Maine Bureau of Insurance

Questions and Answers Regarding Proposed 2026 Health Insurance Rates

August 22, 2025

- How does the rate review process work?
  An overview of the Bureau's rate review process is posted on our website: https://www.maine.gov/pfr/insurance/consumers/rates. In addition, the presentation at the beginning of the public forum provides information on the Bureau's rate review process. The video and meeting materials can be accessed here - https://www.maine.gov/pfr/insurance/news-public-notices/public-event-notices

- Are these proposed rates or are they final?
  The rates discussed at the 8/15/2025 forum are proposed not final. These rates will be finalized at the end of August after any necessary changes and adjustments. The Bureau of Insurance does not set rates, it reviews them for compliance with Maine law. Rates may not be "excessive, inadequate, or unfairly discriminatory," pursuant to Maine's insurance code.

- Are there services that have the same cost to the consumer regardless of which insurance company they have?
  Yes, pursuant to the 2020 Made for Maine Health Coverage Act, the Bureau establishes several standardized plan designs that have the same member cost sharing across health plans for the most common health care services (e.g., office visits, hospital care, prescription drugs). These plans are available through CoverME.gov and are noted as "Clear Choice" plans. In addition, health plans (except federally qualified high deductible health savings account (HSA) plans) must cover preventive care and 3 visits for primary care or mental/behavioral health care at no additional cost to the policyholder.

- Would lower CEO salaries and lower carrier profit margins result in lower costs for insurance?
  While lower profit margins could lower costs, the vast majority of health insurance premiums are used to pay for the cost of health care services. All carriers that participate in the individual and small group market are required to meet a minimum 80% medical loss ratio (MLR). This means that at least $0.80 out of every dollar in

premium goes towards medical claims[1]. The remaining 20% covers administrative expenses and overhead, which includes employee compensation and profit or contribution to surplus. If the carrier does not meet the 80% MLR standard, rebate payments are made to policyholders. The Bureau's review of rate filings does not include an assessment of compensation or other company-specific operations.

- Does the potential expiration of the enhanced subsidies/premium tax credits (EPTC) affect the rates?
  Yes, the expiration of EPTC has a direct impact on rates. Health carriers noted that rates would be 3-4% lower if the enhanced tax credits were extended. However, most of the proposed increase in premiums is due to the underlying increase in medical and prescription drug costs, as well as an increase in the utilization of health care services.

- If Congress decides to extend the enhanced premium tax credits (EPTC) before the end of the year, will the insurance carriers adjust their rates?
  Unless Congress acts within the next few weeks, it is unlikely there will be sufficient time to adjust the rates in time for open enrollment, which begins on November 1, 2025. If the enhanced subsidies are extended, however, many consumers would receive enhanced subsidies that will help make health insurance premiums more affordable.

- Why did MGARA reinsurance savings to premiums decrease?
  The end of enhanced premium tax credits has a direct impact on funding for MGARA's reinsurance program. In addition, state funding for MGARA has remained unchanged since the program began in 2011, while the cost of health care and health insurance continues to climb. Finally, because MGARA is now used to reduce premiums in both the individual and small group markets, the reinsurance program benefits a larger number of people, which limits its average impact on premiums.

- What are cost-drivers in rural counties?
  The increasing cost of medical care and prescription drugs is the main cost-driver in all regions of the state. In some cases, the cost of care benefits from economies of scale. For example, the per-unit cost of a medical procedure may be lower if the

[1] The actual percentages are higher than 80%. Carriers are paying out more than the minimum due to increasing costs.

hospital performs hundreds of procedures every month rather than 30 or 40 each month. Providers in rural areas tend to have lower economies of scale, and may have somewhat higher costs compared to providers in more urban areas. But this difference is not material.

- Why did Anthem call Northern Light's increase in fees "unheard of" when they are raising premiums?
  The Bureau does not offer an opinion on any individual comments.

- Health care and profit are mutually exclusive goals. Can you comment on this?
  America's healthcare system allows for-profit and non-profit companies to enter the market and compete for business. This includes health insurers, hospitals, physicians' offices, pharmaceutical companies, laboratories, ambulatory surgery centers, pharmacy benefits managers and other types of health care-related entities. The structure of the national health care market is largely beyond the control of an individual state.