Testimony of Anthem Blue Cross and Blue Shield

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

Good morning, Senator Ingwersen, Representative Meyer, and Members of the Joint Standing Committee on Health and Human Services. My name is Kristine Ossenfort. I am a resident of Portland, and I am the Senior Government Relations Director for Anthem Blue Cross and Blue Shield in South Portland, Maine. I appear before you this morning to testify 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".**

L.D. 2196 has an admirable goal, and one we strongly support—to reduce the health care in Maine. Unfortunately, however, although well intended, we fear L.D. 2196 will have a number of unintended and negative consequences. As a result, we are opposed to the bill.

Rate Setting (Part A) and Reimbursement Floors (Part C)

Part A of the bill establishes a rate cap on hospital reimbursement, equal to 200% of Medicare.

Establishing rate caps is the functional equivalent of rate setting—it is unrealistic to think that we could successfully negotiate rates that are below the cap.

Our concerns with rate setting include the following:

- Setting rates eliminates our ability to incent or reward those hospitals that provide higher quality and better value.
- The exemption from the rate caps for financially distressed hospitals may lead to the unintended consequence of a lower quality hospital receiving a higher reimbursement rate than a high-quality hospital that operates efficiently.

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- The proposal essentially punishes those hospitals that are more efficient and may serve as a disincentive to being more efficient.
- The bill does not include any criteria for determining what constitutes a "financially distressed" hospital.
- Is there a possibility that a hospital could try to walk that line in order to receive higher reimbursement?
- What incentive do those hospitals who are reimbursed at the cap to remain in-network?

Part C of L.D. 2196 would also establish a minimum reimbursement rate equal to 110% of Medicare for in-network primary care and behavioral health evaluation and management services. Our concerns with this provision include:

- It may increase premiums, without improving access or health outcomes, as any mandated increase in provider payment flows directly into premiums for individuals and employers.
- The legislation does not clearly define which Medicare rates, geographic adjustments, or service settings might apply.
- It does not align with value-based care payment arrangements, capitation, and other alternative payment models.

Prior Authorization (Part B)

Under L.D. 2196, once a prior authorization is approved for a health care service, diagnostic test, procedure, or prescription drug used to treat a chronic condition, a health insurance carrier would be prohibited from requiring another prior authorization for that service, diagnostic test, procedure, or prescription drug for two years.

This means the carrier has no ability to address inappropriate utilization. For example, of an MRI is approved for chronic condition such as chronic back pain, then the member can receive as many MRIs as the provider is willing to order for the next two years, even if is not medically necessary or appropriate.

Part B would essentially allow the unlimited use of health care services, diagnostic tests, and procedures when used to treat a chronic condition, which is broadly defined in the bill and includes any condition that is expected to last 6 months or more, which could include conditions such as cancer. Removing restrictions on prior authorization while at the same time establishing reimbursement caps for hospitals could result in increased utilization of those services to help offset lost revenues.

Healthcare affordability is a top concern for Anthem and the employers, employees, and families we serve across the state of Maine. Health insurance premiums are a direct reflection of the cost and utilization of medical care and prescription drugs.

Prior authorization is a necessary and important tool in managing health care costs. It helps to control healthcare costs by ensuring that the services and treatments being requested are clinically appropriate. It also helps reduce waste, prevent avoidable complications, and protect affordability – without compromising access to needed care. Unnecessary, ineffective, or duplicative services ultimately result in higher health care spending, which results in higher premiums and out-of-pocket expenses.

Prior authorization generally applies to select high-cost or high-risk services—Only about 3 percent of all non-emergent medical procedures are subject to prior authorization and emergency services are not subject to prior authorization.

We recognize that prior authorization must be as simple and efficient as possible, and we have taken meaningful steps to reduce the prior authorization burden and improve the experience for providers and patients. Since January 1, 2024, we have worked to narrow its use and removed prior authorization for more than 400 services and procedures.

One of the most frequent reasons for delay of prior authorization approvals is missing or incomplete clinical information from the provider. Providers who work with us to allow us to access their electronic medical records see a more streamlined process—when information is missing from the initial request, we can access that information directly in the medical record rather than have to ask the provider for that information and wait to receive it.

Placing significant limits on prior authorization or eliminating it entirely would remove an important safeguard and lead to higher overall costs for employers and employees as well as potentially unnecessary and duplicative care.

A very similar proposal was enacted by the House last session and was carried over on the Appropriations Table. The estimated cost of that proposal to the State Employee Health Plan is an increase of $3.8 million per year.

The best approach is to continue work to improve prior authorization, not abandoning it – making it more targeted, faster, and more transparent, while continuing to reduce unnecessary requirements wherever possible.

Filing requirements (Part C)

Part C requires health insurance carriers to submit detailed experience and projected trends in utilization and per-unit payment, by benefit category and by hospital, for each individual and small group rate filing. We are concerned that this provision:

- Significantly increase the regulatory burden for both carriers and the Bureau of Insurance, resulting in higher administrative costs and higher premiums.

- Requires resource-intensive processes that will be difficult and time-consuming to develop.
- Be of limited value since it may produce unreliable results as low-volume hospitals and service categories may produce misleading "outlier" trends that do not reflect underlying cost drivers.
- Move rate review away from actuarial soundness and toward implicit provider-level rate setting.

Thank you for the opportunity to share these concerns. We urge you to vote "ought not to pass" on L.D. 2196. I would be happy to answer any questions you may have either now or at your work session.