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Maine Office of Affordable Health Care

2025 Annual Report

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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 2025. Meetings are open to the public and recordings of all Advisory Council meetings are available on the office’s website.²

Table 1. 2025 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 |
| Maureen Hensley-Quinn | 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 |
| Vacant | Health economics and research |
| Randy Clark | 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 |
| Vacant | 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 [Previous Meetings | Office of Affordable Health Care](#)

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 utilized desk space in the Department of Health and Human Services central office at 109 Capitol Street for most of 2025, but thanks to an appropriation in the FY 2026 budget, the office has secured a permanent office space at 45 Memorial Circle Drive. The office is grateful to DAFS and DHHS for allowing OAHc to use space in other Department buildings in its early years, allowing more of its limited budget to be devoted to research and policy work.

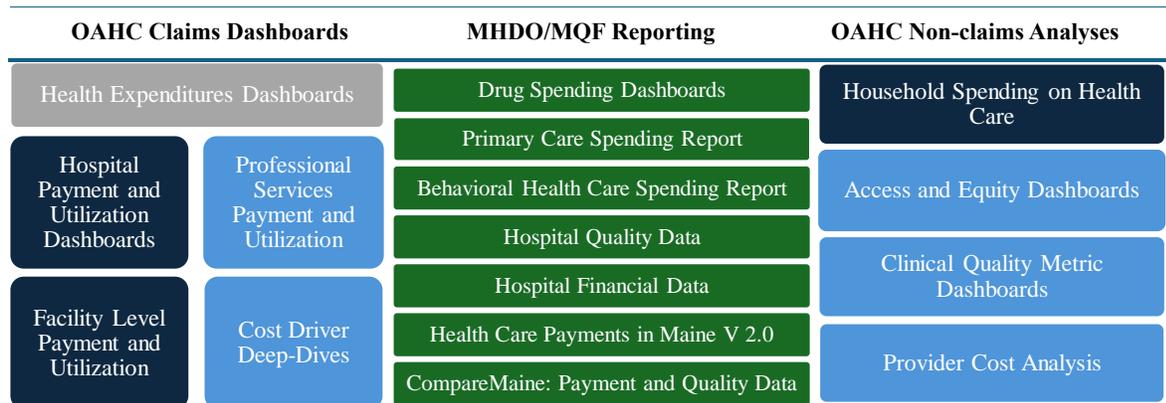
Research and Analysis

Analytics Planning

In 2024, the office established its 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.

In 2025, the office continued to analyze these topics and delivered on two large work streams including updating the *Aggregated Hospital Services Payments and Utilization Dashboards* and creating the *Facility Level Payments and Utilization Dashboards*. The office also established an MOU with MHDO to complete the *Professional Services Payment and Utilization Dashboards* to investigate spending in non-hospital health care settings. In addition to dashboard work, the office also began developing work investigating cost drivers, health care access, and hospital financial performance. Finally, in 2025 OAHc partnered with Wakely Consulting Group to complete an actuarial analysis of premium trends in the Maine health insurance marketplace.

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



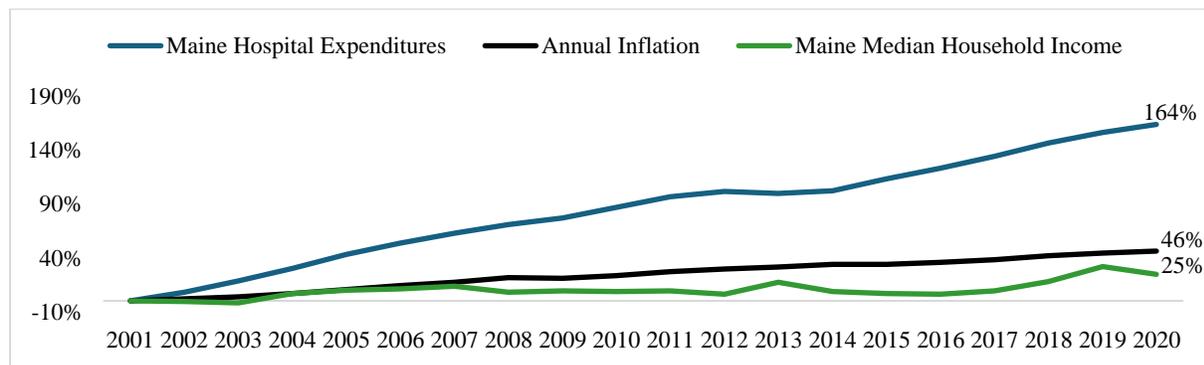
Note: Dark blue boxes represent completed analytical products created by or on behalf of the Office of Affordable Health Care. Lighter blue boxes represent ongoing or planned future work products. Green boxes represent Maine Health Data Organization/Maine Quality Forum reports.

Hospital Payment and Utilization Analysis

Hospital Services

The office chose to begin its analytical work on health care payments and utilization by focusing on hospital spending for two main reasons. First, hospital spending accounts for the largest portion of health care expenditures nationally and in Maine³, and second, spending on hospital services has increased significantly over time, outpacing the Maine median income and national inflation (Figure 2).^{3,4} The office acknowledges that health care spending occurs outside of the hospital setting. However, given the magnitude and increases in hospital spending over time, the office felt that analysis of hospital payments and utilization was the best point at which to begin work investigating historic trends and costs drivers of health care spending.

Figure 2. Cumulative growth in per capita hospital expenditures in Maine, national annual inflation, and Maine median household income, 2001-2020.^{3,4}



³ 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*.

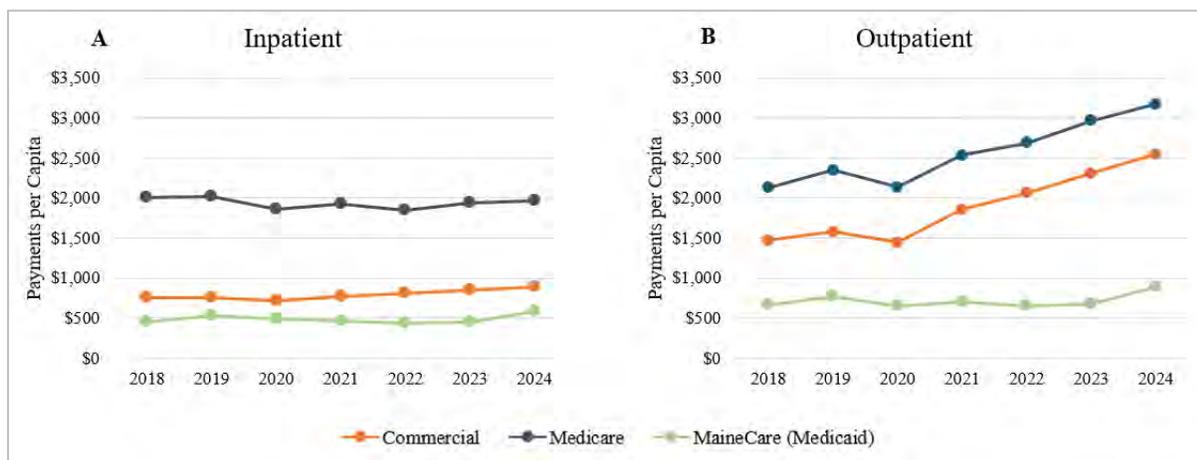
⁴ Federal Reserve Bank of Minneapolis. (2024). *Consumer Price Index 1913-..*. and Federal Reserve Bank of St. Louis. (2024). *Real Median Household Income in Maine*.

Aggregated Hospital Services Payments and Utilization Dashboards

In 2024 the office released the *Aggregated Hospital Services Payments and Utilization Dashboards*, created in collaboration with the Maine Health Data Organization leveraging data from the Maine All Payor Claims Database (APCD). In 2025 the dashboards were updated to include recently released data from 2023 and 2024. The data in these dashboards represent payments made by insurance companies and the expected out-of-pocket payments made by insured members (inclusive of copays, deductibles, and coinsurance) for services provided at Maine hospitals.⁵ The full dashboards and a detailed description of the methodology for this analysis can be found on the OAHC website.⁶

The *Aggregated Hospital Services Payments and Utilization Dashboards* provided the office with insight into trends in spending on hospital services in Maine. To control for the membership size within each payor mix, we analyzed trends in per capita spending for hospital services. Overall, Medicare pays more per member for hospital services than other payors. This finding is expected given the relative age and health profile associated with Medicare beneficiaries. Since 2018, payments per capita for inpatient services have moderately decreased for Medicare and increased slightly for commercial payors (Figure 3A). During the same period, outpatient per capita payments have increased substantially for both Medicare (49%) and commercial payors (73%) (Figure 3B).

Figure 3. Payments per capita for hospital inpatient (A) and outpatient (B) services by payor, 2018-2024.³



To understand what could be driving this increase in per capita payments, we analyzed the separate components of health care spending. At the most basic level, health care spending is the product of how many services are used and the price of those services. Therefore, growing health

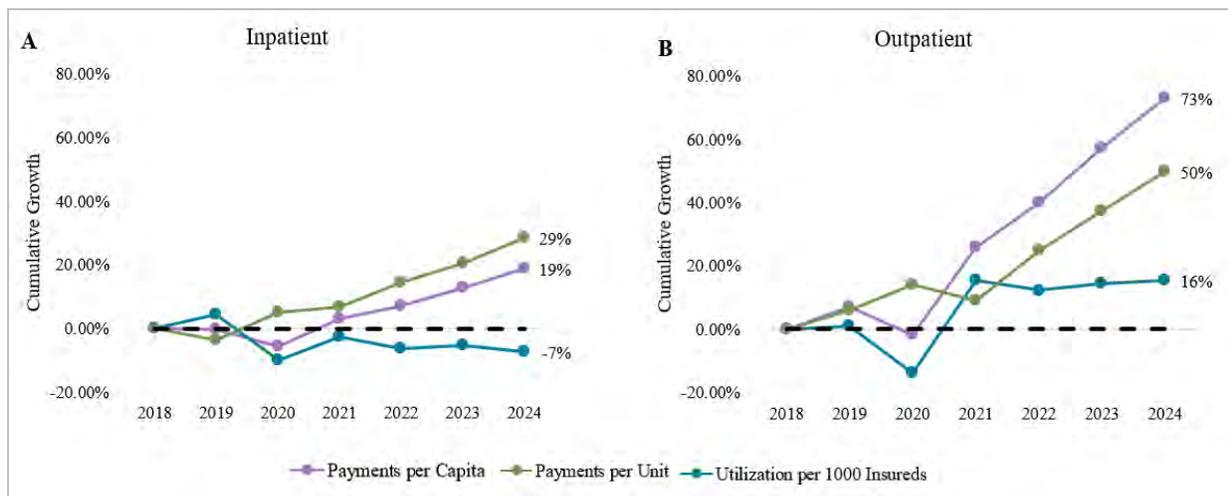
⁵ It is important to note that these data only capture fee-for-service payments made to hospitals, and do not include payments made through alternative payment models, or MaineCare's supplemental payments. Additionally, the data does not include any MaineCare payments to Critical Access Hospitals, due to a historic submission issue which has since been corrected. For these reasons, MaineCare payments are likely underrepresented in this data. These data also do not capture service utilization by uninsured people.

⁶ https://www.maine.gov/oahc/sites/maine.gov.oahc/files/2024-09/Hospital%20Services%20Payment-Utilization%20Methodology_Notes_20240919_final.pdf

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, the office analyzed trends in utilization and payments per unit to understand drivers of health care spending in the commercially insured population. In this analysis, price refers to payments per one unit of service. Units for inpatient and outpatient services are days and procedures/services respectfully.

Figure 4 shows cumulative change in spending per capita (purple), utilization per 1,000 members (blue), and payments per unit (green) for hospital services among commercial payors. From 2018-2024 per capita payments increased by 19% for inpatient services and 73% for outpatient services. During this period utilization decreased by 7% for inpatient and increased modestly by 16% for outpatient services. At the same time, payments per unit increased 29% in inpatient and 50% in outpatient hospital services. These data suggest that increases in payments per unit, and not utilization, have driven spending increases in the commercially insured market.

Figure 4. Cumulative growth in health care payments, utilization, and price per unit in hospital inpatient (A) and outpatient (B) services among Commercial payors, 2018-2024. ³



Facility Level Payments and Utilization Dashboards

Hospital Analysis

Informed by the analysis from the *Aggregate Hospital Payments and Utilization Dashboards*, the office collaborated with MHDO to create the *Facility Level Payments and Utilization Dashboards*. These dashboards showed spending, price, and utilization at different health systems and hospitals in Maine. The aim of these dashboards was to understand how trends in payments and utilization varied across Maine hospitals and health systems. Additionally, the office sought to complete a service level analysis aimed at investigating how prices for comparable services vary across facilities.

Across Maine hospitals inpatient and outpatient utilization among commercial payors has decreased (25% and 21% respectively) (Figure 5). For inpatient services, almost all hospitals

showed declines in commercial utilization from 7% to 89% between 2017 and 2023. For outpatient services, there was more variation (range: 40% to -83%) with most hospitals showing declines and only seven hospitals showing increases in commercial utilization (Figure 5).

Inpatient services showed increases in commercial payments per unit across almost all facilities, with an average increase of 29%. Commercial payments per unit for outpatient services increased across the board except for one hospital with an average increase of 40%. Both inpatient and outpatient commercial payments per unit showed wide variation with some facilities reporting only modest increases and others showing increases over 60% for both categories (Figure 6). In contrast, average inflation increased 24% over this period. These data support the aggregate analysis that increased hospital spending in the commercial market is primarily driven by increased prices, not utilization. However, there is variation by facility.

Figure 5. Utilization for services at Maine hospitals, 2017-2023

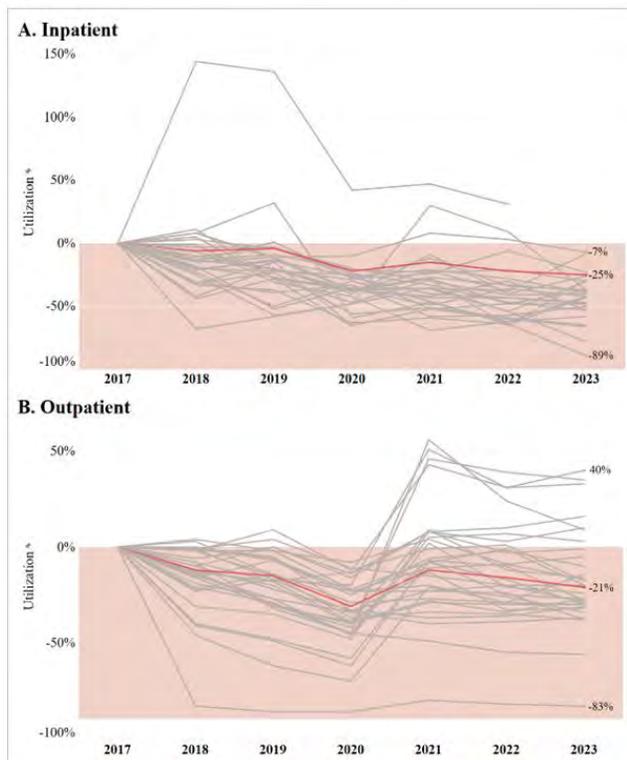
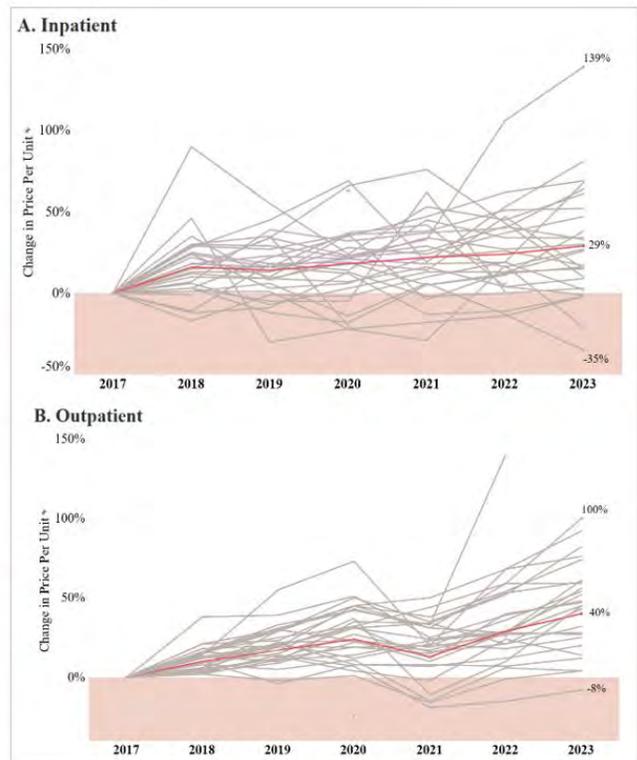
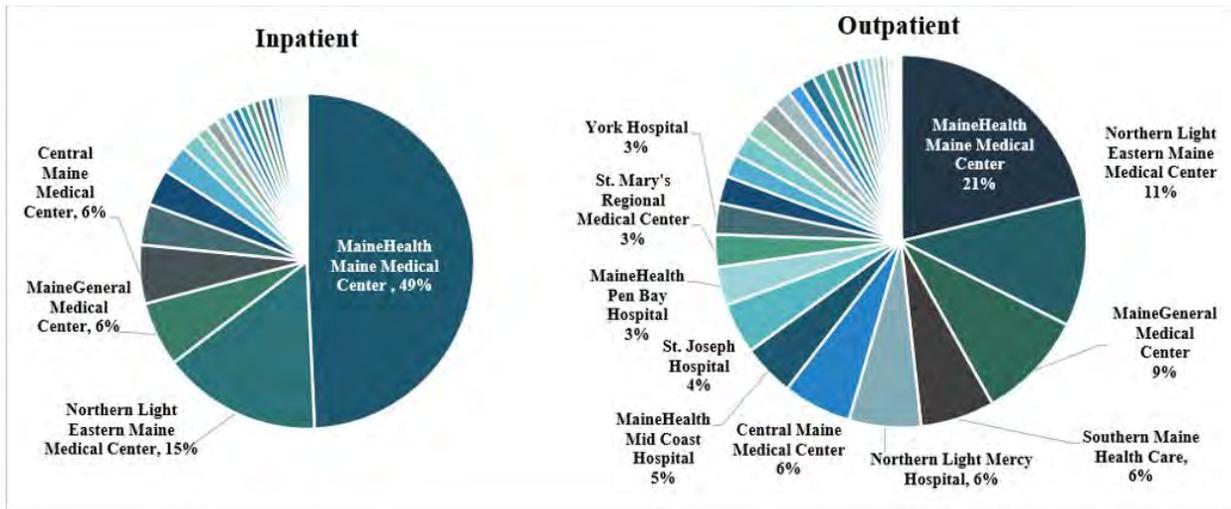


Figure 6. Payments per unit for services at Maine hospitals, 2017-2023



To better understand how impactful increasing prices are at certain facilities we analyzed how total commercial payments are distributed among Maine’s hospitals (Figure 7). In 2023, 75% of all commercial payments for inpatient services came from only four hospitals and nearly 50% came from one hospital. For outpatient services 75% of all payments came from 11 hospitals (Figure 7). Such concentration of payments among a few hospitals results in a system where changes in price and utilization at one facility can produce an outsized impact on total spending.

Figure 7. Percent of total payments for hospital services across Maine hospitals, 2023.



Service Level Analysis

Analyzing payments and utilization at the hospital level does not consider the influence of complexity of services. In Maine, most patients with highly complex health care needs are likely treated at the State’s Peer Group A hospitals. These hospitals are equipped to provide higher level services for broad populations, which may result in higher payments per unit of service. In 2025, the office sought to assess payments and utilization at a service level. This approach aimed to better quantify price variation among health care services and cost drivers in a way which can adjust for variation in the complexity of services provided at different facilities.

To better control for differences in complexity of services across hospitals, we analyzed payments per unit at the service level. To do this, the office investigated the difference in payments per unit by Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and Diagnosis-related Group (DRGs). Detailed methodology and accompanying dashboards with payments and utilization at the service level are available on the OAHC website.⁶

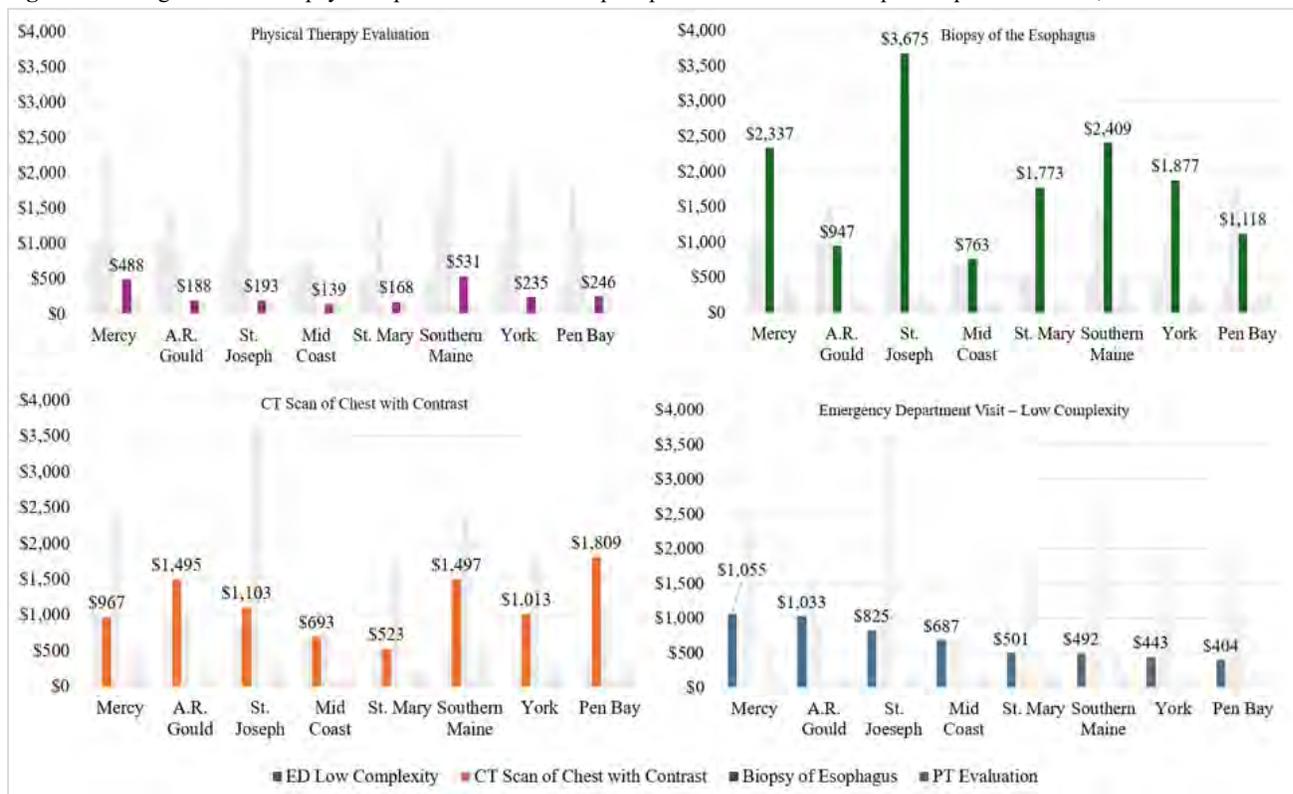
As a preliminary analysis on price variation, the office leveraged data in these dashboards to analyze price variation at comparable hospitals using the Maine Hospital Association’s Peer Group categories.⁷ Selection of the specific services for this preliminary analysis was based on high utilization of CPT codes across all eight Peer Group B hospitals.

The office analyzed average payment per unit among a select group of services at the CPT level among Peer Group B hospitals (Figure 8). In this preliminary analysis the office found that there is wide variation in average payments per unit across hospitals for the same services. For each CPT code analyzed, payments per unit for services among the highest paid hospital are more

⁷ Peer Groups (A – F) are based on the size, services provided, and revenue for each facility.

than double the average payment at the lowest paid hospital. Additionally, there is not one hospital that has consistently higher payments or lower payments among this group (Figure 8).

Figure 8. Average commercial payment per unit for select hospital procedures at Peer Group B hospitals in Maine, 2023.



Findings from this preliminary analysis suggest that price variation for equivalent services is evident in Maine. Further, research suggests that the price paid for health care services is not associated with the quality of those services or health outcomes.⁸ These findings have important implications for consumers who, depending on where they live in the state, could face much higher prices for the same services of similar quality. This preliminary analysis is an initial step in a larger more in-depth analysis that OAHC intends to produce on price variation and cost drivers of health care spending in Maine.

Health Care Access

The establishing statute for the OAHC directs the office to investigate policy solutions for improving health care affordability with special attention to consumer experience. Central to consumer experience is the ability to access desired health care services in a timely manner. In addition to this directive, concerns over health care access have been apparent with increasing attention on services line closures throughout the state. Advisory Council members have also cited access issues such as un- and underinsurance, workforce shortages, and service closures as

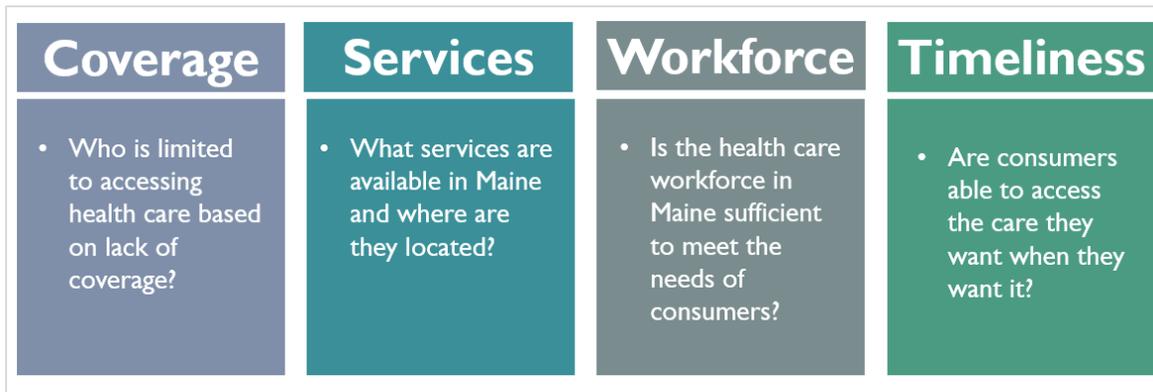
⁸ Hussey, P. S., Wertheimer, S., & Mehrotra, A. (2013). The association between health care quality and cost: a systematic review. *Annals of internal medicine*, 158(1), 27-34.

contributing factors to increasing costs of providing care. Informed by perspectives from consumers and Advisory Council members, the office aims to investigate health care access in tandem with their work on affordability.

The purpose of the office’s work analyzing health care access in Maine is to 1) establish a baseline set of measures of health care access; 2) identify barriers to obtaining services and achieving desired health outcomes; 3) track progress over time. This framework aids the office in describing the current landscape and addressing the challenges that Mainers experience in accessing care. Further, this work can be leveraged to ensure that health policy action on affordability does not negatively affect access to care.

In 2025, the office established its approach to measuring access in Maine through data source investigation, stakeholder input, and identifying ongoing workstreams. As a first step, the office worked to identify available datasets to measure health care access in Maine. Informed by work from the United States Agency for Healthcare Research and Quality (AHRQ), the office identified the four domains relevant to monitoring health care access: Coverage; Services; Workforce; Timeliness (Figure 9). Each of these domains have direct implications on Mainers’ ability to access the health care they need to achieve the best possible health outcomes.

Figure 9. Health care access domains established by the United States Agency for Healthcare Research and Quality.



To assess the adequacy of data sources within these domains, the office evaluated each data source using the following criteria: feasibility, historical availability and replicability, timeliness, and level of detail. Data sources that met these criteria were noted as sources with good potential for use in establishing benchmarks and ongoing monitoring of health care access in Maine. Finally, the office identified previous work completed at the national and state level using identified data sources.

In May of 2025, the office presented this work to the Advisory Council and solicited feedback on data sources and analyses of interest. Following the discussion the office created an outline of future analyses and work products for this work. As a next step, the office aims to gain access to data sources and identify ongoing work streams to limit duplication of work already accessible to

the public. Of note, the Maine Health Data Organization has signaled their intent to collect and report on Emergency Department (ED) Boarding, a key interest of advisory council members. Preliminary data from a report produced by the Maine Hospital Association and the Roux Institute show ED boarding is an issue at Maine hospitals especially for MaineCare and Medicare members.⁹ However, there are limited data currently available to describe or monitor ED Boarding. Due to this gap, MHDO gained support from its board to explore ways to standardize measurement and data collection related to ED boarding. The office has expressed support for MHDO's efforts to collect these data and look forward to exploring the issue in the future.

Financial Performance Analysis

As part of the office's work on health care access, OAHC has also begun analyzing financial performance data for Maine hospitals and health systems. Financial metrics at health care facilities are important indicators for consumer access as poor performance can lead to service and even entire facility closures. In recent years Maine has seen several service and facility closures that have raised concerns about limited health care access, especially in rural areas.

As a first step in analyzing financial performance, OAHC leveraged the data collection and reporting efforts of MHDO's Standardized Annual Hospital Financial Reports.¹⁰ These reports standardize the collection of financial and organizational information available in audited financial statements at Maine hospitals and health systems. Additionally, OAHC team members met with national leaders and local partners to learn best practices in analyzing financial performance metrics in the health care sector. This work included identifying additional data sources for financial information, establishing benchmarks for adequate performance, and understanding inputs for metric calculations.

As part of this work OAHC identified several important considerations when conducting financial analyses. First, hospital and health system financial metrics are volatile year to year. Changes in demand for services, economic swings, and one-time payments (e.g. COVID-19 supplemental payments), can induce significant directional changes in financial metrics year to year. To mitigate this volatility, analysts should consider using multiple years of analysis and measures of central tendency. Additionally, analysts should consider political, economic, and other circumstances that could provide an outside influence on financial performance.

Second, hospital and health system finances are complex. One metric does not describe the entire financial wellbeing of an organization. Additionally, health systems play an important role in understanding a hospital's financial stability. For example, health systems have the capacity to move cash from one entity within the system to another, make large investments, and take on

⁹ Maine Hospital Association, A Clogged System of Care, 2025, https://www.themha.org/uploads/1/5/3/5/153575294/a_clogged_system_of_care.pdf

¹⁰ Maine Health Data Organization Standardized Annual Hospital Financial Reporting: https://mhdo.maine.gov/hospital_financials.htm

more debt compared to a standalone hospital. For these reasons, it is important to consider multiple financial metrics at the hospital and system level when conducting analyses.

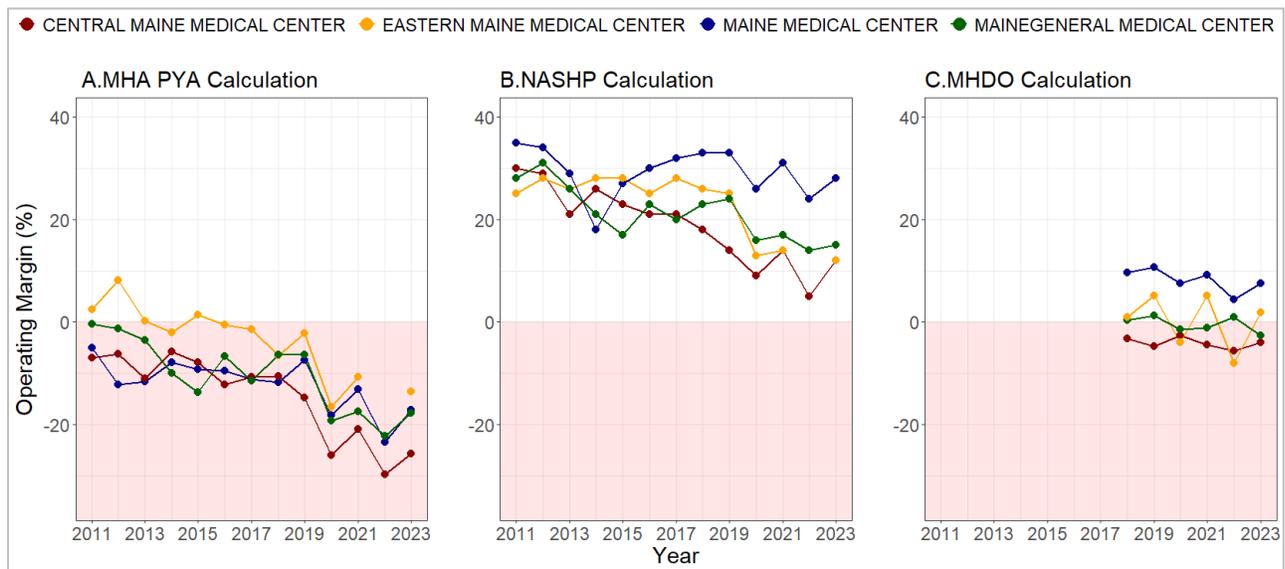
Third, the calculations used for financial metrics are not standard and can result in different results. For example, Table 3 and Figure 10 show different methodologies recently used by the Maine Hospital Association (MHA), the Maine Health Data Organization (MHDO) and the National Academy for State Health Policy (NASHP), to calculate operating margin, a common financial metric. As seen here, the choice of calculation results in significantly different numbers. It is important to note that OAHC asked MHA for their methodology in reporting operating margin. No methodology was provided. OAHC used the median values reported in the MHA PYA report to back calculate what the assumed calculation was for their analysis.

Table 3. Operating Margin calculations and 2023 annual median Maine hospital operating margin.

| Source | Operating Margin Calculation | Median Value for Maine GAC Hospitals 2023 |
|--------------------------|--|---|
| Assumed MHA Calculation* | Assumed: (Net Patient Revenue – Operating Expenses)/ Net Patient Revenue | -12% |
| MHDO Calculation | ((Net Patient Revenue + Other Operating Income) – Operating Expenses)/ Net Patient Revenue + Other Operating Income) | -2% |
| NASHP Calculation | (Net Patient Revenue – Hospital Operating Costs)/ Net Patient Revenue | 11% |

Acronyms: MHA: Maine Hospital Association; MHDO Maine Health Data Organization; NASHP: National Academy for State Health Policy.
 *OAHC asked MHA for their methodology, no information was provided. OAHC then back calculated the operating margin based on MHAs reported median operating margin value. The calculation above is OAHC’s assumption of the calculation used.

Figure 10. Trends in Operating Margins for Maine Peer Group A Hospitals 2011-2023.



OAHC presented this work to the Advisory Council in its July 2025 meeting. During the meeting, OAHC solicited the advice of the Advisory Council to establish an agreed upon data source and a list of financial metrics for monitoring and reporting. In this meeting, the office suggested focusing on MHDO’s reporting and calculations for monitoring and reporting of financial performance. Table 4 shows the list of metrics and related definitions.

Table 4. Financial performance metrics.

| Metric | Category | Definition |
|--|--------------------------|--|
| Total Margin (%) | Profitability | Are the hospital’s total activities profitable? |
| Operating Margin (%) | Profitability | Are the hospital’s core activities profitable? |
| Days Cash on Hand, Incl. Board Designated & Undesignated Investments | Liquidity | How long could the hospital operate and pay its bills without additional income? |
| Days in Accounts Receivable | Liquidity | How long does it take the hospital to collect payments from payers and patients? |
| Debt Service Coverage with Prior Year | Debt Capacity & Solvency | Are the hospital’s earnings high enough to pay its debt service (principal and interest payments)? |
| Cash Flow Divided by Total Debt | Debt Capacity & Solvency | How much of their total debt could they pay off this year? |
| Average Age of Plant (years) | Capital Investment | How old, on average, are the hospital’s fixed assets? |
| Capital Expenditure as portion of Depreciation Expense | Capital Investment | Is the hospital replacing fixed assets as they age and investing in new assets? |

Finally, OAHC aims to conduct future analyses on hospital and health system expenses. The goals of these analyses are to first, understand the trends in input costs facing Maine hospitals and health systems, and second, identify areas for critical services investments and improved efficiencies. As an initial step, OAHC is working with MHDO to enhance their expense reporting to provide more detailed data for analysis.

Medical Trends and Premium Changes in the Marketplace

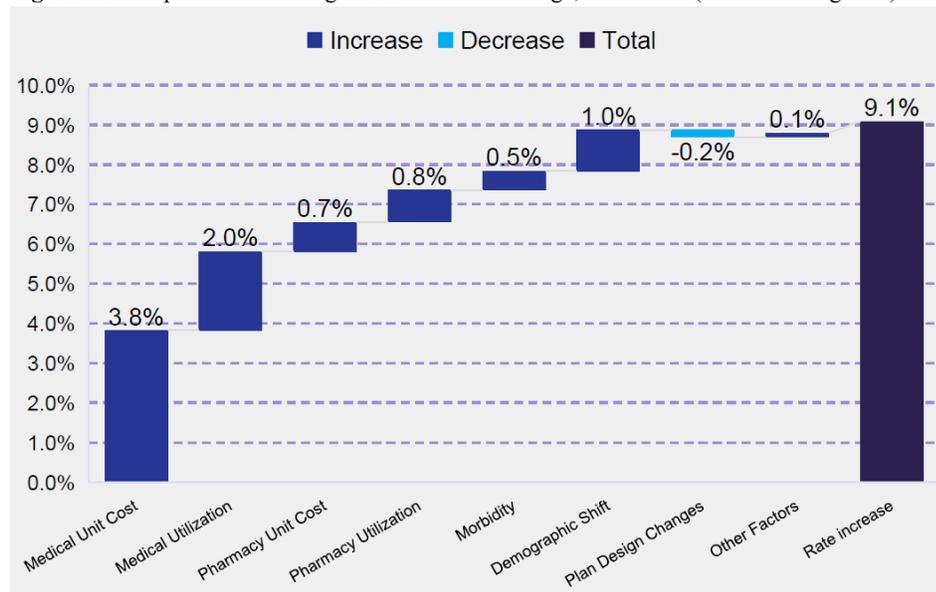
In early 2025 OAHC partnered with Wakley Consulting Group, an HMA company, to assess medical trends and premium changes in Maine’s health insurance marketplace. To complete this work, Wakley used Unified Rate Review Template public use files (URRT PUF) for plan years 2023-2025. URRT PUFs are filed by individual and small group insurers that operate in the state. These files offer information on enrollment, rate changes, loss ratios and categories of claim spending and administrative expenses. The full report and methodology are available at the OAHC website.¹¹

Wakely’s analysis found that the largest component to premium rate increases in these markets was due to medical unit cost, specifically among outpatient facility services. In the individual

¹¹ Wakely Consulting Group. (2025). *Medical Trends and Premium Changes in Maine Marketplace.*: <https://www.maine.gov/oahc/sites/maine.gov/oahc/files/2025-02/Wakely%20Trend%20Analysis%20in%20Maine%20Report%2002.07.2025.pdf>

market, Wakely found that of an average 9.1% premium rate increase, medical unit cost was the largest component at 3.8% while medical services utilization accounted for 2% (Figure 11). While policy changes are often the focus of insurer rate increase justifications, the cost of underlying claims was by far the most significant driver of increasing premium rates for consumers.

Figure 11. Components of Average 2025 Premium Change, All Issuers (Individual Segment)



Notes: Analysis completed by Wakley Consulting Group.¹¹

2025 Public Hearing Summary

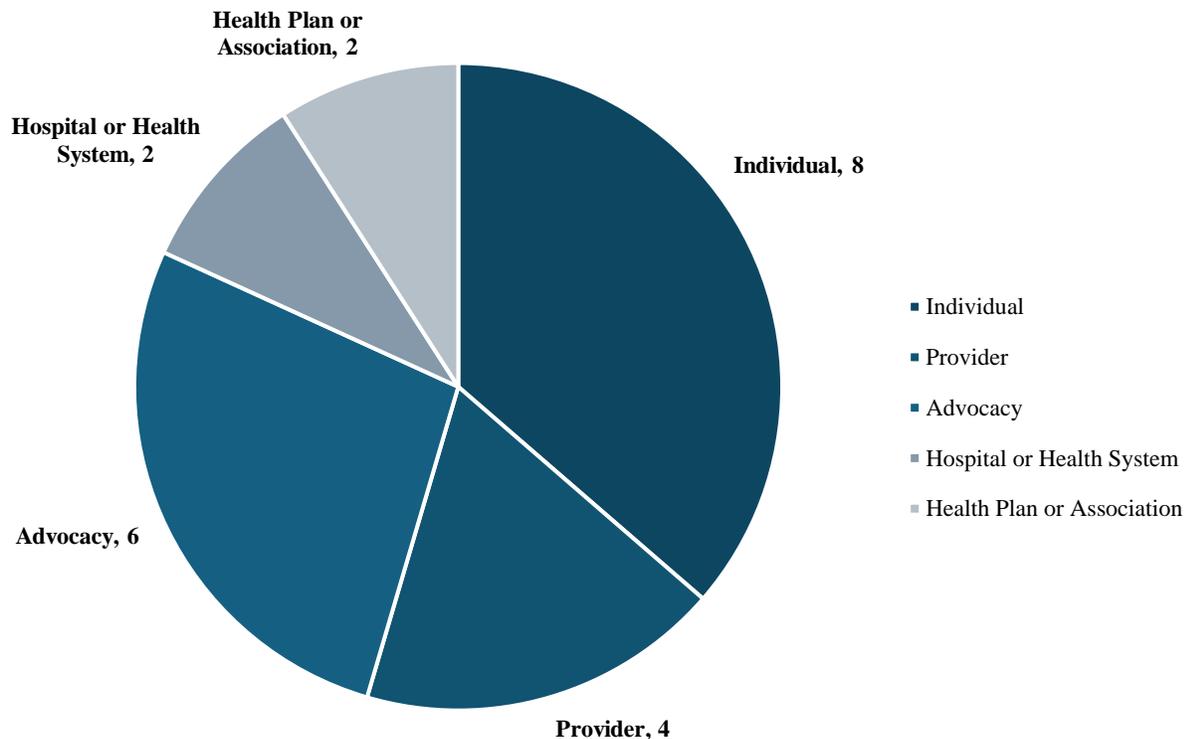
On September 29th, 2025, the Office of Affordable Health Care held its third annual public hearing. The hearing began with presentations of the office’s work on data analysis, including an overview of the facility and service level dashboards described earlier in the report, summaries of efforts to solicit consumer input through listening sessions and polling, as well as an update on the office’s policy development work. 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 10th, 2025. In total the office received 22 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 both common themes related to challenges specific to Maine and common themes related to how federal level changes to health care policy will impact Maine people. The most prevalent comment, present across all commenter categories, was related to concerns about the expiration of Enhanced Premium Tax Credits (EPTCs) and federal level cuts to Medicaid.

Challenges unique to Maine included lack of access to primary and behavioral health care, a highly consolidated provider and hospital landscape, and the overall high cost of care.

Themes from other comments are summarized below in Figure 12 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 12. Distribution of Public Hearing Comments by Commenter Type



Individuals

This category captures comments from individuals providing reflections of 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 choose to skip, delay, or forgo care due to high costs. Several consumers highlighted issues they experienced with hospital payment plans, including lack of availability of longer-term plans. Others noted issues with coverage denials and the ensuing amount of time spent communicating with their health insurer to get more information or to get the denials resolved. One consumer highlighted rising premiums in Medicare supplemental plans. Overall, though, the most prevalent concern amongst consumers who provided testimony was the expiration of EPTCs and cuts to Medicaid, with particular emphasis on impacts to premiums on the Marketplace.

One consumer described the potential impact of rising Marketplace premiums due to the expiration of APTCs, citing that a self-employed member of her family may go without coverage this coming year because premiums have increased from what would have been \$68 a month to over \$200 – an amount their family is unable to afford.

Advocacy Organizations

Comments in the advocacy category include those submitted by, or in affiliation with, groups representing certain populations or interest areas, excluding those representing industries. Like individual consumers, many organizations noted the anticipated impacts of EPTC expiration on Marketplace premiums. Provider and hospital consolidation, leading to higher hospital prices, were also highlighted by multiple organizations. Multiple groups discussed the prevalence of medical debt in Maine and its impact on people’s ability to afford basic necessities like groceries, heat, and gas. One organization raised the issue of proposals to authorize unregulated health products, such as farm bureau plans, and their impact on those seeking coverage and on Maine’s marketplace as a whole.

Administrative burdens, immigrant access to health care, unaffordable prescription drugs, private equity involvement in health care, and the need to focus on hospital efficiency reform were also topics raised in this category.

Many comments in this category also included policy recommendations for the office to consider. Some of the recommendations cited include:

- Implementation of a universal health care system
- Prohibiting anti-competitive terms in contracts between hospitals and insurers
- Strengthening the insurance rate review process
- Providing state-level subsidies for Marketplace consumers

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. Another theme explored by multiple providers was concern about impact of EPTC expiration, including rising premiums in 2026, and federal cuts to Medicaid for Maine people. One provider specifically mentioned risk to those enrolled in MaineCare who may lose coverage, particularly for those treating behavioral health needs and those who receive care in Private Non-Medical Institutions.

Concerns about underinvestment in primary and behavioral health care were also raised, including how underinvestment impacts access to care. Individual providers also mentioned the

prevalence of medical debt, the need to address high hospital prices, issues with coverage denials, profit-driven ownership of health care facilities, and pharmaceutical profits.

Hospitals and Health Systems

Comment this year noted the ongoing financial strain Maine hospitals are experiencing in a precarious and unstable health care delivery system. Both commenters highlighted concerns about cuts to Medicaid on the federal level, expiration of EPTCs, and ensuing impacts in Maine. Hospitals also highlighted the need to consider the complexity of the cost of delivering care. One commenter noted the broken continuum of care, while another mentioned the need to consider the cost of prescription drugs and the State's unique workforce challenges.

Commenters also raised concerns about administrative burden, specifically with prior authorization. One health system highlighted chronic underpayment from government programs.

Insurers

Insurers emphasized challenges with highly concentrated provider networks and hospital systems, noting that this heavily impacts their ability to appropriately negotiate contracts with hospitals and health systems. They also cited high hospital prices in the state, resulting from consolidation. Insurers mentioned the importance of recognizing the need for prior authorization and utilization management. They also highlighted the need to weigh the cost benefit analysis associated with implementing coverage mandates.

One insurer noted issues with Maine's Certificate of Need law, citing that it has not curbed the development of large monopolistic health systems in the state. Another commenter mentioned that the expansion of the reinsurance program, known as MGARA, to include the small group market has contributed to an erosion of the reinsurance program's impact on premiums.

Policy Development

In previous years, the office has worked with the Advisory Council to identify areas of focus for policy development during 2025. Last year, after multiple in-depth discussions and presentations, the office presented five "policy domains" to organize the wide range of issues in health care affordability for possible exploration. The Advisory Council reviewed these domains through a framework assessing feasibility, alignment, and opportunity. Following robust discussion, the group identified three policy areas for the office to focus on in 2025:

- Provider Market Oversight and Consolidation
- Regulating Commercial Prices for Health Services
- Aligning Incentives to Promote Efficiency and Quality

Provider Market Oversight and Consolidation

The office, in collaboration with the Advisory Council, developed the following problem statement to guide work on the Provider Market Oversight and Consolidation category:

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.

The office drafted next steps related to this topic, which included the review and assessment of options for mitigating risk from PE acquisition, including recent efforts in other states. After extensive research, review, and collaboration across state agencies and other stakeholders, the office, in collaboration with Representative Sam Zager, introduced legislation in the 132nd Session to strengthen market oversight mechanisms in Maine. The legislation, [LD 1972](#), featured two main components seeking to address financialization of the health care system and increased transparency of ownership structures. The first component included the creation of a Material Change Transaction Review process, which would have expanded the scope of review of transactions involving health care entities beyond what currently exists in Certificate of Need statute. The second component was new transparency requirements that would have improved the availability of information about corporate structure and ownership of health care entities. While hospitals currently make some of this information available indirectly via audited financial statements and other documents, it requires expert analysis to reconstruct an organizational chart from those filings. For non-hospital providers, there is no comprehensive source of ownership information. This provision would have served as a complement to the financial performance data already being collected by the Maine Health Data Organization.

Ultimately LD 1972 was voted down by the legislature and the concepts advanced in the legislation were instead included in the scope of the [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](#), which was established at the end of the first session of the 132nd Legislature by the Health Coverage, Insurance, and Financial Services committee. The commission was established to evaluate potential changes to the state's CON laws, explore potential legislative changes to require regulatory review and oversight of substantial health care transactions, and assess the role of a private equity company or real estate investment trust taking a direct or indirect ownership interest.

The Director of the office was appointed to serve on the commission, which met five times between October and December of 2025. The commission heard presentations from the Division of Licensing and Certification, the National Academy for State Health Policy, the Maine Attorney General's office, the Department of Health Care Policy at Harvard Medical School, and

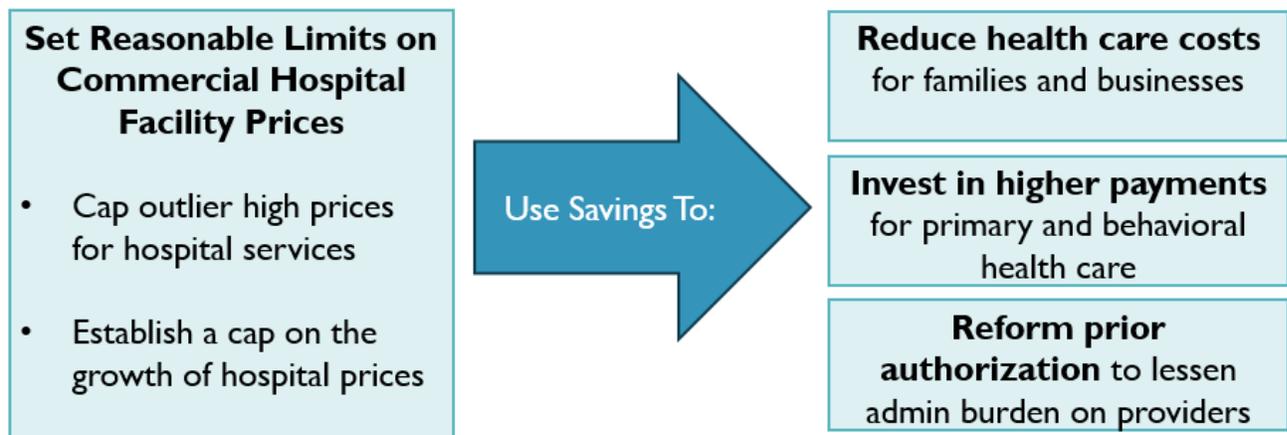
state legislators from Connecticut. During its final two meetings the commission developed a set of recommendations to the legislature which will be presented to the Health Coverage, Insurance, and Financial Services committee at the beginning of the upcoming legislative session.

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 represent 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.

During 2025 the office assessed the magnitude of impact of unit prices on premium increase requests for state-regulated health plans, discussed above in the findings from Wakely’s analysis of individual and small group insurance filings. This assessment confirmed that increasing medical costs, and specifically the prices of medical services, were a major contributor to premium increases in 2025. In light of even greater projected increases in insurance premiums for Maine consumers in 2026, the office felt that it was imperative to begin exploring solutions with the potential to alter the trajectory of rising health care costs. Through the fall, the office developed a policy framework that was presented to the Health Coverage, Insurance, and Financial Services Committee in November (Figure 13) which would utilize the savings from reasonable caps on hospital facility prices to lower costs for families and business while increasing payments for primary and behavioral health care and making reforms to reduce the burden of prior authorization. Since then, staff have worked to solicit further stakeholder input to refine the policy concept, and an analysis of impacts is underway. OAHC looks forward to engaging with the legislature on the policy in the second session of the 132nd Legislature.

Figure 13. Policy Framework



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 office has discussed interest in greater adoption and alignment of payment models across payers and began assessing what role the office could play in convening stakeholders to solution for challenges.

During 2025, a new pathway for this work arose with the creation of the Rural Health Transformation Program at the federal level. This program, created in H.R. 1, will provide states with funding to conduct activities to improve the health of rural populations and sustainability of rural health care. While the funding available through this program is significantly less than projected cuts to the state's MaineCare program also authorized in H.R. 1, it does present an opportunity to develop care delivery and payment models tailored to rural areas. Specifically, the state of Maine's application envisions that the Office of Affordable Health Care will collaborate with the Department of Health and Human Services and other state agencies to facilitate a regionalized rural planning process involving a range of healthcare providers, local government, public health leaders, social services entities, and community members. The process will begin by defining and identifying essential services and the distance to those services, and then determining options for the provision of essential services, including preventive care and disease management, including physical sites, telehealth, and technology-enabled, in-home and mobile care. Finally, the planning process will contemplate existing and potential financing and operational structures to support necessary changes in care delivery, including collaborative models and multi-payer APMs. The office looks forward to contributing to this important work through 2026 and beyond.

Conclusion

After spending 2023 and 2024 building internal capacity and establishing an analytics portfolio, in 2025 the Office of Affordable Health Care was able to more fully meet its statutory direction to develop proposals for consideration by the legislative oversight committee on methods 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 in the State. Unpredictability and a high volume of significant policy changes at the federal level have made this charge particularly difficult, but the office remains committed to finding pathways forward at the state level that are both ambitious and achievable. While no single policy proposal can "fix" the many challenges of this country's health care system, a combination of legislative and collaborative

initiatives have the potential to make Maine a leader in increasing transparency and fairness, and providing much-needed relief to consumers and employers.