Meg Garratt-Reed, Executive Director
Office of Affordable Health Care

March 5th, 2026

Senator Henry Ingwersen
Representative Michele Meyer
Members of the Joint Standing Committee on Health and Human Services
Cross Building, Room 209
100 State House Station
Augusta, ME 04333

Senator Ingwersen, Representative Meyer, and members of the Committee,

I am Meg Garratt-Reed, Executive Director of the Office of Affordable Health Care, and I am grateful for the opportunity to come before you today to testify in support of LD 2196, An Act to Lower Health Insurance Costs, Reduce Barriers to Health Care, and Ensure Fair Prices for Health Care.

This legislation builds on a policy framework developed by my Office after several years of work studying and assessing challenges and opportunities in improving the affordability of health care in Maine. From early on, we identified the issue of hospital prices as a significant driver of affordability barriers for Maine households. Spending on hospital services makes up the largest share of health care spending in Maine and nationally, and the prices hospitals are charging commercial insurance companies have been growing faster than inflation for decades.[1]

Those prices have a direct relationship to the insurance premiums and out of pocket costs that your constituents pay. An analysis of 2025 rate increases in Maine's individual and small group markets found that unit price increases for medical services were the largest contributor to increased rates.[2] Superintendent of Insurance Bob Carey also cited rising costs of care as a significant factor in 2026 rate increases, which averaged 24% in the individual market and 18%

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[1] 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;* Federal Reserve Bank of Minneapolis. (2024). *Consumer Price Index 1913.* https://www.minneapolisfed.org/about-us/monetary-policy/inflation-calculator/consumer-price-index-1913; Rakshit S., Wager E., Hughes-Cromwick P., Cox C., and Amin K. (2024). *How does medical inflation compare to inflation in the rest of the economy.* Paterson – KFF.

[2] Wakely Consulting Group. (2025). *Medical Trends and Premium Changes in Maine Marketplace.* https://www.maine.gov/oahc/sites/maine.gov.oahc/files/2025-02/Wakely%20Trend%20Analysis%20in%20Maine%20Report%2002.07.2025.pdf

for small businesses.[3] Businesses who provide health coverage for their employees have also pointed to hospital prices as the single largest driver of cost increases.[4]

These challenges are not unique to Maine. For decades, health economists and researchers have been highlighting the relationship between the price of health services and the premiums and out-of-pocket costs that individuals and businesses face.[5] For too long, however, that understanding has been shared by the vast majority of health policy experts and economists, but largely overlooked in policy debates. If we are serious about making health care more affordable, that needs to change. As difficult as it will be – and I acknowledge that you will hear significant pushback today – this is a conversation we need to have.

Our office has approached this issue from a data-driven perspective, and although you will likely hear arguments to the contrary in later testimony, we have considered the context in which we are bringing this proposal forward. You may hear that this idea can't work in Maine because our older population means we have more Medicare enrollees and that high commercial prices are necessary to offset payment rates from Medicare and MaineCare. I understand that at face value, that concept seems to make sense. But I want to be clear: there is a broad and robust body of evidence that disproves the notion that there is a direct relationship between public payment rates and commercial prices for hospital services. Even the paper produced by the American Hospital Association which Maine hospitals have used to support this claim about cost-shifting does not actually provide any statistical evidence of a relationship between public payor mix and operating margin.[6] In fact, the authors of the report identified several other factors as key differences between profitable hospitals and non-profitable hospitals like bed size, system affiliation, expense management and length of inpatient stay. I would encourage you to review the bibliography of peer-reviewed research attached to this testimony before accepting this argument as a justification for refusing any limits on commercial hospital prices.

This bill also takes a nuanced approach, which incorporates elements designed for Maine. While the provisions limiting hospital prices have certainly received the most attention, the bill also regulates insurance – capitalizing on an opportunity to address long standing challenges cited by hospitals and other providers in how they are paid. I'd like to briefly walk through the sections of the bill to provide you with additional context about how they were developed.

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[3] *Health insurance rate spikes will hurt Mainers*, Portland Press Herald Opinion. September 4th, 2025. https://www.pressherald.com/2025/09/04/health-insurance-rate-spikes-will-hurt-mainers/

[4] *Hospital Prices*, Healthcare Purchaser Alliance of Maine, Maine Employers for Affordable Health Care. https://www.maineeac.org/hospitalprices

[5] Anderson, G. F., Reinhardt, U. E., Hussey, P. S., & Petrosyan, V. (2003). It's the prices, stupid: why the United States is so different from other countries. *Health Affairs, 22*(3), 89-105. ; Anderson, G. F., Hussey, P., & Petrosyan, V. (2019). It's still the prices, stupid: why the US spends so much on health care, and a tribute to Uwe Reinhardt. *Health Affairs, 38*(1), 87-95.

[6] American Hospital Association Research Brief, "Assessing the Impact of COVID-19 on Rural Hospitals," April 2024.

Part A of the bill includes two provisions intended to make hospital prices more fair, and to lower health care costs for individuals and businesses.

The first is a cap on service-level prices for inpatient and outpatient facility charges by hospitals. Hospitals would be limited to charging no more than 200% of the rate they are paid by Medicare for the same service. That Medicare rate varies from hospital to hospital, and includes adjustments for hospital-specific costs including geographic difference in labor expenses, Graduate Medical Education, and severity of care.

There are also two exemptions from this price cap. The first is for Maine's 17 Critical Access Hospitals, which are the smallest and often most rural hospitals in the state. The second is an exemption for hospitals in financial distress, in recognition that there are hospitals with serious financial concerns that will not be in a position to absorb revenue reductions at the time of enactment. The bill directs our office to develop a methodology to define and identify these hospitals using audited financial data collected by the Maine Health Data Organization. As I noted in my presentation to this Committee last month, hospital financial reporting is complicated, and this approach will allow us to work with hospitals and other stakeholders to develop a methodology that accounts for multiple metrics of financial health, smooths year-to-year volatility, and considers both hospital and system level factors.

Finally, these price caps would be phased-in, allowing hospitals with the highest average aggregate prices more time to gradually come into compliance, and providing a runway to make changes to improve efficiency.

The second provision in this section is a cap on how much hospital prices can grow each year. This growth cap would be tied to the Medicare Inpatient Prospective Payment System Market Basket index, the same adjustment used by Medicare to annually update its payment rates to hospitals. The methodology for this index was developed and is maintained by the Centers for Medicare and Medicaid Services, and is specifically designed to reflect increases in the cost of goods and services associated with providing hospital care, including labor costs. This provision would apply to all acute care hospitals in the state.

Part B of the bill addresses provider and patient concerns about the burden of prior authorization. It adds language to statute that limits how frequently insurance companies in the state-regulated market can require prior authorization for chronic conditions, which providers and hospitals told us was their highest priority for prior authorization reform. We do expect that this provision would increase health insurance premiums if enacted alone, but in this bill, any increase would be more than offset by other savings for consumers.

Part C of the bill requires that health insurance companies pay no less than 110% of the relevant Medicare rate for primary care and behavioral health services. We hear from many providers that rates paid by commercial payers are frequently the lowest they receive for these services from any payer – less than what Medicare or MaineCare pay. This provision requires insurance

companies to pay more for this kind of critical upstream care, a provision especially important for small independent providers that have little to no leverage to negotiate with large insurers.

This bill also takes a creative approach to broaden the reach of both the prior authorization limitations and price floors. States are generally pre-empted by federal law from regulating the kind of self-insured employer plans which cover more than 400,000 Mainers.[7] In this bill, we require those plans to comply with these provisions as a condition of benefitting from hospital price caps - expanding the reach of policies that would otherwise be limited to a small segment of the market.

Finally, the bill includes language which provides more granular data to the Bureau of Insurance to allow them to closely scrutinize the impact of price caps in the insurance rate review process and ensure that savings are passed along to consumers in the form of lower premiums.

When I presented to the Committee on this issue last month, a question was asked about the Advisory Council's position on this policy framework. During a regularly scheduled meeting yesterday, Council members considered and voted on a statement to provide this Committee with a record of their perspective. I'm including that statement with a record of the vote alongside my testimony.

In closing, I want to acknowledge again that this is a difficult conversation, and not one we undertake lightly. Hospitals are a key part of the health care delivery system, and we all want to work together to ensure that Maine people can access critical services when they need them, especially in emergencies. Maine families cannot continue to bear unlimited costs, though, and unbridled increases in prices cannot be the solution.

Thank you for allowing me the time to provide this information, and I welcome any questions.

Sincerely,

Meg Garratt-Reed, Executive Director
Office of Affordable Health Care

[7] American Academy of Actuaries Issue Brief, "ERISA at 50, ERISA and Health Benefits," October 2024. https://actuary.org/wp-content/uploads/2024/11/health-brief-erisa-benefits.pdf

Maine acute care hospitals categorized by type

Hospital Name	Hospital Type	Town	County
Bridgton Hospital	Critical Access Hospital	Bridgton	Cumberland
Calais Community Hospital	Critical Access Hospital	Calais	Aroostook
Down East Community Hospital	Critical Access Hospital	Machias	Washington
Houlton Regional Hospital	Critical Access Hospital	Houlton	Aroostook
LincolnHealth	Critical Access Hospital	Damariscotta	Lincoln
Mayo Regional Hospital	Critical Access Hospital	Dover-Foxcroft	Piscataquis
Millinocket Regional Hospital	Critical Access Hospital	Millinocket	Penobscot
Mount Desert Island Hospital	Critical Access Hospital	Bar Harbor	Hancock
Northern Light Blue Hill Hospital	Critical Access Hospital	Blue Hill	Hancock
Northern Light Charles A. Dean Hospital	Critical Access Hospital	Greenville	Piscataquis
Northern Light Sebasticook Valley Hospital	Critical Access Hospital	Pittsfield	Somerset
Penobscot Valley Hospital	Critical Access Hospital	Lincoln	Penobscot
Redington-Fairview General Hospital	Critical Access Hospital	Skowhegan	Somerset
Rumford Hospital	Critical Access Hospital	Rumford	Oxford
Stephens Memorial Hospital	Critical Access Hospital	Norway	Oxford
Waldo County General Hospital	Critical Access Hospital	Belfast	Waldo
Franklin Memorial Hospital	Critical Access Hospital	Farmington	Franklin
Central Maine Medical Center	General Acute Care Hospital	Lewiston	Androscoggin
MaineGeneral Medical Center	General Acute Care Hospital	Augusta	Kennebec
MaineHealth Maine Medical Center	General Acute Care Hospital	Portland	Cumberland
Northern Light Eastern Maine Medical Center	General Acute Care Hospital	Bangor	Penobscot
Mid Coast Hospital	General Acute Care Hospital	Brunswick	Cumberland
Northern Light A.R. Gould Hospital	General Acute Care Hospital	Presque Isle	Aroostook
Northern Light Mercy Hospital	General Acute Care Hospital	Portland	Cumberland
Pen Bay Medical Center	General Acute Care Hospital	Rockport	Knox
Southern Maine Health Care	General Acute Care Hospital	Biddeford	York
St. Joseph Hospital	General Acute Care Hospital	Bangor	Penobscot
St. Mary's Regional Medical Center	General Acute Care Hospital	Lewiston	Androscoggin
York Hospital	General Acute Care Hospital	York	York
Cary Medical Center	General Acute Care Hospital	Caribou	Aroostook
Northern Light Maine Coast Hospital	General Acute Care Hospital	Ellsworth	Hancock
Northern Maine Medical Center	General Acute Care Hospital	Fort Kent	Aroostook

Select research on "cost-shifting" and commercial payment rates

1. Frakt AB. Hospitals Don't Cost Shift Costs From Medicare or Medicaid to Private Insurers. 2017 JAMA Forum. Mar;89(1):90-130. https://jamanetwork.com/channels/health-forum/fullarticle/2760166
    a. *"... cost shifting only makes sense if hospitals do not fully exploit their market power. If they hold some in reserve and leverage it to negotiate higher private insurer prices just when facing public payment shortfalls, that leads to cost shifting. Although this strategy is possible, it just doesn't seem to be happening."*
2. 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.
    a. *"... a 10 percent reduction in Medicare payment rates led to an estimated reduction in private payment rates of 3 percent or 8 percent, depending on the statistical model used. These payment rate spillovers may reflect an effort by hospitals to rein in their operating costs in the face of lower Medicare payment rates."*
3. 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
    a. *"The share of providers' patients who are covered by Medicare and Medicaid is not related to higher prices paid by commercial insurers. That finding suggests that providers do not raise the prices they negotiate with commercial insurers to offset lower prices paid by government programs (a concept known as cost shifting)."*
4. 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).
    a. *"Taken as a whole, the literature suggests that when Medicare or Medicaid revenues increase, hospitals still aim to negotiate larger, rather than smaller, rate increases from commercial insurers. The higher prices charged to commercial insurers therefore appear to primarily (though maybe not fully) reflect traditional price discrimination, where hospitals negotiate higher rates in situations where they have more market power. "*
5. Rauscher S, Wheeler JR. Hospital revenue cycle management and payer mix: do Medicare and Medicaid undermine hospitals' ability to generate and collect patient care revenue? J Health Care Finance. 2010 Winter;37(2):81-96. PMID: 21294440.
6. 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

Office of Affordable Health Care

Representative Meyer, Senator Ingwersen, and Members of the Committee on Health and Human Services,

As members of the Advisory Council on Affordable Health Care, we are directed by statute to provide feedback to the Office of Affordable Health Care on matters affecting the cost of health care in this State. The Advisory Council has met with the Office on a bi-monthly basis since June 2023 and it offers advice on a range of topics, including analytics, opportunities and challenges of stakeholders, and policy direction.

We believe the intent of the Legislature in creating the Office and this Council was to develop proposals for the Legislature that meaningfully improve the affordability of health care for Maine people. To that end, the Office began presenting data and research identifying the significant role that rising prices of health services play in exacerbating affordability challenges for Maine people early in the process, and they presented policy domains that included strategies to address prices in August of 2024. Since that time, the Office has led a number of conversations with the Council specific to policies that directly address prices.

Advisory Council members are concerned about the financial status of Maine hospitals and the considerations for access if facilities or services close. We also believe that the burden of health care costs on families and businesses in our state is untenable. This is a difficult challenge, and one the Office has approached thoughtfully in the design of the policy – principally by creating exceptions for critical access and distressed hospitals; increasing reimbursement for primary and behavioral health care services; and by including a provision to ease the burden of prior authorization on health care providers.

While members have varying opinions on specific elements of LD 2196, An Act to Lower Health Insurance Costs, Reduce Barriers to Health Care and Ensure Fair Prices for Health Care, we believe that the idea is worthy of consideration and discussion by policymakers. While we believe the specific cap levels, evaluation methodology, and implementation structure is something the Legislature should ultimately determine, we believe this proposal is worth consideration to address the urgent healthcare affordability crisis in Maine.

Support	• Trevor Putnoky, Chair – representing purchasers of health care • Kate Ende, Vice Chair – representing health care consumer advocates • Dr. Richard Evans – representing interests of older residents • Amanda Burgess – representing health economics and research • Maureen Hensley-Quinn – representing health economics and research
Oppose	• Katie Fullam-Harris – representing hospital interests • Randy Clark – representing health care management, finance, and administration
Abstain	• Kevin Lewis – representing health insurance interests
Absent	• Dr. Renee Fay-LeBlanc – representing health care workforce interests • Malory Shaughnessy – representing behavioral health care interests • Representative Anne Graham – representing primary care providers