Statement for the Record
American College of Physicians
Hearing Before the United States House Oversight and Reform Committee
on "Examining Pathways to Universal Health Coverage"
March 29, 2022

The American College of Physicians (ACP) is pleased to submit this statement to the House Oversight and Reform Committee and offer our views on how moving towards universal coverage can advance health equity in the United States. We applaud Chairwoman Maloney for conducting this hearing to assess how uninsurance and underinsurance negatively affects health outcomes and what reforms can expand access to affordable health care and move the nation towards universal coverage, including passage of H.R. 1976, the *Medicare for All Act of 2021*. Our recommendations, as outlined below, are consistent with ACP's goals of achieving universal health coverage, including the adoption of a single payer system, adoption of a public option, 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.

ACHIEVING UNIVERSAL HEALTH COVERAGE

The United States remains the only wealthy industrialized nation without universal health coverage, a crucial component to ensuring quality health care for all without financial burden that causes delay or avoidance of necessary medical care. The Patient Protection and Affordable Care Act of 2010 (ACA) led to historic reductions in the number of uninsured persons, yet millions remain uninsured or underinsured and even before the public health emergency caused by COVID-19, the number of uninsured persons was expected to grow.[12]

ACP has been a longstanding advocate for a health system that provides universal coverage to all Americans as 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. In that paper, ACP recommended that the United States transition to a system that achieves universal coverage with essential benefits and lower

administrative costs. Coverage should not be dependent on a person's place of residence, employment, health status, or income. Coverage should ensure sufficient access to clinicians, hospitals, and other sources of care. We recommended that two options could achieve these objectives -- a single-payer financing approach, or a publicly financed coverage option to be offered along with regulated private insurance. ACP believes that the U.S. health care system requires systemic reform and envisions a health care system where everyone has coverage for and access to the care they need, at a cost they and the country can afford.[3] Unfortunately, 30 million Americans lack health care coverage[4] and many insured people struggle to pay for the care they need.

Public Option

ACP strongly believes that a public option concept could broaden access to affordable coverage choices, rein in excessive hospital and prescription drug costs, promote preventive and primary care, reduce health inequities, relieve administrative burdens, and embrace innovative payment and delivery systems designed to improve patient care and enhance value, helping to achieve universal coverage. Yet designing a coverage option from scratch is an incredibly complicated endeavor that could trigger unintended consequences or amplify existing problems, including health system fragmentation, undervaluation of primary care and other physician services, and lack of viability in rural and other underserved areas.

We provided extensive comments to the House Energy and Commerce and Senate Health, Education, Labor and Pension committees regarding our recommendations summarized below on how such a public choice—or public option—model might be designed to achieve our policy objective of ensuring that all Americans have coverage for essential benefits that are not dependent on their income, health status, place of residence, or employment.

ACP believes that fundamental reforms are needed to make affordable coverage available to all Americans. We call on Congress to enact legislation to create a public option, consistent with the following principles and recommendations:

1. Make a public option broadly available so that all Americans have a choice of enrolling in a public option plan or in a qualified private employer-based or non-group plan, provided that the benefits and cost-sharing in the private insurance options are comparable to those available from the public option. If the public option is to be made initially available only in the nongroup market and to the Medicaid coverage gap population, it should subsequently be expanded to offer a choice to people with employer-sponsored insurance and other populations.

2. Under a public option, payment rates to physicians and other clinicians, as well as to hospitals and other facilities that offer health care services, must be sufficient to ensure access to needed care and should not perpetuate disparities in current payment methods. Current Medicare payment rates generally are insufficient to achieve the objectives of universal coverage.

3. Physician payment policies must ensure robust participation and not undervalue primary care and cognitive services, including the primary, preventive, and comprehensive care provided by internal medicine physician specialists.

4. Physicians are more likely to be able to afford to participate in, and see a significant number of patients, in a public plan that offers high-quality service to patients, limits administrative burdens for physicians, and provides fair and sufficient reimbursement rates. It is particularly important that payments to physicians under a public option support an increased investment in undervalued primary and comprehensive care, consistent with the consensus report of the National Academies of Sciences, Engineering and Medicine (NASEM), Implementing High Value Primary Care: Rebuilding the Foundation of Health Care, which notes that primary care is the foundation of a high-functioning health care system.[5] Innovative alternative payment models to support primary care should be adopted by the public plan. Specifically, health care delivery and payment under a public plan should be redesigned to support physician-led, team-based care delivery models in providing effective, patient- and family-centered care as stated in, "Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms." Policies and necessary oversight to support broad and sufficient networks of physicians and other clinicians should be included. Physicians should be allowed to choose to participate in the public option. Participation in Medicare, Medicaid, other public coverage program should not be contingent on whether a physician participates in the public option.

5. Under a public option model, coverage must include an essential health care benefit package that emphasizes high-value care, preferably based on recommendations from an independent expert panel that includes the public, physicians, economists, health services researchers, and others with expertise. Cost sharing that creates barriers to evidence-based, high-value, and essential care should be eliminated, particularly for low-income patients and patients with certain defined chronic diseases and catastrophic illnesses.

6. The public option should include income-adjusted premium and cost-sharing subsidies especially for persons at or below 138 percent of the Federal Poverty Level (FPL). ACP has recommended extending the ACA marketplace's premium tax credits to people with incomes over 400 percent of the FPL. Similar premium subsidies and eligibility could be applied to persons choosing the public option.

7. In a public option system, employers should be required to offer comprehensive coverage to their employees (and families) that is at least as generous as the public insurance option or pay a portion of the cost of their employees' public insurance plan coverage (that is, "pay or play").

ACP has also offered recommendations for a public option that would be available alongside private insurance in the ACA marketplaces to inject competition into areas underserved by private insurers and reduce premiums. Evidence shows that areas with a single insurer have faster premium growth than those with multiple insurance options.[6] A federal public option plan made available along with regulated insurance, must be designed to protect and ensure that patients can get, and physicians are

able to provide, the care they need consistent with evidence-based guidelines, essential guaranteed benefits determined with patient and physician input, and overall available resources.

Enact legislation to offer individuals aged 55 through 64 the option to buy into Medicare

ACP also supports a Medicare buy-in option for persons aged 55 through 64 years.[7] By doing so, older adults will have an opportunity to enroll in the popular Medicare program, potentially improving both the Medicare and marketplace risk pools and driving down premiums. Specifically, ACP recommends:

- A Medicare Buy-in Program must include financing that assures that premiums and any subsidies are sufficient to fully cover expenses without further undermining the solvency of the Medicare trust funds;
- A Medicare Buy-in Program should include subsidies for lower-income beneficiaries to participate;
- Eligibility for a Medicare Buy-in Program should include adults age 55-64 regardless of their insurance status; and
- Enrollment in a Medicare Buy-in program should be optional for eligible beneficiaries and should include the full range and responsibilities of Medicare benefits (Parts A, B, Medicare Advantage and Part D).

Extension of ACA's Premium Tax Credit and Cost Reduction Subsidies

President Biden signed into law the American Rescue Plan Act last year. That law included provisions supported by ACP to expand coverage as well as reduce premium costs under the ACA. It also increased 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 subsidized the marketplace-based health coverage of people earning up to 150 percent of 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.

The House-passed H.R. 5376, the *Build Back Better Act* (BBBA), would have provided temporary enhanced ACA Marketplace cost-sharing reduction assistance to individuals with household incomes below 138 percent of the FPL for calendar years (CY) 2022 through 2025. That bill would have expanded eligibility to taxpayers with household incomes below 100 percent of the FPL and specified 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 BBBA would also have continued 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. ACA therefore urges congress to pass H.R. 369, the *Health Care Affordability Act of 2021*, which would increase the benefits 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. This legislation will help many of these uninsured and underinsured low- and middle- income Americans achieve health care coverage.

Expanded Medicaid Coverage

H.R. 5376 would have provided ACA-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, which ACA supported. 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 or cap the program funding, or otherwise imposing mandatory work requirements, premiums and cost-sharing for vulnerable individuals, and benefit cuts.

ACP also supports passage of H.R. 340, the *Incentivizing Medicaid Expansion Act of 2021*, which 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.

Medicaid Pay Parity

Medicaid enrollment has increased by more than eight percent over the past year because 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.

We urge congress to pass H.R. 1025, *the Kids Access to Primary Care Act of 2021/S. 1833, Ensuring Access to Primary Care for Women & Children Act*, which would ensure that Medicaid payment rates for primary care services are equal to Medicare rates. The 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

We were pleased last year 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. With the ongoing COVID-19 pandemic, patients are even more concerned about whether they can afford their medications and 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 most viable vehicle for passing legislation, the House-passed BBBA, did 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 any new legislation. The House-passed BBBA would have allowed 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 would have applied an excise tax on drug manufacturers for raising prices faster than the rate of inflation, reduced out-of-pocket expenses for customers, and ensured 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. ACP is also supportive of legislation to contain the rising costs of insulin.

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, a bipartisan group of 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).

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. 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 all communities, including for racial and ethnic communities historically underserved and disenfranchised.[8]

ACP supported provisions in the House-passed H.R. 5376, that sought to improve the nation's healthcare infrastructure and workforce. That legislation would have created 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. ACP was pleased that an additional 4,000 Medicare-supported GME slots were 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 included: $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 to serve those needing primary and behavioral care.

ACP also supports several pieces of legislation introduced in the 117th Congress to assist medical graduates and the overall physician workforce, including:

- *The Resident Physician Shortage Reduction Act of 2021* (H.R. 2256/S. 834) is bipartisan legislation that would take steps to alleviate the physician shortage by gradually providing 14,000 new Medicare-supported graduate medical education (GME) positions.
- *Conrad State 30 and Physician Access Reauthorization Act* (H.R. 3541, S. 1810) allows states to sponsor foreign-trained physicians to work in medically underserved areas in exchange for a waiver of the physicians' two-year foreign residence requirement.
- *The Student Loan Forgiveness for Frontline Health Workers Act* (H.R. 2418) would forgive student loans for physicians and other clinicians who are on the frontlines of providing care to COVID-19 patients or helping the health care system cope with the COVID-19 public health emergency.
- *The Resident Education Deferred Interest Act* (H.R. 4122) would make it possible for residents to defer interest on their loans.

PAID LEAVE

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 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 House-passed BBBA included four weeks of paid leave, which ACP supported. 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.

CONCLUSION

We appreciate the commitment of the Oversight and Reform Committee to examine ways to extend universal health coverage in America and to craft solutions both during and post-COVID-19 so that patients will receive the treatment and services necessary to improve their physical and mental health. The United States is the only wealthy industrialized country without universal health coverage. It spends more on health care than its peers, and spending is growing at an unsustainable rate, care is unaffordable for many Americans (including insured persons), and health outcomes lag behind those of countries with universal coverage. ACP believes that achieving universal coverage and access is an ethical obligation. We look forward to working with the committee and congress to adopt the recommendations outlined in this statement and are happy to provide guidance of internal medicine physicians as a resource as you draft legislation concerning this issue. Please contact George Lyons, Jr., Director of Legislative Affairs, by phone at (202) 261-4531 or via email at glyons@acponline.org with any further questions or if you need additional information.

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[1] Collins SR, Gunja MZ, Doty MM. How well does insurance coverage protect consumers from health care costs? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016. The Commonwealth Fund, 18 October 2017. Accessed at www.commonwealthfund.org/publications/issue-briefs/2017/oct/how-well-does-insurance-coverage-protectconsumers-health-care on 15 October 2019.

[2] 5 Congressional Budget Office. Federal subsidies for health insurance coverage for people under age 65: 2019 to 2029. May 2019. Accessed at www.cbo.gov/system/files/2019-05/55085-HealthCoverageSubsidies_0.pdf on 15 October 2019.

[3] Robert Doherty, BA, Thomas G. Cooney, MD, Ryan D. Mire, MD, Lee S. Engel, MD, Jason M. Goldman, MD, for the Health and Public Policy Committee and Medical Practice and Quality Committee of the American College of Physicians. Envisioning a Better U.S. Health Care System for All: A Call to Action by the American College of Physicians; 2020. https://doi.org/10.7326/M19-2411.

[4] US Census report from Sept 2021:https://www.census.gov/library/publications/2021/demo/p60-274.html

[5] Linda McCauley, Robert L. Phillips, Jr., Marc Meisnere,and Sarah K. Robinson, Editors. Implementing High-Quality Primary Care Rebuilding the Foundation of Health Care. The National Academies of Sciences, Engineering, and Medicine. 2021. https://www.nap.edu/read/25983/chapter/1

[6] Parys JV . ACA marketplace premiums grew more rapidly in areas with monopoly insurers than in areas with more competition. Health Aff (Millwood). 2018;37:1243-51. [PMID: 30080465] doi:10.1377/hlthaff.2018.0054

[7] American College of Physicians. Developing a Medicare buy-in program. A position paper. Philadelphia: American College of Physicians; 2005. Accessed

[8] 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 10 Physicians; 2021.
https://www.acponline.org/acp_policy/policies/understanding_discrimination_affecting_health_and_health_care_persons_populations_highest_risk_2021.pdf