# Office of Affordable Health Care

Presentation to the Joint Standing Committee on Health and Human Services

February 19th, 2026

# About the Office

The Office of Affordable Health Care (OAHC) was authorized in PL 2021 Ch. 518, codified at 5 MRSA Part 8, Ch. 310-A.

- The office is an independent executive agency
- The OAHC establishing legislation directs the office to:
  - Analyze health care cost growth and spending trends, including correlation to quality and consumer experience.
  - Develop proposals to improve:
    - the cost-efficient provision of high-quality health care;
    - coordination, efficiency, and quality of the health care system;
    - consumer experience with the health care system;
    - and health care affordability and coverage for individuals and small businesses.
  - Monitor the adoption of Alternative Payment Models in Maine and across the country.
  - Provide staffing support to the Maine Prescription Drug Affordability Board.
- The office meets bi-monthly with the 13-member Advisory Council on Affordable Health Care

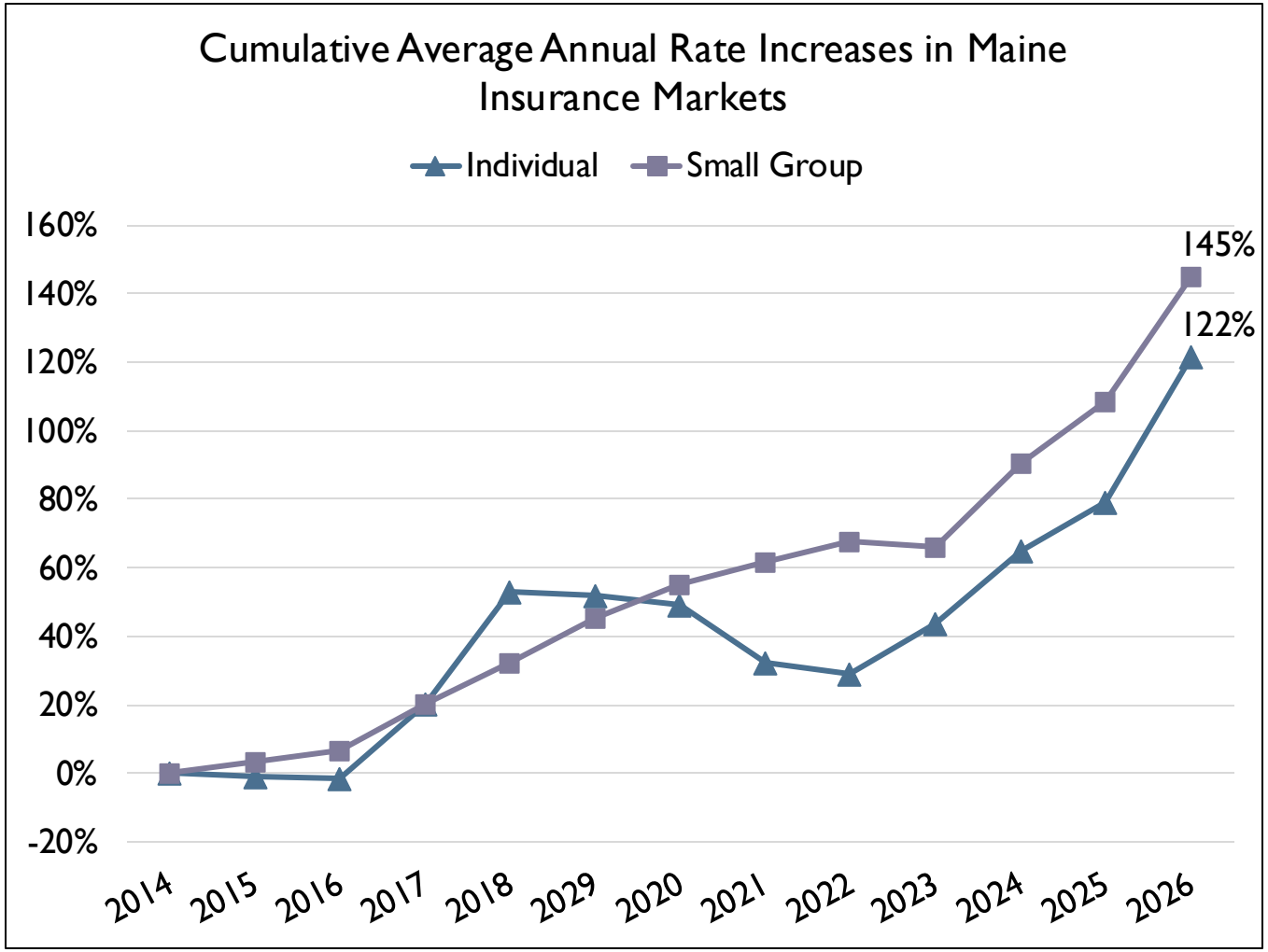
# Guiding Principles

- **Focus on the "big picture"**
  - Prioritize opportunity with the most significant potential for meaningful long-term impact
  - Recognize the complexity of interdependent systems and actors in health care
- **Define affordability from a consumer perspective**
  - Focus on cost control policies that provide relief for end-payers (individuals and families, businesses, government), with a particular emphasis on consumer cost burden that may result in delayed or deferred care
  - Avoid policies that simply shift costs, unless cost-shifting is undertaken intentionally to promote better outcomes
- **Deliver results**
  - Take into account whether proposals are achievable, and other implementation considerations
  - Recognize that continuing the status quo is not sustainable

# The Status Quo is Not Sustainable

A 2023 survey found that more than **one in three Mainers skipped or delayed going to the doctor** when they were sick due to costs.

A 2025 survey found that **two out of three families experienced financial impacts as a result of medical bills**, most often struggling to pay for necessities, like food, heat or housing, had a bill sent to collections or incurred additional credit card debt.




May 2023, *Views of Maine Voters on Health Care Affordability*. Digital Research Inc & Consumers for Affordable Health Care. https://drive.google.com/file/d/14-Ywr3GM8FdKP5qa9U3Kp6Q3EdlcIG_4/view

March 2025, *Examining Voters' Views Towards Health Care in Maine.* Digital Research Inc & Consumers for Affordable Health Care. https://drive.google.com/file/d/1of-aZWztHbCJDGZODeqoWEVvYcokHw41/view

Maine Bureau of Insurance. (2025). *Public Information Meeting 2026 Individual and Small Group Major Medical Rate Requests.* https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/Combined-Slide-Deck-Rate-Forum-8-15-25.pdf

# Current OAHC Areas of Policy Focus

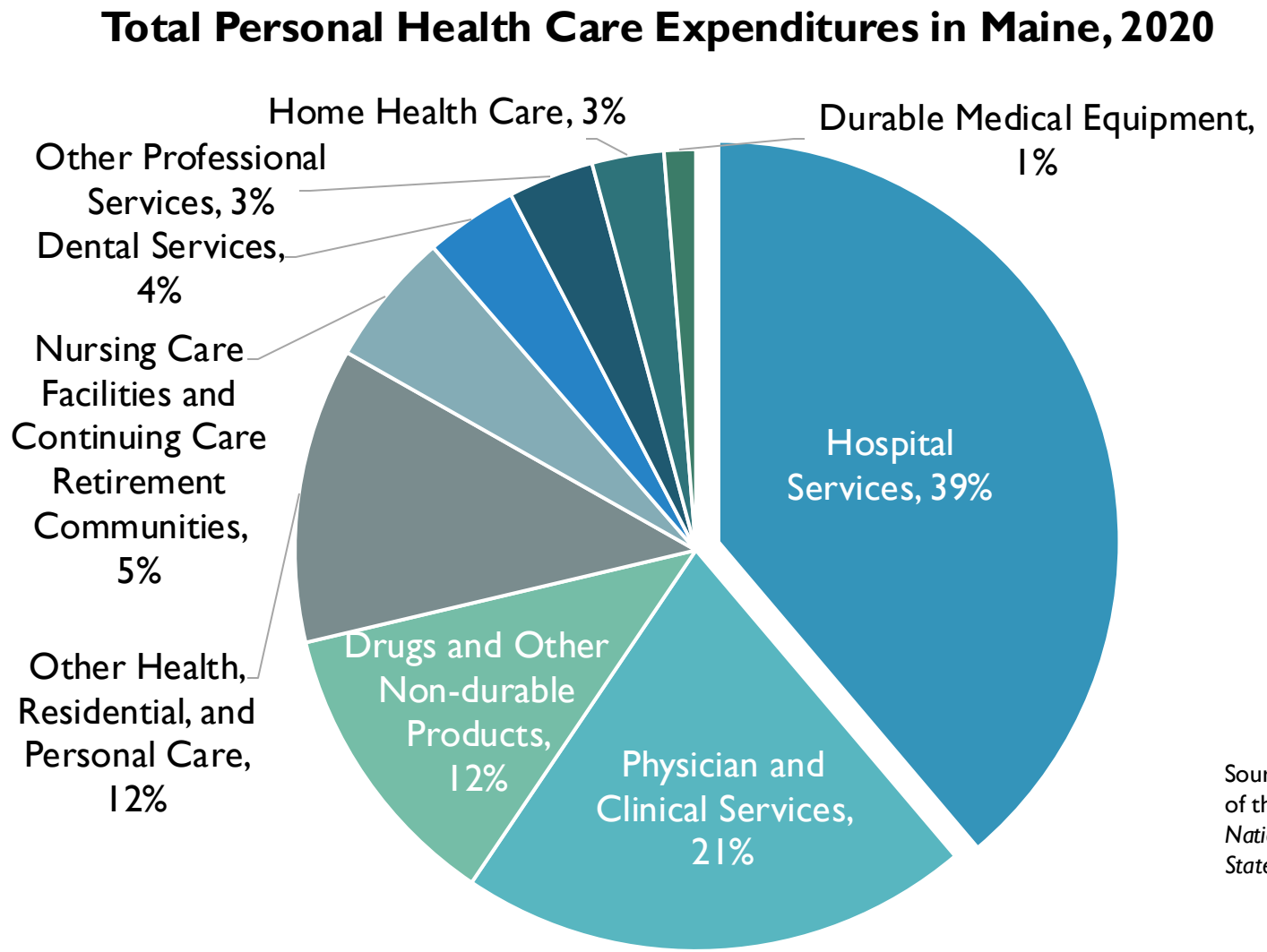
**Provider Market Oversight and Competition:** Private equity (PE) investment in health care has grown dramatically in the U.S. over the last 10 years, and early evidence suggests that PE ownership of health care providers can lead to higher prices, staff reductions, and in some cases lower quality of 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.

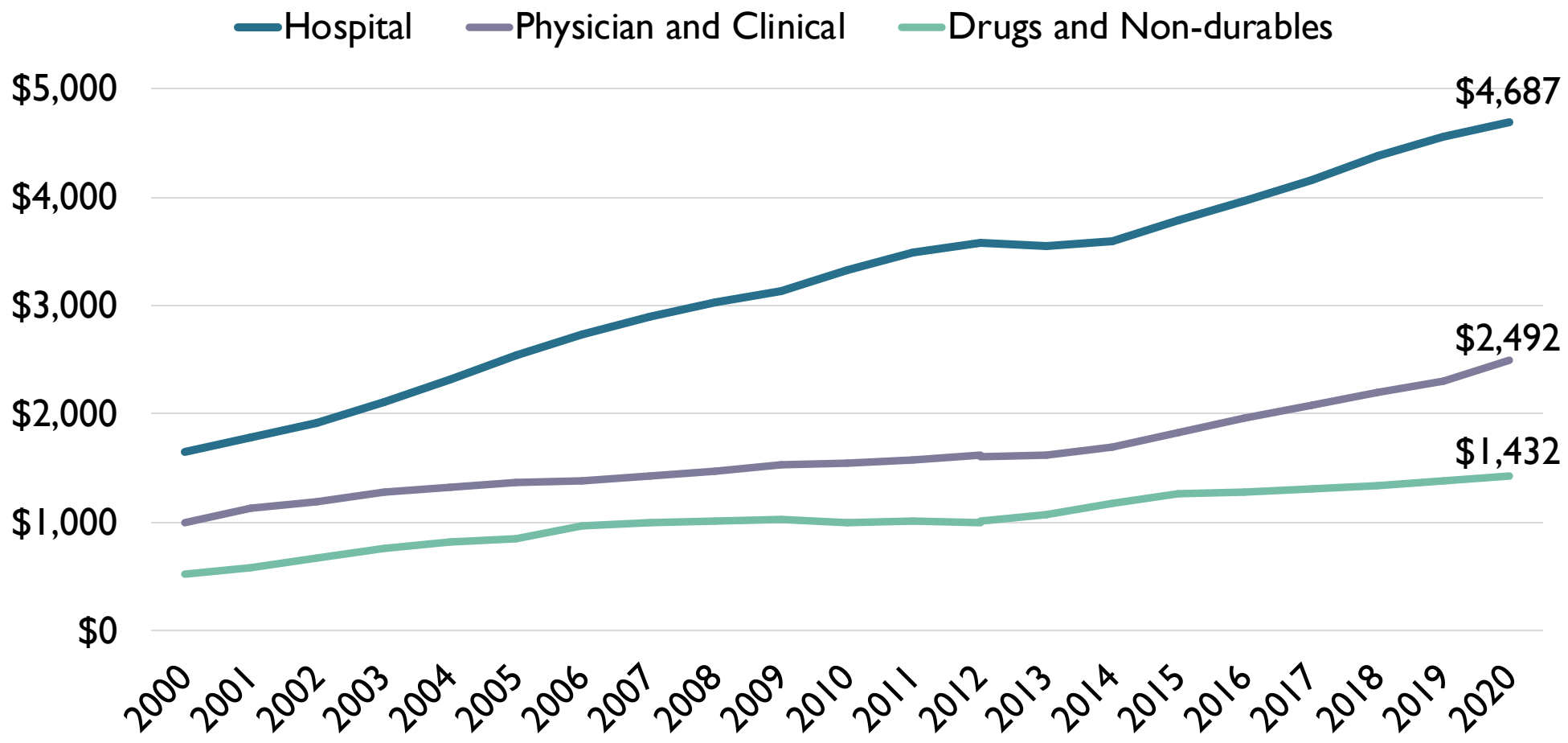
# The Role of Hospital Prices in Consumer Affordability

# In Maine and across the country, hospital services contribute the most to total health care spending



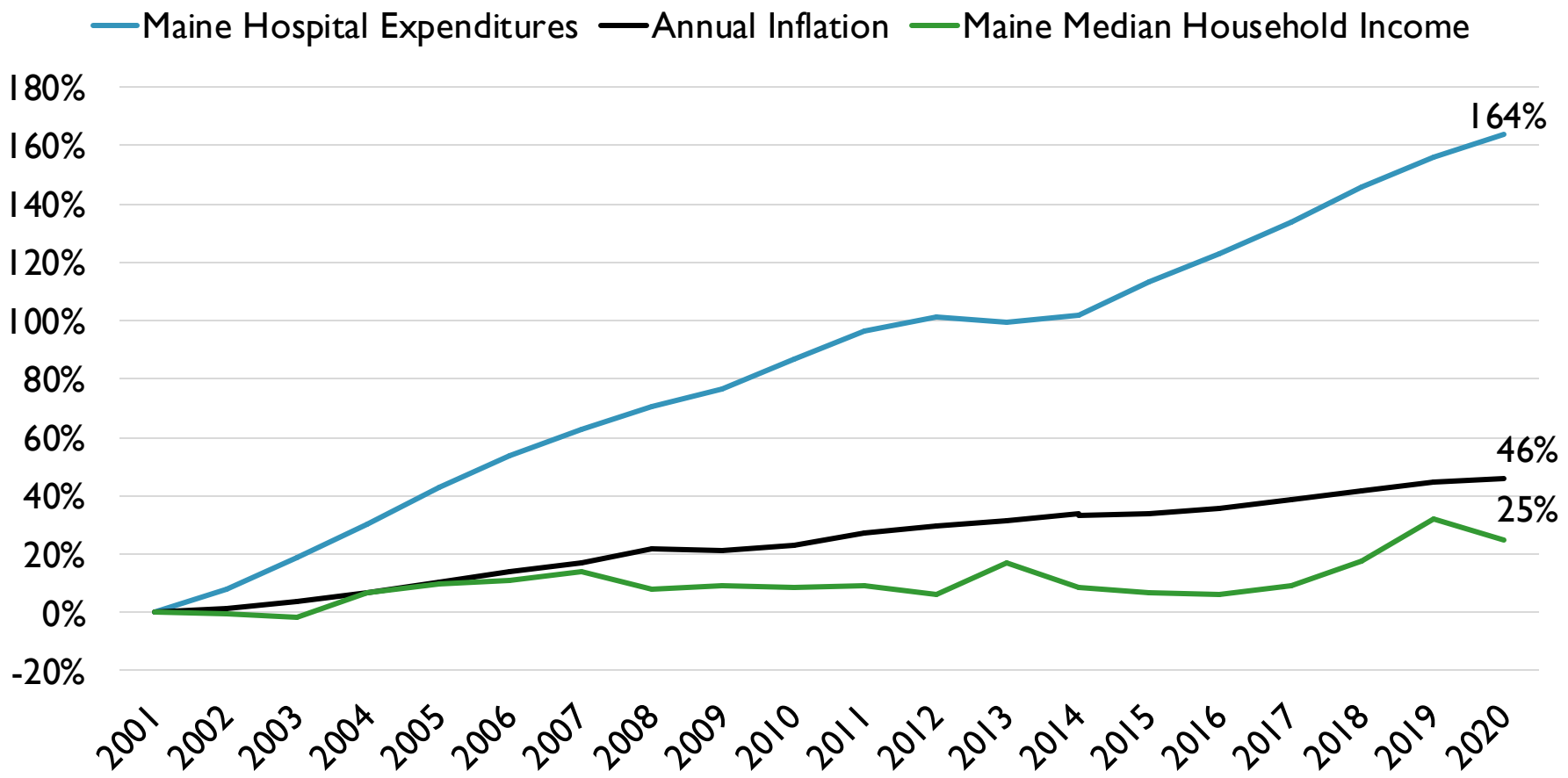

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. (2024). *National Health Expenditure Data: Health Expenditures by State of Residence, August 2022.*

# 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.*

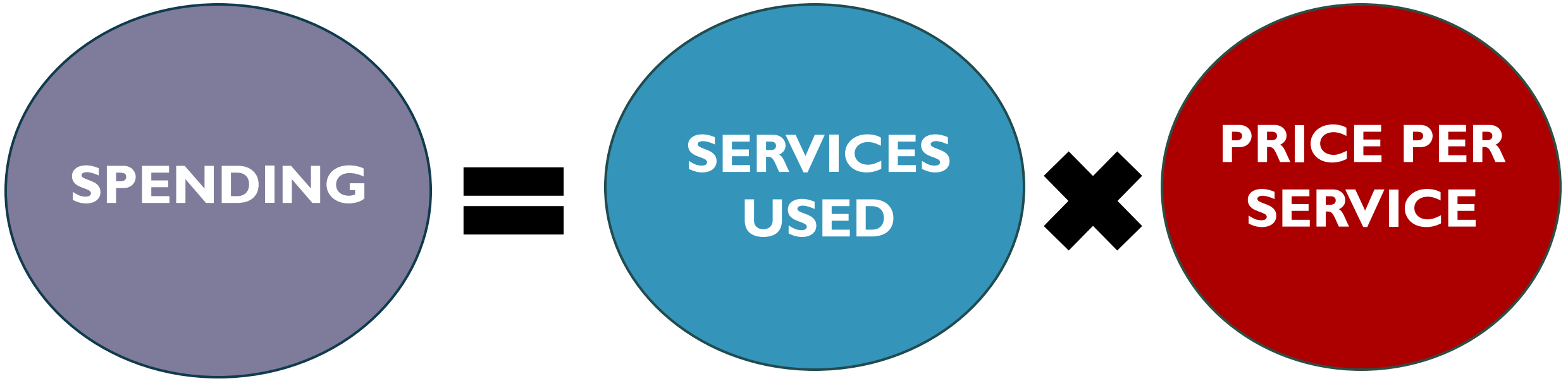
# Maine's per capita hospital expenditures have grown much faster than inflation and income



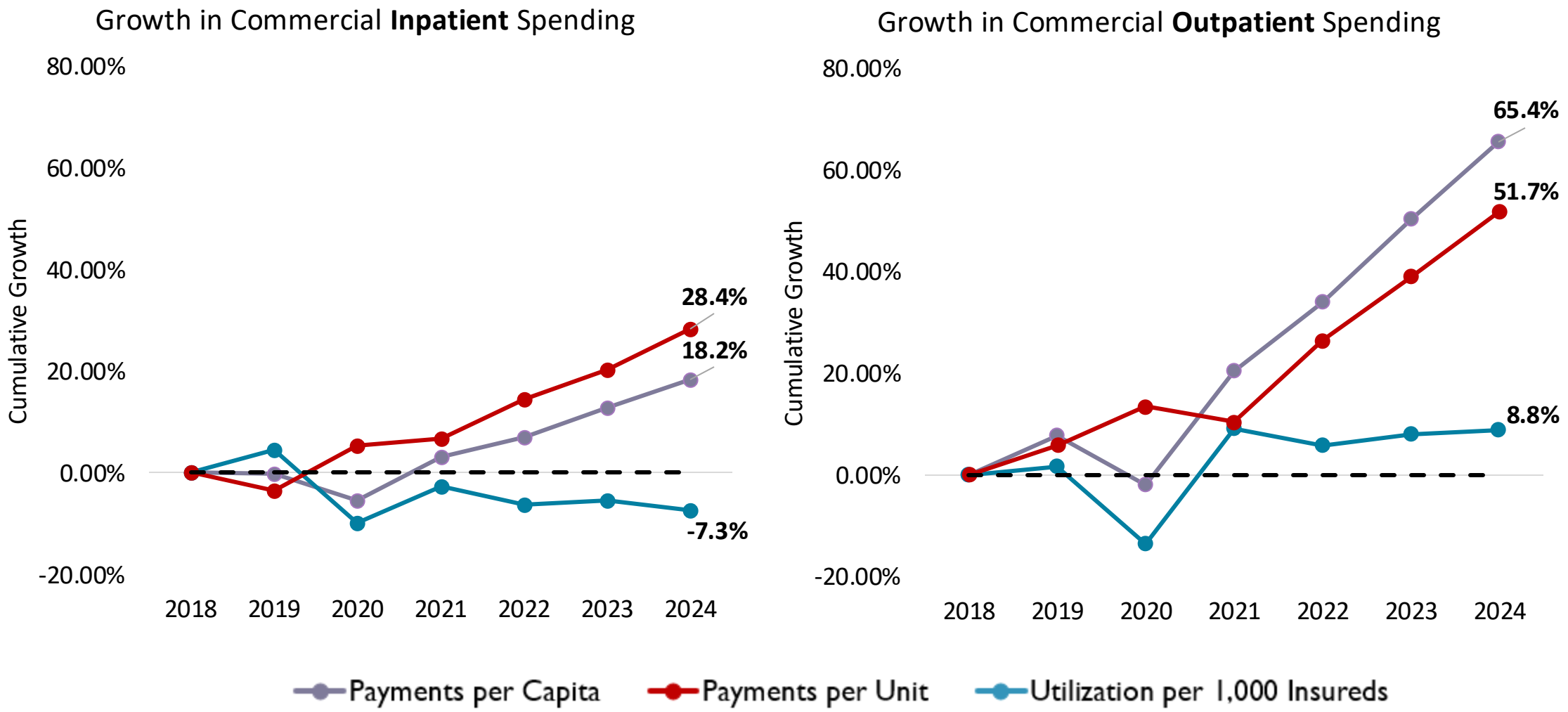

Per capita hospital expenses in Maine and nationally have significantly outpaced national inflation and Maine households' median income.

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;* Federal Reserve Bank of Minneapolis. (2024). *Consumer Price Index 1913-.*. and Federal Reserve Bank of St. Louis. (2024). *Real Median Household Income in Maine.*

# Spending is a function of utilization and price

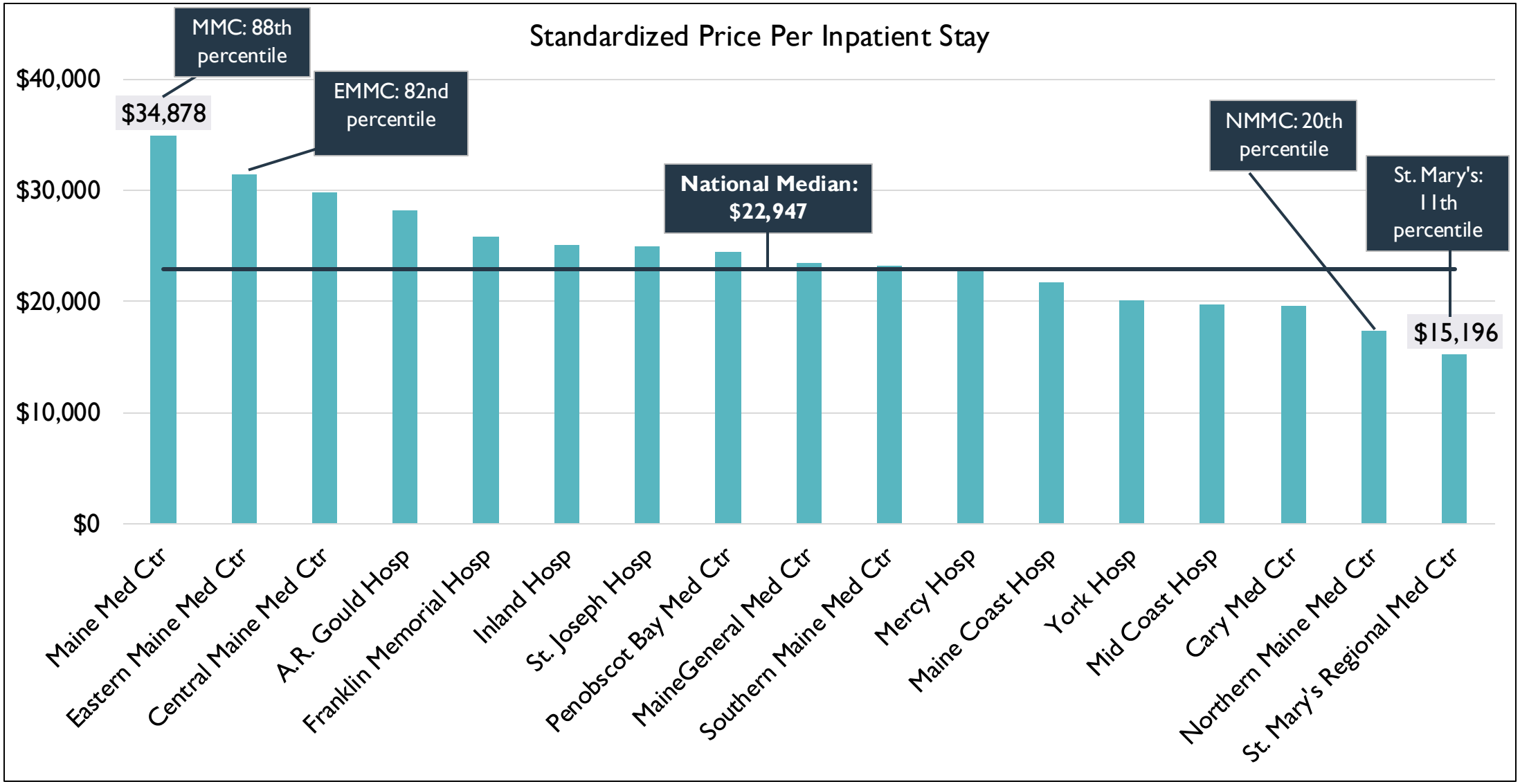


# Payments per unit (price) drive hospital services spending growth for the commercially insured




Source: Maine Health Data Organization. (2024). *Hospital Services Payments and Utilization Dashboard*

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

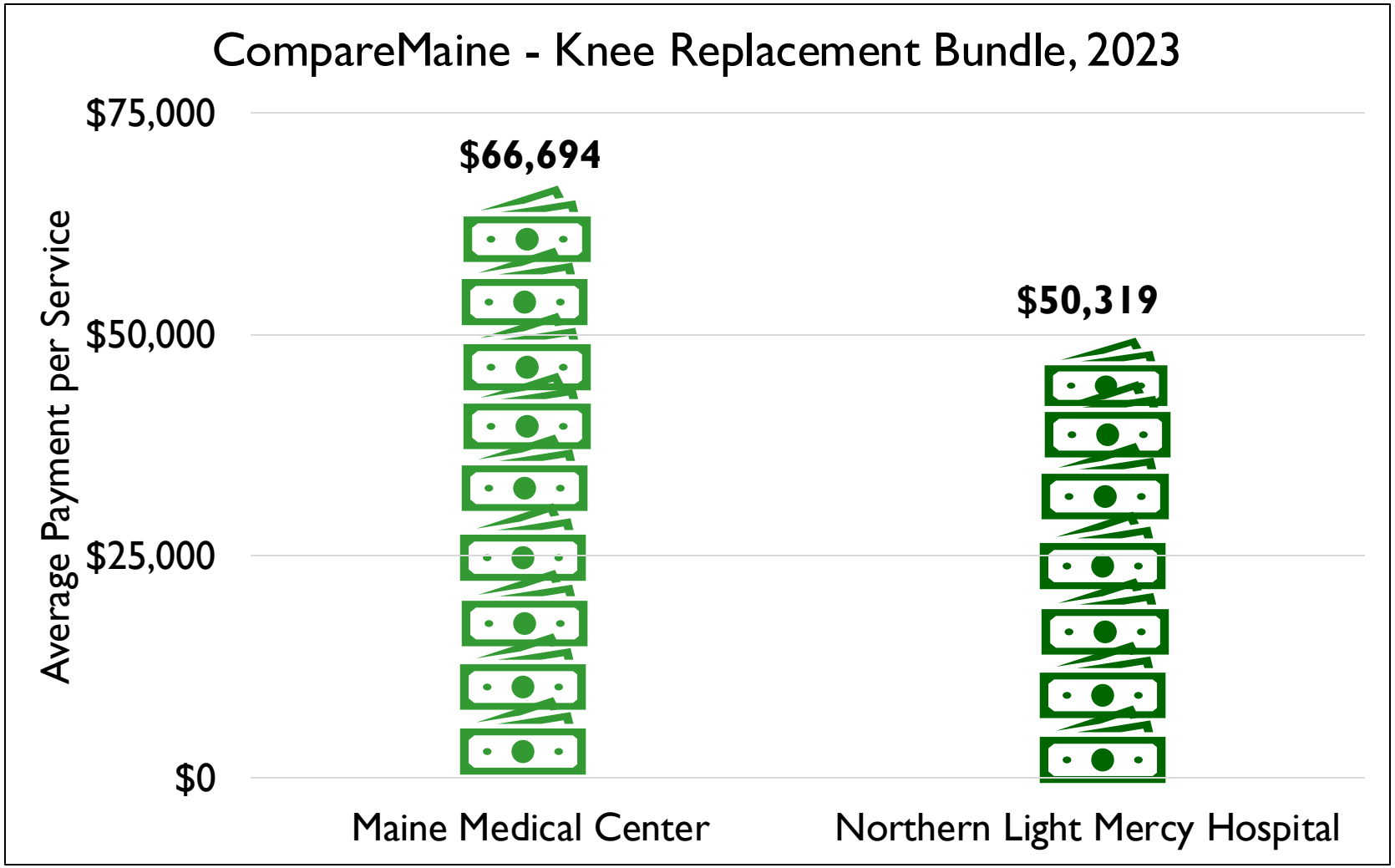



**Source:** RAND (2024). Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. Visualization adapted from Bailit Health.

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

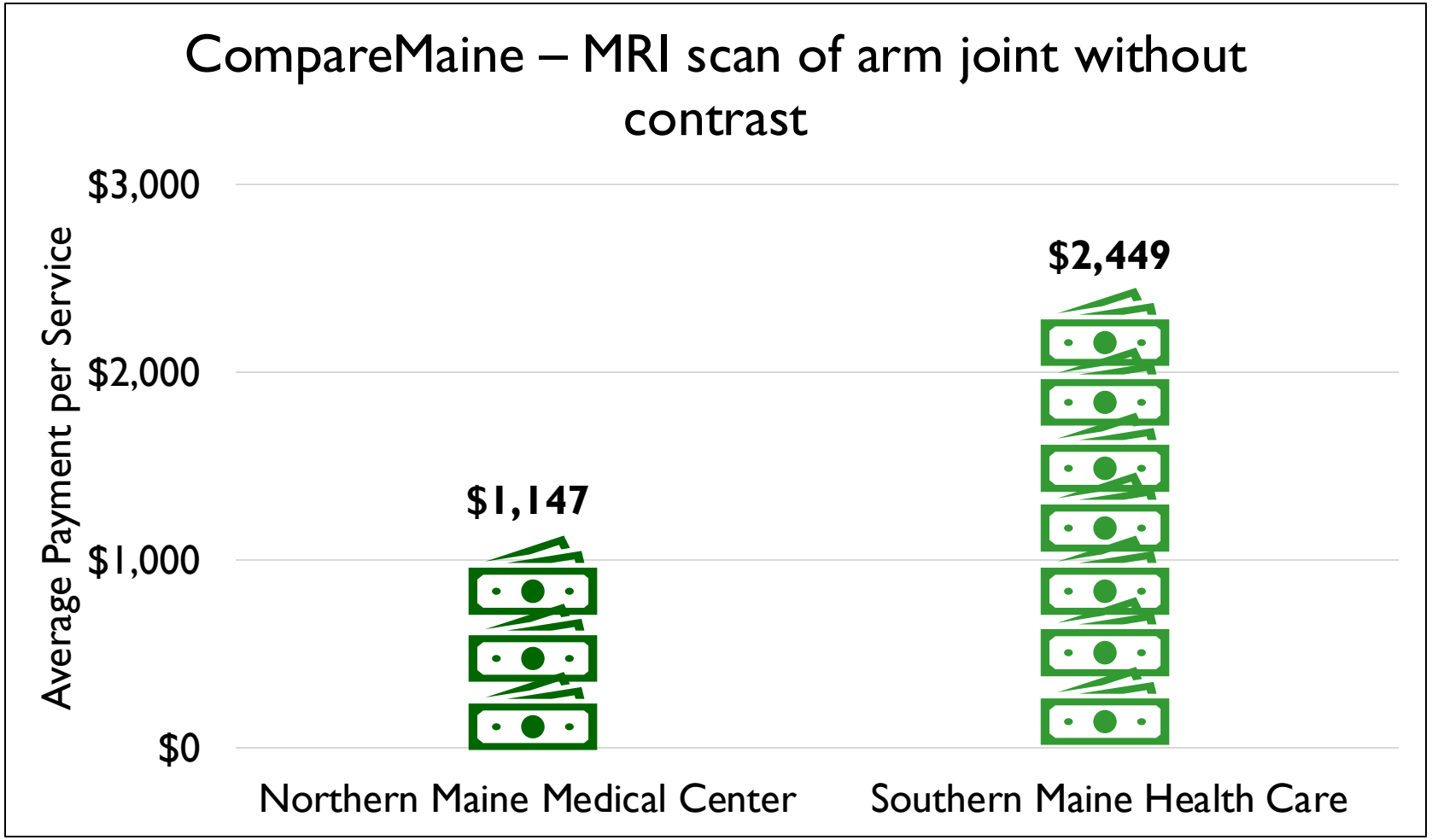
In the same area, patients can pay vastly different prices for the same service based on where they go to receive care.

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



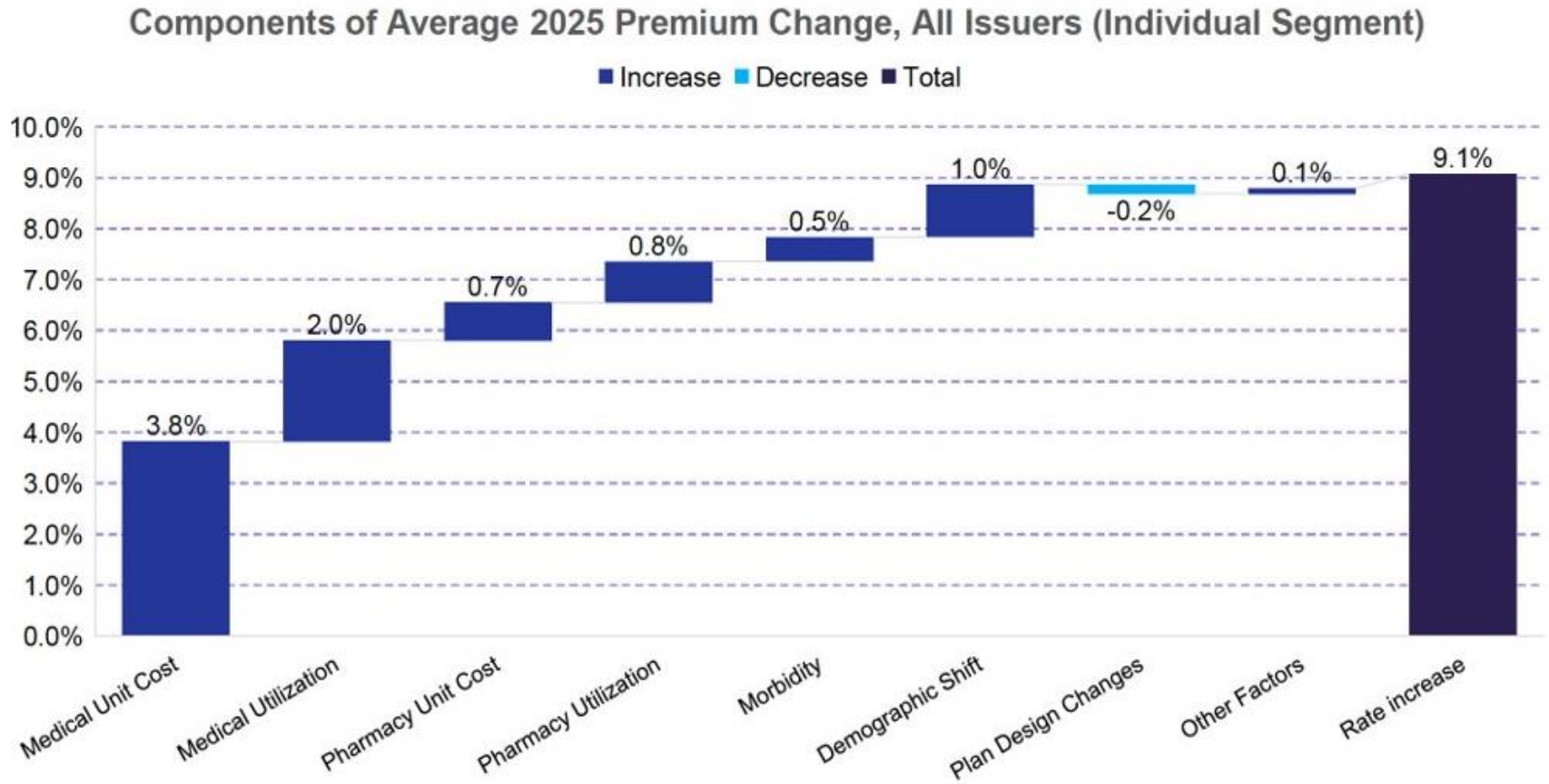
# In Biddeford payments are twice as much, on average, for the same service compared to Fort Kent

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 health insurance premiums

## Drivers of the 2025 Average Rate Change




For 2026, the average weighted increase in premiums in the individual market was **23.9%** and for small group plans was **17.7%.**

In 2026, rate filings, allowed medical trend for major carriers ranged from 8.1% to 11.3%.

*Medical Trends and Premium Changes in Maine Marketplace, Wakley Consulting Group, February 7th, 2025*

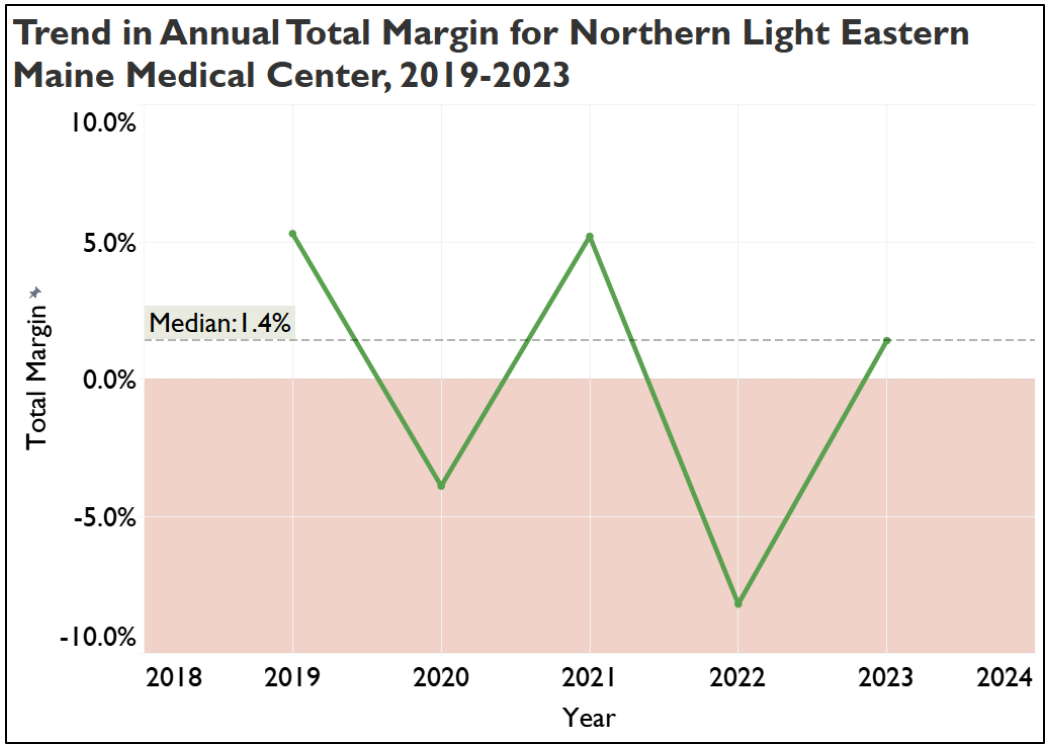
# Considering Hospital Financial Performance

# Analytical Considerations for Measuring Hospital Financial Performance

**Comprehensive financial analyses should look for ways to mitigate metric volatility to better understand the long-term financial outlook by:**

- Considering multiple years given the influence of changes in demand, market dynamics, and one-time funding (e.g. COVID-19 supplemental payments).
- Considering multiple metrics across financial indicators such as profitability, liquidity, debt capacity and solvency, and capital investment.
- Comparing facilities of similar relative size and service complexity.

**Example of Metric Volatility – Northern Light Eastern Maine Medical Center**




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

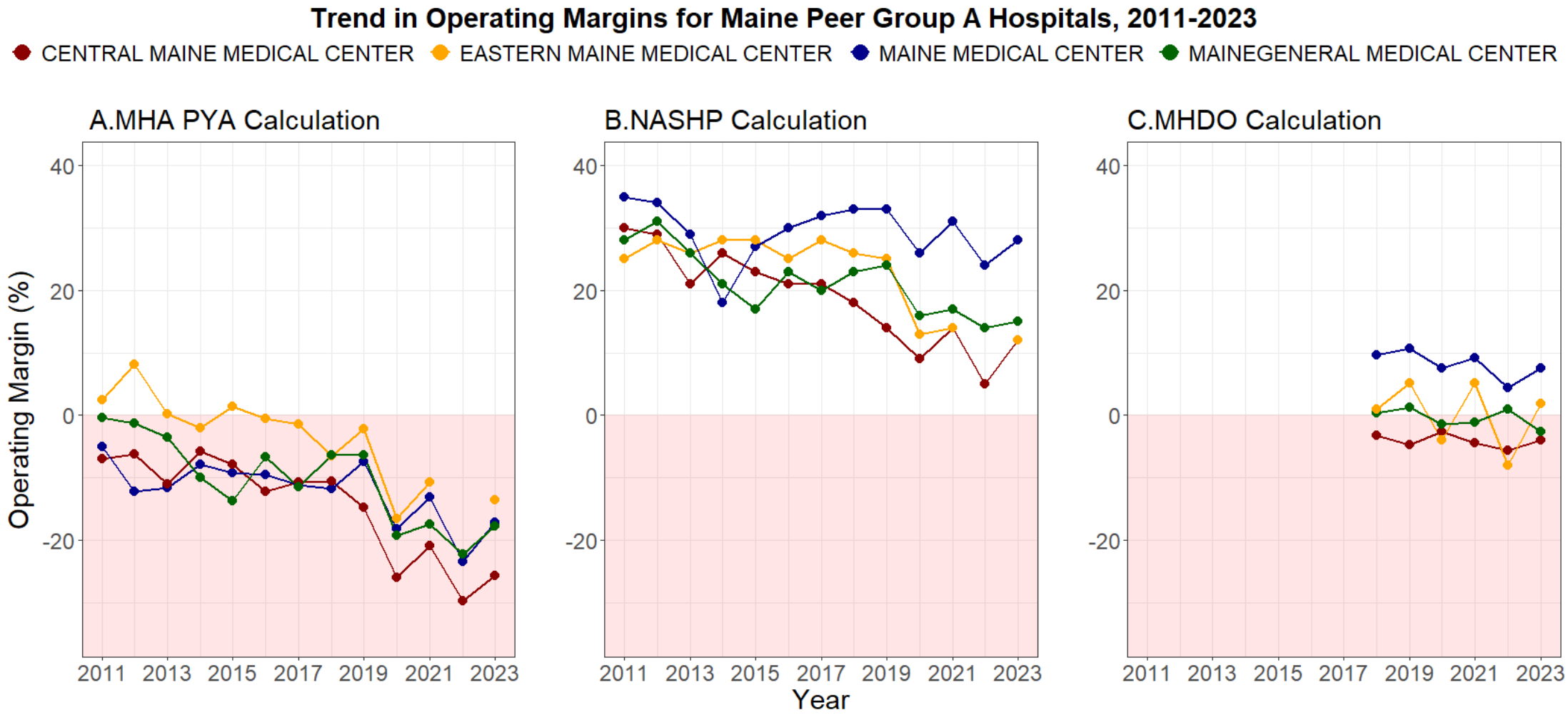
# Analytical Considerations for Measuring Hospital Financial Performance

**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

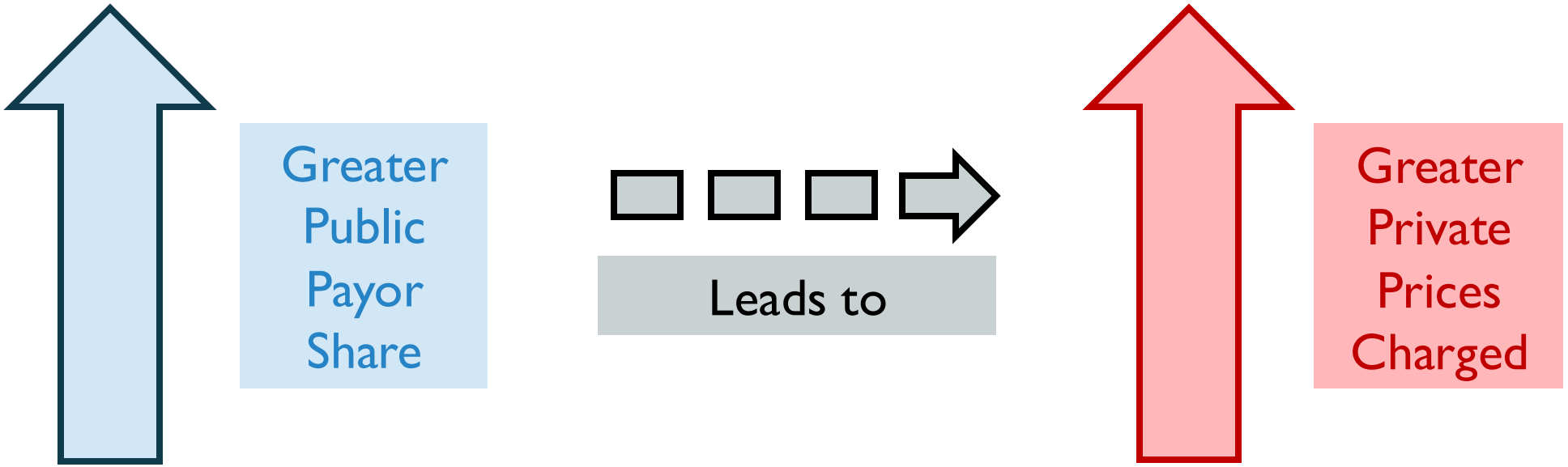



**Source:** Medicare Cost Reports and Maine Health Data Organization. *Report A: 2019-2023 Select Hospital Data Elements and Ratios. https://mhdo.maine.gov/hospital_financials.htm*

# 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.

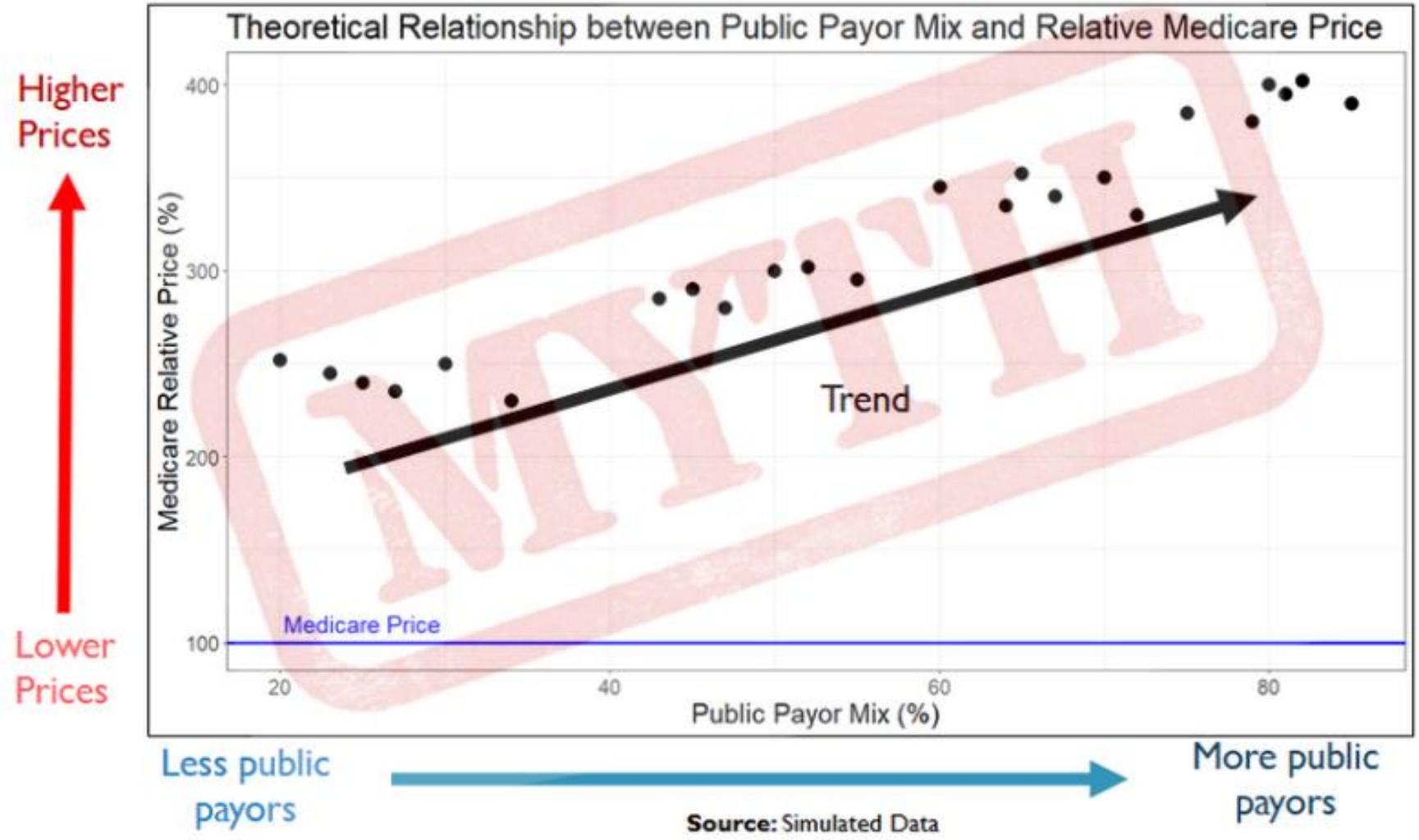


# The cost shifting myth in the data

***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

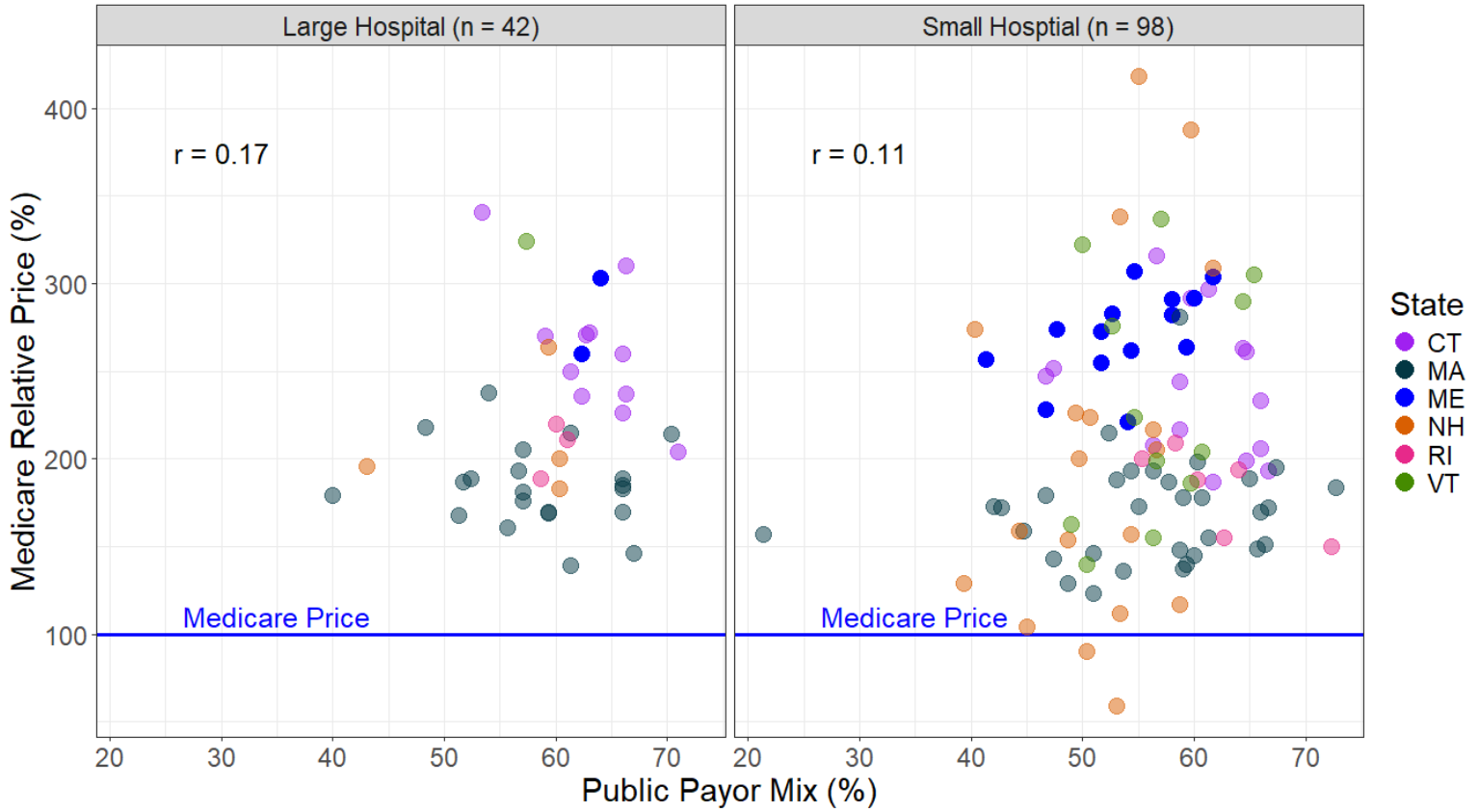
**Myth**

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




**Source:** Medicare Cost Reports and RAND Hospital Price Transparency 5.0

# 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 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.

# Supporting Hospital Efficiency

Maine's application to the Rural Health Transformation Program (RHTP) requested **$108 million** to support hospital efficiency and financial management.

This funding will provide tools and tailored technical assistance to improve the efficiency and financial management of at-risk hospitals serving rural Maine residents. Strategic investments in capital improvements and technology, aligned with these plans, will help these hospitals strengthen their financial stability.

# 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 health insurance rate review process and market conduct examinations.

# 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**

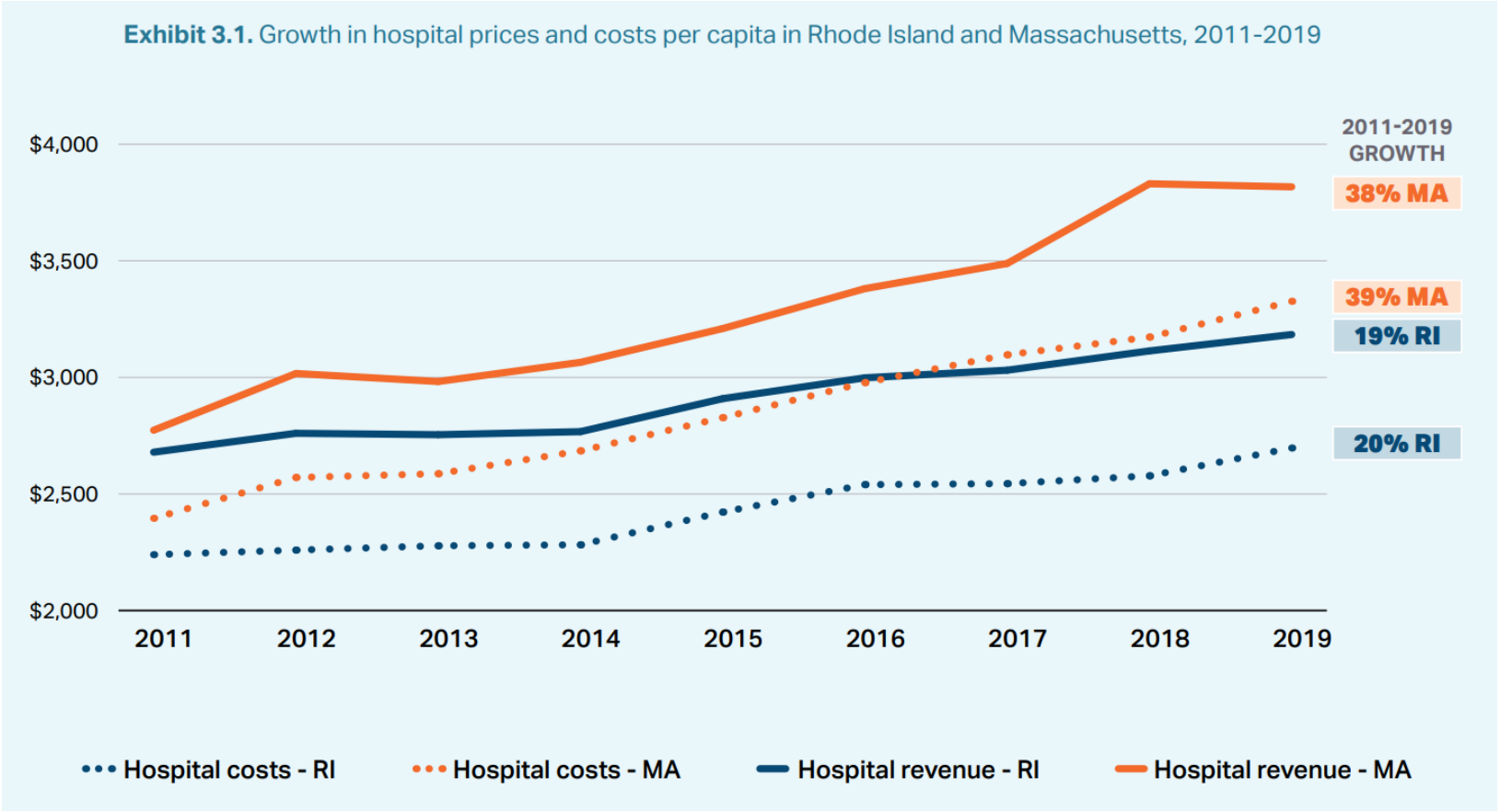
- $64M of this accrued to employers providing health insurance, while $23.7M accrued to consumers in the form of premium and out-of-pocket cost savings.
- By 2022, the authors found that hospital price reductions translated into annual savings for consumers of of $1,000 per member in fully-insured plans.

**Sources:** Ryan AM, Whaley CM, Fuse Brown EC, Radhakrishnan N, and Murray RC. Rhode Island's Affordability Standards Led To Hospital Price Reductions And Lower Insurance Premiums. *Health Affairs* 2025 44:5, 597-605. Baum A, Song Z, Landon BE, Phillips RS, Bitton A, and Basu S. Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers. *Health Affairs*. 2019;38(2):237–45

# 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.




**Source:** Massachusetts Health Policy Commission, *2023 Annual Health Care Cost Trends Report and Policy Recommendations*, September 2023.

# 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.

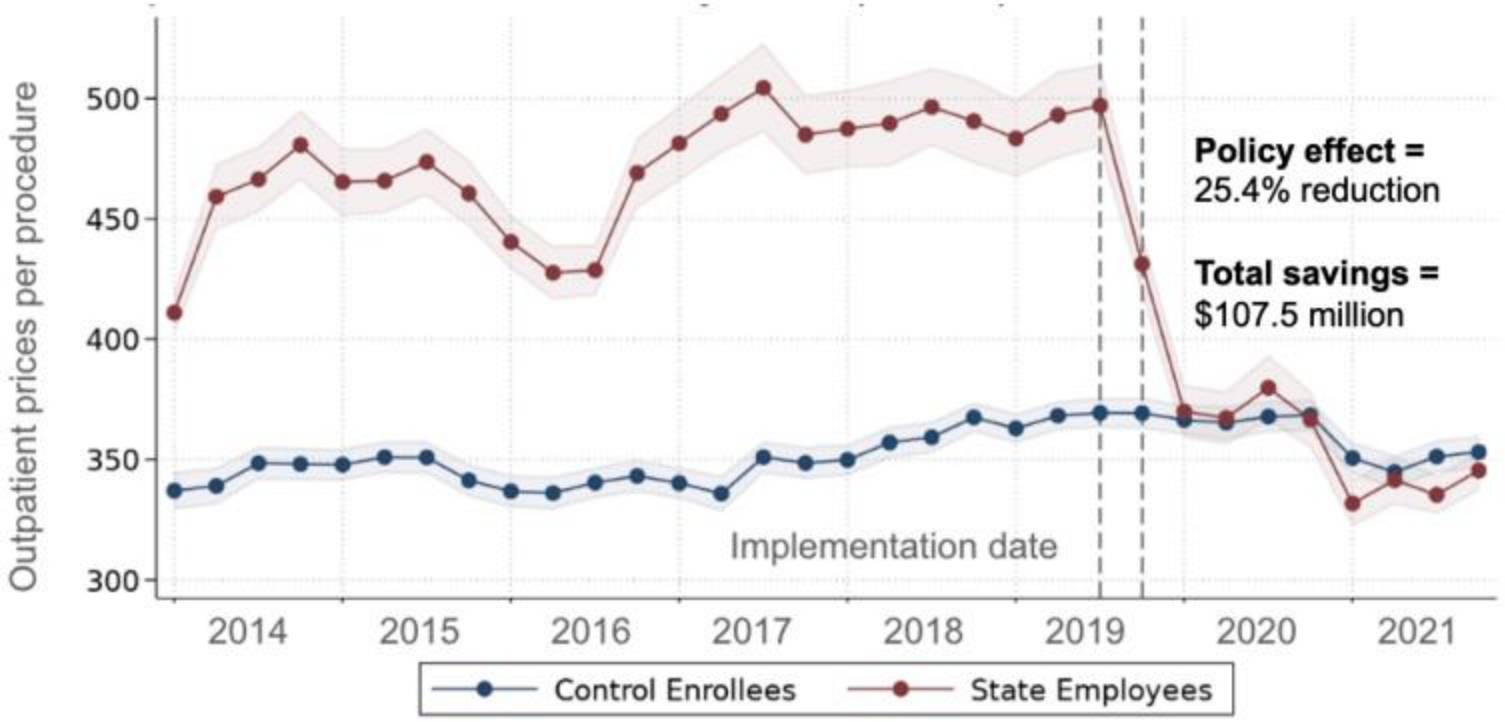
**State Examples**

- 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




**Source:** Roslyn C. Murray, *Hospital Payments Caps Impact on Prices and Spending Lessons from the Oregon State Employee Plan*, Testimony Submitted to the House Appropriations Committee of the Washington State Legislature, January 28, 2025.

# Evidence of Success in Oregon

A 2025 evaluation found that there were no statistically significant changes in net patient revenue, patient care expenses, or operating margins.

The study did find modest improvement in measures of patient experience, and no evidence of disruption to hospital operations (including staffing reductions, cuts to clinical compensation, or service-line closures).

The Oregon state employee health plan covers roughly 15% of the commercially insured population in Oregon.

**Source:** Murray RC, Ryan AM, Whaley C. Murray RC, Brown ZY, Miller S, Norton EC, Ryan AM. Hospital Finances, Operations, And Patient Experience Remain Stable After Oregon's Hospital Payment Cap Was Implemented. Health Affairs, December 2025.

# Price Caps in Public Option Plans

Two operational public option plans in the country 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.

**Sources:** Washington Health Benefit Exchange, Cascade Select will be available across Washington in 2025, October 15, 2024. Roslyn Murray and Christopher M. Whaley, "Can Public Option Plans Improve Affordability? Insight from Colorado," *Health Affairs*, January 15, 2024,

# New Models Passed in 2025

**Indiana** – requires non-profit hospitals to bring prices in line with the state average, with a focus on the largest hospital systems in the state. If hospitals do not 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.

# Proposed Policy Framework

# 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

# OAHC 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