MAINE CHAPTER
American College of Emergency Physicians

Quarterly Newsletter | Spring 2026

Let Them Eat Lunch

This is settled science: eating and drinking at your workstation in the emergency department does not violate OSHA regulations, is not a Joint Commission infraction, and does not harm patients. Despite years of myth-busting from multiple stakeholders — most importantly, The Joint Commission itself — this remains a sticking point in hospitals, and the collateral damage is often nurses and other non-provider staff.

If you look closely, the development of "hydration stations" or the forced removal of food from desks is often a reactive move by internal hospital representatives conducting mock surveys. These are institution-specific interpretations of broad regulatory dicta. I've participated in many external surveys: never has there been a critical finding on this topic. Our teams feel disrespected — and hungry — inciting a culture of fear and resentment, and our collective ability to work effectively and safely erodes in the process. Well-meaning infection prevention policies that prohibit eating or drinking anywhere near a patient care area sound reasonable in a conference room, but they have serious consequences for the productivity and well-being of a workforce that cannot walk away from the bedside, while also being asked to shoulder an increasing burden of patients who have nowhere else to turn.

National ACEP has already done the heavy lifting here. The evidence is compiled, the position is clear, and the regulatory myths have been systematically dismantled. [Links below.] What's needed now (still) is local leadership: emergency physicians bringing this to the table with nursing colleagues, infection prevention, and mock survey teams — not to pick a fight, but to reframe the conversation around what actually keeps our teams safe, fed, and performing at their best.

Eating & Drinking in the ED

Who Determines Where We Eat & Drink

Preparing for a TJC visit means ensuring teams are well-versed in patient care protocols, medication storage, life-safety measures, and environment-of-care initiatives. It also means ensuring front-line staff are ready and willing to answer direct questions from surveyors competently. Best to do this on a full stomach.

Chapter Updates

Advocacy: Here and in DC

Earlier this year, we provided written and in-person testimony against LD 2196, a bill that would have capped hospital reimbursement at 200% of the Medicare rate. In reality, this would have been financially disastrous for the very institutions whose EDs we staff, likely accelerating service contractions and hospital closures. I am happy to report that this bill was defeated in its current form.

The full written testimony is attached. Special thanks to President-Elect Brandon Giberson, DO, for providing live, in-person testimony.

Later this month, we head to Washington for the ACEP Leadership and Advocacy Conference. This will be an important time to meet with Maine's congressional delegation ahead of several key elections this fall. The chance to sit down directly with our elected leaders on matters important to Maine EPs will not be wasted.

Continued on Page 2

Chapter Updates – *Continued*

Leadership Summit: September 14 in Freeport

Join us at the Harraseeket Inn for our Annual Maine ACEP Leadership Summit. We plan to build on last year's theme, "**All Physicians Are Leaders**" — with a diverse group of speakers from within and outside emergency medicine. More details to come.

Treasurer Transition

At our March Membership Meeting, **Jordan Maresh, MD, FACEP,** was elected Maine ACEP treasurer, replacing **David Stuchiner, MD, FACEP,** after a distinguished 18-year run. Congratulations, Jordan — and thank you, David!

Jordan Maresh
MD, FACEP

David Stuchiner
MD, FACEP

– Stay well
Sheldon

Sheldon H. Stevenson, DO, FACEP
President, Maine Chapter
American College of Emergency Physicians

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March 3, 2026

LD 2196: Maine ACEP Position Statement

Introduction

Maine's emergency physicians witness healthcare inequity everyday, and we care for all patients regardless of insurance status. LD 2196 addresses a real and urgent problem: the cost of healthcare in Maine is unsustainable for families, small businesses, and state government. We share that concern.

However, Maine ACEP opposes this bill as written. This bill contains provisions that would significantly improve care for our patients, alongside provisions that risk destabilizing the very infrastructure that emergency medicine depends upon. We urge the Legislature to preserve what works and substantially revise what does not.

The data presented by the Office of Affordable Health Care is compelling and should not be dismissed:

- More than one in three Mainers skipped or delayed care due to costs (2023 survey).
- Two out of three families experienced financial impacts from medical bills in 2025, including difficulty paying for food, heat, or housing.
- Commercial inpatient hospital spending in Maine grew 28.4% from 2018–2024, driven primarily by price per unit, not utilization.

Maine ACEP acknowledges the urgency of this problem and supports substantive legislative action.

What We Support

Part B: Prior Authorization Reform for Chronic Conditions

Every emergency physician in Maine has witnessed a patient arrive in the emergency department because their chronic condition management was interrupted by an insurer denial. Often, this leads to expensive and time-consuming testing, ordered by physicians who know patients have nowhere else to turn. Part B's requirement that prior authorizations for chronic conditions remain valid for up to two years directly addresses this cycle.

This provision reduces administrative burden, protects patients with stable, ongoing treatment plans, and addresses a meaningful upstream driver of emergency department utilization. Maine ACEP strongly supports Part B.

Part C: Price Transparency and Reporting

Requiring insurers to submit detailed utilization and payment trend data by hospital and benefit category is a necessary step toward evidence-based policymaking. Maine ACEP **supports**

transparency as a foundation for informed reform. The data that drove this bill's development came from exactly this kind of analysis, and expanding this analysis will lead to better-calibrated solutions.

Where We Oppose

Part A: Hospital Price Caps at 200% of Medicare

The core concern with Part A is not whether hospital prices should be addressed — they should. It is whether a blunt, uniform price cap tied to Medicare rates, applied broadly and rapidly, is the right tool for Maine's unique market.

The Medicare Rate Baseline Problem

Medicare reimburses hospitals below the actual cost of providing care for many services.: a cost that includes paying living wages to thousands of essential Maine workers. A cap at 200% of Medicare does not represent a generous ceiling — in many service lines and for many Maine hospitals, it represents a compression of margins that are already thin. Unlike large urban health systems with diverse revenue streams, many of Maine's hospitals rely heavily on commercial reimbursement to sustain services that Medicare and MaineCare underpay.

Key: Maine's Price Variation Is Not Uniform

The OAHC data demonstrates the problem with a uniform cap: St. Mary's Regional Medical Center is at the 11th percentile nationally for inpatient pricing. Northern Maine Medical Center is at the 20th percentile. These hospitals are not outliers in need of correction — they are examples of responsible pricing that a blunt cap would do nothing to reward and could inadvertently harm by restricting their ability to renegotiate contracts upward.

The current evidence does not support the scale proposed in Maine

The most relevant precedent cited in the OAHC presentation is Oregon's state employee health plan, where hospital prices were capped at 200% of Medicare. A *2025 Health Affairs* study found no statistically significant changes in net patient revenue, operating margins, or staffing. This is an important finding, but the Oregon plan covered approximately 15% of the commercially insured population in that state.

LD 2196 applies to virtually all commercially insured patients in Maine. No peer-reviewed evidence exists for the effects of price caps at this scale. Maine would be conducting a large, uncontrolled experiment on its hospital infrastructure, with emergency departments bearing the first consequences of any miscalculation.

Price caps do not reduce the need for emergency care-they reduce the capacity to deliver it. Emergency department readiness — trauma capability, on-call specialist coverage, NICU services, transfer capacity — depends on the financial stability of the hospital ecosystem that surrounds us.

The "Financial Distress" Exception Is Too Uncertain

The bill's exception for financially distressed hospitals is intended as a safety valve, but it is not sufficiently reliable as written. The OAHC's own presentation shows that operating margins for

the same Maine hospitals range from −12% to +11%, depending on the methodology used. If the state cannot agree on how to calculate financial health, a distress exception administered by an executive agency — without defined timelines, transparent criteria, or an appeals process — will not provide meaningful protection for hospitals making multi-year workforce and capital decisions.

The ERISA Exemption Creates Inequity

Large self-insured employers — and their employees — are largely exempt from this bill's hospital price caps unless they voluntarily opt in , an unlikely scenario. The financial burden of reduced hospital reimbursement will fall primarily on smaller, fully-insured populations, which disproportionately include lower-income Mainers. If cost reform is the goal, this exemption should be explicitly acknowledged and its equity implications addressed.

Maine ACEP's Recommendations

Emergency physicians support efforts to improve affordability. The bill's provisions that reduce unnecessary prior authorizations and support primary and behavioral health reimbursement are worthwhile — but these improvements must not be tied to a blunt price cap that risks destabilizing our emergency care safety net.

Maine ACEP calls on the Legislature to:

- Not pass Part A as written.
- Commission a Maine-specific financial impact analysis using a consistent, pre-defined margin methodology before any caps take effect, with results reviewed by an independent body.
- Strengthen and clarify the "financial distress" exception with defined timelines, transparent criteria, an independent review process, and interim protections for hospitals under review.
- Convene a collaborative stakeholder group — including practicing physicians, rural hospitals, tertiary centers, payers, and patient advocates — to develop solutions that protect both affordability and access.

Conclusion

Emergency physicians see the immediate consequences when the healthcare system falters. LD 2196, as written, would jeopardize access to timely local emergency care, regional trauma care, neonatal intensive care, specialty interventions, and emergency transfers across Maine.

We urge you to oppose LD 2196 as written and support a thoughtful, collaborative approach that protects both affordability and emergency readiness.

Maine Chapter, American College of Emergency Physicians