American College of Physicians
Leading Internal Medicine, Improving Lives

September 1, 2021

The Honorable Ron Wyden
Chair
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the American College of Physicians (ACP), I would like to offer our recommendations on key policies to support primary and comprehensive care as the Senate Finance Committee begins drafting provisions within its jurisdiction for inclusion in forthcoming FY 2022 budget reconciliation legislation. Our recommendations, as outlined below, are consistent with ACP's goals of stabilizing the Medicare physician payment system, achieving universal health coverage, including the expansion of Medicare and Medicaid, reforming prescription drug purchasing, supporting the primary care physician workforce, and establishing new federal family leave benefits.

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 and clinical expertise to the diagnosis, treatment, and compassionate 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.

STABILIZING MEDICARE PHYSICIAN PAYMENT

ACP is pleased that earlier this year the 117th Congress approved legislation, H.R. 1868, to delay the implementation of a 2 percent Medicare cut to physicians scheduled on April 1, 2021 that would have been triggered by a process known as sequestration, designed to reduce federal spending. We remain concerned that H.R. 1868 only delayed the 2 percent Medicare sequestration cut to physicians until January 1, 2022 and unless Congress acts before the end of this calendar year – this cut will be implemented. H.R. 1868 also failed to waive additional Medicare cuts that would be imposed on physicians through a federal law known as PAYGO – that would reduce Medicare payments to physicians up to 4 percent at the end of this year.

We also appreciate that at the end of last year, CMS finalized a Medicare Physician Fee Schedule (MPFS) final rule that provided an increase in payments for physicians' undervalued Evaluation and Management (E/M) services effective on Jan. 1, 2021. A significant portion of the work of internal medicine physicians is tied to E/M services (office-based visits with patients) that have long been undervalued in both Medicare and Medicaid. ACP fully supported the implementation of this increase in payment for E/M services, noting it was long overdue and absolutely essential but it only partially offsets the huge losses of revenue from the COVID-19 pandemic experienced by internal medicine specialists and other frontline physicians.

Federal law requires that any increases to physician services in the MPFS final rule (such as those applied to E/M services in the 2021 PFS) must be offset by an across-the-board budget neutral (BN) reduction to all services paid under the fee schedule, to keep overall spending budget neutral. The 2021 PFS rule would have imposed a substantial BN adjustment, with physicians providing undervalued E/M services seeing improvements, but these improvements were being significantly reduced by the BN adjustment; and those who do not bill for E/M were facing overall reductions in payment for other services in Medicare. ACP was pleased that at the end of last year, Congress passed legislation, H.R. 133, the Consolidated Appropriations Act of 2021, that included a provision providing for a temporary 3.75 percent increase to ALL services which has helped to mitigate a substantial portion of the cuts that were expected from budget neutrality while protecting the increased payments to frontline primary and comprehensive care physicians. All physician services will again be subject to reductions due to the application of budget neutrality in the 2022 PFS unless Congress steps in to stop it.

All too often, physician payments are the targets for federal budget trimming and ways to pay for federal spending. One example is the pay for contained in the bipartisan infrastructure bill that was passed in the Senate. While ACP supports that bill, we urge Congress to find other ways than extending the Medicare sequester to pay for it. Physician payments have also failed to keep up with the rate of inflation over the past 2 decades. Congress should prevent the cuts that would be imposed by sequestration, PAYGO, and budget neutrality to ensure that internal medicine physicians who have suffered significant financial, well-being, and health challenges imposed by the pandemic are able to keep their practices open to care for Medicare patients.

In a recent survey by the Larry Green Center from July 2021, primary care clinicians reported that pandemic-related strain is still at severe or near severe levels, specifically noting that they are facing structural obstacles, such as the inability to staff positions and challenges with maintaining patient volume. Yet, in spite of these challenges, this pandemic has shown the value of internal medicine physicians (internists) who remain on the frontlines of diagnosing and treating patients with COVID-19, as well as continuing to care for patients with chronic illnesses such as cancer, heart disease, and diabetes—via both in-office visits and telemedicine. Additionally, internists and other primary care physicians continue to see a significant increase in the number of patients in need of treatment for mental health and substance use disorders, which have increased significantly during the pandemic.

We urge Congress to stabilize the Medicare physician payment system and prevent Medicare cuts to physicians by including the following provisions in the FY 2022 budget reconciliation legislation:

- Enact legislation that would prevent the 2 percent Medicare sequestration cut scheduled for January 1, 2022
- Waive additional Medicare cuts of up to 4 percent that would be imposed on physicians at the end of this year through a federal law known as PAYGO
- Approve an across the board 3.75 percent increase to *ALL* physician services to offset cuts that will be imposed due to the application of budget neutrality in the 2022 MPFS.

ACHIEVING UNIVERSAL HEALTH COVERAGE

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 has already enacted legislation this year to expand eligibility for and the amount of premium tax credits to purchase coverage through the Affordable Care Act (ACA) as well as increase incentives for states to expand their Medicaid population.

Congress passed and President Biden signed into law *the American Rescue Plan Act*. That legislation included provisions supported by ACP to expand coverage as well as reduce premium costs under the ACA. It also increases federal funding for states to expand Medicaid by raising a state's base Federal Medical Assistance Percentage (FMAP) for two years for states that newly expand Medicaid and it fully subsidizes the marketplace-based health coverage of people earning up to 150 percent of the federal poverty level (FPL) in 2021 and 2022. In addition, enrollees who make over 400 percent of the FPL would become eligible for tax credits and have their premium costs capped at 8.5 percent of income for two years.

In addition, Medicaid enrollment has increased by more than 8 percent over the past year as a result of pandemic-related job and income loss, making the demand for primary care and pediatric clinicians in the Medicaid program more acute than ever. At the same time, physician practices have faced financial challenges due to decreased visit volume and increased expenses such as personal protective equipment, technology to provide telehealth and infrastructure to administer COVID-19 tests and vaccines. Physician practices that accept large numbers of Medicaid patients face further challenges. The low payment rate for Medicaid services, compared with that of Medicare or private payers, is exacerbating their financial instability. Under Medicaid, on average, a clinician treating a Medicaid enrollee is paid about two-thirds of what Medicare pays for the same services and only half of what is paid by private insurance plans.

More action is needed however by Congress to expand coverage and increase affordability, and we urge the committee to include the following in its budget reconciliation recommendations:

- H.R. 340*, the Incentivizing Medicaid Expansion Act of 2021* would provide the same level of Federal matching assistance for every State that chooses to expand Medicaid coverage to newly

eligible individuals, regardless of when such expansion takes place. It would expand Medicaid by providing states with 100 percent FMAP for expansion beneficiaries for the first three years and gradually declines the FMAP to 93 percent by year six of expansion. The FMAP would eventually drop to 90 percent for year seven and beyond.

- H.R. 369*, the Health Care Affordability Act of 2021* would increase the generosity of the ACA premium tax credits across all income levels and would permanently expand the eligibility for premium tax credits to people with incomes above 400 percent of the federal poverty level. It would guarantee that anyone who buys ACA insurance can purchase a plan for 8.5 percent of their income or less.

- H.R. 1025*, the Kids Access to Primary Care Act of 2021/*S. 1833, *Ensuring Access to Primary Care for Women & Children Act*, would ensure that Medicaid payment rates for primary care services are equal to Medicare rates. The Affordable Care Act (ACA) included a provision that required states to raise Medicaid payment rates for primary care services equal to Medicare rates in 2013 and 2014 but this provision expired after those two years and was not renewed by Congress.

REFORMING PRESCRIPTION DRUG PURCHASING

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 9 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 that 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.

Action is needed by Congress in order to empower Medicare to negotiate drug prices and we urge the committee to include the following in its budget reconciliation recommendations:

- S. 833*, the Empowering Medicare Seniors to Negotiate Drug Prices Act of 2021*, which would allow the Secretary of HHS to negotiate directly with drug companies for price discounts for the Medicare Prescription Drug Program, thus eliminating a restriction that bans Medicare from negotiating better prices.

SUPPORTING THE PRIMARY CARE PHYSICIAN 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.

The training and costs associated with becoming a medical or osteopathic doctor (M.D. or D.O) are significant. A student who chooses medicine as a career can expect to spend four years in medical school, followed by three to nine years of graduate medical education (GME), depending on the choice of specialty. GME is the process by which graduated medical students progress to become competent practitioners in a particular field of medicine. These programs, referred to as residencies and fellowships, allow trainees to develop the knowledge and skills needed for independent practice. GME plays a major role in addressing the nation's workforce needs, as GME is the ultimate determinant of the output of physicians. 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 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.

In 2020, bipartisan congressional leaders worked together to provide 1,000 new Medicare-supported GME positions in *the Consolidated Appropriations Act, 2021*, H.R. 133, an action supported by ACP. This was the first increase of its kind in nearly 25 years. The new slots must be distributed with at least 10 percent of the slots to the following categories of hospitals: hospitals in rural areas; hospitals training over their GME cap; hospitals in states with new medical schools or new branch campuses; and hospitals that serve areas designated as health professional shortage areas (HPSAs).

More action is needed however by Congress to expand and support the primary care physician workforce, and we urge the committee to include the following in its budget reconciliation recommendations:

- H.R. 2256/S. 834, *the Resident Physician Reduction Shortage Act of 2021*, 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.

ACP also considers it vital for Congress to support ongoing funding for Community Health Centers (CHCs), the National Health Service Corps (NHSC), and Teaching Health Centers (THC) Graduate Medical Education (GME) sites nationwide. These programs are vital to expanding primary care services.

ESTABLISHING FEDERAL FAMILY LEAVE BENEFITS

The United States is currently the only developed country that does not have some form of federal paid maternity 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 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. The American Families Plan (AFP) proposed by the Biden administration would eventually guarantee 12 weeks of paid parental, family, and personal illness/safe leave. The pay would be equal to two-thirds of the worker's average weekly wages, up to $4,000 per month.

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. The birthing process is physically taxing, and women continue to have physical and hormonal changes for weeks or months afterward. An analysis of mothers at various periods after childbirth showed a relationship between leave duration and decreases in depressive symptoms until six months postpartum.

More action is needed however by Congress to ensure comprehensive paid family and medical leave and we urge the committee to include the following in budget reconciliation recommendations:

- H.R. 804/S. 248, *the Family and Medical Insurance Leave (FAMILY) Act*. This legislation would provide up to 12 weeks of partial income to workers who need leave from their job for a serious personal health issue or care for a family member such as a child, parent, spouse or domestic partner, care for a newborn or newly adopted child, or for care associated with a military deployment or serious injury; would be funded through payroll contributions from employers and employees of two-tenths of one percent each (two cents per $10 in wages), split between employers and employees; would guarantee that the coverage is portable; would

provide 66 percent of wage replacement, up to $4,000 per month; and would cover workers in all companies, no matter how many employees. ACP recommends that the FAMILY Act be improved by updating the FMLA's existing definition of eligible caregiving. ACP policy calls for increased flexibility in paid leave policies to care for various family members, including parents in-law and grandparents; however, parents in-law and grandparents are omitted from existing FMLA regulations.

CONCLUSION

Thank you for this opportunity to provide our input and recommendations on these important issues. We urge the committee to work in a bipartisan manner to ensure that these policies are included in the reconciliation package moving forward, and we stand ready to serve as a resource when needed. Should you have any further questions, please contact Brian Buckley at bbuckley@acponline.org.

Sincerely,

Thomas G. Cooney, MD, MACP
Chair, Board of Regents