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Testimony in Opposition to L.D. 2196
An Act to Lower Health Insurance Costs, Reduce Barriers to Health Care and Ensure Fair Prices for Health Care
March 5, 2026

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

My name is Dan Demeritt, the Executive Director of the Maine Association of Health Plans. Insurance coverages offered or administered by our member plans provide access to care and better outcomes for many of the Mainers who receive coverage through private insurance. Our mission as an association is to improve the health of Maine people by promoting affordable, safe, and coordinated health care.

The rising cost of health care is an ever increasing burden for Maine families, employers, and taxpayers. L.D. 2196 provides state regulators with vast new authority to audit and regulate private entities without the input of stakeholders and subject matter experts responsible for providing or managing health coverage for most of the 700,000 Mainers with individual or employer-sponsored health insurance.

While we support collaborative efforts to find solutions and cost-savings, L.D. 2196 was drafted without robust stakeholder input from those responsible for financing and managing commercial coverage in Maine and fundamentally changes private contract dynamics between payers and providers.

Engagement Through Rural Health Transformation Program

Maine's Rural Health Transformation Program (RHTP) received a $190 million award from the U.S. Centers for Medicare and Medicaid Services in December of 2025 for its first year of work.[1] This promising and collaborative opportunity to strengthen rural health care is a mechanism for bringing stakeholders together to explore sustainable and workable solutions to our state's health care challenges.

We are particularly concerned that L.D. 2196 will only focus on some of Maine's providers without addressing affordability and access issues that are driving costs higher across our vast and rural state.

The bill automatically exempts Maine's 18 critical access hospitals from price caps and provides the Office of Affordable Health Care with the authority to further exempt "financially distressed" general hospitals from its payment limits (Sec. A-6, p.3, line 11), without any criteria for what constitutes financial distress.

Maine's RHTP project narrative suggests that many of Maine's hospitals may be distressed financially.[2]

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[1] https://www.maine.gov/dhhs/ruralhealth
[2] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/webform/dhhs_web_request/_sid_/V2_SoM_RHTP_Project%20Narrative_11Dec25_CMS%20Response%20ADDED.pdf P.8

Establishment of Price Floors for Primary and Behavioral Health Care

The bill also establishes the authority for the state to set minimum reimbursement for primary and behavioral health care services. Setting the precedent of a price floor for these services will shift negotiations between private parties with expert insights into the supply, demand, and costs of health care services to elected officials at the State House where lawmakers can count on being asked every biennium to adjust prices through the political process.

A better and lasting approach to strengthening primary care is already underway. Last year the Legislature created the Primary Care Advisory Council and charged it with identifying specific actions required to create a sustainable, high-functioning primary care system in the State. The Council's first annual report was published this January and is shared with my testimony.[3]

Needless and Expensive Limitations on Utilization Management

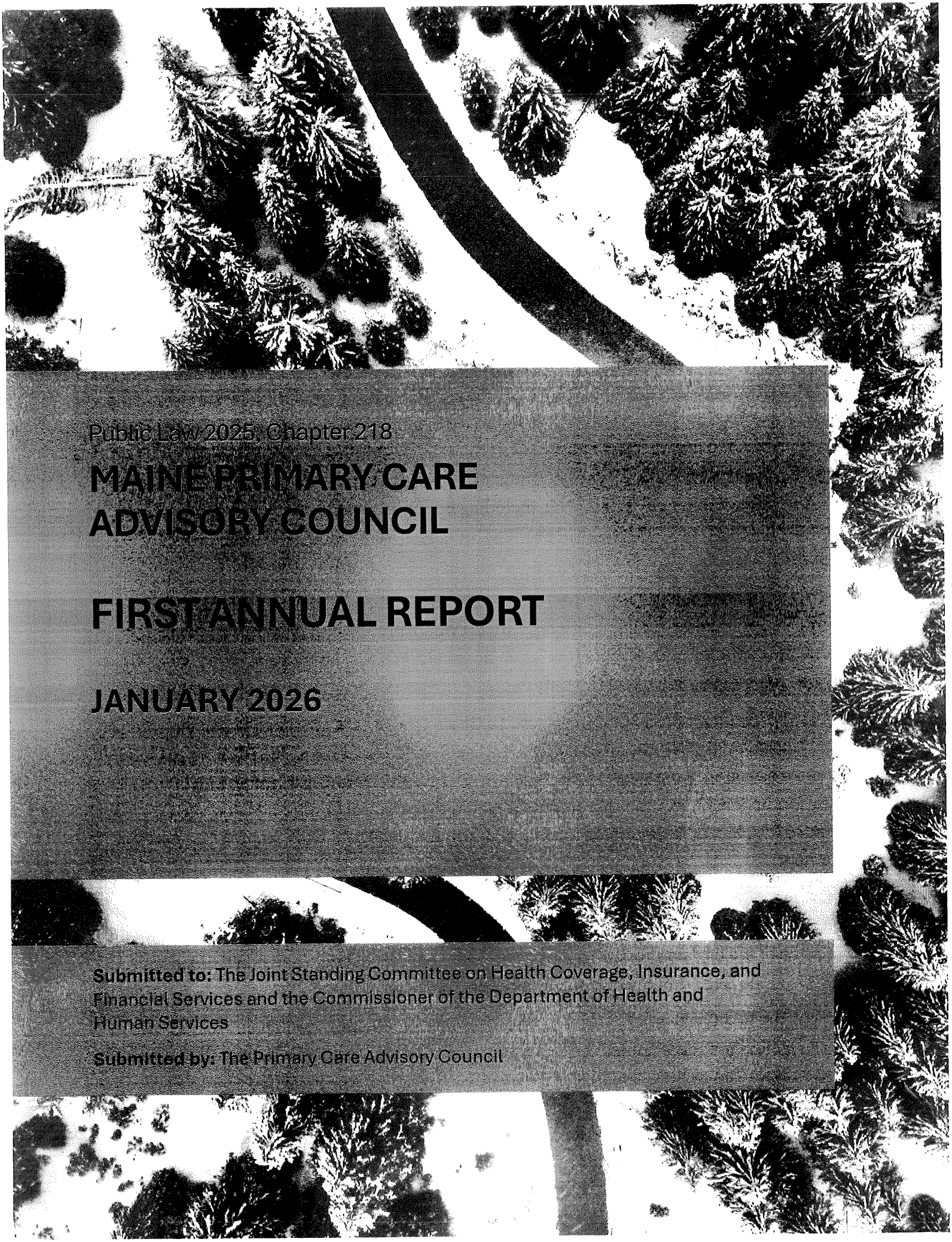
Health insurance carriers use prior authorization to make sure members are getting access to medically appropriate health care in the correct setting.

$3.86 Million Fiscal Note on L.D. 1496: Section B of the bill (p. 3, line 32) includes provisions that are similar to legislation considered during the First Special Session of the 132nd Legislature that would limit the use of prior authorization for chronic care conditions. The Maine Bureau of Insurance opposed the bill as introduced because of concerns about the impact on health insurance premiums. L.D. 1496 currently sits on the Special Appropriations Table owing to a $3.86 million fiscal note for the additional annual cost to taxpayers associated with limiting prior authorization for chronic conditions, as defined in the bill, under the State Employee Health Plan.[4] [5]

Fragmented Pricing and Utilization Rules: About two-thirds of Mainers with private health insurance are covered by employer-sponsored, self-insured plans that are exempt from state regulation under the federal ERISA law. L.D. 2196 attempts to extend state regulation to these self-insured, employer-sponsored health plans by imposing state utilization review and prior authorization limitations to access the maximum price caps the bill would set for inpatient and outpatient services. The legislation risks further fracturing the commercial market into different pricing and utilization regimes with greater administrative burden for providers and health plans as well as member confusion.

For these reasons we urge a vote of ought-not-to-pass on L.D. 2196 and thank the Committee for its thoughtful consideration.

[3] https://mhdo.maine.gov/primary_care_adv_cncl.htm
[4] https://legislature.maine.gov/backend/app/services/getDocument.aspx?doctype=test&documentId=191052
[5] https://legislature.maine.gov/legis/bills/bills_132nd/fiscalpdfs/FN149602.pdf



Public Law 2025, Chapter 218

MAINE PRIMARY CARE ADVISORY COUNCIL

FIRST ANNUAL REPORT

JANUARY 2026

Submitted to: The Joint Standing Committee on Health Coverage, Insurance, and Financial Services and the Commissioner of the Department of Health and Human Services

Submitted by: The Primary Care Advisory Council

Introduction: Maine s New Legislation to Improve Primary Care

A robust and well-supported primary care system is crucial to the health and well-being of Maine residents. Accessible, high quality primary care helps identify and address people's needs, provides resources to support health in the community, and provides preventive services that can improve health and lower long-term costs. To help sustain a high-functioning primary care system, Maine passed legislation to assess the status of primary care, identify gaps that need to be addressed, and provide policy recommendations to sustain and improve primary care in the state.

Public Law, 2025 Chapter 218, *An Act to Amend the Laws Governing Primary Care Reporting by the Maine Quality Forum and to Establish the Primary Care Advisory Council*, established the Primary Care Advisory Council (PCAC) to report out recommendations that identify specific actions required to create a sustainable, high-functioning primary care system in the State. This work will include assessing the overall status of primary care in the state using available data (both quantitative and qualitative data), including but not limited to, investment, timely access to primary care services, utilization of services, quality of care, equity and adequacy of the workforce.

PCAC Council Membership: The PCAC consists of 18 members as defined in Statute (see Appendix A). Members represent primary care providers in Maine, at least three of which much be actively practicing primary care medicine, hospitals, FQHCs, employers, consumers, third-party payors, and the State government.

Leadership and Staffing: The Council elected a Chair, Dr. Marco Cornelio, MD and Vice-Chair Lori M. Towne, MSN, FNP-BC, of the PCAC, both serving a 2-year term. The PCAC is staffed by Karynlee Harrington, Executive Director of the Maine Health Data Organization and Maine Quality Forum (MQF), and the research team at the University of Southern Maine, led by Kimberley Fox, Senior Research Associate, which supports MQF's work under a Cooperative Agreement.

PCAC Annual Reporting: Starting in January 2026 and annually thereafter until January 15, 2031, the PCAC will submit a report detailing its activities and recommendations to the joint standing committee of the Legislature having jurisdiction over health coverage and health insurance matters and the Department of Health and Human Services.

Logistics: The PCAC will meet at least quarterly each year. Meetings will be public and held virtually to accommodate schedules and distances. MQF has created a Primary Care Advisory Council page on its website where all meeting documentation will be posted https://mhdo.maine.gov/primary_care_adv_cncl.htm.

PCAC 2025 Meetings

After the PCAC members were identified (October 2025), they held two meetings on October 31 and December 19.

- **October 31, 2025 Meeting**: The first meeting focused on introductions, an overview of the legislation, a summary of the upcoming federal Rural Health Transformation Program and funding, including the highlights of potential opportunities for supporting primary care in Maine, a proposed outline for the PCAC's first annual report, and logistics for future Council meetings. The Council also discussed a preliminary strategic framework proposed by staff to help guide and organize the Council's work defined by the domains identified in the legislation.

  During introductions, each member answered the following question: ***What do you see as the most immediate need that, if addressed, will help support a sustainable, high-functioning primary care system in Maine?"*** Themes of members' responses reflected similar areas of interest identified in the statute, including:

  - Primary Care **Investment**/primary care spending related to the need for new approaches to how we pay for primary care and strategies for increasing primary care investment (e.g., funding needed to support team-based care, moving to value-based payment models instead of FFS).
  - Growing challenges of limited **access** to primary care and affordability of healthcare for consumers, particularly noting the impact that upcoming Medicaid coverage losses due to federal (HR-1) Medicaid eligibility changes will have on access to primary care, particularly in rural areas.
  - **Primary care workforce** shortage concerns resulting from currently licensed primary care physicians retiring or leaving the field due to burnout/admin burden/loss of relationship with patients and being asked to do more with less, and the difficulty of attracting future professionals into the field given lower pay relative to other specialties.

- **December 19, 2025 Meeting**: At the December meeting, the Council elected Dr. Marco Cornelio, MD to serve as Chair and Lori M. Towne, MSN, FNP-BC, Vice-Chair, both serving a two-year term. The Council heard from Maine's Office for Affordable Health Care regarding a policy framework that would result in higher payments for primary and behavioral health care, as well as reforms to prior authorization to lessen the administrative burden on providers.

Most of the December meeting was dedicated to a discussion on how best to organize the PCAC's work, specifically assessing the status of primary care in the state using available data and developing a comprehensive dashboard to display the status of primary care in Maine. The PCAC will review scorecards and/or dashboards from other states, as well as relevant national reports to help inform their work. This work will help inform the PCAC as they identify gaps in the status of primary care and potential approaches to address the gaps that will:

(a) Ensure sufficient investment in primary care services that will result in better health for residents of the State and lower overall health expenditures,

(b) Ensure a sufficient number and geographic distribution of primary care providers so that each resident of the State has a primary care provider near that resident's home, with a focus on ensuring equity in all counties,

(c) Ensure a resident's ability to access services from a primary care provider in a timely manner; and

(d) Improve the health of residents by ensuring adequate access to preventive and screening services.

The PCAC emphasized the necessity of defining the core attributes of a high-functioning primary care system, along with the scope and purpose of primary care itself, early in its process to establish a clear foundation for the group's work.

Planning for 2026 Data and Measurement

The PCAC plans to meet in February, May, July, September, and November of 2026. Measurement and the collection of information related to people's experience with access to primary care and barriers to primary care is crucial for understanding the state of primary care in Maine, which will help inform policy recommendations aimed at improving primary care in the state.

Building off prior environmental scans included in the Maine Quality Forum's Annual Primary Care Spending reports, staff has identified primary care measures in the area of investment, access, utilization of services, quality of care, and adequacy of the workforce, that Maine and other state/national organizations are reporting as a way to monitor the performance of their primary care system.

In addition to Maine, 15 other states (AR, CA, CO, CT, DE, MD, MA, NM, NY, NC, OR, RI, TX, VA, and VT) have established primary care advisory committees tasked with improving their primary care system.[1,2] Some states, including Delaware, Massachusetts, New Mexico, New York,

Oregon, Rhode Island, and Virginia have developed dashboards or reports that measure key indicators, which could help inform the roadmap for creating Maine's primary care dashboard. Examples of primary care-related measures reported by other states include:

- **Investment:** Calculated rate of primary care payment based on a defined population (primary care Per Member Per Month (PMPM) payments) and primary care per visit/unit costs
- **Timely Access to Care:** Percent of people with a usual source of care and/or primary care physician, wait time to appointments, and percent of providers accepting new patients
- **Utilization of Services**: Percent of people who had a preventive or primary care visit in the last year and percent of avoidable emergency department visits or hospitalizations
- **Prevention or Screening Services**: Preventive care screening rates (e.g., breast cancer screening, colonoscopy) and immunization rates
- **Workforce:** Percent of primary care providers per population and percent leaving or retiring

Appendix B is a sample of measures reported in selected States and Maine.

Conclusion

Health care data and evidence play a critical role in highlighting the need for and value of primary care. In many states, data has been used to identify areas of need, inform programmatic and policy priorities, and measure the impact of policy changes. Maine is rich in healthcare data, such as the all-payer claims database and the hospital discharge data managed by the Maine Health Data Organization. While this data is used by many entities for different purposes other data may also be needed to provide additional insight. In 2026, the PCAC will look at available qualitative and quantitative data in Maine that reflects the health of primary care in the state, identify data gaps, and make recommendations for future approaches to understand the people of Maine's experiences, challenges, and barriers to accessing primary care. Throughout this work, the PCAC plans to align with and/or track other related initiatives in the state to help inform what's needed to improve primary care through policy recommendations and other opportunities.

Appendix A. Primary Care Advisory Council Membership

Nominating/ Appointing Organization	Name	Title & Organization	Initial Term (years)
Maine Academy of Physician Associates	Christopher Bates-Withers, PA-C	Clinical Co-Director and Staff Physician Assistant at the Islesboro Health Center *(actively practicing)*	1
Maine Association of Health Plans (1 of 2 members)	Matthew Toohey, MD,	Managing Medical Director, Maine & New Hampshire Anthem Blue Cross and Blue Shield	1
Consumers for Affordable Healthcare (1 of 2 members)	Kate Ende	Policy Director, Consumers for Affordable Health Care	1
Commissioner of DHHS (1 of 2 members)	Lisa Letourneau, MD	Senior Advisor for Delivery System Change, DHHS Commissioner's Office	1
Maine Medical Association	James Jarvis, MD	President Maine Medical Association, Director of Education for NL Eastern Maine Medical Center	2
Maine Osteopathic Association	Kathryn Brandt, DO, MS, MEDL	Chair, Primary Care, University of New England College of Osteopathic Medicine	2
Maine Primary Care Association	Renee Fay-LeBlanc, MD, FACP	Chief Medical Officer, Greater Portland Health	2
Maine Nurse Practitioner Association	Lori M. Towne, MSN, FNP-BC	Medical Staff President, Northern Light Mayo Hospital, Family Nurse Practitioner, Clinical Lead, Primary Care Service Line *(actively practicing)*	2
Purchaser Alliance of Maine	Trevor Putnoky	President & CEO, Healthcare Purchaser Alliance of Maine	2
Maine Hospital Association	Rob Chamberlain, MD, MBA	Vice President of Population Health Management and Primary Care, MaineHealth	3
Independently Owned Practice Setting	Marco Cornelio, MD	Family Medicine, Martin's Point *(actively practicing)*	3

Nominating/ Appointing Organization	Name	Title & Organization	Initial Term (years)
Maine Association of Health Plans (1 of 2 members)	Dan Demeritt	Executive Director, Maine Association of Health Plans	3
Consumers for Affordable Healthcare (1 of 2 members)	Linda Sanborn, MD	Consumer, Former Legislator, Chair of Board for Consumers for Affordable Health Care	3
Commissioner of DHHS (1 of 2 members)	Olivia Alford	Deputy Director of Policy & Programs, DHHS Office of MaineCare Services	3
President of the Senate	Senator Henry Ingwersen, M.S.Ed.	Maine Senate	Exempt
Speaker of the House	Representative Sam Zager, MD, MPhil, FAAFP	Family Medicine, Martin's Point, and the Maine House of Representatives	Exempt
Executive Director of the Permanent Commission on the Status of Racial, Indigenous and Tribal Populations or designee (ex officio)	Ariel Ricci	Executive Director, Permanent Commission on the Status of Racial, Indigenous, and Tribal Populations	Exempt
Superintendent of Insurance or designee (ex officio)	Robert (Bob) Carey	Superintendent of Insurance	Exempt

Terms: Except for legislators and ex officio members, members of the advisory council serve three-year terms. A member may not serve more than 2 consecutive terms. The terms of Legislators serving as members of the advisory council coincide with those members' legislative terms of office.

Staggered Terms Required as follows: of the initial non-legislative and non-ex officio appointments made to the Primary Care Advisory Council,

- 4 members must be appointed to one-year terms
- 5 members must be appointed to 2-year terms and
- 5 members must be appointed to 3-year terms

Appendix B. Preliminary Sample Measures Reported in Selected States and Maine[3] *

Primary Care Measures by State	DE[4-6]	ME[7±]	MA[8,9]	NM[10]	NY[11]	OR[12]	RI[13]	VA[14]
Investment								
% primary care of total medical expenses	•	•	•		•	•	•	•
Per member per month	•		•			•	•	•
Unit costs							•	
Timely Access to Care								
% with a usual source of care/primary care physician			•	•	•	•		•
Timeliness of getting an appointment (patient-reported)			•					•
% of practices/providers accepting new patients	•		•				•	
Utilization of Services								
% with a preventive or primary care visit	•	•	•					•
% of avoidable emergency department visits			•		•			•
Number or rate of preventable hospitalizations					•			•
Prevention or Screening Services								
Preventive care screening rates	•		•	•	•			•
Immunization rates			•		•			•
Measures of delayed care (e.g., % diagnosed with late-stage colon cancer)			•					
Workforce								
Full time equivalents (FTE)	•			•		•	•	
% primary care clinicians per population	•	•	•	•	•	•	•	•
% leaving or retiring from primary care	•		•		•		•	

Working document for planning purposes

* Maine measures reflect those reported in MQF's annual primary care spending report and Maine data reported in national primary care scorecards. Other primary care-related measures may be reported for other public health and health efforts in the state that are not primary care-specific, consistently updated and/or publicly reported. These will be explored further in 2026 as additional sources for developing a comprehensive Maine primary care dashboard.

Endnotes

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