Maine Office of Affordable Health Care

2024 Annual Report

Introduction

The Maine legislature established the Office of Affordable Health Care (OAHC) when it enacted P.L. 2021 Chapter 459, codified at 5 Maine Revised Statutes Annotated (MRSA) Part 8, Chapter 310-A.[1] The 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 is an independent executive agency, which performs its duties under the general policy direction of a 13-member Advisory Council on Affordable Health Care and the Joint Standing Committee on Health Coverage, Insurance, and Financial Services. The Advisory Council provides the Office with stakeholder guidance on matters affecting health care costs in Maine. Members are appointed and confirmed by the legislature and serve five-year terms. A full list of current Advisory Council Members is shown in Table 1. The Advisory Council meets every two months, for a total of six meetings in 2024. Meetings are open to the public and recordings of all Advisory Council meetings are available on the Office's website.[2]

Table 1. 2024 Advisory Council for the Office of Affordable Health Care

Member	Area of expertise/ representation
Trevor Putnoky (Chair)	Purchasers of health care
Kate Ende (Vice Chair)	Health care consumer advocate
Christy Daggett	Health economics and research
Renee Fay-LeBlanc	Primary care provider interests
Katie Fullam-Harris	Hospital interests
Anne Graham	Health care workforce
Kevin Lewis	Health insurance interests
Trish Riley	Health economics and research
Jeff Sanford	Health care management, finance, administration
Malory Shaughnessy	Behavioral health care interests
Vacant	Interests of older residents
Jordan Rhodes	ex officio - Department of Health and Human Services
Jenny Boyden	ex officio - Department of Administrative and Financial Services

In 2023, the Office worked with the Advisory Council to develop guiding principles to inform the ongoing work of the Office (Table 2). The guiding principles assist the Office in identifying areas of focus for policy development and allocating resources.

[1] https://legislature.maine.gov/statutes/5/title5ch310-Asec0.html
[2] https://www.maine.gov/the OAHC/advisory-council/meeting-records

Table 2. Office of Affordable Health Care Guiding Principles

Principle 1: Focus on the "big picture"
• Prioritize opportunities with the most significant opportunity for meaningful long-term impact • Recognize the complexity of interdependent systems and actors in health care
Principle 2: 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
Principle 3: Deliver results
• Take into account whether proposals are achievable, and address implementation considerations • Recognize that continuing the status quo is not sustainable

The staff of the Office has grown throughout 2024, and now includes the Executive Director, a Senior Analyst, and a Policy Analyst. The Office vacated 221 State Street as that building is being prepared for renovation, so staff are currently utilizing office space in the Department of Health and Human Services central office at 109 Capitol Street. The Office is grateful to DHHS for allowing OAHC to use this space, allowing more of its limited budget to be devoted to research and policy work.

Research and Analysis

Analytics Planning

In 2024, the Office established an analytics plan to provide structure to current and anticipated research projects (Figure 1). This framework considers the statutory direction provided to the Office, guiding principles, existing work products produced by the Maine Health Data Organization (MHDO) and Maine Quality Forum (MQF), and the availability of data sources.

Figure 1. Office of Affordable Health Care framework for monitoring and analysis of health care costs and spending.

Note: Dark blue boxes represent completed analytical products created by or on behalf of the Office of Affordable Health Care. Lighter blue boxes planned future work products. Green boxes represent Maine Health Data Organization/ Maine Quality Forum reports.

During 2024 OAHC made significant progress in delivering products in the analytic plan, including publishing *Hospital Payment and Utilization Dashboards*[3] created in collaboration with MHDO and its analytics vendor. In addition, the Urban Institute developed a report at the request of the Office - *An Overview of Health Coverage and Costs in Maine for 2025*[4]- to estimate household health care spending and insurance status for Mainers under 65. An overview and key takeaways from these analytical products were presented at the Office's 2024 Public Hearing and Advisory Council meetings and findings are summarized below.

In addition to new data analytics, the Office also produced *A Public Option for Maine: Considerations for Policymakers* in response to legislative resolve P.L. 2023 Ch. 87. The report reviews different public option models, key decision points, and a discussion of how such a plan might impact Maine's insurance market. The full report is available in the "Reports" section of OAHC's website.

An Overview of Health Coverage and Household Costs in Maine

Most Maine residents are covered by commercial health insurance, meaning they receive coverage through their job or buy individual insurance, often through the CoverME.gov Marketplace (Figure 2).[5,6] Since 2015, the share of Mainers who are uninsured has steadily decreased, while the share of residents covered by Medicare (federal health insurance based on age and/or disability status) have steadily increased (Figure 3). As Maine's population ages, the share of Mainers covered under Medicare is likely to continue to grow. The share of residents covered by commercial health insurance reached highs in 2017 and 2021 but has since decreased. The share of residents covered by MaineCare (Maine's Medicaid program) reached a low in 2017 but has since steadily increased (Figure 3).[5]

[3] https://www.maine.gov/oahc/hospital-payments-utilization-dashboards
[4] Buettgens, M., Banthin J., Akel, M., and Simpson, M. (2024). An Overview of Health Coverage and Costs in Maine for 2025. Urban Institute. https://www.urban.org/sites/default/files/2024-02/An%20Overview%20of%20Health%20Coverage%20and%20Costs%20in%20Maine%20for%202025.pdf
[5] KFF. (2024). *Health Insurance Coverage of the Total Population – KFF Analysis of Census Bureau's American Community Survey 2008-2022 1-Year Estimates.* https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[6] Maine Bureau of Insurance. (2024). *2023 Financial Results for Health Insurance Companies in Maine (Detailed Version).* https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/rule945-report-detail-tables.pdf

Figure 2. Health Insurance Coverage by Type in Maine, 2022.[5,6]

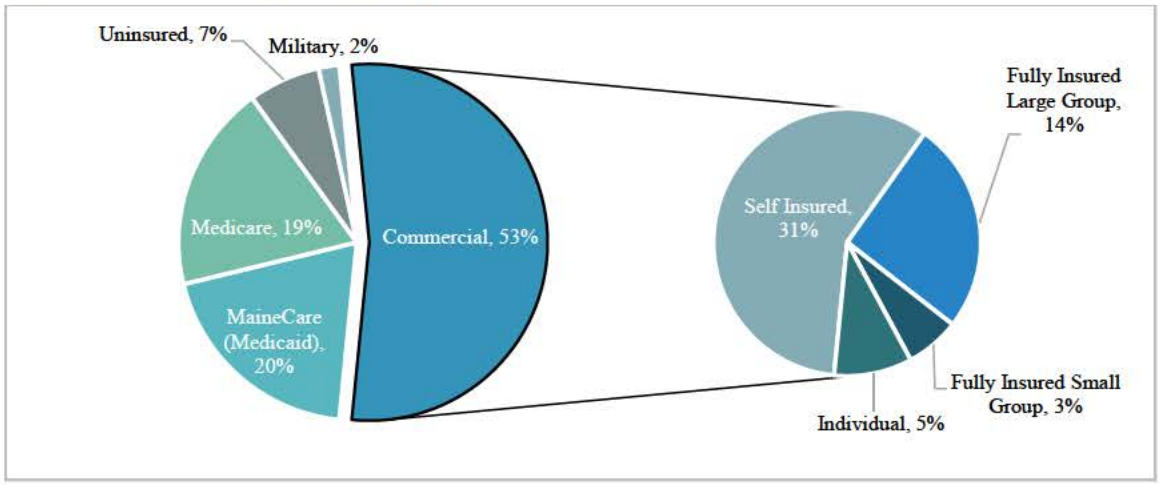
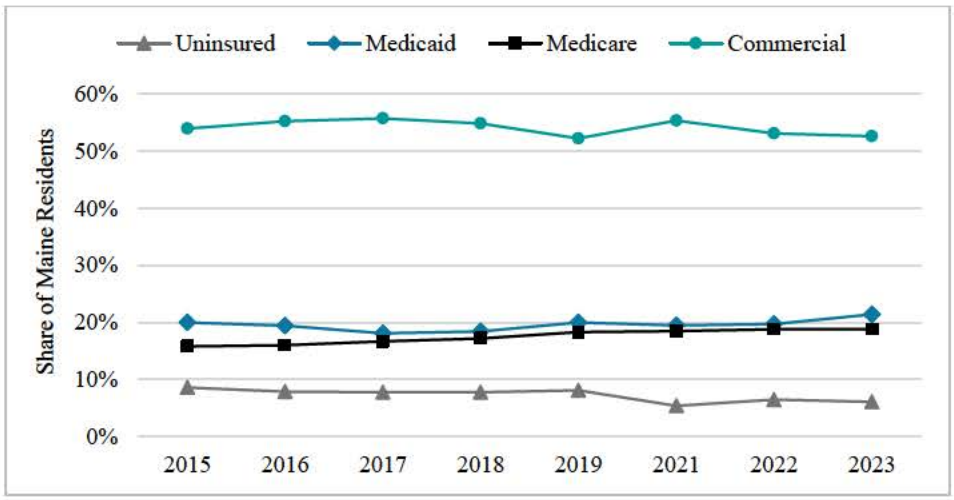


Figure 3. Share of Maine residents by Health Insurance Coverage by Type, 2015 – 2023.[5]

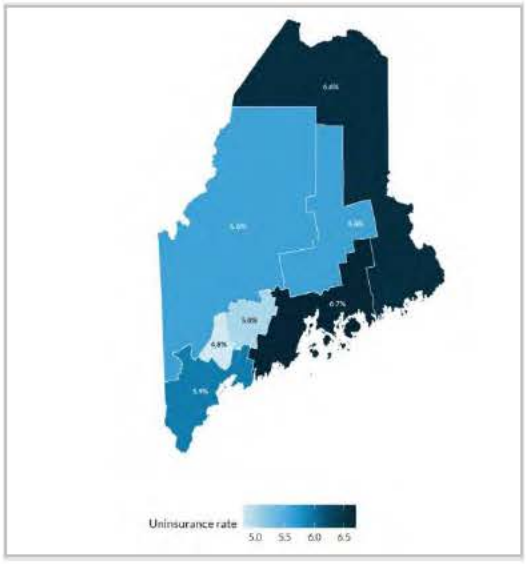


To gain a better understanding of the status of insurance coverage and consumer burden of health care in Maine, OAHC solicited the expertise of the Urban Institute and their Health Insurance Policy Simulation Model (HIPSM). HIPSM is informed by American Community Survey (ACS) data and other sources that incorporate more timely data for some inputs, including the MHDO APCD, and Medicaid and Marketplace enrollment. The final product of this analysis was the report *An Overview of Health Coverage and Costs in Maine for 2025* available on the Urban Institute's website.[4] The report estimates rates of coverage and cost in 2025, following the end of federal rules related to Covid-19 which prevented state Medicaid programs from disenrolling members even if they had changes in income or other circumstances that would previously have made them ineligible.

The report estimates that, for 2025, 5.8% of Mainers (59,000) will be uninsured and uninsurance will be concentrated in young adults ages 19-34. An estimated 70% of uninsured Mainers will be

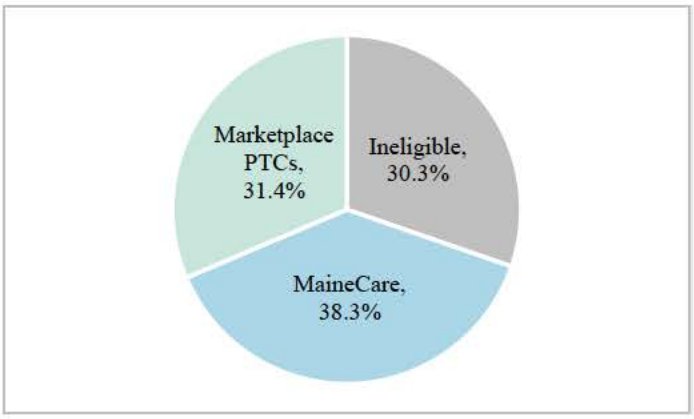
living in families with at least one full time worker. Counties with the largest share of uninsured people are expected to be Aroostook, Hancock, Lincoln, and Washington (Figure 4).[4]

Figure 4. Estimated percent of population with uninsurance by Maine county for 2025.[4]



The report also estimates that nearly 70% of uninsured Mainers will be eligible for public benefits that would support obtaining health insurance, with nearly 40% being eligible for MaineCare, and a further 30% eligible for Marketplace Premium Tax Credits (Figure 5).[4]

Figure 5. Percent of uninsured people in Maine by eligibility for public benefits, 2025.[4]

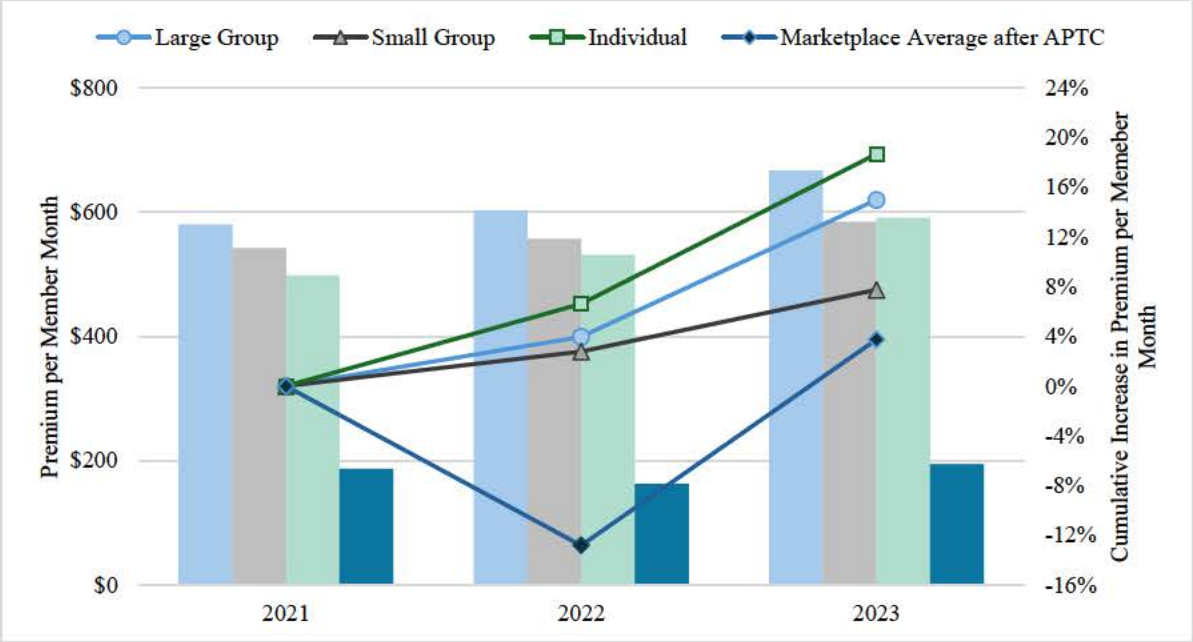


Trends in Premiums

Data from the Maine State Bureau of Insurance show that within the fully insured market per member month premium costs have increased in recent years (Figure 6). On average, from 2021 and 2023 premiums per member month increased by 15% for large group plans, 8% for small group plans, and 19% for individual plans.[6] It is important to note, however, that average premiums paid by customers on the CoverME.gov Marketplace, where most individual consumers purchase plans, increased only 4% when accounting for Advance Premium Tax

Credits[7] while employers and employees in the large and small group markets bear the full cost of premium increases.

Figure 6. Total allowed (bars) and cumulative increases (lines) in premiums per member month in the fully insured large group, fully insured small group, and individual health insurance markets, and the marketplace average after APTC in Maine, 2021-2023.[6]



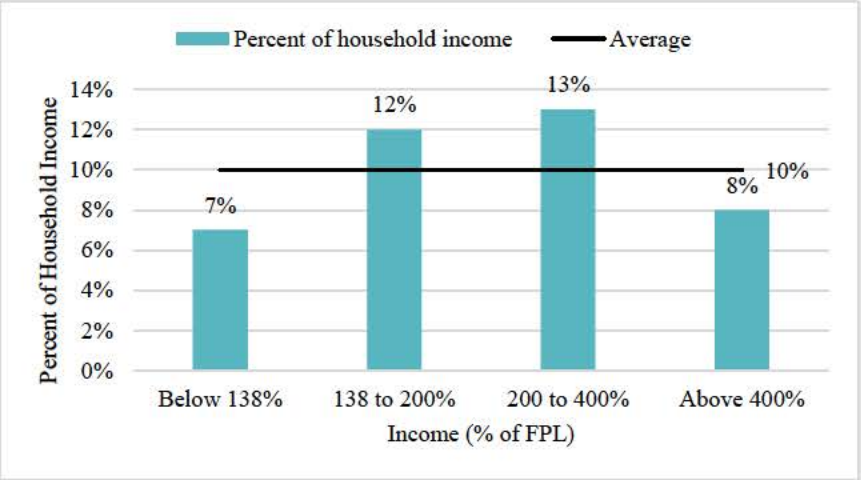
Note: APTC = Advanced Premium Tax Credit

Household Spending on Health Care

The Urban Institute report estimates that in 2025, residents under 65 will spend an average of 10% of their income on health care. For middle income earners the proportion of health care spend is 13% of their income, the highest among all income brackets (Figure 7).[4] For a family of four making 300% of the federal poverty line, or $93,600, this would equate to spending an average of $12,168 annually on health care, inclusive of premiums and out of pocket costs.

[7] KFF analysis of Marketplace Open Enrollment Period Public Use Files for 2017-2024 Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services. https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-premiums-and-average-advanced-premium-tax-credit-aptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

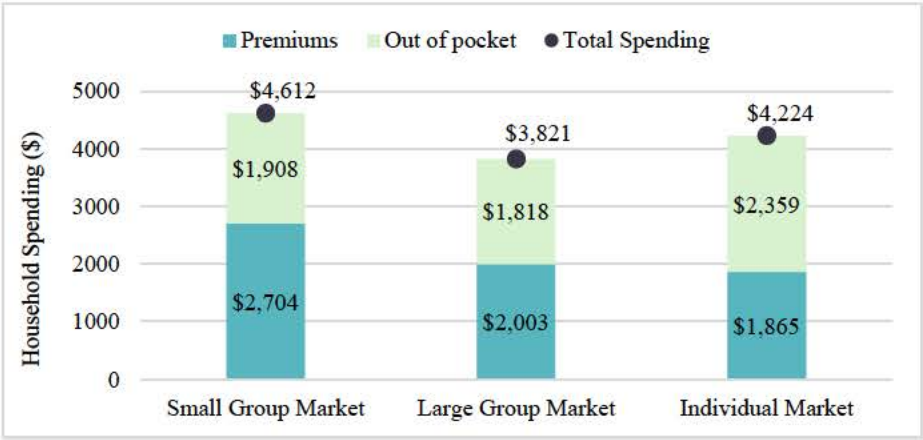
Figure 7. Household spending on health care for those under 65 in Maine for 2025.[4]



Note: FPL = Federal Poverty Line

The report also estimates that for 2025, premiums would account for roughly half of health care expenses for those with employer sponsored insurance (Figure 8).[4] These data suggest that in addition to rising costs of premiums, consumers are expected to pay large out of pocket expenses in deductibles, copayments, and coinsurance.

Figure 8. Projected average household health spending by type of spending for those under 65 in Maine for 2025.[4]



Drivers of Health Care Spending

The Centers for Medicare and Medicaid Services (CMS) National Health Expenditure Data estimate health care spending by category for all states and the nation.[8] Maine spends the largest portion of its health care expenditures on hospital services (39%) (Figure 9). From 2001-2020 growth in per capita hospital expenditures have outpaced all other top spending categories,

[8] 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*. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence

including spending on drugs and other non-durable products (Figure 10).[8]In 2020, Maine's per capita hospital spending ranked 14th highest in the nation. Further, Maine's per capita hospital expenditures have outpaced the national average, inflation, and Maine household median income from 2001-2020 (Figure 11).[8,9]

Figure 9. Maine health care expenditures by category for 2020.[8]

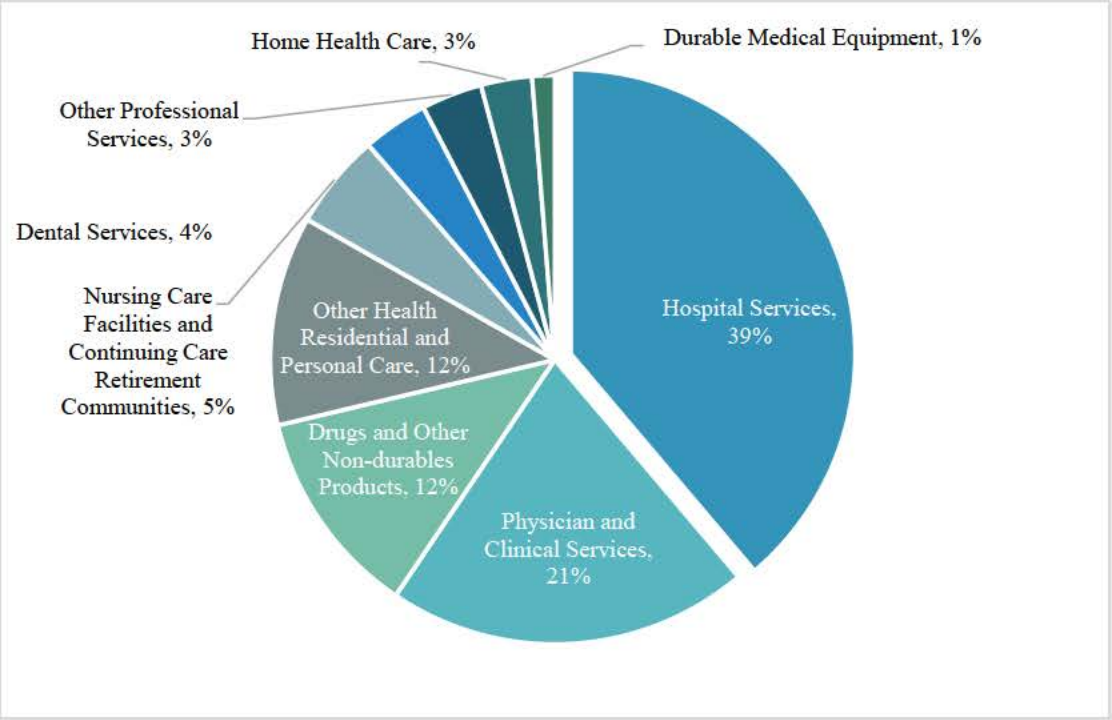
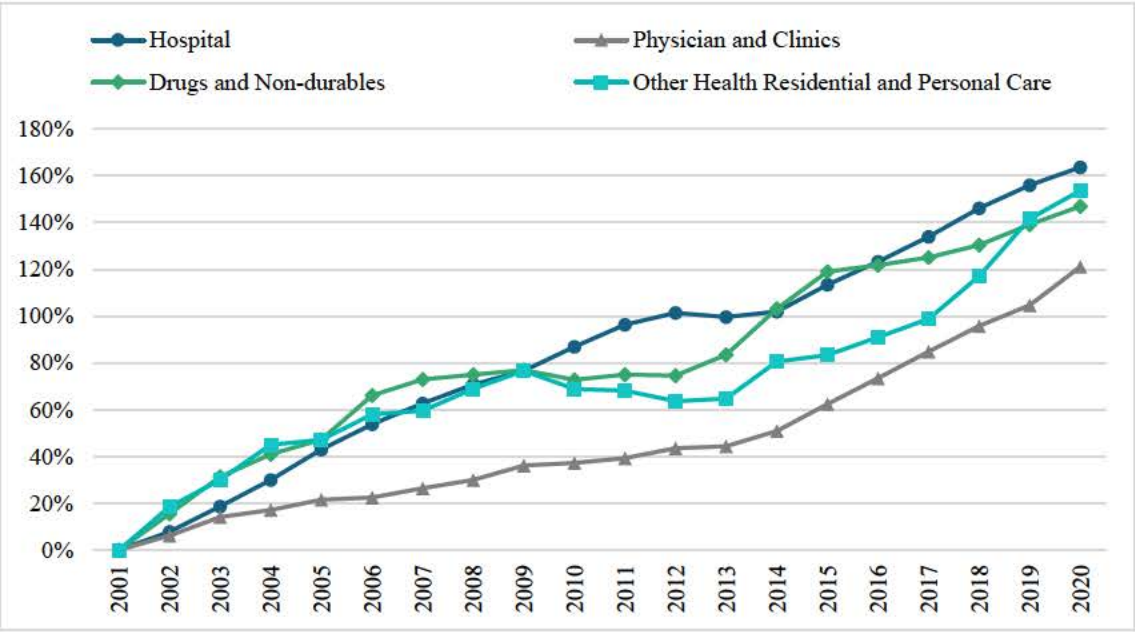
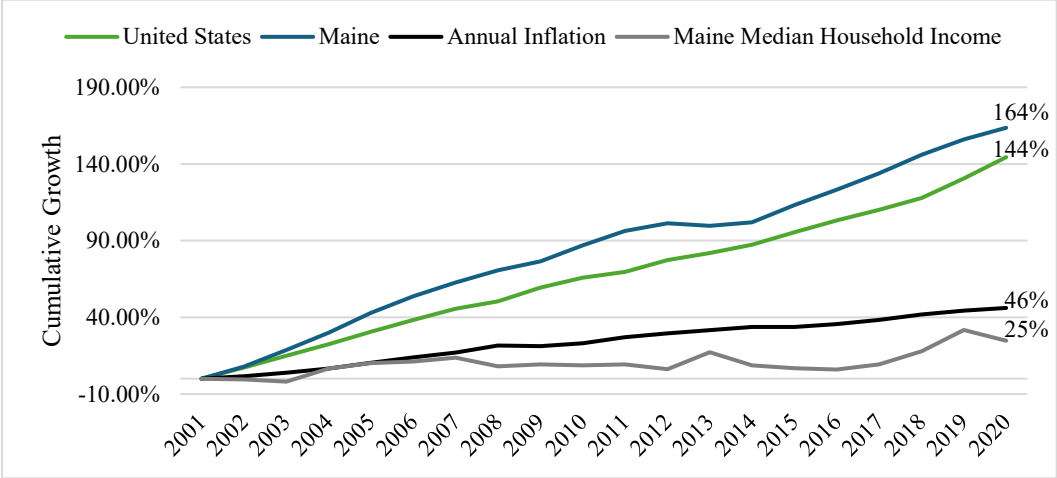


Figure 10. Growth in Maine per capita health expenditures by top four spending service categories, 2001-2020.[8]



[9] Federal Reserve Bank of St. Louis. (2024). *Real Median Household Income in Maine.*

Figure 11. Cumulative growth in per capita hospital expenditures in Maine and the U.S., national inflation, and Maine median household income, 2001-2020.[8,8]



Maine Hospital Payments and Utilization

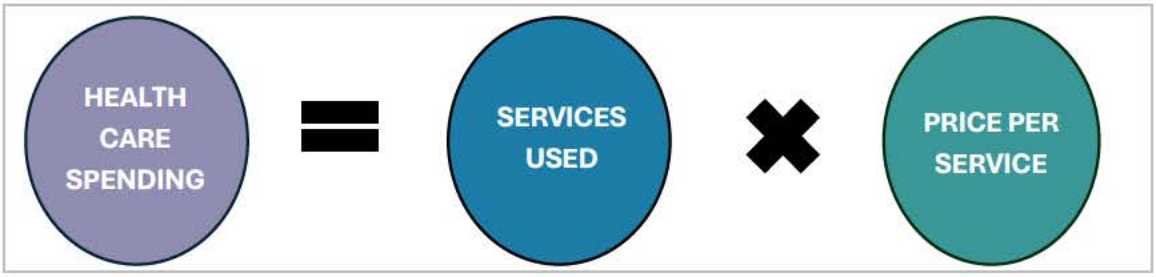
Given that hospital spending is the largest portion of health care spending in Maine, OAHC worked with MHDO to create a set of dashboards to analyze hospital services in greater depth.[3] In these dashboards, payments represent payments made by insurance companies and the expected out of pocket payments made by insured members (inclusive of copays, deductibles, and coinsurance). It is important to note that these data only capture fee-for-service payments made to hospitals, and do not include payments made through alternative payment models, or MaineCare's supplemental payments. Additionally, the data does not include any MaineCare payments to Critical Access Hospitals, due to a historic submission issue which has since been corrected. For these reasons, MaineCare payments are likely underrepresented in this data. Full dashboards and a detailed description of the methodology for this analysis can be found at the OAHC website.[10] Although the dashboards include other payer segments, the summaries below focus on those that cover the most lives in Maine - Commercial, MaineCare, and Medicare.

Spending, Utilization, and Price

At the most basic level, health care spending is the product of how many services are used and the price of those services (Figure 12). Therefore, growing health care spending can be the result of either increasing consumption of services, increasing prices, or a combination of the two. Applying this schematic to Maine, we first analyzed recent trends in spending for hospital services to understand the landscape of health care spending in the State. Then, to understand drivers of this spending, we analyzed trends in utilization and unit price across these services.

Figure 12. Health care spending schematic.

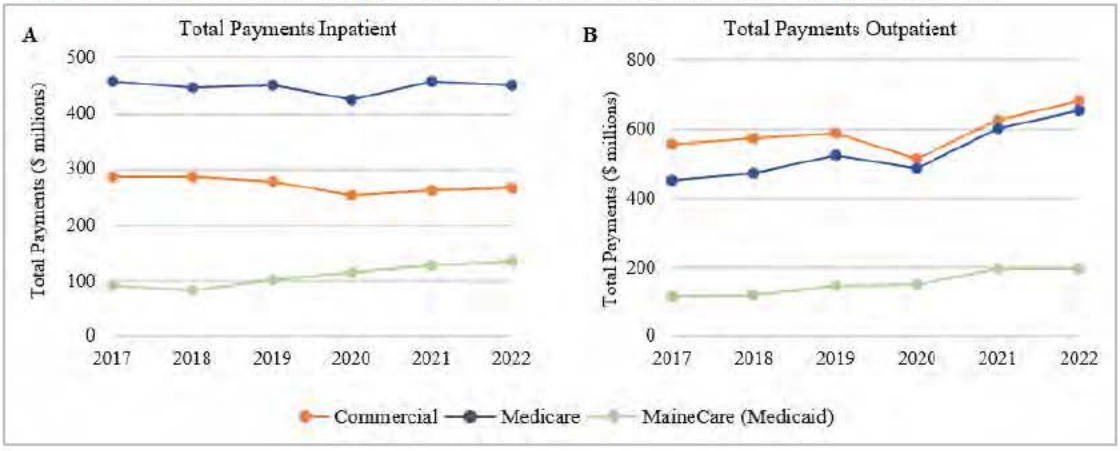
[10] https://www.maine.gov/oahc/sites/maine.gov.oahc/files/2024-09/Hospital%20Services%20Payment-Utilization%20Methodology_Notes_20240919_final.pdf



Total Health Care Spending for Hospital Services

First, to understand how much is spent on hospital services in Maine, we analyzed total health care payments by insurance type (Figure 13). From 2017-2022, spending on inpatient services has remained steady with slight decreases for Commercial and Medicare payors. Medicare spends the most on hospital inpatient services, far above that of commercial and MaineCare payors (Figure 13A). Spending on outpatient services has increased for all payors since 2017, particularly in recent years for Medicare and Commercial payors. Commercial payors spend the most for outpatient services, followed closely by Medicare payors (Figure 13B).

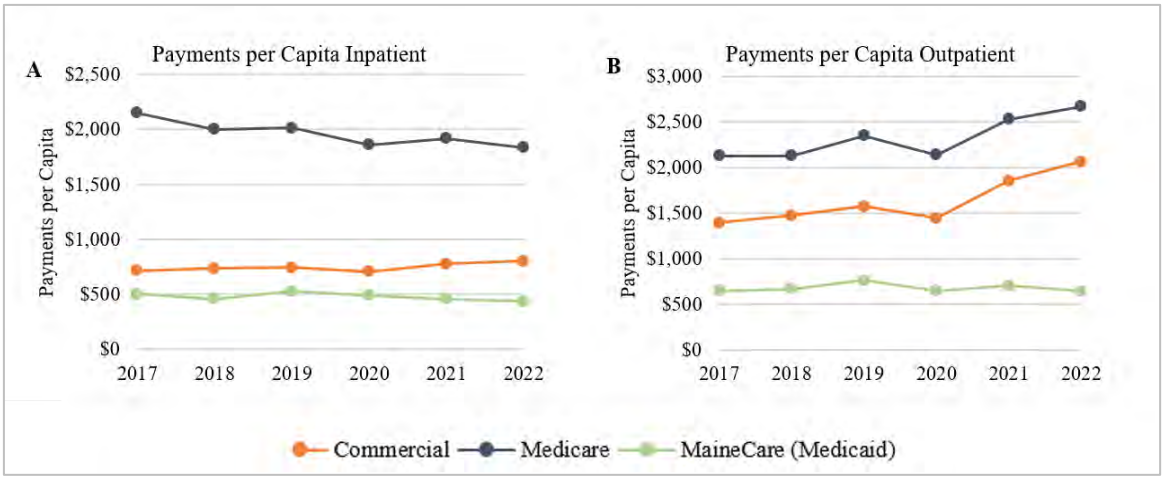
Figure 13. Total payments for hospital inpatient (A) and outpatient (B) services by payor, 2017-2022.[3]



It is important to note that total payment data are impacted by the number of people enrolled in each coverage type. Significant shifts in enrollment between coverage types will impact total spending metrics. To compare spending directly between coverage types of varying size, the dashboards make use of metrics that control for the size of the underlying population covered in each payor type (e.g. payments per capita, utilization per 1,000 insureds, payments per unit).

Figure 14 shows payments per capita which represent the average spending per one member for that coverage type. Overall, Medicare pays more per member for hospital services than other payors. Since 2017, payments per capita for inpatient services have steadily decreased for Medicare but increased slightly for Commercial payors (Figure 14A), while outpatient per capita payments have increased for both Medicare (25%) and commercial payors (49%) (Figure 14B).

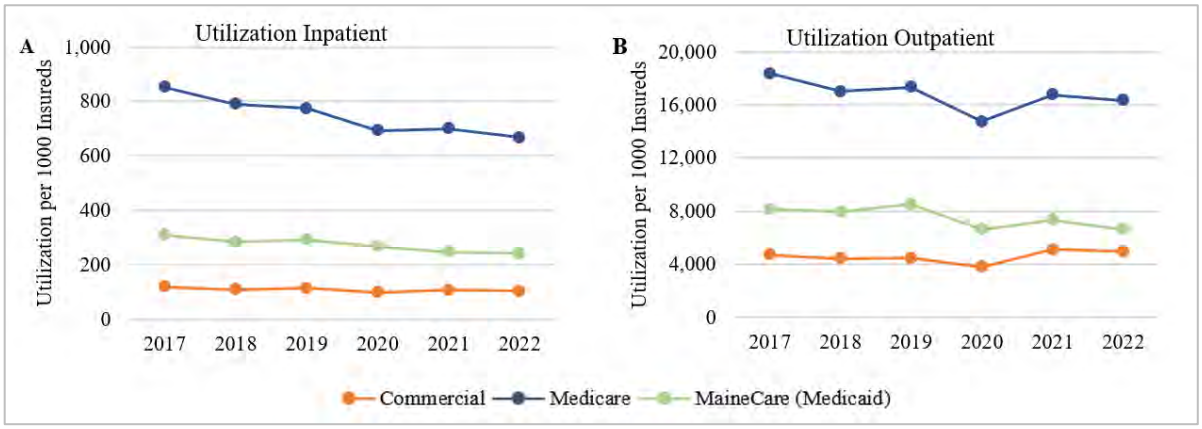
Figure 14. Payments per capita for hospital inpatient (A) and outpatient (B) services by payor, 2017-2022. [3]



Utilization

To understand if increasing use of hospital services are driving these trends in hospital services spending, we analyzed utilization per 1,000 members by payor type (Figure 15). For both inpatient and outpatient care, Medicare members utilize significantly more services than enrollees of other coverage types, though utilization has declined in both categories since 2017. Utilization is lowest among enrollees in commercial insurance, but increased slightly (5%) for outpatient services, while remaining fairly level for inpatient care.

Figure 15. Utilization per 1000 members for hospital inpatient (A) and outpatient (B) services by payor, 2017-2022. [3]



Payments per Unit

To understand if increasing prices for services are driving these trends in hospital services spending, we analyzed payments per unit. Figure 16 shows payments per unit for hospital services, where units refer to one hospitalization stay for inpatient services or one procedure/service for outpatient services. Commercial payors pay more per unit for both hospital inpatient and outpatient services than Medicare and MaineCare (Figure 16). Across all payors,

payments per unit have increased, with the greatest increases among Commercial payors, and outpatient per unit payments increasing more than that of inpatient services (Table 3).

Figure 16. Payment per unit for hospital inpatient (A) and outpatient (B) services by payor, 2017-2022.[3]

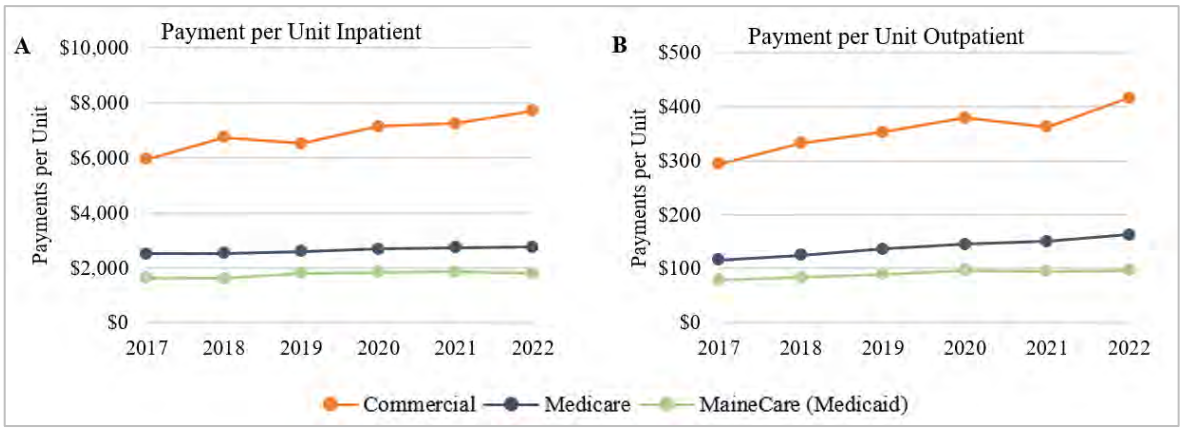


Table 3. Cumulative change in payments per unit for hospital services by payor type, 2017-2022.[3]

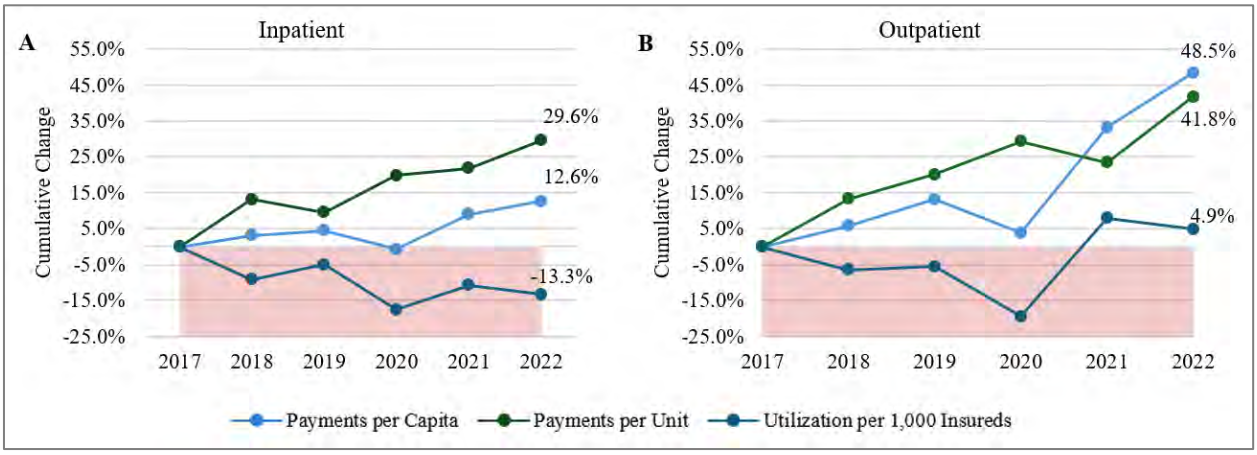
	Commercial	Medicare	MaineCare
Outpatient services	42%	41%	23%
Inpatient services	30%	9%	10%

Commercial Payor Trend Analysis

To understand drivers of health care spending in the Commercially insured population, we analyzed payment and utilization data in the MHDO APCD. Total payments and payments per capita showed that Commercial payors are spending more for hospital services and that spending has increased in recent years. To understand what drives spending, we can consider its two components - utilization and price.

Bringing these components together, Figure 17 shows cumulative change in payments per capita, utilization per 1,000 members, and payments per unit for hospital services among Commercial payors. From 2017-2022 per capita spending increased by 13% for inpatient services and 49% for outpatient services. At the same time, payments per unit increased 30% in inpatient and 42% in outpatient hospital services. Utilization decreased by 13% in inpatient and increased by only 5% in outpatient services. These data suggest that increases in payments per unit, and not utilization, have driven increases in per capita spending in hospital services.

Figure 17. Cumulative growth in health care payments, utilization, and price per unit in hospital inpatient (A) and outpatient (B) services among Commercial payors, 2017-2022. [3]



Note: Red shaded area denotes negative change since 2017.

Stakeholder Engagement

Community Conversations

In late October, the Office had the opportunity to collaborate with national non-profit United States of Care to host three community conversations with consumers in Maine, to better understand their experiences with the health care system. These conversations supplemented the Public Hearing by providing a relaxed and conversational forum, allowing members of the public to participate who may not feel comfortable preparing or delivering formal remarks. Participants were provided with a meal at the sessions and received a gift card to thank them for their time. More detailed summaries of all three meetings are available on the United States of Care website.[11]

Consumers

The first two community conversations were held in Machias and Auburn, and included people from different identities, incomes, and political affiliations. The 90-minute conversations covered a variety of health system topics which generally revealed significant dissatisfaction and frustration with the current health care system where people expressed a sense of hopelessness and anger regarding the challenges they face in accessing affordable and quality care. High costs, including insurance premiums, deductibles, and prescription drug prices, were major concerns with participants sharing they often disregard health care bills altogether and accept medical debt as the cost of using care. Participants also expressed significant concerns about the lack of access

[11] Portland: https://unitedstatesofcare.org/wp-content/uploads/2024/12/Portland-Businesses-Collateral_USofCare.pdf; Auburn: https://unitedstatesofcare.org/wp-content/uploads/2024/12/Auburn_Lewiston_USofCare.pdf
; Machias: https://unitedstatesofcare.org/wp-content/uploads/2024/12/Washington-County-Machias_USofCare.pdf.

to mental health services, particularly in rural areas, and difficulty using primary care because of long wait times for appointments.

Employers

The final conversation was held in Falmouth, and focused on employers, including a mix of business owners and financial and HR management professionals. The businesses and organizations represented ranged in size from just a handful of employees to more than a thousand. Participants all agreed that increasing cost of providing health insurance for employees was a major challenge, with some participants noting that health care costs were a barrier to growing their business or increasing wages for employees. Many participants discussed their efforts to implement programs to encourage the use of high quality and lower cost sites of care, and the challenge of overcoming employees' preference to follow a provider's referral. Several speakers also noted Maine's consolidated health care landscape as a contributing factor to rising costs. The need for greater access to behavioral health care was also discussed, including preventative mental health care, to support adults in joining and remaining in the workforce.

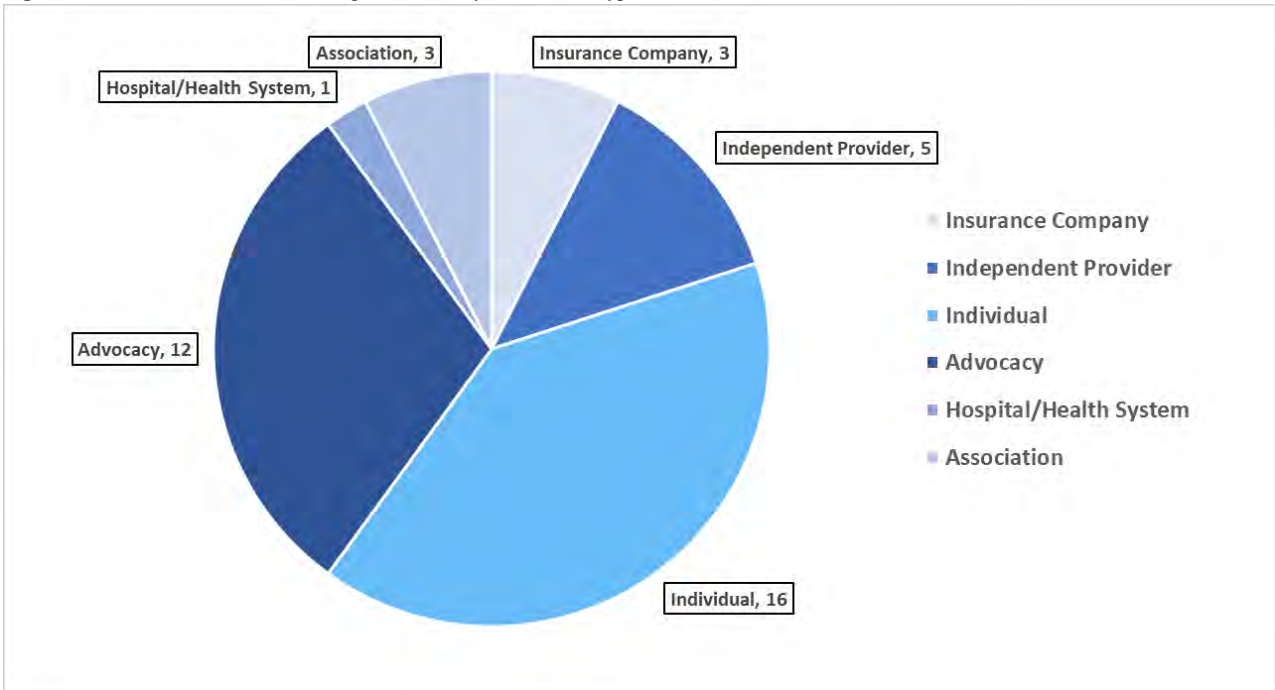
2024 Public Hearing Summary

On September 24th, 2024, the Office of Affordable Health Care held its second annual public hearing. The hearing began with presentations of the Office's work on data analysis including an introduction to the Office's new Hospital Payment and Utilization Dashboards. These presentations provided insight into how the Office develops priorities and makes policy recommendations. The floor was then opened to public comment where 11 individuals and organizations testified in person or virtually. Members of the public were also invited to submit comments in writing through October 4th, 2024. In total the Office received 40 comments from individuals and organizations. Comments received were organized into general categories in order to synthesize the responses and identify common themes.

While the comments received explored different barriers and solutions to accessing affordable healthcare, there were common themes related to challenges specific to Maine. These unique challenges included rurality, a highly consolidated provider and hospital landscape, and the high cost of living in the state.

Themes from other comments are summarized below by the categories of commenters. Themes have been identified here when the point was raised by two or more comments in a given category, or when a category included a small number of responses.

Figure 18. Distribution of Public Hearing Comments by Commenter Type



Individuals

This category captures comments from individuals providing reflections and requests based on their personal experiences with the health care system. Given the diversity of the group, there was a great deal of variation in the comments, but there were some commonalities. Multiple individuals highlighted high premiums, deductibles, and out of pocket costs. Some chose to skip, delay, or forgo care due to these high costs. Several consumers also shared that they have received unexpected medical bills for preventative services that had either been covered in the past or that they believed should have been covered based on their insurance plan.

The complexity of using coverage was a similar theme. Lack of price transparency and consistency were discussed by multiple consumers. One commenter described the inability to get an accurate cost estimate before scheduling services, making it difficult to plan financially. Two consumers described losing MaineCare coverage during the "unwinding" of Covid-19 related maintenance of effort requirements and struggled to identify alternative affordable plans. Finally, two consumers discussed changes they felt should be made to MaineCare eligibility requirements. Multiple consumers suggested a single payer system as a solution to high health care costs in the state.

Advocacy Organizations

Advocacy comments include those submitted by, or in affiliation with, groups representing certain populations or interest areas, excluding those representing health care professionals or

industries. Like individuals, many organizations noted high premium, deductible, and out of pocket costs for consumers across the state. Provider and hospital consolidation was also described by multiple organizations. Notably, four organizations discussed issues with access and transparency of hospital free care programs and gaps in eligibility for coverage programs based on immigration status. Multiple organizations highlighted the high costs of prescription drugs and issues related to medical debt, as well.

Along with sharing feedback about barriers to health care, many comments in this category also included policy recommendations for the office to consider. Recommendations reflected in two or more comments include:

- Eliminating immigration status related eligibility criteria for MaineCare
- Bolstering access to and transparency of hospital free care programs
- Introducing a public option plan
- Limiting facility fees

Independent/Individual Providers

This category represents comments submitted by individual health care providers in a personal capacity, or on behalf of an independent practice. One resounding theme among these comments was concern that patients are delaying or forgoing preventative care due to high costs. Many noted that delaying care strains our health care system and can lead to greater costs for consumers. Two providers discussed issues related to rurality and transportation in the state, one of whom mentioned the high volume of patients who are forced to chose between the costs of maintaining vehicles and paying for medical care.

While comments emphasized the need to address high premiums, deductibles, and out of pocket costs, commenters generally did not propose specific policies to do so.

Professional and Industry Associations

The category of associations was used for organizations that represent the interests of professionals or industries that are involved in the delivery of health care, excluding hospitals and insurers which were categorized separately. There was a consistent acknowledgement that premiums and out-of-pocket costs are a major barrier for patients in accessing care. There were some shared recommendations among commenters, including encouraging adoption of value-based payment reform and support for greater investment in primary care.

Hospitals and Health Systems

At the 2023 public hearing, comments from health systems and the association representing hospitals in Maine were among the most consistent in their themes. This year, while only one hospital system provided comment, themes were similar to past comments from other hospitals or hospital systems.

Comment this year noted the challenges hospitals have experienced providing care during the pandemic and resulting impacts on infrastructure and workforce. The comment also mentioned the broken continuum of care in Maine that leaves hospitals overwhelmed. Recommended policy changes this year included further MaineCare rate reform.

Insurers

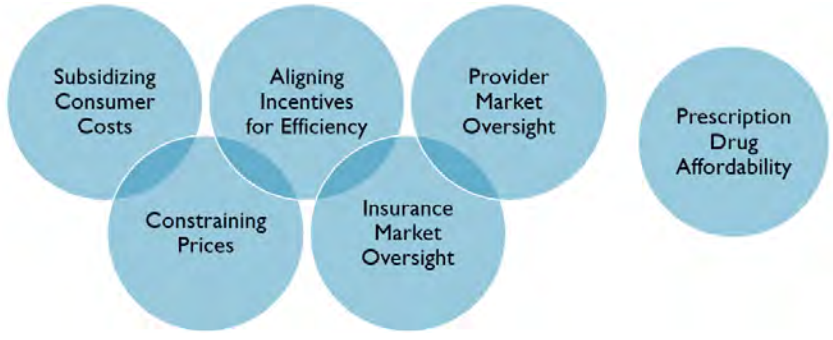
Insurers emphasized challenges with highly concentrated provider networks and hospital systems. They also mentioned the importance of recognizing the need for prior authorization and utilization management. Insurers also discussed the need to adhere to mandate studies prior to final consideration of any mandates passed by the legislature.

There were also several recommendations represented in multiple comments. Insurers recommended that the legislature reconsider utilization management limitations and avoid imposing further restrictions. They also urged that new coverage mandates undergo study and that their cost impacts be considered. One carrier mentioned the need to prohibit anti-competitive contract terms, such anti-steering, anti-tiering, and all-or-nothing clauses. One group also mentioned MaineCare rate reform and the need to reflect higher rates of MaineCare reimbursement in commercial price negotiations.

Policy Planning

In addition to producing quantitative and qualitative research projects, the office has also worked with the Advisory Council to identify areas of focus for policy development during 2025. This work began by reviewing the landscape of action in other states via a presentation from the National Academy for State Health Policy during the April meeting of the Council. The group subsequently heard presentations from some of the states reviewed to better understand how they had identified and developed their policy approaches. Based on learnings from other states and the priorities raised in public hearings and other stakeholder engagement, the office presented to the group a set of "policy domains" to organize the wide range of issues in health care affordability.

Figure 19. Policy Domains as Presented to the Advisory Council on Affordable Health Care



The office and Advisory Council then reviewed these domains through a framework assessing the following considerations:

1. Alignment – How well does the domain align with the office's statute and guiding principles?
2. Feasibility – How realistic is the policy within operational/ legal/ contextual realities?
3. Opportunity – Is the work already within the purview of another state entity, or is the office uniquely positioned to address it?

Following robust discussion, the group identified three policy areas for the office to focus on in 2025, and in the final meeting of the year problem statements were developed along with planned next steps to advance progress in each area:

1. **Provider Market Oversight and Competition**

   Problem statement: 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.

   Next Steps:

   - Review and assess options for mitigating risk from PE acquisition, including recent efforts in other states

2. **Regulating Commercial Prices for Health Services**

   Problem statement: 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 report rising input costs, including the need for higher salaries for recruitment and retention of staff.

   Next Steps:

   - Assess the magnitude of impact of unit prices on premium increase requests for state-regulated health plans
   - Expand analyses of price and utilization to more specifically identify geographic and/or service level trends, and to include non-hospital services
   - Analyze hospitals' audited financial reports to understand changes in input costs to health care providers

3. **Aligning Incentives to Promote Efficiency and Quality**

   Problem Statement: 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.

   Next Steps:

   - Assess processes in other states for collecting and reporting on adoption of Alternative Payment Models, to fulfill statutory duty
   - Study existing quality and access metrics in use around the state and develop draft key measures for regular reporting by the office
   - Discuss with stakeholders a model for regularly convening government, payers, providers, and other stakeholders for collaborative goal-setting and to address barriers to delivery system reform.

The Office of Affordable Health Care looks forward to collaborating with policymakers to make progress toward solutions in these three domains in the year ahead and stands ready to assist with other policy opportunities to advance quality, efficient, and affordable health care in our state.