October 10, 2025

Megan Garratt-Reed, Executive Director
Office of Affordable Health Care
11 State House Station
Augusta, ME 04333-0011

Re: 2025 Annual Public Hearing of the Office of Affordable Health Care

Dear Ms. Garratt-Reed:

On behalf of Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield (Anthem), I am pleased to submit these comments in connection with the public hearing by the Office of Affordable Health Care that took place on September 29, 2025.

Anthem has been providing high-quality, affordable healthcare for Maine residents for more than 85 years. As one of Maine's largest health insurers, Anthem provides healthcare services to more than 200,000 members throughout the state. We share the goal of increasing access to affordable, quality healthcare for Maine residents and appreciate the opportunity to offer these comments.

Provider Market Consolidation

As we have noted in our comments in prior years, Maine has a highly concentrated provider landscape that is dominated by two large hospital systems. Of the 35 hospitals in Maine, over 60% are owned by just two hospital systems. MaineHealth owns 12 of those hospitals, or 34% of all hospitals in the state, while Northern Light owns 9 hospitals, or 26% of the hospitals in Maine. These two systems also own a large number of physician practices. This means that these provider systems are in a position of extreme strength and hold significant leverage when negotiating contracts with health insurers, particularly when combined with network adequacy requirements.

In concentrated health system markets, healthcare costs and, in turn, health insurance premiums have increased as a result of consolidation, despite claims by

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health systems that consolidation will result in lower costs and greater efficiencies. For example, a Federal Trade Commission Staff Policy Paper issued in August 2022 noted that there were substantial increases in commercial inpatient prices at unregulated hospital (Maine Medical Center) during the certificate of public advantage (COPA) period (at least 38%) and by 62% after the expiration of the COPA – an average increase of 50% during the post-merger period.[1] Similarly, the prices at Southern Maine Medical Center (SMMC) increased by almost 50% after the COPA period ended in 2015, with a decline in SMMC's quality measures.

Similarly, a recent study on the impact of hospital consolidation on healthcare prices, referenced in the presentation by Office of Affordable Health Care (OAHC) staff at the public comment session on September 25, found that a 5% increase in healthcare prices results in over 200 jobs lost and $32 million in lost wages.

A recent Issue Brief by the Kaiser Family Foundation[2] and an article in Health Affairs Forefront[3] also discussed the impact of hospital consolidation on healthcare prices. In the Forefront article, Health Affairs notes:

> The weight of the empirical literature shows horizontal hospital consolidation increases hospital prices from 20 percent to 40 percent, depending on the degree of concentration and market power. Economic evidence also suggests that cross-market hospital mergers—consolidation between hospitals in separate geographic markets—can increase hospital prices by an estimated 6–16 percent. Estimates of the price increases from vertical hospital-physician consolidation range from 14.0 percent to 33.5 percent, depending on the market concentration and specialty.
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> On top of that, research has found that higher prices from hospital mergers come directly from wages. Researchers found that higher provider prices from consolidation increased the cost for insurance premiums and out-of-pocket costs, which are taken from workers' wages. This led to an estimated reduction in US worker wages by nearly $1 trillion from 2012 to 2022, with other studies finding increases in "deaths of despair."[4]

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[1] FTC Policy Perspectives on Certificates of Public Advantage, Staff Policy Paper, August 15, 2022, https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf, p. 10.
[2] "Ten Things to Know About Consolidation in Health Care Provider Markets," Levinson, Godwin, and Neuman, April 19, 2024, Ten Things to Know About Consolidation in Health Care Provider Markets | KFF.
[3] "The Rise Of Health Care Consolidation And What To Do About It", Health Affairs Forefront, September 9, 2024.
[4] *Id.*

The article goes on to state that "The increased costs in health care markets due to consolidation have come with no gain, and even decreases, in quality. Oftentimes, improved patient quality of care is touted as a justification for consolidation, but there is little evidence to support this claim."[5] A 2023 report issued by the Elevance Health Public Policy Institute showed similar results.[6]

Large health systems are able to leverage their market share in several ways, including:

1. Limiting an insurer's ability to exclude affiliated facilities or professionals from a preferred tier, regardless of cost or quality.
2. Prohibiting or limiting an insurer's ability to direct or "steer" members to lower-cost, higher-quality care.
3. Requiring "all or nothing clauses" that require insurers to contract with all affiliated facilities and professionals, regardless of cost or quality.

These anti-competitive contract terms, known as "anti-tiering," "anti- steering," and "all-or-nothing" clauses, as well as similar provisions, protect providers' highly inflated costs – costs that patients and consumers pay through higher premiums and out-of-pocket costs.

Hospital systems can and do use this leverage in their negotiations with health plans in several ways, including:

- Demanding exorbitant rate increases;
- Requiring favorable positions in a carrier's network, such as placement in a higher tier to the exclusion of competitors, regardless of cost or quality;
- Insisting on the same preferential treatment for all owned hospitals; and
- Threatening to terminate all providers in the system when a contract for only one hospital is the subject of negotiations.

We have seen this dynamic repeatedly in the Maine market. To address this provider consolidation issue, Anthem recommends the following policy solutions:

- ***Address anti-competitive contracting practices:*** Anthem recommends prohibiting anti-competitive provisions in contracts between carriers and providers, such as all-or-nothing, anti-tiering, and anti-steering clauses. These

[5] *Id.*
[6] Costs & Quality After Independent Hospitals Are Acquired by Health Systems, Elevance Health Public Policy Institute, August 2023 (https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/63/EH_Hospital%20Merger_R6_7-21-2023_FINAL.pdf).

reforms will enhance competition among providers and create an opportunity for health plans to engage in access and network innovation.

- ***Increase state review of hospital and healthcare provider consolidation:*** Consolidation of previously independent provider groups under a single hospital system is driving up the price of healthcare services. These are the same services provided before and after the consolidation with the exception that the consolidation under the hospital system can trigger higher contract prices for payers.
- ***Recognize the hospital financial data reported to the Maine Health Data Organization (MHDO) as the "source of truth":*** There is conflicting information about the financial status of some of Maine's largest hospital systems—one source of truth is needed. The MHDO should be the source of truth for hospital financial information, particularly as it relates to the work of OAHC. Since hospitals are required to submit financial data to the MHDO[7], we believe MHDO is a consistent, reliable source of hospital financial information.

We would note that some of these concepts may be considered by the recently established 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 (the "Health Care Oversight Committee").

Certificate of Need

Maine's Certificate of Need ("CON") law, while well meaning, has not operated as intended. At Anthem, we are constantly seeking to provide our members with access to high quality healthcare services at the lowest prices possible. An important element of that effort includes redirecting care, when possible, from high-cost providers to lower cost providers who can provide equally effective care.

For example, Ambulatory Surgical Centers ("ASCs") provide high quality, lower cost alternatives, often providing a better patient experience. A report issued by the Anthem Public Policy Institute in July of 2020 looked at claims from 3.7 million members covered under Anthem health plans across our fourteen states and found that services delivered at ASCs are less expensive and of comparable quality to that of a hospital outpatient department.[8] For example, a total knee replacement costs approximately $60,000 at hospitals within 50 miles of Portland Maine while the

[7] 22 M.R.S.A. § 8709 and MHDO Rule Chapter 300, "Uniform Reporting System for Hospital Financial Data".
[8] Comparing Outpatient Sites of Service for Gastrointestinal Procedures, Anthem Public Policy Institute, July 2020, Comparing Outpatient Sites of Service for Gastrointestinal Procedures (https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/41/41_report.pdf).

same procedure can be obtained within 50 miles of Portsmouth, NH for as little as $26,000[9].

These costs impact not only premiums but also members' out of pocket costs and plan design, as benefit design can be used to incent people to use lower cost sites of care.

In Maine, however, there is a significant lack of affordable alternative providers and sites of care to which we can redirect our members. Unfortunately, CON has not curbed the development of large, monopolistic systems but has served as a barrier to the development of alternative sites of care. For example, in 2021, Central Maine Health Systems sought to create an ASC in Topsham, but the application was denied due, in large part, to significant opposition from a competitor, who sought and obtained approval for their own ASC in 2025.

We would also note that Certificate of Need is one of the issues to be considered by the recently established Health Care Oversight Committee.

Recognizing the need for prior authorization and utilization management.

Increasingly, we are seeing efforts to limit the ability of health plans to use tools such as prior authorization to manage utilization. Employers, individuals, and families purchasing health insurance coverage entrust health plans to manage care and ensure that members receive the right care, in the right setting, at the right time.

Today, these vital tools used by health plans at the request of insurance purchasers are under constant attack. In the 131st Legislature, two pieces of legislation were enacted to curtail the ability of health plans to use prior authorization that ensures members are getting the right care and maximizing the benefits under their plan.[10] Yet another bill, L.D. 1496, is pending in the 132nd Legislature that would increase costs significantly by essentially putting prior authorizations related to the treatment of chronic conditions in place for three years, regardless of continued medical efficacy, medical necessity or the development of newer and more effective and less expensive treatments.[11]

Health plans use prior authorization in limited circumstances to protect patients and lower their out-of-pocket costs by preventing misuse, overuse, and unnecessary or

[9] Data obtained though Find Care logged in as a member on Anthem.com.
[10] 131st Legislature, L.D. 796, "An Act Concerning Prior Authorizations for Health Care Provider Services," and L.D. 1383, "An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services".
[11] 132nd Legislature, L.D. 1496, "An Act to Ensure Ongoing Access to Medications and Care for Chronic Conditions by Changing Requirements for Prior Authorizations".

potentially harmful care, and to ensure that care is consistent with evidence-based practices.

According to a Milliman analysis commissioned by the Blue Cross Blue Shield Association in March 2023, the estimated premium impact of removing prior authorization would range from $37.30 to $58.31 per member per month (PMPM).[12] In addition, another analysis commissioned by Elevance Health in June 2023, conducted by the consulting actuarial firm Pasco Advisers, estimates that the premium impact of removing prior authorization in the state of Connecticut would be $6.22 to $16.83 PMPM, representing an increase of 1.5% to 3.4% depending on business segment.

Without utilization management tools, health plans will be left with few, if any, strategies to effectively drive quality and safety, ensure proper utilization, and rein in unnecessary spending. This will result in employers and consumers bearing the brunt of increased costs through higher premiums.

Establishing Cost Growth Targets

Elevance Health shares states' goals of making healthcare more affordable, accessible, and equitable. We are concerned, however, that a cost growth target diverts states' and insurers' attention and resources from important reforms that will have an immediate, positive impact on consumers and employers in the form of lower premiums and out-of-pocket costs.

Implementing a cost growth target requires states and insurers to invest significant resources in programs that do not yield new information and are redundant to existing processes for gathering and analyzing healthcare cost data. For example, California's 2022-23 Budget allocated $15.5 million to its cost growth benchmark program to cover the cost of 59 staff members; that number has increased to $32 million for up to 142 staff members for 2024-2025 and annually thereafter.
No state has been able to demonstrate a correlation between implementation of its cost growth benchmark program and lower healthcare costs. States that have implemented cost growth benchmarks have not seen a meaningful reduction in their overall healthcare spending. Only Massachusetts has published cost benchmarking results for periods prior to 2022, and those results show that:

- Massachusetts has exceeded its cost benchmark in seven of the eleven years that its program has been in place.

[12] Potential impacts on commercial costs and premiums related to the elimination of prior authorization requirements, Milliman, March 30,2023, https://www.milliman.com/en/insight/potential-impacts-elimination-of-prior-authorization-requests.

- For 2020-2021, Massachusetts experienced a 9% increase in cost growth;for 2021-2022, 5.8% cost growth; and for 2022-2023 8.6% cost growth– far exceeding the state's 3.1% and revised 3.6% target benchmarks.[13]
- Since establishing its cost growth benchmark program in 2013, Massachusetts regulators have required only one hospital system to implement a performance improvement plan.[14]

Maine already has extensive healthcare price transparency and solutions to drive lower spending growth, including:

- An extensive individual and small group market rate review process, which yields detailed information on cost drivers.
- An all payer claims database (APCD) that systematically collects healthcare claims data from a variety of payer sources which includes claims from most healthcare providers.
- In 2020, CMS issued the Hospital Price Transparency Rule requiring that effective January 1, 2021, hospitals' standard charges, including the rates they negotiate with insurance companies, be made publicly available, free of charge, and presented in a consumer-friendly display.[15]

To effectively slow the speed of healthcare cost growth, policymakers should focus on addressing the largest components of spending. Using data from 2020-2022, AHIP has identified the following as the largest areas of healthcare spending[16]:

- Prescription Drugs—24.2%
- Out-Patient Hospital Costs—19.9%
- In-Patient Hospital Costs—17.6%
- Doctor Visits—11.6%
- Other Out-Patient Care—7.1%

The following proposals will lead to more meaningful and lasting change with a more immediate impact for consumers, as opposed to the implementation of a resource

[13] Massachusetts Center for Health Information (CHIA), "2025 Annual Report on the Performance of the Massachusetts Health Care System." March 2024. Available at: https://www.chiamass.gov/assets/2025-annual-report/2025-Annual-Report.pdf
[14] Massachusetts Health Policy Commission voted in January 2022 to require Mass General Brigham to implement a Performance Improvement Plan (PIP). More details available at: https://masshpc.gov/cost-containment/pips/mgb
[15] Centers for Medicare and Medicaid Services hospital price transparency requirements. More detail can be found at: https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/hospitals
[16] AHIP, "Where Does Your Health Care Dollar Go?" October 24, 2024. Available at: https://www.ahip.org/resources/where-does-your-health-care-dollar-go.

intensive cost growth target to collect information that states already obtain through existing channels.

- Address anti-competitive contracting practices;
- Provide for State enforcement of the requirements around appropriate billing for professional healthcare services;
- Enact meaningful prescription drug reforms; and
- Allow reasonable utilization management.

Reference-Based Pricing

Anthem does not support reference-based pricing to drive affordable, high-quality care. Arbitrarily reducing provider payments using blunt price controls will negatively impact consumers through reduced access and potentially lower quality care.

If doctors, hospitals, and other providers are forced to accept substantially more patients at Medicare rates, which are 40 percent lower on average than private insurance rates, providers likely would have to limit the number of patients they accept. Hospitals and clinics could be forced to close or reduce care options, and the long-term supply of providers would be reduced, leaving health plan enrollees with longer waits or unable to see the doctors they want and trust.

Targeted policies that address rising healthcare costs are a more effective approach to improving affordability and access to quality healthcare coverage. As discussed above, Anthem is supportive of policy changes aimed at addressing increasing provider and prescription drug costs, reducing inappropriate utilization, strengthening the individual market, and improving health information interoperability and consumer access to information on price and quality.

Healthcare cost trends for Maine and the country make clear that changes are needed to achieve our shared goals. Achieving meaningful change takes collaboration with providers, and Anthem is at the forefront of the effort to shift to provider value-based reimbursement.

Our philosophy is deeply rooted in partnerships that empower care providers in Maine and across the country by:

- ***Contracting for value*** with reimbursement models and aligned incentives that give providers autonomy and flexibility, allowing them to focus on traditional preventive care as well as consumers' pharmacy, behavioral health, and social needs; and

- ***Collaborating for success*** with tools and resources that make it easier for providers to access the data necessary to help patients make the right care decisions at the right time.

Value-based care is about allowing providers the freedom to treat the unique needs of their patients and communities, while at the same time meeting evidence-based standards that help ensure all consumers benefit from high performance. It's beneficial for patients, for the healthcare system, and for society at large. We know that value-based care — particularly when providers share in downside risk — increases preventive care, reduces the need for costly invasive care, incentivizes whole health, lowers costs, and allows providers to focus on their patients.

Anthem recommends that policymakers focus on policy reforms that address healthcare cost growth by increasing quality through value-based payment arrangements and alternative payment models (APMs), and by increasing interoperability between healthcare systems to reduce unnecessary administrative costs and streamline data sharing.

Public Option Proposals

Government designed and mandated public options and other similar proposals are not new and have been raised as part of healthcare reform debates for several years, at both the federal and state levels.

Recent experience in Colorado has clearly demonstrated that state public option proposals do not address the underlying costs of care and are ineffective at reducing premium costs. A 2024 study found that the Colorado public option failed to generate meaningful premium decreases, reduced consumer choices, and hurt competition in the Colorado insurance marketplace.[17] CMS data shows that the Colorado Option fell far short of its 10 percent premium reduction target in its second year of operation.

- In the overwhelming majority of Colorado service areas, the Colorado Option reduced premiums by less than one percent. In 23 of Colorado's 34 service areas, which together encompass the vast majority of the state's market, the Colorado Option reduced premiums by less than 0.5 percent, while reinsurance lowered premiums by 15-32 percent.

[17] Colorado's Health Care Future, New Study: Colorado Option Fails to Deliver on Promises of Greater Affordability and Coverage, November 12, 2024, https://coloradoshealthcarefuture.org/co-option-fails-to-deliver-on-promises-of-affordability-and-coverage.

- In the Denver service area, which encompasses 40 percent of the Colorado market, the Colorado Option reduced premiums by less than 0.2 percent whereas reinsurance reduced premiums by 15 percent.[18]
- In reviewing carriers' NAIC SERFF filing for actual 2024 benefit year rates, only 0.6 percent (three plan/county combinations out of 468 total) met the 10% premium reduction target. The Colorado premium reduction targets are at the county level. As a result, any Colorado Public Option plan offered in multiple counties will have multiple premium reduction targets for each county, which means that there are 468 plan/county combinations to assess whether carriers are or are not meeting the 10% premium reduction target for the 2024 benefit year.[19]

We believe a public option will be largely ineffective in expanding access to care and reining in rising healthcare costs. These goals are better achieved by addressing underlying prices for healthcare services, while building on the private coverage that over 170 million[20] Americans now enjoy.

Introduction of a government designed and mandated public option plan always results in an unlevel playing field, as the public option plan has a competitive advantage over private plans, such as mandates that providers be reimbursed at Medicare rates and join the public option network if they participate in other federal programs such as Medicare and Medicaid. The Congressional Budget Office (CBO) notes that the public option's competitive advantages would result in the following:

- Fewer coverage options as a result of private insurers being forced to exit the market;
- Reduced access to care for seniors and low-income families as the public option decreases providers' revenue leading them to opt out of Medicaid and Medicare ; and,
- Increases in private plan premiums as insurers lose market share and bargaining power with providers.[21]

Some suggest that a government plan could exist on a level playing field if it were required to negotiate provider payments and meet all the same requirements as

[18] Colorado's Health Care Future. Despite New Federal Pass-Through Funding, the Colorado Option is Still Failing to Increase Affordability. September 16, 2024. https://coloradoshealthcarefuture.org/the-colorado-option-is-still-failing-to-increase-affordability/
[19] Carrier 2024 Rate Filings – BY24 Colorado Option Rate Reduction Notice Templates. https://filingaccess.serff.com/sfa/home/CO
[20] Nonelderly population. ASPE Office of Health Policy. "Trends in the U.S. Uninsured Population, 2010-2020". (February 11, 2021).
[21] "A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications," Congressional Budget Office, 4/21. Retrieved from https://www.cbo.gov/publication/57125.

private plans. However, as the CBO notes, the federal government would face significant, administrative complexities in negotiating with thousands of healthcare providers. More importantly, even if the program initially adopted this approach, political pressure to reduce costs would quickly lead to price-setting. This is precisely what happened with the Medicare program, which was initially set up to pay private rates in 1965, but quickly resorted to government price controls. The end result of a public option would be fewer plan choices, reduced access to care, lower quality care, and increases in taxes, and state spending.[22]

Mandated Benefits

In looking at the cost of health insurance, mandated benefits must be examined. According to the Bureau of Insurance, mandated benefits represent approximately 10.5% of the health insurance premiums.[23] Mandated benefits limit flexibility in plan design and increase costs—often resulting in higher premiums and higher out-of-pocket costs for health plan enrollees. As a state, we need to carefully consider the cost -benefit analysis in considering whether to enact additional mandated benefits.

Thank you again for the opportunity to share these comments. Anthem stands ready and looks forward to continuing to work with the Office of Affordable Health Care, policymakers, and other stakeholders to advance policy approaches to make healthcare more affordable, accessible, and equitable. In this letter, we detail actions that Maine policymakers can take today to address the underlying drivers of healthcare costs and build on the private coverage that over 170 million Americans now enjoy. We ask you for your support on these recommendations, so everyone receives the care they need regardless of age, gender, race and ethnicity, income, disability or place of residence—urban, suburban or rural.

Sincerely,

Kristine M. Ossenfort
Senior Government Relations Director

[22] Joseph Antos and James Capretta, "The Heavy Hand of the Public Option," RealClearPolicy, 6/18/19.
[23] "Review and Evaluation of Amendment to LD 1832, An Act to Require Reimbursement of Fees for Treatment Rendered by Public and Private Ambulance Services," Maine Bureau of Insurance, January 2024, pp. 21-31 (https://www.maine.gov/pfr/sites/maine.gov.pfr/files/inline-files/LD-1832-Paramedicine-Report_0.pdf).