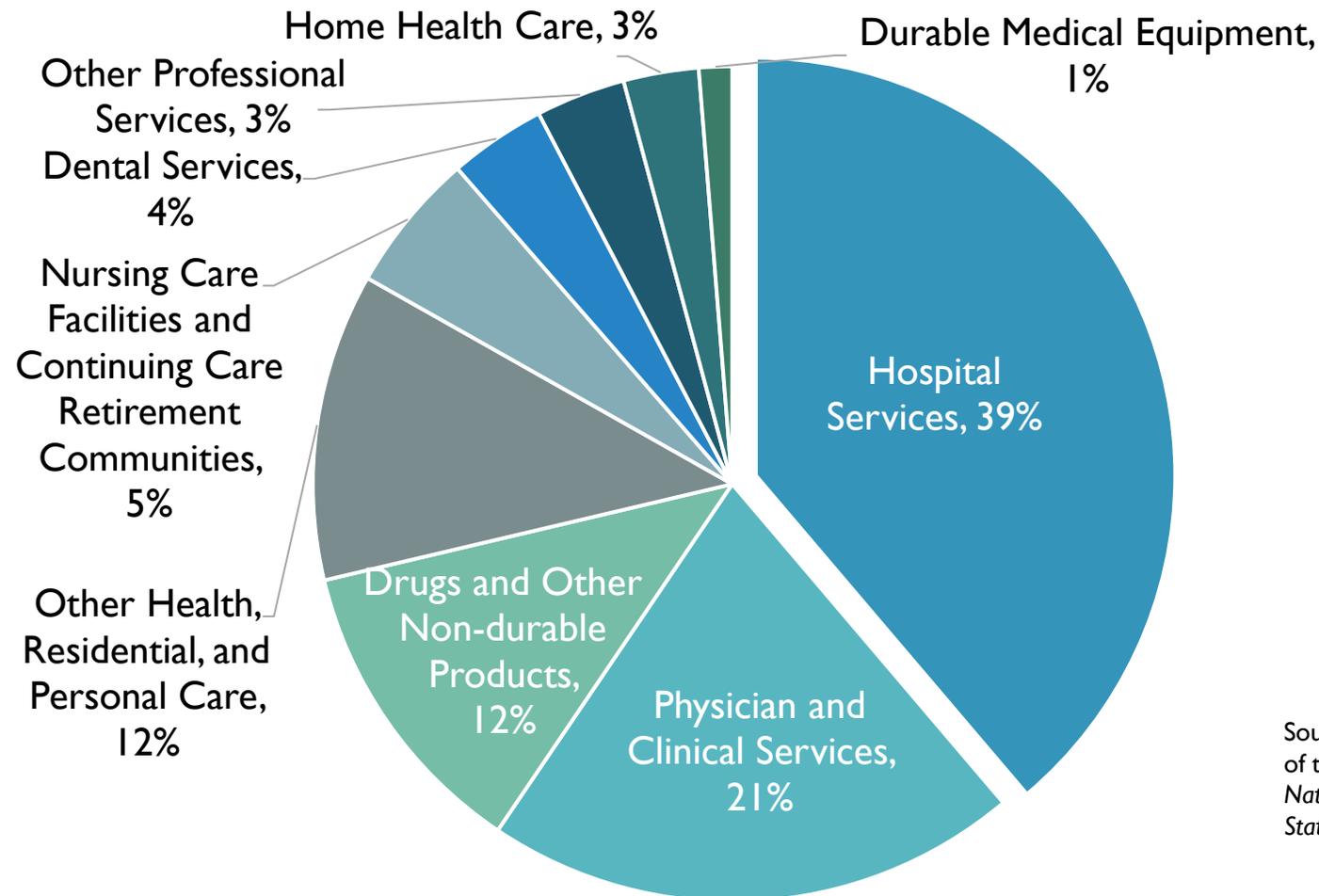
Aligning Incentives to Promote Efficiency and Quality: There is general agreement that paying for health care on a traditional fee-for-service basis is not the best model to support efficient, high-quality, and patient-centered care. Payers and providers in Maine have made progress in introducing new models for payment and delivery of care, but fragmentation of the payer landscape and other operational challenges are a barrier to more significant transformation.



The Role of
Hospital Prices
in Consumer
Affordability

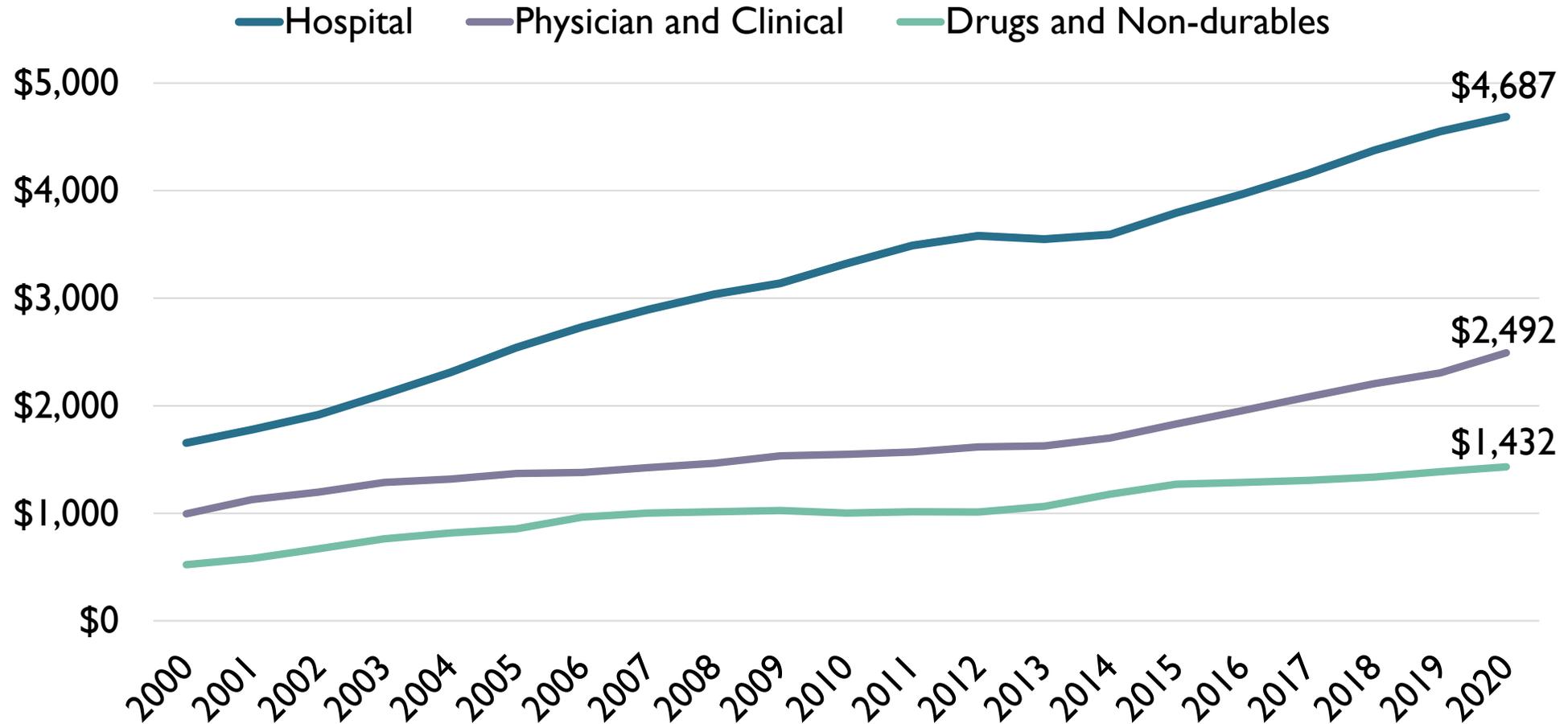
In Maine, hospital services contribute the most to total health care spending

Total Health Care Expenditures in Maine, 2020



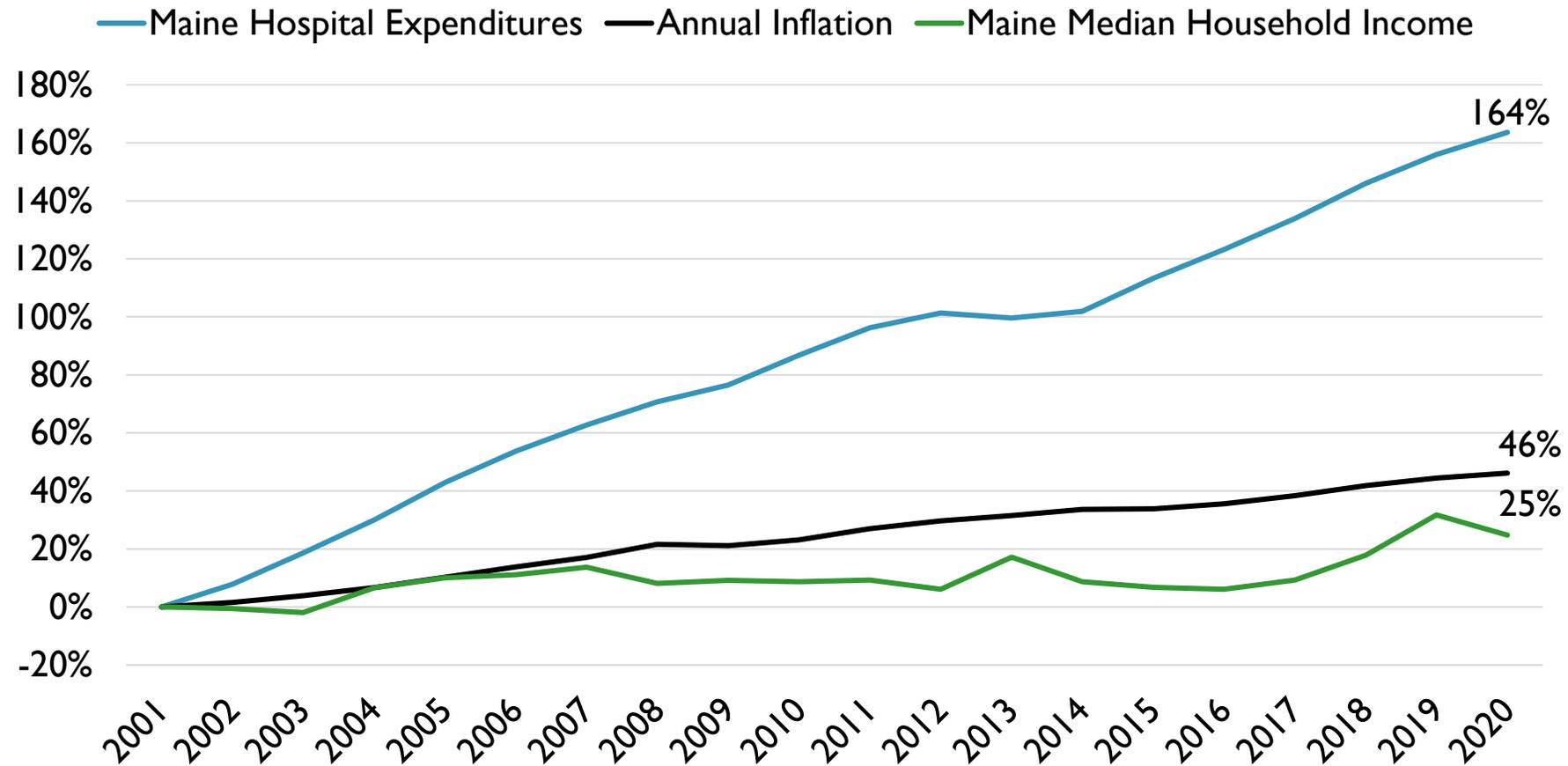
Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. (2024). *National Health Expenditure Data: Health Expenditures by State of Residence, August 2022.*

Maine annual per capita spending on hospital services has risen to more than \$4,500



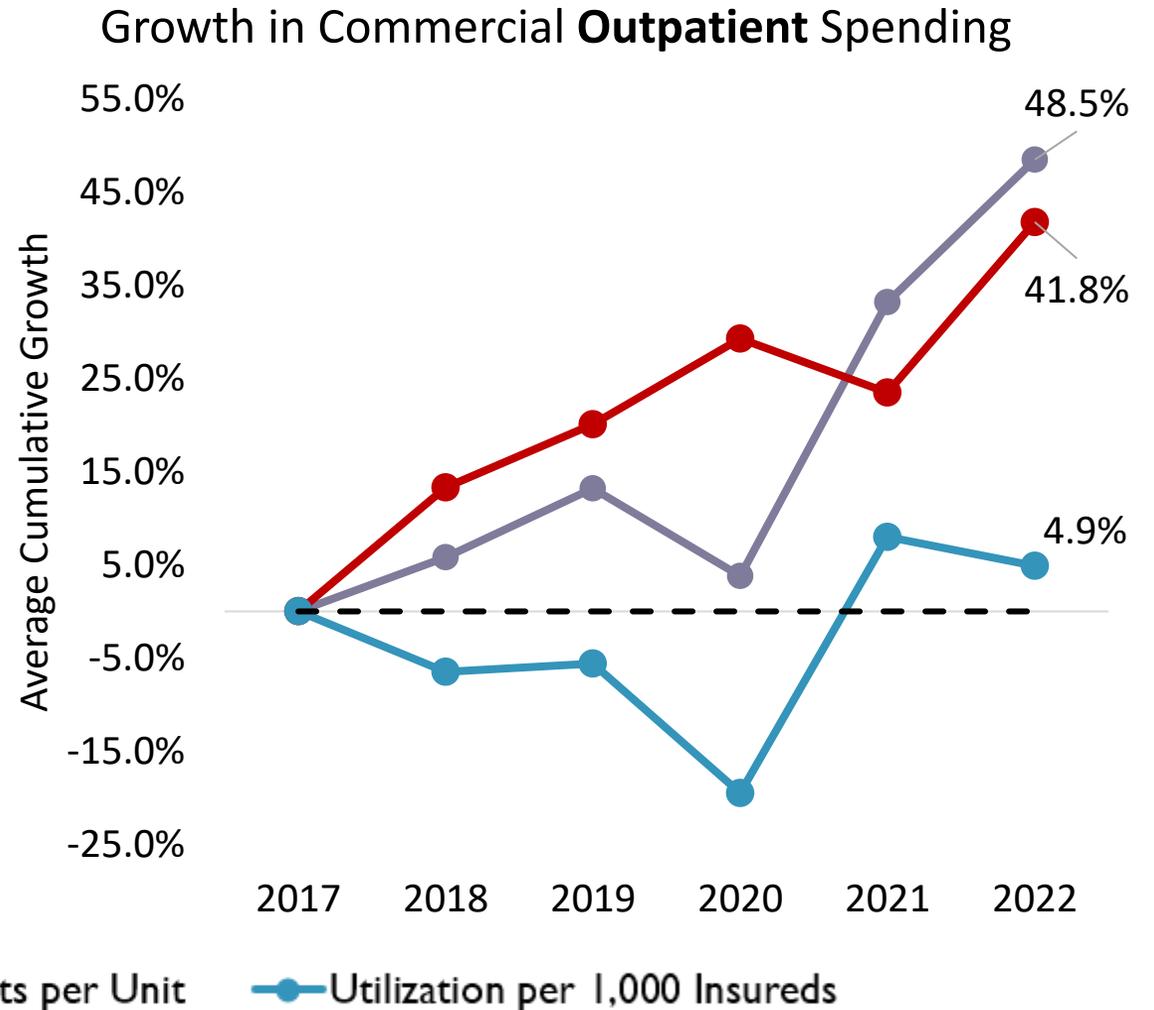
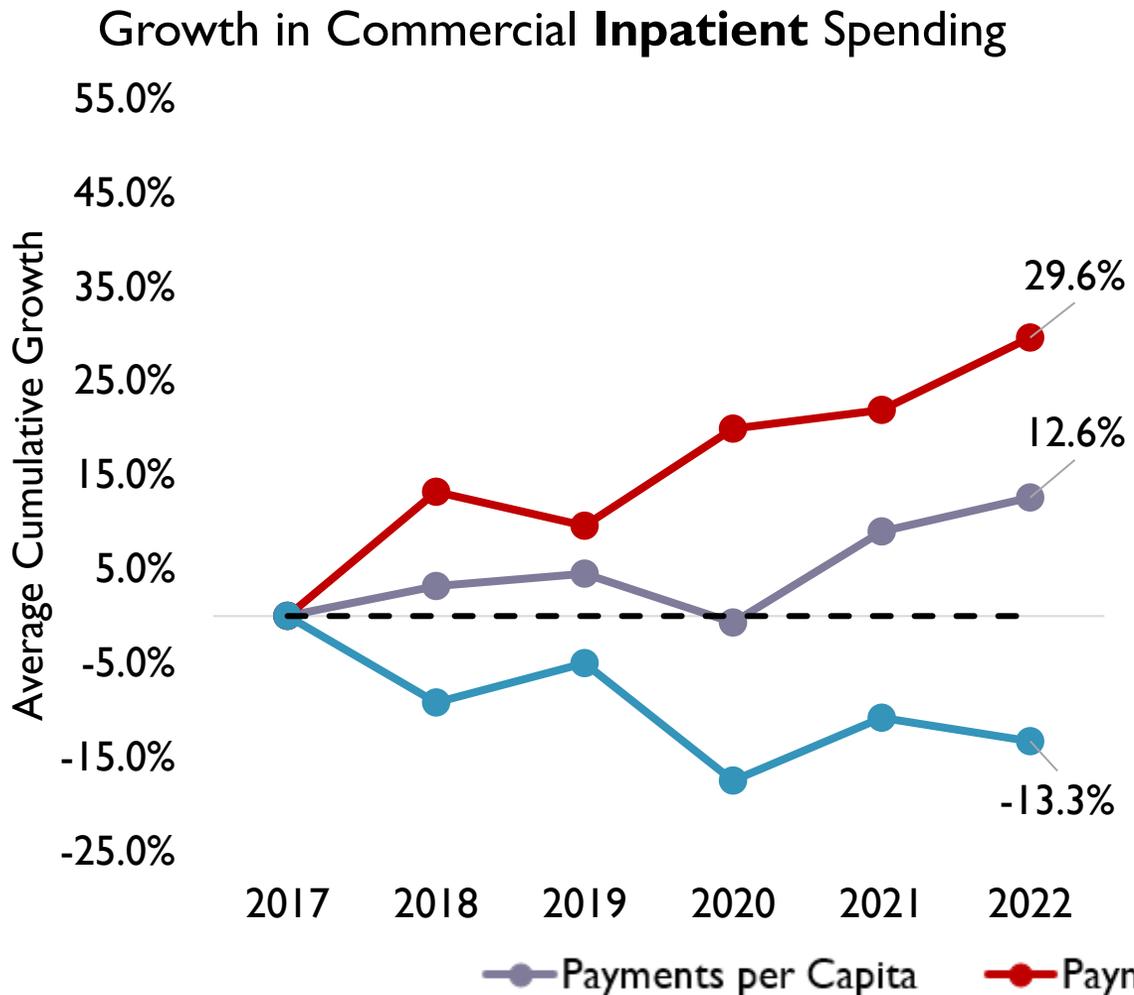
Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. (2024). *National Health Expenditure Data: Health Expenditures by State of Residence, August 2022.* and Federal Reserve Bank of St. Louis. (2024). *Real Median Household Income in Maine.*

Maine's per capita hospital expenditures have grown much faster than inflation and income



- Per capita hospital expenses in Maine and nationally have significantly outpaced national inflation and Maine households' median income.

Payments per unit, not utilization, drive hospital services spending growth for the commercially insured



Prices at some Maine hospitals are among the highest in the nation while others are among the lowest

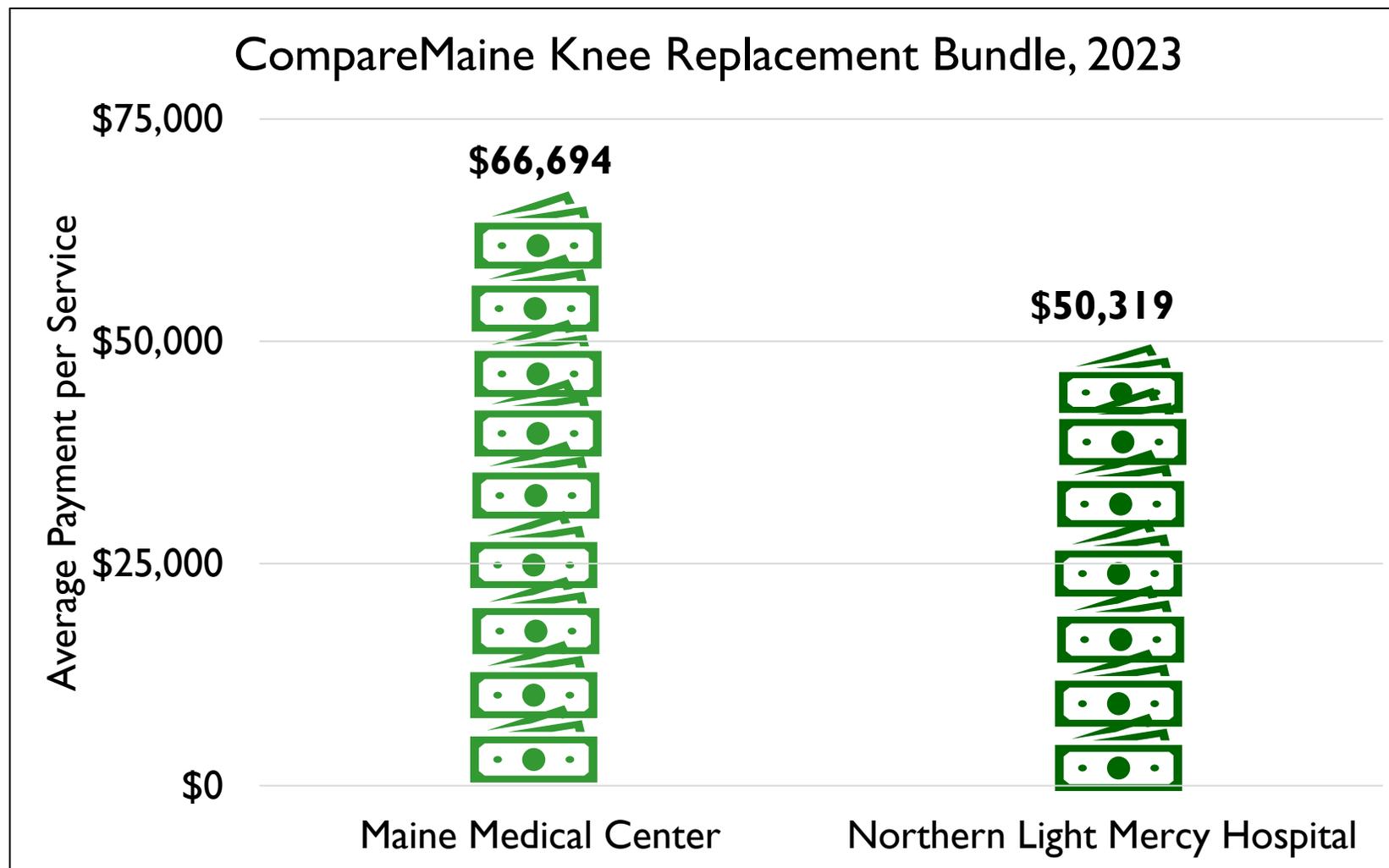


Source: RAND (2024). Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. Adapted from Bailit Health.

For a knee replacement in the same city, charges could be \$15,000 higher based on which hospital a patient chooses

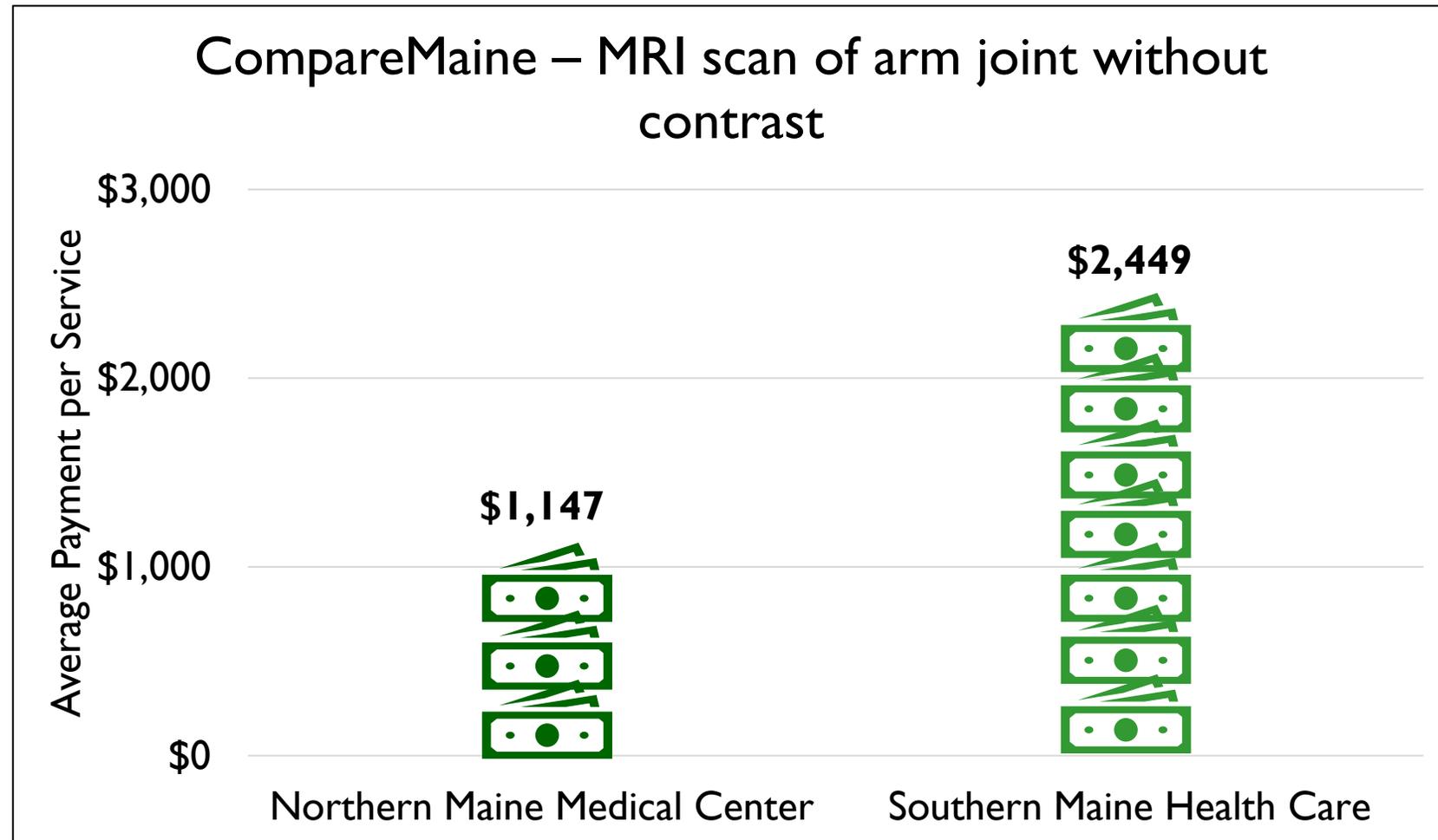
In the same area, patients can pay vastly different prices for the same service based on where they go to receive care.

For this procedure, both facilities provided almost the identical number of services.



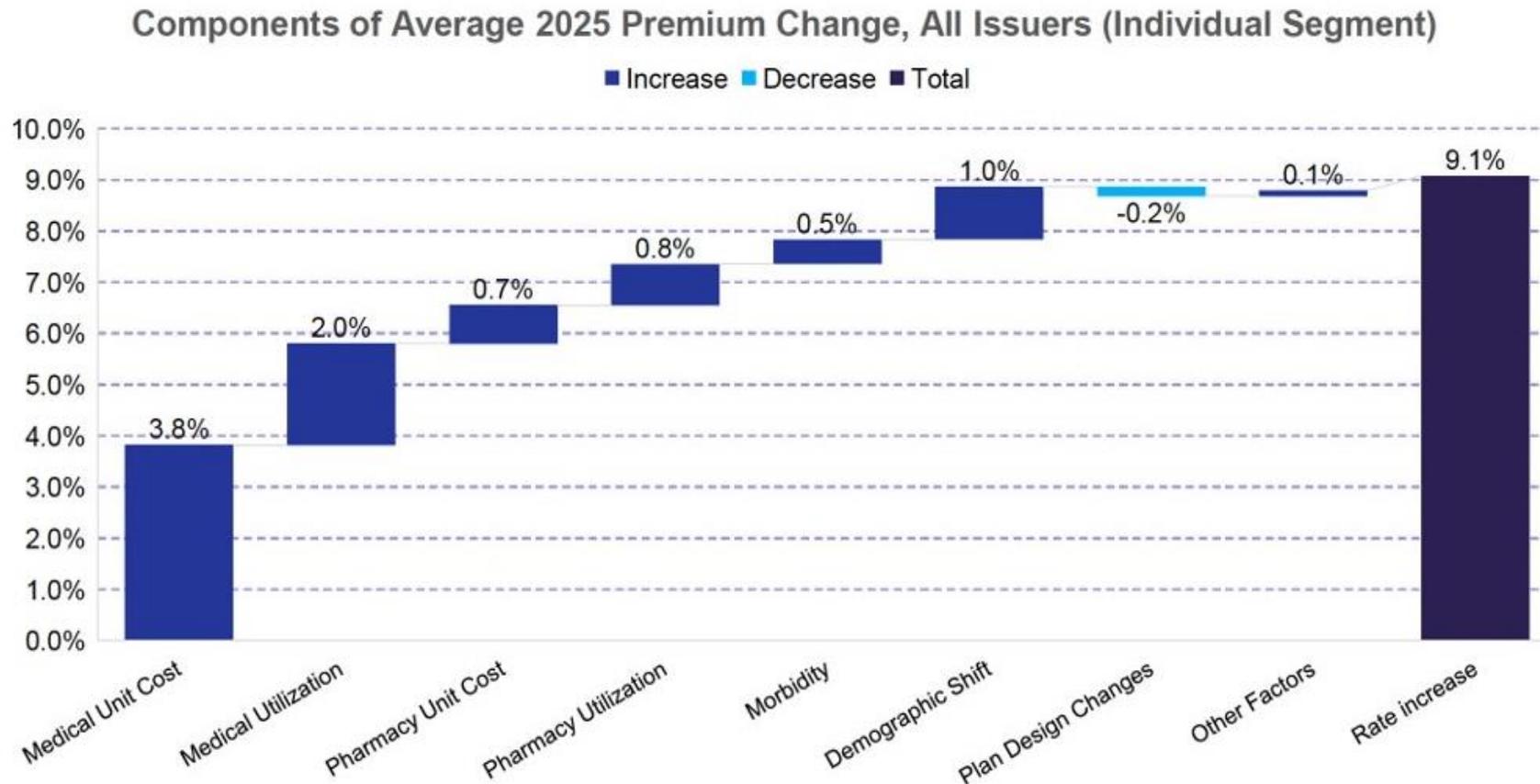
In Biddeford payments are twice as much, on average, for the same service compared to Fort Kent

The rurality of a facility, which is often pointed to as a driver of higher costs to provide care, does not necessarily correlate to higher prices.



Spending on health care services is the primary driver of increasing premiums

Drivers of the 2025 Average Rate Change





Considering Hospital Financial Performance



Analytical Considerations for Measuring Hospital Financial Performance

How you calculate metrics matter.

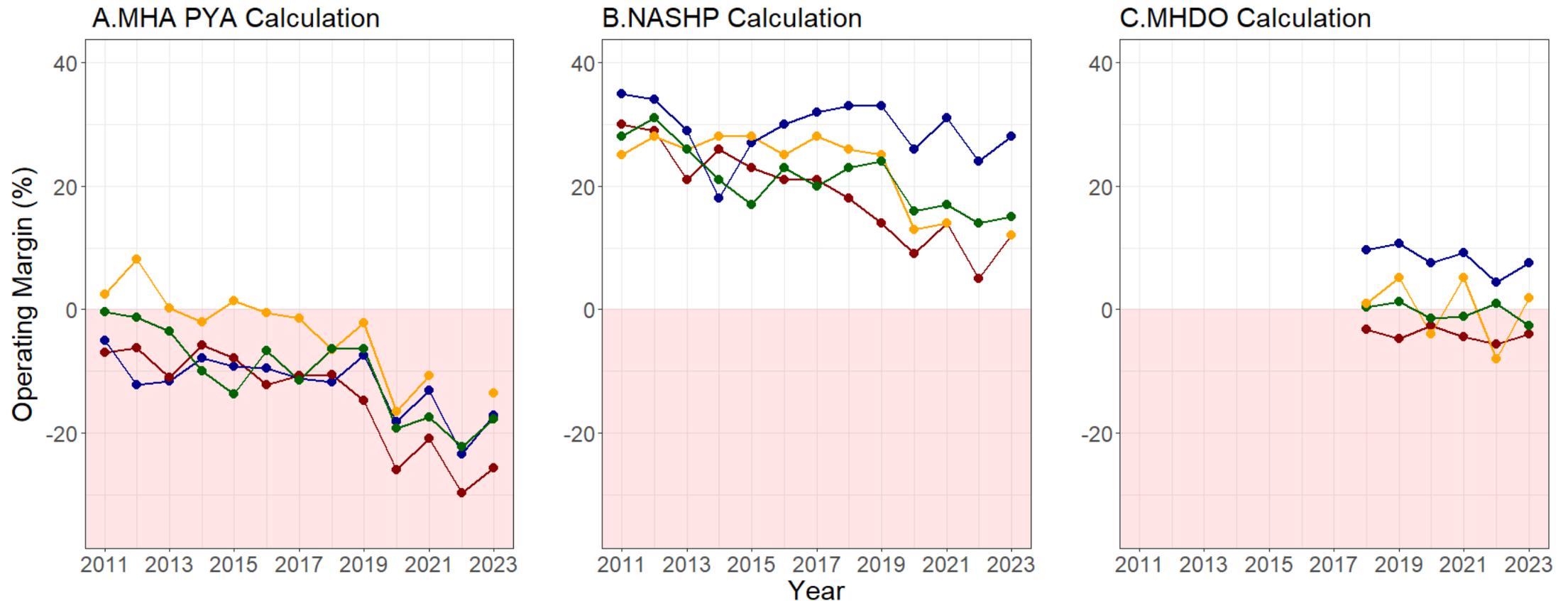
- Even though some metrics seem standard, there are several different ways to calculate financial metrics. It is important to consider what is and is not included in these calculations.

Source	Operating Margin Calculation	Median Value for Maine General Acute Care Hospitals 2023
Maine Hospital Association Report	Assumed: (Net Patient Revenue – Operating Expenses)/ Net Patient Revenue	-12%
National Academy for State Health Policy	(Net Patient Revenue – Hospital Operating Costs)/ Net Patient Revenue	11%
Maine Health Data Organization	((Net Patient Revenue + Other Operating Income) – Operating Expenses)/ Net Patient Revenue + Other Operating Income)	-2%

Performance of Maine hospitals varies based on methodology

Trend in Operating Margins for Maine Peer Group A Hospitals, 2011-2023

● CENTRAL MAINE MEDICAL CENTER ● EASTERN MAINE MEDICAL CENTER ● MAINE MEDICAL CENTER ● MAINEGENERAL MEDICAL CENTER

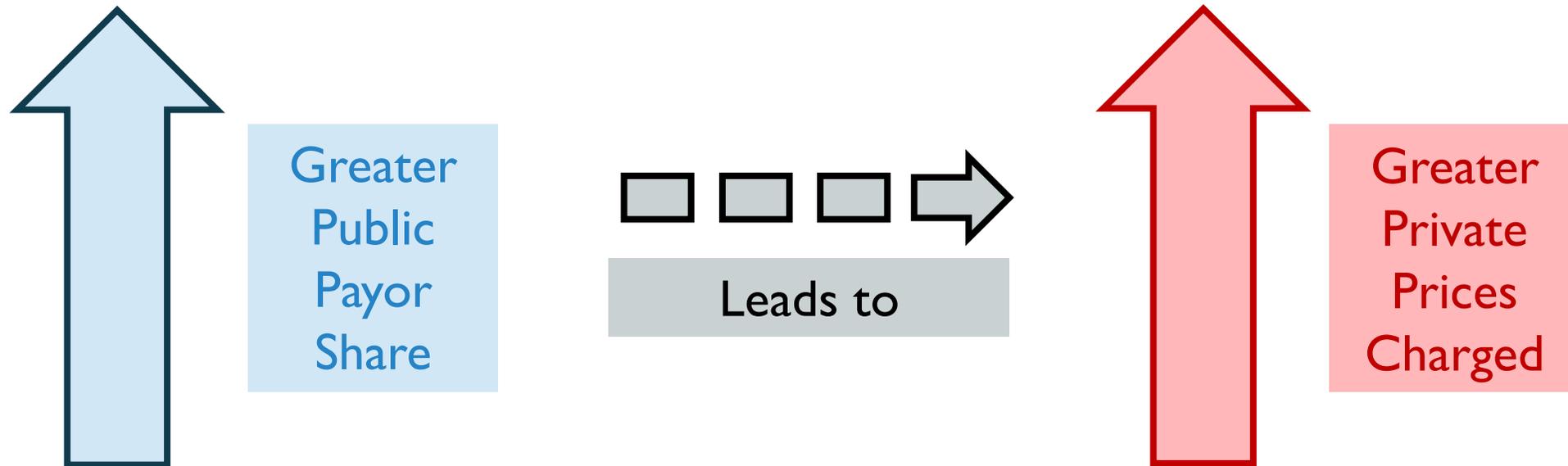


Source: Medicare Cost Reports and Maine Health Data Organization. Report A: 2019-2023 Select Hospital Data Elements and Ratios. https://mhdo.maine.gov/hospital_financials.htm

Addressing the cost shifting myth

Claim:

- Hospitals that serve more Medicare and Medicaid patients must charge private (commercial) payors higher prices to break even on core operating activities.

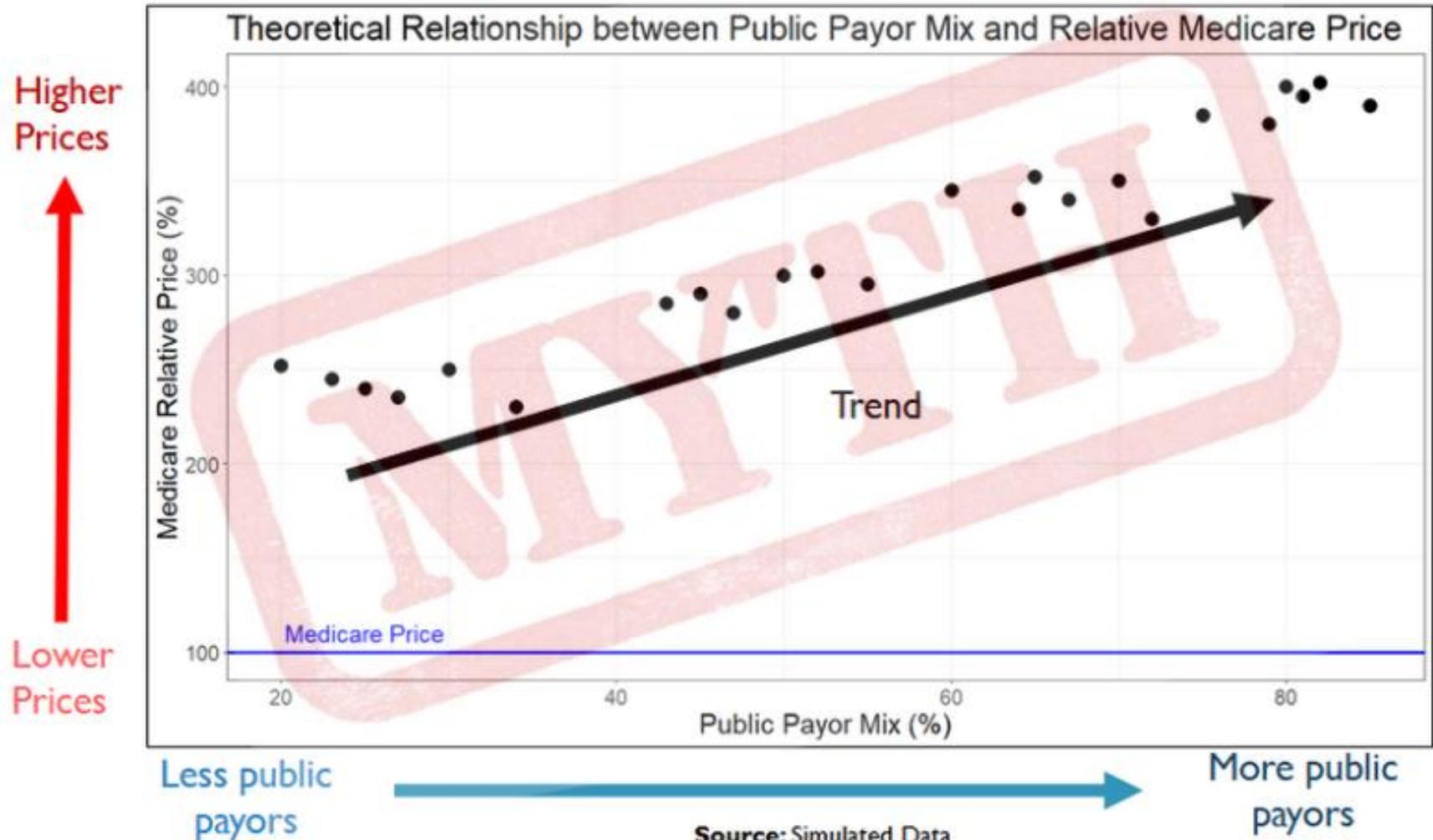


The cost shifting myth in the data

Public Payor Mix: The percentage of hospital services provided to Medicaid, Medicare, and Medicare Advantage payor types, measured in charges.

What we would expect to see if the myth were true:

- As the share of public payors increases, the commercial prices increase.
- On the graph, this will look like an upward trending line.



There is no relationship between hospital prices and share of public payors

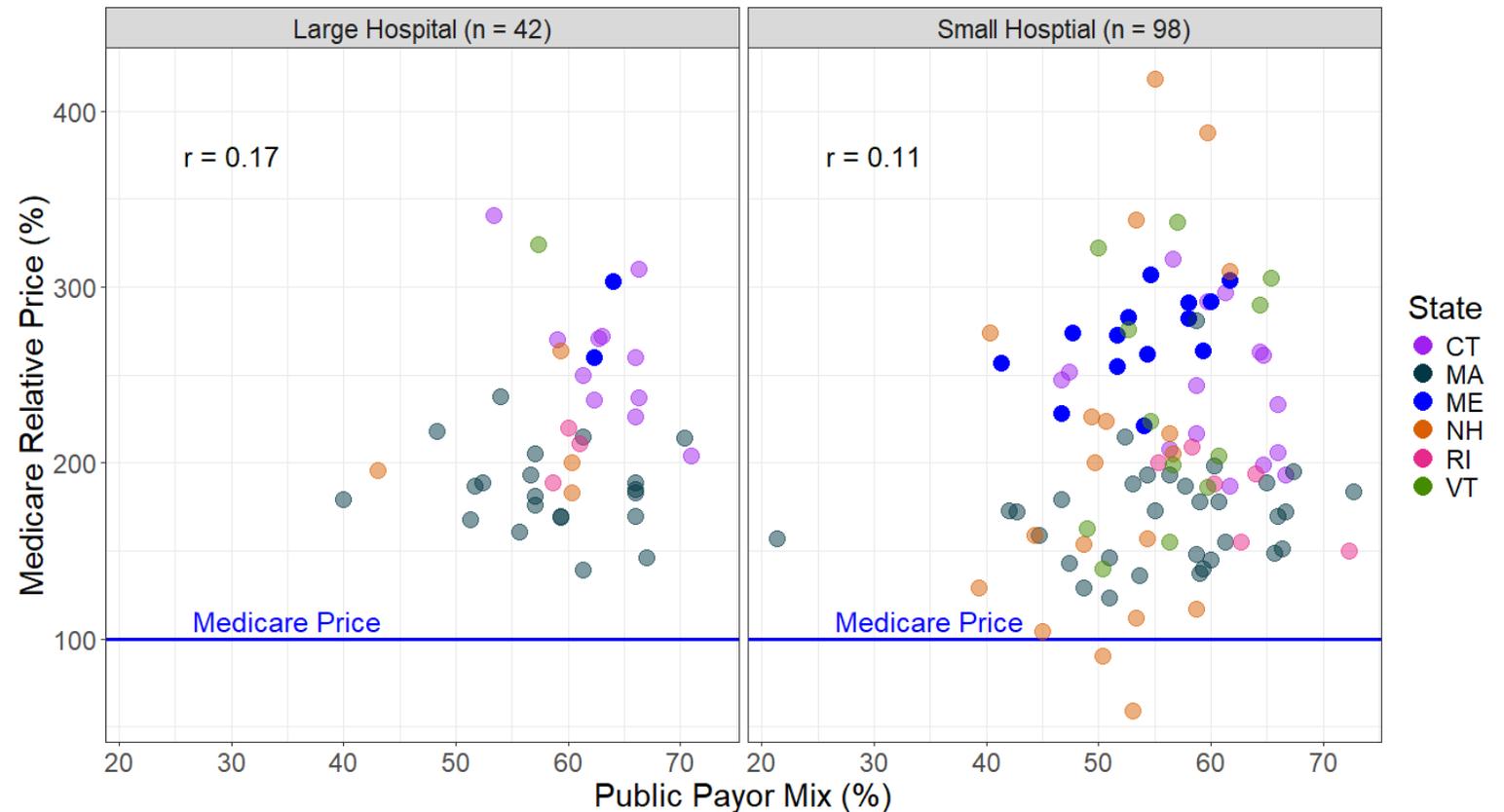
Myth

- Hospitals that serve more Medicare and Medicaid patients must charge higher prices to commercial payors to break even.

Reality

- Maine hospitals have similar payor mix and relatively high commercial prices compared to other New England nonprofit hospitals.

Relationship between Average Public Payor Mix and Medicare Relative Price at Nonprofit General Acute Care Hospitals in New England, 2020 - 2022



A broad body of research finds that cost shifting is not a driver of increases in commercial prices

- A meta study by the Congressional Budget Office found that a hospital's **share of public paying patients had little to no impact on their commercial prices.**
- Studies have found that **when public payor rates decrease, commercial payor rates also decrease** – the opposite of what would be expected under cost shifting.
- Research has found that **hospitals with greater shares of government paying patients are more cost efficient**, suggesting that hospitals have the capacity to curb expenses and attain financial stability on government reimbursement rates.
- Multiple studies have found that **hospital market power is the strongest predictor of commercial prices among hospitals.**

Sources: Congressional Budget Office. (2022). The Prices that Commercial Insurers and Medicare Pay for Hospitals' and Physicians' Services. <https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf>; Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy, Chapter 15: Congressional request on health care provider consolidation. March 2020, 468-469, 497-499 (Appendix 15-A). White, C. (2013). Contrary to cost-shift theory, lower Medicare hospital payment rates for inpatient care lead to lower private payment rates. *Health Affairs*, 32(5), 935-943.; Suhui (Evelyn) Li, David Jones, Eugene Rich, Aimee Lansdale, How do hospitals exert market power? Evidence from health systems and commercial health plan prices, *Health Affairs Scholar*, Volume 3, Issue 1, January 2025, qxae179, <https://doi.org/10.1093/haschl/qxae179>; Blavin, F., Kane, N., Berenson, R., Blanchfield, B., & Zuckerman, S. (2023, February). Association of Commercial-to-Medicare relative prices with health system financial performance. In *JAMA Health Forum* (Vol. 4, No. 2, pp. e225444-e225444). American Medical Association.; Stensland, J., Gaumer, Z. R., & Miller, M. E. (2010). Private-payer profits can induce negative Medicare margins. *Health Affairs*, 29(5), 1045-1051.



Regulation of
Provider Prices
in Other States

Regulation of Hospital Prices in Other States

Recognizing the role that prices paid for health care services contribute to both household health spending and system-wide spending, states are increasingly implementing programs to exert direct or indirect downward pressure on provider prices, such as:

**Hospital
price growth
caps**

**Reference-
based pricing
in state
employee
programs**

**Price caps in
public
option plans**

Price Growth Caps

A price growth cap limits how much provider payments can grow each year; the cap can be linked to an economic indicator such as Consumer Price Index (CPI), gross state product (GSP) growth, or to Medicare growth indices.

- Measured at the service level or an aggregate level.
- Applied to all hospitals, or to certain classes of hospitals where price growth has been problematic.
- Could vary based on relative baseline prices.

State examples: Rhode Island and Delaware

Price Growth Caps State Example: Rhode Island

Since 2010, Rhode Island has utilized “Affordability Standards” in insurance rate review, which includes a limit on the average annual payment increases for hospital inpatient and outpatient services in insurer contracts.

- The current price growth cap is the Consumer Price Index (CPI) + 1%.

The State enforces the price growth cap through the rate review process and market conduct examinations. While this technically limits enforcement to the state-regulated insurance market, Rhode Island insurers generally negotiate rates across product lines, so regulators believe the growth caps have also had some more limited impact on costs in the self-insured employer market.

Evidence of Success from Rhode Island

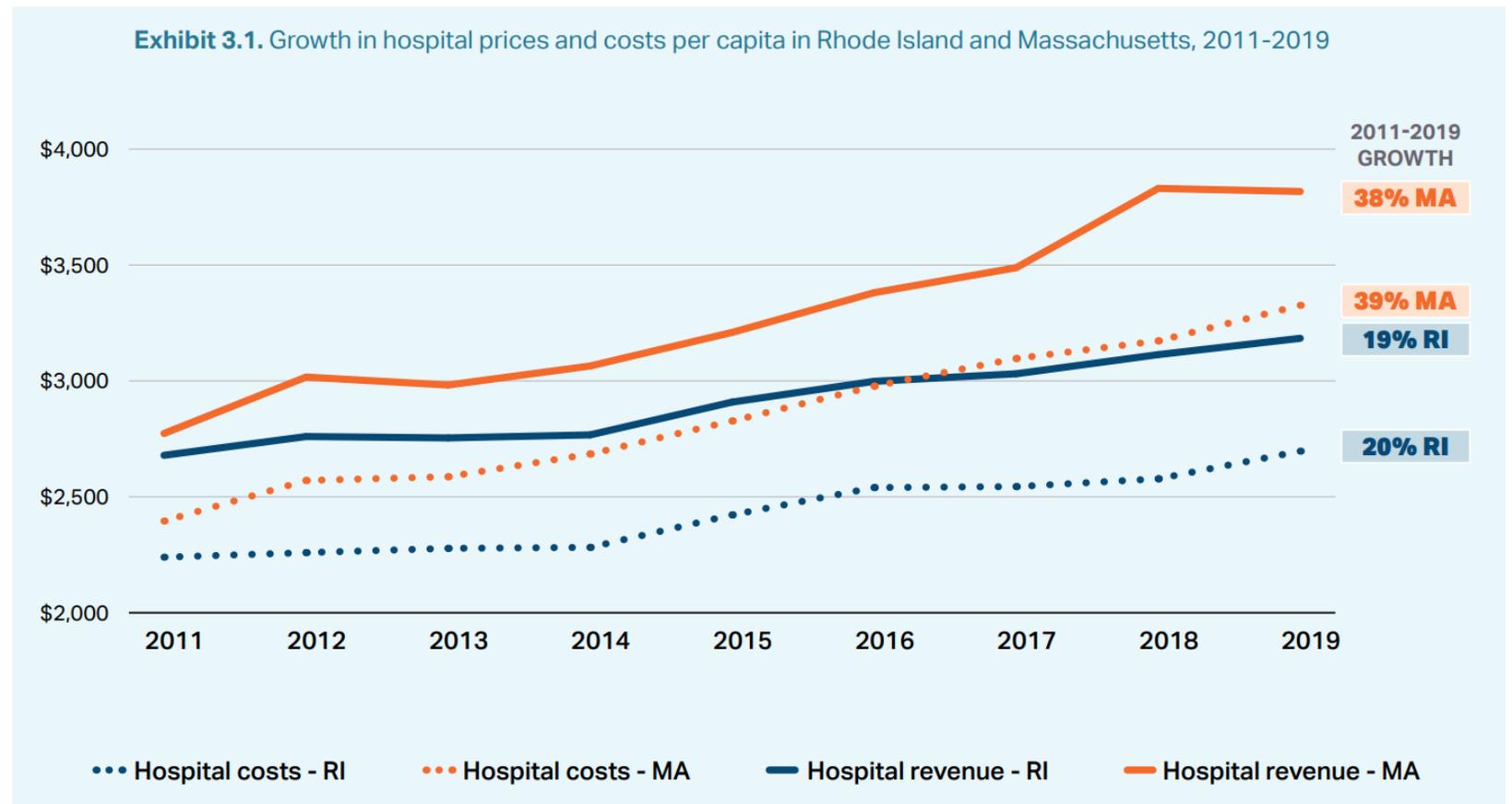
A 2025 study published in *Health Affairs* found that the Affordability Standards resulted in an average of **\$87.7M in annual savings**

- \$64M of this accrued to employers, while \$23.7M accrued to consumers in the form of premium and out-of-pocket cost savings.
- By 2022, the authors found that hospital price reductions translated into annual savings of \$1,000 per member in fully-insured plans.

An earlier evaluation found that the Affordability Standards were associated with a 5.8% decrease in total per capita health care spending among the commercially insured population.

Evidence of Success from Rhode Island

While hospital revenue and costs in Massachusetts and Rhode Island were similar in 2011, revenue grew significantly more slowly in RI following the implementation of the hospital price growth cap. Importantly, as growth of prices was limited in Rhode Island, growth of patient care costs also slowed.



Reference-based Pricing in State Employee Health Plans

Under reference-based pricing strategies, hospital payments are capped at a certain level, typically at a percentage of Medicare rates, for both inpatient and outpatient services. Price caps can be implemented on a service level, or at an aggregate level.

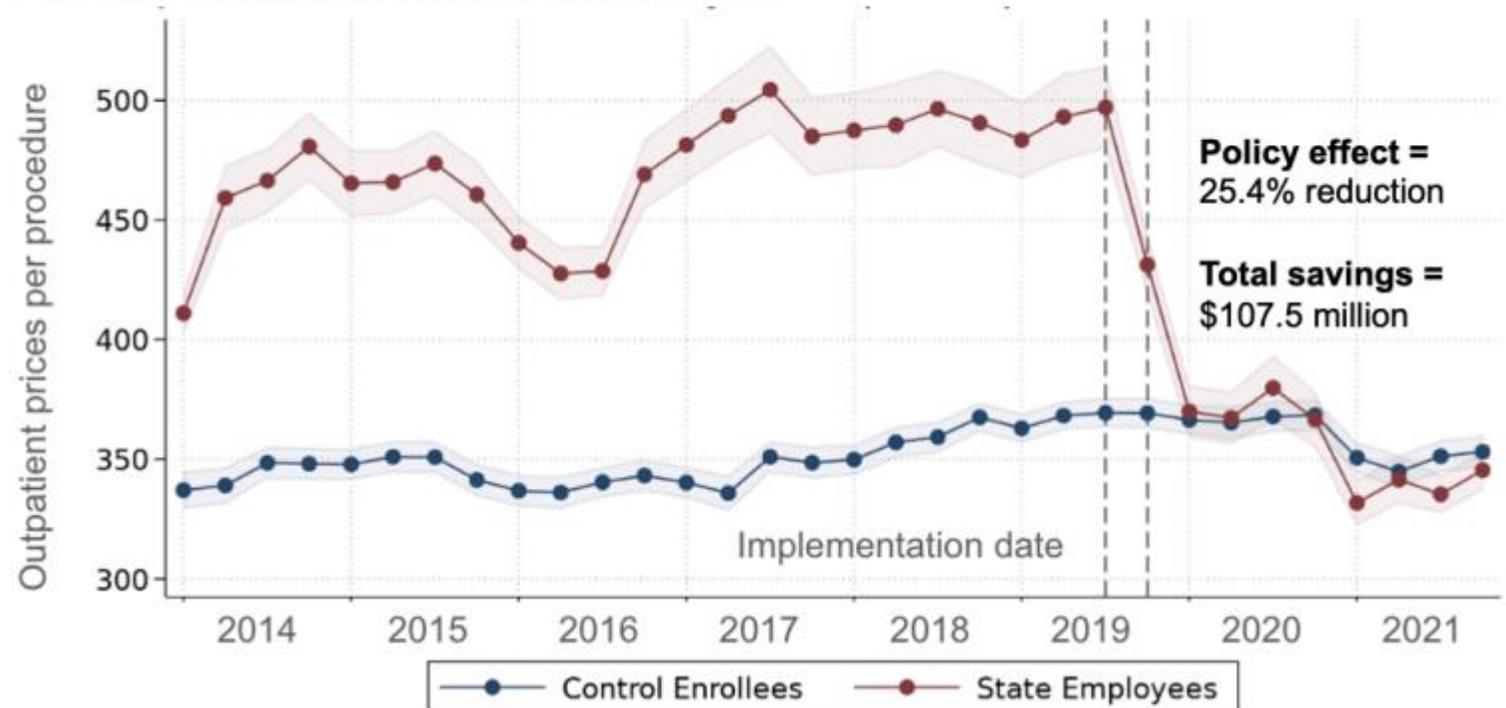
State Examples

- Oregon's state employee health plan pays no more than 200% of Medicare prices for in-network hospital services, and 185% of Medicare prices for out-of-network services. Some small and/or rural hospitals were exempted from the program.
- Washington recently passed legislation limiting how much Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) plans pay for hospital inpatient and outpatient services to no more than 200% of the Medicare rate. The law also sets minimum payment levels for primary care and behavioral health services at 150% of Medicare.

Evidence of Success in Oregon

A 2024 evaluation found that the price caps generated over **\$100 million in savings** over the first two years of implementation, driven mostly by reduced outpatient prices.

Figure. Reduction in outpatient facility prices following introduction of the Oregon State Employee Plan Hospital Payment Cap, 2014-2021



Evidence of Success in Oregon

The same evaluation found that there were no negative impacts on:

- Access to care for employees – none of the 24 hospitals participating in the plan exited its network
- Hospital finances, operations, or patient experience of care
- Cost-shifting to other commercial insurers

The Oregon state employee health plan covers roughly 13% of the commercially covered population in Oregon.

Price Caps in Public Option Plans

State-based public option plans are a strategy that states are increasingly turning towards to contain health care costs – particularly by putting downward pressure on health care prices and carriers' administrative costs. The two operational public option plans in the country also include some form of price caps to contain costs for members.

State Examples

- **Washington's** public option plan includes a hospital price cap of 160% of Medicare for larger non-rural hospitals, a primary care rate floor at 135% of Medicare, and floor of 101% of Medicare rate floor for rural CAHs and sole community hospitals.
- Carriers offering a public option plan in **Colorado** must meet premium rate reduction targets statewide. If they fail to do so, the Department of Insurance is authorized to set hospital and provider rates at no less than 165% and 135% of Medicare rates, respectively.

Evidence of Success in Colorado and Washington

Implementation of these public option plans has taken time, and enrollment in the plans has grown over time since they were initially introduced.

- As of plan year 2025, Washington's Cascade Select plans are available in all 39 counties of the state, and have the lowest premiums among Silver plans in 26 counties. 30% of Marketplace enrollment is now in Cascade Select plans.
- In Colorado, nearly half of Marketplace consumers are enrolled in a Colorado Option plan, and a recent analysis found that the Colorado Option was associated with \$100 in monthly savings in premiums for the lowest- and second-lowest-cost Silver plans in Colorado relative to comparison states.

New Models Passed in 2025

Indiana – requires non-profit hospitals to move prices closer toward the state average, with a focus on the largest hospital systems in the state. If hospitals are unable to comply by 2029 the state may revoke the hospital's nonprofit status.

Vermont – while the Green Mountain Care Board has had authority to review and approve hospital budgets since 2013, new legislation this year requires the Board to establish reference-based caps on hospital prices by 2027.



Recommended
Policy Action

Considerations for Policy Development

- Ability to implement policy without reliance on federal government collaboration
- Reach of the policy to the maximum number of people possible
- Prioritizing cost relief for consumers
- Balancing cost relief with investments to improve access

Recommended Policy Framework

Set Reasonable Limits on Commercial Hospital Facility Prices

- Cap outlier high prices for hospital services
- Establish a cap on the growth of hospital prices

Use Savings To:

Reduce health care costs for families and businesses

Invest in higher payments for primary and behavioral health care

Reform prior authorization to lessen admin burden on providers

Price and Price Growth Caps – Next Steps

- Establishing the basis of a benchmark
 - Recommend using Medicare prices as a benchmark. Rates are developed through a rigorous and transparent process, and made available through public data files.
- Establishing caps
 - Considering current payment rates, what is a reasonable cap on prices as a percent of the benchmark.
- Considering the scope of the cap, and exemptions
 - Other states have generally included exemptions for small and rural hospitals.
 - Maine could also include an exemption for financial performance, in light of stability concerns.

Increasing Investment in Primary Care and Behavioral Health Care – Next Steps

- Evaluating mechanisms for increased investment
 - Proposed concept: institute price floors for these services which insurers would have to comply with in order to benefit from price caps.
- Defining the scope of primary care and behavioral health care services for increased investment
 - E.g. Evaluation and Management codes when services are provided by specific provider types.
- Establishing benchmark levels
 - Current price levels will be analyzed to understand baseline.
 - Weigh the prioritization of increased investment with delivering savings to consumers

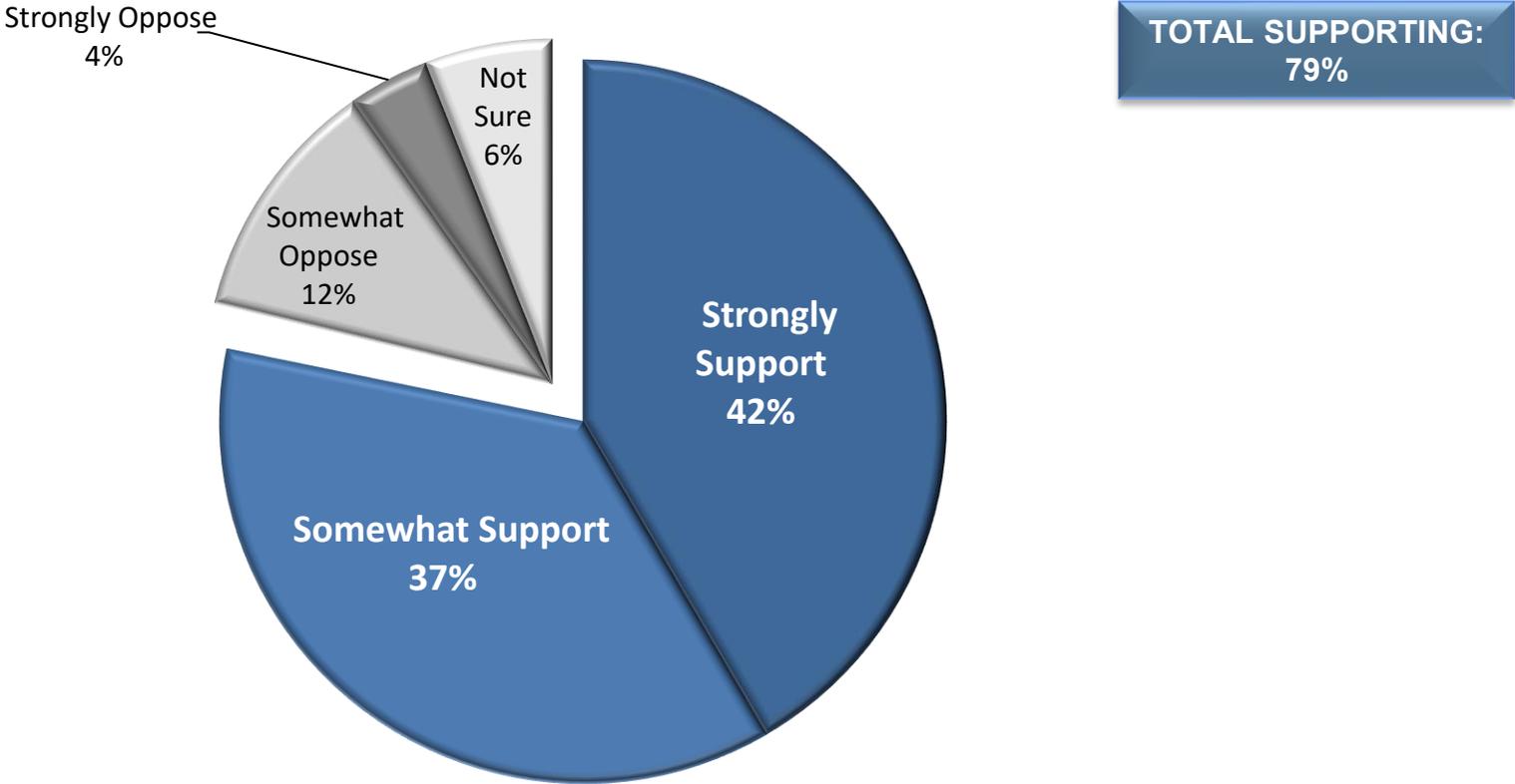
Incorporating Changes to Prior Authorization

– Next Steps

- Proposed starting point would be to require self-insured plans to comply with the limitations on prior authorization which currently apply to the fully-insured market, as a condition of benefitting from price caps. These current limitations include:
 - A request by a provider for PA must be answered by a carrier within 72 hours or 2 business days, whichever is less
 - Prohibition on retrospective denials coverage or payment for the originally approved service (with exception for fraud or materially incorrect information)
 - Requirement that appeals be reviewed by a clinical peer who was not involved in the initial decision
- Also soliciting input from Advisory Council members and others about changes that could reduce the use of prior authorization in the case of services that are generally approved, or other opportunities to reduce inefficient PA processes.

Eight out of ten surveyed Mainers are in favor of allowing the state government to set limits on hospital prices

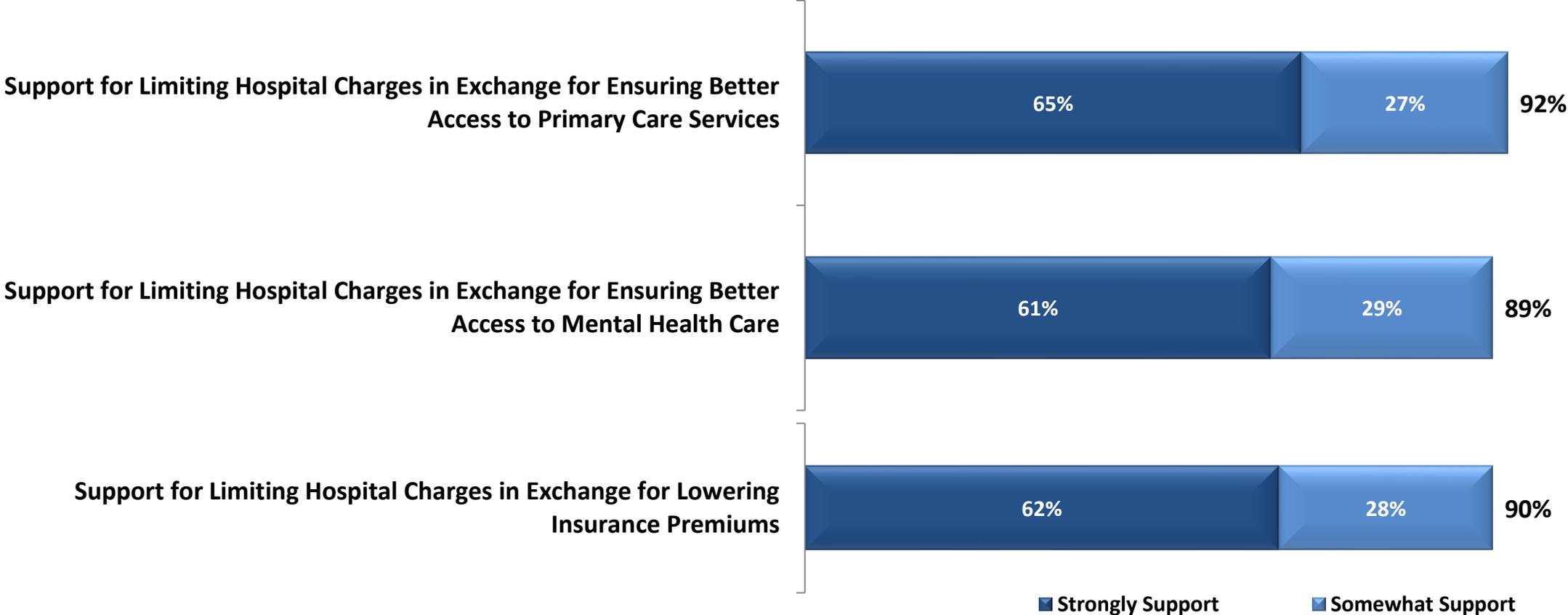
Support for Allowing the Government to Set Limits on Hospital Prices



Would you support or oppose allowing the government to set limits on hospital prices to prevent excessive costs for consumers?

Almost all surveyed Mainers – nine out of ten overall – support letting the state government limit hospital prices, regardless of whether the savings are invested in improved access to primary care or mental health care or are used to lower health insurance premiums.

Support for Limiting Hospital Prices in Order to Support Specified Outcomes



To what extent would you support or oppose a proposal that allowed the state government to limit the prices hospitals can charge for services, if the savings were invested in...

Anthem Blue Cross and Blue Shield and Northern Light Health Announce New Agreement

New contract ensures in-network access for Anthem members throughout Maine

South Portland, Maine — Northern Light Health and Anthem Blue Cross and Blue Shield in Maine (Anthem) have reached an agreement that will provide in-network access to all Northern Light Health hospitals, clinics, and providers for Anthem health plan members, including those enrolled in employer-sponsored, individual, and Medicare Advantage health plans.

The new agreement applies to Anthem members across Maine who rely on Northern Light Health for comprehensive, community-based care. The renewed partnership reflects both organizations' shared commitment to providing access to high-quality, affordable care for individuals, families, and employers throughout the state.

"This new agreement allows our patients to continue receiving high-quality care from the providers they know and trust. Northern Light Health has long been a reliable source of care in Maine and will remain that for generations to come. Throughout the negotiations we kept our patients' needs at the forefront, and we will continue to advocate for them and the communities we serve," shared **R. Guy Hudson, MD**, President and CEO, Northern Light Health.

"Anthem is deeply committed to ensuring Mainers have broad access to the care they need at prices they can afford," said **Denise McDonough**, President of Anthem Blue Cross and Blue Shield in Maine. "We're pleased to have reached an agreement that keeps Northern Light Health in-network for our members and helps us continue delivering on our promise to improve lives and strengthen the health of our Maine communities."

The multi-year contract takes effect retroactively to November 1, 2025. This means all care delivered since Nov. 1 will be treated as in-network for Anthem members.

Due to confidentiality agreements, the specific contractual details of the new arrangement are not being released.

About Northern Light Health

At Northern Light Health, we're building a better approach to healthcare because we believe people deserve access to care that works for them. As an integrated health delivery system serving Maine, we're raising the bar with no-nonsense solutions that are leading the way to a healthier future for our state. Our care team—in hospitals, primary and specialty care practices, long-term and home healthcare, behavioral healthcare, and ground and air medical transport and emergency care—are committed to making healthcare work for you: our patients, communities, and employees. To learn more about Northern Light Health and our locations across Maine, visit www.northernlighthealth.org.

About Anthem Blue Cross and Blue Shield

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc., an independent licensee of the Blue Cross Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. Additional information about Anthem Blue Cross and Blue Shield in Maine is available at anthem.com. Follow us on X, Facebook, and LinkedIn @AnthemBCBS.



**Maine State Legislature
OFFICE OF POLICY AND LEGAL ANALYSIS**

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MEMORANDUM

TO: Members, Joint Standing Committee on Health Coverage, Insurance and Financial Services

FROM: Colleen McCarthy Reid, Principal Analyst

DATE: November 6, 2025

RE: Update on Carry Over Bills

LD #	Title	Explanation of carry over request	Status Update
378	An Act to Strengthen the Health Care System in Maine (Sen. Bailey)	This bill is being carried over at the request of the sponsor.	Concept draft; no draft language provided at this time
519	An Act to Remove the Requirement That Individual and Small Group Health Plans Be Offered Through a Pooled Market and to Eliminate the Provision of Law Establishing a Pooled Market for Those Plans (Rep. Morris)	This bill is being carried over to allow time for a stakeholder group to be convened by the Bureau of Insurance to study issues related to long-term sustainability and value of the Maine Guaranteed Access Reinsurance Association (MGARA) and other issues related to the individual and small group health insurance markets.	Bureau of Insurance hosted first stakeholder group meeting on Nov. 4 and has contracted with a consultant to analyze long-term sustainability of MGARA; another meeting is planned in December and report expected in January
663	An Act Regarding Health Care (Rep. Mathieson)	This bill is being carried over at the request of the sponsor.	Concept draft; no draft language provided at this time
910	An Act to Collect Data to Better Understand the Consumer's Health Insurance Experience (Sen. Tepler)	This bill is being carried over as a vehicle for the committee to consider changes to the prior authorization process following completion of a report by the Bureau of Insurance over the interim.	Bureau of Insurance completed data collection and posted report on website; work session scheduled for Nov. 6 (today)

LD #	Title	Explanation of carry over request	Status Update
961	An Act to Address Maine's Health Care Workforce Shortage and Improve Access to Care (Rep. Mathieson)	This bill is being carried over at the sponsor's request to allow additional time for stakeholders to consider changes to the proposal in hopes of reaching consensus.	Sponsor worked with stakeholders to develop proposed amendment; work session scheduled for Nov. 6 (today)
1119	An Act Regarding Reproductive Health Care (Rep. Moonen)	This bill is being carried over at the request of the sponsor.	Concept draft; no draft language provided at this time
1220	An Act to Allow Chiropractors to Treat Dogs and Equids (Rep. Foley)	This bill is being carried over to allow time for a stakeholder group to be convened by DPFRR to conduct a review and evaluation of the expanded scope of practice for chiropractors in a similar manner as a sunrise review as required by current law.	DPFRR working with Board of Chiropractic Licensure and Board of Veterinary Medicine to convene stakeholder group in late November
1301	An Act to Prohibit the Use of Artificial Intelligence in the Denial of Health Insurance Claims (Sen. Tipping)	This bill is being carried over in deference to the ongoing task force studying issues related to the use of artificial intelligence, including in the health insurance industry. The report is expected to be submitted before the Second Regular Session.	AI Task Force issued its report on Oct. 31 and includes discussion and broad recommendations related to use of AI tools by health care industry
1502	An Act to Update the Requirements for Health Insurance Coverage of Prostate Cancer Screening (Rep. Moonen)	This bill is being carried over to allow time for the Bureau of Insurance to complete a review and evaluation of the mandated health benefit proposal in the bill as required by current law.	The Bureau of Insurance has contracted with an actuarial consultant and the actuarial work has been completed; the bureau is working on the report and it will be completed in early January
1530	An Act to Improve the Sustainability of Emergency Medical Services in Maine (Sen. Curry)	This bill is being carried over to allow time for the Bureau of Insurance to complete a review and evaluation of the mandated health benefit proposal in the bill as required by current law.	The Bureau of Insurance has contracted with an actuarial consultant and the actuarial work has been completed; the bureau is working on the report and it will be completed in early January

LD #	Title	Explanation of carry over request	Status Update
1803	An Act to Amend the Laws Governing Optometric Practice (Sen. Brenner)	This bill is being carried over to allow time for a stakeholder group to be convened by DPFR to conduct a review and evaluation of the expanded scope of practice for optometrists in a similar manner as a sunrise review as required by current law.	DPFR convened a stakeholder group and intends to meet January 15 th report back date. Meetings were held on September 30 (discussed patient access issues) and October 27 (discussed proposed procedures and patient safety issues). Additional meeting planned for December 15, (to discuss implications to the Board of Optometry).
1890	An Act to Facilitate the Development of Ambulatory Surgical Facilities by Exempting Certain Facilities from the Requirement to Obtain a Certificate of Need (Rep. Foley)	This bill is being carrier at the request of the sponsor to allow stakeholders additional time to develop proposed changes with input from the Department of Health and Human Services.	Sponsor developing proposed amendment with input from stakeholders and Oversight of Health Care Transactions Commission; public hearing expected in early January
1901	An Act to Regulate Shared Appreciation Agreements Relating to Residential Property (Rep. Bell)	This bill is being carried over at the to allow additional time for the Superintendent of Consumer Credit Protection to work with stakeholders to consider changes to the proposal.	Bureau of Consumer Credit Protection engaged in discussions with stakeholders
1915	An Act to Regulate Earned Wage Access Services Providers (Rep. Skold)	This bill is being carried over at the to allow additional time for the Superintendent of Consumer Credit Protection to work with stakeholders to consider changes to the proposal.	Bureau of Consumer Credit Protection engaged in discussions with stakeholders
1970	An Act to Amend the Laws Regarding Consent for HIV Testing and Disclosure of Related Medical Information for Insurance Purposes (Rep. Osher)	This bill was recommitted to HCIFS after being reported out to allow additional time to work with stakeholders to consider additional amendments.	Sponsor developing proposed amendment with input from stakeholders; anticipates work session in early January



STATE OF MAINE
DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
BUREAU OF INSURANCE



Janet T. Mills
Governor

Robert L. Carey
Superintendent

Joan F. Cohen
Commissioner

TO: Senator Donna Bailey, Chair, Joint Standing Committee on Health Coverage, Insurance and Financial Services
Representative Kristi Mathiesen, Chair, Joint Standing Committee on Health Coverage, Insurance and Financial Services

FROM: Bob Carey
Superintendent, Bureau of Insurance

DATE: October 15, 2025

RE: Status Update on Carryover Bills

The committee has requested a status update on the following bills:

LD 519, An Act to Remove the Requirement That Individual and Small Group Health Plans Be Offered Through a Pooled Market and to Eliminate the Provision of Law Establishing a Pooled Market for Those Plans

The Bureau remains opposed to demerging of the individual and small group market. We continue to monitor the merged market in terms of enrollment, premiums, health plan availability, participation by health insurers, the impact of the state's reinsurance program (MGARA) on premiums, and other matters that affect the market.

LD 1502, An Act to Update the Requirements for Health Insurance Coverage of Prostate Cancer Screening

The actuarial work has been completed, and the Bureau is working on the report for the Committee.

LD 1530, An Act to Improve the Sustainability of Emergency Medical Services in Maine

The actuarial work has been completed, and the Bureau is working on the report for the Committee.

LD 910, An Act to Collect Data to Better Understand the Consumer's Health Insurance Experience

The Bureau has completed a prior authorization report based on previous legislation¹, which may be found [here](#). We are evaluating the requests made to carriers under existing authority to determine whether we can ask for additional information, and we are willing to modify our requests to include information the Committee would find useful, such as denial reasons. We oppose quarterly reporting, as this would require a significant amount of staff time and is of questionable value. The bill's provision requiring us to include in the report information "provided to the superintendent by the United States

¹ [LD 791, 131st Legislature, Second Regular Session, Public Law 2023, Chapter 680](#)

Department of Health and Human Services regarding claim and prior authorization denials under the federal Affordable Care Act” is unclear because we receive no information fitting this description.

Office Location: 76 Northern Avenue, Gardiner, Maine 04345
Mailing Address: 34 State House Station, Augusta, Maine 04333
www.maine.gov/pfr/insurance