Office of Affordable Health Care

Presentation to the Primary Care Advisory Council

December 19th, 2025

Health care affordability is an urgent issue for Maine people

Health care expenditures in Maine equal 23% of total gross state product.

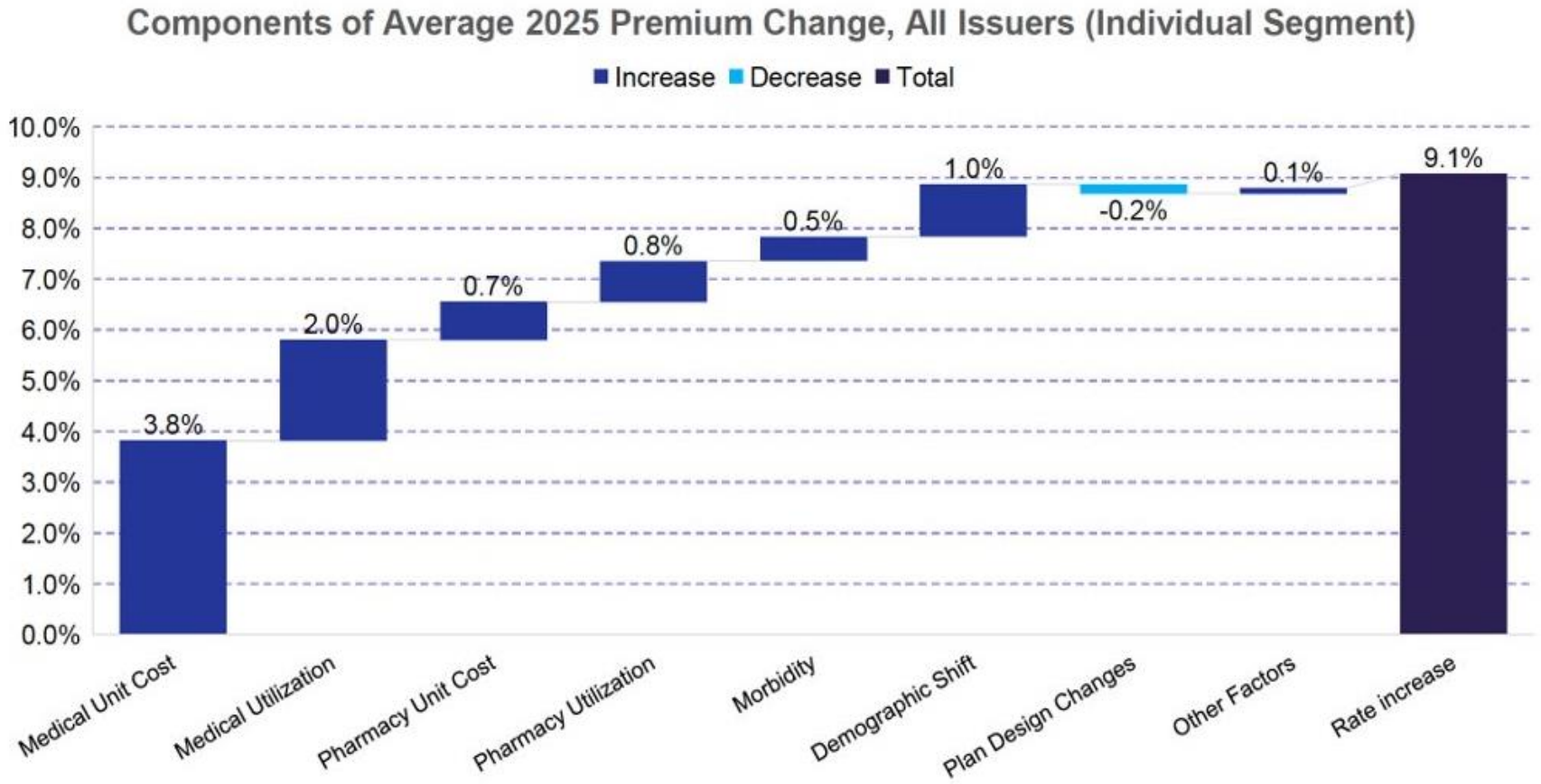
43% of Maine people have delayed or avoided seeking medical care due to concern about cost.

Average annual approved rate increases in the fully insured market

Year	Individual Market	Small Group Market
2023	11.4%	-0.7%
2024	14.6%	14.6%
2025	8.6%	9.4%
2026	23.9%	17.5%

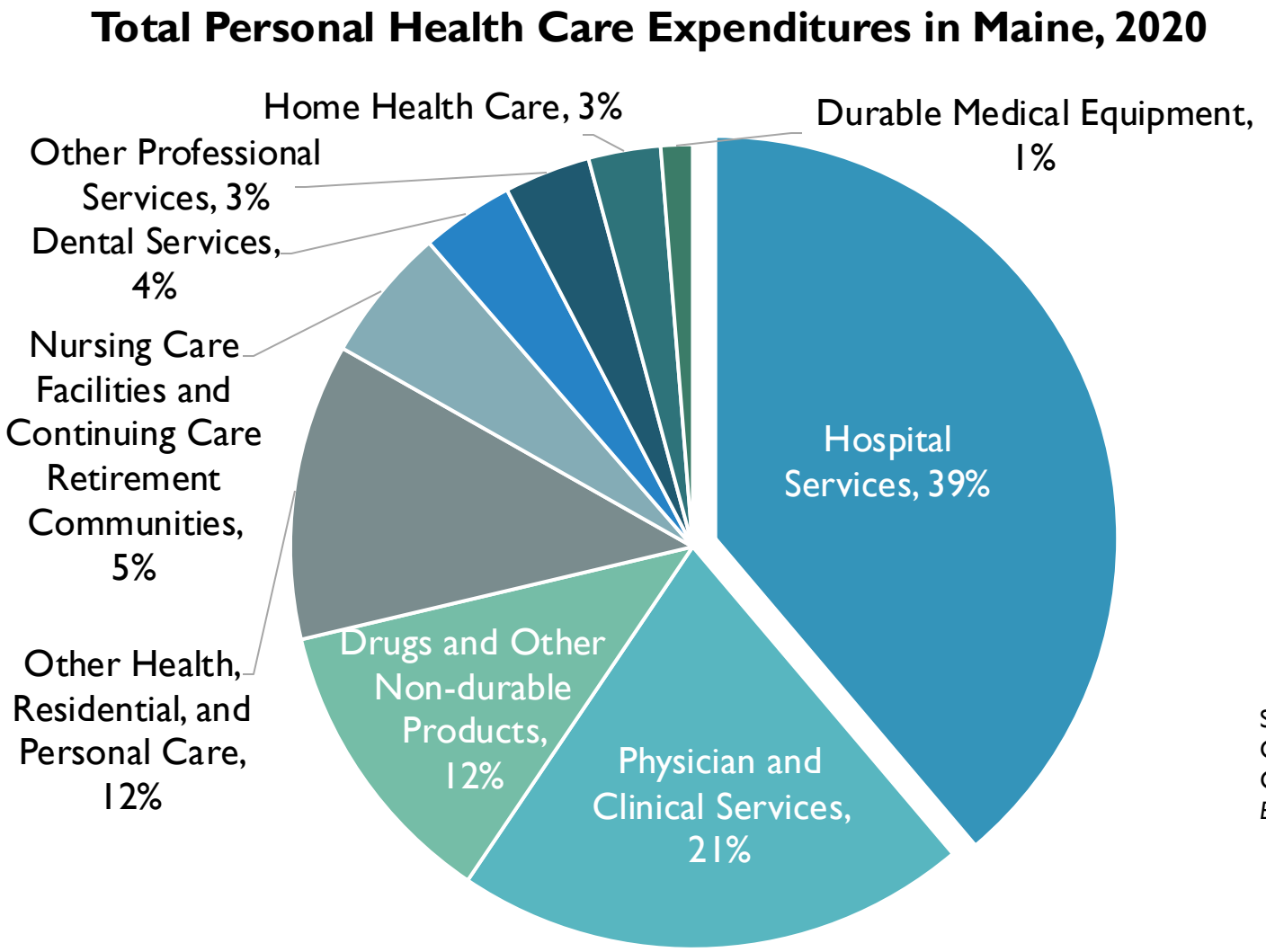
Spending on health care services is the primary driver of increasing premiums

Drivers of the 2025 Average Rate Change



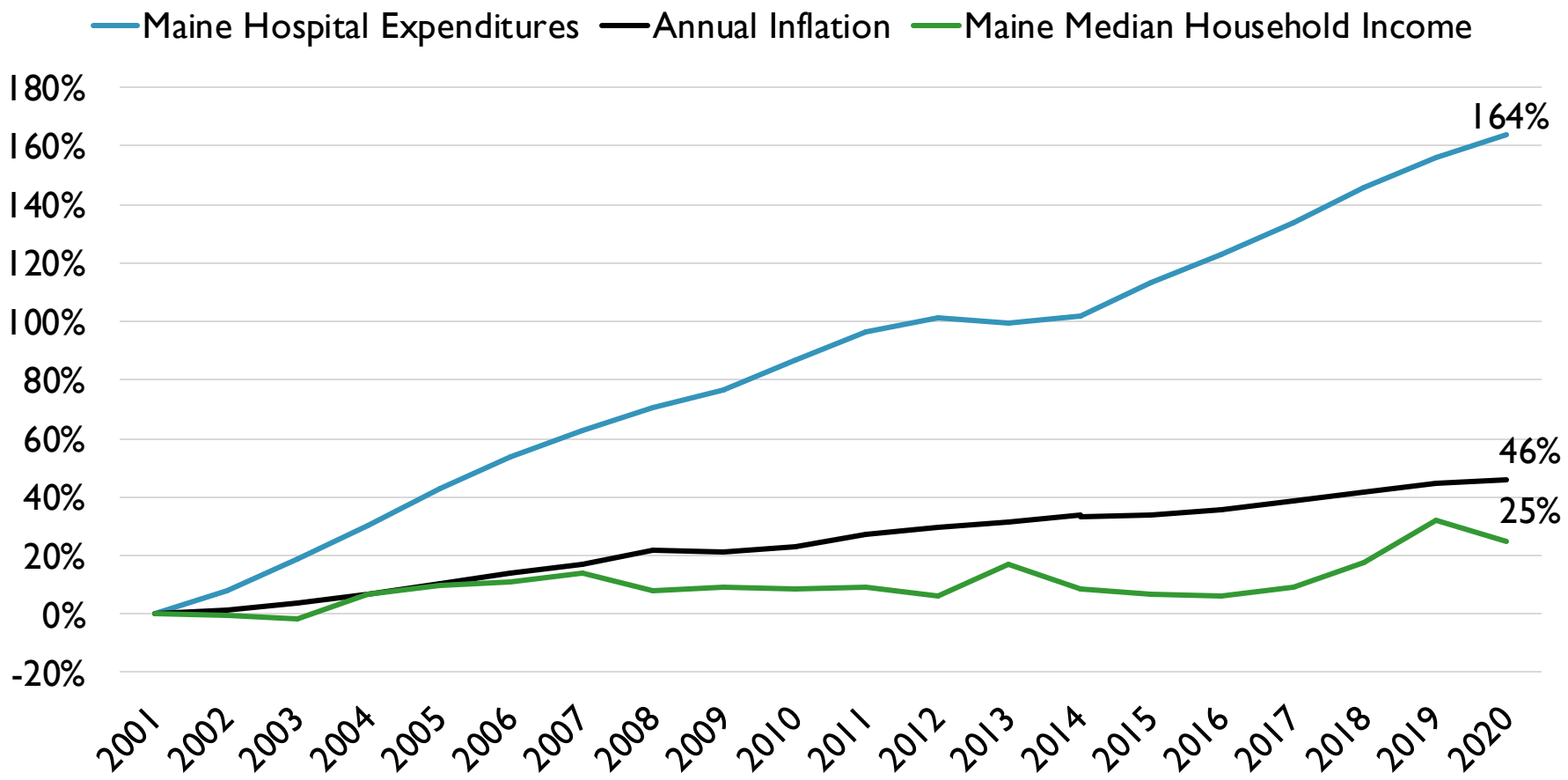
Medical Trends and Premium Changes in Maine Marketplace, Wakley Consulting Group, February 7th, 2025

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



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

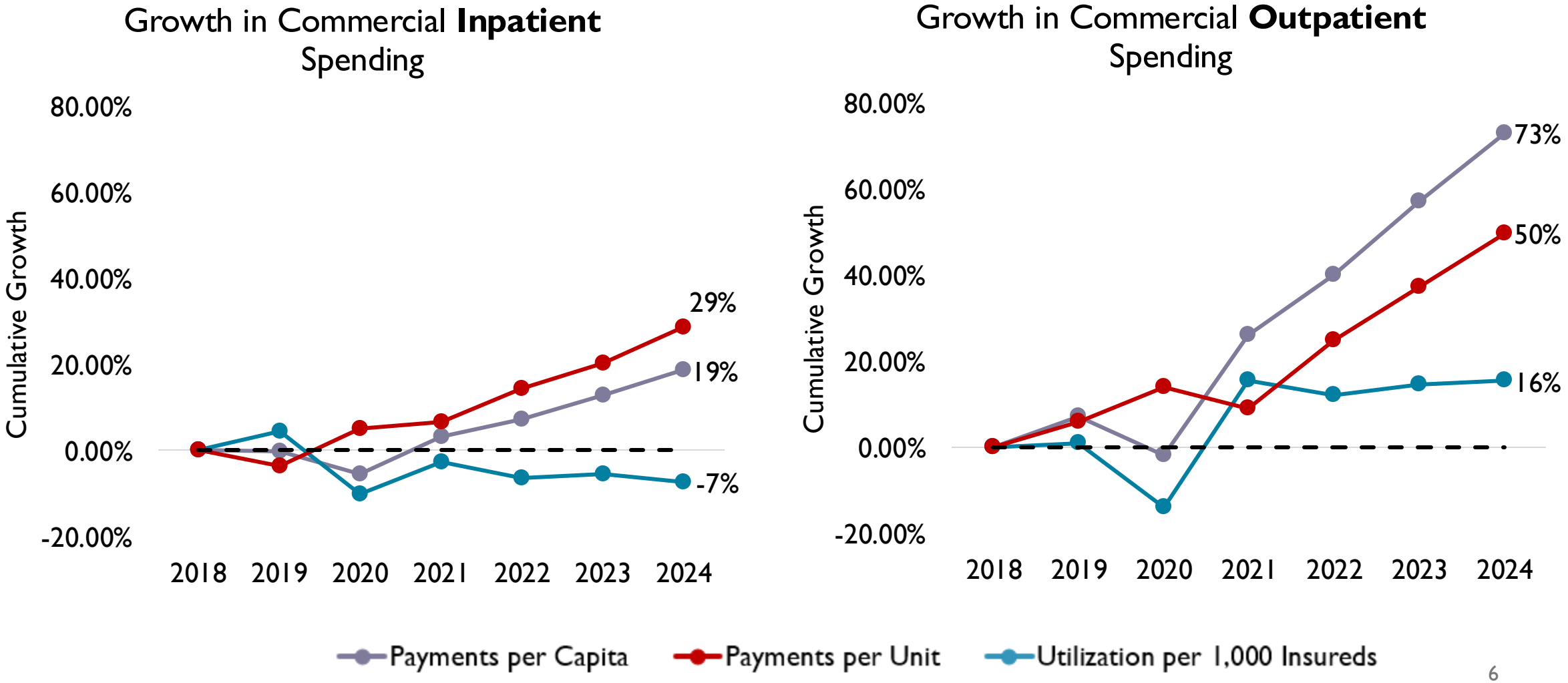
Maine's per capita hospital expenditures have grown much faster than inflation and income



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

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. (2024). *National Health Expenditure Data: Health Expenditures by State of Residence, August 2022;* Federal Reserve Bank of Minneapolis. (2024). *Consumer Price Index 1913-.*. and Federal Reserve Bank of St. Louis. (2024). *Real Median Household Income in Maine.*

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



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

Success in Addressing Hospital Prices in Other States

- Since 2010, **Rhode Island** has utilized "Affordability Standards" in insurance rate review, which includes a limit on the average annual payment increases for hospital inpatient and outpatient services in insurer contracts.
  - By 2022, the authors of a recent evaluation found that reductions in hospital price growth translated into annual savings of **$1,000 per member** in fully-insured plans.
- **Oregon's** state employee health plan pays no more than 200% of Medicare prices for in-network hospital services, and 185% of Medicare prices for out-of-network services. Some small and/or rural hospitals were exempted from the program.
  - A 2024 evaluation found that the price caps generated over **$100 million in savings** over the first two years of implementation and found no negative impacts on access to care, hospital finances and operations, or patient experience of care.

Growing State Interest in Addressing Hospital Prices

Several new pieces of legislation were passed around the country in 2025, including:

- **Washington** will now limit how much Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) plans pay for hospital inpatient and outpatient services to no more than 200% of the Medicare rate. The law also sets minimum payment levels for primary care and behavioral health services at 150% of Medicare.

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

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

Recommended Policy Framework

Set Reasonable Limits on Commercial Hospital Facility Prices

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

Use Savings To:

Reduce health care costs for families and businesses

Invest in higher payments for primary and behavioral health care

Reform prior authorization to lessen admin burden on providers

Price and Price Growth Caps – Next Steps

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

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

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

Incorporating Changes to Prior Authorization – Next Steps

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

- Also soliciting input from Advisory Council members and others about changes that could reduce the use of prior authorization in the case of services that are generally approved, or other opportunitiess to reduce inefficient PA processes.

Thank You

Meg Garratt-Reed

meg.garratt-reed@maine.gov

APPENDIX: Considering Hospital Financial Performance

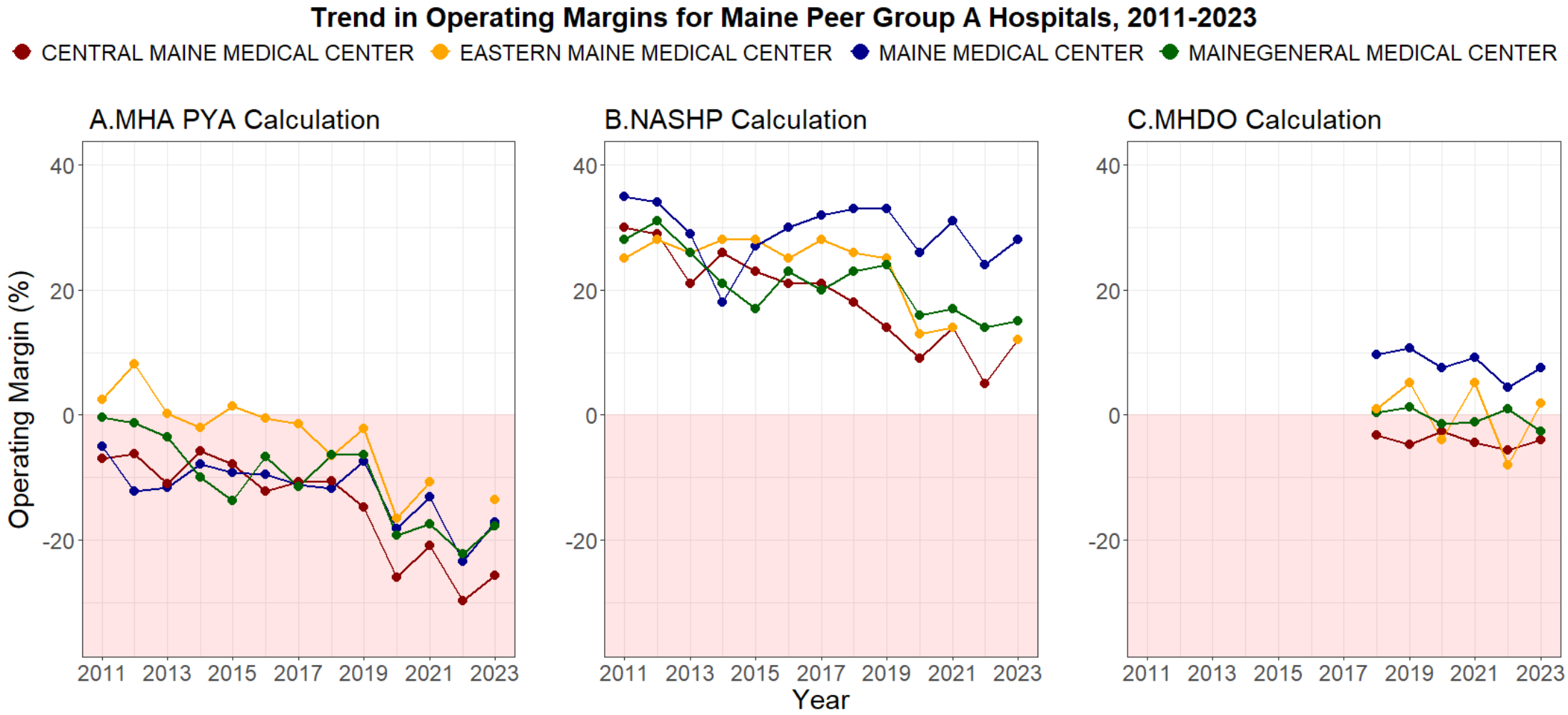
Analytical Considerations for Measuring Hospital Financial Performance

How you calculate metrics matter.

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

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

Performance of Maine hospitals varies based on methodology

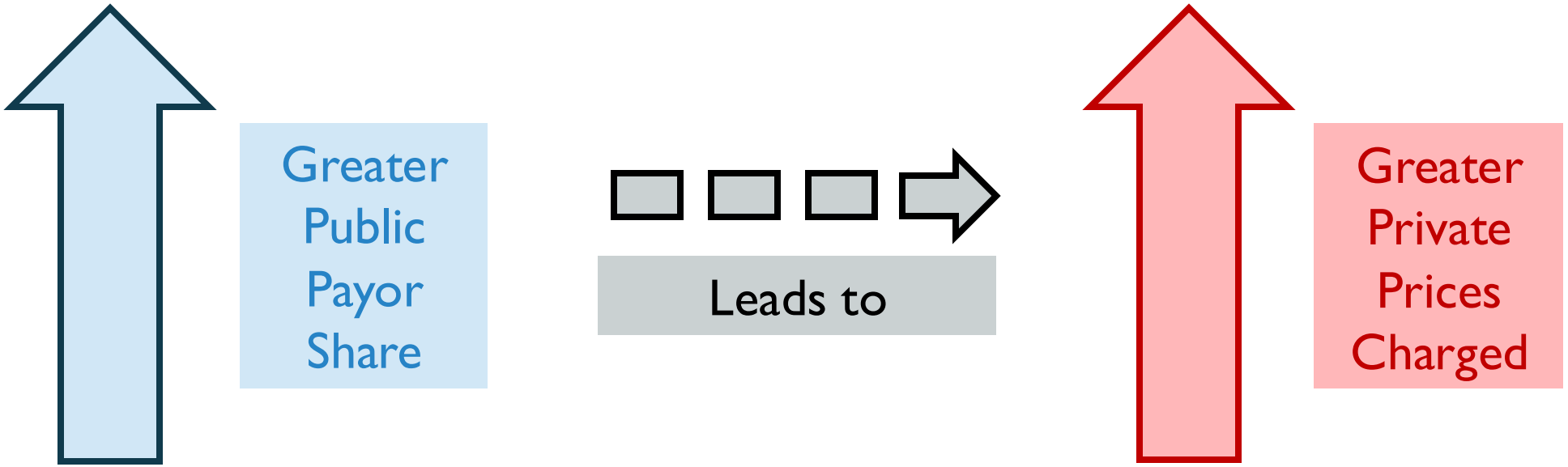


Source: Medicare Cost Reports and Maine Health Data Organization. *Report A: 2019-2023 Select Hospital Data Elements and Ratios. https://mhdo.maine.gov/hospital_financials.htm*

Addressing the cost shifting myth

Claim:

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

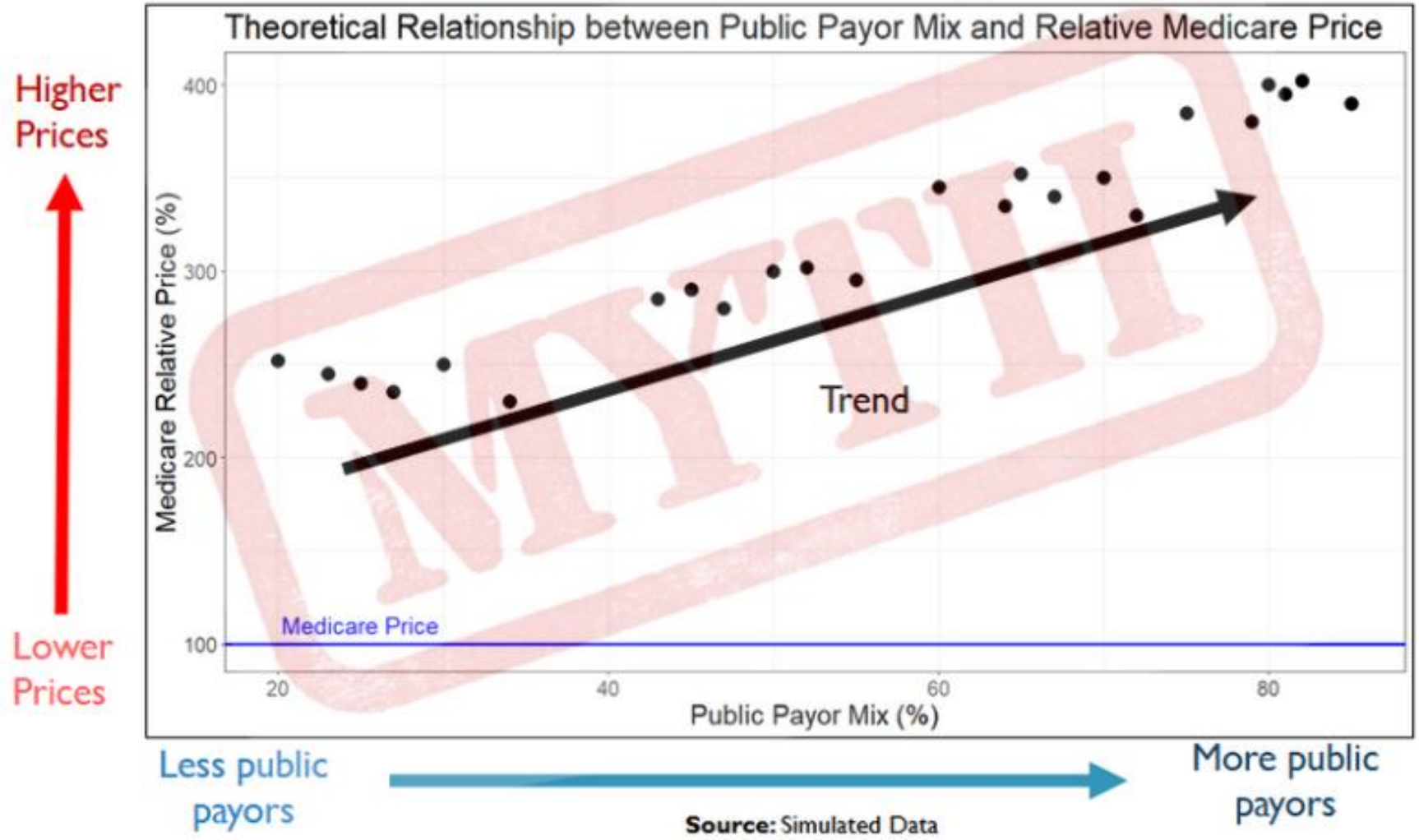


The cost shifting myth in the data

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

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

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



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

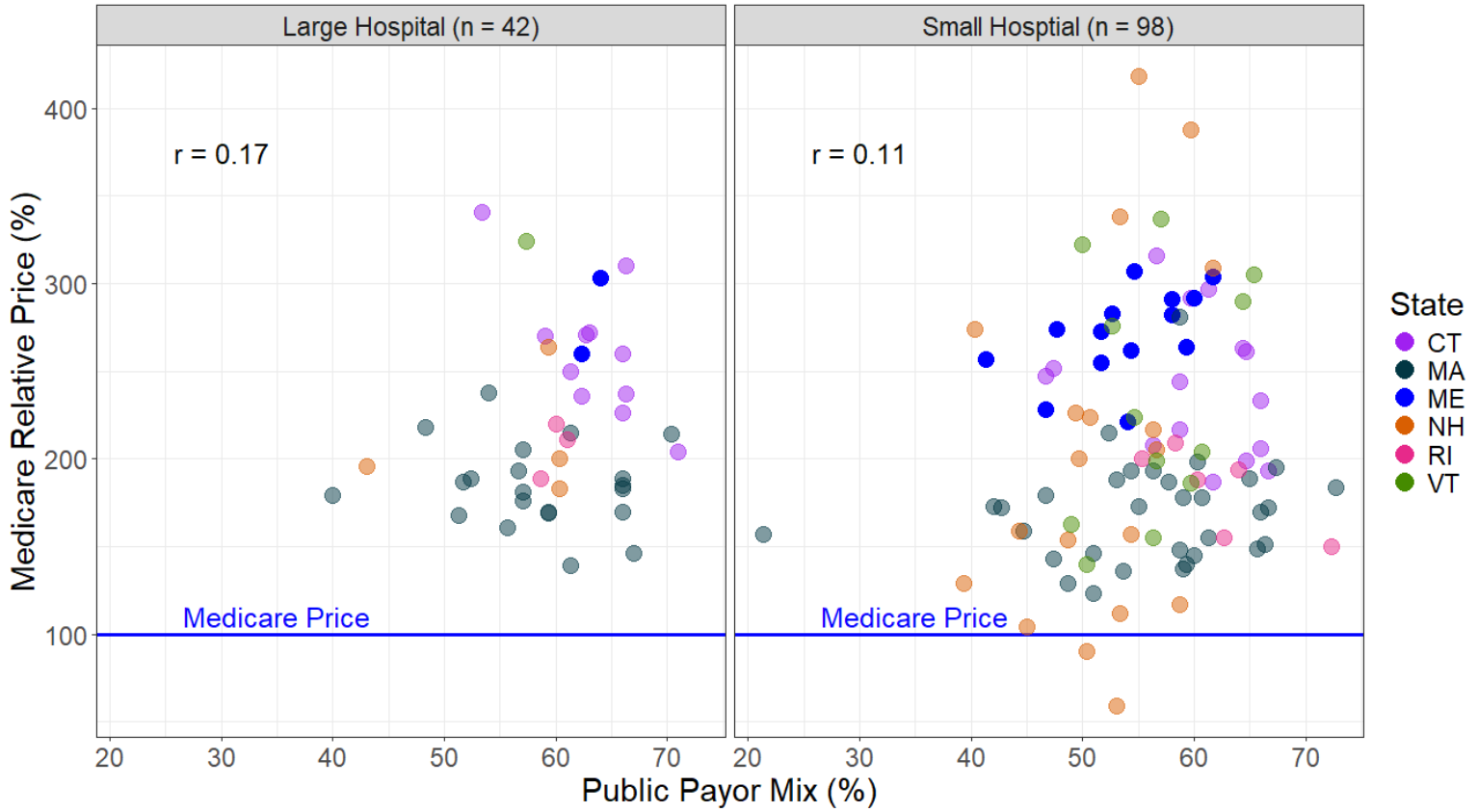
Myth

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

Reality

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

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



Source: Medicare Cost Reports and RAND Hospital Price Transparency 5.0

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

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

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