



# Office of Affordable Health Care

2025 Public Hearing - September 29, 2025



# Office of Affordable Health Care

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## Overview



# About the Office

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

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

# Guiding Principles

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- **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
- **Define affordability from a consumer perspective**
  - Focus on cost control policies that provide relief for end-payers (individuals and families, businesses, government), with a particular emphasis on consumer cost burden that may result in delayed or deferred care
  - Avoid policies that simply shift costs, unless cost-shifting is undertaken intentionally to promote better outcomes
- **Deliver results**
  - Take into account whether proposals are achievable, and other implementation considerations
  - Recognize that continuing the status quo is not sustainable



Analytics  
Updates –  
Digging in to  
Spending and  
Utilization

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# OAHC Analysis Planning

Complete

In Progress

Not Yet Started

## OAHC Claims Dashboards

## MHDO and MQF Reporting

## OAHC Non-claims Analyses

Health Expenditures Dashboards

Hospital Payment and Utilization Dashboards

Facility Level Payment and Utilization

Professional Services Payment and Utilization

Cost Driver Deep-Dives

Drug Spending Dashboards

Primary Care Spending Report

Behavioral Health Care Spending Report

Hospital Quality Data

Hospital Financial Data

Health Care Payments in Maine V 2.0

CompareMaine: Payment and Quality Data

Household Spending on Health Care

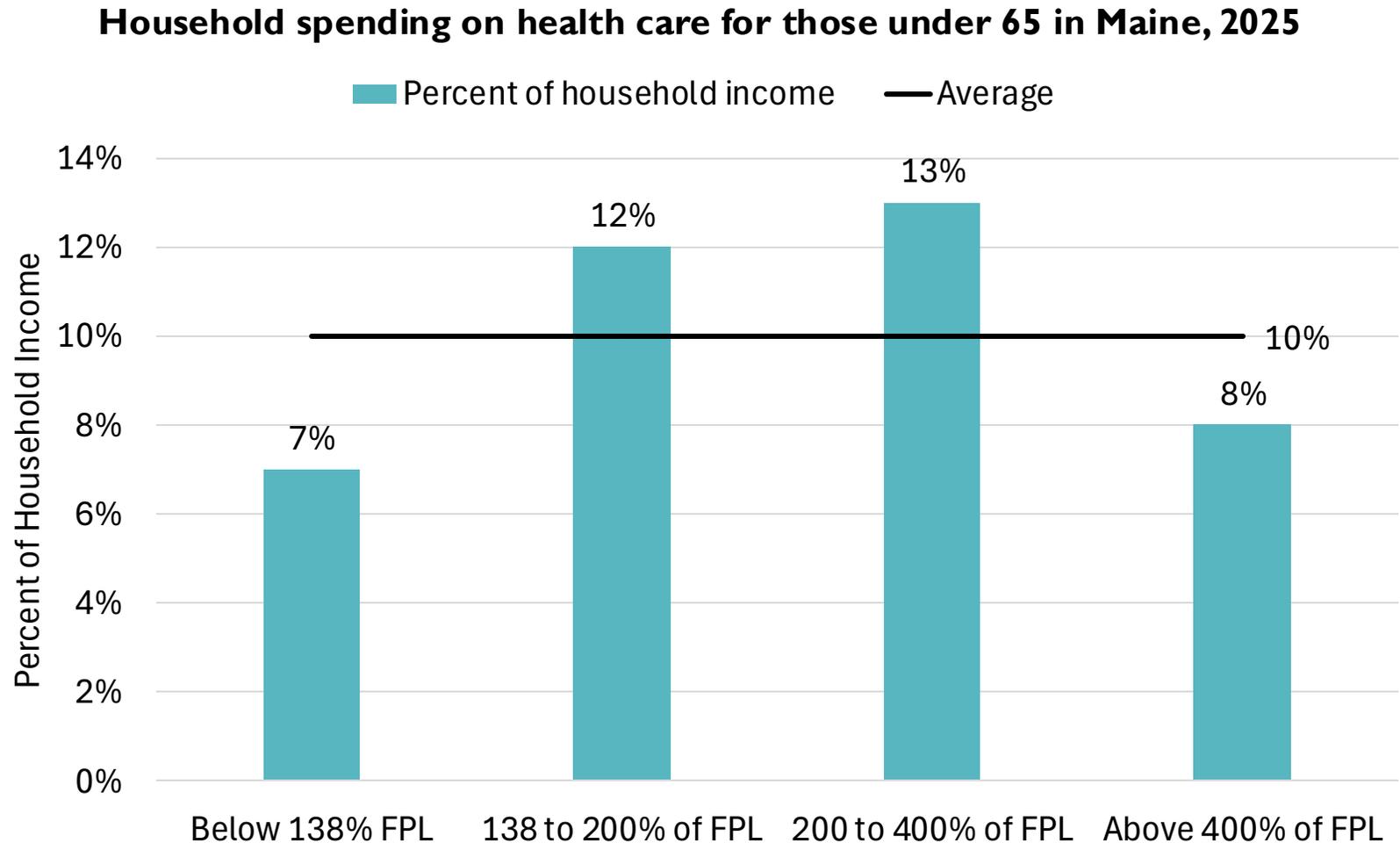
Access and Equity Dashboards

Clinical Quality Metric Dashboards

Provider Cost Analysis

# Health care spending represents a substantial portion of Maine residents' household income

- On average, Maine households spend 10% of income on health care expenses, including premiums, out of pocket costs, and other expenses.
- Middle income earners spend an average of 13% of their income on health care, the **highest proportion of all income brackets.**



# Health Care costs for many Mainers will rise in 2026

## Average annual approved rate increases in the fully insured market

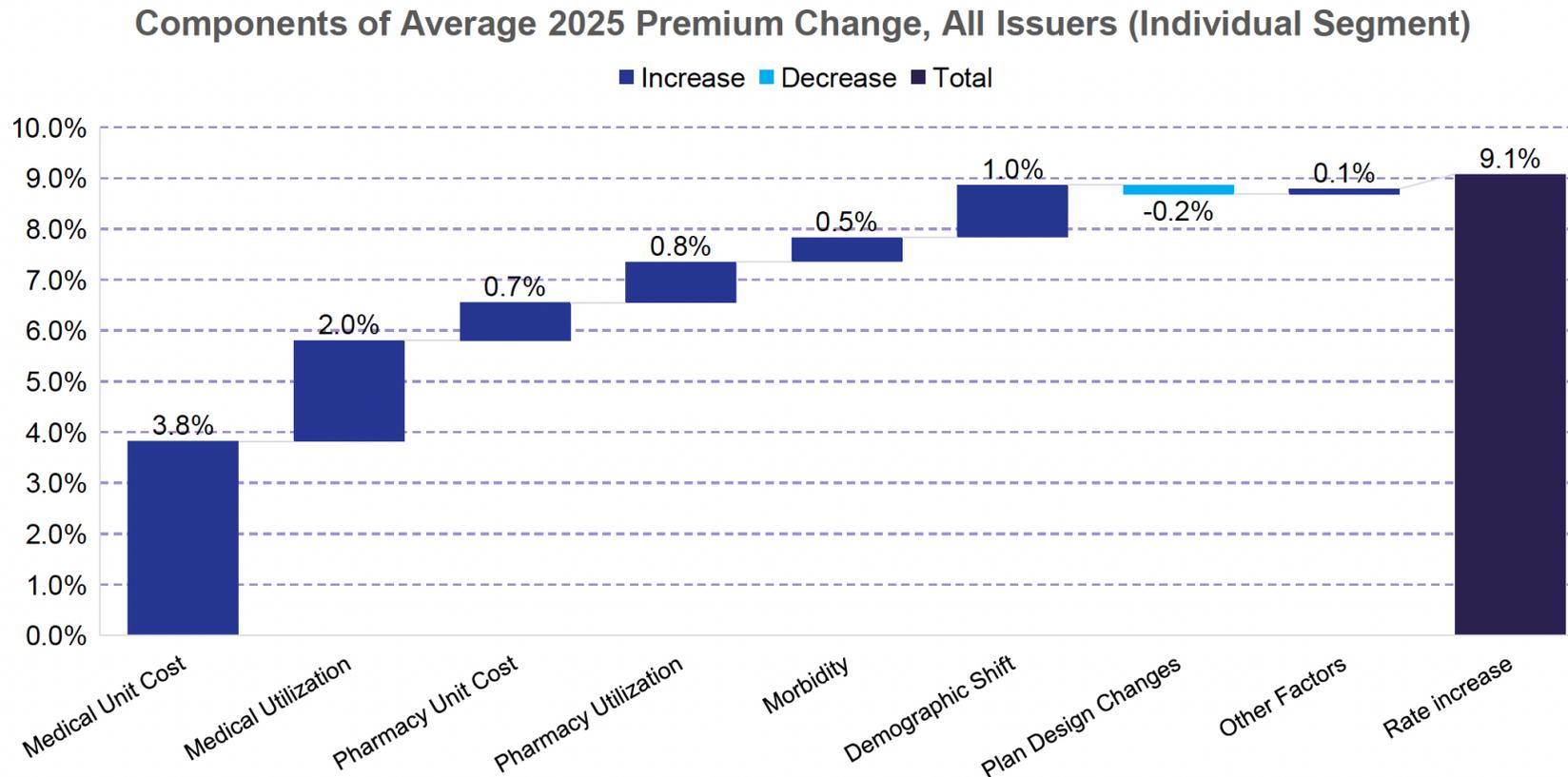
Year	Individual Market	Small Group Market
2023	11.4%	-0.7%
2024	14.6%	14.6%
2025	8.6%	9.4%
2026	23.9%	17.5%

For the roughly 50,000 Maine people who qualify for financial assistance through the Marketplace this increase will be magnified by the decision of Congress not to extend Enhanced Premium Tax Credits.

At the direction of the legislature, in 2025 OAHHC published a [report on costs and impacts of state-level subsidies](#).

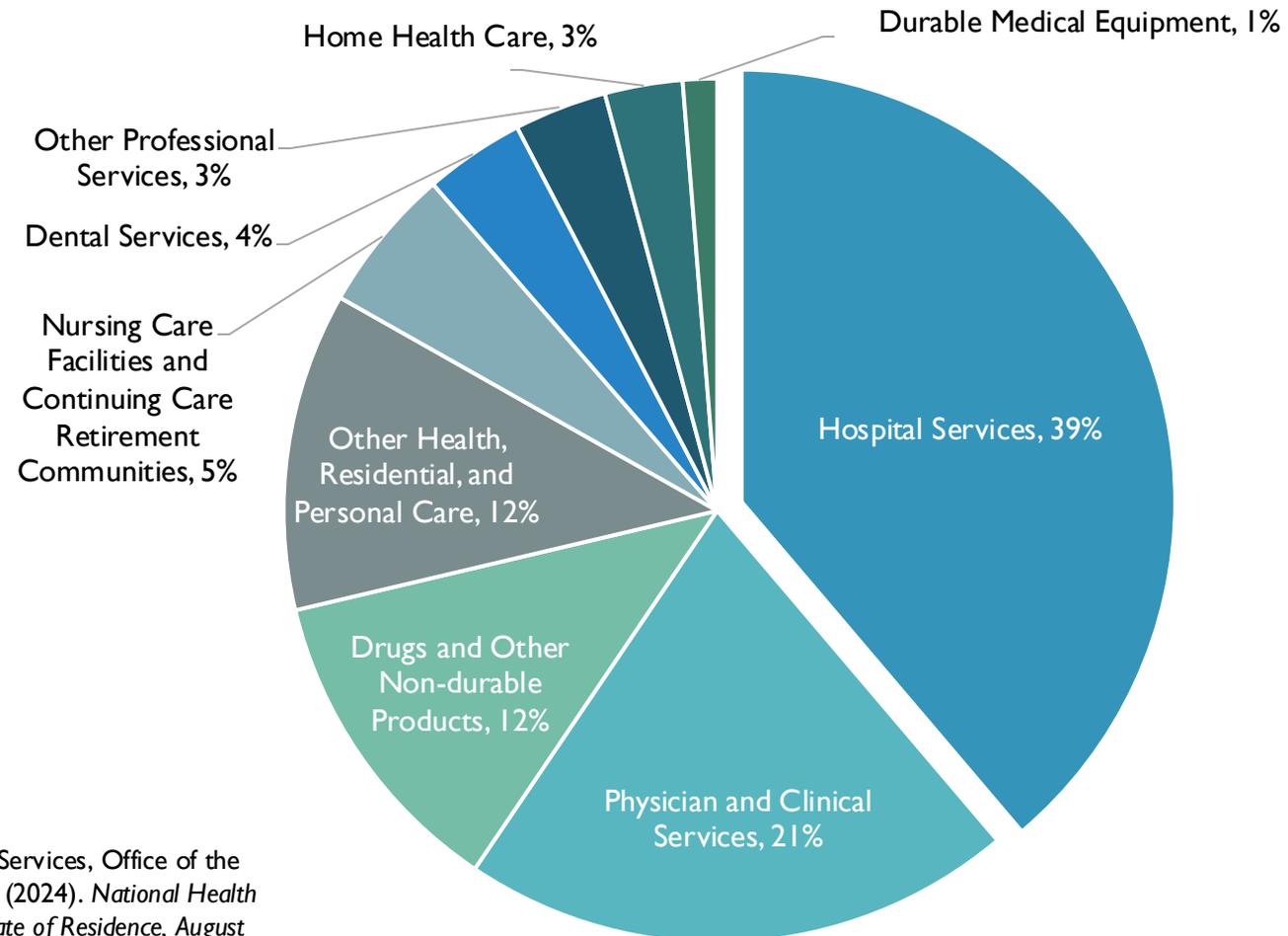
# Medical and pharmacy costs have historically been the major driver of increased premiums

## Drivers of the 2025 Average Rate Change



# Hospital services contribute the most to total health care spending

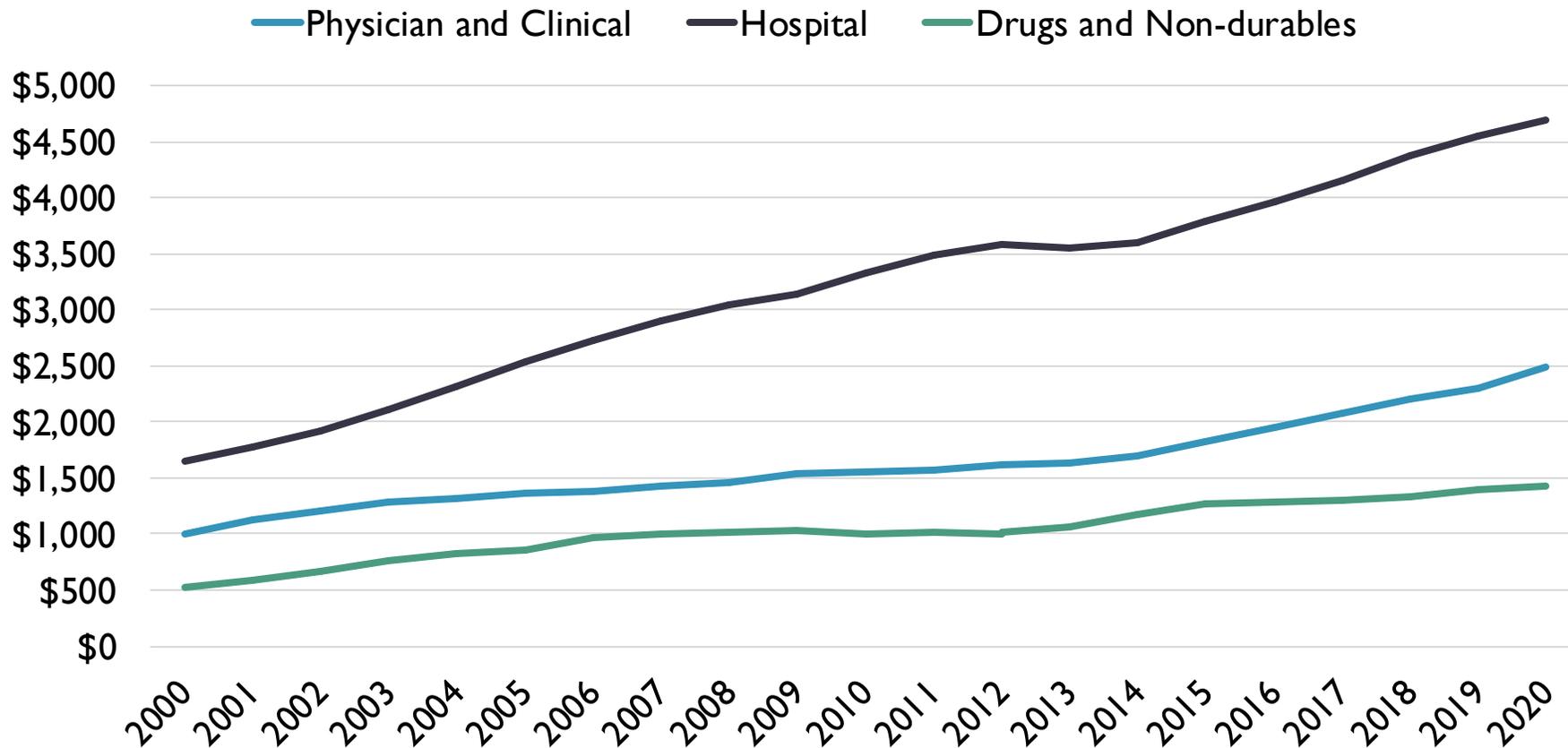
**Total Health Care Expenditures in Maine, 2020**



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*.

# Annual per capita spending on hospital services has risen to more than \$4,500

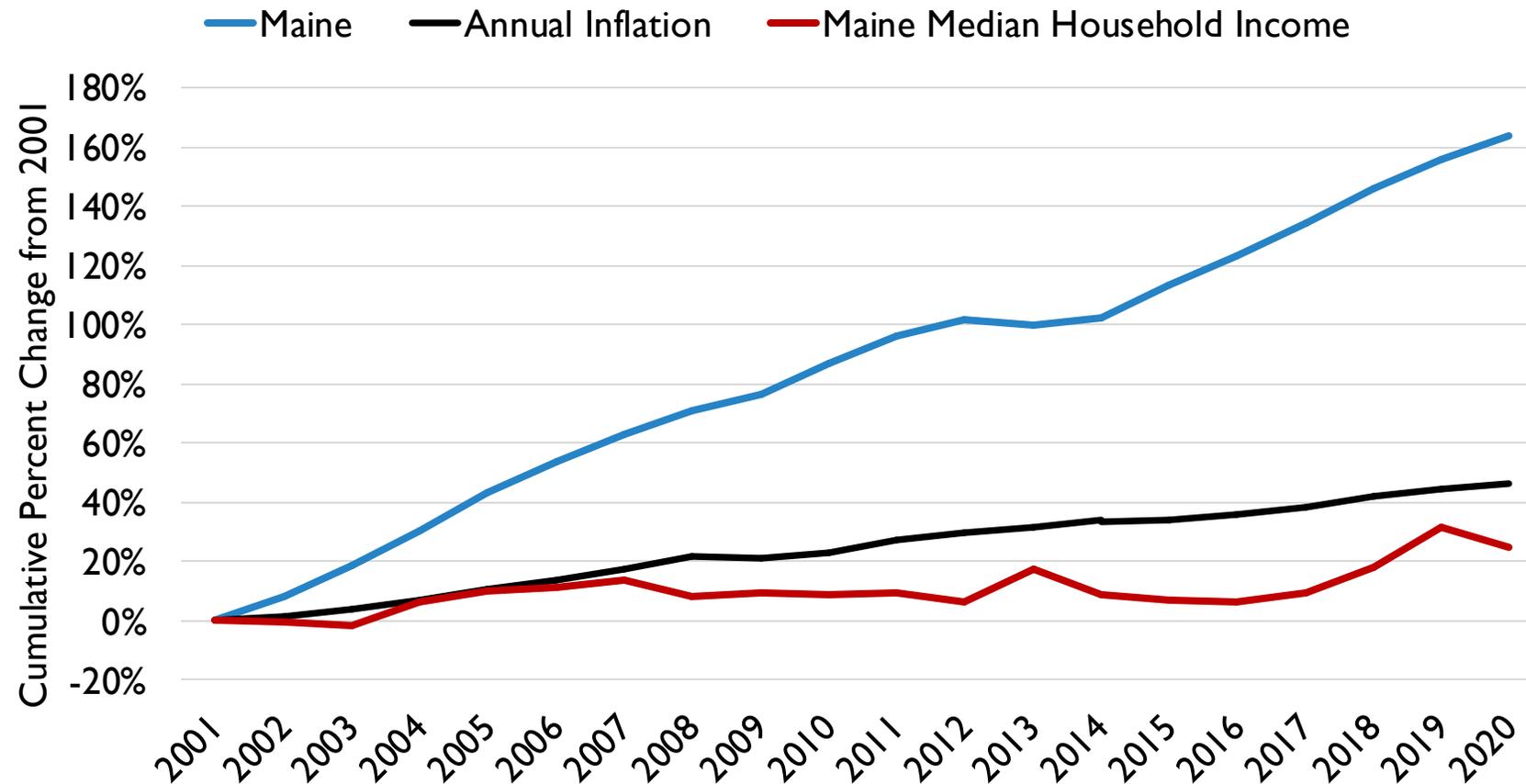
## Maine Per Capita Health Expenditures by Service Category, 2001-2020



- Per capita hospital spending for Mainers (\$4,687) ranks 14th highest in the nation, above U.S. average per capita hospital spending (\$3,855)

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

## Cumulative Growth in Per Capita Hospital Expenditures, 2001-2020



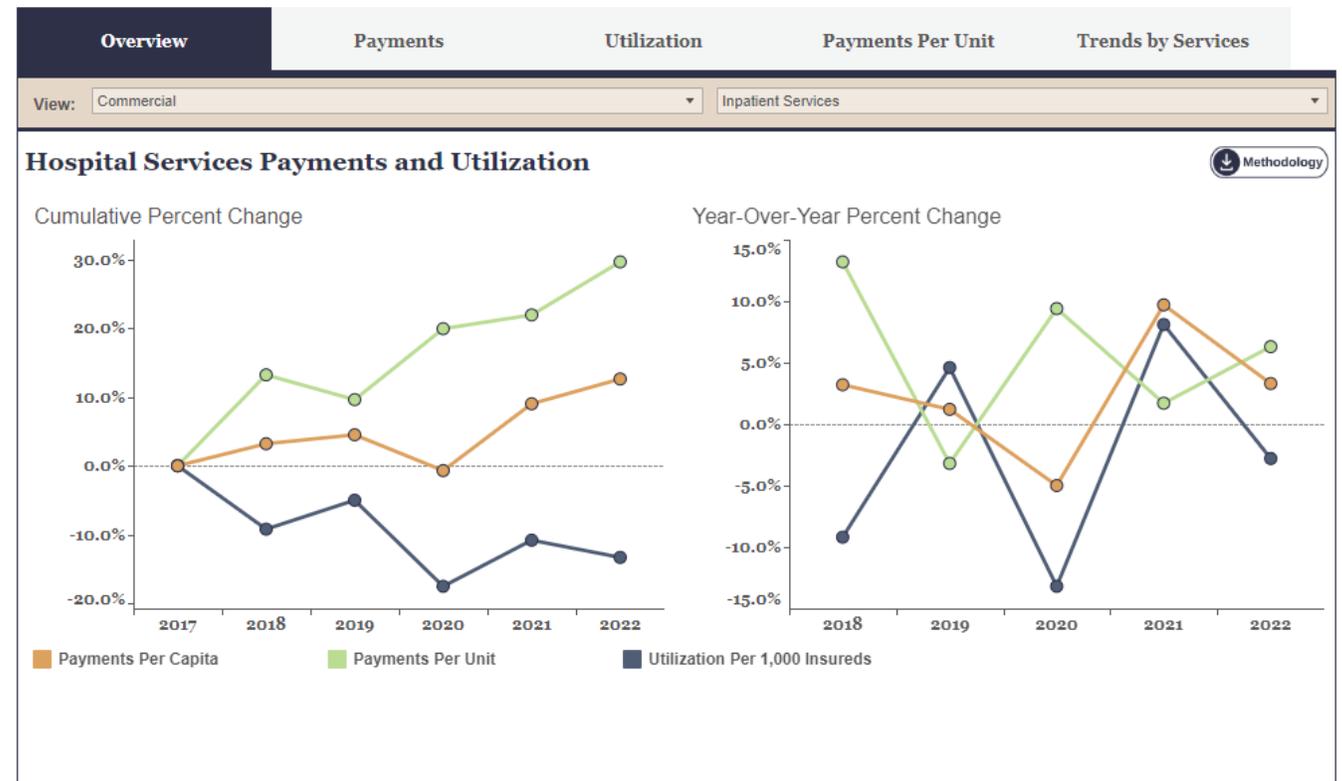
- Per capita hospital expenses in Maine and nationally have significantly outpaced national inflation and Maine households' median income.



**Maine Hospital  
Payments and  
Utilization**

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# Full Dashboards Available on [www.maine.gov/oahc](http://www.maine.gov/oahc)



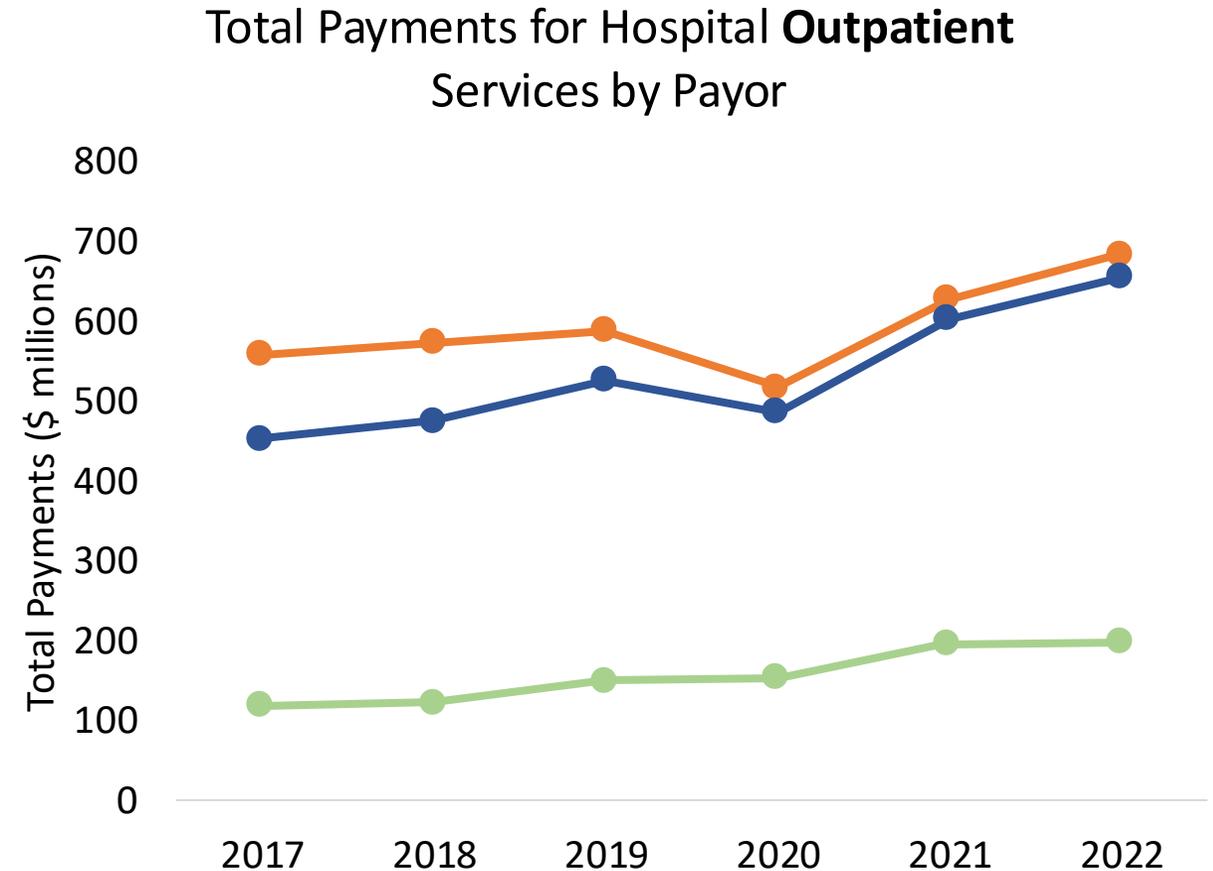
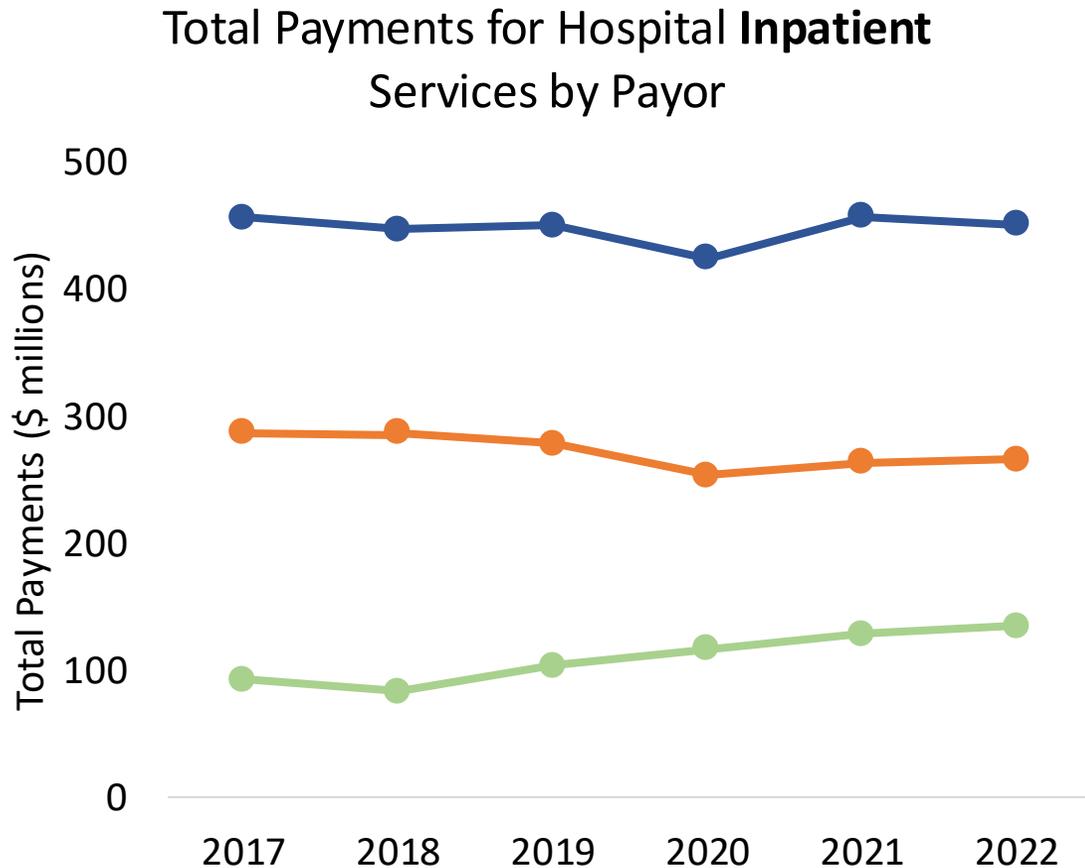
# Methods – All Payor Claims Database

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Maine Health Data Organization All Payors Claims Database (APCD)

- The data represent **payments** -
  - Defined as the combined payments made by the payor and member liability (inclusive of copay, coinsurance, and deductible) for medical services and procedures.
- Covers MaineCare (Medicaid), Medicare and Commercially insured members
  - Self insured commercial plans are not obligated to submit, but can and do on a voluntarily basis
- The data do not capture uncompensated care or the uninsured population

# Total spending on outpatient services has increased for all payors, particularly Medicare and commercial



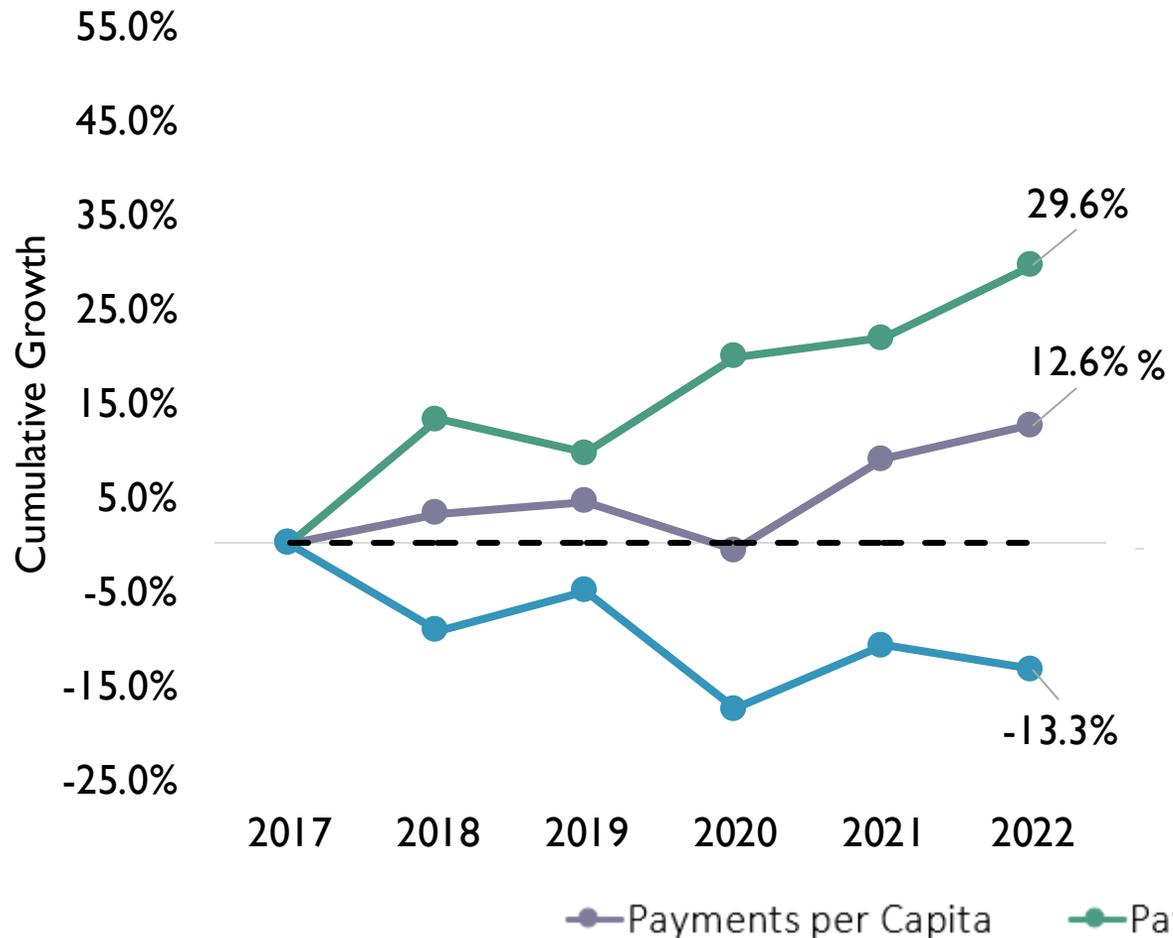
# Health care spending depends on use and price

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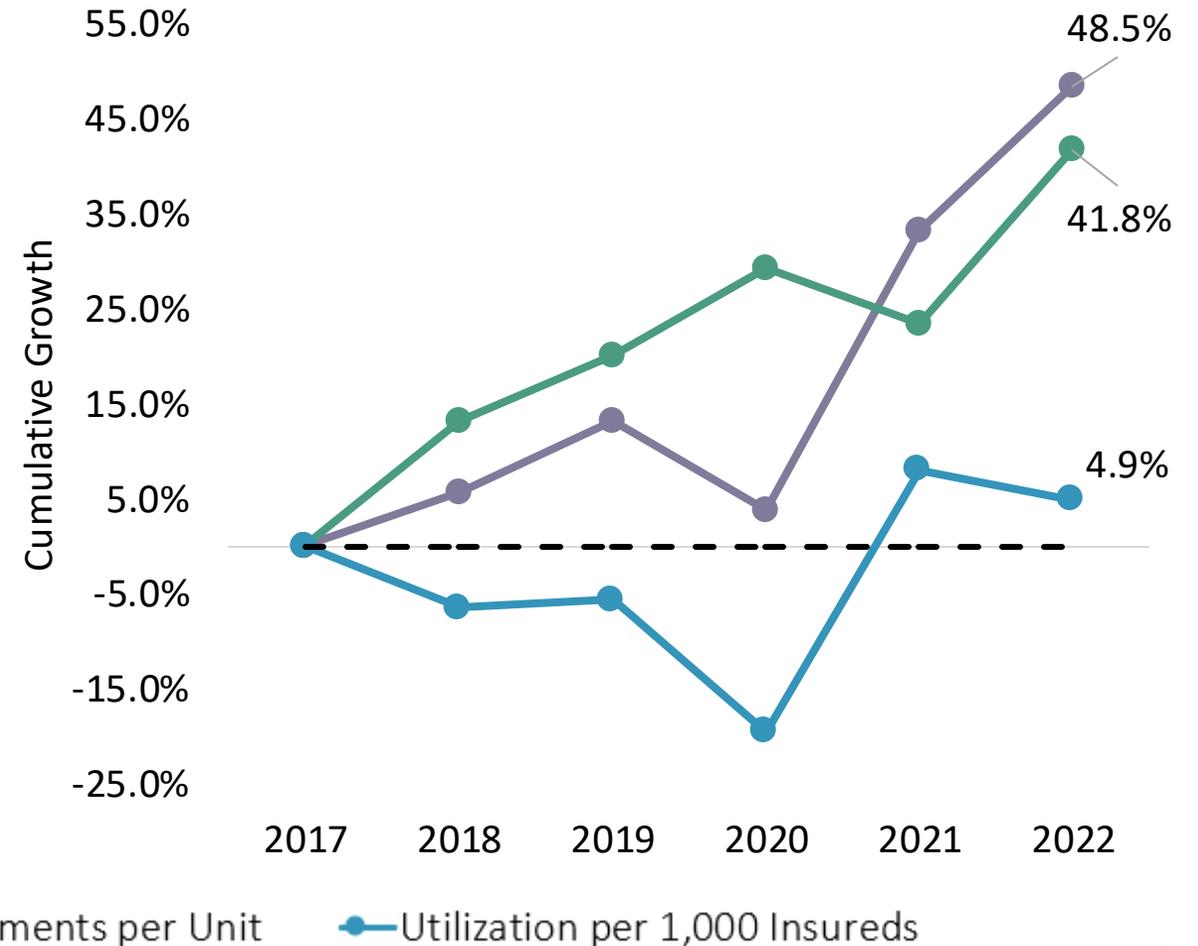


# Takeaway: Price not utilization drives hospital services spending growth for the commercially insured

## Growth in Commercial **Inpatient** Spending



## Growth in Commercial **Outpatient** Spending



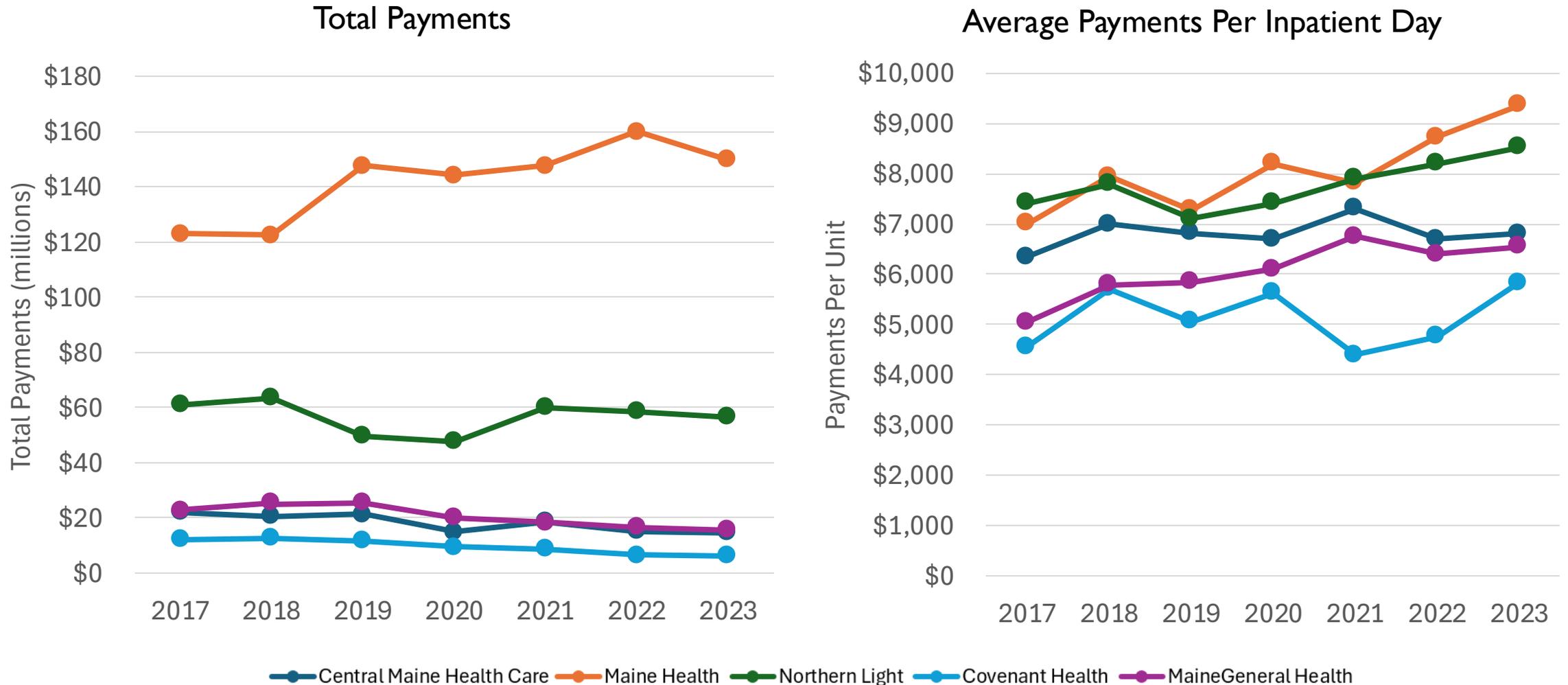


# Maine Facility Level Dashboards

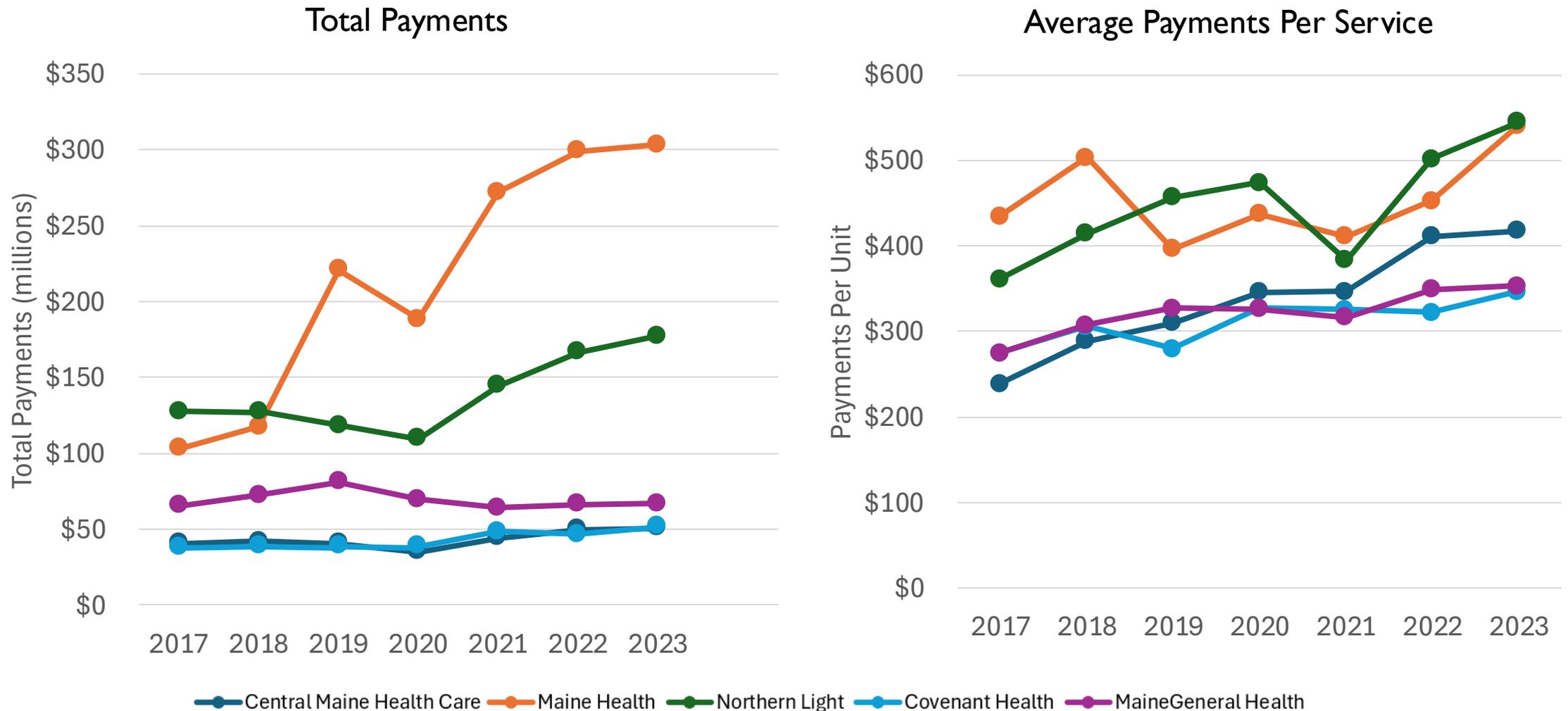
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# Total commercial spending and payments per unit on hospital **inpatient** services by hospital system



# Total commercial spending and payments per unit on hospital **outpatient** services by hospital system



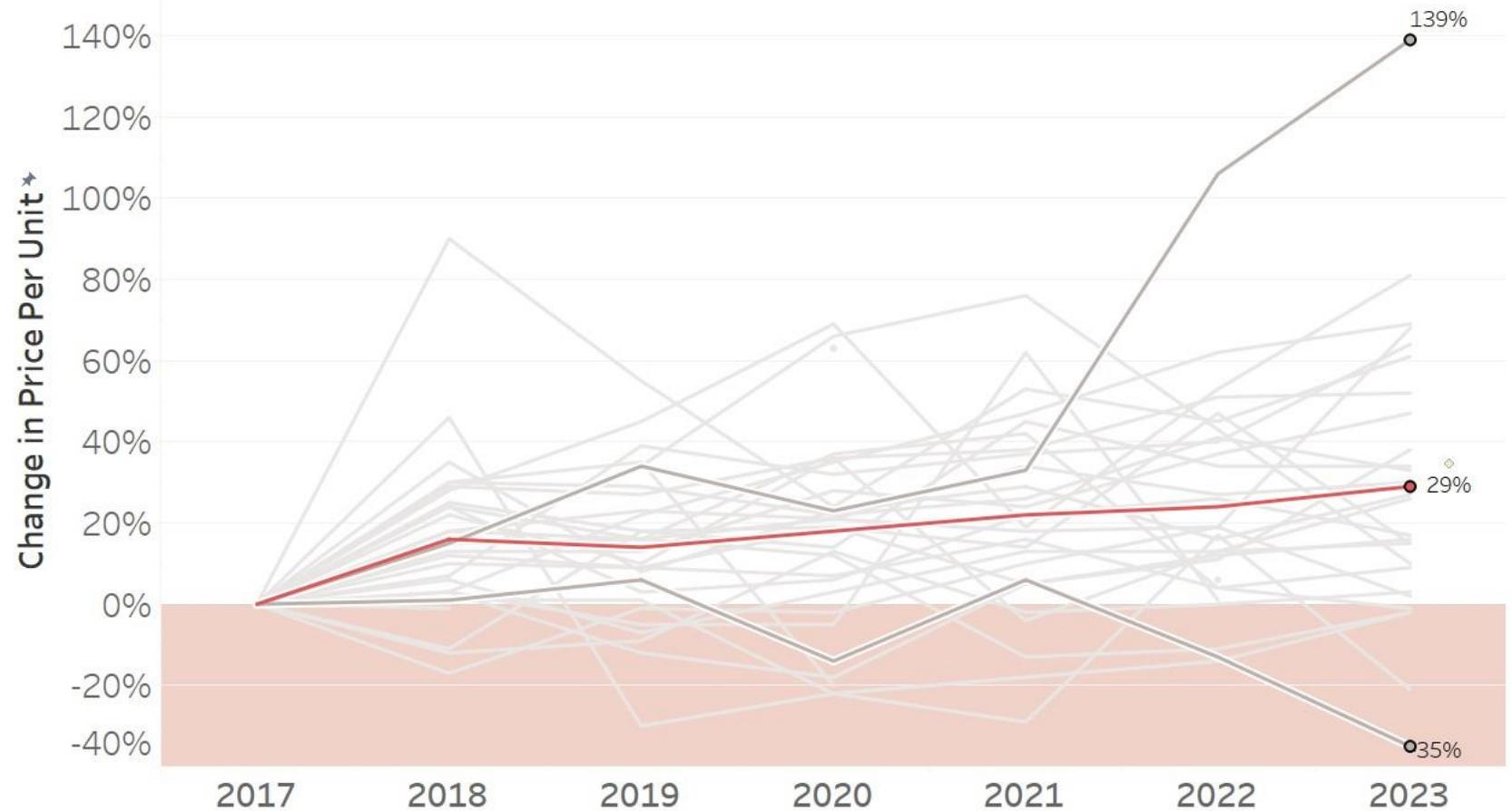
# Hospital commercial payments per unit for inpatient services have increased, but there is variation

From 2017 to 2023 inpatient payments increased 29% per hospital day. General U.S. inflation during this period was 24%.

Average payment per unit changes vary significantly from a 35% decrease at Waldo County Hospital to a 139% increase at Maine Coast Hospital.

\*Data does not adjust for changes in services provided

### Cummulative Change in Inpatient Price Per Unit, 2017 - 2023



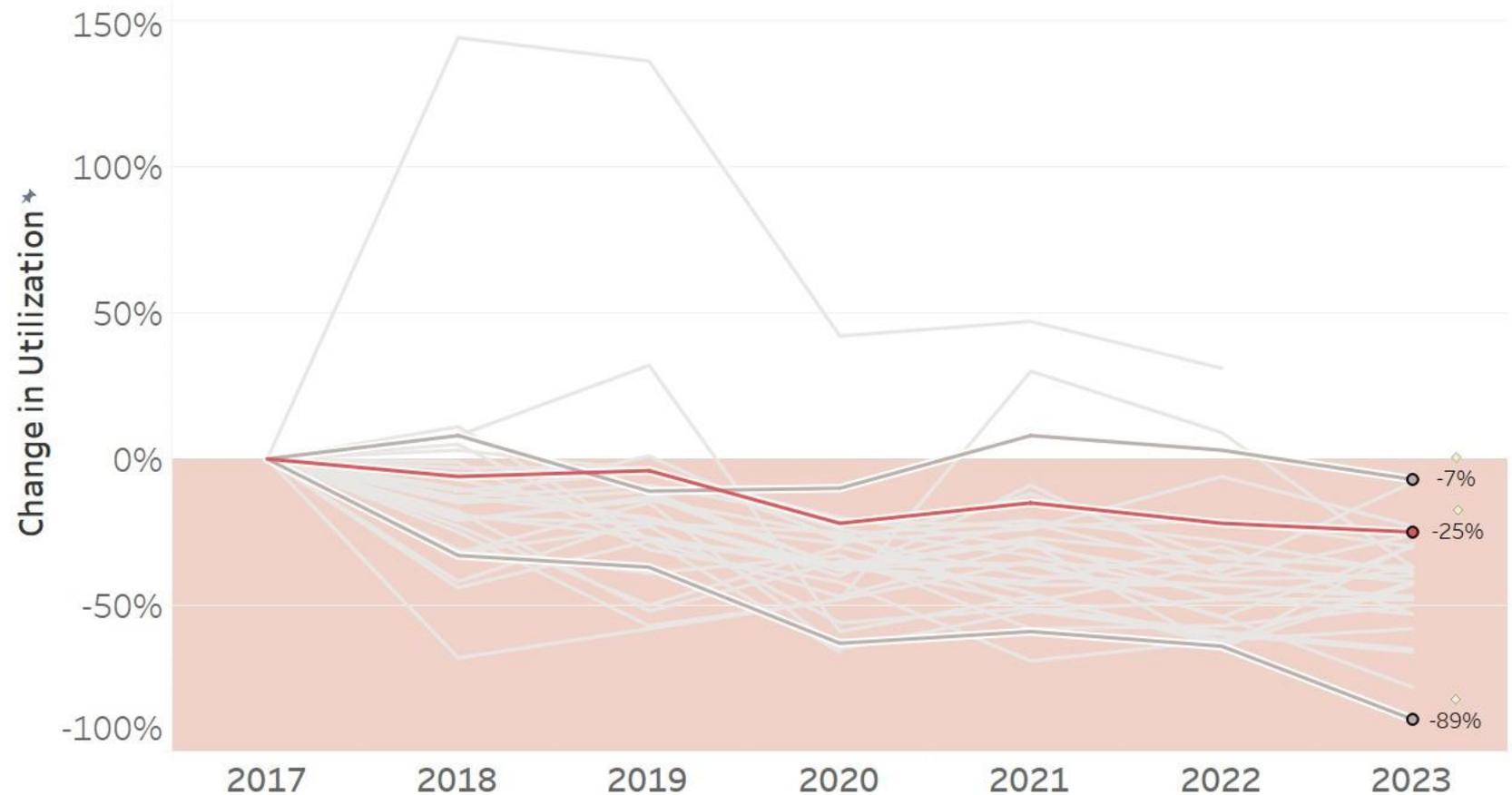
# Hospital commercial utilization for inpatient services has decreased, but there is variation

From 2017 to 2023 inpatient utilization decreased on average by 25%.

Utilization changes vary significantly from an 89% decrease at Houlton Regional to a 7% decrease at Eastern Maine Medical Center.

\*Data does not adjust for changes in services provided

Cummulative Change in **Inpatient** Utilization, 2017 - 2023



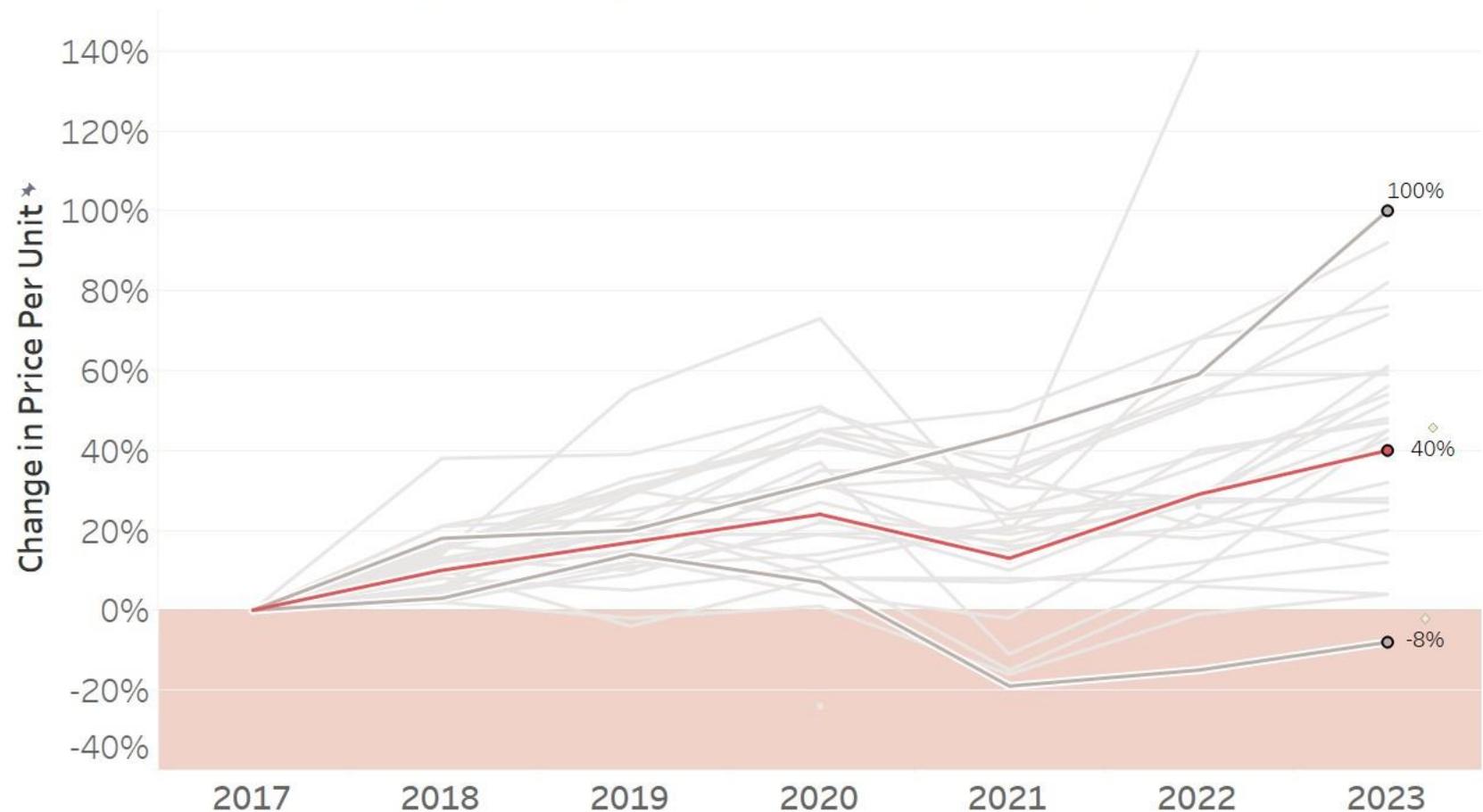
# Hospital commercial payments per unit for outpatient services have increased, but there is variation.

From 2017 to 2023 outpatient payments increased 40% per service. General U.S. inflation during this period was 24%.

Average payment per unit changes vary significantly from an 8% decrease at Houlton Regional Hospital to a 100% increase at Maine Medical Center.

\* Data does not adjust for changes in services provided

### Cummulative Change in Outpatient Price Per Unit, 2017 - 2023



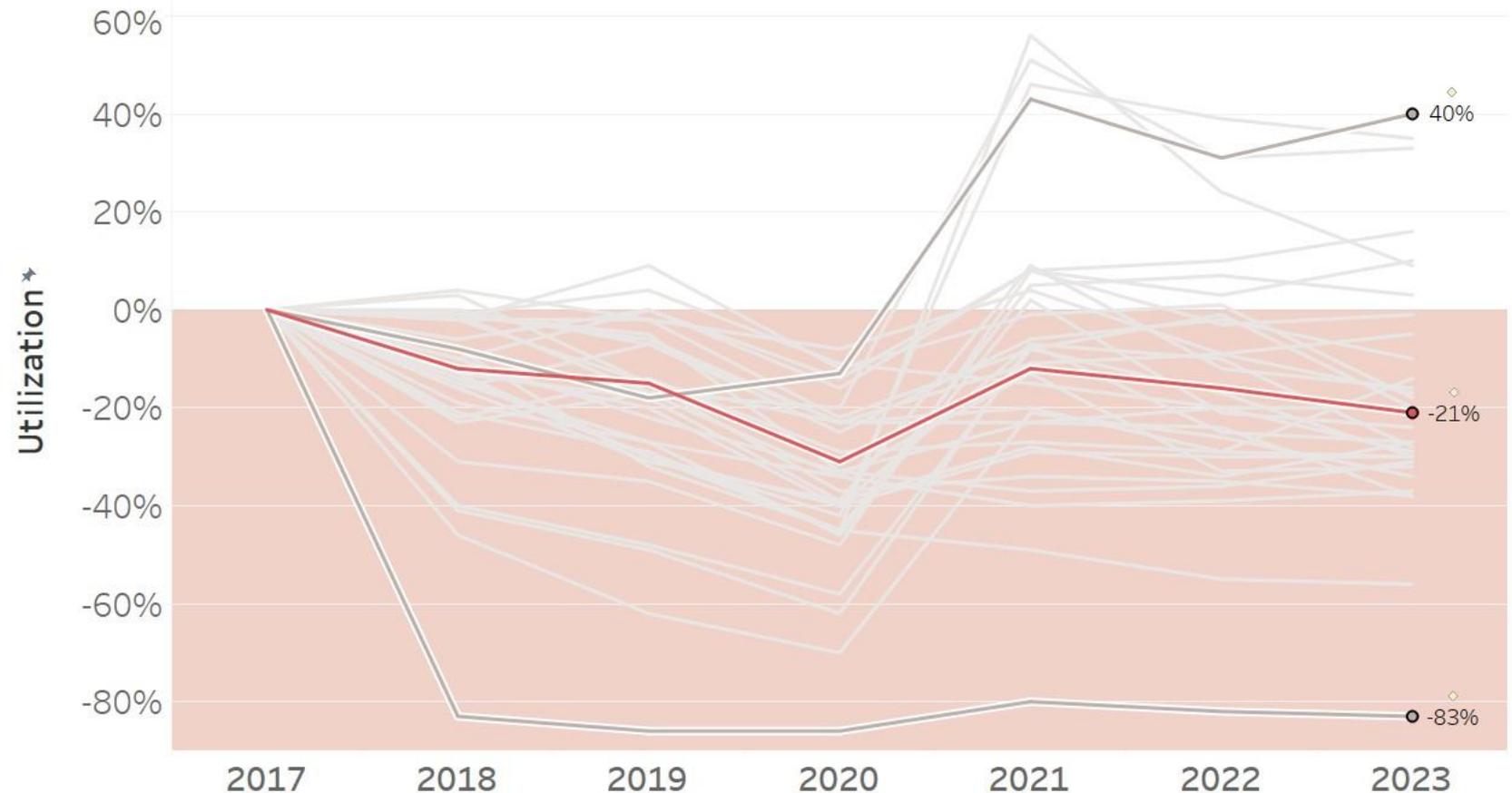
# Hospital commercial utilization for outpatient services has decreased, but there is variation

From 2017 to 2023 outpatient utilization decreased on average by 21%.

Utilization changes vary significantly from an 83% decrease at Pen Bay Hospital to a 40% increase at Bridgton Hospital.

\*Data does not adjust for changes in services provided

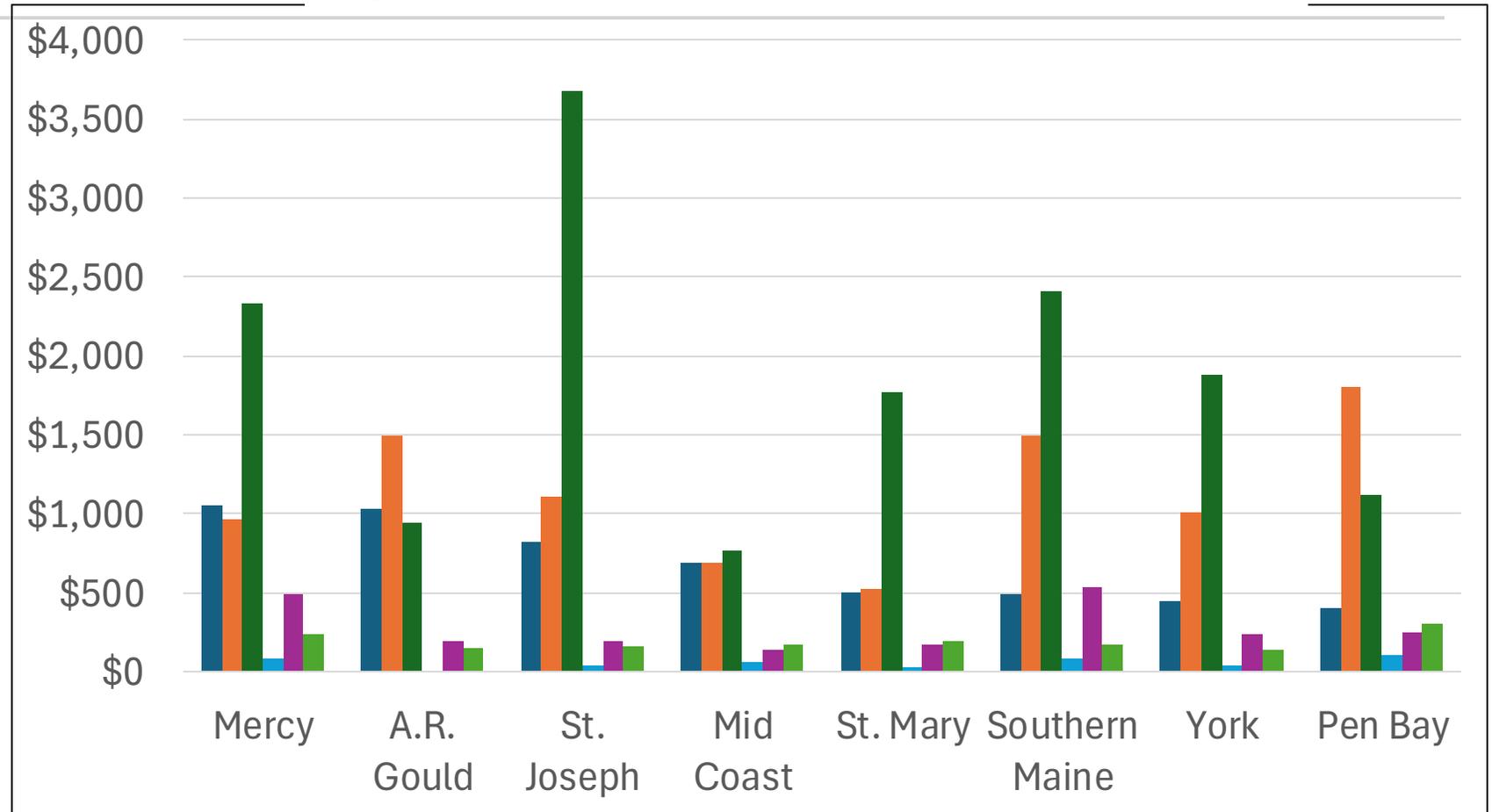
Cummulative Change in **Outpatient** Utilization, 2017 - 2023



# Service Payment Analysis - Commercial

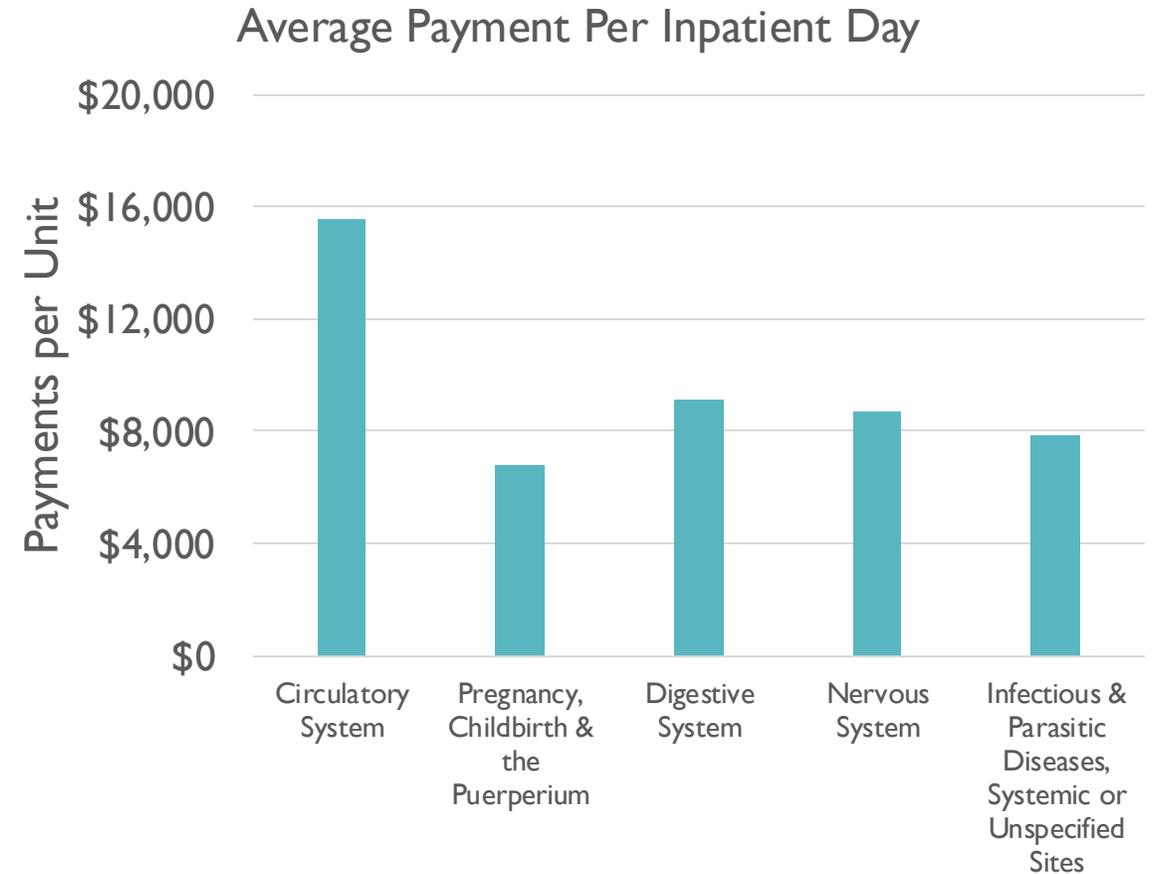
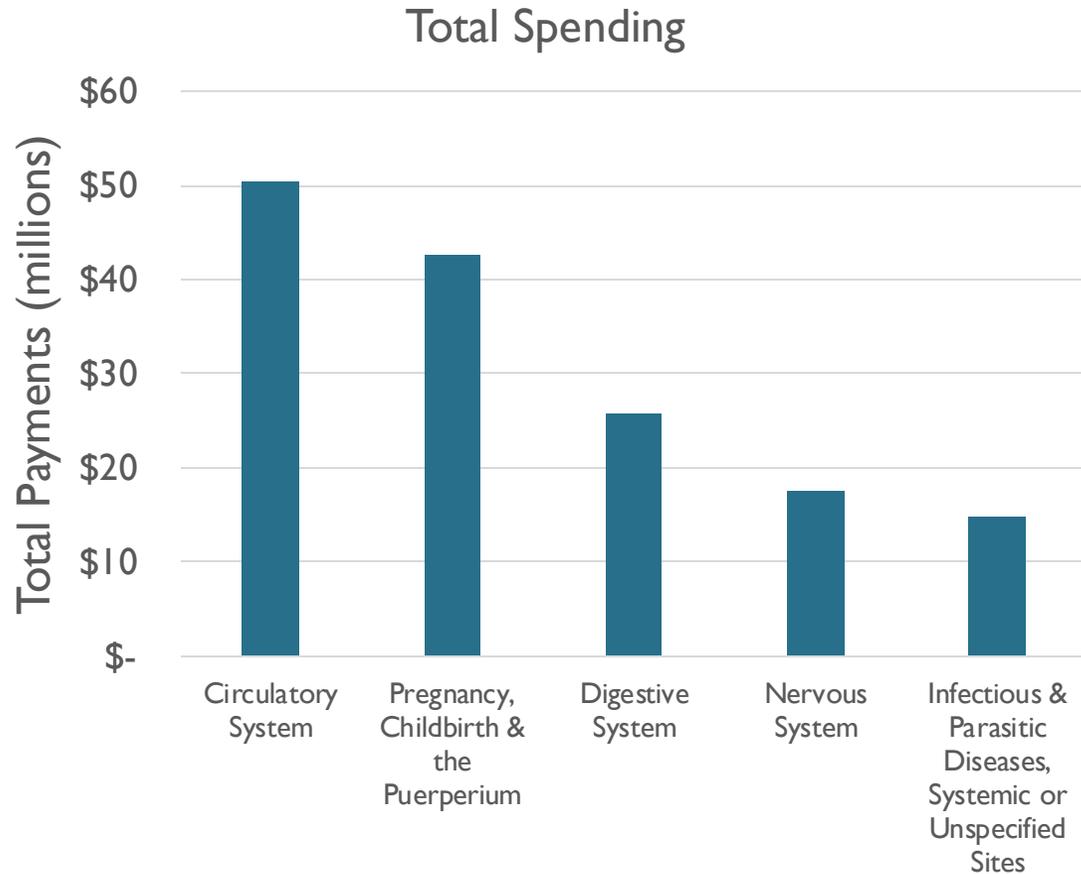
## Payment Variation for Select Services, 2023

To better understand how prices vary at hospitals for the same services, we can assess payments for common services at Peer Group B hospitals for 2023.



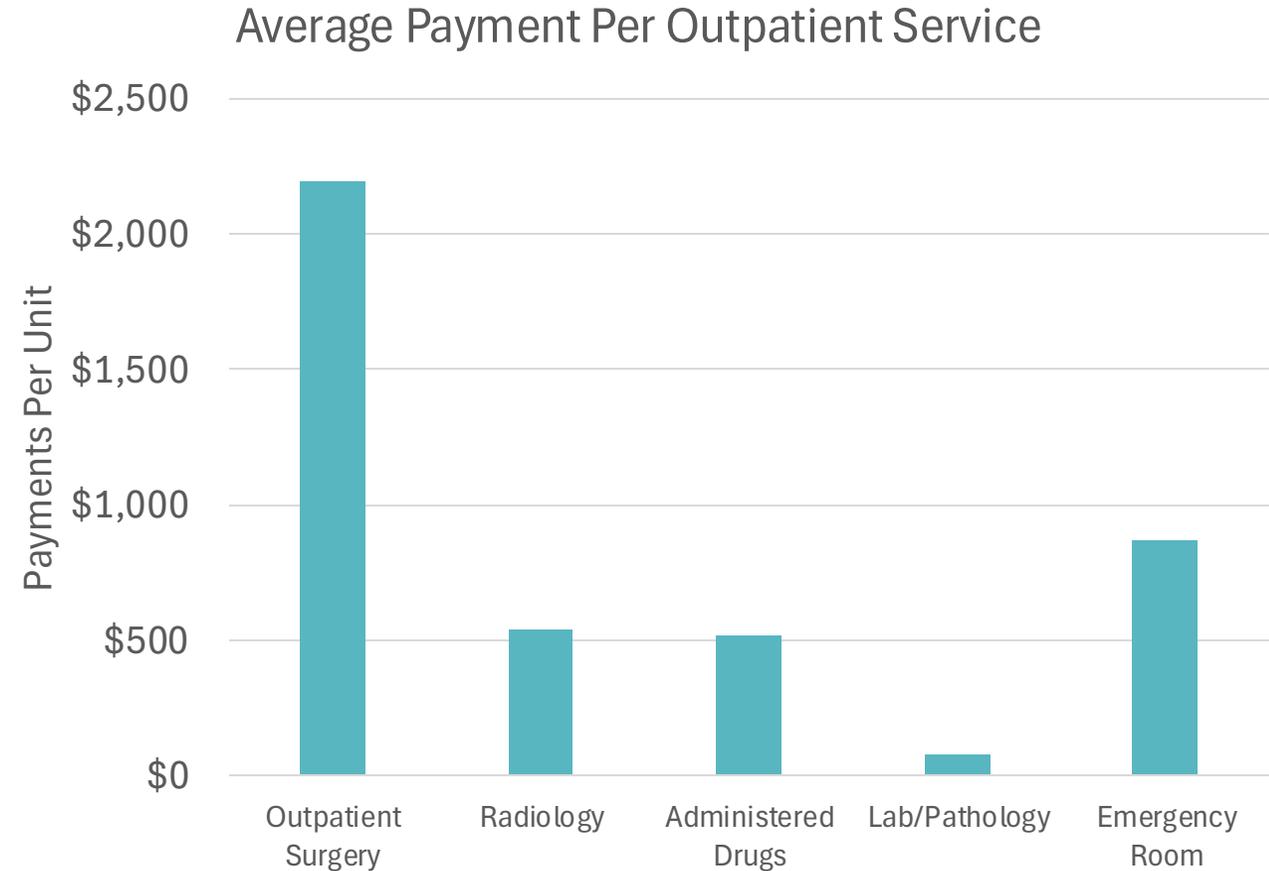
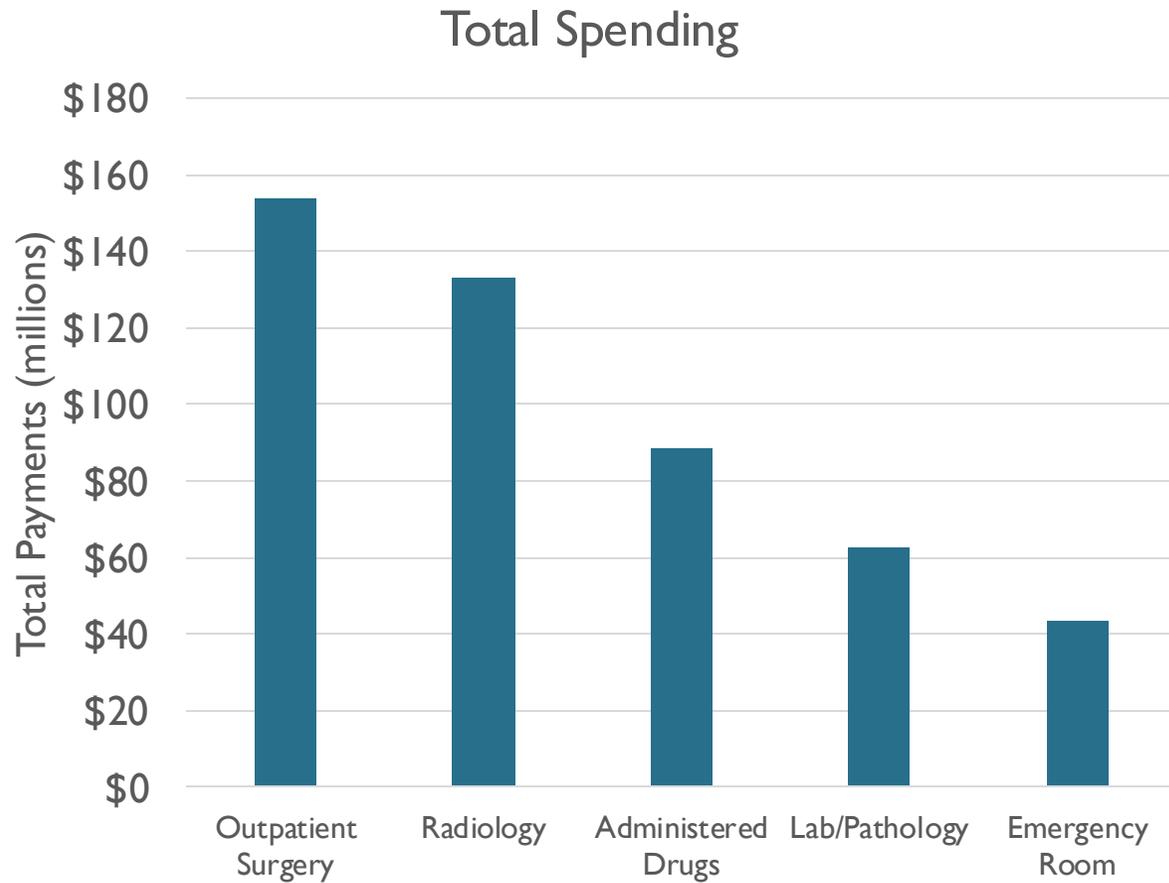
Source: Maine Health Data Organization. (2025). Facility Level Services Payments and Utilization Dashboard

# Common Hospital **Inpatient** Service Categories with High Commercial Payments, 2023



~16,000 inpatient days

# Common Hospital **Outpatient** Service Categories with High Commercial Payments, 2023



~1,300,000 outpatient services

# What's Next: Future Analyses

Complete

In Progress

Not Yet Started

## OAHC Claims Dashboards

## MHDO and MQF Reporting

## OAHC Non-claims Analyses

Health Expenditures Dashboards

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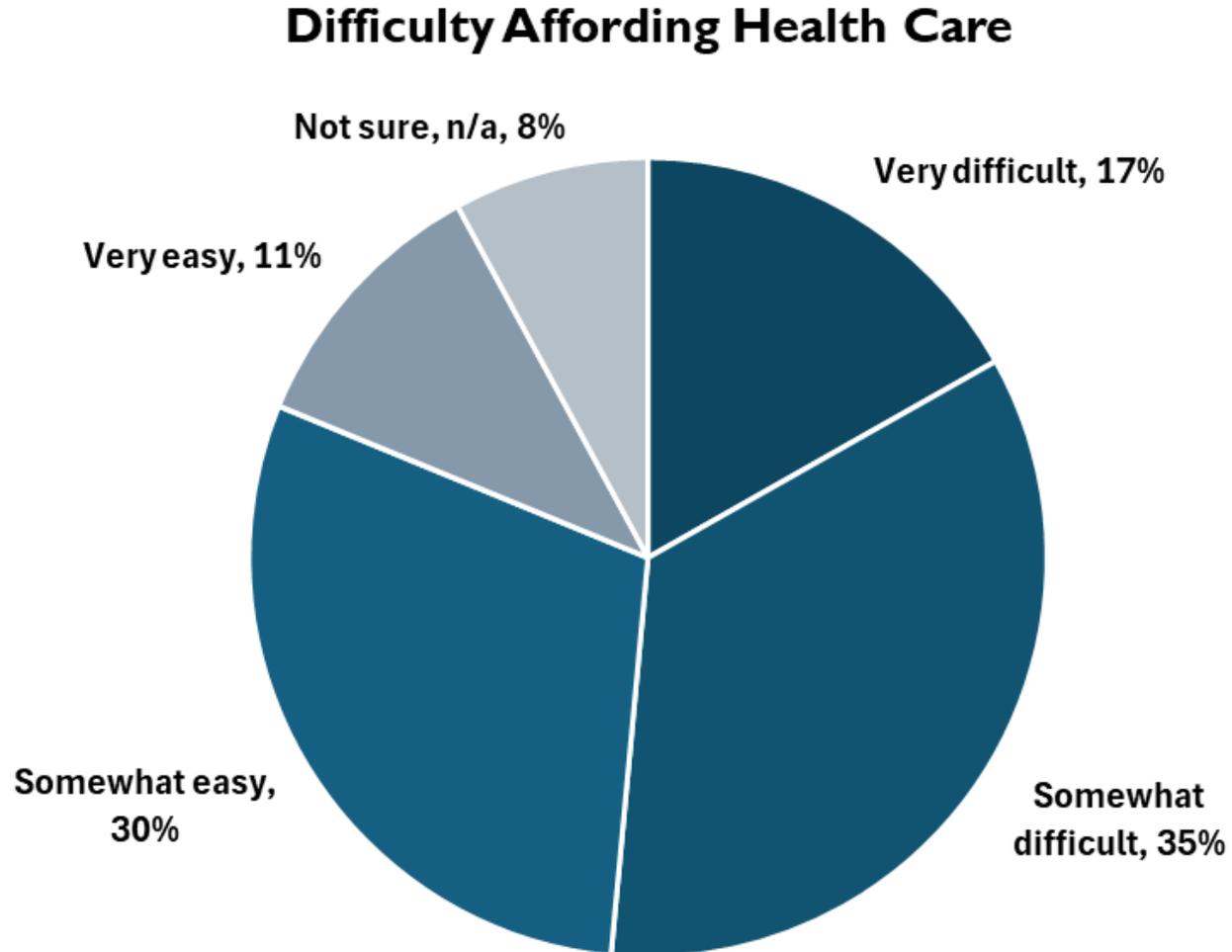


# Listening to Maine People

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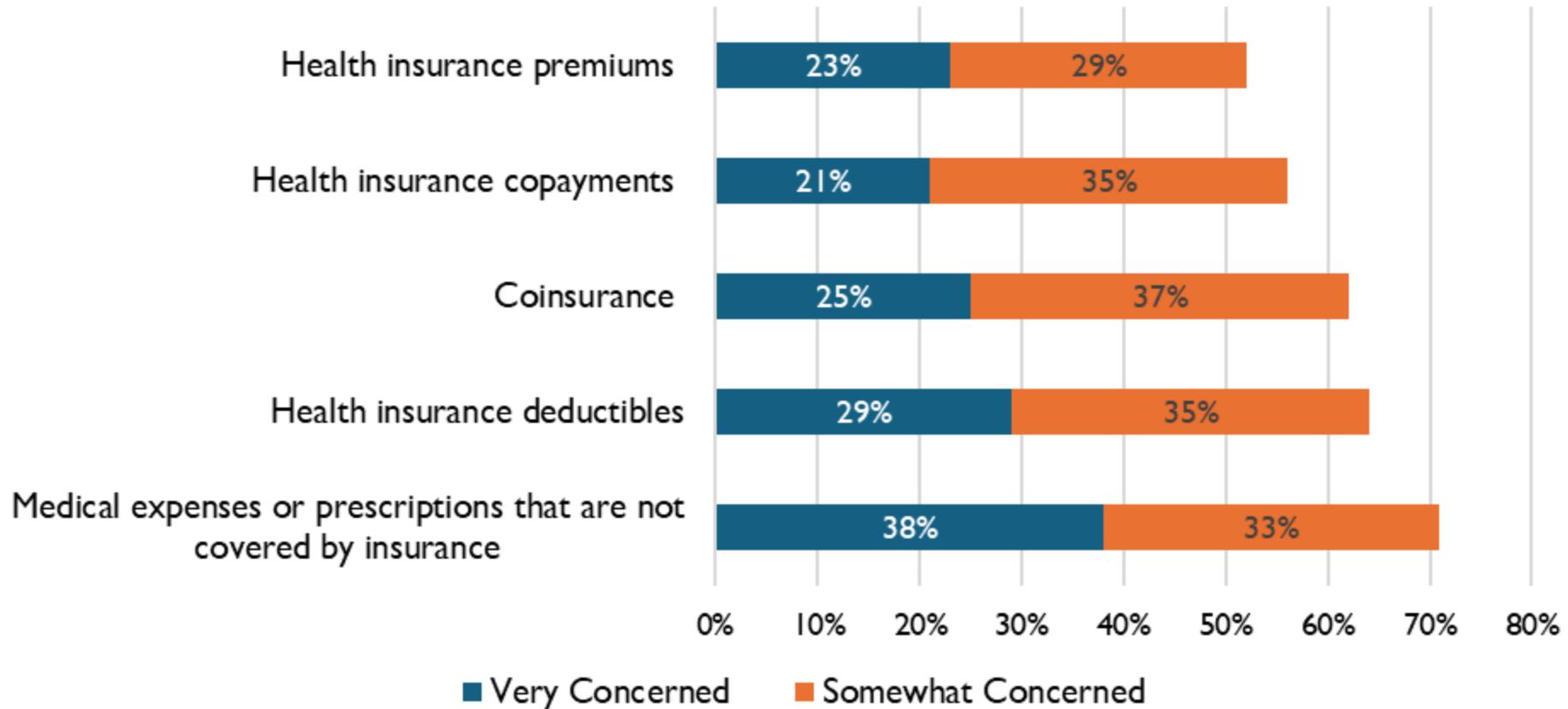


# Half of surveyed voters in Maine find it difficult to afford health care



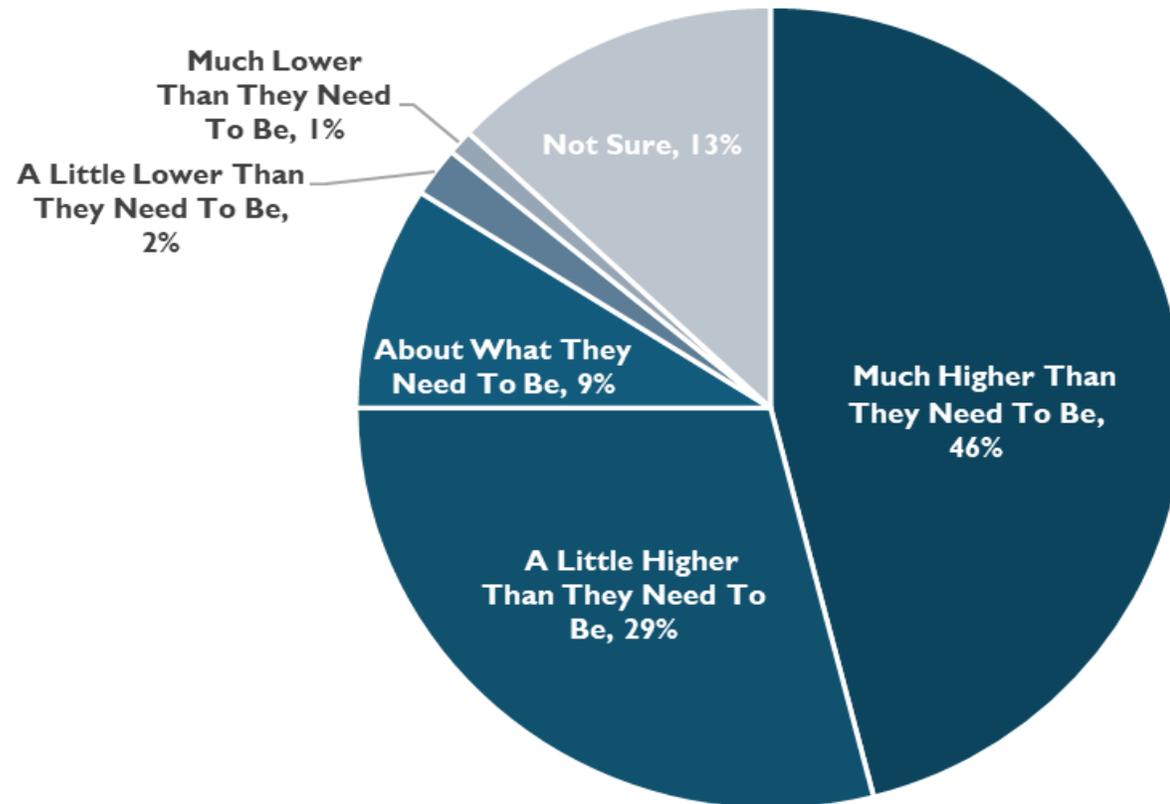
# Mainers are most concerned about out-of-pocket costs

## Concern about ability to afford medical costs



# Many Mainers believe health care costs in the state are higher than they need to be

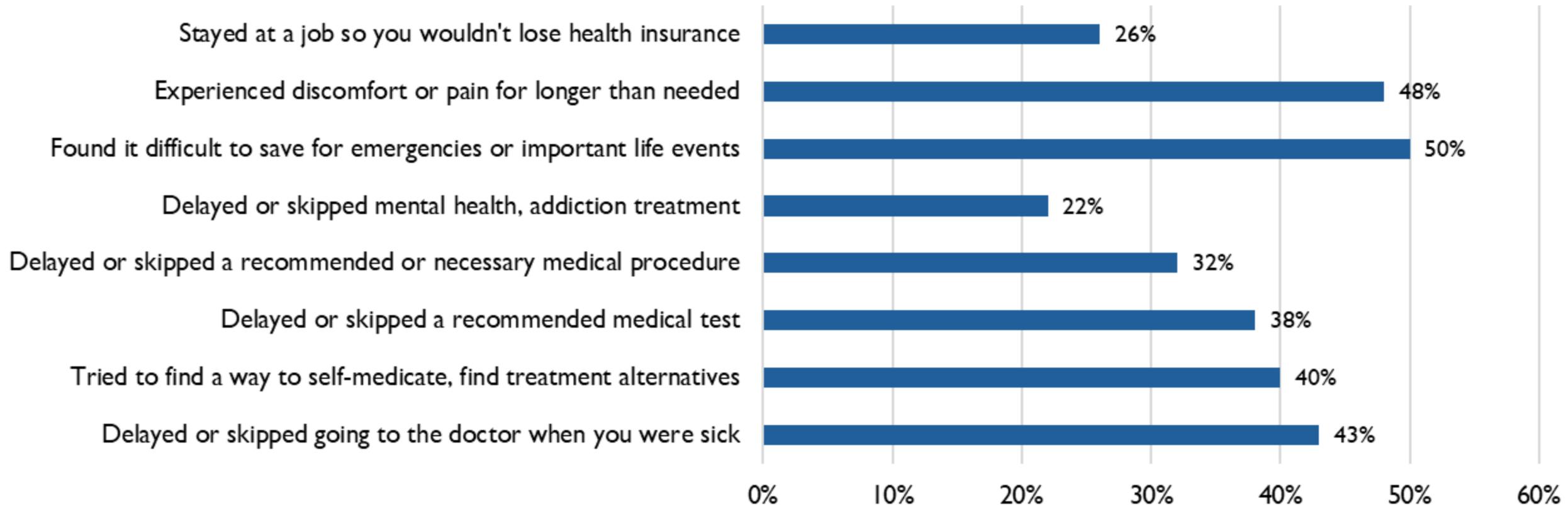
**Views Towards the Cost of Health Care**



# Mainers are experiencing reduced access to health care due to concerns about costs

## Actions Taken Due to Medical Costs

(Percentage who have taken actions due to concerns about costs)



# Listening Sessions Across the State

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To better understand Mainers' experiences with health care, the Office hosted a series of community listening sessions with consumers and employers in diverse communities across the state, traveling to the Lewiston Auburn area, Washington County, and Portland



# Consumer Voices from Washington County

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## Key findings:

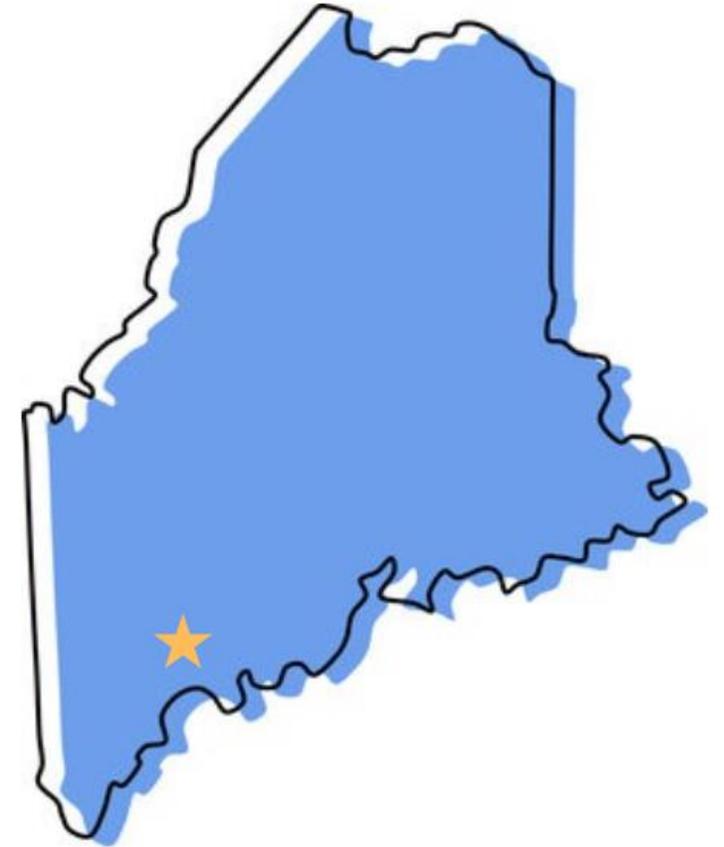
- Significant challenges accessing affordable health care. High costs, including premiums, deductibles, and prescription drugs were of high concern.
- Insurance carriers and pharmaceutical companies were highlighted, however there were concerns voiced about actors across the health care system.
- In particular, there was discussion of the difficulty of accessing timely care, especially for primary and mental health care.
- Participants expressed frustration with poor communication and inconsistent care experiences.



# Consumer Voices from Lewiston & Auburn

## Key findings:

- Affordability and accessibility challenges were consistently discussed. Some participants shared stories about delaying care due to cost.
- Several participants had experienced extremely long waits for specialty care.
- Socioeconomic status, education, and geography were identified as significant contributors to health disparities. Racial and ethnical disparities in both access and quality of care were also discussed.
- Participants highlighted the need for more mental health services.

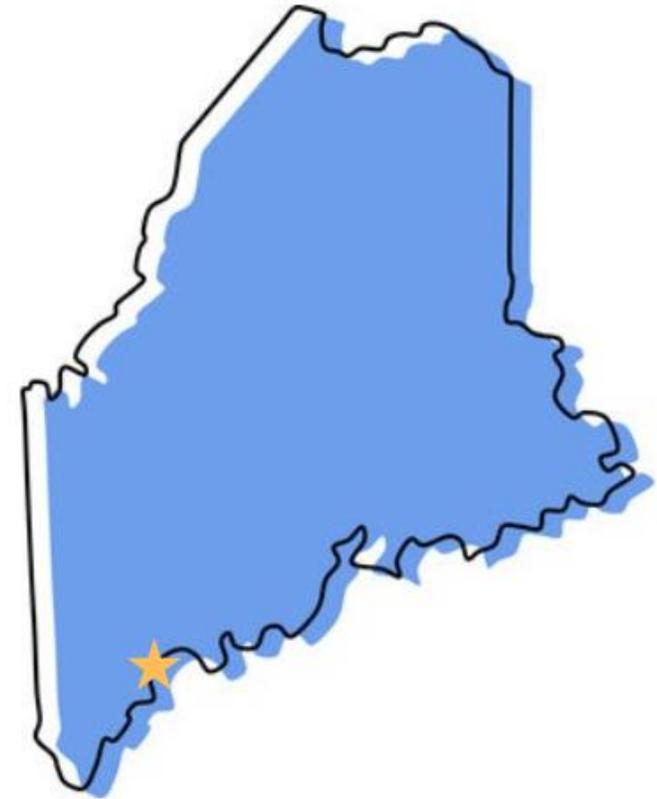


# Employer Voices

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## Key findings:

- Small and midsize employers are struggling with high health care costs.
- Employers bear a significant financial burden due to the disparity in pricing for similar procedures and increasing provider prices.
- Large health care systems play an outsized role in shaping access to and the cost of care.
- Access to primary care is a significant challenge
- Participants expressed concern that rising health care costs consume resources that would otherwise be used to hire additional employees or provide wage increases.



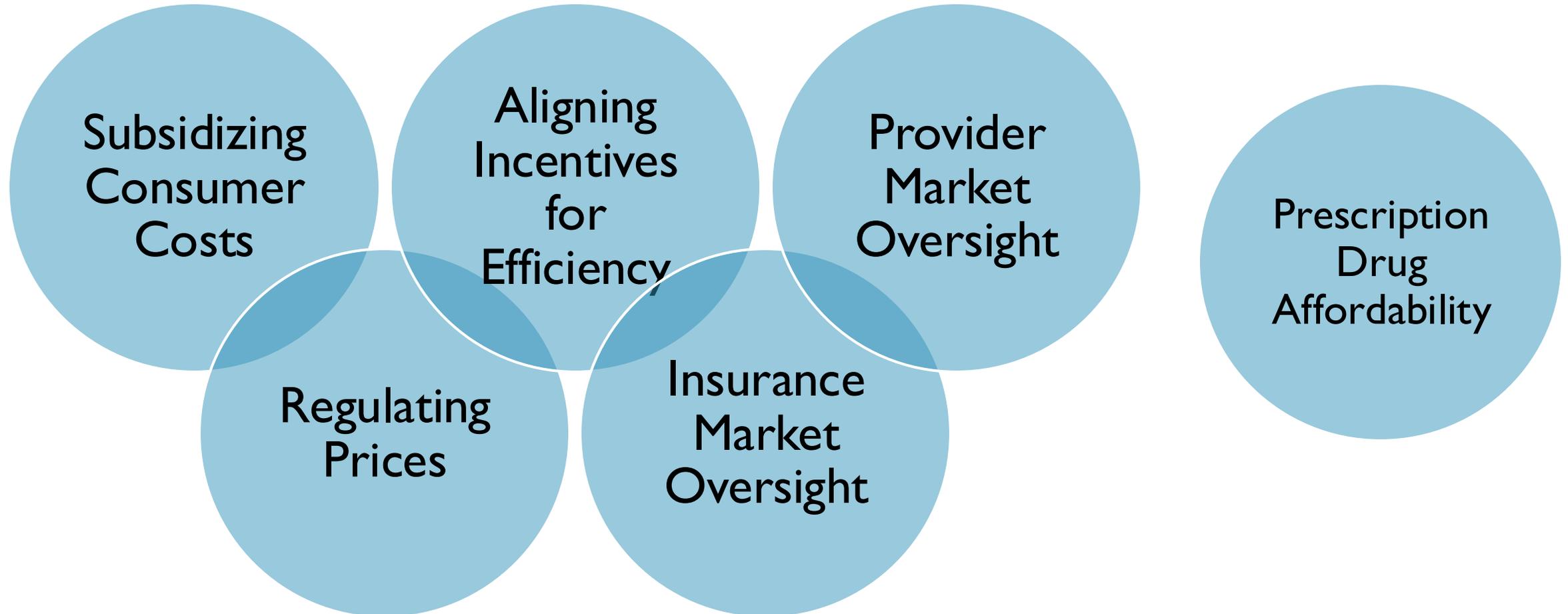


**Policy  
Priorities**

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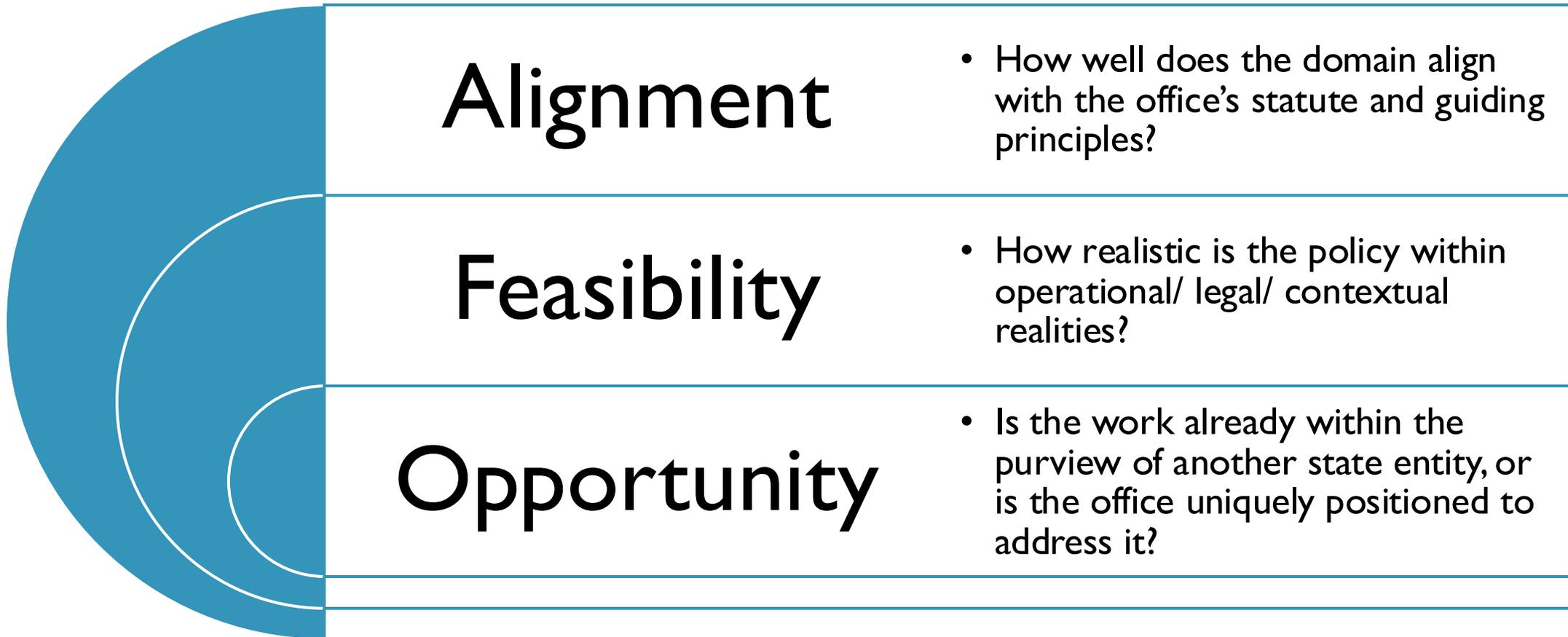
# Policy Domains Considered by OAHC

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# Framework for Assessing Policy Domains

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# Assessment of Policy Domains

Domain	Alignment	Feasibility	Opportunity
Subsidizing Consumer Costs	High opportunity for relief for a segment of consumers, does not address underlying costs	Anticipate identifying new revenue for subsidies or expansion would be a significant challenge	High level of coordination necessary regarding both revenue and coverage options
Regulating Prices	Opportunity for broad impact across markets, potential to redirect resources for greater efficiency	Requires an understanding of where and how savings can be achieved without impacting access or quality	Currently not within the purview of any other state agency
Aligning Incentives for Efficiency	Highly aligned in that initiatives could encompass affordability, quality, and efficiency	Anticipate that there could be alignment with existing stakeholder initiatives and ability to identify shared goals	While other agencies have expertise in this area, believe OAHC is well-positioned to be a broader convener
Insurance Market Oversight	Opportunity for intervention for a segment of the market, but reach is limited by federal preemption	Established structure for state authority, though there have been significant developments in the space recently	Bureau of Insurance has authority and expertise in this area
Provider Market Oversight	See particularly high alignment in considering how to protect against financialization of health care providers	Taking protective measures may be minimally disruptive, although the legal landscape for action is complex	DHHS has authority in this space, but some new market dynamics may not be a focus
Prescription Drug Affordability	Both acute affordability challenges for patients and concerning recent trends in overall spending across payers	Challenging for states to regulate because of the multi-party out-of-state supply chain	Bureau of Insurance has authority over PBMs; relationship to Prescription Drug Affordability Board

# Areas of Focus – Problem Statements

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**Provider Market Oversight and Competition:** Private equity (PE) investment in health care has grown dramatically in the U.S. over the last 10 years, and early evidence suggests that PE ownership of health care providers can lead to higher prices, staff reductions, and in some cases lower quality of care. While Maine has seen less PE activity in the health care sector than other parts of the country, protective action could be warranted given the significant impacts to access and quality experienced in other states.

**Regulating Commercial Prices for Health Services:** Increasing commercial prices for health care services are a driver of higher insurance premiums and out-of-pocket costs, which are widely cited by consumers as a barrier to accessing care and a growing financial burden on households and employers. Meanwhile, providers cite difficulty in financing key services, particularly primary care and behavioral health care, and recruiting and retaining physicians, nurses, and other staff.

**Aligning Incentives to Promote Efficiency and Quality:** There is general agreement that paying for health care on a traditional fee-for-service basis is not the best model to support efficient, high-quality, and patient-centered care. Payers and providers in Maine have made progress in introducing new models for payment and delivery of care, but fragmentation of the payer landscape and other operational challenges are a barrier to more significant transformation.

# LD 1972 – Market Oversight Efforts in the Legislature

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In the first regular session of the 132nd Legislature, the Office worked with Representative Sam Zager to introduce [LD 1972, An Act to Enhance Transparency and Value in Health Care Transactions](#). In its original form, the bill would have:

- Modernized the state's Certificate of Need (CON) program to provide a more comprehensive and consumer-oriented review of certain health care transactions
- Created a new Material Change Transaction review process, applying to a wider range of transactions than the current CON process, including closure of services, outsourcing of major hospital functions, and acquisitions of smaller health care entities

## **LD 1972 Status:**

- The bill was voted down by the Health Coverage, Insurance, and Financial Services committee
- Themes explored in the bill and public hearing led to the establishment of a 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 (through the passage of [LD 1578](#))

# Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions

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The Commission is comprised of 15 members, including legislators, hospital representatives, consumer and employer advocates, providers, insurance carriers, the Office of Affordable Health Care, and others.

The group is tasked with evaluating:

- Potential changes to the State's Certificate of Need laws
- Potential legislative changes to require regulatory review and oversight of substantial health care transactions
- The role of a private equity company or real estate investment trust taking a direct or indirect ownership or financial control of a hospital in the State

The Commission will convene for its first meeting on Wednesday, October 8th at 10:00 am. More information can be found on the [website for the Commission](#) maintained by the Legislature.

# Cost containment policies of focus

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Recognizing the role that prices paid for health care services contribute to both household health spending and system-wide spending, states are increasingly beginning to consider programs to monitor and exert direct or indirect downward pressure on provider prices, such as:

Cost growth  
target  
programs

Reference-  
based pricing  
in state  
employee  
programs

Price caps in  
public option  
plans

# Examples from other states

Policy	State Examples
<b>Cost growth target programs</b>	MA, RI, CA, CT, DE, NJ, WA, OR, NV <ul style="list-style-type: none"><li>Notable program: Massachusetts' program, established in 2013, includes a statewide cost growth target and establishes accountability for meeting that target across broad sectors (hospitals, carriers, etc.)</li></ul>
<b>Reference-based pricing in state employee program</b>	OR, WA <ul style="list-style-type: none"><li>Notable program: Oregon established hospital price caps in their SEHP in 2017. The program generated an estimated <b>\$107.5 million</b> (or 4% of total plan spending) in savings to the SEHP during its first two years of operation.</li></ul>
<b>Price caps in public option plans</b>	CO, WA <ul style="list-style-type: none"><li>Notable program: Carriers offering a public option plan in Colorado must meet premium rate reduction targets statewide. If they fail to do so, the Department of Insurance is authorized to set hospital and provider rates at no less than 165% or 135% of Medicare rates, respectively</li></ul>



# Public Comment

Reminder: written comments will be accepted through **Friday, October 10<sup>th</sup>**

To submit, visit:

[Annual Public Hearing | Office of Affordable Health Care](#)