132nd MAINE LEGISLATURE

SECOND REGULAR SESSION-2026

Legislative Document **No. 2196**

H.P. 1475 House of Representatives, February 3, 2026

An Act to Lower Health Insurance Costs, Reduce Barriers to Health Care and Ensure Fair Prices for Health Care

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 203.

Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

ROBERT B. HUNT
Clerk

Presented by Representative GATTINE of Westbrook.
Cosponsored by Senator INGWERSEN of York and
Representatives: Speaker FECTEAU of Biddeford, MEYER of Eliot, MOONEN of Portland,
Senators: BAILEY of York, President DAUGHTRY of Cumberland.

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 5 MRSA §3122, sub-§3, ¶F, as enacted by PL 2021, c. 459, §3, is amended to read:

F. Develop proposals for consideration by the legislative oversight committee on potential methods to improve consumer experience with the health care system, including the provision of a consumer advocacy function on health care matters not addressed by the Health Insurance Consumer Assistance Program established in Title 24-A, section 4326 or the Department of Professional and Financial Regulation, Bureau of Insurance, Consumer Health Care Division established in Title 24-A, section 4321; ~~and~~

Sec. A-2. 5 MRSA §3122, sub-§3, ¶G, as enacted by PL 2021, c. 459, §3, is amended to read:

G. Provide staffing assistance to the Maine Prescription Drug Affordability Board established in chapter 167~~.~~;

Sec. A-3. 5 MRSA §3122, sub-§3, ¶H is enacted to read:

H. Based on financial data reported by a hospital to the Maine Health Data Organization in accordance with Title 22, section 8709, determine whether a hospital is financially distressed for the purposes of Title 22, section 1730-B, subsection 4, paragraph C;

Sec. A-4. 5 MRSA §3122, sub-§3, ¶I is enacted to read:

I. Monitor compliance with Title 22, section 1730-B. In carrying out this duty, the office may request from a hospital or an insurer information necessary to review and audit compliance and, upon request, an insurer or hospital shall provide any requested information. Any proprietary information requested by the office under this paragraph is confidential. For the purposes of this paragraph, "proprietary information" means information that is a trade secret or production, commercial or financial information the disclosure of which would impair the competitive position of the hospital or insurer submitting the information and would make available information not otherwise publicly available; and

Sec. A-5. 5 MRSA §3122, sub-§3, ¶J is enacted to read:

J. Monitor the impact of the implementation of Title 22, section 1730-B on the quality and accessibility of hospital care in this State and on the costs of nonhospital services. The office may adopt rules pursuant to subsection 10 as necessary to address its duties under this paragraph.

Sec. A-6. 22 MRSA §1730-B is enacted to read:

§1730-B. Hospital facility price growth ceiling; maximum and minimum pricing requirements for services

1. Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "General hospital" has the same meaning as in section 7932, subsection 2-A.

B. "Hospital facility price" means the total amount a hospital expects to receive for health care services, including both the amount paid to a hospital by any insurer or plan sponsor and any payment received directly from an insured or uninsured individual for institutional services.

C. "Insurer" has the same meaning as in Title 24-A, section 3952, subsection 6.

D. "Plan sponsor" means any person, other than an insurer, that establishes or maintains a health plan covering residents of this State, including, but not limited to, plans established or maintained by 2 or more employers or jointly by one or more employers and one or more employee organizations, associations, committees, joint boards of trustees or other similar groups of representatives of the parties that establish or maintain the plan. "Plan sponsor" does not include the MaineCare program; the federal Medicare program; the Civilian Health and Medical Program for the Uniformed Services, known as TRICARE; the Federal Employees Health Benefits Program; the United States Department of Health and Human Services, Indian Health Service; or any program providing health benefits administered by the United States Department of Veterans Affairs.

2. Hospital facility price growth ceiling. Beginning January 1, 2028 and annually thereafter, the annual growth of hospital facility prices in this State is limited to a percentage equal to the inpatient prospective payment system hospital market basket established by the federal Medicare program. Beginning January 1, 2028, a general hospital may not:

A. Enter into a contract with any insurer or plan sponsor in which the growth of the allowed amount for any inpatient or outpatient facility service exceeds the hospital facility price growth ceiling for that plan year; or

B. Charge or collect payment for any inpatient or outpatient facility service in an amount that exceeds the prior year's price for that same service by more than the hospital facility price growth ceiling for that plan year, including any amount charged to or collected from an insurer, plan sponsor or individual or any other source with respect to the service.

3. Maximum price for inpatient and outpatient services. Except as otherwise provided in subsection 4, beginning January 1, 2028, a general hospital may not:

A. Charge or collect payment from any insurer, plan sponsor or patient for any inpatient or outpatient facility service in an amount that exceeds 200% of the Medicare rate for the same service in the same geographic area. If a general hospital has an aggregate average commercial price that exceeds 225% of the Medicare rate on January 1, 2028, the hospital may comply with this paragraph by reducing the aggregate average commercial price relative to the rate paid by Medicare by 25 percentage points annually until the hospital's charge for any inpatient or outpatient service does not exceed 200% of the Medicare rate;

B. Enter into a contract with any insurer or plan sponsor in which the allowed amount paid for any inpatient or outpatient facility service exceeds 200% of the Medicare rate for the same service in the same geographic area; or

C. Charge or collect payment for any amount exceeding the allowed amount for a covered health care service pursuant to this subsection, except for any applicable

in-network coinsurance, deductible or copayment amount, including any amount charged to or collected from an insurer, plan sponsor or individual or any other source with respect to the service.

4. Exceptions. The maximum prices required by subsection 3 do not apply to:

A. Charges for services to a critical access hospital;

B. Charges for services made under a contract with an insurer or plan sponsor unless the insurer or plan sponsor complies with the requirements for utilization review and prior authorization in Title 24-A, sections 4304, 4304-A and 4304-B and for the minimum allowed amount for primary care and behavioral health care services in Title 24-A, section 4320-A, subsection 3-C; or

C. Charges for services made to a general hospital determined to be financially distressed by the Office of Affordable Health Care. A determination of financial distress is valid for a period of no less than one year.

5. Enforcement. A hospital that fails to comply with the requirements of subsection 2 or 3 commits a civil violation for which a fine equal to at least 110%, and no more than 200%, of any charge exceeding the caps set forth in subsection 2 or 3 may be adjudged.

6. Self-insured health benefit plans. This section may not be construed to apply to an entity providing or administering a self-insured health benefit plan that is subject to the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988), except as provided in subsection 4, paragraph B for such an entity that elects to be subject to the provisions of this section. An entity providing or administering a self-insured health benefit plan that elects to be subject to the requirements for utilization review and prior authorization in Title 24-A, sections 4304, 4304-A and 4304-B and for the minimum negotiated charge for in-network primary care service and behavioral health care evaluation and management service as provided in Title 24-A, section 4320-A, subsection 3-C shall provide notice, on an annual basis, to the Office of Affordable Health Care, on a form and in a manner prescribed by the office, attesting to the entity's election to be subject to those provisions. The entity shall amend the entity's health benefit plan, coverage policy, contract and any other plan documents to reflect that the provisions of this section apply to the health benefit plan's members.

PART B

Sec. B-1. 24-A MRSA §4304-B is enacted to read:

§4304-B. Prior authorization for treatment of chronic conditions

1. Chronic condition defined. For the purposes of this section, "chronic condition" means a medical condition diagnosed by a health care provider that is expected to last 6 months or more and that:

A. Requires ongoing medical attention by a health care provider to effectively manage the condition or to prevent an adverse health event; or

B. Limits one or more activities of daily living, as defined in Title 22, section 1717, subsection 1, paragraph A.

2. Length of prior authorization for treatment of chronic conditions. If a carrier requires a prior authorization for health care services for the treatment of a chronic

condition, an approved prior authorization remains valid for one year. If health care services for the treatment of a chronic condition are necessary for more than one year, a carrier may not require the renewal of the prior authorization more frequently than once every 2 years, except when a new treatment protocol is introduced for the chronic condition. The prior authorization approval is valid from the date the enrollee receives the notice of the approval.

3. Length of prior authorization for diagnostic procedures or tests related to treatment of chronic conditions. A prior authorization for a diagnostic procedure or test related to the treatment of a chronic condition remains valid for subsequent, necessary recurring orders of the diagnostic procedure or test for one year. A carrier may not require the renewal of a prior authorization more frequently than once every 2 years for a diagnostic procedure or test that continues for more than one year, and the prior authorization approval remains valid from the date the enrollee receives notice of the approval.

4. Coverage restriction prohibition; notice. A carrier may not restrict coverage for a health care service, diagnostic procedure or test used in the treatment of a chronic condition under this section, including coverage for a prescription, that received prior authorization approval under a previous carrier within 90 days of enrollment in the carrier's health plan by an enrollee if that enrollee's health care provider determines that the enrollee should continue receiving that health care service, diagnostic procedure, test or prescribed drug as determined by a health care provider and, with respect to a prescribed drug, if the prescribed drug is included on the health plan's formulary at the time of that enrollee's enrollment. The carrier shall provide the enrollee with at least 90 days' notice prior to restricting coverage pursuant to this subsection.

PART C

Sec. C-1. 24-A MRSA §2736-C, sub-§2, ¶K is enacted to read:

K. For each rate filing submitted for the 2028 plan year and each plan year thereafter, a carrier shall provide in a format determined by the superintendent detailed information on the experience period and projected trend in both utilization and per-unit payment by benefit category and by hospital.

Sec. C-2. 24-A MRSA §2808-B, sub-§2-A, ¶D is enacted to read:

D. For each rate filing submitted for the 2028 plan year and each plan year thereafter, a carrier shall provide in a format determined by the superintendent detailed information on the experience period and projected trend in both utilization and per-unit payment by benefit category and by hospital.

Sec. C-3. 24-A MRSA §4320-A, sub-§3-C is enacted to read:

3-C. Minimum negotiated charge for in-network primary care service or behavioral health care evaluation and management service. The minimum negotiated charge of a carrier for any in-network primary care service or behavioral health care evaluation and management service may not be less than 110% of the Medicare rate for the same service in the same geographic area.

SUMMARY

Part A of this bill limits, beginning January 1, 2028 and annually thereafter, the annual aggregate growth in hospital prices to a percentage equal to the inpatient prospective payment system hospital market basket established by the federal Medicare program. Part A also limits the maximum amount that a hospital may charge or collect for any inpatient or outpatient facility service to no more than 200% of the Medicare rate for the same service in the same geographic area beginning January 1, 2028 subject to certain exceptions. An insurer or health plan sponsor must comply with statutory requirements related to utilization review and prior authorization in order to access the caps on maximum prices charged by hospitals. Part A authorizes the Office of Affordable Health Care to fine hospitals if they do not comply with these requirements.

Part B of the bill requires that a prior authorization for health care services for the treatment of a chronic condition and for diagnostic procedures or tests related to the treatment of a chronic condition remains valid for one year. It prohibits a health insurance carrier from requiring the renewal of a prior authorization more frequently than once every 2 years for treatment of a chronic condition that is necessary for more than one year. It also prohibits a health plan from restricting coverage for a health care service or a prescription that was approved under a previous health plan within 90 days of an enrollee's enrollment in the new health plan if the prescribed drug is included on the health plan's formulary at the time of that enrollee's enrollment and requires a health plan to provide at least 90 days' notice to an enrollee prior to restricting coverage of a previously approved health care service or prescription.

Part C of the bill requires each rate filing submitted by a carrier for the 2028 plan year and for each plan year thereafter to provide detailed information to the Superintendent of Insurance within the Department of Professional and Financial Regulation related to the experience period and projected trends in utilization and per-unit payment by benefit category and by hospital. Part C also requires that the minimum negotiated charge of a health insurance carrier for in-network primary care or behavioral health care services may not be less than 110% of the Medicare rate for the same service in the same geographic area.