



November 23, 2021

The Honorable Charles Schumer
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, D.C. 20510

Dear Majority Leader Schumer and Leader McConnell:

On behalf of the American College of Physicians (ACP), I want to express our strong support for key provisions within the recently-passed House bill, H.R. 5376, the *Build Back Better Act* (BBBA), for which we have policy. The \$1.75 trillion legislation advances President Joe Biden's Build Back Better agenda and represents one of the largest investments in the modern era to strengthen the social safety net for millions of Americans who live and/or work in underserved communities disproportionately disadvantaged by societal and economic problems and the lingering effects of the COVID-19 pandemic. It examines social determinants of health care (SDOH) and seeks to address racial and economic disparities in access and quality of health care services, particularly for communities of color. H.R. 5376 would extend incentives and provide measures to combat climate change, improve the health care workforce and prescription drug pricing, address eldercare assistance, extend permanently the Children's Health Insurance Program (CHIP), expand broadband coverage, and improve upon maternal and behavioral health services, while expanding coverage under the Patient Protection and Affordable Care Act (ACA).

The American College of Physicians is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions like diabetes, heart disease and asthma.

In this letter, we will comment on sections of the BBBA that are consistent with ACP policy. Our comments focus upon the following core areas of the legislation: affordable health care coverage and access, maternal and behavioral health, expanding the health care workforce, public health emergency (PHE) preparedness and climate change. We urge the Senate to retain the provisions in the House bill that address prescription drug pricing reform and paid leave.

I. Affordable Health Care Coverage and Access

A. ACA's Premium Tax Credit and Cost Reduction Subsidies

The recently-enacted American Rescue Plan Act (ARPA) provided premium tax credits to lower insurance premiums bought through the health insurance marketplace. That law contains provisions to fully subsidize the health coverage of certain individuals. The BBBA provides temporary enhanced ACA Marketplace cost-sharing reduction assistance to individuals with household incomes below 138 percent of the federal poverty level (FPL) for calendar years (CY) 2022 through 2025. The bill expands eligibility to taxpayers with household incomes below 100 percent of the FPL, specifies that taxpayers with household incomes below 138 percent of the FPL with access to employer sponsored coverage or a qualified small employer health reimbursement arrangement can still receive credits. ACA cost-sharing reduction assistance is provided to individuals receiving unemployment compensation for CY 2022 through 2025.

The legislation also continues expanded eligibility created by ARPA through financial subsidies for health coverage purchased through the health insurance marketplace. Enrollees who make over 400 percent of the FPL would become eligible for subsidies and have their premium costs capped at 8.5 of income for three more years. ACP fully supports policies to eliminate the 400 percent FPL premium tax credit eligibility cap and to enhance the premium tax credit for all levels. The premium tax credit and cost-sharing subsidies have made nongroup coverage more affordable. While the ACA has extended comprehensive coverage to millions of people, many remain uninsured or underinsured. This extension will help many of these uninsured and underinsured low- and middle- income Americans achieve health care coverage. We believe further that these premium tax reforms should be extended permanently.

B. Health Insurance Affordability Fund

The BBBA establishes a health insurance affordability fund, with \$10 billion made available annually for states to establish a state reinsurance program or use the funds to provide financial assistance to reduce out-of-pocket costs. H.R. 5376 requires the Centers for Medicare and Medicaid Services (CMS) to establish and implement a reinsurance program in states that do not apply for federal funding. Many good things came out of the ACA, but it is also the case that the health insurance marketplace has experienced periods of struggle due to a confluence of many factors. In some areas of the country, premiums have increased, and insurer participation has been limited. In addition, efforts by some in Congress and the past administration have led to a further destabilization of the market by undermining patient protections, resulting in "adverse selection" among persons obtaining coverage in the individual market. ACP policy states that the federal government should stabilize the marketplace by establishing a permanent reinsurance program. Reinsurance can help ensure that patients get to keep the coverage they have while protecting insurers from high costs.

C. Health Care Coverage in Non-Expansion States

H.R. 5376 provides ACA-provided insurance subsidies to nearly four million low- to moderate - income Americans living in 12 states that did not take advantage of incentives to expand

Medicaid under the ACA. These individuals residing in the “coverage gap” earn too much to qualify for traditional Medicaid, but not enough to qualify for premium tax credits and cost-sharing reductions for marketplace-based coverage. The legislation provides individuals with \$0 premiums, thus making healthcare affordable and accessible.

ACP has long supported the Medicaid program as vital in the effort to ensure that this nation’s most vulnerable population has access to health coverage. ACP’s advocacy has focused on protecting the Medicaid program, encouraging states to expand their programs, and opposing efforts by federal lawmakers to cut/cap the program, or otherwise imposing mandatory work requirements, premiums and cost-sharing for vulnerable individuals, and benefit cuts.

D. Medicaid Payment Cuts to Disproportionate Share Hospitals (DSH)

The House-passed BBBA would cut Medicaid payments to disproportionate share hospitals by approximately \$444 million as a pay-for to expand Medicaid coverage in non-expansion states. While the BBBA’s increased subsidies for Medicaid expansion are set to expire after 2025, the bill’s Medicaid DSH cuts would be permanent. Also, Medicaid DSH cuts specified under the Affordable Care Act have been repeatedly delayed, but they are now due to be implemented in FY2024. Estimated at \$8 billion in that year, those cuts are much [larger](#) than the DSH cuts specified in the BBBA. Unless Congress intervenes, these ACA-related DSH reductions would be in addition to the \$444 million in DSH cuts in the BBBA for the 12 non-expansion states.

ACP has been [supportive](#) of increased Medicaid funding for DSH. Hospitals that care for many low-income people, including teaching, essential, and children’s hospitals, strive to provide high quality care to all patients, including the most vulnerable. Due to their patient populations, many of these hospitals often have lower operating margins than the rest of the hospital industry. Without a stable flow of Medicaid DSH payments, hospitals that rely on these payments could see massive funding shortfalls that would threaten access to care for the most vulnerable in society. ACP urges Congress not to cut DSH payments as a means to pay for Medicaid expansion in non-expansion states and to continue the delay of DSH cuts overall until a more sustainable solution is reached.

E. Children’s Health Insurance Program Extension

ACP has been a staunch supporter of CHIP over the years and has advocated for a long-term extension of funding for the program. Under the BBBA, CHIP is permanently authorized to provide states the option to increase Medicaid and CHIP eligibility levels for children up to 300 percent of FPL without receiving a waiver. It authorizes permanent funding for CHIP. The legislation also provides permanent funding for several programs related to CHIP, including the pediatric quality measures program and the child enrollment contingency fund to provide states with additional funding in the event its CHIP allotment is insufficient. It ensures that all CHIP programs are able to receive low-cost prescription drugs. Since its inception in 1997, CHIP, together with Medicaid, has helped to reduce the number of uninsured children by a remarkable 68 percent. CHIP has a proven track record of providing high-quality, cost-effective coverage for low-income children and pregnant women in working families.

F. Medicare Expansion for Hearing

The BBBA expands coverage for Medicare patients. Beginning January 1, 2024, qualified audiologists can deliver aural rehabilitation and treatment services in addition to the hearing and balance assessment services provided under current law. The bill also allows for qualified hearing aid professionals to deliver hearing assessment services, beginning January 1, 2024.

While ACP does not have specific policy on a Medicare hearing benefit, ACP has been a longstanding advocate for a health system that provides universal coverage to all Americans and last year, we released an ambitious [New Vision for Health Care](#) that provides a series of recommendations to achieve universal coverage along with reforms to support team-based care and reduce discrimination and disparities in health care. Although a pathway to universal coverage remains uncertain, we are pleased that Congress is addressing the continued need to expand eligibility for and the amount of premium tax credits to purchase coverage through the ACA as well as to increase incentives for residents in Medicaid non-expansion states to obtain coverage.

G. Home and Community-Based Services (HCBS) and Home Care Assistance

The BBBA provides states with a permanent six percentage point increase to the federal medical assistance percentage (FMAP) if the state implements an HCBS improvement program to strengthen and expand HCBS. The legislation provides an enhanced FMAP of 80 percent for administrative costs associated with improving HCBS. It also provides a six-quarter increase to the FMAP of two percentage points if a state adopts an HCBS model that promotes self-direction of care and meets certain other requirements.

In addition, the BBBA improves on Medicaid coverage for home care services for seniors and people with disabilities by investing \$150 billion to end the backlog for elderly and disability care in the home and to improve working conditions for home health care workers. Medicaid provides an essential source of coverage for more than 75 million children, pregnant women, adults, and seniors. The ACA created policies, including federal funding for Medicaid expansion, that have allowed many more people to qualify for coverage, yet more can and must be done to strengthen and expand Medicaid, including home and community-based services.

Efforts to [increase](#) the FMAP to expand HCBS services will greatly benefit the elderly, people with disabilities and underserved communities with waiting lists for HCBS. For the past year and a half, due to the COVID-19 pandemic, the health of Americans and that of the health care system have suffered. The health-related provisions in the BBBA will provide considerable relief to both patients and physicians. There are still gaps, and ACP's goal of universal coverage has not yet been reached, but incentives like these represent great progress that builds on the ACA and Medicaid.

H. Prescription Drug Reform

We are pleased that House members were able to reach near-agreement on reforming prescription drug pricing even though the provision was scaled back considerably from earlier versions. For many years, ACP has continued to express concern over the rising cost of prescription drugs, particularly for patients as they struggle to afford basic and life-saving medications prescribed by their physicians to treat diseases and chronic conditions. Now, with the ongoing COVID-19 pandemic, patients are even more concerned about whether they can afford their medications and even whether they will have health coverage in general should they unexpectedly lose their job because of the pandemic. In a May 2020 [study](#) by Gallup, “nearly nine in 10 U.S. adults are very (55 percent) or somewhat (33 percent) concerned that the pharmaceutical industry will leverage the COVID-19 pandemic to raise drug prices. Americans are also concerned -- to a somewhat lesser extent -- about rising health insurance premiums and the cost of care generally. Overall, 79 percent are very or somewhat concerned about their health insurance premiums rising and 84 percent are very or somewhat concerned about the cost of care generally rising, with 41 percent very concerned about each.”

ACP has longstanding [policy](#) supporting the ability of Medicare to leverage its purchasing power and directly negotiate with manufacturers for drug prices. We supported a provision in H.R. 3, the *Elijah E. Cummings Lower Drug Costs Now Act*, that would mandate that the Secretary of Health and Human Services (HHS) identify 250 brand name drugs that lack competition in the marketplace and that account for the greatest cost to Medicare and the U.S. health system and then negotiate directly with drug manufacturers to establish a maximum fair price for a bare minimum of 25 of those drugs. In a 2019 [estimate](#) by the Congressional Budget Office, projections indicated that \$456 billion in savings over 10 years would be realized by allowing Medicare to directly negotiate prescription drug prices with manufacturers.

We remain concerned that the House-passed BBBA does not include this more robust provision of price negotiation in H.R. 3. We believe that giving HHS the authority to negotiate drug prices with manufacturers is one of the most effective ways to lower the cost of prescription drugs and we urge lawmakers to include that provision of H.R. 3 or similar legislation in the final bill.

The House-passed BBBA allows HHS to negotiate the price of 10 of the most expensive drugs by 2025 and going up to 20 drugs by 2028 on drugs that are beyond their period of exclusivity. The bill applies an excise tax on drug manufacturers for raising prices faster than the rate of inflation, reduces out-of-pocket expenses for customers and ensures patients pay no more than \$35 a month for insulin products. While ACP reaffirms its support for a full repeal of the noninterference clause, ACP is also supportive of an interim approach, such as allowing the Secretary of HHS to negotiate for a limited set of high-cost or sole-source drugs.

I. Paid Leave

While the House-passed BBBA includes four weeks of paid leave, which ACP supports, we urge the Senate to include a more generous six-week policy. The United States is currently the only developed country that does not have some form of federal paid leave. In 2016, only 13 percent of private sector workers had access to any kind of paid family leave, which includes

parental leave or leave to care for a sick family member. The rate of new mothers' access to maternity leave is stagnant, with no discernable increase among women who took maternity leave between 1994 and 2015. Less than half of the women who did take maternity leave in 2015—47.5 percent—were compensated. Caregivers—up to 75 percent—are women and those who care for a close relative are at higher risk for health issues because of the physical and emotional toll of caregiving. The 1993 Family and Medical Leave Act (FLMA) made certain employees eligible for up to 12 weeks of unpaid leave but did not require a paid leave standard.

ACP strongly [supports](#) paid family and medical leave at the federal level, including efforts by Congress and the administration to expand such benefits. As stated in a May 2021 statement to the Senate Committee on Health, Education, Labor and Pensions and in a 2018 paper, [Women's Health Policy in the United States: An American College of Physicians Position Paper](#), ACP supports the goal of universal access to family and medical leave policies that provide a minimum period of six weeks' paid leave and calls for legislative or regulatory action at the federal, state, or local level to advance this goal. For example, paid leave policies can improve health outcomes for women and their families after the birth of a child which can have significant physical and emotional effects.

II. Maternal and Behavioral Healthcare Expansion

A. Maternal Mortality

The BBBA increases investment in maternal health. Among its provisions, H.R. 5376 invests: \$100 million in funding for maternal mental health equity grants; \$75 million to the Office of Minority Health to address SDOH affecting pregnant and postpartum individuals; \$75 million to grow and diversify the maternal mental health and substance use disorder treatment workforce; \$30 million to expand use of technology enabled collaborative learning for pregnant and postpartum individuals; and \$30 million to promote equity in maternal health outcomes through digital tools.

ACP is pleased that the BBBA includes robust investments in programs that advance steps for birth equity by centering the voices, needs and preferences of Black and Indigenous individuals, who disproportionately experience inequities in maternal health. We [support](#) provisions of the *Black Maternal Health Omnibus Act, H.R. 959*, and are pleased they have been included in this legislation. In that regard, the reconciliation bill focuses on investing in community-based organizations, addressing social determinants of maternal health, expanding the perinatal workforce, addressing the effects of climate change on maternal and infant health and investing in maternal mental health.

B. Medicaid Postpartum Coverage

The legislation requires state Medicaid programs to provide 12 months of continuous Medicaid and CHIP eligibility to postpartum women; 12 months of continuous eligibility to children enrolled in Medicaid and CHIP; and coverage to justice-involved individuals 30 days prior to their release. It also allows states to smoothly transition out of the coverage requirements put in place during the public health emergency.

ACP supports extending the postpartum coverage period for individuals who were enrolled in Medicaid while pregnant to a full year after the end of pregnancy. Hundreds of national and state organizations have also voiced their [support](#) for this important need. Continuous access to Medicaid is crucial to addressing our nation's rising rate of maternal mortality. Medicaid paid for 43 percent of U.S. births in 2018, including 50 percent of births in rural areas, 60 percent of births to Latina women, and 66 percent of births to Black women. Under current law, women who are eligible for Medicaid based on the fact that they are pregnant become ineligible for coverage 60 days after the end of pregnancy. While some women are able to successfully transition to other sources of coverage at this time, many are left in the untenable position of being uninsured shortly after a major medical event.

C. Substance Abuse and Mental Health Services Administration (SAMHSA) Funding

H.R. 5376 provides \$50 million in funding for the Minority Fellowship Program at SAMHSA. It provides \$25 million to support SAMHSA's Recovery Community Services Program Statewide Network program, which seeks to strengthen recovery community organizations and their statewide network of recovery stakeholders. That bill also provides \$15 million in funding to support SAMHSA's Project AWARE program, which helps build or expand coordination among state and local governments to increase awareness of mental health issues among school-aged youths and provides \$75 million in funding to support the infrastructure of the National Suicide Prevention Lifeline, the 24/7, free, and confidential national suicide prevention hotline. Further, the bill provides \$123,716,000 to the Director of the Indian Health Service, to remain available until September 30, 2031, for mental health and substance use prevention and treatment services, including facility renovation, construction, or expansion relating to mental health and substance use prevention and treatment services.

ACP supports this increased funding for SAMHSA activities. The pandemic increased demand for mental health and addiction services. Recently, the U.S. Government Accountability Office (GAO) released a report, [Behavioral Health: Patient Access, Provider Claims Payment, and the Effects of the COVID-19 Pandemic](#). The purpose of the report was to determine if the need for and access to mental health and addiction services varied as the availability to care diminished during the public health emergency (PHE) caused by COVID-19. The report showed several concerning trends. The Centers for Disease Control and Prevention (CDC) found that 38 percent of individuals surveyed reported symptoms of anxiety or depression from April 2020 to February 2021. This was a 27 percent increase from 2019 for the same time period. CDC data found that emergency department visits for overdoses was 26 percent higher and suicide attempts were 36 percent higher for the time period of mid-March through mid-October 2020 when compared to that period during 2019. SAMHSA found that in September 2020, opioid deaths in certain sections of the United States increased anywhere from 25 to 50 percent when compared to the same time during 2019. SAMHSA data also showed that contacts by individuals to the Disaster Distress Helpline increased during the PHE in 2020 over comparable timeframes in 2019. Recently, the CDC released provisional data that there were over 100,000 overdose deaths in the United States over the 12-month period ending in April 2021. These

trends underscore the need for additional funding for SAMHSA-sponsored programs and native American behavioral health programs.

III. Expanding the Healthcare Workforce

According to the Association of American Medical Colleges (AAMC) in a June 2021 [report](#), it is projected that there will be a shortage of 17,800 to 48,000 primary care physicians by 2034. Now, with the closure of many physician practices and near-retirement physicians not returning to the workforce due to COVID-19, it is even more imperative to assist those clinicians serving on the frontlines.

With an aging population with higher incidences of chronic diseases, it is especially important that patients have access to physicians trained in comprehensive primary and team-based care for adults—a hallmark of internal medicine graduate medical education (GME) training. It is worth noting that the federal government is the largest explicit provider of GME funding (over \$15 billion annually), with most of the support coming from Medicare. ACP urges Congress to pass H.R. 2256/S. 834, the *Resident Physician Reduction Shortage Act of 2021*, which reflects the 1,000 new GME slots added by H.R. 133 and would create 14,000 (instead of 15,000) new GME positions over seven years.

A. Pathway Training and Graduate Medical Education Training

ACP supports provisions in H.R. 5376 that seek to improve the nation’s healthcare infrastructure and workforce. The bill creates a new Pathway to Training Program to provide scholarships for tuition and other fees to underrepresented and economically disadvantaged students planning to attend medical schools. A student would be required to practice a year in a medically underserved area after residency for each year they receive a scholarship. ACP is pleased that an additional 4,000 Medicare-supported GME slots have been included in the House-passed BBBA in Sec. 137405 pertaining to the Pathways to Practice Training Program. A thousand slots associated with the Pathways to Practice Training Program can be found in Sec. 137404.

Other provisions affecting the health care workforce include: \$3.37 billion in supplemental Teaching Health Center (THC) Graduate Medical Education; \$200 million for Children’s Hospital GME; \$2 billion for the National Health Service Corps (NHSC); \$20 million for training physicians in palliative care; \$85 million for healthcare professions schools to identify and address risks associated with climate change; and 500 new residency positions at Veterans Affairs Medical Centers. ACP also considers it vital for Congress to support ongoing funding for Community Health Centers, NHSC and THC Graduate Medical Education sites nationwide. These programs are essential to expanding primary care services.

Primary care physicians, including internal medicine specialists, continue to serve on the frontlines of patient care during this pandemic with increasing demands placed on them. During the pandemic’s worst months, there was an increasing reliance on medical graduates, both U.S. and international, to fight against COVID-19. Many residents and medical students played a critical role in responding to the COVID-19 crisis and providing care to patients firsthand. For

residents, COVID-19 has inflicted additional strain on them as they were redeployed from their primary training programs and put onto the frontlines to care for the sickest patients, often putting their own health at risk.

B. Pell Grants

ACP [supports](#) policies to provide a pathway to U.S. citizenship for undocumented individuals who were brought to the United States when they were only children, who are also known as the “Dreamers.” The BBBA increases the maximum Pell Grant by \$550 for students enrolled in public and private colleges, non-profit colleges and expand access to DREAMERS. ACP continues to [support](#) increases in Pell Grants since they have not kept up with the rising costs of college.

C. Veteran Affairs (VA) Funding

The BBBA provides \$2,3 billion in funding, which ACP supports, for improving the Department of Veteran Affairs (VA) infrastructure and ability to provide services to veterans. The funding includes \$268 million for the VA to invest in its statutory mission to conduct an education and training program for health professional students and residents by authorizing VA to increase the number of health professions residency positions at its medical facilities by up to 500 over seven years. This is in addition to larger funding of over \$103 billion which ACP [supports](#) for the VA.

ACP physician members work and provide care within the Veterans Health Administration (VHA) and are deeply committed to the VA’s mission to provide high quality, comprehensive and timely care to veterans in their time of need and throughout their lifetime. ACP recognizes the important health care services that the VHA provides to this nation’s military veterans as well as its significant overall contribution as the nation’s largest health care system, the largest provider of graduate medical education and a valuable contributor of medical and scientific research.

D. Recapture of Unused Visas

The BBBA allows for the recapture of family-sponsored and employment-based visas that went unused during fiscal years 1992 through 2021. This section also allows certain individuals who were selected to apply for diversity visas in fiscal years 2017, 2018, 2019, 2020, or 2021, but who were refused a visa or denied admission to the United States because of specific executive orders, or who were unable to complete the visa or admissions process because of COVID-19-related restrictions, to reapply for such visas.

ACP supports this provision as well as the bipartisan S. 1024, the *Healthcare Workforce Resilience Act*. During this global pandemic, the role of International Medical Graduates (IMGs) in augmenting the physician workforce is especially critical to the care of the thousands of patients battling COVID-19. This innovative legislation would recapture 40,000 unused visas and use them to provide additional green cards to 15,000 physicians and 25,000 professional nurses. The visas, which would not count towards the annual limit and would be recaptured from a pool of over 200,000 employment-based visas left unused between 1992 and 2020,

would provide a pathway to employment-based green cards and quickly address one of the health care system's most pressing needs. By recapturing a limited number of unused visas from prior years and allocating them to doctors and nurses, the *Healthcare Workforce Resilience Act* offers the advantage of not only addressing the physician shortage that existed before the pandemic but recognizing that the shortages are growing more severe as the need for caregivers becomes greater with each passing day.

IV. Pandemic Preparedness and Public Health Programs

A. Pandemic Preparedness

The BBBA provides \$1.4 billion in funding to support renovation, improvement, expansion and modernization of state and local public health laboratory infrastructure. It enhances the capacity of the laboratories at CDC, provides \$1.3 billion in funding to the Assistant Secretary for Preparedness and Response to prepare for, and respond to, public health emergencies. The bill also provides \$300 million for improving infrastructure at the Food and Drug Administration (FDA).

ACP supports this spending for pandemic preparedness. ACP has [requested](#) that the Biden administration increase funding for the public health infrastructure to address population health needs related to COVID-19. We have consistently provided input and [recommendations](#) to lawmakers surrounding the ongoing need for personal protective equipment, increased support for the frontline physician workforce, adequate funding for COVID-19 testing, contract tracing, and vaccine distribution and continued telehealth expansion. Support for these policies is vital to the pandemic response effort now after the national PHE comes to an end.

A. Other Initiatives to Protect the Public

H.R. 5376 provides \$9 billion for lead remediation projects, including lead service line replacement funding to be distributed pursuant to the Safe Drinking Water Act. ACP [supports](#) provisions in the legislation to upgrade our water infrastructure to ensure that all Americans have access to safe drinking water that will replace all of the nation's lead pipes and service lines. We know that the consequences of lead ingestion can be serious and are sometimes irreversible.

The legislation also promotes nutrition security – expands free school meals – to support children's health. ACP policy supports healthy nutrition for children. We were one of several organizations [supporting](#) bipartisan, bicameral legislation that would start the process of convening a national White House conference on food, nutrition, hunger, and health.

B. Broadband Coverage

H.R. 5376 provides \$280 million to establish a pilot program that will provide grants to public-private partnerships for projects that increase access to affordable broadband service in urban communities, including communities of color and low- and middle- income consumers, through long-term solutions. ACP supports this measure. Lacking access to reliable and affordable

Internet or mobile service limits not only a person's ability to utilize technology for health-related purposes but also their ability to access other important services, such as emergency assistance or employment opportunities. There is an increased emphasis on integrating technology into medical care, and lack of reliable Internet access can hinder a person's ability to access medical portals or electronic health records (EHRs). ACP supports the ongoing commitment of federal funds to enhance the broadband infrastructure needed to support telehealth activities. Equitable access to broadband internet is critical to the promotion of health equity and quality of care outcomes through telehealth.

V. Addressing Climate Change

H.R. 5376 represents a major step in moving the nation to reach the President's goal of cutting greenhouse gas (GHG) emissions in half based on 2005 standards by 2030. This would be accomplished through a \$555 billion combination of tax credits, rebates, grants, loans, clean energy technology deployment and resilient investments to address the catastrophic effects of extreme weather events. The bill aims to increase renewable energy and its use in electric generation.

ACP has policy on climate change and the environment based on these principles, and our policy would:

- Ensure federal agencies communicate apolitical, science-based information regarding climate change and greenhouse gas emissions and eliminate any restrictions and agency guidance that interfere with the ability of career scientists to provide such information.
- Protect career scientists and other federal employees engaged in this area.
- Rollback regulations that would increase carbon emissions and associated respiratory diseases and other health outcomes, including the Affordable Clean Energy and methane emissions rules.
- Lay policy and regulatory groundwork for rapid shift from use of fossil fuels to clean, renewable energy and support efforts to reduce GHG in the health care sector.
- Prevent contamination of the U.S. water supply and ensure everyone has access to clean, affordable drinking water.

A. Clean Energy Incentives

The BBBA contains numerous incentives (tax credits, rebates, grants, and loans) for investments to reduce GHG emissions and to spur clean and renewable energy development and use. Our policy supports the investment in clean energy to mitigate the increased rate of disease, injuries and premature deaths associated with climate change. ACP supported the Clean Power Plan that was finalized by the Obama Administration in 2015 which sought to reduce power plant carbon emissions by 32 percent below 2005 levels by 2030.

B. Environmental Justice

The BBBA provides \$3 billion for investments in community led projects in disadvantaged communities and community capacity building centers to address disproportionate

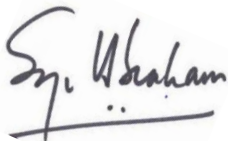
environmental and public health harms related to pollution and climate change. ACP joined a coalition [letter](#) to Congress asking them to pass legislation making substantial investments that advance health equity and environmental justice.

Environmental factors and other social drivers of health that disproportionately affect racial and ethnic minorities, including the effect on health of large-scale infectious disease outbreaks and climate change, must be addressed as recommended in “Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health”,¹ “Addressing Social Determinants to Improve Patient Care and Promote Health Equity”,² and “Climate Change and Health”.³⁴ These social drivers and environmental factors influence an individual’s health status even though they are sometimes not part of the health care system. ACP released the position paper, “[Understanding and Addressing Disparities and Discrimination Affecting the Health and Health Care of Persons and Populations at Highest Risk](#),” which offered specific recommendations to address issues that disproportionately affect racial and ethnic minorities, including during the environment.

VI. Conclusion

In conclusion, the Build Back Better Act represents a transformative investment in human infrastructure and provides a larger safety net for those marginalized the most in society. It also advances efforts to combat climate change while improving our drinking water and air quality. We urge Congress to include prescription drug pricing reform, paid leave, and to fully address the shortages of trained physicians in this important legislation, as so recommended in this letter.

Sincerely,



George M. Abraham, MD, MPH, MACP, FIDSA
President

¹ Butkus R, Rapp K, Cooney TG, Engel LS et al. Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health. *Ann Intern Med.* 2020;172:S50-S59. doi:10.7326/M19-2410.

² Daniel H, Bornstein S, Kane GC et al. Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper. *Ann Intern Med.* 2018;168:577-578. doi:10.7326/M17-2441.

³ Crowley R. Climate Change and Health: A Position Paper of the American College of Physicians. *Ann Intern Med.* 2016;164:608-610. [Epub ahead of print 19 April 2016]. doi:10.7326/M15-2766.

⁴ Serchen J, Doherty R, Hewett-Abbott G, Atiq O, Hilden D; Health and Public Policy Committee of the American College of Physicians. *Understanding and Addressing Disparities and Discrimination Affecting the Health and Health Care of Persons and Populations at Highest Risk: A Position Paper of the American College of Physicians.* Philadelphia: American College of Physicians; 2021.

cc: Senate Budget Committee
Senate Finance Committee
Senate Health, Education, Labor and Pensions Committee
Senate Judiciary Committee
Senate Veterans' Affairs Committee