Statement for the Record
American College of Physicians
To the United States Senate Committee on Health, Education, Labor and Pensions
On
"Examining Our COVID-19 Response: Improving Health Equity and Outcomes by Addressing Health Disparities"
March 25, 2021

The American College of Physicians (ACP) is pleased to submit this statement and offer our views regarding the response to the public health emergency (PHE) caused by Coronavirus (COVID-19). We greatly appreciate that Chair Murray, Ranking Member Burr, and the Health, Education, Labor and Pensions (HELP) Committee have convened this hearing, "Examining Our COVID-19 Response: Improving Health Equity and Outcomes by Addressing Health Disparities", held on March 25, 2021. Thank you for your shared commitment to ensuring that clinicians have the opportunity to share their views about the response to the PHE caused by COVID-19 including how health disparities have contributed to different outcomes across racial and ethnic minority populations. Through the experiences of its physicians on the frontlines of furnishing primary care during the COVID-19 pandemic, ACP has consistently provided input and recommendations surrounding COVID-19 and health disparities during the pandemic.

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 163,000 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.

In April 2020, early on in the pandemic, ACP strongly urged that the U.S. Department of Health and Human Services (HHS) and other federal agencies collect and publicly release racial, ethnic, and patients' preferred language data regarding COVID-19 testing, hospitalizations, and deaths. This need remains imperative to equip physicians, researchers, and policymakers with sufficient information to better understand the circumstances and characteristics unique to treating and caring for racial and ethnic minority communities and those with limited English proficiency (LEP). At the beginning of 2021, 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 impact racial and ethnic minorities, including during a pandemic.

ACP believes that policymakers should recognize and address how increases in the frequency and severity of public health crises, including large-scale infectious disease outbreaks such as COVID-19, poor environmental health, and climate change, all disproportionately contribute to health disparities for Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other vulnerable persons.[1]

Historical experiences with the 1918 Spanish flu and 2009 H1N1 swine flu outbreak have shown that minority populations and those with LEP do not receive adequate health information and are more likely to transmit disease and die during pandemics.[2] While exhaustive and conclusive data are still lacking for the current COVID-19 pandemic, racial disparities are emerging.[3] One national analysis of Centers for Disease Control and Prevention (CDC) data found that Latinx and Black residents were three times as likely to contract COVID-19 and two times as likely to die than their White neighbors.[4] Another analysis of hospitalization, mortality, and census demographic data found counties with a majority African American population had infection rates three times higher and mortality rates six times higher than those counties with a majority White population.[5] In a recent systemic review appearing in the Annals of Internal Medicine, African American/Black and Hispanic populations experienced disproportionately higher rates of SARS-CoV-2 infection and COVID-19–related mortality but similar rates of case fatality. The observed disparities are more likely to be due to exposure-related factors than susceptibility (that is, comorbid conditions), but more evidence is needed to confirm this finding and evaluate the effects of health care access and exposure-related factors, such as population density.[6] Differences in health care access and exposure risk may be driving higher infection and mortality rates. In San Francisco, Asian American persons faced the highest mortality rate out of any other group, accounting for 52 percent of deaths despite only being 34 percent of the population.[7]

Specifically, there are actions that Congress should take or require that the administration take, either immediately or in the short term, to mitigate the impact of COVID across racial and ethnic minority populations:

- **Collect COVID-19 and Racial Disparity Data.** Collect racial, ethnic, and language preference demographic data on testing, infection, hospitalization, and mortality during a pandemic and release that data in a uniform and timely manner at a local and national level. These data should be shared with local, state, territorial, and tribal governments. Frequent, granular, and high-quality disaggregated demographic data are needed to fully understand the impact on racial and ethnic minority communities and better offer targeted care.[8]

- **Equitably Distribute COVID-19 Vaccines and Treatments.** Testing, treatments, vaccines, and other resources should be equitably distributed in a transparent manner based on need, especially in historically underserved racial and ethnic minority neighborhoods. These services and supplies should be affordable and accessible regardless of socioeconomic status.[9]

- **Protect Essential Workers.** With so many members of racial and ethnic minority populations required to work during the PHE caused by COVID-19, the U.S. Department of Labor's (DOL)

Occupational Safety and Health Administration (OSHA) should issue appropriate workplace protections to protect the health and well-being of essential workers during a pandemic.[10]

- **Permanently Expand Access to Family and Medical Leave.** Congress should provide universal access to family and medical leave that provides a minimum period of six weeks of paid leave that should be mandated and funded, with flexibility that allows for the caring of family members, as recommended in "Women's Health Policy in the United States".[11] Legislative or regulatory action at the federal, state, or local level are needed to advance this goal.[12]

- **Address Environmental and Social Drivers of Health.** Environmental factors and other social drivers of health that disproportionately affect racial and ethnic minorities, including the impact 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",[13] "Addressing Social Determinants to Improve Patient Care and Promote Health Equity" ,[14] and "Climate Change and Health".[15] [16] These social drivers and environmental factors influence an individual's health status even though they are sometimes not part of the health care system. It is likely that existing comorbidities do not fully explain COVID-19 disparities and that other factors like structural racism, uninsurance, poor quality of care, food and housing insecurity, workplace risks, and other social drivers of health have contributed to these disparities.[17] These issues can include the location of an individual's neighborhood and community, environmental conditions—such as pollution and air quality—of where someone lives, access to quality housing, access to good transportation resources, meaningful employment opportunities, and negative interactions with the criminal justice system.[18]

One possible explanation for COVID-19–related racial disparities is that certain racial and ethnic minority groups have higher rates of chronic disease, such as hypertension, diabetes, obesity, asthma, and cardiovascular disease.[19] For instance, diabetes rates among Asian American persons, Hispanic persons, non-Hispanic African American persons, and American Indian and Alaska Native persons are higher than among White persons.[20] All of these underlying chronic diseases heighten one's risk for severe illness from COVID19, leaving minority communities particularly vulnerable in an environment with inadequate testing and treatment capacities. One analysis found that 34 percent of American Indian and Alaska Native nonelderly adults and 27 percent of Black nonelderly adults were at higher risk of serious COVID-19–related illness due to an underlying health issue, compared to 21 percent for White nonelderly adults.[21] Impact from COVID-19—related racial disparities are caused by underlying health equity and racial disparity issues that Congress needs to take action to address on a structural level.

Specifically, there are actions that Congress should take or require that the administration take, either in the medium or long term, to not only mitigate the impact of COVID-19 across racial and ethnic minority populations, but also reduce structural health equity and racial disparities:

Improve Access to Health Coverage and Expand Physician Workforce

ACP believes that public policy must strive to make improvements to coverage, quality, and access to care for everyone, while addressing the disproportionate effect on those at greatest risk because of their personal characteristics. Universal health coverage, either through single-payer or public choice model as recommended in "Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care"[22] is fundamental in addressing the underlying racial and ethnic disparities in comorbidities that increase risk of negative health outcomes. Having adequate health coverage is closely associated with one's access to care and well-being. Compared to those who are insured, uninsured individuals are three times less likely to visit a doctor or health professional regarding their health.[23] While the Patient Protection and Affordable Care Act (ACA) greatly decreased the coverage gap, additional measures are needed to achieve universal coverage and eliminate persistent disparities in coverage. As the overall population has seen a decrease in the uninsured rate since the ACA was implemented, racial and ethnic minorities have experienced some of the largest gains but still have higher uninsured rates compared to White persons.[24]

Medicaid eligibility should be expanded and Children's Health Insurance Program and Medicaid coverage should be unified in all states so that families are covered under a single program. As 46 percent of all Black persons and 36 percent of all Hispanic persons in the U.S. live in states that did not expand Medicaid, expanding Medicaid eligibility in the remaining holdout states could have a meaningful impact on coverage for racial and ethnic minorities.[25] ACP strongly supports the American Rescue Plan (ARP) Act that provided incentives for states to expand Medicaid by temporarily increasing the state's base FMAP by five percentage points for two years for states that newly expand Medicaid. This provision will hopefully promote adoption of Medicaid expansion by all states, providing coverage to tens of millions of low-income persons who currently are not eligible in states that have declined so far to expand Medicaid.

Insurance marketplace subsidies should be expanded to provide assistance to those individuals in states that did not expand Medicaid with incomes too high to qualify for Medicaid and too low to qualify for marketplace premium subsidies. Premium subsidies made available under the ACA for marketplace exchange plans provide another avenue for decreasing coverage disparities. Under the ACA, premium subsidies in the form of tax credits are provided to those who obtain insurance on an ACA marketplace exchange and make between 100 percent and 400 percent of FPL. The ARP Act contains provisions to fully subsidize the health coverage of people earning up to 150 percent of the federal poverty level (FPL) under the ACA and those on unemployment insurance for a period of two years. In addition, enrollees who make over 400 percent FPL would become eligible for subsidies and have their premium costs capped at 8.5 percent of income for two 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 two-year extension will help many of these uninsured and underinsured low- to middle- class Americans achieve health care coverage. We believe further that these premium tax credit reforms should be extended permanently by Congress.

Approaches should also be explored to offer coverage for unauthorized immigrants, including allowing them to obtain coverage in the insurance exchange. Unauthorized immigrants, a population that is

primarily made up of racial and ethnic minorities, have been consistently left out of legislative efforts to expand coverage.

Lastly, funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health care professionals providing care for racial and ethnic communities historically underserved and disenfranchised.[26] ACP was pleased that bipartisan congressional leaders worked together to provide 1,000 new Medicare-supported Graduate Medical Education (GME) positions in the Consolidated Appropriations Act, 2021—the first increase of its kind in nearly 25 years—and that some of those new slots will be prioritized for hospitals that serve Health Professional Shortage Areas (HPSAs). In addition, ACP calls on Congress to pass the Resident Physician Reduction Shortage Act of 2021 (H.R.2256/S. 834) which would provide 14,000 new GME positions over seven years, or 2,000 per year. ACP also supports other physician and clinician workforce programs and we strongly supported providing $800 million for the National Health Service Corps (NHSC) and $330 million to expand the number of Teaching Health Centers (THC) Graduate Medical Education (GME) sites nationwide and increase the per resident allocation that were in the ARP Act. Indeed, a recent study appearing in the Annals of Internal Medicine showed that in counties with fewer primary care physicians (PCP) per population, increases in PCP density would be expected to substantially improve life expectancy.[27] Accordingly, Congress should enact policies that will not only increase the overall number of PCPs, but also ensure that these additional PCPs are located in the communities where they are most needed.

Address Health Literacy and Cultural Awareness Gaps

ACP believes that physicians and other clinicians must make it a priority to meet the cultural, informational, and linguistic needs of their patients, with support from policymakers and payers. Health literacy among those facing disparities on the basis of personal characteristics must be strengthened in a culturally and linguistically sensitive manner. Funding and support should be made available for clinicians to implement and expand health literacy interventions and adapt their practice to accommodate the cultural, informational, and linguistic needs of their patients. Lack of health literacy can impact adherence to treatment plans and make it difficult to understand prescription labels, forms, bills, appointment slips, discharge information, and other medical documents. Research has found that physicians tend to overestimate patients' health literacy and understanding of instructions while patients tend to be unaware of their health literacy and overestimate their ability to recall health information.[28] Low health literacy is associated with more hospitalizations and use of emergency care, lower rates of mammography screenings and influenza vaccination, misadherence of medication treatment plans, difficulty in understanding health communications and labels, and poorer health status and higher mortality rates among the elderly.[29]

Health care communications must be conveyed in a language the patient understands. Congress should make it possible for clinicians to be reimbursed by public and private payers for translation services needed in providing care for those with limited English proficiency (LEP) or who are deaf. Patients with language-discordant physicians reported worse interpersonal care and less health education, although use of a clinic interpreter mitigated some of these effects.[30] A review of the literature highlights Interpretation services have shown to be effective on improving care for patients with LEP. Access to trained professional interpreters is associated with improved patient satisfaction,

quality of care, and outcomes. When informal interpreters are used, such as family members or unqualified interpreters, more errors occur.[31] Use of interpreter services was also associated with receiving more preventive services, more office visits, and the filling of more prescriptions.[32] [33]

Implement Policies to Decrease Maternal Mortality

ACP believes that policies must be implemented to address and eliminate disparities in maternal mortality rates among Black, Indigenous, and other women who are at greatest risk. Congress should ensure access to affordable, comprehensive, and nondiscriminatory public or private health care coverage that includes evidence-based care over the course of a woman's lifespan, including high-quality and patient-centered preconception, antenatal, delivery, postpartum, and other care and appropriate specialists and subspecialists. Congress should help state and localities establish maternal mortality review committees (MMRCs) and other state or local programs to collect pertinent data, identify causes of maternal death, and develop and implement strategies with the goals of preventing pregnancy-related or pregnancy associated death and improving maternal outcomes. MMRCs should have access to necessary data across jurisdictions and implement best practice standards for data collection including consistency and comparability of data. Congress should incentivize health care institutions to undertake safety and quality improvement activities that are shown to be effective in improving maternal and other health. Congress should require payers to cover resources like doulas and patient navigators by public and private payers. ACP supports ongoing research and evaluation of such services in order to demonstrate which models are most effective.[34]

Collect Racial and Ethnic Health Disparity Data

ACP believes that more research and data collection related to racial and ethnic health disparities are needed to empower policymakers and stakeholders to better understand and address the problem of disparities. Collected data must be granular and inclusive of all personal identities to more accurately identify socioeconomic trends and patterns.

Without adequate data for marginalized communities, it is impossible to know the full extent of the various social, economic, and health issues they face. In "Addressing Social Determinants to Improve Patient Care and Promote Health Equity",[35] ACP calls for additional research into social drivers of health, including an increased effort to recruit disadvantaged and underserved populations into large-scale research studies and community-based participatory studies. Further research and inclusive and coordinated data collection efforts are necessary to better understand the presence of and identify possible solutions for disparities in health, health care, and social drivers of health in communities that face discrimination on the basis of race, ethnicity, religion, and cultural identity.[36]

Conclusion

We commend you and your colleagues for working in a bipartisan fashion to examine health disparities to improve health equity and outcomes and to develop legislative proposals to combat the ongoing Coronavirus crisis—as well as future pandemics. We wish to assist in the HELP Committee's efforts in this area by offering our input and suggestions about ways that Congress and federal health departments and agencies can intervene through evidence-based policies both now and beyond the PHE. Thank you for consideration of our recommendations that are offered in the spirit of providing the necessary support to physicians and their patients going forward. Please contact Jared Frost, Senior

Associate, Legislative Affairs, by phone at (202) 261-4526 or via email at jfrost@acponline.org with any further questions or if you need additional information.

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