COMMUNITY Health Options

Testimony Neither For Nor Against

LD 2196, An Act to Lower Health Insurance Costs, Reduce Barriers to Health Care and Ensure Fair Prices for Health Care

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March 5, 2026

Senator Ingwersen, Representative Meyer and distinguished members of the Health and Human Services Committee, my name is Kim Cook and I am an attorney with Government Strategies, testifying neither for nor against LD 2196 on behalf of Community Health Options. Community Health Options is Maine's nonprofit CO-OP health insurance company and exists for the benefit of its Members and its mission which is to provide affordable, high-quality benefits that promote health and wellbeing.

We support the bill's broader goal of lowering the total cost of care. Rising health care prices are a primary driver of premium increases for health coverage, and reforms that increase price transparency and level negotiating imbalances are essential to health care affordability.

Part A

While we don't take a position on whether 200% of Medicare is the right benchmark, we do believe that having set prices would introduce greater cost transparency and predictability as well as create a more level playing field among insurers. Rather than competing on negotiating leverage, which favors larger insurance companies and health systems, price caps directly benefit consumers by shifting competition among health plans toward service, innovation, and benefit design. This approach can help moderate system-wide cost increases and create a fairer competitive environment that is also more transparent and consumer-centric. It is important to note that the Legislature has already embarked on setting rates between health care service providers and health insurance carriers when it set the reimbursement rates that ambulance providers are reimbursed by private health insurance carriers for certain services at either 180 or 200% of Medicare.[1]

In recognition of widespread desire by all parties to achieve greater affordability and accessibility of care, a possible exception to the price caps for the Committee to consider would be for alternative payment arrangements that are – at a minimum – fixed fee methodologies

[1] PL 2021, c. 241, An Act To Implement the Recommendations of the Stakeholder Group Convened by the Emergency Medical Services' Board Related to Reimbursement Rates for Ambulance Services by Health Insurance Carriers and To Improve Participation of Ambulance Service Providers in Carrier Networks

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and that meet an established timeline for achieving certain hallmarks of value based purchasing that produce lower total costs of care.

Part B

We are, however, concerned that certain aspects of the bill's prior authorization provisions would undermine cost-containment gains by allowing non-medically necessary utilization. Prior authorization is a management tool that allows health plan clinicians to verify both the appropriateness of care being provided and that the service is covered under the plan's benefits. Limiting our ability to review proposed treatment may increase unnecessary and expensive care. It would also reduce the effectiveness of our care management, as we would not have the awareness in real time to introduce opportunities for alternatives to higher cost treatments or medications.

Most authorizations are issued for 90 days, and extensions are routinely granted when medically appropriate. As drafted, the bill could effectively create a standing authorization for high-cost services without periodic reassessment. For example, if advanced imaging such as an MRI is approved for a chronic musculoskeletal condition, the authorization could remain in place for a full year without any review of whether additional imaging remains clinically necessary. In practice, this could result in multiple high-cost scans being performed even if the patient's condition is stable or improving.

According to CompareMaine.org, the average price of an MRI in Maine ranges from $900 to $1000, though in some locations costs exceed $4,000 per scan.[2] If someone receives repeat imaging every three months under a year-long authorization without reassessment, total imaging costs alone could exceed $16,000 annually for one condition. We are concerned that even modest increases in utilization would materially increase overall claims costs and, ultimately, premiums.

Sustained increases in claims generally translate into higher premiums. This is of particular concern in relation to prescription drugs. A medication approved for a chronic condition may later be removed from the formulary in favor of a lower cost alternative. If a prior authorization remains locked in for a full year without review, both the member and the plan may continue paying avoidable costs. The prior approval process alerts providers to changes in the formulary and the availability of generic drugs, thus promoting savings for Members both in the form of cost sharing and ultimately through premiums that are reduced as a result.

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[2] CompareMaine. https://www.comparemaine.org/?page=choose&search-text=mri#.

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Many drugs that people take over the span of several years, like SSRI's or cholesterol-lowering drugs, do not require prior authorization. Drugs that may be prescribed for several years and do require prior approval usually have high costs and significant side effects. These prescriptions often are treating conditions for which new drugs are being developed. Some drugs require prior approval and are not intended for long term consumption and can be contraindicated for use with other prescriptions. The prior approval process screens for safety concerns, reflects established medical guidelines, and alerts for opportunities to lower the costs of treatment.

Thank you for the opportunity to express our support for reforms aimed at lowering the total costs of care and improving transparency and market competition. Establishing common reimbursement standards can meaningfully control health care costs and shift insurer competition toward quality, service, and value for Maine consumers. At the same time, we oppose the blunt instrument of locking in a treatment plan for longer timeframes and undermining prior authorization as a management tool in a traditional fee for service reimbursement model.