acofp AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
advocacy • education • leadership

330 East Algonquin Road • Suite 1
Arlington Heights, IL 60005
Phone: 847.952.5100
Fax: 847.228.9755
www.acofp.org

June 5, 2019

VIA ELECTRONIC SUBMISSION to LowerHealthCareCosts@help.senate.gov

The Honorable Lamar Alexander
Chairman
Senate Committee on Health, Education, Labor and Pensions

The Honorable Patty Murray
Ranking Member
Senate Committee on Health, Education, Labor and Pensions

Dear Chairman Alexander and Ranking Member Murray:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to respond to the Senate Health, Education, Labor and Pensions (HELP) Committee's Discussion Draft of legislation entitled, the *Lower Health Care Costs Act of 2019*.

ACOFP is the professional organization representing more than 20,000 practicing osteopathic family physicians, residents, and students throughout the United States who are deeply committed to advancing our nation's health care system by improving health care delivery and outcomes and ensuring that patients receive high-quality care.

Osteopathic family physicians' practice in variety of settings, including in solo, small, group, rural, Native American Indian healthcare, and alternative payment models. We support the overall goal of this legislation to lower health care costs and to protect patients. We strongly urge the Committee to consider and recognize the benefits of primary care in contributing to higher health quality and lower costs and ensure physicians, especially those in solo, small, and rural practices, are not unnecessarily burdened by these efforts. We have concerns that some efforts to lower costs may place significant burdens on physicians, leading to poorer quality outcomes.

Our full comments are detailed on the following pages. Thank you for the opportunity to share these with you. Should you need any additional information or if you have any questions, please feel free to contact ACOFP at advocacy@acofp.org or (847) 952-5100.

Sincerely,

Robert C. DeLuca, DO, FACOFP *dist.*
ACOFP President

Specific Comments to the Discussion Draft

Overall, ACOFP supports efforts to ensure patients obtain needed, medically appropriate care in a timely fashion. We also understand the critical importance of ensuring patients are not adversely impacted by "surprise" billing, which can create unanticipated financial burdens for patients. However, we are concerned with several elements of the Lower Health Care Costs Act of 2019 Discussion Draft as they do not address the root cause of high health care costs and place the financial burden on physician practices to lower the cost of medical care.

ACOFP is concerned that the current insurance paradigm – the balance between physicians, especially those in solo, small, or rural practices, and insurers – skews far too heavily in favor of insurers. Physicians are forced to accept lower payment from insurers or are excluded from networks because insurers seek to limit their network. In rural areas where there are fewer patients and limited insurance options, a practice excluded from the network and unable to obtain payment to cover costs, is essentially a death knell for these community-based physicians. Primary care practices should not be the primary targets in an effort to lower health care costs; any additional burdens on these physicians will continue to erode the availability of community-based care. It is primarily through this lens that we provide comments.

Transparency and Information Exchange Associated with Surprise Billing

Section 309 of the Discussion Draft would place an additional burden on such physicians by requiring they provide an expected cost-sharing amount at the time of scheduling or not later than 48 hours after the patient requests such information. Many smaller practices do not have the administrative capacity to confirm the details of each patient's health insurance coverage at the time of scheduling. In addition, we have no way of determining the status of a patient's deductible or out-of-pocket status. Subsequently, any estimated cost-sharing amount could be extremely inaccurate and deter patients from obtaining needed care. We believe that this Section should only include the requirement for health plans to provide such cost-sharing estimates to patients; coverage policies are set by insurers, not physicians, and therefore it should only be the insurer's responsibility to help patients navigate and understand potential cost-sharing.

ACOFP supports requiring health plans to provide claims, network, and cost information as described in Section 501. We believe this requirement for health plans should be expanded to include such information for services or episodes of care provided in a physician office. In addition, we believe it is important for patients to understand how insurers negotiate prices and the cost-sharing associated with those services. This change to Section 501 would obviate the need for the physician cost-sharing transparency requirement in Section 309 and is more appropriate.

We support requiring health plans to maintain up-to-date provider directories. However, we urge the Committee to revise Section 304 to ensure that health plans make good faith efforts to ensure network providers verify their directory information. In rural areas or areas without stable internet connection, it can be challenging for such practices to maintain a consistent online presence. Subsequently, we believe there should be guardrails around the insurer process to verify and update the provider directory. Requiring certified mail or other trackable communication to verify directory information will ensure that health plans or issuers do not inadvertently exclude providers to the detriment of plan enrollees.

ACOFP also is concerned with the provisions of Section 502. Specifically, we call to the Committee's attention the hardships facing solo, small, and rural physician practices with regards to increasing

technology requirements. Many of these practices have difficulty purchasing and implementing adequate electronic health record systems. In addition, these requirements are additional expenses, including administrative staff time and system updates, that practices have not budgeted for. Therefore, we request the Committee consider a pathway for such practices to adopt and implement strong cybersecurity practices.

Reducing Prescription Drug Costs

ACOFP supports efforts to reduce the high cost of prescription drugs. Specifically, we support the Committee's efforts to improve transparency, educate physicians about biological products, and increase access to generic drugs. In addition, we support efforts to address the lack of transparency in terms of prescription drug rebates and increasing oversight of pharmacy benefit managers. We also urge the Committee to consider additional steps to more directly address the high cost of all prescription drugs. While we agree that increasing transparency about biological and generic drugs and increasing competition will help, we believe more direct action must be taken as well.

With all efforts to address prescription drug costs, we urge the Committee to ensure there will not be an adverse impact on patient access to medications and that insurers do not create unnecessary barriers (e.g., prior authorization, step therapy) to medications that have been effective for patients. This determination should be between the physician and the patient, and insurers should not be permitted to delay needed treatment that a physician believes is best for the patient.

Improving Public Health

We appreciate the Committee's focus and commitment to improve public health. Family physicians play a crucial role in the public health of our country, and we therefore strongly support the efforts in this Discussion Draft. ACOFP urges the Committee to recognize that many of the issues identified under Title IV of the Discussion Draft are much broader in scope than addressed. For example, we recognize and are extremely alarmed by the unacceptable rates of maternal mortality and severe maternal morbidity. However, the training programs to reduce and prevent discrimination (Section 407) should not be limited to the provision of prenatal, labor, and postpartum care. The implicit biases are present in all forms of health care delivery and grants should be available for broader use.

ACOFP also supports Section 405 and efforts to improve public health data systems. We have pursued efforts to leverage data and systems to improve population health and offer our support as the Committee seeks to refine this concept. We have firsthand experience with the challenges and benefits of operating such a system and remind the Committee that many physicians continue to face infrastructure challenges, which limit the utility of an electronic database. We look forward to collaborating with the Committee to ensure that public health data system modernization has utility for all physicians and not just those in urban and suburban areas.

We also support efforts to expand capacity to increase access to health care services, as described under Section 404. Many of the health care issues identified, including addressing chronic diseases and conditions, mental health, and substance use disorders, are those treated by family physicians. ACOFP urges the Committee to specifically support primary care physicians as we are often the first line of defense for these health care issues.

Additional Comments for Consideration

Overall, ACOFP believes this legislation will address many of the outcomes that result in high health care costs; it will not address the underlying causes and does not support what we believe to be the solution – primary care. We reiterate our previous comments to the Committee that increased access to primary care is more likely to result in preventive services and treatment for medical conditions before they become chronic and costly to treat.[1, 2] In other words, increased primary care reduces the need for unnecessary, high cost, specialty care, including emergency services.

In light of its benefit, we strongly urge the Committee emphasize the value of primary care services and ensure that elements of the Discussion Draft do not inadvertently limit or create barriers to primary care services. As we previously shared with the Committee the United States faces shortages of 20,400 primary care physicians by 2020.[3] By 2025, the United States is expected to require nearly 52,000 additional primary care physicians to treat the aging population and account for the additional consumption of resources during the projected 565 million primary care office visits.[4] The Centers for Medicare & Medicaid Innovation Primary Cares Initiative is a first step in terms of appropriately rewarding primary care physicians for the value they provide. However, this is a small step with minimal impact on restoring the family physician pipeline.

In order to address this shortage and to ensure patients continue to have access to primary care physicians, we reiterate our past recommendations:

- Support community-based primary care residencies as physicians are more likely to practice in or near the location where they completed their residency training;
- Incentivize primary care careers, especially those in rural and underserved areas by significantly increasing the federal government's commitment to loan forgiveness programs and ensuring federal health program reimbursement appropriately reflects the value of primary care;
- Support innovative primary care-focused value-based arrangements and models, including a Direct Primary Care (DPC) model; and
- Increase the number of primary care physician residency positions to reflect workforce needs, including through reforming the graduate medical education (GME) program.

ACOFP also has long supported efforts to redesign how health care is delivered, especially in terms supporting access to family medicine and primary care services. Our members recognize the importance of value-based care as evidenced by the 40 percent of our members participating in accountable care organizations (ACOs) and Advanced Alternative Payment Models (APMs). ACOFP members have firsthand experience of the reality of implementing value-based arrangements, including ACOs. Moreover, while primary care services alone can reduce costs and improve care, new studies[5] have also shown that primary care is a key contributor to successful ACOs. We are actively reviewing the Primary Cares Initiative, with many of our eligible members likely to participate.

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[1] A. B. Bindman, K. Grumbach, D. Osmond et al., "Primary Care Receipt of Preventive Services," Journal of General Internal Medicine, May 1996 11(5):269–76

[2] L. A. Blewett, P. J. Johnson, B. Lee et al., "When a Usual Source of Care and Usual Provider Matter: Adult Prevention and Screening Services," Journal of General Internal Medicine, Sept. 2008 23(9):1354–60

[3] HRSA Bureau of Health Professions, "Projecting the Supply and Demand for Primary Care Practitioners Through 2020," November 2013. Available from: https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projectingprimarycare.pdf

[4] S.M. Patterson et al., "Projecting US Primary Care Physician Workforce Needs: 2010-2025," Ann Fam Med, November/December 2012 10(6):503-509

[5] *See,* Y. Jabbarpour, M. Coffman, A. Habib et al., "Advanced Primary Care: A Key Contributor to Successful ACOs," August 2018. Available at https://www.pcpcc.org/sites/default/files/resources/PCPCC%202018%20Evidence%20Report.pdf.

While we appreciate the opportunities the Agency has offered, we believe that there must be a concerted congressional effort to support and expand on primary care services. Therefore, we urge the Committee to emphasize legislative efforts on the solution to high health care costs – improving access to primary care services, especially those provided by small, independent practices. Such efforts will lower health care costs without placing additional burdens on physicians or patients.

Conclusion

ACOFP thanks the Committee for soliciting feedback and comments on the Discussion Draft. We strongly believe that primary care physicians are critical to reducing health care costs by focusing on preventive services and reducing avoidable and high cost downstream utilization, and more can be done in this legislative proposal to expand access to primary care. We also believe this legislation would address many of the drivers of high health care costs, but would like to work with the Committee to address concerns related to unintended consequences and impacts on physician practices. We offer our support and welcome the opportunity to provide additional details or discuss these issues further.