Janet T. Mills
Governor

STATE OF MAINE
STATE EMPLOYEE HEALTH COMMISSION
61 State House Station
Augusta, ME 04333-0061

Jonathan French
Labor Member, Co-Chair

Michael Dunn
Management Member, Co-Chair

STATE EMPLOYEE HEALTH COMMISSION MEETING

Thursday, August 21, 2025 @ 8:30am
Microsoft Teams Meeting
45 Commerce Drive
Department of Public Safety Champlain A & B Conference Rooms
Augusta, ME 04330

Commission Members in Attendance Olivia Alford, Lois Baxter, Claire Bell, Cecile Champagne-Thompson, Lynn Clark, Kevin Dionne, Michael Dunn, Jonathan French, Joan Hanscom, Christopher Ike, Kelly John, Rebekah Koroski, Danielle Murphy, Doris Parenteau, Shonna Poulin-Gutierrez, Heidi Pugliese, Joanne Rawlings–Sekunda, Kim Vigue, Frank Wiltuck, and Nathaniel Zmek.
(Total = 16)

Commission Members Absent: Laurie Doucette and Chris Russell.
Vacant Seat(s): 2

Others Present: Paige Lamarre, Emma-Lee St. Germain, Devon French, Roberta Dupont, Charles Luce, Emily Charlton, Rebecca Adams, Neva Parsons, and Nathan Morse – The Office of Employee Health, Wellness, and Workers' Compensation; Sabrina DeGuzman-Simmons and Kevin Fenton – Aetna; Becky Craigue, Kristine Ossenfort, Amanda Brown and Kathy Caiazzo – Anthem Blue Cross and Blue Shield; Marie Bridges – Northeast Delta Dental; Kristin Poulin and Lori Fecteau – MCD Global Health; Amy Deschaines, Ken Ralff, Ed Pierce, and Mark Holloway – Lockton; Trevor Putnoky and Lisa Nolan – Health Purchasers Alliance; Avni Doshi, Laura Kayvonfar and Brenden Horwitz – Capital Rx; Laura Robert – Sun Life; Joe Miller – Novo Nordisk; Miriam White and Zachary Breton – University of Maine; William Savage.

Agenda Item	Discussion	Action/Next Steps
I. Call Meeting to Order (8:36 am)	**Labor Member, Jonathan French** called the meeting to order.	
II. Introductions		
III. Review and Approval of Minutes (June 26, 2025)		**Labor Member, Kevin Dionne** made a motion to approve the June 26, 2025, minutes. **Labor Member, Joan Hanscom** seconded the

		motion. **Management Member, Lynn Clark** abstained**.** Motion approved.
	IV. Recurring Monthly Business	
a. Employee Health and Wellness Highlights – *The Office of Employee Health, Wellness, and Workers' Compensation*	Information contained in written report; highlights and discussion noted below: **Wellness Highlights –** • Bumper Crop: State of Maine Health Plan primary subscribers on the plan as of July 1, 2025, received $30 worth of vouchers along with the 2025 Bumper Crop program brochure by mail in July. Vouchers can be used at any participating farmers' markets in Maine and expire on 3/31/2026 to allow members to use vouchers at winter markets. The brochure included a QR code for the pre-survey. • Virta Health: The Office of Employee Health, Wellness, & Workers' Compensation worked with Virta and Anthem to produce a targeted home mailer directed to about 5,000 active plan members at risk of diabetes, pre-diabetes, and/or diagnosed Type 2 Diabetes. Virta reported 235 enrollment applications in July, the second-highest enrollment since October 2024. Current engagement is at 524 enrollments with 67 members in the Type 2 Diabetes Reversal (T2DR) program, 457 members in the weight loss program, and 173 members with applications in progress. **Communications Highlights –** • 2015-2026 Plan Year: All subscribers on the State of Maine Health Plan as of July 1, 2025, received updated identification cards from Anthem. The website has been updated to reflect all new plan documents and benefits guides. • Northern Light and Anthem Negotiations: A link to Anthem's information site regarding the ongoing contract negotiations with Northern Light can be found on the updated website.	Management Member Frank Wiltuk asked historically what negotiations entailed and what the results are; Anthem has no retrospective available, will have to take this back for an answer.

- Constant Contact Metrics: The following campaigns have been sent to one or more of the State of Maine groups in June and July, 2025 – WellstarME Summer Resources (11,717 Recipients, 49% Open Rate, 2% Click Rate), National Camping Month (14,774 Recipients, 50% Open Rate, 1% Click Rate), Gym Reimbursement Program (11,687 Recipients, 45% Open Rate, 1% Click Rate), UV Safety Month (14,356 Recipients, 47% Open Rate, 1% Click Rate), Healthy Vision Month (14, 570 Recipients, 48% Open Rate, 1% Click Rate), Aetna Healthy Home Visit (730 Recipients, 60% Open Rate, 2% Click Rate), and Bumper Crop Promotion (14,542 Recipients, 53% Open Rate, 6% Click Rate). Please note that the Open Rate for Book of Business is 50% and the Click Rate for the Book of Business is 3%.

General Reminders –

- As of September, State of Maine new hires and employees will enroll in benefits using PRISM while ancillary group hires and employees will continue to enroll in benefits using the digital Benefits Enrollment/Chane form located on the website.

- The September State Employee Health Commission meeting has been rescheduled to Wednesday, September 17.

- The second 2025 State Employee Health Commission Retreat will be scheduled this fall, likely in November. Educational sessions will be a part of the agenda.

- Roberta Dupont will be sending emails to ancillary members making sure they all have access to Move It folders to further secure our data.

- Letters and invoices regarding the Maine Guaranteed Access Reinsurance Association (MGARA) will be going out to ancillary bodies. How MGARA is tracked and how payments are obtained from responsible parties is being reviewed. As a fiduciary body, we carefully track expenses and how these expenses affect plan design. When fees are not paid, the plan must absorb the cost. Going forward, those bodies not paying their MGARA fees will be noted in this public meeting.

	• Northern Light Negotiations: Anthem had been in communication with Northern Light since February 2025 and was surprised that Northern Light informed the media that they had walked away from negotiations. Anthem believes that Northern Light should be fairly paid and are working toward that end in seeking a way to bring them back to the table. Lines of communication are open between the Northern Light Chief Executive Officer and the plan president. A contingency plan is in progress to be proactive, but Anthem is hopeful that a contract will be in place. Anthem is working with Primary Care Providers statewide and can provide 1000 slots for patients to access care at Penobscot Community Health Care in Bangor, with a rapid turnaround time for appointments. Those members in the care of specialists are protected by continuity of care requirements, and Anthem is identifying eligible members. Their treatment will continue, and they will be held harmless with in-network charges and will not be subjected to balance billing. Anthem has provided a microsite for updates on the negotiations and will be releasing further communications as information becomes available.	
b. Committee Updates - *Chair*	**Plan Design Subcommittee –** Lockton presented recommendations for the 2026 Aetna Medicare Advantage plan renewal. The 2025 renewal increase of +27.9% on Part A&B plan (+22.4% overall combined plans) required benefit decrements to meet the allowable increase of +5.9% dictated by Consumer Price Index+3% formula. $8.75 was carried over into the 2026 renewal in lieu of additional plan decrements. In the 2026 renewal, Consumer Price Index+3% represents a 5.7% increase. With the $8.75 increase carryover from the 2025 renewal, the percentage change reduces to a 5.6% increase. Lockton's plan design recommendation is to renew the Medicare Advantage plan "as is" with no plan design changes and a 5.6% increase.	**Labor Member, Lois Baxter made** a motion to approve the Aetna Medicare Advantage Plan 2026 renewal as recommended by Lockton. **Management Member, Joanne Rawlings-Secunda** seconded the motion. Motion approved.
V. QUARTERLY PLAN UPDATES		
a. Medicare Advantage Plan – *Aetna*	Information contained in written report; highlights and discussion noted below: • Your Member Demographics: There are 9,123 members with an average age of 75.5. 48.9% of members were male, while 51.1% were female.	

- Measures Showing Most Significant Change: There was a 26.6% increase in inpatient admissions per 1,000; a 7.7% increase in inpatient surgery per 1,000; a 1.9% increase in ambulatory surgery per 1,000; a 6.7% increase in total medical/pharmacy paid amount; and a 3.9% increase in the percentage of total paid amount for catastrophic claims. There was a 6.5% decrease in Emergency Room cases per 1,000.

- State of Maine Aetna Medicare Advantage Cost Results: The prior data period was May 1, 2023, through April 30, 2024, and the current data period is May 1, 2024, through April 30, 2025. Total Medical/Pharmacy at $171,675,694 was a 6.7% change over prior period; Total Pharmacy Paid Amount at $63,266,824 was a -1.4% change; Pharmacy Paid Amount Per Member at $6,936 was a -1.9% change; Total Medical Paid Amount at $108,398,870 was a 12.0% change; Medical Paid Amount Per Member at $11,882 was a 11.5% change; Inpatient Paid Amount Per Member at $3,710 was a 19.9% change; and Ambulatory Paid Amount Per Member at $8,172 was an 8% change. Key takeaway is that Medical Paid is contributing to overall spend.

- Utilization Results: A high-cost claimant is a member who has incurred $75K+ in medical costs. There are 217 high-cost claimants, which are 23.7 claimants per 1,000. The average cost per claimant if $134,096, representing 26.8% of total paid. The top spend for these claimants by diagnosis are Oncologic (32.7%), Cardiac (15.2%), Neurological (8.3%), Musculoskeletal (8.3%), and Injury/Poisoning (5.1.%).

- Top 10 Medical Catastrophic Claims Over $75,000: The top ten claims over $75,000 range from total medical paid of $306,759 to $438,971. Inpatient cost was $12,812,154 and ambulatory was $16,286,738 for a total of $29,098,892.

- Specialist and Primary Physician Office Visits: There was a 9.3% increase in Specialist Physician pay per office visit from $77 to $84; a 0.9% increase in the percentage of members with a visit from 86.9% to 87.8%; a 4.2% increase in visits per 1,000 from 4,629.2 to 4,823.9; and a 3.2% increase in visits per claimant from 5.3 to 5.5 visits.

- The top Specialist Physician visits by specialty were Dermatology, Cardiovascular Disease, Ophthalmology, Urology, and Orthopedic Surgery. There was a 3.8% increase in Primary Physician pay per visit from $101 to $105; a decrease of -0.2% in percentage of members with visit from 74.8% to 74.7%; a decrease of -2.4% in visits per 1,000 from 2,600.9 to 2,537.7; and a decrease of -2.2% in visits per claimant from 3.5 to 3.4 visits. The top Primary Physician visits by diagnosis were Unspecified Morbidity, Hypertension, Diabetes Mellitus, Neurologic Disorders-Other, and Skin Disorders-Other.

- Diagnostic Categories: Of the $108,399,095 total paid, Cardiac was 14.7%, Oncologic was 13.4%, Musculoskeletal was 11.4%, Neurologic was 8.1%, Digestive was 6.0%, Endocrine/Metabolic was 5.4%, Rheumatologic was 4.8%, Respiratory was 4.7%, Eye was 4.5%, Infectious Disease was 4.3%, Injury/Poisoning was 3.0%, Urologic was 2.7%, Skin was 2.7%, Ear/Nose/Throat was 2.3%, and all other diagnostic categories were 12.0%.

Pharmacy Plan D Plan Performance –

- State of Maine Aetna Part A & B Pharmacy Utilization: In Q2 of 2025, there were 9,112 members enrolled of which 8,637 were utilizing members, and 1,139 members in catastrophic phase. There were 116,679 scripts or which 255,810 were 30-day scripts, or "normalized" scripts. Generic utilization was 87.3% and mail order utilization was 3.2%. There were 1,692 specialty scripts, of which 2,147 scripts were normalized, for 406 unique members.

- State of Maine Part A & B Top Prescription Drugs Filled: The top ten prescription drugs filled by percentage of total cost were Eliquis, Jardiance, Humira Pen Inj, Trulicity Inj, Xarelto, Dupixent Inj, Mounjaro (4) Inj, Abiraterone, Trelegy, and Ofev.

- State of Maine Aetna Part B Pharmacy Utilization: In Q2 of 2025 there were 500 enrolled members, with 460 utilizing members. Sixty-one members were in catastrophic phase. There were 5,237 scripts, with 11,698 normalized scripts. Generic utilization was 87.4% and mail order utilization was 3.8%. Specialty scripts numbered 75 with 104 normalized scripts. There were 21 unique members.

- State of Maine Part B Top Prescription Drugs Filled: The top ten prescription drugs filled by percentage of total cost were Eiliquis, Verzenio, Lenalidomide, Austedo, Humira, Skyrizi Pen Inj, Jardiance, Abiraterone, Trulicity Inj, and Eliquis.

Clinical Outcomes and Engagement –

- Initiatives That Help Prioritize Your Retiree's Health: Healthy Home Visit is an annual home visit available to all members with higher risk members prioritized. 5,709 members were contacted for a visit, and 1,098 completed visits. There were 909 in-home visits and 189 virtual visits. The completion rate of 19% is lower than the Aetna Book of Business at 21% completion rate. The Health Risk Assessment is a biannual survey which helps to ensure accurate health status. There were 305 members contracted for the Assessment and of these, 67 members completed Assessments. The 15.1% completion rate is almost on par with the Aetna Book of Business completion rate of 15.4%.

- Your Program Results: Data from January 1, 2025, to June 30, 2025, revealed the following program results. Silver Sneakers had 2,243 retirees enrolled. Of those enrolled, 350 visited gyms with an average 7.4 visits per month. Sixty-one retirees used rides in the Transportation program for a total of 173 rides. In the Meal Delivery program, 6,556 meals were delivered to 212 retirees. The Resources for Living program made 15 connections for members to local community resources.

Industry Updates –

- Inflation Reduction Act Timeline Key Events: Upcoming key events in the Inflation Reduction Act timeline includes the Medicare negotiated Maximum Fair Price (MFP) program for 10 Part D drugs in 2026. This will set a $2,100 annual out of pocket maximum. Another key event in continued implementation of the program with a further 15 drugs added in 2027, another 15 added in 2028 and 20 added annually starting in 2029.

	Next Best Actions – • 2025 (Q 3) Next Best Actions Campaign: Starting in August, Aetna will reach out to educate members on lifestyle changes and initiation of blood sugar monitoring in Medicare members with diabetes or who are at high risk for a future blood sugar related event. Outreach is provided by email, text and direct mail to 15,000 group members. Beginning in late August, communication will go out reminding members to pick up medications on time and will stress prescription adherence, as well as promoting the convenience of mail order delivery and encouraging members to switch to larger fills. Outreach is done via email, direct mail, text and calls from CVS pharmacy staff to 27,100 group members. Starting on September 28, 2025, a campaign launches encouraging members with hypertension and low to high risk of developing cardiovascular disease to speak with their Primary Care Providers about how to better manage hypertension and reduce associated medical costs. Outreach is provided via email, text and direct mail and will reach 260,000 members.	
b. State of Maine Health Plan – Medical Update – *Anthem*	Information contained in written report; highlights and discussion noted below: • About Your Review: The current reporting period used in this review is Paid July 2024-June 2025; the prior reporting period is Paid July 2023-June 2024. High-Cost Claimants (HCCs) are members with paid claims equal to or greater than $100K, and non-High-Cost Claimants (Non-HCCs) are those with paid claims under $100K. Per Member Per Month (PMPM) is used throughout this analysis, and data includes Medical and Specialty. • Financials and Demographics: Employees comprised 51% of membership for 48% of paid amount while 15% were spouses at 12% of paid amount. Children constituted 29% of membership at 40% of the paid amount. As of June, there were 14,797 subscribers and 26,224 members with a total paid of $18,752,060. • Enrollment: Membership increased 1.8% in the current period. The average member age was 38.8 compared to 37.4 for the benchmark. Of employees,	

52% were female and average age of employees was 48.8 while total members were 52% female, with the average of all members at 38.8.

- Executive Summary (Medical): The current period Per Member Per Month trend was an increase of 11.3%, and the High-cost Claimant Per Member Per Month trend increased 21.9%. The total plan spend was $215.8M, with 32.1% of this spend from High-Cost Claimants. Circulatory, Cancer and Health Status were the top 3 conditions for 29% of plan spend. Chronic Conditions impacted 43% of members, while 24.5% were impacted by Behavioral Health claims. Primary Care Physician visits were completed by 77.2% of members, while 61% completed Adult Wellness Compliance.

- Insights on Medical Trend: Total medical trend increased by 11.3%, which is a $70 Per Member Per Month increase, and was largely driven by High-Cost Claimants, Dependents and the Behavioral Health condition category. Other conditions driving trend were Newborn, Genitourinary System, Digestive System, and Cancer.

- Place of Service: Understanding the financial and utilization trends across settings of care and educating members on appropriate utilization can help shift spend toward more cost-efficient care. Inpatient was at $151 Per Member Per Month at $472.2M, or 21.9% of total spend, with Circulatory System as the highest spend condition. Outpatient was at $264 Per Member Per Month at $82.6M, or 38.3% of total spend, with Cancer as the highest spend condition. Emergency was at $56 Per Member Per Month at $17.6M, or 8.1% of total spend, with Abdominal/Pelvic Pain, Throat/Chest Pain and Back Pain as top diagnoses by visits. Professional was at $219 Per Member Per Month at $68.4M, or 31.7% of total spend with Behavioral Health and Health Status as the highest spend categories.

- Top 5 Health Condition Categories: The number 1 condition was Circulatory with 4,461 claimants for $21.9M. Number 2 was Cancer with 1,058 claimants at $21.1M. The number 3 category was Health Status with 20,892 claimants at $20.5M. Number 4 was Digestive with 3,978 claimants at $20M, and number 5 was Musculoskeletal at $18M with 9,314 claimants.

- Non-High Cost Claimant Top 5 Health Conditions: The number 1 condition was Health Status at $18.8M with 20,587 claimants. Number 2 was Musculoskeletal with 9,113 claimants for $15.1M. Number 3 was Digestive with 3,847 claimants at $14.7M and number 4 was Ill-Defined Conditions at $13.1M with 11,095 claimants. Number 5 was Behavioral Health at $12.8M with 7,018 claimants.

- Potentially Impactable Conditions: Many chronic conditions may be preventable or treatable with lifestyle modification. Implementing wellness initiatives or incentives that target healthy eating, exercise, and stress management should be considered. Obesity had the highest prevalence rate, followed by Hypertension, Low Back Pain, Diabetes, Asthma, and Cancer, with 22% of members having 2+ chronic conditions. The top rising chronic condition by prevalence was Obesity and the top falling chronic condition by prevalence was Low Back Pain.

- High-Cost Claimants: There were 326 High-Cost Claimants, and their Per Member Per Month increased 22% with Medical Specialty drugs accounting for 16% of the spend. The top 5 High-Cost Claimant condition categories by spend were Cancer, Circulatory, Digestive, Nervous, and Newborn.

- Behavioral Health Details: The paid Per Member Per Month increased by 29.5% to a current $50.24 for a population of 7,131 claimants which is 24.5% of total membership. Of these claimants, 89% had a Primary Care Provider visit.

- Behavioral Health Metrics: Of members with a behavioral health diagnosis 52.4% have at least one other chronic condition. The top chronic conditions with Behavioral Comorbidity are Chronic Obstructive Pulmonary Disease (COPD), Asthma, Low Back Pain, Obesity, Transplant, Congestive Heart Failure, and End State Renal Disease (ESRD).

- Preventive Screenings: Prevention and well visits play a key role in the wellbeing of a population. Regular wellness checks and cancer screenings increase early detection which improves outcomes and decreases illness severity and cost. Primary care relationships help to promote screenings. Screening rates have increased in 7 out of 8 categories and 61% of members had an adult wellness visit. Seventy-seven percent of members had a Primary

Care Provider visit and members without a visit had lower compliance for cancer screenings.

- Traditional Engagement: Members should be encouraged to establish a Primary Care Provider relationship and be given communication regarding health benefits available to them via an engagement with a nurse. Consider the Anthem advocacy solution to support members for personalized care. Of High Cost Claimants, 28.5% engaged with a nurse.

- Top Ten In-Network Facility Providers: The top ten inpatient facility providers were Maine Medical Center, Eastern Maine Medical Center, MaineGeneral Medical Center, Brigham and Women's Hospital, Massachusetts General Hospital, Central Maine Medical Center, Acadia Hospital, Children's Hospital, Mid-Coast Hospital and Mercy Hospital. The top ten outpatient facility providers were MaineHealth Medical Center, MaineGeneral Medical Center, Eastern Maine Medical Center, Central Maine Medical Center, Mercy Hospital, St. Joseph Hospital, Pen Bay Medical Center, Mid-Coast Hospital, The Aroostook Medical Center, MaineHealth Lincoln Hospital, Damariscotta.

- Top 20 Emergency Department Providers by Paid Amount: MaineGeneral Thayer Center for Health, Maine Medical Center, Northern Light Eastern Maine Medical Center, Central Maine Medical Center, Pen Bay Hospital, St. Joseph Hospital, Mid-Coast Hospital, LincolnHealth – Miles Campus, MaineHealth Franklin Hospital, Northern Light AR Gould, St. Mary's Regional, Northern Light Mercy, Redington-Fairview, Northern Light Inland, Cary Medical Center, Northern Light Maine Coast, MaineHealth Stephens, MaineHealth Waldo, Down East Community, Northern Light Sebasticook Valley.

- High Level Administrative Fees and Claims: Administrative Fees-Medical was $459,323; and Claims-Medical was $22,789,097. Health and Wellness Fees was $14,372; State Surcharges and Fees (NY_CLA) was $14.35; State Surcharges and Fees (VCC_IMM) was $160,404; and Maine Guaranteed Access Reinsurance Association (MGARA) Fees were $16,388.

V. SEMI-ANNUAL UPDATE

a. Compliance Review i. **State – *Anthem***	Information contained in written report; highlights and discussion noted below: Legislative Update: In the First Regular and First Special Sessions 1,988 bills were printed. The First Regular Session ended March 21, 2025, and non-emergency legislation enacted was effective June 20, 2025. The First Special Session began March 25, 2025, and adjourned June 25, 2025, and non-emergency legislation enacted is effective September 24, 2025. More than 400 bills were carried over to the Second Regular Session. **Enacted Legislation - Mandated Benefits –** ○ L.D. 163, ***An Act to Require Health Insurance Coverage for Federally Approved Nonprescription Oral Hormonal Contraceptives and Nonprescription Emergency Contraceptives***. Effective 01/01/2026, it requires first dollar coverage of over-the-counter oral hormonal contraceptives and nonprescription emergency contraceptives approved by the FDA. Requires that most insurers provide mechanisms for enrollees to purchase them at pharmacies with no cost or payment at the point of sale and reimbursement through submission of claims for reimbursements. Introduced as L.D. 2203 last year and was subject to a pocket veto. *Enacted P.L. 2025, c. 445.* **Enacted Legislation – Pharmacy and Pharmacy Benefit Managers –** ○ L.D. 178, ***An Act Regarding Coverage for Step Therapy for Metastatic Cancer***. Prohibits the use of step therapy protocols for drugs on a carrier's formulary for the treatment of metastatic cancer and associated conditions before the carrier provides coverage of a prescription drug approved by the FDA. *Status: Enacted, P.L. 2025, c. 448.* ○ L.D. 180, ***An Act Regarding Reimbursements by Health Insurance Carriers or Pharmacy Benefits Managers to Pharmacies***. Prohibits carriers or Pharmacy Benefits Managers from reimbursing a pharmacy for a prescription drug or pharmacy service in an amount that is less than the amount the carrier or pharmacy benefits manager reimburses a pharmacy	

affiliated with the carrier or pharmacy benefits manager for the same prescription drug or pharmacy service. *Status: Enacted, P.L. 2025, c. 335.*

- L.D. 1018, ***An Act to Protect Health Care for Rural and Underserved Areas by Prohibiting Discrimination by Participants in a Federal Drug Discount Program***. Seeks to protect provider discounts under the Federal 340B drug program. Status: L.D. 1018 died because the provisions were included in the supplemental budget, L.D. 210 (Part P), enacted as P.L. 2025, c. 388.

- L.D. 1100, ***An Act to Clarify the Requirements for Accessing Nonformulary Drugs and Drugs Used to Treat Serious Mental Illness***. Requires that if a drug used to treat serious mental illness is unavailable due to a shortage, a carrier must approve a prior authorization request for an equivalent nonformulary drug if there is no equivalent drug available on the carrier's formulary. *Status: Enacted, P.L. 2025, c. 473.*

- L.D. 1580, ***An Act to Prohibit Carriers and Pharmacy Benefits Managers from Using Spread Pricing***. The bill prohibits pharmacy benefits managers (PBMs) from entering spread pricing contracts with carrier or plan sponsors for 5 years. It applies to contracts issued or renewed on or after January 1, 2026, and sunsets January 1, 2031. *Status: P.L. 2025, c.291.*

- L.D. 1687, ***An Act to Clarify and Increase Access to HIV Prevention Medications***. Requires reimbursement of pharmacists for prescribing, dispensing, and administering HIV prevention (PrEP) drugs. It also requires coverage of HIV prevention (PrEP) medications, including injectable preexposure prophylaxis drugs of any duration, with no out-of-pocket cost with an A or B rating from the United States Preventive Services Task Force and guidelines issued by Centers for Medicare and Medicaid Services. *Status: Enacted, P.L. 2025, c. 483.*

Enacted Legislation - Maine Vaccine Board –

- L.D. 93, ***An Act to Reduce Cost and Increase Access to Disease Prevention by Expanding the Universal Childhood Immunization***

Program to Include Adults. Expands the Universal Childhood Immunization Program to include adults. Allows the Vaccine Board to assess up to 10% of the program costs as an "administrative allowance" for the Department of Health and Human Services. The assessment could exceed $2M based on the current costs of the program for children alone. *Status: Enacted, P.L. 2025, c. 440.*

Enacted Legislation - Miscellaneous –

- L.D. 1310, ***An Act to Amend the Laws Governing Insurance Coverage of Preventive and Primary Health Services***. Exempts fully insured large group health plans that have co-pays only with no deductible and no coinsurance from the requirement to have one primary care office visit and one behavioral health office visit without cost shares and parity in cost sharing for subsequent primary care and behavioral health office visits. *Status: Enacted, P.L. 2025, c. 213.*

- L.D. 1361, ***An Act to Require Insurance Coverage for Covered Dental Services Provided by Licensed Dental Hygienists and to Authorize Licensed Dental Hygienists to Bill Commercial Dental Insurance***. Requires dental plans to provide coverage for services performed by a licensed dental hygienist and allows the hygienists to directly bill for those services. *Status: Enacted, P.L. 2025, c. 478.*

- L.D. 1497, ***An Act to Amend the Laws Governing Primary Care Reporting by the Maine Quality Forum and to Establish the Primary Care Advisory Council***. Requires the Maine Quality Forum to submit an annual report to Department of Health and Human Services and relevant legislative committees beginning January 15, 2026, focusing on key measures related to the status of primary care in the state, including primary care expenditures as a percentage of overall health care spending, the capacity of the primary care workforce, access to primary care services, and overall health metrics reflecting preventive and screening service usage. Also establishes the Primary Care Advisory Council, which will be responsible for assessing the primary care system's status, identifying gaps, and recommending policy changes to enhance the sustainability and functionality of primary care in

Maine. The council will also submit an annual report detailing its activities and recommendations. The provisions of the bill are repealed effective January 15, 2031. *Enacted, P.L. 2025, c.218*.

- L.D. 1511, ***An Act to Expand Direct Health Care Service Arrangements***. As enacted, the bill amends the law governing direct care arrangement to remove the requirement that a physician or advanced health care practitioner be authorized to provide primary care services. It also makes a corresponding change to the existing law that prohibits health insurer from denying payment for a covered service solely on the basis the referral was made by a direct health care provider. *Enacted, P.L. 2025, c. 358.*

- L.D. 1578, ***Resolve, to Establish the Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State***. Establishes the Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Services in the State. The commission is required to: 1. Evaluate potential changes to the State's certificate of need laws, including, but not limited to, expanding the scope of review to the termination or disruption of health care services and changing the monetary thresholds that trigger review; 2. Evaluate potential legislative changes to require regulatory review and oversight of substantial health care transactions, such as transfers of ownership or control, among hospitals, health care facilities and health care provider organizations, and 3. Evaluate the role of a private equity company or real estate investment trust taking a direct or indirect ownership interest, operational control or financial control of a hospital in the State. The Commission's report to the Health Coverage Insurance and Financial Services (HCIFS) Committee is due by January 15, 2026; the committee may report out legislation. *Enacted, Res. 2025, c.106.*

- L.D. 1785, ***An Act to Require Health Insurance Carriers to Provide Contact Information for Employees Responsible for Negotiating Health Care Provider Contracts***. Provides that upon request by a health care provider at the time a contract for a preferred provider arrangement is offered, the health insurance carrier must provide the health care provider with contact information for the carrier's employee responsible for negotiating

contract terms with the provider, including the fee schedule, at the time the contract is offered to the provider. The carrier must also keep this information updated on the carrier's electronic portal for providers or, if the carrier does not have an electronic portal, by other means of electronic notification. *Enacted, P.L. 2025, c 295.*

- L.D. 1800, ***An Act to Prohibit Health Care Entities Providing Dental Plans from Requiring a Dental Provider to Charge Fees for Uncovered Dental Services***. Prohibits insurers, third-party administrators, and other similar entities from requiring dentists and other dental professionals to provide dental care services that are not covered services at a set fee. *Enacted, P.L. 2025, c. 298.*

- L.D. 1837, ***An Act to Amend the Laws Affecting Insurance.*** Omnibus bill from the Bureau of Insurance. Relevant provisions include amending the Maine Insurance Data Security Act to require that a person who is licensed under the insurance laws of the State must require that a contracted third-party service provider notify that person when the third-party provider becomes aware of any cybersecurity event affecting nonpublic information obtained from the person that has occurred in an information system maintained by the third-party service provider or an ancillary service provider if the event has a reasonable likelihood of materially harming any consumer or any material part of the normal operations of the person. "Ancillary service provider" is defined as a person, not licensed under the insurance laws of this State, that contracts with a third-party service provider or another ancillary service provider to maintain, process or store nonpublic information obtained from a person licensed under the insurance laws of this State or is otherwise permitted access to that information through its services to the third-party service provider or other ancillary service provider. *Status: Enacted P.L. 2025, c. 348.*

- L.D. 1906, ***An Act to Improve Accountability and Understanding of Data in Insurance Transactions***. Establishes certain statutory provisions governing a plan's sponsor's claims audits of third-party administrators and pharmacy benefit managers. *Status: Enacted, P.L. 2025, c. 487.*

Legislation Held by the Governor –

- L.D. 784, ***An Act to Require Health Insurance Coverage for Specialized Risk Screening for First Responders***. Introduced as L.D. 444 last year, the bill initially required health plans to cover certain specialized risk screenings recommended by healthcare providers for first responders. As amended, it created a rebuttable presumption in litigation against a health insurance carrier that the carrier has failed to exercise ordinary care in denying coverage for a covered specialized risk screening for an enrollee who is a first responder and whose provider has determined the specialized risk screening is medically appropriate and has meaningful potential for preventive clinical benefit to the enrollee. *Status: Enacted; held by Governor.*

- L.D. 697, ***An Act to Direct the Maine Prescription Drug Affordability Board to Assess Strategies to Reduce Prescription Costs and to Take Steps to Implement Reference-based Pricing***. Amends the authority of Maine's Prescription Drug Affordability Board to include assessing strategies to reduce prescription drug costs, review of upper payment limits and reference-based pricing and establishing annual spending targets. *Status: Enacted, held by Governor.*

Legislation Carried Over - Mandated Benefits –

- L.D. 107, **An Act to Require Health Insurance Coverage for Biomarker Testing.** Requires insurance coverage for biomarker testing effective 01/01/2027. Very similar to L.D. 1577 from last year, which was subject to a pocket veto by the Governor. *Status: Carried over on the Appropriations Table.*

- L.D. 582, ***An Act to Require Health Insurance Carriers to Provide Coverage for Blood Testing for Perfluoroalkyl and Polyfluoroalkyl Substances***. Requires coverage of PFAS (Per- and Polyfluoroalkyl Substances) blood testing effective 01/01/2027. Similar to L.D. 132 from last year, except L.D. 582 permits cost-sharing, which L.D. 132 did not. *Status: Carried over on the Appropriations Table.*

- L.D. 1502, **An Act to Update the Requirements for Health Insurance Coverage of Prostate Cancer Screening**. Expands Maine's existing prostate cancer mandate to include medically necessary follow-up testing as directed by a physician, at no cost share including, but not limited to, urinary analysis; serum biomarker testing; and medical imaging. *Status: Carried over for mandate study by Bureau of Insurance.*

- L.D. 1530, ***An Act to Improve the Sustainability of Emergency Medical Services in Maine.*** Proposed amendment would require ambulance reimbursement at 300% of Medicare for in-network ambulance providers (currently 200% of Medicare) and 280% of Medicare for out-of-network ambulance providers (currently 180%). Would also amend the statute to require reimbursement for non-transporting ambulance services at the same percentages of Medicare. Prohibits double billing for covered services when both transporting and non-transporting services are involved. Requires reimbursement for administration and dispensing of opioid overdose-reversing medications. *Status: Carried over for mandate study by Bureau of Insurance.*

Legislation Carried Over - Prior Authorization –

- L.D. 910, ***An Act to Collect Data to Better Understand the Consumer's Health Insurance Experience***. Requires health insurance carriers to submit quarterly reports to the Superintendent of Insurance re: claim and prior authorization denials. Legislation enacted last year already requires reporting on some of this date. *Status: Carried over.*

- L.D. 1301, ***An Act to Prohibit the Use of Artificial Intelligence in the Denial of Health Insurance Claims.*** Prohibits health insurance carriers from using artificial intelligence to make final decisions (both approvals and denials) on coverage for healthcare services. *Status: Carried over.*

- L.D. 1496, **An Act to Ensure Ongoing Access to Medications and Care for Chronic Conditions by Changing Requirements for Prior Authorizations**. Prohibits carriers from requiring the renewal of a prior authorization for treatment of a chronic condition, including diagnostic procedures and tests, more frequently than once every 3 years of treatment

that is necessary for more than one year. *Status: Carried over on Appropriations Table.*

Legislation Carried Over - Miscellaneous –

- L.D. 896, ***An Act to Provide Young Children Stable Access to Health Care***. Proposes to establish the continuous eligibility for children enrolled in Medicaid through age 5, regardless of changes in the family's income. *Status: Appropriations Table.*

- L.D. 1890, **An Act to Facilitate the Development of Ambulatory Surgical Facilities by Exempting Certain Facilities from the Requirement to Obtain a Certificate of Need**. This bill exempts certain ambulatory surgical facilities from the requirement to obtain a certificate of need from the Department of Health and Human Services to finance or incur expenditures for a project. An ambulatory surgical facility that is owned or operated by a hospital is exempt from the requirement only if the facility is operated and paid only as an ambulatory surgical facility and does not share space with a hospital or the outpatient surgery department of a critical access hospital, even if the facility and hospital or outpatient surgery department are not open at the same time. *Status: Carried over in Health Coverage, Insurance and Financial Services (HCIFS) Committee.*

Legislation That Failed - Mandated Benefits –

- L.D. 627, ***An Act to Require Insurance Coverage for Glucagon-like Peptide-1 Receptor Agonist Medication***. Requires coverage of Glucagon-like Peptide-1 (GLP-1) medications for any purpose with a prescription and prohibits prior authorization. Extremely broad and expensive ($84-$99 per member per month before rebates and $56-$66 after rebates). *Status: Dead.*

- L.D. 1053, ***An Act to Ensure that Rebates from Prescription Drug Manufacturers are Passed on to Patients at Pharmacies***. Required that all prescription rebates be passed through at the point of sale and would eliminate the ability to use rebates to reduce premiums. A premium increase of 7% to 8% was estimated by Anthem. *Status: Dead.*

Legislation That Failed - Single Payer/Public Option/Medicare for All –

- L.D. 1070, ***Resolve, to Study a Medicaid Forward Plan for Maine***. The Resolve requires the Office of Affordable Health Care to study extending Medicaid to residents who are under 65 years of age, who have a household income greater than 138% of the federal poverty level and who are not otherwise eligible for and enrolled in health care coverage, and report to the Legislature by January 1, 2026. *Status: Dead.*

- L.D. 1269, ***Resolve, to Study the Costs and Funding of a Universal Health Care Plan for Maine.*** This resolve directs the Office of Affordable Health Care, in consultation with the Department of Health and Human Services, to study the costs and potential funding of a publicly funded, privately and publicly provided, universal health care plan for the State. *Status: Dead.*

- L.D. 1713, ***An Act to Prohibit Certain Provisions in Health Care Provider Contracts with Insurance Carriers.*** Beginning January 1, 2026, this bill prohibits contractual agreements between health insurance carriers and health care provider that include anti-tiering, anti-steering, and all-or-nothing clauses. *Status: Dead.*

State Employee Health Plan Legislation –

- L.D. 328, ***An Act Requiring the State to Pay a Retired State Employee's or Retired Teacher's Premium for Medicare Part B Under Medicare Advantage.*** Requires the State to pay 100% of a retired state employee's or retired teacher's premium for Medicare Part B under the Medicare Advantage plan beginning January 1, 2026. *Status: Carried over.*

- L.D. 467, ***An Act to Require the State to Pay Medicare Part B Premiums for Certain Retired State Employees***. Requires that the State pay 100% of the premiums for Medicare Part B for retirees not eligible for benefits under the Social Security Act whose base annual state pension benefits on or after January 1, 2026, is projected to be less than or equal to the maximum amount

of the retirement benefits that is subject to the cost-of-living adjustment. *Status: Carried over.*

- L.D. 707, ***An Act to Amend the Membership of the State Employee Health Commission and Make Referential Changes to Office of Employee Health, Wellness and Workers' Compensation***. The bill changes the name of the Office of Employee Health and Wellness to the Office of Employee Health, Wellness and Workers' Compensation, adds the State Human Resources Officer as an ex-officio member of the Commission, and provides that the management co-chair is designated by the Commissioner of the Department of Administrative and Financial Services (DAFS). *Status: P.L. 2025, c. 48.*

Participation in the State Employee Health Plan –

- L.D. 91, ***An Act to Authorize Employees of the Maine Association of Retirees to Be Eligible for Participation in the State Employee Health Insurance Program***. This bill makes employees of the Maine Association of Retirees eligible to participate in the State employee health plan. *Status: Dead.*

- L.D. 999, ***An Act to Include Employees of the Maine Indian Tribal-State Commission in the State's Group Health Plan and to Clarify Future Eligibility for the State's Group Health Plan***. This bill makes employees of the Maine Indian Tribal-State Commission eligible to participate in the State's group health plan. *Status: P.L. 2025, c. 278.*

ii. Federal – *Lockton*

- L.D. 1115, ***An Act to Expand Eligibility Under the State's Group Health Plan to Employees and Members of the Maine Association for the Education of Young Children***. This bill expands eligibility under the State's group health plan to employees and members of the Maine Association for the Education of Young Children. *Status: Dead.*

One Big Beautiful Bill Act and Benefit Plan Sponsors –

- Key Changes to Employee Benefit Plans: Key changes are a permanent extension of first-dollar telehealth coverage for High Deductible Health Plans

(HDHPs) and Health Savings Accounts (HSAs); direct primary care is no longer HSA-disqualifying and certain monthly payments are reimbursable; increased dependent care Flexible Spending Account (FSA) limit beginning in 2026; permanent tax-free nature of employer payments of employee student loan; and Trump Accounts will be effective in 2026.

- When Does All of This Come into Play?: Starting in 2025, the permanent extension of first-dollar telehealth coverage for High Deductible Health Plans and Health Savings Accounts are retroactive to plan years starting after December 31, 2024. Starting in 2026, direct primary care is no longer Health Savings Account-disqualifying, effective for months beginning after December 31, 2025, and employer payments of employee student loans will take on permanent tax-free nature subject to indexed limits.

ACA Updates –

- ACA Cost-of-Living Adjustment (COLA) Limits for 2026: The out-of-pocket limit for non-grandfathered plans is $10,600/$21,200. The affordability thresholds percentage for Safe Harbors increased to 9.96% for 2026. The maximum employee contribution for the Federal Poverty Level Safe Harbor is $129.89 per month, single coverage. The Tier 1 and Tier 2 employer mandate penalties are $3,340/$5,010.

- Other Cost-of-Living Limits for 2026: The out-of-pocket limit for High Deductible Health Plans is $8,500/$17,000. The High Deductible Health Plan minimum deductible is $1,700/$3,400. The annual Health Savings Account contribution maximum is $4,400/$8,750. The annual Health Savings Account catch-up contribution maximum is $1000. The maximum Flexible Spending Account contribution for parking, commuter Cost of Living Adjustment is to be determined.

- New Option for ACA Reporting Forms: Plan sponsors (and health insurance providers for fully insured plans) are no longer required to send the Accountable Care Act and 1095-C forms to all full-time employees and covered individuals. Instead, these forms must only be sent in response to an employee/covered individual's request. If requested, the applicable form must

be provided by the later of January 31 or 30 days after the date of the request. To take advantage of this change, plan sponsors must provide notice to employees informing them about their right to request a form.

- Other News on Accountable Care Act Filings: Plan sponsors will now have at least 90 days to respond to a proposed Employer Shared Responsibility Payment before further action is taken. The statute of limitations on penalty assessment is now a six-year period for collecting payments, counted from the due date for filing applicable forms 1095-B and 1095-C, or the actual filing date, whichever is later. It's now permissible to use an employee's date of birth on 1095 forms if the Social Security number isn't available.

- Preventive Care Update for 2026: For non-grandfathered calendar year plans additional imaging for breast cancer screening (ultrasound, MRI) are allowed if deemed necessary by a healthcare provider, as well as patient navigation services for breast and cervical cancer screening and follow-up.

Other Issues –

- Mental Health/Substance Abuse Parity: For plan years beginning on or after January 1, 2025, there are updated definitions of terms such as "medical/surgical benefits," "mental health benefits," and "substance use disorder benefits". There's a requirement to adhere to current versions of independent medical standards as well as Employee Retirement Income Security Act fiduciary certification of prudent process in selecting a comparative analysis vendor. For plan years beginning on or after January 1, 2026, there will be meaningful benefits/core treatment requirements, a prohibition on discriminatory factors and evidentiary standard, evaluation of outcomes data and heightened comparative analysis requirements. The Department of Labor announced they will not be enforcing the new requirements for 2025 and 2026.

- Game-Planning Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance: Plans must have a Non-Quantitative Treatment Limitations (NQTL) Comparative Analysis working with Third-Party Administrators (TBAs) and Pharmacy Benefits Managers (PBMs). Plans should be reviewed for any

	quantitative treatment limitations and compliance red flags, and plan sponsor should review service provider contract language and work to incorporate provisions ensuring service provider will assist in compliance, including providing an adequate comparative analysis. • Mental Health/Substance Abuse Parity: Red flags in the Mental Health Parity and Addiction Equity Act Report to Congress include exclusions related to nutritional counseling, Applied Behavioral Analysis (ABA) therapy, residential treatment, telehealth benefits, drug testing and opioid treatment; experimental/investigational determinations; preauthorization and concurrent review requirements; network adequacy; and provider reimbursement rates and admission criteria. • Johnson & Johnson/Wells Fargo Lawsuits: There's a current lawsuit trend claiming fiduciary breach regarding Pharmacy Benefits Manager contract and benefits claiming mismanagement and breach of fiduciary duties with respect to prescription drug plan, resulting in higher costs and fees. Current cases are looking at large employers with plan trust. Fiduciary rules are not new, but recent Affordable Care Act and Consolidation Appropriations Act transparency rules reveal plan costs. • Three Keys to Being a Prepared Fiduciary: The keys to being prepared are: know who the plan fiduciaries are, understand your fiduciary duties, identify and mitigate primary compliance risks, implement good plan governance and document everything.	
	VI. OTHER BUSINESS	
a. Executive Session **b. Health Commission Contract Access Policy Update** **c. Open Discussion**	Committee members entered Executive Session from 11:50 am to 12:15 pm. Because the Attorney General is out of the office, there's no firm guidance yet on the Health Commission contract access policy update. Management Member Heidi Pugliese reported that she had received communication from an employee regarding a change in provider for a prescribed specialty drug. The	**Labor Member, Kevin Dionne** made a motion to enter Executive Session. **Labor Member, Joan Hanscom** seconded the motion. **Management Member, Frank Wiltuck** abstained. Motion approved.

	employee was unaware that Capital Rx had changed vendors from Optum to Costco. Paige responded that the website had been updated with this information and that members had received letters informing them of the vendor change.	Paige Lamarre will research to make sure that the Capital Rx pharmacy booklet is updated, and Charles Luce will provide a copy of the disruption letter sent by Capital Rx to members, with member-specific medication information redacted.
a. **VIII. Adjourn Meeting (12:38 pm)**		**Labor Member, Kevin Dionne** made a motion to adjourn; **Labor Member, Lois Baxter** seconded the motion. Motion approved.

2025 meeting schedule available at www.maine.gov/bhr/oeh