American College of Physicians
Leading Internal Medicine, Improving Lives

October 2, 2026

The Honorable Ron Wyden
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

The Honorable Jon Ossoff
United States Senate
Washington, DC 20510

The Honorable Raphael Warnock
United States Senate
Washington, DC 20510

The Honorable Lisa Blunt Rochester
United States Senate
Washington, DC 20510

The Honorable Tammy Baldwin
United States Senate
Washington, DC 20510

The Honorable Sheldon Whitehouse
United States Senate
Washington, DC 20510

The Honorable Jeff Merkley
United States Senate
Washington, DC 20510

Senator Elissa Slotkin
United States Senate
Washington, DC 20510

The Honorable Elizabeth Warren
United States Senate
Washington, DC 20510

The Honorable Tina Smith
United States Senate
Washington, DC 20510

The Honorable Peter Welch
United States Senate
Washington, DC 2510

Dear Senators Wyden, Warner, Ossoff, Warnock, Blunt Rochester, Baldwin, Whitehouse, Merkley, Slotkin, Warren, Smith, Welch:

On behalf of the American College of Physicians (ACP), I am writing to provide our response to the recent Request For Information (RFI) that solicits comments to ensure that our patients have access to affordable, comprehensive health insurance coverage that meets their needs as well as ensure proper regulation and oversight of private equity investment in health care. We remain deeply concerned that the U.S. health care system is fragmented, inefficient, costly, and fails to serve patients well. We look forward to sharing our recommendations to improve access to care for patients without imposing unnecessary burdens on physicians.

ACP 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, 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 physicians also comprise the largest share of physicians delivering primary care in the U.S.

Our health care system requires comprehensive reform. The United States is 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 United States spends far more per capita on health care than other wealthy countries do, with nearly 18% of the nation's gross domestic product in 2024 directed to health care. In addition, administrative costs total $900 per person annually in the United States. Complex medical billing, documentation, and performance reporting requirements for value-based payment initiatives have made the U.S. health care system one of the most administratively burdensome in the world. This takes time away from direct patient care, generates billions of dollars of unnecessary administrative costs and contributes to unprecedented levels of burnout among physicians and other clinicians.

The growing involvement of private equity in the health care sector raises important questions about its effect on cost, quality, access, and the physician workforce. Private equity investment in health care is associated with increased costs and, in some settings, adverse effects on care delivery and outcomes. Rising costs, administrative burdens, workforce shortages, and declining reimbursement have made independent practice increasingly difficult, contributing to physician transitions to corporate ownership models. Physicians employed by private equity–owned health care organizations may also experience challenges due to the evolving dynamics of their work environment. State and federal regulators, as well as lawmakers, should consider implementing policy interventions to address these challenges.

Ensure Comprehensive Affordable Health Insurance Coverage for all Americans

The Affordable Care Act of 2010 (ACA) led to historic reductions in the number of uninsured persons, yet nearly 30 million remain uninsured, millions more are underinsured, and the number of uninsured persons is expected to grow to 37 million between 2026 and 2036.

In part, this is the result of congressional policy decisions, including enacted legislation that restricts or reduces eligibility for Medicaid, the expiration of enhanced premium tax credits and cost-sharing reduction assistance to people. These decisions by Congress have an even greater impact in the states that have continued not to broaden Medicaid eligibility after the 2012 U.S. Supreme Court decision that made expansion optional. The ACP has offered recommendations for improving the ACA's coverage provisions.

The cost of premiums and deductibles continues to rise to levels that are unaffordable for too many individuals and families with health coverage. Affordability of coverage is a common reason for remaining uninsured. The 2026 Milliman Medical Index found that total health care costs (including employer subsidy, employee contribution, and employee out-of-pocket cost at time of service) for a typical American family of 4 with an employer-sponsored preferred provider organization insurance plan at $37,824.

We urge the Senate to enact the following policies to ensure that all Americans have access to affordable comprehensive coverage as well ensure a fair, simpler, and less costly health care system to ensure that our patients can maintain their existing coverage.

Ensure Universal Coverage through Single-Payer or a Public Choice Model of Care

In 2020, we published a series of policy proposals that offer a New Vision for Health Care to examine ways to achieve universal coverage with improved access to care, reduce per capita health care costs and the rate of growth in spending, reform clinician compensation, and reduce the complexity of our health care system.

We recommend 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. 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.

A review of 25 U.S. federal and state single-payer proposals found that most included provisions on comprehensive benefits, patient choice of clinicians with little or no cost sharing, guidelines and standards, electronic medical records, billing, formularies, and payment reform. Common physician payment scenarios include a fee-for-service model where reimbursement is negotiated by a rate-setting panel and “provider” representatives, salaries, or capitation arrangements. Global budgets for hospitals are also common.

Transforming the current pluralistic U.S. system to one that is government-financed would probably cause major disruption in the health care industry and create winners and losers. For physicians, a single-payer system could lessen administrative burden and free time for direct

patient care. Uncompensated care costs resulting from lack of insurance or unpaid cost sharing would no longer be a concern. However, these benefits may come at the expense of physician autonomy and increased demand for care. Many single-payer proposals would base payments to physicians on Medicare's flawed payment system, which encourages volume over value, undervalues cognitive services and primary care, overvalues procedures, and bases payments on the input costs of each billable service rather than on value to patients. As discussed in the ACP paper "Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms, any system of universal coverage should not perpetuate the existing flawed Medicare payment system. Any single payer system should ensure that it provides sufficient payment for patient care that allows physicians to maintain their practice and deliver high quality care for patients. However, evidence shows that areas with a single insurer have faster premium growth than those with multiple insurance options.

Depending on its structure and implementation, a public choice (or public option) model available to all could help to achieve universal coverage, better access, and improved outcomes without the disruption of a single-payer approach. Under a public choice approach, those covered by employer-sponsored insurance can choose to enroll in the public insurance plan or remain in their existing plan. The public plan would be available nationwide, ensuring portability from state to state. The ACP has 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. Colorodo's public option plan has lowered premiums and expanded plan choice in the individual market.

A public option approach could potentially achieve ACP's vision of a system where everyone will have coverage for and access to the care they need, at a cost they and the country can afford, with less disruption than a single-payer system. A public option approach could also partially address ACP's vision of redirecting administrative spending to fund coverage, research, public health, and interventions to address social determinants of health.

Public option proposals also have noteworthy disadvantages. Continuing the multi-payer system would require more complex regulatory structure and stricter oversight and result in fewer savings from lowering overall administrative costs than a single-payer model and still would probably require substantial controls over prices to keep coverage affordable. If physician payments in the public plan were based on Medicare rates, physician practices could face financial difficulties that would undermine participation, especially in areas with workforce shortages. Such price controls could perpetuate undervaluation of primary care. Without sufficient controls, however, costs could make a public plan infeasible.

The ACP concludes that of the currently available approaches that have been extensively modeled and researched, either a single-payer or public choice model offers the best

opportunity to achieve our vision of universal coverage at a cost the patient and the country can afford, while recognizing that each has advantages and disadvantages. The ACP acknowledges concerns about giving government too much control over health care but notes that the current system gives insurers, many of whom act like or are for-profit companies, too much control, while the government already has a substantial role in regulating and financing health care. Implementation of any system, whether single-payer or a public choice approach 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.

Restore Eligibility for Medicaid and Expand Enhanced Premium Tax Credits to Purchase Health Insurance in the ACA Marketplace

As we work toward a system that provides universal health care coverage, we urge the Senate to take steps now to reduce the rate of uninsured by strengthening Medicaid and reinstating enhanced premium tax credits to purchase qualified health plans through the health insurance exchange.

While ACP appreciates the need to ensure Medicaid's program integrity and sustainability, we oppose provisions in H.R. 1, the One Big Beautiful Bill, that would disqualify millions of eligible Americans from Medicaid – due to red tape and administrative barriers. Our patients who rely on Medicaid are among the most vulnerable; the policies in this legislation will not improve their health especially if they lose coverage or have to pay more when they visit their doctor. We urge you to eliminate Medicaid work requirements, restore states' ability to provide sufficient reimbursement to physicians through state-directed payments, ensure states have the tools to fund their share of the Medicaid program and reduce onerous enrollment barriers for Medicaid-eligible patients. We look forward to working with you to prevent waste, fraud, and abuse in the Medicaid program while ensuring that all individuals who qualified for the program before H.R. 1 was enacted do not lose eligibility for Medicaid coverage because of new administrative hurdles.

We also urge Congress to pass H.R. 247, the Health Care Affordability Act, that would permanently extend the enhanced premium tax credits for exchange-based health insurance coverage that expired at the end of last year. These enhanced premium tax credits have dramatically reduced health insurance costs for our patients by an average of 44 percent, or $705 per enrollee. We are concerned that their expiration is estimated to more than double what subsidized enrollees currently pay annually for premiums—a 114% increase from an average of $888 in 2025 to $1,904 in 2026.

Remove Cost Sharing for Essential Services

Over the past decade, enrollment in low-deductible health plans has decreased while enrollment in high-deductible health plans has grown for adults in employer-based plans. In the RAND Health Insurance Experiment, cost sharing reduced utilization of both effective and ineffective services. Low-income, sick patients in plans with zero cost sharing had better hypertension and vision outcomes than those with cost sharing, but those with cost sharing had fewer restricted-activity days and worried less about their health. The RAND study suggests that cost sharing should be minimal or nonexistent for low-income individuals. Evidence shows that even very low Medicaid copayments are associated with decreased use of necessary care.

High deductibles and other forms of onerous cost sharing may serve as a barrier to receiving high-value, preventive care and treatment after diagnosis. One study found that switching from a low-deductible to a high-deductible employer-based plan was associated with delays in breast cancer diagnosis and chemotherapy initiation among women, regardless of income.

These observations lead ACP to recommend reducing or eliminating cost sharing for high-value essential services, including primary care visits and highly rated preventive services, particularly for low-income individuals as well as those with special health care needs, serious illnesses, and chronic conditions. **We urge the approval of H.R. 9257, the Primary and Behavioral Health Access Act.** This legislation would require group and individual health insurance plans to fully cover three primary care visits and three behavioral health visits annually without any cost-sharing requirement. ACP also supports expanding access to consumer-friendly standardized plans that incorporate value-based insurance design concepts.

Ensuring Consumers Have Objective Information About Their Health Coverage Options

People often struggle with understanding cost-sharing requirements and insurance concepts. In the spirit of transparency, health care plans must provide plan materials, including explanations in plain, easy-to-understand language regarding benefits, applications, renewal forms, and grievance and appeals processes. Materials should also meet the needs of specific types of patients, such as those with disabilities, limited English proficiency, and limited literacy. Managed care concepts, including networks, cost sharing, formularies, utilization management, and coverage restrictions, need to be clearly described so patients understand how to use their coverage. Decision-support tools should be provided to help patients determine whether the plan covers their preferred clinician or prescription drug.

Increase Oversight of Out-of-Pocket Costs and Ensure Medicare Advantage Plans have financial protection for enrollees

ACP strongly recommends that CMS increase oversight of out-of-pocket costs and ensure plans have financial protection for enrollees. Medicare Advantage (MA) plans should be required to give clear, standardized reporting on out-of-pocket limits, and beneficiaries should have easy-to-understand educational resources about their cost responsibilities. Despite the perception that MA plans save enrollees money, high out-of-pocket costs remain an important concern. Plans frequently come with hidden expenses that add up quickly. The MA maximum out-of-pocket in 2025 increased to $9,350 for in-network costs alone, with even higher costs for out-of-network care.

Increase Funding for Impartial Enrollment Assistance

Insurance counseling and education programs provide valuable counterweight to biased or deceptive brokers and agents but are often underused and under resourced. ACP supports programs to help patients navigate the multiple health plan options for MA, Medicaid managed care, and the health insurance marketplaces, including the State Health Insurance Assistance Program, Navigators, and HealthCare.gov customer service representatives.

Insurers and state and federal governments must fund efforts to promote the ACA's coverage programs, especially during open enrollment. State and local health departments also may be able to provide outreach and enrollment assistance. Persons who receive enrollment assistance from a Navigator or other application helper are more likely to obtain coverage than those who do not; therefore, Navigator grants and other outreach and educational initiatives need sustained, sufficient funding to carry out their mission of reducing confusion and expanding understanding of what the law has to offer. Further, resources may be best directed toward persons who are eligible for Medicaid or premium tax credits but are not enrolled in coverage. School-based enrollment initiatives and outreach through workplaces, the court system, and non– health-related public benefit programs may be options to reach the remaining uninsured. Survey data show that the volume of television commercials for federally sponsored health insurance is associated with persons shopping for and enrolling in marketplace-based insurance. Television advertising, social media, and other marketing efforts should communicate about open enrollment.

Requiring MA plans to provide clear, standardized cost-sharing education before enrollment will help beneficiaries make more informed decisions. This could be through paper information sheets, video explanations, or telephone consultations that are easily accessible. Strengthening CMS oversight and standardizing cost disclosures will improve transparency, protect

beneficiaries from unexpected financial strain, and ensure that MA plans prioritize affordability alongside access to care.

Ensure Robust Oversight and Regulation of Marketing Tactics used to Enroll Seniors in MA and Managed Care Plans

ACP strongly urges that CMS provides robust oversight and regulation of MA marketing practices to prevent misleading advertisements that confuse beneficiaries. Plans engaging in deceptive marketing should face penalties, such as fines or star rating reductions, to protect the integrity of the program and ensure that beneficiaries are able to make informed decisions. Reports from Medicare oversight bodies and advocacy groups have revealed a persistent and ongoing pattern of deceptive marketing tactics in MA, leading to confusion, unauthorized enrollments, and disruptions in care.

Seniors and vulnerable persons with health needs have reported being misled by advertisements, mounds of paper mail, and sales agents who misrepresent plan benefits, resulting in unexpected out-of-pocket costs and difficulties accessing their physicians.

Specifically, these practices could be in the form of agents claiming that Medicare endorses their plan, threatening to remove the enrollee's benefits if they do not sign up for their plan, and plans setting their own time limits for persons to sign up for their plan. States have reported various additional concerns, including marketing targeted at persons with dementia, or instances where enrollees were switched to plans that did not cover their current physicians. Community health plans have reported notable member disenrollment due to misleading and aggressive marketing tactics by competing plans, agents, or brokers. Medicare Advantage plans have been increasingly relying on third-party marketing organizations and lead generations that inflate costs for enrollees and taxpayers. Spending on "agents and brokers fees and commissions" by insurance companies investigated by the committee has nearly tripled, with an increased $2.4 billion to $6.9 billion.

Furthermore, the process of "seamless conversion" into these plans should be stopped entirely and reevaluated so that newly eligible Medicare beneficiaries are not automatically enrolled in their commercial insurer's MA plan without their knowledge or understanding of the need to opt out of coverage. The CMS has taken steps to improve oversight, such as special election periods to correct enrollment errors, but stronger enforcement mechanisms and penalties are necessary to protect beneficiaries.

ACP strongly supports stringent oversight to prevent improper marketing of managed care plans. Concerns have been raised that agents and brokers selling Medicare products direct enrollees to plans that pay high commissions and other incentives and not to plans that would better meet the patient's needs. Agents and brokers of managed care plans must meet the

following requirements: be licensed by the state where they are selling the plan, use marketing materials approved by the regulatory body, undergo testing to ensure they are providing accurate information to potential enrollees, and have their commission capped. ACP supports adequate resources and robust enforcement of these individuals' actions to stop nefarious marketing activity by managed care plans.

Streamline the Prior Authorization Approval Process with Faster Response Times and Reduced Administrative Burdens on Physicians

As we work toward universal coverage for all Americans, we should approve measures to simplify our health system to reduce administrative burdens and costs that create barriers to care for our patients and physicians. A variety of studies over the last two decades have found that administrative expenses account for approximately 15% to 25% of total national health care expenditures, an amount that represents an estimated $600 billion to $1 trillion per year of the total national health expenditures of $3.8 trillion in 2019. We look forward to working with you to approve the following measures to increase access to care as well as reduce costs and administrative burdens in our health care system.

The widespread use of prior authorization (PA) in MA has been a source of particular concern for physicians and patients due to its administrative burden and potential to delay necessary care. Medicare Advantage plans have used utilization management techniques like PA to ensure that a service is medically necessary before approval. Prior authorization was originally intended as a cost control measure, and for many years lacked clear regulations for oversight or acceptable clinical guidelines. However, increasing evidence suggests that PA requirements have become overly burdensome, often creating unnecessary delays in patient care without clear clinical justification.

A 2023 Kaiser Family Foundation report found that nearly 50 million PA requests were submitted to MA insurers, and although many denials were later overturned on appeal, the appeals process itself is often time-consuming and complex, delaying necessary treatments for patients. The high rate of overturned denials suggests that many initial denials are made in error or without sufficient review, adding undue administrative burden on both beneficiaries and their physicians. Patients may be unaware of which treatments or medications require PA and are not given a reason behind the denial. It can take weeks or even months to get a peer-to-peer consultation, and the process leaves patients uncertain and stressed about their health care. These inefficiencies not only disrupt timely access to care but also contribute to physician burnout, as clinicians must navigate excessive paperwork and appeals instead of focusing on patient care.

We urge the Senate to pass **S. 1816, the Improving Seniors Timely Access to Care Act**, which would require that all MA plans establish an electronic prior authorization process to streamline approvals and denials and the Department of Health and Human Services (HHS) to establish a process for MA plans to provide "real-time decisions" for prior authorization requests of items and services that are routinely approved. Further, we appreciate the provision that would require MA plans that are unable to meet these real-time prior authorization decisions due to "extenuating circumstances" to issue final prior authorization decisions within a 72-hour and 24-hour time frame for regular and urgent services, respectively. We also support the transparency requirements in the bill, which would require MA plans to report on how often they use prior authorization and their rates for approvals or denials.

Improving Regulation and Oversight of Private Equity Investment in Health Care

We are concerned about the rising trend of private equity investment in health care as estimated private equity deal values increased from $41.5 billion in 2010 to $119.9 billion in 2019. Recent investment has increasingly focused on primary care and multispecialty practices driven in part by financial pressures and increased administrative burdens on physician practices.

Instead of individual physicians or small groups of physicians funding and expanding their practices, investment patterns have shifted from physician-led expansion to institutional investment by large firms. These investors may lack health care expertise, and the absence of physician involvement has raised concerns about outcomes in critical areas, such as cost, quality, access, equity, clinical involvement, and autonomy.

We urge Congress and federal regulators to implement the following recommendations to increase transparency and regulation related to private equity investment in health practices.

Establish Safeguards to Ensure Physicians Retain Control Over Patient Care

ACP urges federal and state policymakers to protect clinical autonomy and the sanctity of the patient– physician relationship by establishing safeguards that ensure physicians retain control over patient care. State lawmakers and regulators must strengthen existing prohibitions against the corporate practice of medicine, invest in measures to support physician well-being, and prohibit restrictive contractual arrangements. Corporate practice of medicine doctrines generally prohibit nonphysicians from owning or controlling medical practices. These frameworks were designed to preserve the independence of medical decision making from

commercial control. The ability of private equity firms and their medical management companies to control medical decision making and clinical care varies widely by state. Nearly half of all states have no rule prohibiting medical management companies from manipulating clinical practice and medical judgment. Even where regulations exist, private equity firms can find loopholes, such as naming physicians as practice owners while having a parent company control the finances.

We support provisions in the **Stop Corporate Takeovers of Physicians Act, S. 5419/H.R. 10444,** that would protect physician independence by prohibiting corporate interference with clinical decisions and banning restrictive contract terms, such as non-compete agreements, nondisclosure agreements, and non-disparagement agreements. We appreciate that this ensures that physicians retain ultimate control of medical practices by requiring that physician owners are meaningfully engaged in providing medical care in the state in which their practice is located. We recommend that in order to ensure that physicians maintain independence and clinical decision making for patients by ensuring that all provisions in the bill concerning ownership and control of practices require *physician* majority ownership of medical practices.

Improve Transparency and Regulation of Private Equity Acquisition of Physician Practices

ACP recommends that federal and state policymakers require private equity firms to disclose information about their investments, investors, and the financial health of their portfolios, including pre- and post-acquisition data on patient experiences and outcomes, price changes, adverse patient events, and practice-level workforce metrics. The actual influence of private equity in health care is difficult to measure, as firms have few disclosure requirements regarding their ownership. Physicians are also routinely required to sign NDAs, which protect sensitive information in contemplation of, during, and after a business transaction, prohibiting any outside parties from fully seeing the nature of the transaction.

This lack of transparency makes it nearly impossible to monitor the actual effects of private equity on health care, and it impedes patients' and referring physicians' ability to make a fully informed decision. **ACP calls on lawmakers and regulators to require review of most, if not all, private equity takeovers of hospitals, nursing homes, hospice agencies, and medical practices, rather than only those that trigger current threshold requirements.** The safety and well-being of patients and physicians must take precedence over the interests of investors.

Policymakers should also require the acquiring company to demonstrate how it will deliver on the promised efficiencies and maintain quality. Mandatory reporting of patient experiences or other outcomes that may be less easily manipulated, such as changes in prices or 90-day post-discharge mortality, must also be considered. This approach may improve accountability,

although further evaluation would be needed to determine its effect on quality and market behavior.

Private equity acquisitions have also been associated with changes in workforce composition, including increased use of advanced practitioners. Research from the National Institute for Health Care Management found a significant yearly increase in advanced practitioners at private equity–acquired practices after an ownership change, which may replace existing staffing structures. To the extent that entering and exiting a practice reflect turnover, this has implications for physician satisfaction and workforce stability. There may also be effects on quality of care, continuity of care, and health equity. Shifting toward ancillary service clinicians and advanced practitioners is one way private equity firms maximize profits by increasing revenues or cutting costs. These staffing and service delivery changes may affect health equity. Financial incentives may favor service patterns oriented toward commercially insured patients and higher-margin markets.

Lawmakers and regulators must address these significant shifts in practice delivery as patient care suffers due to a more transient workforce. **ACP calls on policymakers to establish oversight frameworks that require firms to demonstrate that major ownership and staffing changes will not compromise patient care.**

Increase Research to Evaluate the Impact of Private Equity on the U.S. Health System

ACP calls on federal and state regulators to research how private equity firms' investments in systems and practices participating in Medicare, Medicare Advantage, and other government and rural health programs have impacted beneficiary enrollment, spending, and clinical and health equity measures.

Research is not a policy solution, but it is necessary for effective policy reform. Over the past decade, private equity firms have made significant investments in health care, with major transactions across a range of entities, including health systems, nursing homes , hospice agencies , physician management companies , ambulatory surgical centers, and medical practices. However, the effects of private equity investment on the clinician workforce remain understudied. **ACP urges policymakers to conduct studies to understand how private equity acquisitions affect workforce composition and retention over time, especially as acquired practices are subsequently sold**. This research must also examine changes to the service mix or patient composition, as well as administrative and management practices and broader factors affecting physician burnout, including overall stress, high work demands, and a lack of personal time. While existing evidence demonstrates important trends, continued surveillance and

targeted research are needed to better understand the long-term effects of private equity ownership on workforce stability, patient outcomes, and system costs.

ACP calls on policymakers to commission studies that assess the full effects of private equity on the U.S. health system. Policymakers must examine how private equity's participation, whether direct or indirect, has affected federal programs such as Medicare, Medicare Advantage, and rural health programs. CMS quality and financial benchmarks, along with International Classification of Diseases, Ninth Revision (ICD-9) and 10th Revision (ICD-10) codes, should be used to comprehensively examine the effect on health disparities and health equity measures.

Lower Threshold for Review of Private Equity Mergers and Acquisitions

Antitrust regulators should also expand their review of private equity mergers and acquisitions. Currently, only mergers above a transaction threshold of $111.4 million are subject to federal regulatory review, a cutoff met by only a minority of private equity acquisitions. Despite being exempt from review, the remaining smaller acquisitions can still have a meaningful effect on consolidation, especially in local markets, as private equity firms often acquire multiple clinical entities within a specialty in a specific geographic area. **ACP recommends that federal regulators analyze the entire series of acquisitions to prevent roll-up strategies from evading antitrust scrutiny.**

Conclusion

We look forward to working with you to enact these comprehensive reforms to ensure that our patients maintain universal access to quality affordable health care coverage, reduce unnecessary administrative burdens that increase costs to our system and create barriers to patient care, as well as increase oversight and regulation of private equity investment in health care. Should you have any questions or would like to discuss these policies in greater detail, please feel free to contact Brian Buckley at bbuckley@acponline.org.

Sincerely,

Jan K. Carney, MD, MPH, MACP, FRCP
President, American College of Physicians