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Date: (Filing No. H- )

**HEALTH AND HUMAN SERVICES**

Reproduced and distributed under the direction of the Clerk of the House.

**STATE OF MAINE  
HOUSE OF REPRESENTATIVES  
132ND LEGISLATURE  
SECOND REGULAR SESSION**

COMMITTEE AMENDMENT “ ” to H.P. 1475, L.D. 2196, “An Act to Lower Health Insurance Costs, Reduce Barriers to Health Care and Ensure Fair Prices for Health Care”

Amend the bill by striking out everything after the enacting clause and inserting the following:

**'PART A**

**Sec. A-1. 5 MRSA §3122, sub-§3, ¶F**, as enacted by PL 2021, c. 459, §3, is amended to read:

F. Develop proposals for consideration by the legislative oversight committee on potential methods to improve consumer experience with the health care system, including the provision of a consumer advocacy function on health care matters not addressed by the Health Insurance Consumer Assistance Program established in Title 24-A, section 4326 or the Department of Professional and Financial Regulation, Bureau of Insurance, Consumer Health Care Division established in Title 24-A, section 4321; and

**Sec. A-2. 5 MRSA §3122, sub-§3, ¶G**, as enacted by PL 2021, c. 459, §3, is amended to read:

G. Provide staffing assistance to the Maine Prescription Drug Affordability Board established in chapter 167-;

**Sec. A-3. 5 MRSA §3122, sub-§3, ¶H** is enacted to read:

H. Review and audit compliance with Title 22, section 1730-B. In carrying out this duty, the office may request from a hospital or an insurer information necessary to review and audit compliance and, upon request, a hospital or an insurer shall provide any requested information. Information provided by a hospital or an insurer is confidential unless a request to review the information is made in accordance with Title 1, section 408-A and the office, in consultation with the Office of the Attorney General, determines that the records do not contain proprietary information. For the purposes

**COMMITTEE AMENDMENT**

1 of this paragraph, "proprietary information" means information that is a trade secret or  
2 production, commercial or financial information the disclosure of which would impair  
3 the competitive position of the hospital or insurer submitting the information and would  
4 make available information not otherwise publicly available;

5 **Sec. A-4. 5 MRSA §3122, sub-§3, ¶I** is enacted to read:

6 I. Monitor the impact of the implementation of Title 22, section 1730-B on the quality  
7 and accessibility of hospital care in this State and on the costs of nonhospital services.  
8 The office may adopt rules pursuant to subsection 10 as necessary to address its duties  
9 under this paragraph; and

10 **Sec. A-5. 5 MRSA §3122, sub-§3, ¶J** is enacted to read:

11 J. Beginning January 15, 2027 and annually thereafter, report on the impact of the  
12 implementation of Title 22, section 1730-B to the joint standing committee of the  
13 Legislature having jurisdiction over health and human services matters and to the joint  
14 standing committee of the Legislature having jurisdiction over health coverage,  
15 insurance and financial services matters. The report must summarize the status of the  
16 implementation of Title 22, section 1730-B, its impact on the quality, accessibility and  
17 utilization of hospital care in the State and its impact on premiums paid by individuals  
18 insured by the state group health plan established in section 285, by an individual health  
19 plan, as defined in Title 24-A, section 2736-C, subsection 1, paragraph C, and by a  
20 small group health plan governed by Title 24-A, section 2808-B.

21 **Sec. A-6. 22 MRSA §1730-B** is enacted to read:

22 **§1730-B. Hospital facility price growth ceiling**

23 **1. Definitions.** For the purposes of this section, unless the context otherwise indicates,  
24 the following terms have the following meanings.

25 A. "General hospital" has the same meaning as in section 7932, subsection 2-A.

26 B. "Hospital facility price" means the total amount a hospital expects to receive for  
27 health care services, including both the amount paid to a hospital by any insurer or plan  
28 sponsor and any payment received directly from an insured or uninsured individual for  
29 institutional services.

30 C. "Individual health plan" has the same meaning as in Title 24-A, section 2736-C,  
31 subsection 1, paragraph C.

32 D. "Insurer" has the same meaning as in Title 24-A, section 3952, subsection 6.

33 E. "Plan sponsor" means any person, other than an insurer, that establishes or maintains  
34 a health plan covering residents of this State, including, but not limited to, plans  
35 established or maintained by 2 or more employers or jointly by one or more employers  
36 and one or more employee organizations, associations, committees, joint boards of  
37 trustees or other similar groups of representatives of the parties that establish or  
38 maintain the plan. "Plan sponsor" does not include the MaineCare program; the federal  
39 Medicare program; the Civilian Health and Medical Program for the Uniformed  
40 Services, known as TRICARE; the Federal Employees Health Benefits Program; the  
41 United States Department of Health and Human Services, Indian Health Service; or  
42 any program providing health benefits administered by the United States Department  
43 of Veterans Affairs.

1 F. "Small group health plan" means an insurance plan governed by Title 24-A, section  
2 2808-B.

3 **2. Hospital facility price growth ceiling.** A general hospital may not:

4 A. Beginning January 1, 2027, enter into a contract with a carrier that issues an  
5 individual health plan or a carrier that issues a small group health plan in which the  
6 growth of the allowed amount for any inpatient or outpatient facility service, for the  
7 services covered by such plans, exceeds a percentage equal to the inpatient prospective  
8 payment system annual hospital market basket update established by the United States  
9 Department of Health and Human Services, Centers for Medicare and Medicaid  
10 Services for that plan year, except that an acute care hospital with standardized  
11 commercial inpatient prices below the national first quartile may enter into a contract  
12 with any individual or small group market carrier in which the growth of the allowed  
13 amount for any inpatient or outpatient facility service does not exceed a percentage  
14 equal to the inpatient prospective payment system annual hospital market basket update  
15 established by the Centers for Medicare and Medicaid Services for that plan year plus  
16 1%;

17 B. Beginning January 1, 2028, enter into a contract with any administrator of the state  
18 employee health insurance program established in Title 5, chapter 13 in which the  
19 growth of the allowed amount for any inpatient or outpatient facility service exceeds a  
20 percentage equal to the inpatient prospective payment system annual hospital market  
21 basket update established by the United States Department of Health and Human  
22 Services, Centers for Medicare and Medicaid Services for that plan year; or

23 C. Beginning January 1, 2027, bill or collect payment for any inpatient or outpatient  
24 facility service from any out-of-network insurer whose plan would otherwise be subject  
25 to the caps in paragraph A or from the state employee health insurance program, subject  
26 to the caps in paragraph B, if the hospital is out of network with the state employee  
27 health insurance program or from an individual covered by any such plan in an amount  
28 that exceeds the hospital's median commercial negotiated rate for that same service as  
29 of the effective date of this section by more than the cumulative growth in the inpatient  
30 prospective payment system annual hospital market basket update established by the  
31 United States Department of Health and Human Services, Centers for Medicare and  
32 Medicaid Services for that plan year.

33 Upon the agreement of a carrier and hospital, individual service-level prices may exceed  
34 the caps established by paragraphs A to C as long as the average of all price changes,  
35 applied against the previous year's service mix, does not result in the growth of prices  
36 exceeding a percentage equal to the inpatient prospective payment system annual hospital  
37 market basket update established by the United States Department of Health and Human  
38 Services, Centers for Medicare and Medicaid Services for that plan year.

39 **PART B**

40 **Sec. B-1. 24-A MRSA §2736-C, sub-§2, ¶K** is enacted to read:

41 K. For each rate filing submitted for the 2028 plan year and each plan year thereafter,  
42 a carrier shall certify that its contracts with hospitals meet the requirements of Title 22,  
43 section 1730-B and provide in a format determined by the superintendent detailed

1 information on the experience period and projected trend in both utilization and per-  
2 unit payment by benefit category and by hospital.

3 **Sec. B-2. 24-A MRSA §2808-B, sub-§2-A, ¶D** is enacted to read:

4 D. For each rate filing submitted for the 2028 plan year and each plan year thereafter,  
5 a carrier shall certify that its contracts with hospitals meet the requirements of Title 22,  
6 section 1730-B and provide in a format determined by the superintendent detailed  
7 information on the experience period and projected trend in both utilization and per-  
8 unit payment by benefit category and by hospital.

9 **Sec. B-3. 24-A MRSA §4320-A, sub-§3-C** is enacted to read:

10 **3-C. Minimum negotiated rate for certain in-network primary care services or**  
11 **behavioral health care evaluation and management services.** The minimum negotiated  
12 rate of an individual or small group health plan or the state group health plan established  
13 in Title 5, section 285 for any in-network primary care service or behavioral health care  
14 evaluation and management service may not be less than the greater of the carrier's  
15 negotiated rate with the same provider as of January 1, 2026 and the following:

16 A. For plans with an effective date beginning January 1, 2028 and ending December  
17 31, 2028, 100% of the Medicare rate for the same service in the same geographic area;

18 B. For plans with an effective date beginning January 1, 2029 and ending December  
19 31, 2029, 105% of the Medicare rate for the same service in the same geographic area;

20 C. For plans with an effective date beginning January 1, 2030 and ending December  
21 31, 2030, 115% of the Medicare rate for the same service in the same geographic area;

22 D. For plans with an effective date beginning January 1, 2031 and ending December  
23 31, 2031, 125% of the Medicare rate for the same service in the same geographic area;

24 E. For plans with an effective date beginning January 1, 2032 and ending December  
25 31, 2032, 135% of the Medicare rate for the same service in the same geographic area;

26 F. For plans with an effective date beginning January 1, 2033 and ending December  
27 31, 2033, 145% of the Medicare rate for the same service in the same geographic area;  
28 and

29 G. For plans with an effective date from January 1, 2034 and thereafter, 150% of the  
30 Medicare rate for the same service in the same geographic area.

31 **PART C**

32 **Sec. C-1. Appropriations and allocations.** The following appropriations and  
33 allocations are made.

34 **OFFICE OF AFFORDABLE HEALTH CARE**

35 **Office of Affordable Health Care Z320**

36 Initiative: Provides funding for the Office of Affordable Health Care to contract with  
37 external consultants to conduct data analysis and build functionality to support  
38 implementation and compliance monitoring.

39 <b>GENERAL FUND</b>	<b>2025-26</b>	<b>2026-27</b>
40 All Other	\$0	\$25,000

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GENERAL FUND TOTAL	\$0	\$25,000
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Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

**SUMMARY**

This amendment, which is the majority report of the committee, makes the following changes to the bill.

1. It updates the price growth ceilings to apply only to individual health plans, small group health plans and the state employee health plan.
2. It adds an exception to price growth ceilings for acute care hospitals with standardized commercial inpatient prices below the national first quartile and provides the circumstances under which those hospitals may enter into a contract with an individual or small group market insurer.
3. It adds language providing that, upon the agreement of a carrier and hospital, individual service level prices may exceed the price caps as long as certain criteria are met.
4. It removes provisions establishing maximum prices for inpatient and outpatient hospital services.
5. It removes the requirement that the Office of Affordable Health Care determine whether a hospital is financially distressed.
6. It removes provisions regarding limitations on prior authorizations for treatment of chronic conditions.
7. It clarifies that the minimum negotiated rate requirements for in-network primary care or behavioral health care evaluation and management apply only to individual health plans, small group health plans and the state employee health plan.
8. It adds a graduated implementation period for minimum negotiated rate requirements for in-network primary care or behavioral health care evaluation and management.
9. It adds language requiring the Office of Affordable Health Care to, beginning January 15, 2027, report on the impact of growth caps to the joint standing committee of the Legislature having jurisdiction over health and human services matters and to the joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters. The report must summarize the status of the implementation of growth caps, their impact on the quality and accessibility of hospital care in the State and their impact on premiums paid by individuals insured by the state employee health plan, individual health plans and small group health plans.

**FISCAL NOTE REQUIRED**  
**(See attached)**