



MAINE'S LEADING
VOICE FOR HEALTHCARE

TESTIMONY OF THE MAINE HOSPITAL ASSOCIATION

In Opposition To

LD 2196 - An Act to Lower Health Insurance Costs, Reduce Barriers to Health Care and Ensure Fair Prices for Health Care

March 5, 2026

Senator Ingweresen, Representative Meyer, and distinguished members of the Joint Standing Committee on Health and Human Services, I am Jeffrey Austin with the Maine Hospital Association testifying **in opposition to LD 2196**. The Maine Hospital Association (MHA) represents 32 community-governed hospitals including 29 non-profit general acute care hospitals, 2 private psychiatric hospitals, and 1 acute rehabilitation hospital.

Overview. This legislation cuts \$1.2 billion from hospitals in 2028 (see the appendix at the end of this testimony). It is a nearly 30% cut to current commercial reimbursement rates.

Our testimony can be reduced to essentially one argument: That cuts of this magnitude come with tradeoffs.

There is simply no ability for hospitals to absorb a \$1.2 billion cut in 2028. Hospitals can't absorb a cut of 10% of this proposed cut. Hospitals barely broke even in 2024. A cut of \$1.2 billion will have significant and lasting damage to our health care system in Maine and the worst impact will be on accessibility, particularly for Medicaid recipients.

Affordability. Affordability is a real issue. It is obviously much bigger than healthcare. It is also housing and higher education and utilities and taxes.

Affordability is also an issue that hospitals face. Hospitals feel the rising cost of labor and utilities and pharmaceuticals and regulation and taxes and, health care for their own employees. This bill does nothing to reduce or even limit the growth of all the 'input' costs hospitals themselves face.

It is neither accurate nor fair nor even responsible to force one party in the health care system to bear the responsibility for all of its affordability ills.

Hospital Financial Situation. The next page lists hospital operating margins, as reported by MHDO, for the past 3 years for the larger hospitals that face the price cap in LD 2196. The MHDO data demonstrates the very precarious position Maine's hospitals are in right now.

Maine Operating Margins as Reported by MHDO

MAINE HOSPITALS 2024 OPERATING MARGINS - MHDO					
<u>Hospital Name</u>	<u>FY 2022</u>	<u>FY 2023</u>	<u>FY 2024</u>		
<u>Larger Hospitals (PPS)</u>					
Central Maine Medical Center	-5.57%	-4.02%	-5.84%		
Maine Medical Center (*Consolidated)	-2.00%	0.15%	1.67%		
MaineGeneral Medical Center Augusta (* Consolidated)	0.80%	-2.82%	-1.99%		
NLH Eastern Maine Medical Center	-8.01%	1.80%	-8.41%		
Mid Coast Hospital	-9.14%	-2.26%	0.50%		
NLH AR Gould Hospital	-7.11%	3.65%	-5.69%		
NLH Mercy Hospital	-5.10%	2.79%	3.28%		
Pen Bay Medical Center	-1.78%	-3.61%	-3.72%		
Southern Maine Health Care	-4.53%	-3.28%	3.04%		
St. Joseph Hospital	-5.39%	0.87%	1.62%		
St. Mary's Regional Medical Center	-22.59%	-13.88%	-2.25%		
York Hospital	-1.47%	-5.92%	-9.39%		
Cary Medical Center	0.63%	0.53%	-0.92%		
NLH Maine Coast Hospital	3.27%	4.17%	-1.54%		
Franklin Memorial Hospital (*Now CAH)	-3.02%	-0.54%	-5.21%		
Northern Maine Medical Center (*Now CAH)	-3.55%	-5.43%	-1.69%		
NLH Inland Hospital (*Now Closed)	-10.91%	-3.17%	-16.42%		
All Hospitals Average:			-5%	-2%	-3%

Source: MHDO Hospital Data

Unconsolidated: https://mhdo.maine.gov/_pdf/Report_A_FY24_Select_Financial_Hosp_251211.pdf

Consolidated: https://mhdo.maine.gov/_pdf/Report_C_FY24_All_Financial_HealthSys_251231.pdf

We asked our national consultant, PYA, to assess what would happen to hospital margins if this legislation were to pass. This is their conclusion:

- Total margin [comparable to MHDO's "operating margin"] would decrease from 1% to a **negative 18.1% margin**;
- *Current ratio which describes the amount of current (liquid) assets to cover current liabilities declines to less than 1.0 which is a high-risk proposition for any business.*
- *The median equity financing ratio (the % of assets financed with equity vs. debt) would decline to 28% from 41%. With significant negative margins for more than a few years, this value would place an organization in a highly leveraged (high risk) position.*

Maine's PPS hospitals were classified primarily in the Medium Risk category in the PYA Benchmarking Study dated April 9, 2025; if these hospitals experienced the decline in revenue as assumed, 5 hospitals would be considered higher risk, with another 5 hospitals at the cusp of higher risk classification which would represent 71% of the Maine PPS hospitals."

The State of Maine recognized the challenges Maine hospitals face today in its rural fund application:

The availability of appropriate hospital services is key to ensuring long-term improvements in the health and well-being of rural residents. However, many Maine hospitals are facing acute financial challenges that put them at risk of closure or significant service changes driven by short term financial pressures rather than population health needs.

In 2023, 19 of 23 (83%) rural hospitals fell below the S&P Global threshold for adequate days cash on hand, 43% had financially vulnerable operating margins, 57% had financially vulnerable total margins, and 74% did not meet the target for adequate average age of plant. Eight of the 23 rural hospitals failed in all four benchmarks, underscoring widespread financial vulnerability.

The Healthcare Purchasers Alliance recently concluded a study of hospital financial metrics that largely reached a conclusion that we have been stating for years: that hospitals cross-subsidize services and that “profits” in one area are often used to offset losses in another area.

With this broader lens, we were able to see that, in those instances where hospital revenues exceed hospital expenses, systems were siphoning off most excess revenues to cover shortfalls associated with non-hospital activities elsewhere in the system, including primary care services, assisted living facilities, behavioral health, and other negative-margin entities. System CFOs claimed that such intra-system transfers explain why hospitals that look profitable in MCRs are just breaking even once revenue transfers to other parts of the system are taken into account.

Furthermore, the HPA also noted the role that public payers play in alleviating the burden on commercial premiums.

Should purchasers be funding parts of the system that would be more appropriately financed with state dollars? While extracting additional dollars from state or local budgets is challenging, purchasers could consider advocating in favor of legislation or other efforts designed to increase funding for essential cross-subsidized services, particularly those not heavily utilized by the commercially insured population — with the caveat that such increased funding should be tied to a commensurate reduction in commercial rates.

Finally, Maine hospital expenses are below the national average and are the lowest in New England according to a widely utilized metric. (See bar chart in the appendix.)

Access. There is no ability for our members to simply absorb \$1.2 billion in cuts. Any national think tank that tells you otherwise is not being honest or truthful.

Maine hospitals employ people who treat people 24-hours per day, 365-days per year. It is both a very labor-intensive service and one where the technology and overhead are enormous. To reduce \$1.2 billion in lost revenue will mean the loss of thousands of jobs and access to services.

To be clear, the services that will be first to be cut are those that lose money. Hospitals provide some services to some populations that make money (think orthopedics or surgery for the commercially insured) and provide other services to other groups that lose money (think pediatric behavioral health for Medicaid recipients or SUD services for the uninsured).

Medicaid and uninsured populations – roughly 1/3 of Maine’s population – will see no benefit from this legislation but will bear the burden of significantly reduced services.

Healthcare Ecosystem. The State’s rural fund plan discusses the rural health “ecosystem” and what needs to be done to sustain it. We greatly appreciate the State’s use of that term and think it correctly describes how the different parts of the system rely on one another. This committee knows this better than any other. Hospitals rely on each other, nursing homes, ambulance services, community mental health providers and on and on. A breakdown in any one of these provider groups tends to have a negative impact on the others. So, you may be able to exempt a hospital from a direct cut, at least for now; but due to the interconnectedness of our hospitals to each other there is no hospital that will be exempt from the negative impacts to access that will be caused by this legislation.

Input Costs. Probably the biggest issue this bill fails to recognize is that the prices hospitals charge simply reflect the input costs they incur to provide care. If the state is going to use its awesome power to limit what hospitals may charge to recoup their costs, shouldn’t it also use its power to cap what those input costs are as well?

Government Rate Setting. Roughly 60-70% of hospital patients are covered by either government insurance programs – Medicare or Medicaid – or Maine’s mandatory hospital free care programs. The government sets reimbursement rates for these programs today. This bill is a dramatic expansion of the government’s power to also set rates in the commercial insurance market.

Other States. No other state has done anything like this. Oregon did a very small version of this. Please see the Oregon one-pager at the appendix at the end of this testimony. Suffice it to say, the cut proposed by LD 2196 is 72-times larger (on a proportionate basis) than the one enacted in Oregon. Nevertheless, hospitals in Oregon went from consistently in the black to consistently in the red following enactment of their small version of this bill.

Finally, it didn’t work. The Office of Affordable Health Care presented a chart showing Maine’s individual market premium increase in 2025 of 9.1%. The average premiums in Oregon went up 9.3% in 2025. Where is the evidence that this is working to reduce premiums?

The Rhode Island experiment is not useful either. Since Rhode Island instituted its growth cap – which are more generous and applies less broadly than those proposed in LD 2196 – four hospitals have gone into receivership. That is almost 20% of all the hospitals in R.I. Two are still stuck there.

Bonds/Financing. The ability of hospitals to service their outstanding bonds, or borrow in the future, would be jeopardized, leaving bondholders in a difficult position. The State’s MHHEFA program itself would be compromised. The taxpayers back the debt of many hospitals. This is a concern.

Conclusion. The fact that a problem is difficult to solve does not justify any possible action. The legislature would do well to follow the lead of healthcare clinicians themselves – first do no harm.

This bill does incredible harm to Maine’s hospitals, Maine’s healthcare system and Maine’s people.

Appendix

Office of Affordable Health Care Preliminary Estimate of the Impact of LD 2196

The following power point slide was in the Office of Affordable Health Care’s presentation to its Advisory Committee late last year. See [here](#).

ROUGH Estimate of Savings from Price and Growth Cap Policies

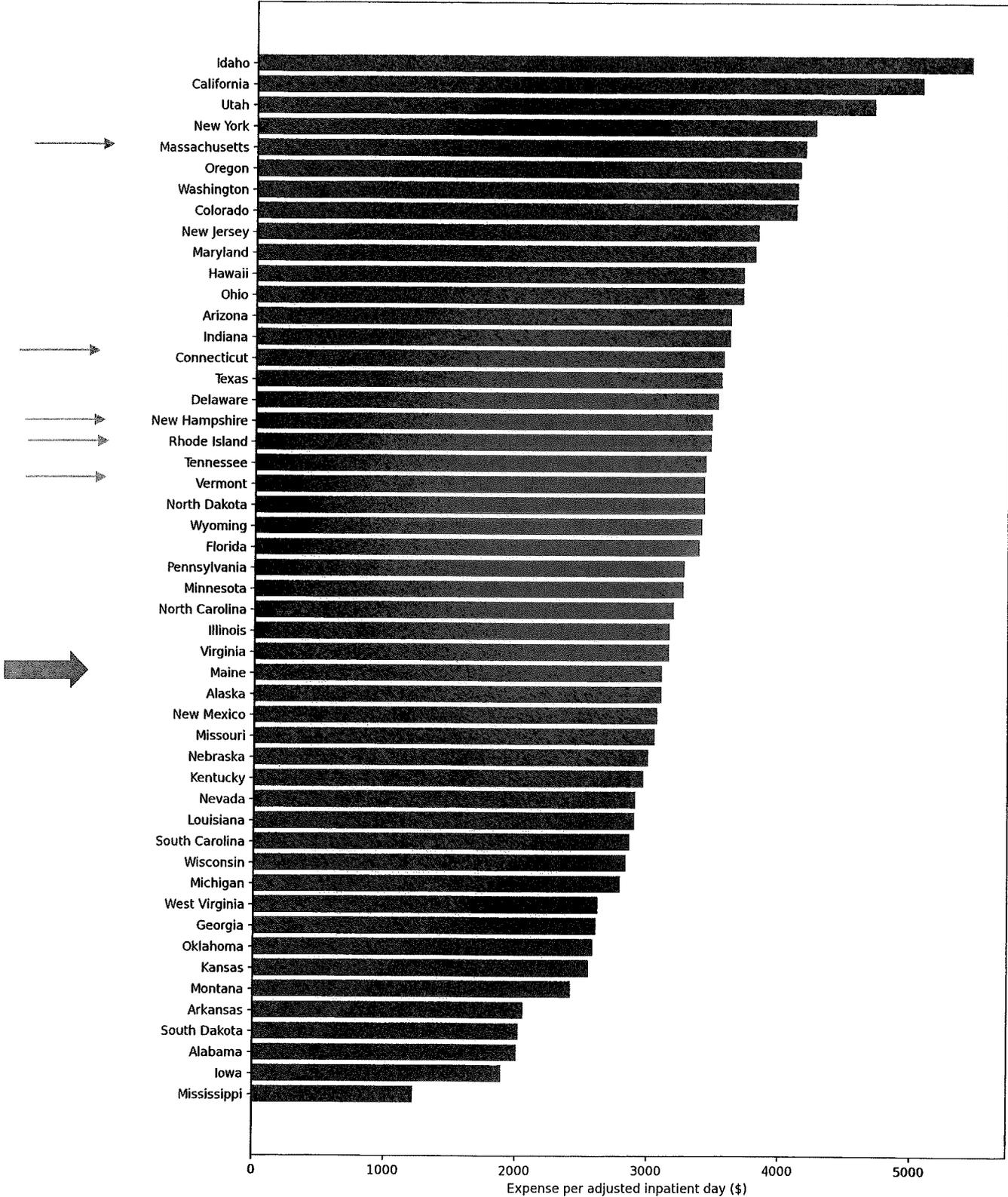
	Year 1	Year 2	Year 3*	Year 4	Year 5	Total 10 Years
250% Medicare Benchmark						
Service Level Price Cap*	N/A	N/A	\$532M	\$574M	\$618M	\$5.6B
Price Growth Cap	\$56M	\$117M	\$183M	\$255M	\$333M	\$4.0B
250% TOTAL	\$56M	\$117M	\$715M	\$829M	\$951M	\$9.6B
225% Medicare Benchmark						
Service Level Price Cap*	N/A	N/A	\$763M	\$810M	\$860M	\$7.6B
Price Growth Cap	\$56M	\$117M	\$183M	\$255M	\$333M	\$4.0B
225% TOTAL	\$56M	\$117M	\$946M	\$1.1B	\$1.2B	\$11.6B
200% Medicare Benchmark						
Service Level Price Cap*	N/A	N/A	\$994M	\$1.05B	\$1.1B	\$9.6B
Price Growth Cap	\$56M	\$117M	\$183M	\$255M	\$333M	\$4.0B
200% TOTAL	\$56M	\$117M	\$1.2B	\$1.3B	\$1.4B	\$13.6B

* Phased in price caps begin year 3

Source: Ballit Health (2025), Analysis of RAND S.1 Hospital Transparency Data; Maine Health Data Organization, (2025), Hospital Financial Reporting

Hospital Costs

Nonprofit hospital expenses per adjusted inpatient day by state (2024)
Source: Becker's Hospital Review / KFF



The Oregon Experiment is Hurting Oregon Hospitals.

The Oregon price cap, which cut \$50M per year from Oregon hospitals, is limited in scope. The \$1.2B cut in LD 2196 is 72-times larger than the cut in Oregon. Even though it was a relatively modest cut, it is correlated with declining hospital operating margins in Oregon.

So many factors go into hospital operating margins that it is difficult to isolate the impact of a single change. But, removing \$50+ million per year is a significant contributor to their financial problems. Furthermore, I believe there have been indirect impacts (carriers using the cap as the negotiating ceiling for all lines of insurance, not just the ones capped in the legislation).

Here are the operating margins before and after adoption of the price cap in 2019 according to the public information that is available on the Oregon Health Authority [webpage](#).



Things have headed down for Oregon hospitals in a pretty dramatic way. In 2019, Oregon hospitals had an operating surplus of \$164 Million; last year they had a loss of \$55 Million. Any claims of no harm from the price cap are untrue.

Plus, Oregon is three times larger than Maine. The \$50 million per year cut in Oregon is proportionate to a \$17 million cut in Maine. A \$17 million cut would be meaningful to Maine hospitals – who in the aggregate only made \$21 million in 2024.

LD 2196 as drafted is a \$1.2 billion cut. This is 72 times larger than the Oregon cut. Maine should not adopt a \$1.2 billion cut because Oregon has struggled under a \$17 million cut (proportionate to Maine's population).