



Office of Affordable Health Care

2026 Public Hearing - September 23, 2026



Office of Affordable Health Care

Overview



About the Office

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

- **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 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



OAHC Analysis Planning

Complete

In Progress

Not Yet Started

OAHC Claims Dashboards

Health Expenditures Dashboards

Hospital
Payment and
Utilization
Dashboards

Professional
Services
Payment and
Utilization

Facility Level
Payment and
Utilization

Cost Driver
Deep-Dives

MHDO and MQF Reporting

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

OAHC Non-claims Analyses

Household Spending on
Health Care

Access and Equity
Dashboards

Quality Metric
Dashboards

Provider Cost Analysis

In Progress Analyses Updates

Analysis	Updates	Next Steps
Cost Driver Deep Dive	Analyzing aggregate hospital payments and utilization dashboards to identify any trends in spending drivers by service category.	Produce analysis from the hospital dashboards in the coming months.
Provider Cost Analysis	- Assessed data sources in this space, with limited success. - Identified opportunity to expand granularity of MHDO hospital financial reporting on operational expenses to improve data analysis capabilities.	MHDO adopted new rulemaking for Chapter 300 reporting. Waiting on the first round of data collection.
Quality Metric Dashboards	- Working with Maine Quality Forum and partners from other states to determine the best approach for analyzing state-level quality. - Established scope of work for a fellow to analyze other state initiatives to inform planning	Produce recommended next steps and approach by end of year 2026.
Access and Equity Dashboards	- Assessed data sources in this space with limited success. - Gained access to Maine BRFSS data.	Working to scope out approach to reporting.

Next Phase of Analyses

- Met with Advisory Council in September and discussed possible areas of focus for next analyses.
- Working to investigate feasibility of topics of interest.
- Identifying partners who are doing similar work to avoid duplicative work streams.



Payments and Utilization Dashboards

Maine.gov

Agencies | Online Services | Help | Search Maine.gov



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Office of Affordable
Health Care

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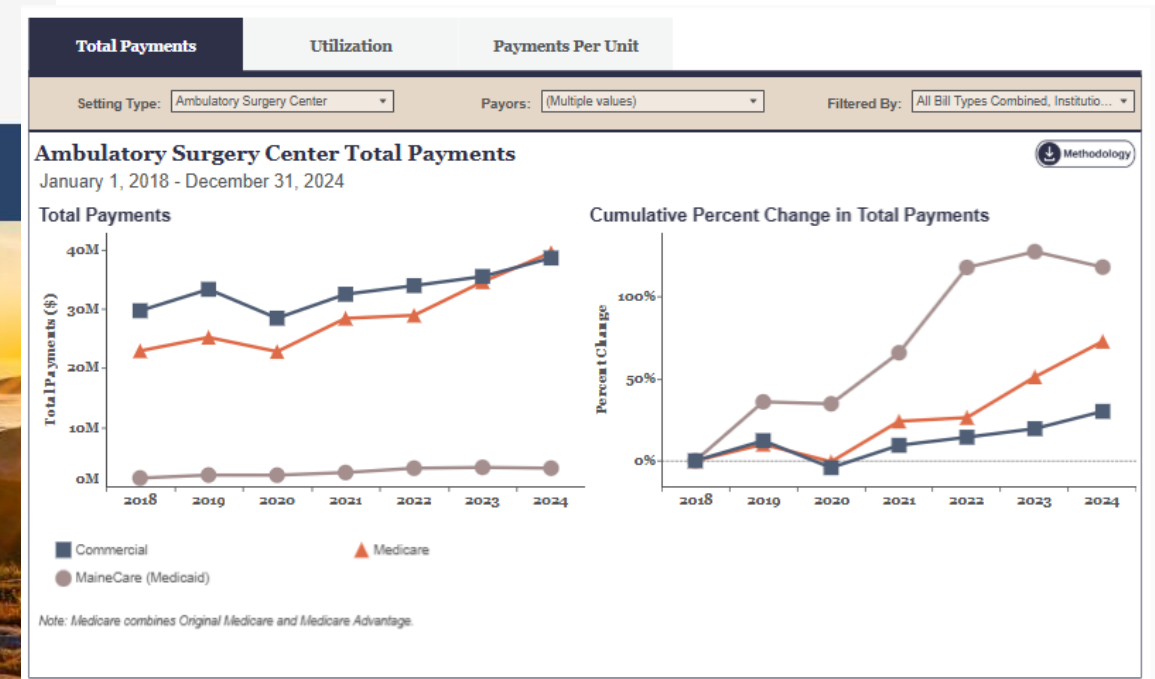
Public Hearing

Aggregate Hospital
Payments
Dashboards

Facility and Service
Level Payment
Dashboards

Non-Hospital
Services Dashboards

Welcome to the Office of
Affordable Health Care Website





Payments and Utilization Dashboards – *new Non-Hospital Setting Data*



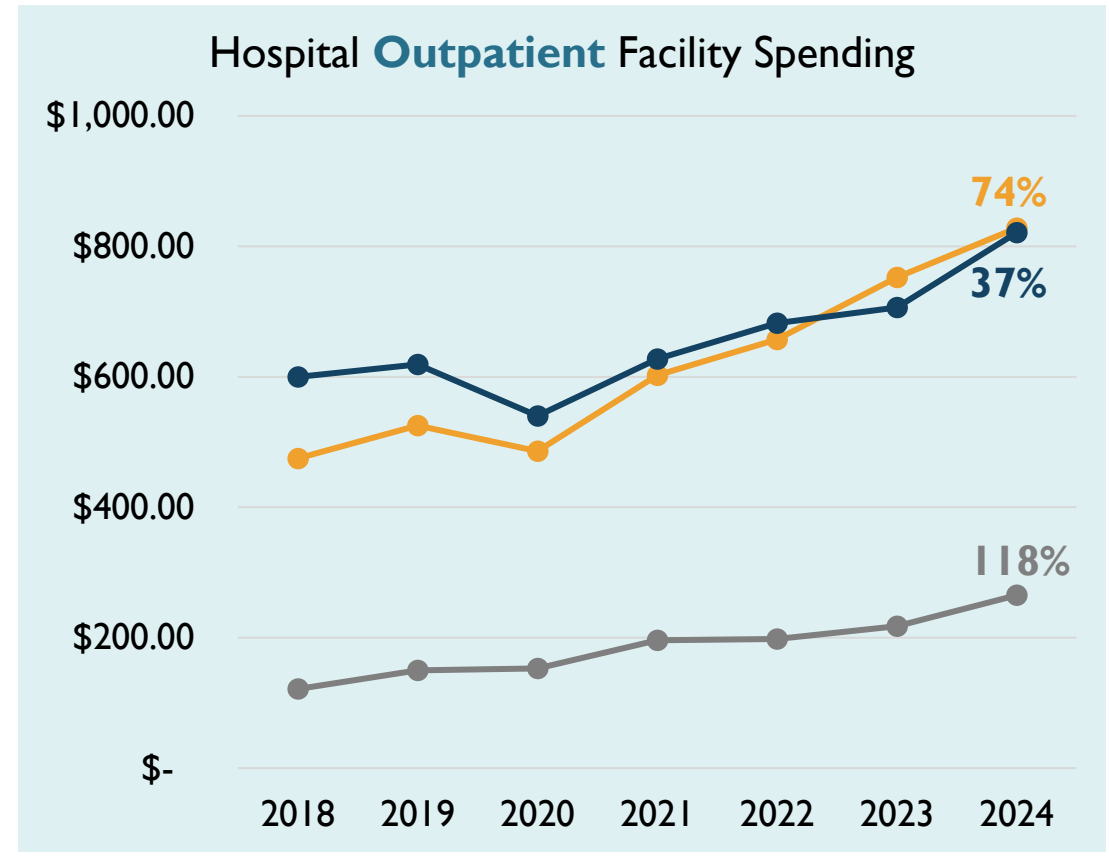
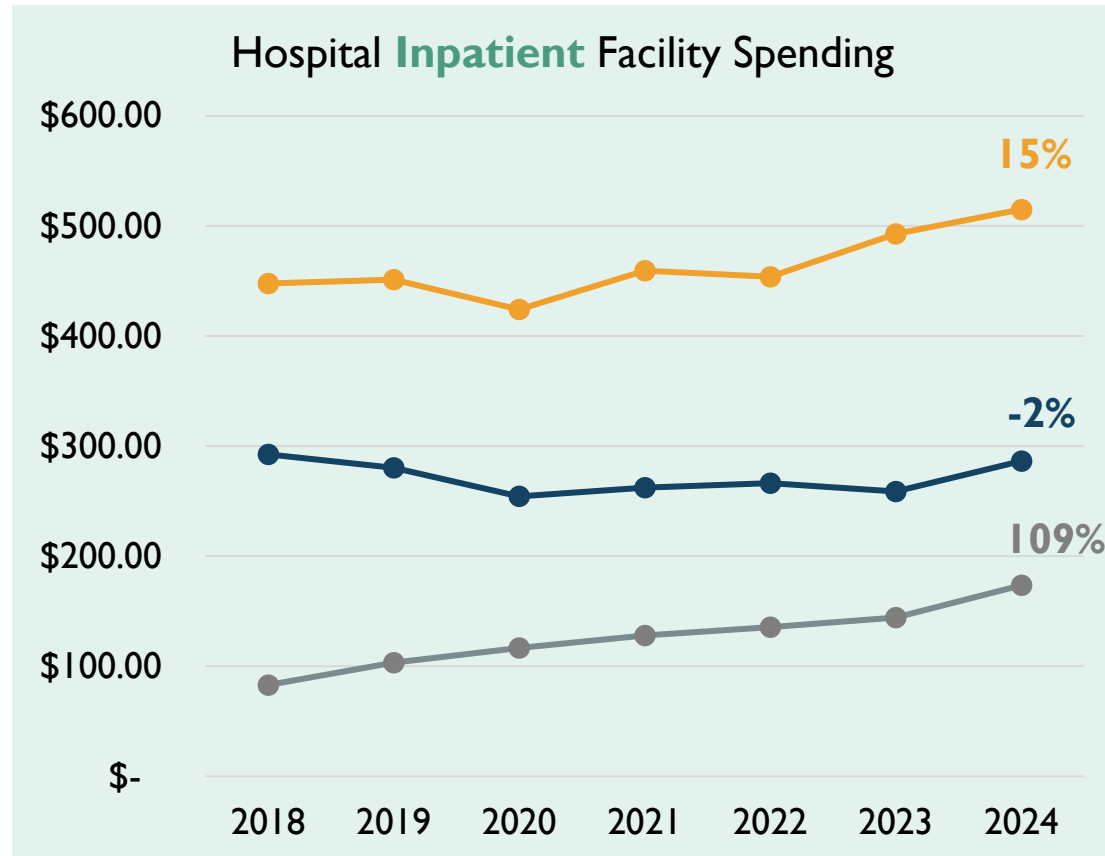
Payments and Utilization Dashboards

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.
- The data includes 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.

Updated Data Years '23 and '24 shows total spending continues to increase

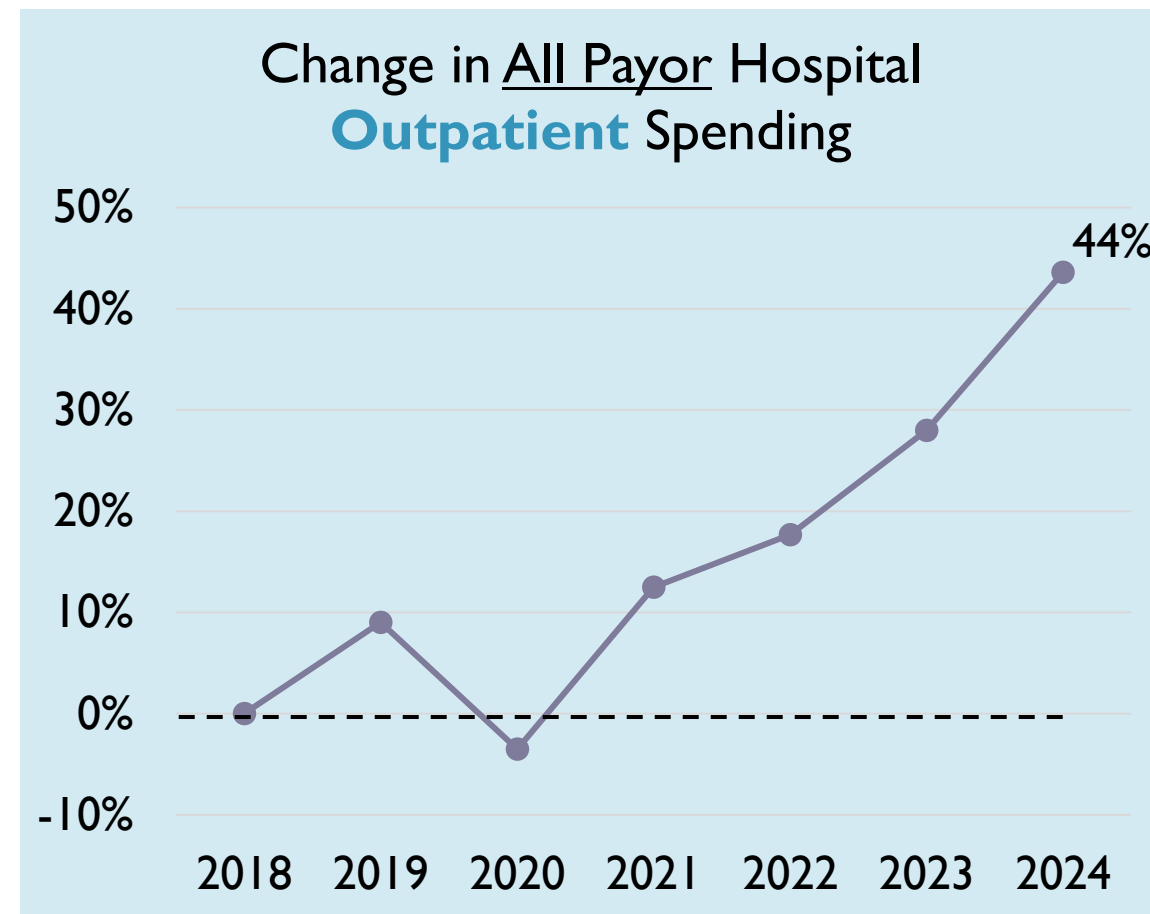
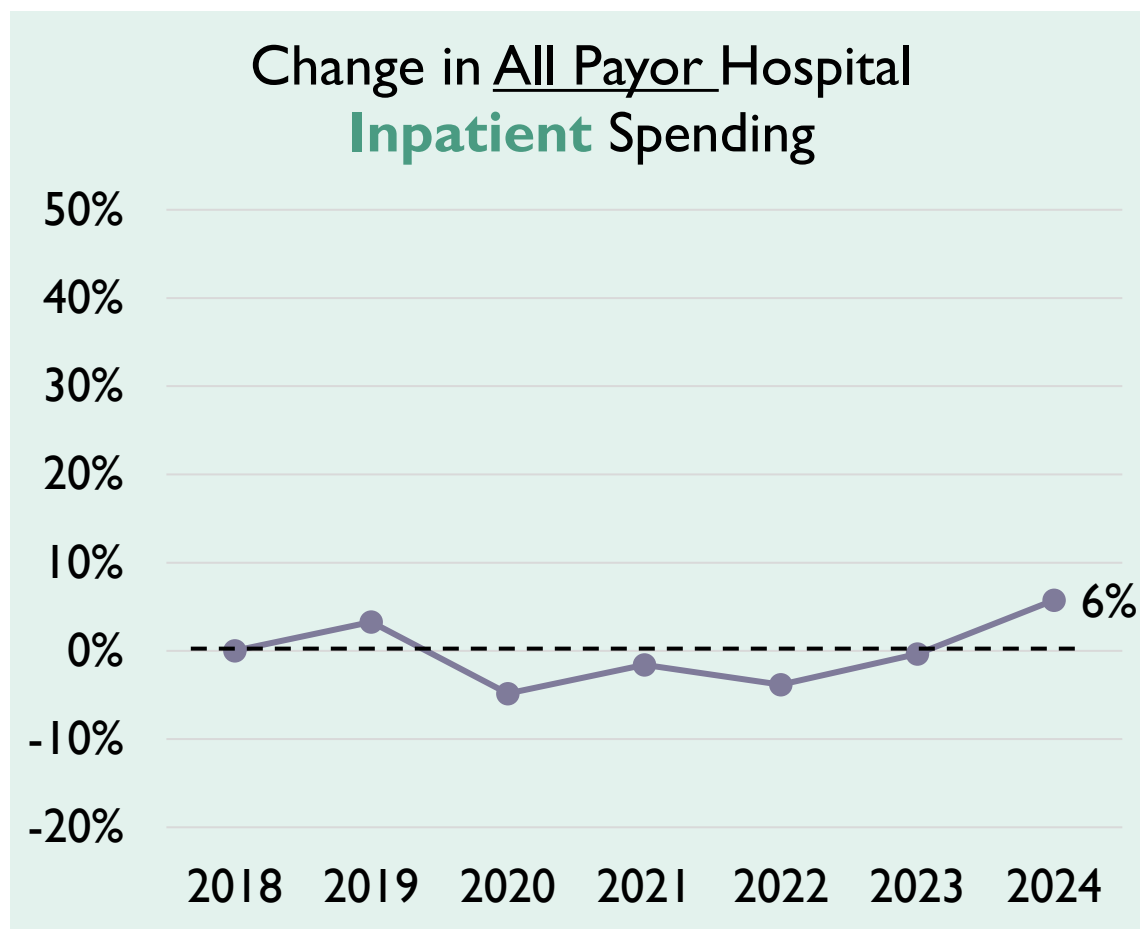
- Health care spending on hospital services continues to rise, especially in the outpatient setting.
- Slight decline in spending in the commercial inpatient hospital setting.



RECAP: Health care spending depends on use and price

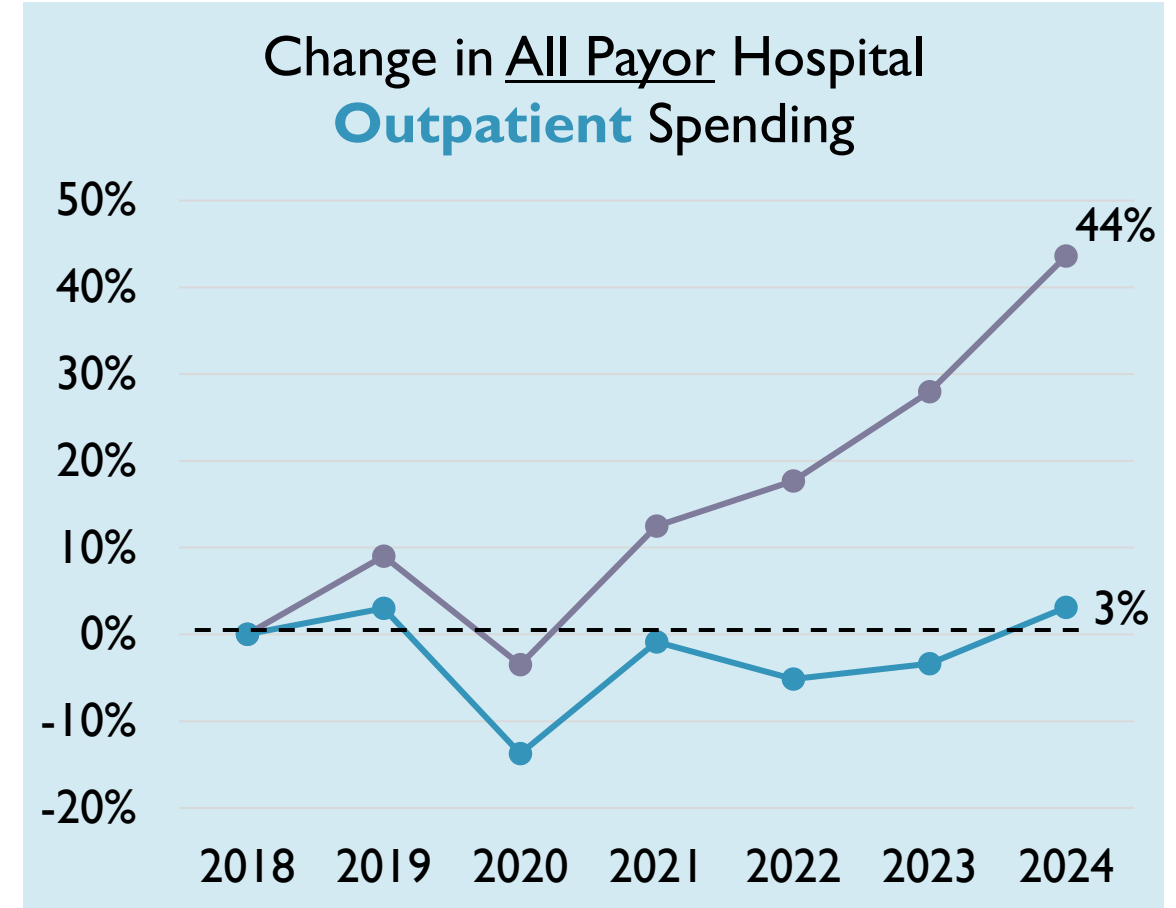
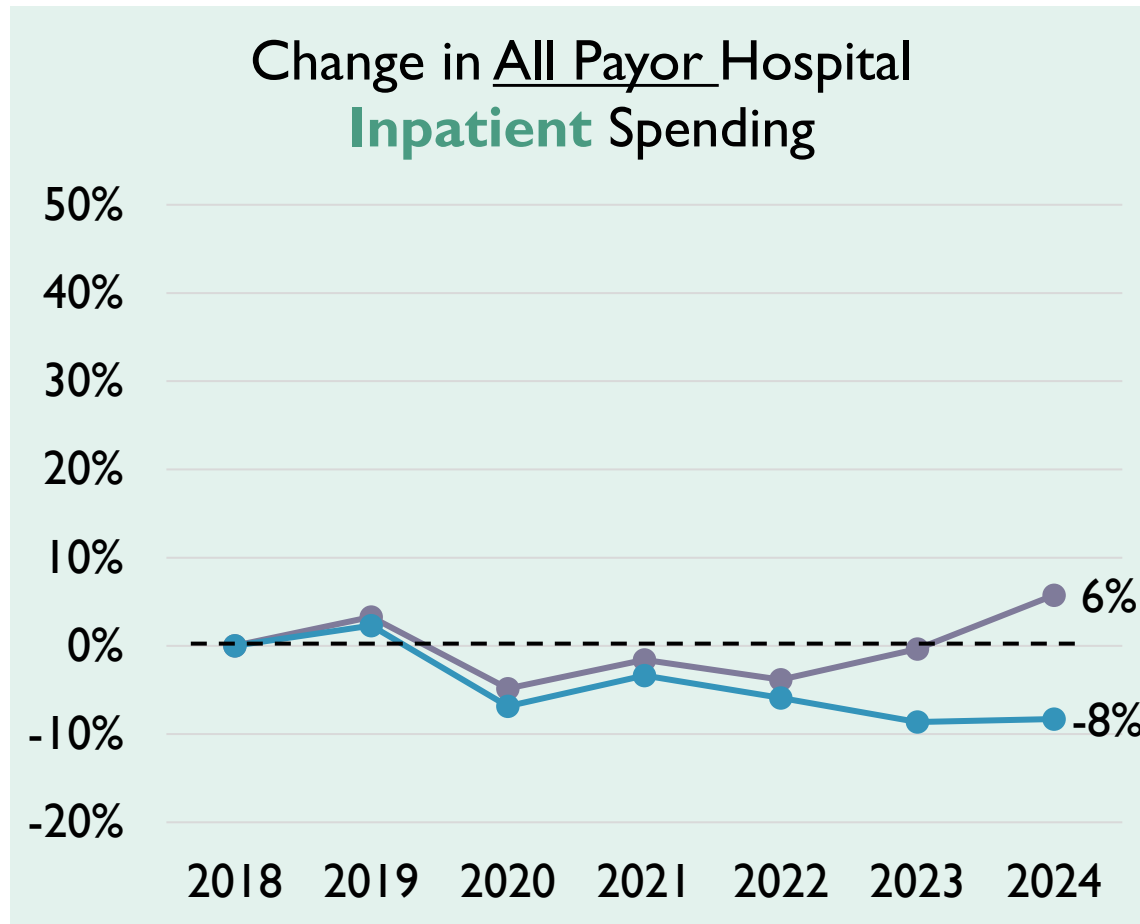


Updated years '23 and '24 show payments per capita continue to rise in outpatient hospital setting



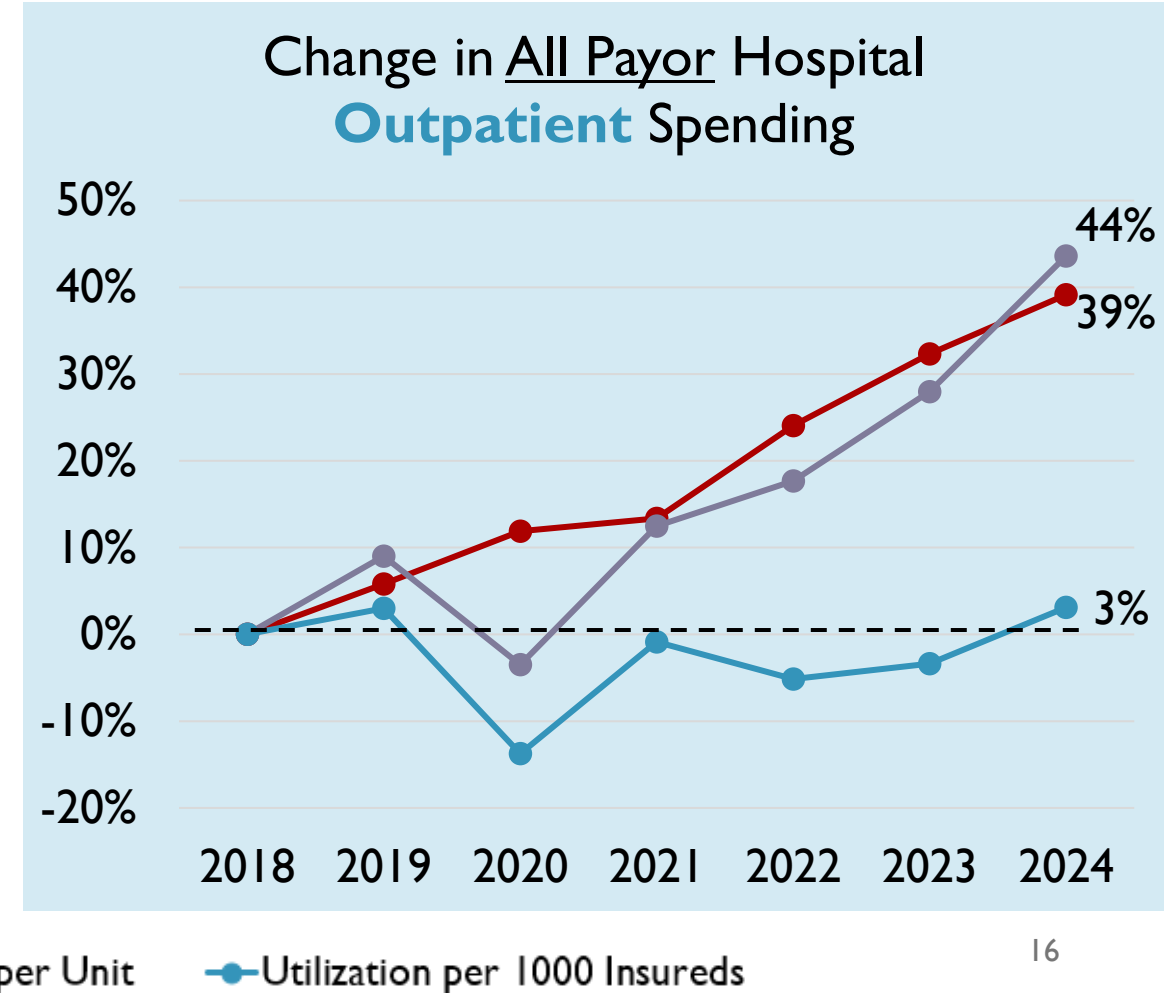
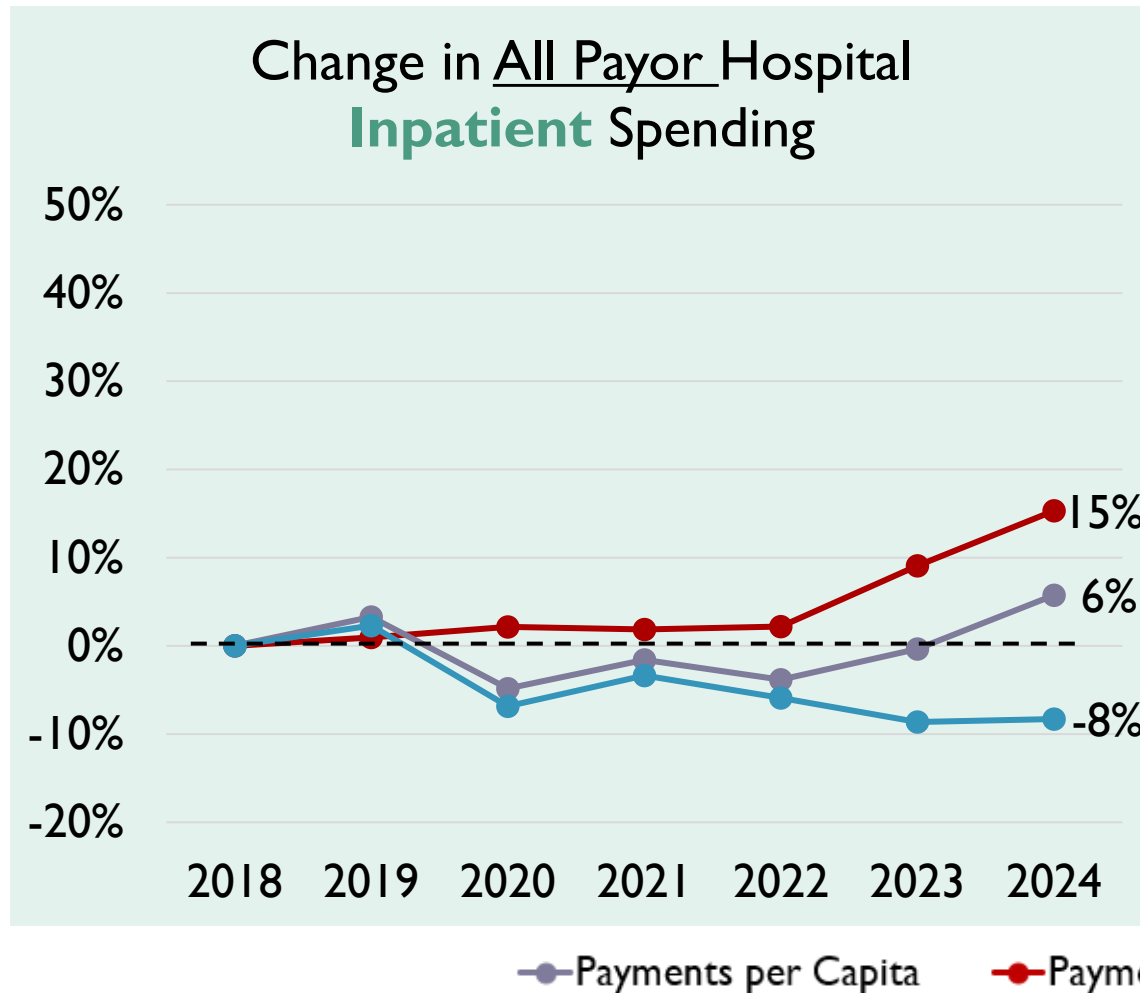
Updated Data Years '23 and '24 shows prices still drive spending in the hospital setting

- Prices, not utilization drive health care spending in the hospital setting for all payors combined.



Updated Data Years '23 and '24 shows prices still drive spending in the hospital setting

- Prices, not utilization drive health care spending in the hospital setting for all payors combined.



How do these trends look in the non-hospital setting?

New work product from the office – non-hospital dashboards!

Non-hospital setting types: Office visits outside of the hospital, ambulatory surgical centers, urgent care centers, federally qualified health centers, and independent laboratories.

Looking at spending, price, and utilization in the non-hospital setting can help us understand

- How has spending changed in non-hospital settings?
- What drives spending changes in these settings – prices or utilization?

Non-Hospital Payment and Utilization Dashboards

Overview: Working with MHDO, this year we created dashboards to measure payments and utilization across non-hospital settings in Maine.

Purpose: To identify and describe variation in payments and utilization across non-hospital settings in Maine.

Metrics: For each non-hospital setting type we will report -

- Total payments by payor and bill type (institutional and professional)
- Payments per unit by payor and bill type (institutional and professional)
- Utilization by payor and bill type (institutional and professional)

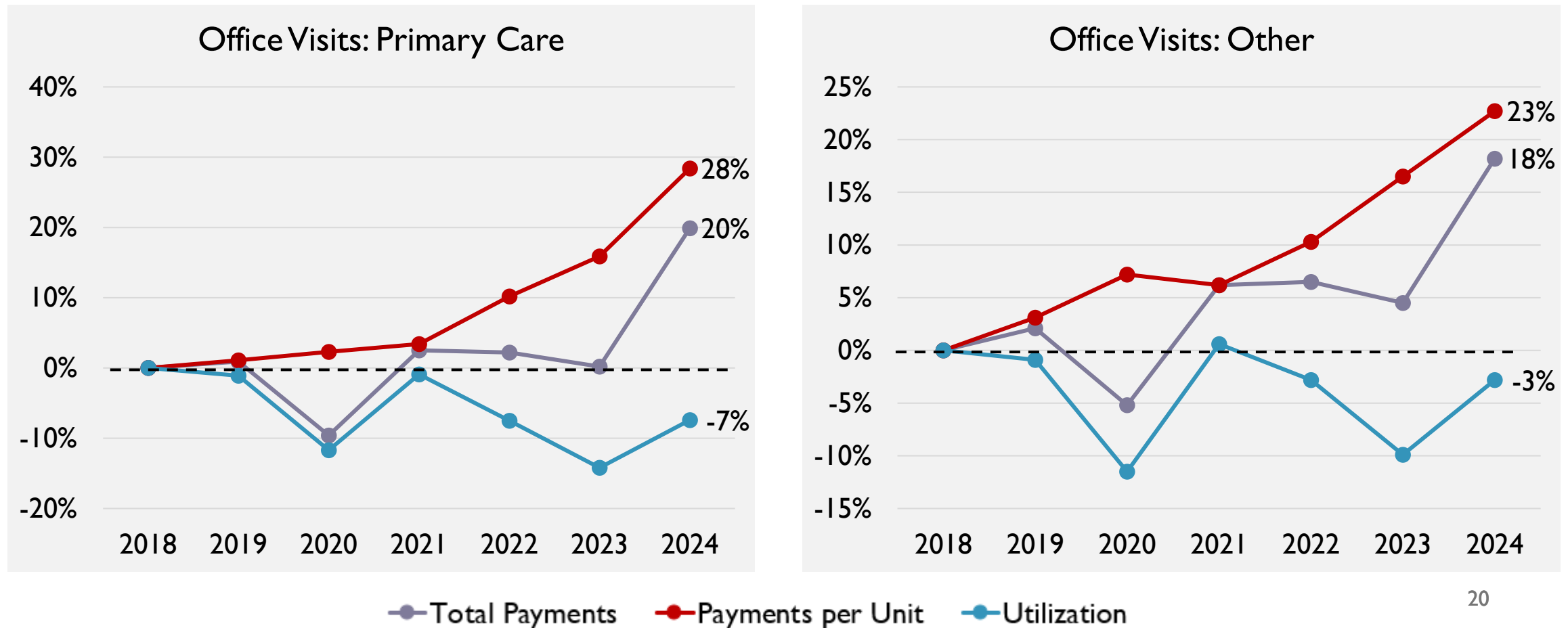
Data Source: MHDO All Payor-Claims Database, January 2018 - December 2024

Review of Non-Hospital Setting Dashboards

Non-Hospital Setting Type	Description
Federally Qualified Health Center (FQHC)	Community-based health centers that provides primary and preventive care to underserved populations.
Independent Laboratory	Facilities that provide laboratory services and are free-standing laboratories that are not owned or operated by a hospital.
Urgent Care Facility	Facilities distinct from a hospital emergency room or physician's office that provide immediate medical attention for unscheduled, ambulatory patients that need to be treated within 12-24 hours to avoid an emergency.
Office: Primary Care	Primary care services from individual and organization providers. May include providers who are affiliated with Maine hospitals and health systems. <i>Does not include services from other identified non-hospital setting types (e.g. FQHC) for the purposes of this analysis.</i>
Office: Other	All services provided in an office setting that are not primary care services. <i>Does not include services from other identified non-hospital setting types (e.g. FQHC) for the purposes of this analysis.</i>
Ambulatory Surgical Center (ASC)	Facilities that provide surgical services to patients who do not require hospitalization and whose expected stay is less than 24 hours.

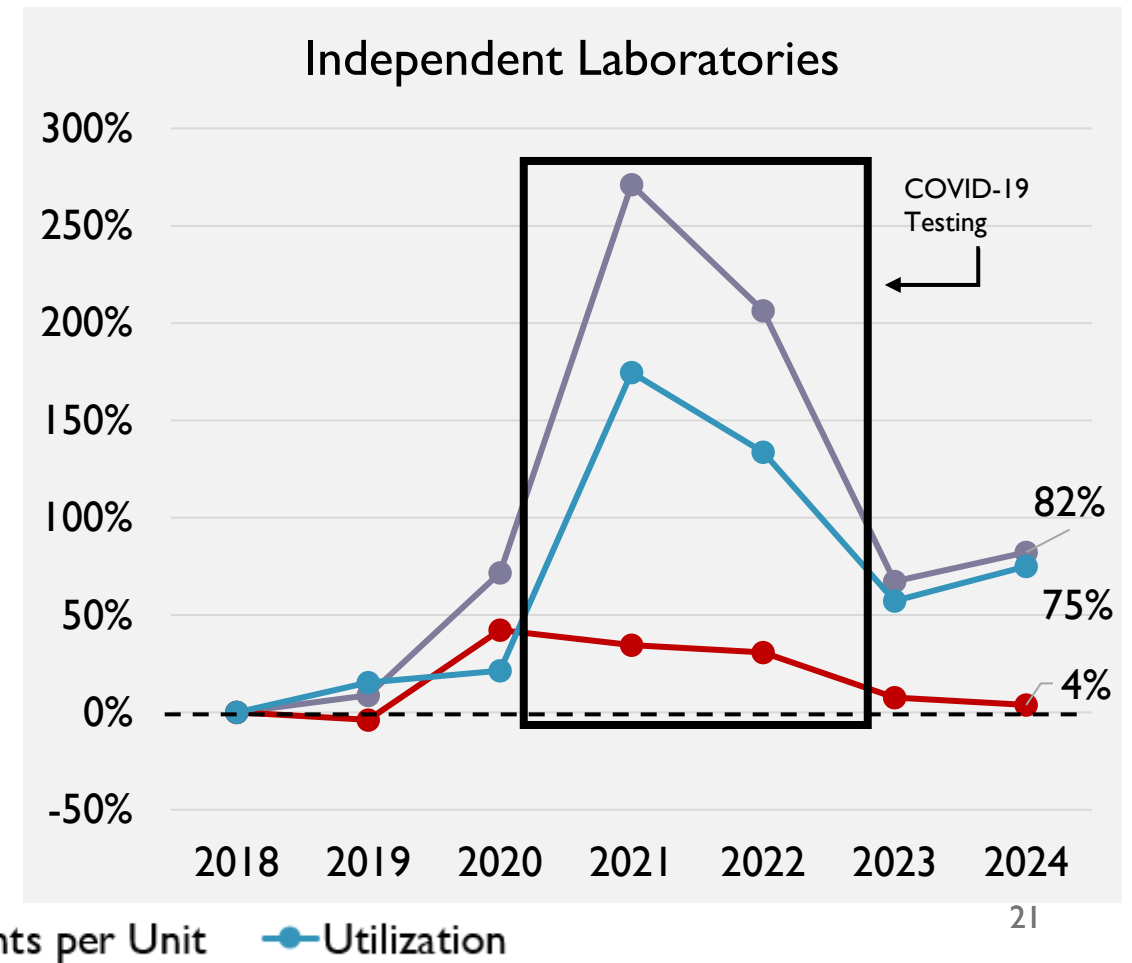
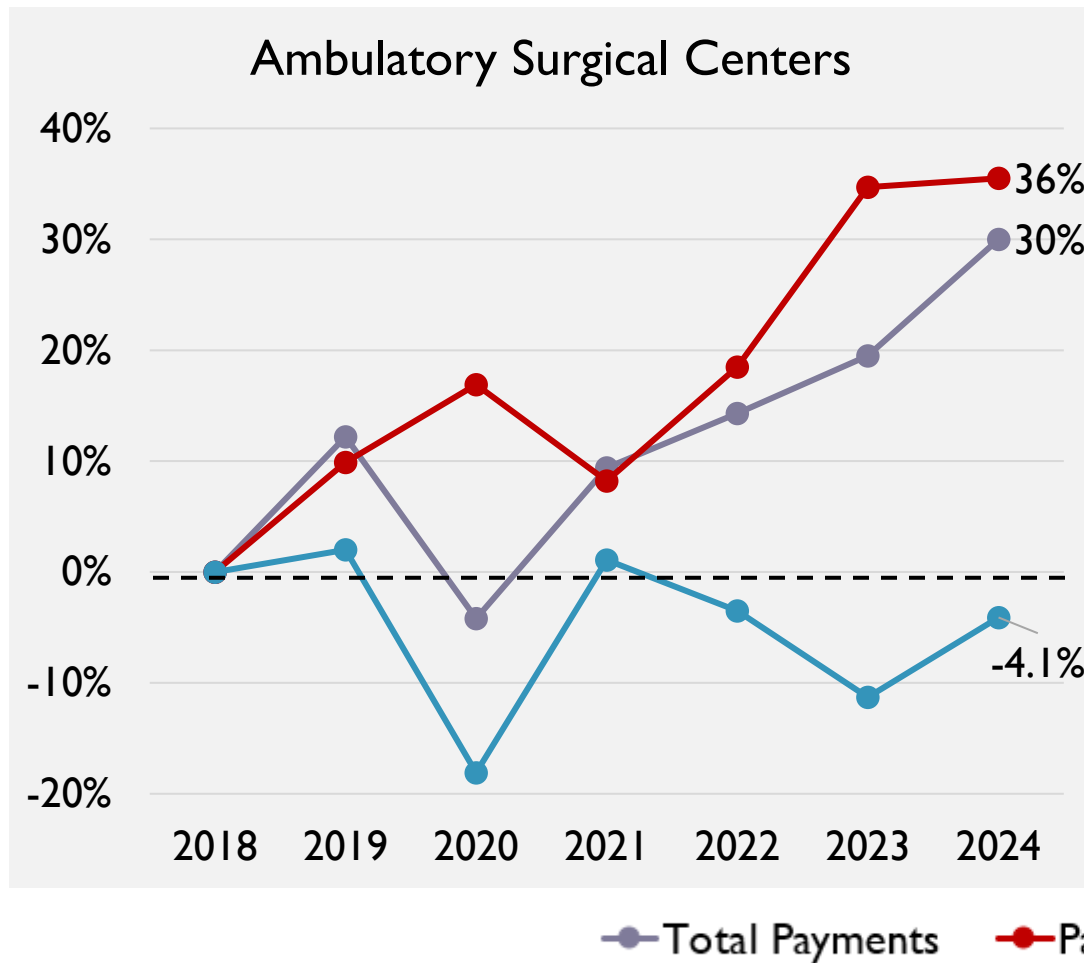
Non-hospital Spending – Commercial Payors

- For office visits in primary care and specialty settings, prices drive spending among commercial payors.



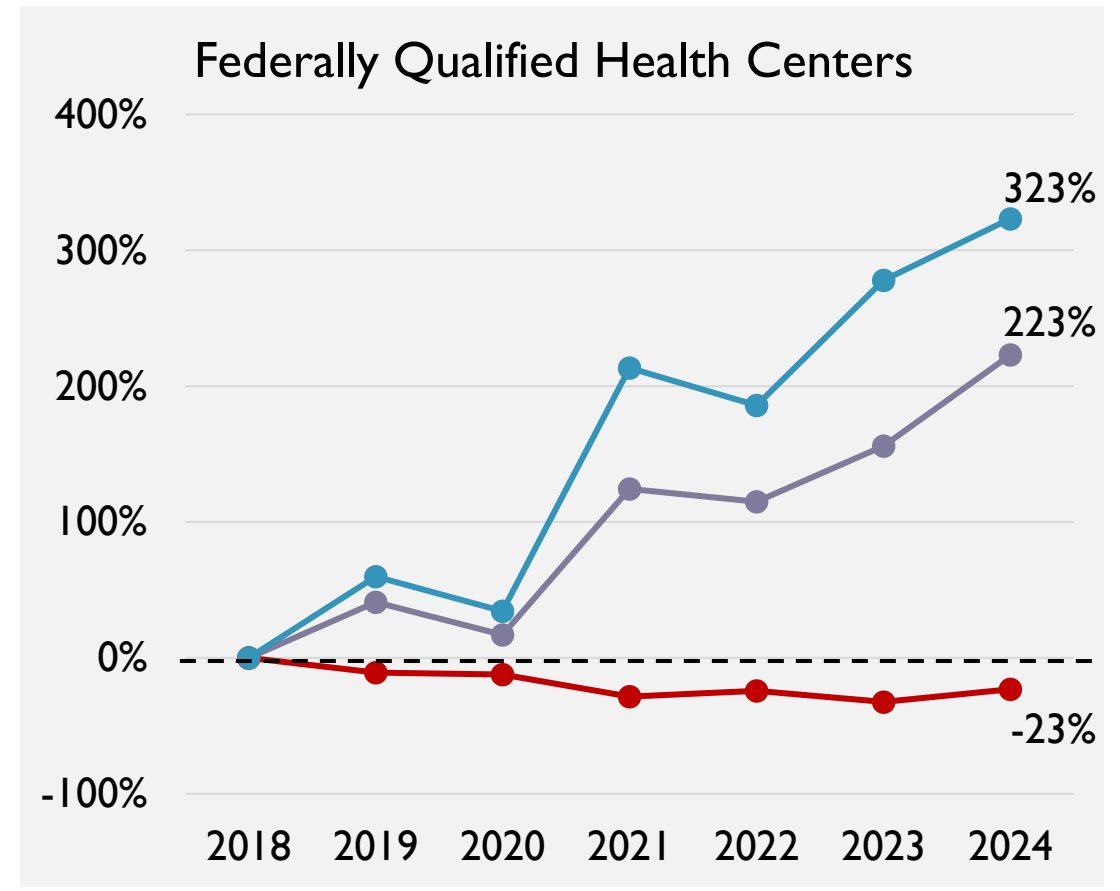
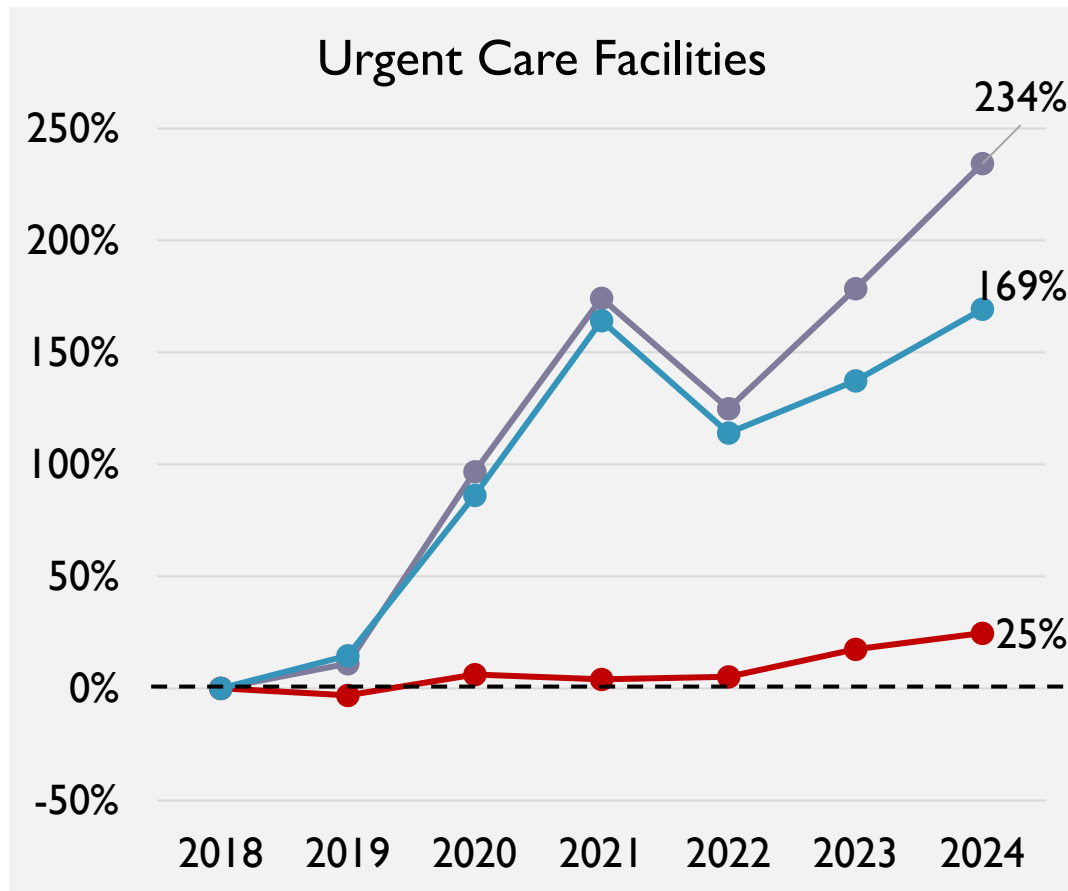
Non-hospital Spending – Commercial Payors

- At ambulatory surgical centers prices drive spending. At independent laboratories, utilization drive spending.



Non-hospital Spending – Commercial Payors

- At urgent care facilities and FQHCs utilization drives spending.





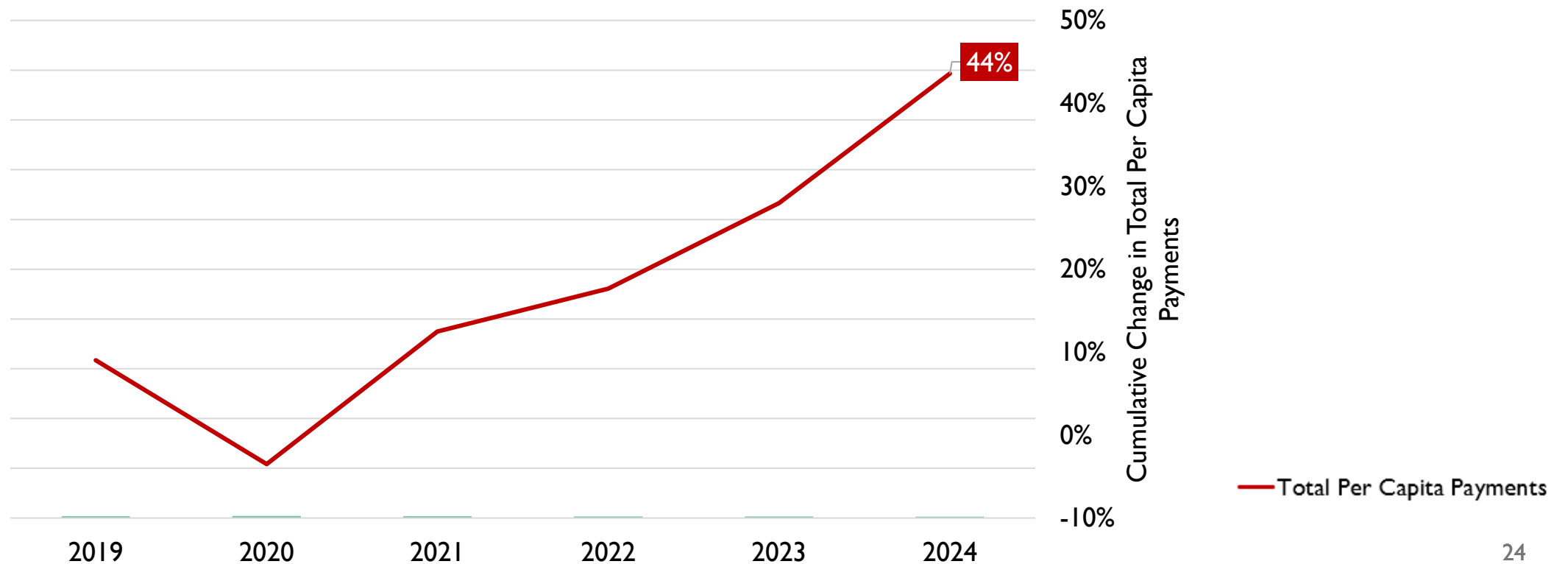
Cost Drivers by Types of Services



What services make up most of per capita hospital outpatient spending?

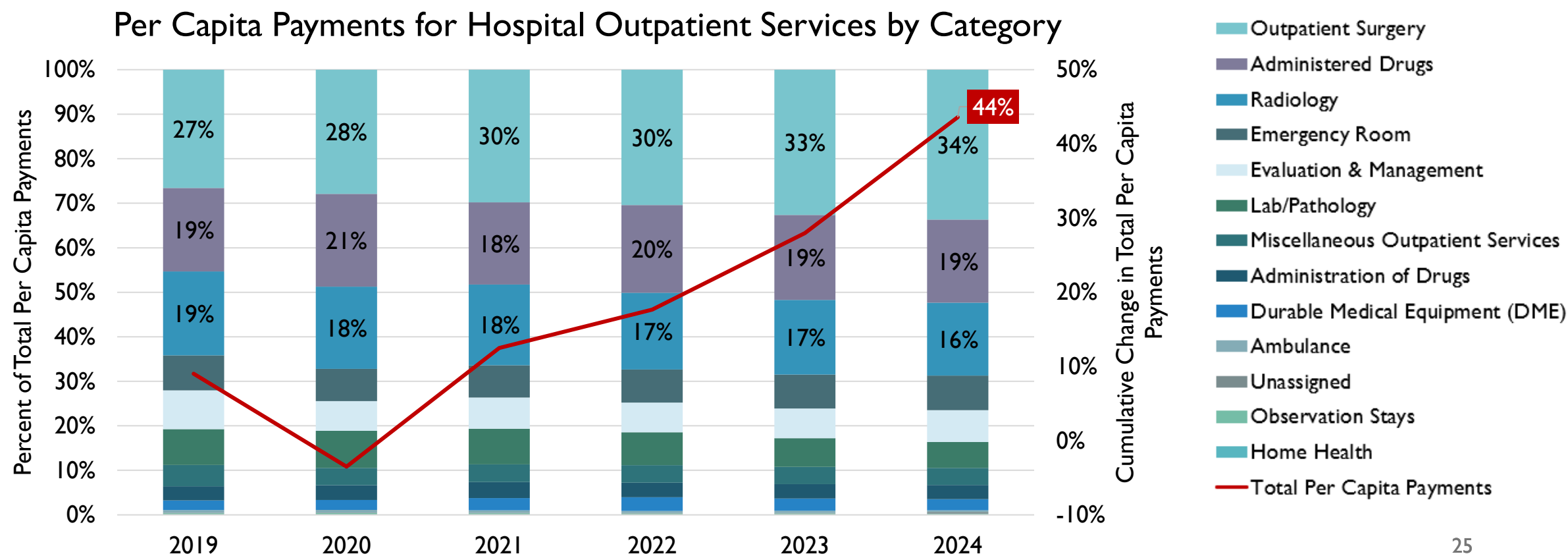
- Total per capita payments on hospital outpatient services **increased by 44%** from 2018-2024.

Per Capita Payments for Hospital Outpatient Services by Category



Surgery, drugs, and radiology make up most of per capita hospital outpatient spending.

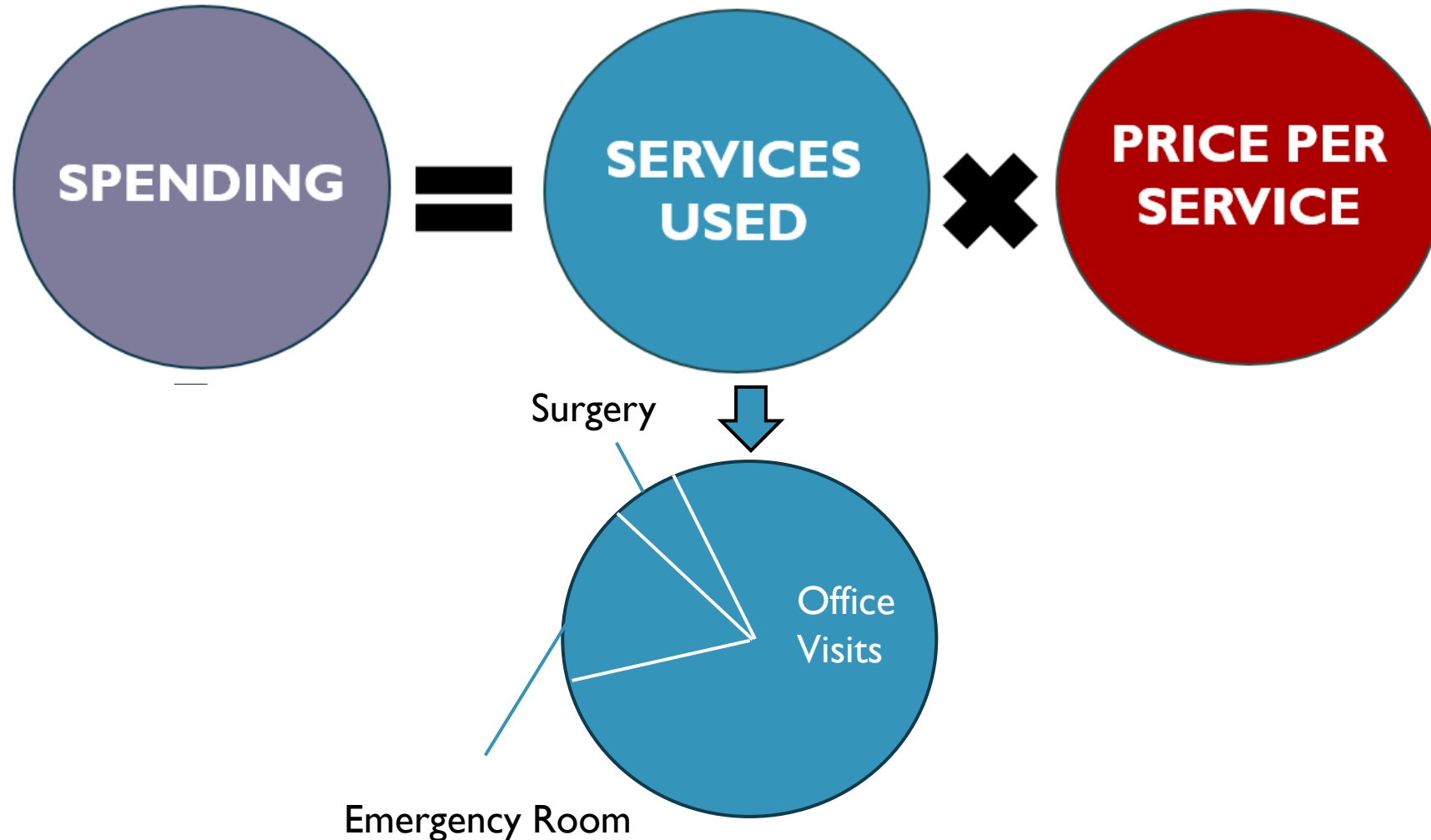
- Total per capita payments on hospital outpatient services **increased by 44%** from 2018-2024.
- Most of that spending was in **outpatient surgery, administered drugs, and radiology** which is consistent over recent years.



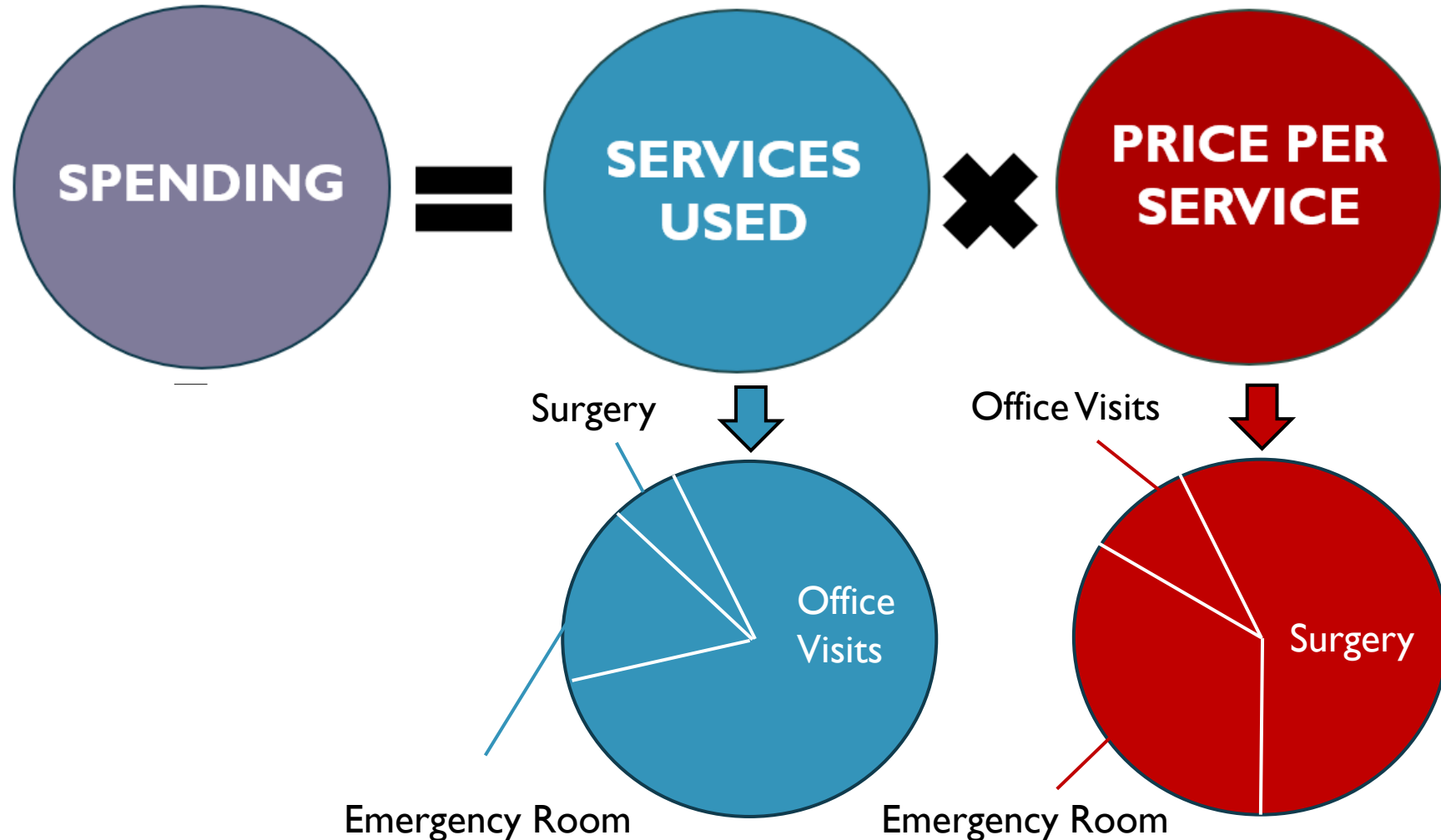
Health care spending depends on use and price –
but what services drive these categories?



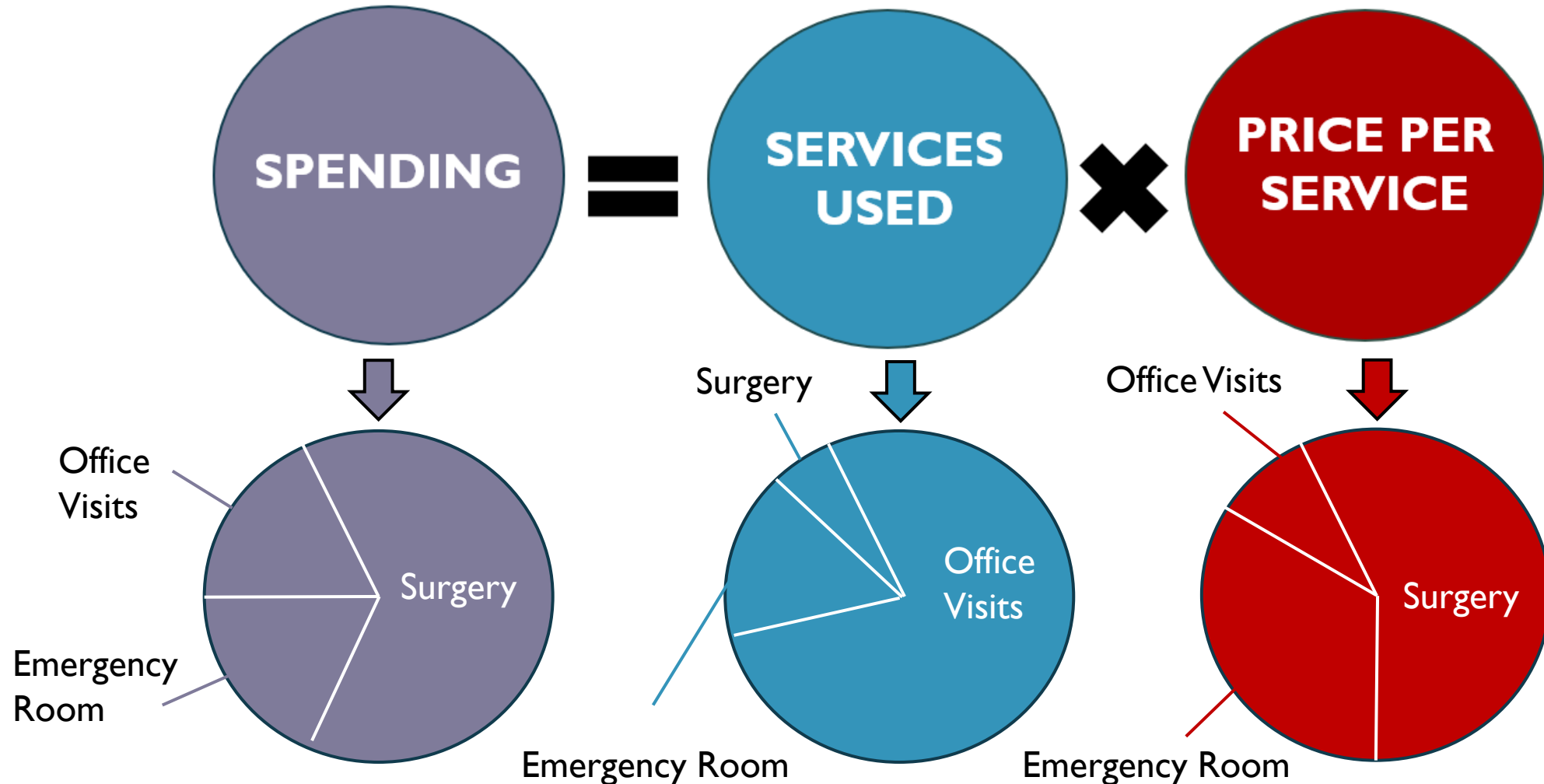
Illustrative example – not real data



Illustrative example – not real data



Illustrative example – not real data



Price, not utilization, drives spending in most hospital outpatient service categories that saw increased spending.

Hospital Outpatient Service Category	Percent of Total Payment per Capita Change	Change in Total Payments per Capita
Outpatient Surgery*	51%	84%
Administered Drugs*	21%	51%
Radiology*	10%	22%
Emergency Room	8%	42%
Durable Medical Equipment (DME)	4%	73%
Administration of Drugs	3%	46%
Evaluation & Management	3%	13%
Observation Stays	1%	-3%
Ambulance	-0.1%	-6%
Lab/Pathology	-0.3%	-2%

* Largest spending categories

Price, not utilization, drives spending in most hospital outpatient service categories that saw increased spending.

Hospital Outpatient Service Category	Percent of Total Payment per Capita Change	Change in Total Payments per Capita	Change in Utilization/1000 Insureds
Outpatient Surgery*	51%	84%	7%
Administered Drugs*	21%	51%	-2%
Radiology*	10%	22%	17%
Emergency Room	8%	42%	-1%
Durable Medical Equipment (DME)	4%	73%	8%
Administration of Drugs	3%	46%	5%
Evaluation & Management	3%	13%	12%
Observation Stays	1%	-3%	-35%
Ambulance	-0.1%	-6%	-39%
Lab/Pathology	-0.3%	-2%	-2%

* Largest spending categories

Price, not utilization, drives spending in most hospital outpatient service categories

Hospital Outpatient Service Category	Percent of Total Payment per Capita Change	Change in Total Payments per Capita	Change in Utilization/1000 Insureds	Change in Payments per Unit
Outpatient Surgery*	51%	84%	7%	72%
Administered Drugs*	21%	51%	-2%	54%
Radiology*	10%	22%	17%	5%
Emergency Room	8%	42%	-1%	43%
Durable Medical Equipment (DME)	4%	73%	8%	60%
Administration of Drugs	3%	46%	5%	39%
Evaluation & Management	3%	13%	12%	1%
Observation Stays	1%	-3%	-35%	50%
Ambulance	-0.1%	-6%	-39%	53%
Lab/Pathology	-0.3%	-2%	-2%	1%

* Largest spending categories

Takeaways – All Payor Hospital Outpatient Spending

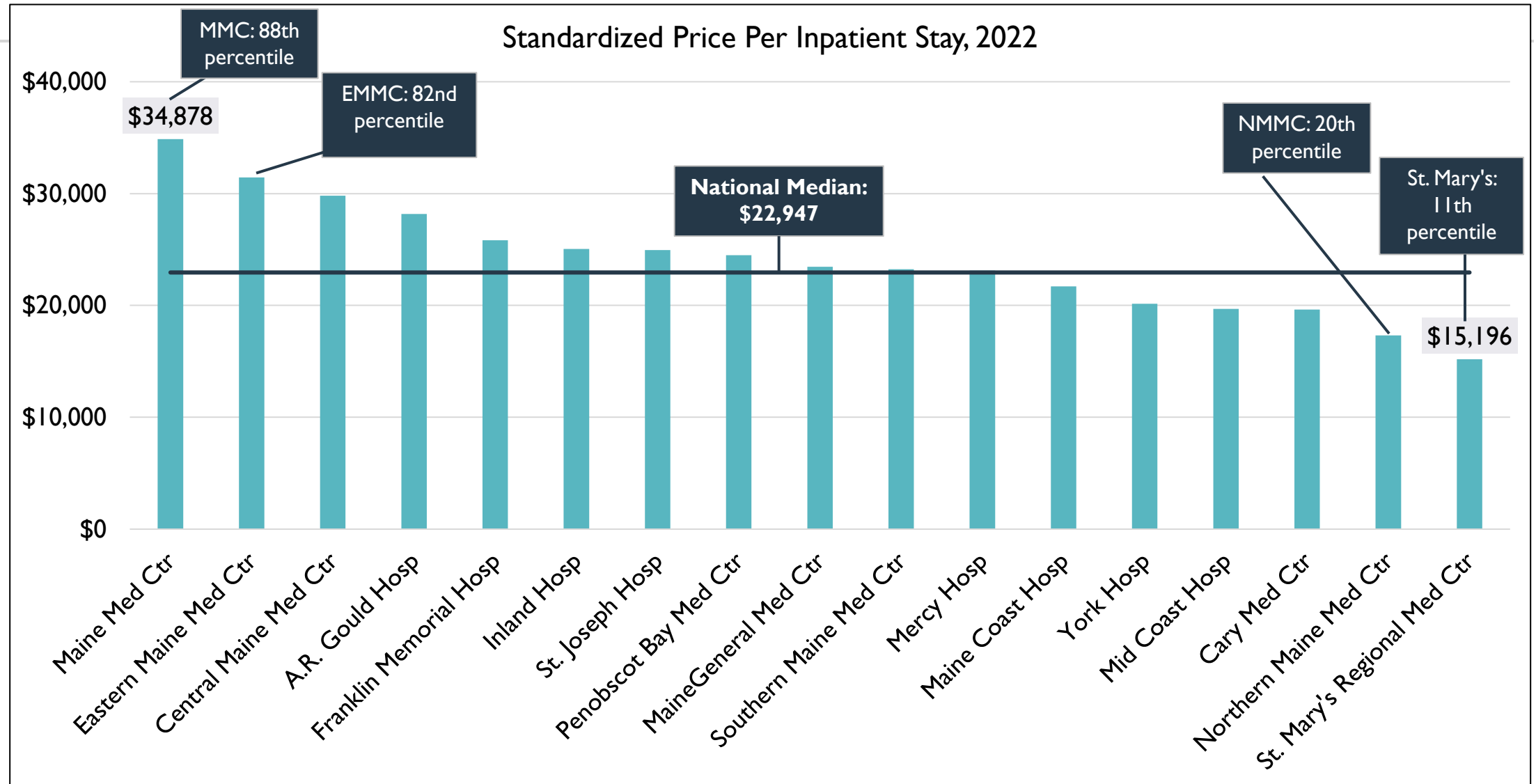
- Per capita payments on hospital outpatient services **increased by 44%** from 2018-2024
- The largest spending categories were in **outpatient surgery, administered drugs, and radiology**.
 - Outpatient surgery and administered drugs had increased spending driven by price.
 - Radiology had increased spending driven by a combination of increased utilization and modest price increase.
- **Other possible cost drivers** to watch are **durable medical equipment and emergency room services**, with large increases in prices, although only modest impact on overall spending.



Research Summary – Context for Discussing Hospital Prices



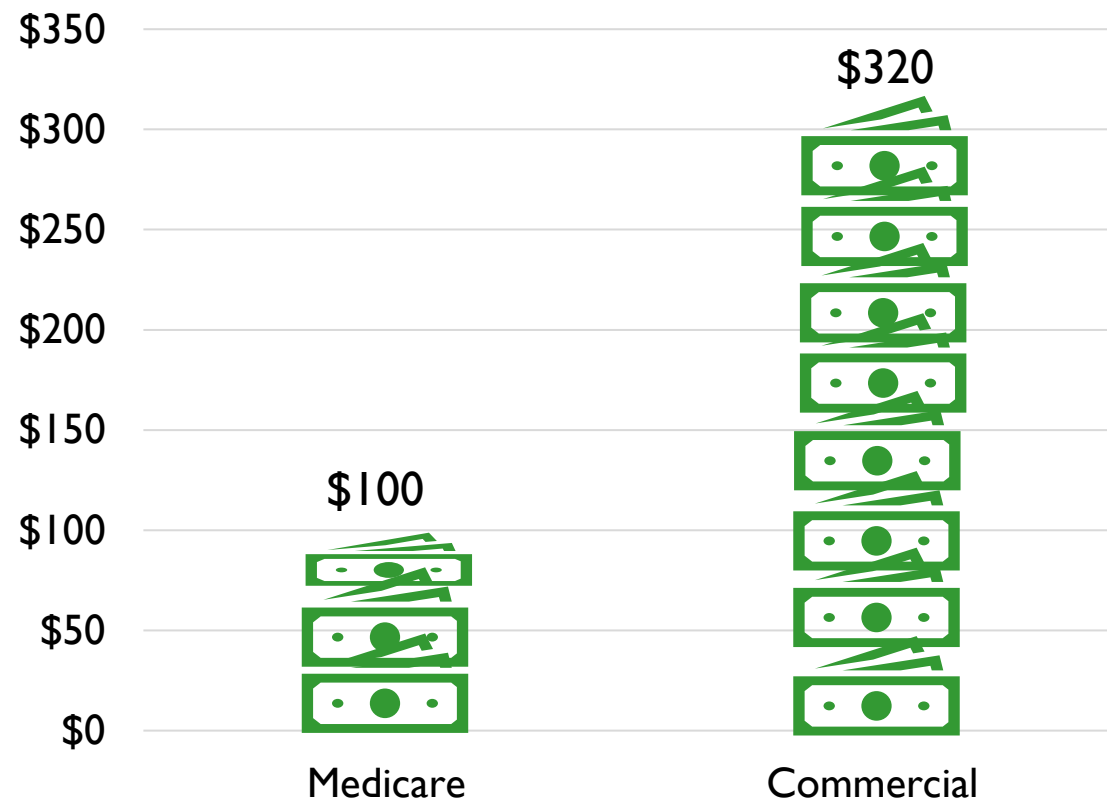
Prices at some Maine hospitals are among the highest in the nation while others are among the lowest



Commercial insurers pay far more than Medicare for the same hospital services

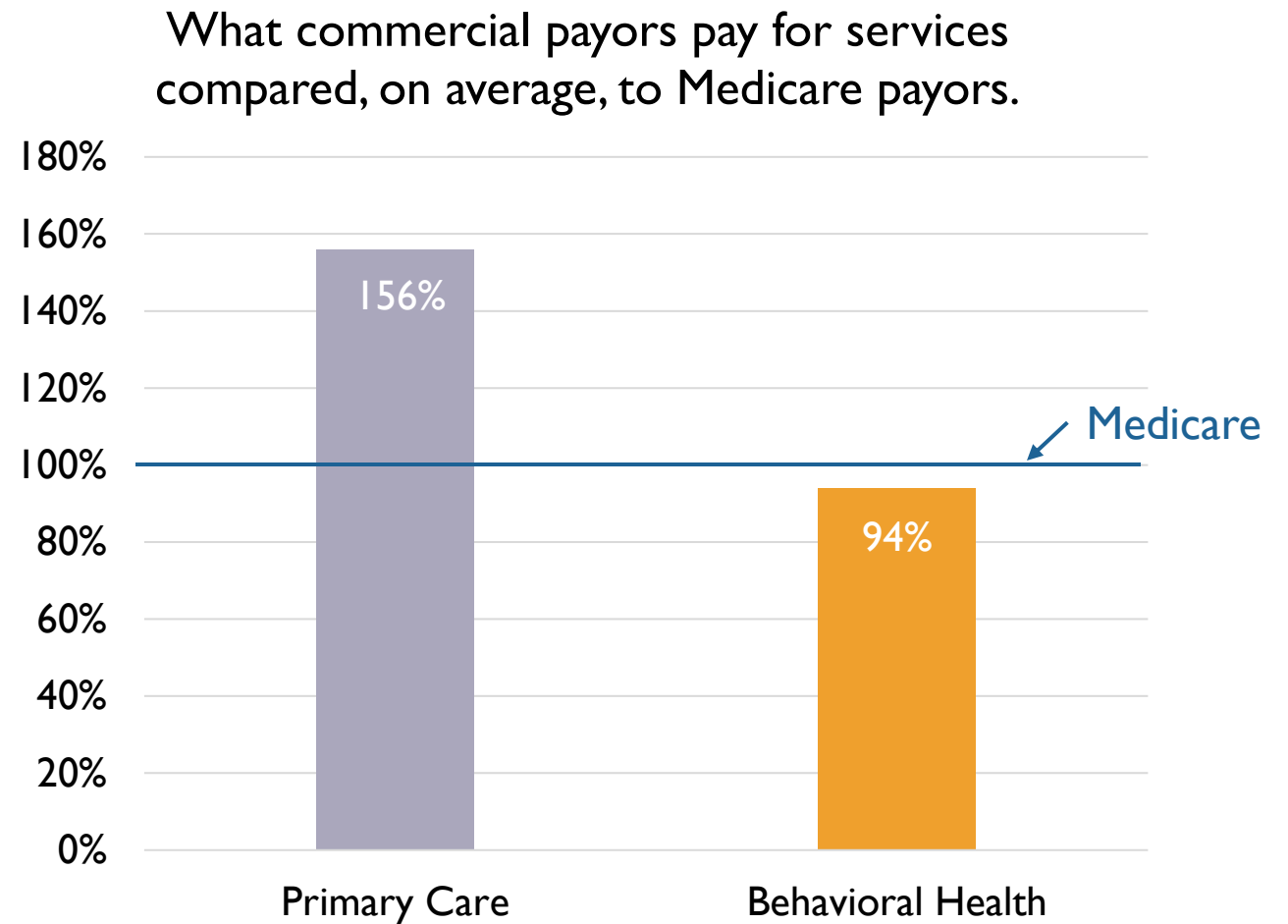
- In 2024 people in Maine with private/commercial health insurance paid, **on average, 2.2 times more** those with **Medicare** for the same hospital services.

What people with commercial insurance pay, on average, for the same hospital services compared to people with Medicare



Commercial payments for primary care and behavioral health are much closer to Medicare

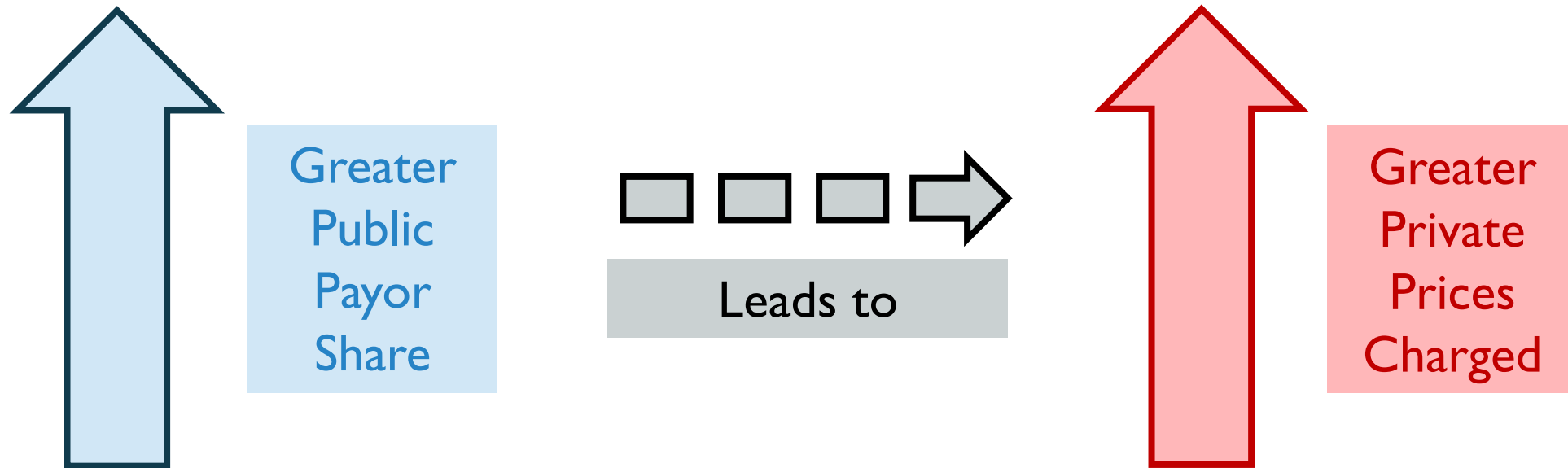
- In Maine in 2024:
 - Primary care and behavioral health see much lower relative rates compared to hospital services.
 - **Primary care** services were reimbursed by commercial payors on average **156% of what Medicare would have paid.**
 - **Behavioral health** services were reimbursed on average, **94% of what Medicare would have paid.**



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.

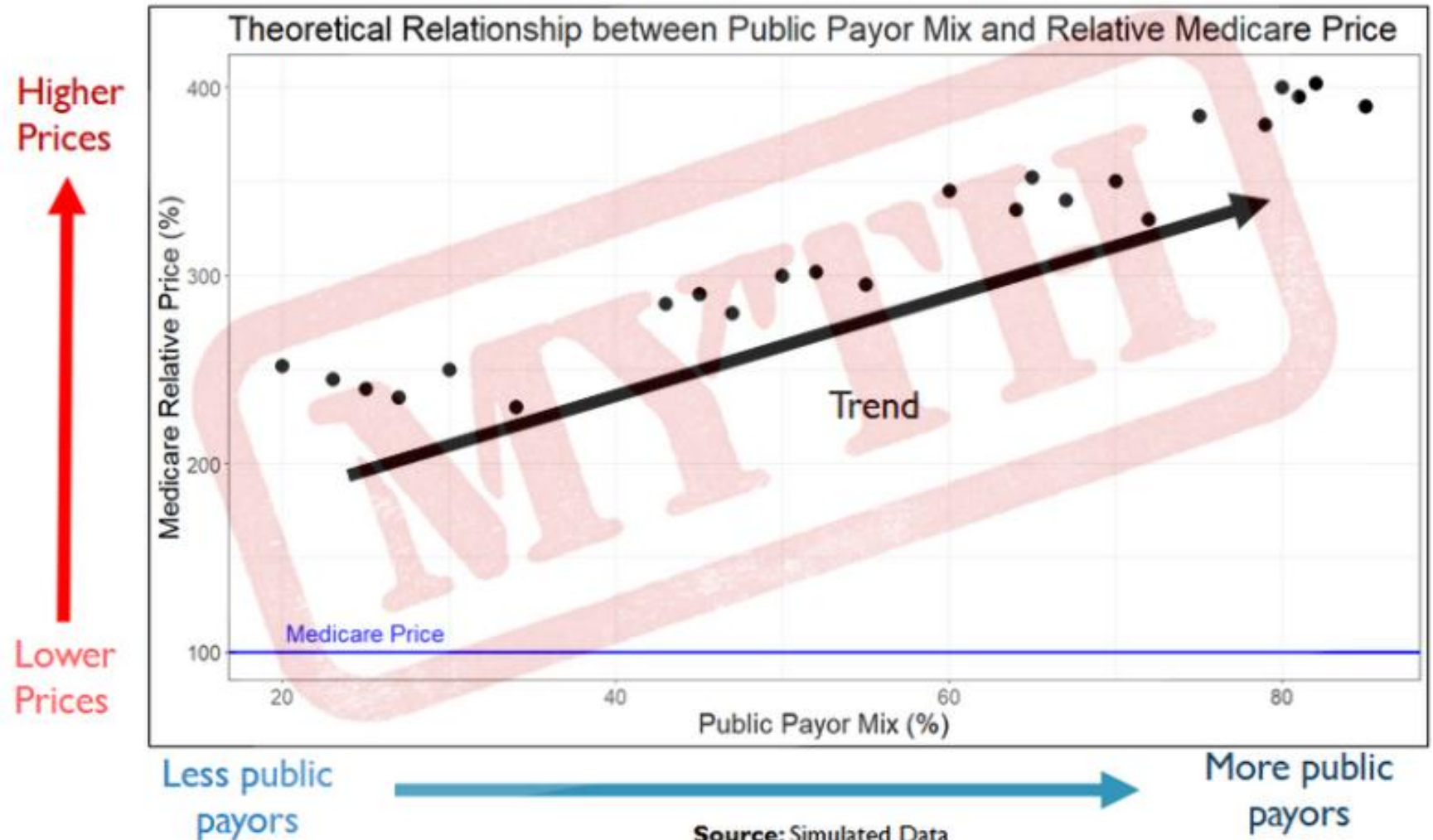


The cost shifting myth in the data

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

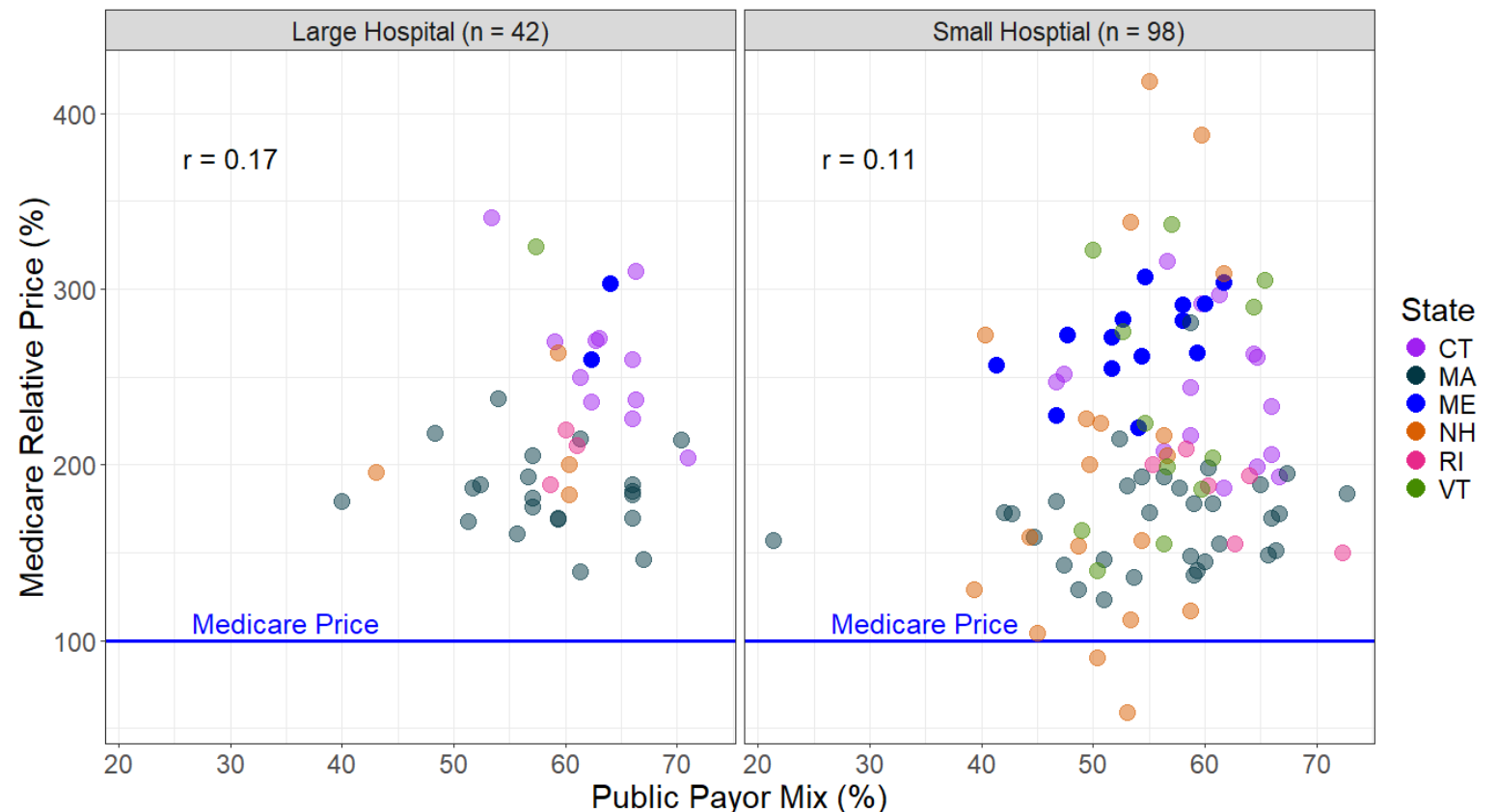
Myth

- 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



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.



Updates on Policy Initiatives



Updates on OAHC Areas of Policy Focus

Provider Market Oversight and Competition

- In 2025 the Office collaborated with Rep. Sam Zager to introduce LD 1972, which would have created a new and more consumer-oriented state review process for health care transactions including the closure of services, the outsourcing of major hospital functions, and the acquisition of non-facility health care providers.
 - The bill was voted ought-not-to-pass by the Health Coverage, Insurance, and Financial Services Committee, but was included in the scope of a legislative task force which met over the summer of 2025.
- Among other recommendations, that task force resulted in LD 2201, which followed the structure of LD 1972 but narrowed the scope to transactions involving private equity, hedge funds, and managed services organizations.
- LD 2201 was passed by the legislature and signed by the Governor and DHHS rulemaking to implement the law is anticipated this year.

Updates on OAHC Areas of Policy Focus

Regulating Commercial Prices for Health Services

- In 2026, the office collaborated with Rep. Drew Gattine and other legislators on LD 2196. The original bill would have:
 - Capped what hospitals can charge commercial insurance at 200% of Medicare, with an exemption for Critical Access Hospitals,
 - Limited how much hospitals can increase prices for the commercially insured each year,
 - Required insurance companies to pay at least 110% of Medicare for primary care and behavioral health care services,
 - Set new restrictions on insurance companies' use of prior authorization.
- LD 2196 was significantly amended by the Health and Human Services Committee. The version voted out by the Committee included only caps on the growth of hospital prices, and increased floors for primary care and behavioral health care up to 150% of Medicare by 2034.
- The bill was tabled in the House so did not receive a vote and died on adjournment.

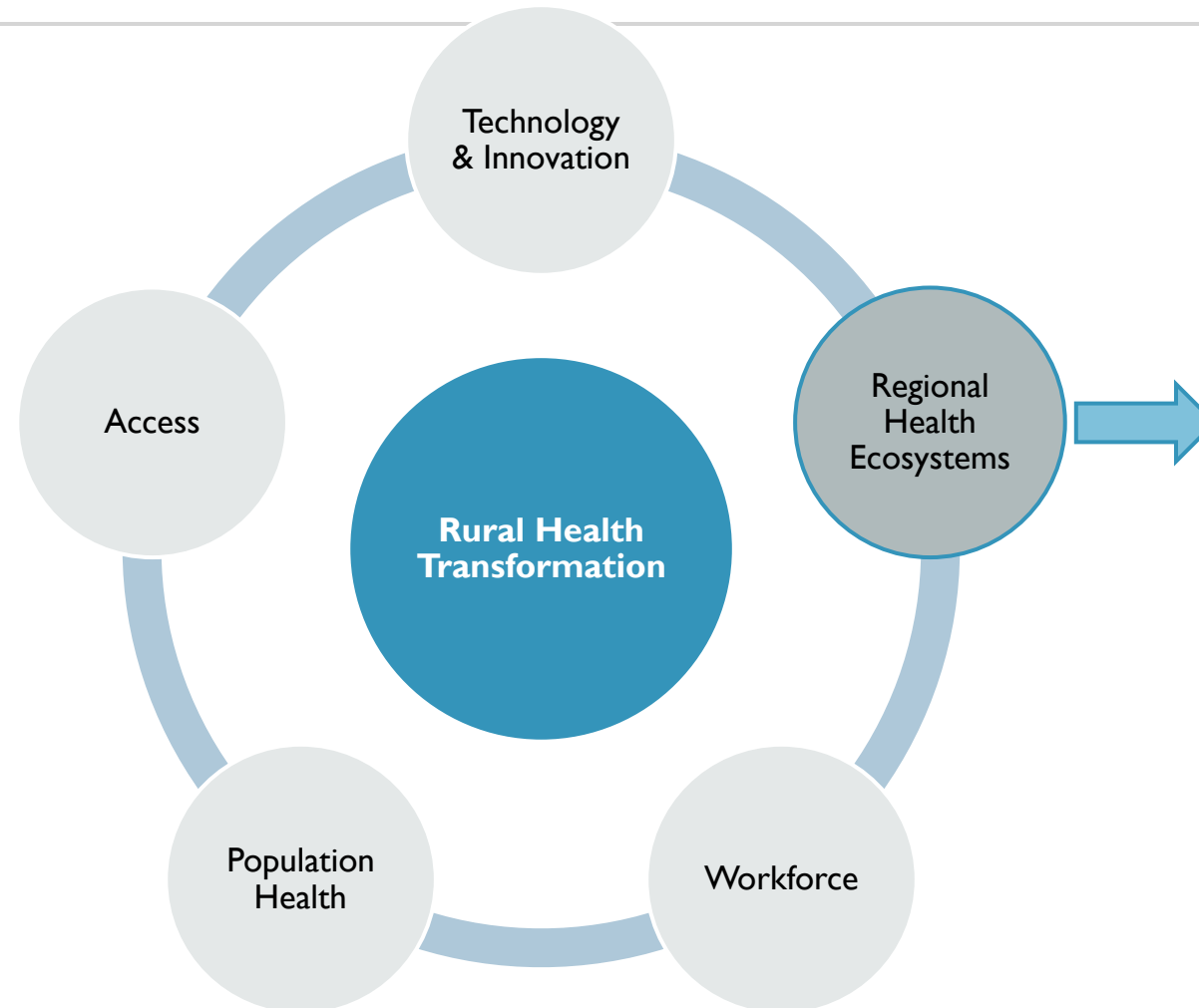
Updates on OAHC Areas of Policy Focus (continued)

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. Payors and providers in Maine have made progress in introducing new models for payment and delivery of care, but fragmentation of the payor landscape and other operational challenges are a barrier to more significant transformation.
- When the Rural Health Transformation Program (RHTP) was created by Congress we focused on that opportunity as a vehicle for this work.

Rural Health Transformation Program: Regional Health Ecosystems

Maine's Rural Health Transformation Program consists of 5 interconnected initiatives. The combined activities under these initiatives will lead to transformation in how care is delivered, accessed and paid for across rural communities in the state.



Regional Health Ecosystems
The Regional Health Ecosystems Initiative aims to strengthen the long-term sustainability and resilience of Maine's rural health system. It is built off the learnings and successes of all the other RHTP initiatives.

Why Regional Health Ecosystems?

Big challenges in our rural health care system require broad collaboration to address. This work will require:

- New relationships and partnerships between different health care facilities and providers
- Support and collaboration from community organizations and community members
- Aligning efforts across state government, statewide and local non-profit organizations, and the private sector

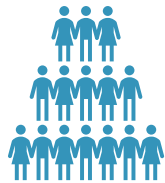
How will we get there?

The regional health ecosystems planning process will provide a structure and funding to bring people together to reassess how care is delivered and paid for in rural areas, and plan projects to develop more efficient and effective systems of care.

Regional Health Ecosystems – What’s Next?

To successfully design a regional approach to rural care, the early planning phase will encompass strategic planning efforts and information gathering to make key decisions on how this work will launch.

Information will be gathered from...



PEOPLE

The RHTP team will be engaging in internal and external conversations with key partners and leaders in the health care and community services fields. The conversations will help formalize the vision of regional health ecosystems planning, create buy-in for the planning process, and inform the launch phase of the project.



DATA

Both past data and reports as well as new data pulls and analyses will help create an assessment of existing delivery systems in rural areas and inform future expectations of shifting landscapes impacting Maine’s health system, like demographic changes, payer mix and expected service utilization.



PAST WORK

The regional health ecosystems work will be built upon past initiatives in Maine and learnings from other states. There’s a robust history of delivery system reform that will be critical to informing regional network design and ensuring challenges and successes from the past are considered for future efforts.

Rural Hospital Efficiency Fund

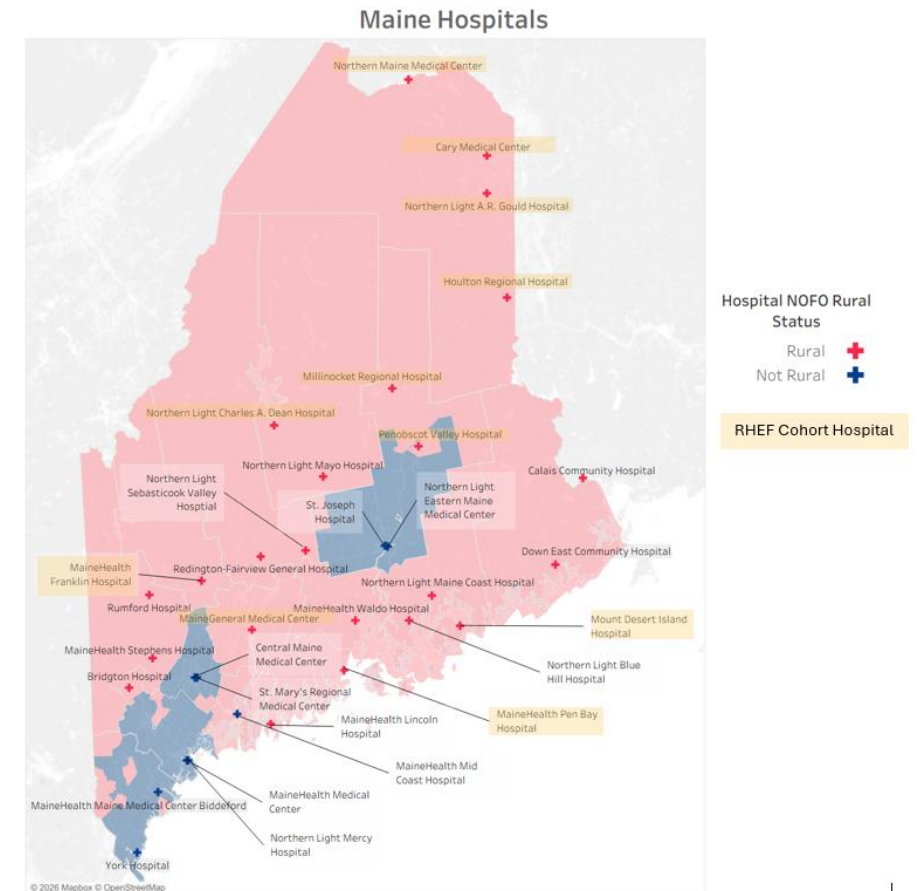
- \$30 million project intended to **strengthen the long-term financial health and sustainability** of rural hospitals across Maine
- Participating hospitals will receive **individualized technical assistance** from industry experts on financial efficiency and sustainability. Hospitals will use that assistance to develop individualized **sustainability plans identifying priority projects**.
- Eligible projects may focus on improving **financial oversight and management, increasing structural and operational efficiency, or strengthening regional planning to ensure efficient delivery of service**. Projects will be tailored to the circumstances of each hospital and are intended to produce lasting improvements in financial health and operational efficiency.

Invited Hospitals

- Hospitals were invited to participate based on two factors:
 - Rurality, aligning with the definition used by CMS in the RHTP application
 - An assessment of financial metrics using MHDO's audited financial reporting to identify hospitals that could benefit most from the investment.

- Cary Medical Center
- Houlton Regional Hospital
- MaineGeneral Medical Center – Alford Center for Health
- MaineHealth Franklin Hospital
- MaineHealth Pen Bay Hospital

- Millinocket Regional Hospital
- Mount Desert Island Hospital
- Northern Light AR Gould Hospital
- Northern Light CA Dean Hospital
- Northern Maine Medical Center
- Penobscot Valley Hospital





Public Comment

Reminder: written comments will be accepted through **Friday, October 2nd**

To submit, visit:

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