AMA
AMERICAN MEDICAL ASSOCIATION

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May 19, 2021

The Honorable Rhonda Fields
Chair
Committee on Health and Human Services
Colorado State Senate
200 E Colfax
RM 246
Denver, CO 80203

Re: AMA concerns with House Bill 1232

Dear Chairwoman Fields:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I am writing to express our concerns with House Bill (H.B.) 1232, legislation to establish a standardized health benefit plan in Colorado.

The AMA shares your deep interest in improving access to, and affordability of, health insurance. Covering the uninsured and improving health insurance affordability have been long-standing goals of the AMA. Since the enactment of the Affordable Care Act (ACA), the AMA's proposal for reform has continued to evolve to ensure that AMA policy is able to address how to best cover the remaining uninsured in the current coverage environment. Recently, we put forward an updated series of proposals to cover the uninsured that also considers the impact of the COVID-19 pandemic on health insurance coverage, as well as the enactment of the American Rescue Plan into law.

The AMA believes that, with guardrails in place to protect patients and physicians, public options should have the goals of maximizing patient choice of health plan, as well as health plan marketplace competition. In fact, AMA policy offers meaningful criteria that, in our view, could lead to a public option that responds to the unique needs of patients, and physicians and their practices.[1] However, we recognize the limitations of public option proposals as stand-alone reforms to cover the uninsured. With our policy in mind, we highlight below the areas where we think changes to the legislation are most needed to move forward.

First, we are concerned with government mandates in H.B 1232 on physicians to participate in the standardized health benefit plan at a rate to be determined by the Insurance Commissioner if a health insurer identifies that physician as somehow responsible for its failure to build an adequate network.

The AMA supports physicians' freedom of choice when it comes to health plan participation and, therefore, strongly opposes this effort to require physician participation. These provisions, which we believe would be the first of their kind in the nation, ignore the complexity of running

a physician practice and the balance involved in determining the capacity and ability of a practice to serve a mix of patients.

There are many reasons as to why a practice may not participate with a plan including payment levels, but also factors such as a history of unfair contracting and business practices of a payer, burdensome administrative requirements, saturation of practice resources and physician time, engagement in alternative payment models, pending retirement, and so on. It is critical that physicians be able to weigh their contract options and make decisions that are best for their practice, patients, and employees.

Establishing a provider network that meets the needs of enrollees is one of the most basic and fundamental responsibilities of health insurance plans, as they collect premium payments from patients in exchange for timely access to health care. Knowing the importance of networks that meet their needs of patients, the AMA has long fought for improved network adequacy requirements that are based on objective and meaningful standards at the state and federal levels. Unfortunately, H.B. 1232 shifts that network adequacy responsibility onto physicians and other providers, allowing plans to simply turn to regulators, rather than negotiate, when physicians are not in a position, to accept their contract terms.

Recognizing that provider networks are critical to the success of the proposed standardized health benefit plan and any product, there are ways to incent physician contracting as alternatives to requiring participation. For example, H.B. 1232 could require that payers administering a plan reduce prior authorization and other costly and administratively burdensome programs that require physicians to hire extra staff and spend hours on paperwork and interaction with health plans.[2] Additionally, guarantees of transparent payer business practices, reduced denials of medically necessary services, decreased paperwork, rapid credentialing, and streamlined appeals processes would make plan participation an attractive choice for many physicians, negating the need for government mandates. We urge the legislature to consider such alternative paths to establishing provider networks.

Second, while H.B. 1232 places significant premium reduction requirements on health insurers for their standardized health benefit plans, the legislation again allows this responsibility to be shifted onto physicians and other health care providers. Specifically, H.B. 1232 allows the Insurance Commissioner to set rates for physicians when a plan identifies them as having "prevented the carrier from meeting the premium rate requirements...." Physicians are ready and willing to be part of the solution when it comes to health care costs in Colorado, and we are eager to work with legislators and regulators to advance meaningful reforms. However, allowing plans to point to physician payment rates as the cause of their failure to meet premium reduction requirements and then lean on regulators to set rates is not an answer to reducing health care costs, and certainly not a market-based solution as has been suggested.

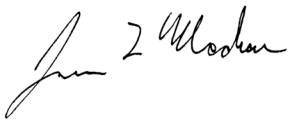
Such a provision fails to consider the multiple factors that continue to result in higher health care costs, including of course, the record setting profits of health insurance companies and pharmacy benefit managers year after year and the failure of our health care system to invest in prevention, public health, and value-based care initiatives. We urge you to remove this provision from the legislation and instead work with physicians and other health care providers in Colorado to meaningfully reduce costs while improving care.

In conclusion, the AMA, in collaboration with the Colorado Medical Society, stands ready to work with the Colorado legislature toward a public option that both increases access to affordable care for Colorado patients and protects the financial sustainability of physician practices in Colorado.

If you have any questions or would like to follow-up, please contact Emily Carroll, JD, Senior Legislative Attorney, Advocacy Resource Center, at emily.carroll@ama-assn.org.

Thank you for your consideration.

Sincerely,



James L. Madara, MD

cc: Colorado Medical Society
Colorado Senate Health and Human Services Committee Members

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[1] Options to Maximize Coverage under the AMA Proposal for Reform H-165.823: Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:

a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

[2] https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf