Association of
American Medical Colleges
655 K Street, NW, Suite 100, Washington, DC 20001-2399
T 202 828 0400
aamc.org

July 29, 2021

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Patty Murray
Chair
Committee on Health, Education, Labor, and Pensions
U.S. Senate
Washington, DC 20510

Dear Chairman Pallone and Chair Murray:

On behalf of the AAMC (Association of American Medical Colleges), I appreciate the opportunity to respond to your May 26 Request for Information to develop legislation to establish a public option for health coverage to lower health care costs and help more families get quality, affordable health care. The AAMC is dedicated to improving the health of people everywhere and believes that everyone should have access to high quality, affordable, and comprehensive health care coverage.

The AAMC is a not-for-profit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

In partnership with their physician faculty, AAMC-member teaching hospitals are at the forefront of providing care to the most vulnerable and medically complex patients, and often care for patients who are unable to receive care elsewhere. While only 5% of all inpatient U.S. hospitals are AAMC-member teaching hospitals, these teaching hospitals and physicians provide 22% of all Medicare inpatient days, 25% of all Medicaid inpatient days, and 32% of all charity care costs. In addition, AAMC member teaching hospitals provide 24% of inpatient psychiatric unit beds, 25% of the nation's medical and surgical intensive care beds, 61% of pediatric intensive care beds, and are home to 63% of all Level 1 Trauma Centers.

The Affordable Care Act (ACA) has drastically reduced the number of uninsured Americans and Congress and the Biden Administration have taken important steps to continue to expand access to health care. The AAMC commends these efforts and supports additional work to build upon the success of the ACA and address the Medicaid coverage gap. It is also crucial to address the growing number of underinsured individuals by ensuring that they have access to high quality,

affordable, and comprehensive health care coverage that covers the care they need, when they need it. Finally, it is imperative that we intentionally and aggressively address health equity issues pertaining to lack of coverage, inadequate coverage, and poor access to care.

Strengthen the ACA

The ACA and subsequent actions to build upon its success have expanded access to health care across the country. Prior to the enactment of the ACA, gaps in the public insurance system and a lack of access to affordable private coverage left millions of people without access to health insurance. The ACA addressed many of these gaps by providing incentives for states to expand Medicaid to additional low-income individuals, establishing exchanges, and providing premium subsidies for individuals below 400% of the federal poverty level (FPL). As a result of these policies, the number of uninsured nonelderly Americans decreased from over 46.5 million in 2010 (the year the ACA was enacted) to just below 27 million (10% of the nonelderly population) in 2016.[1] Unfortunately, beginning in 2017, the gains in coverage stalled and the number of nonelderly uninsured increased for consecutive years, largely due to the high cost of insurance.[2]

Congress and the Biden Administration have taken important steps to strengthen the ACA to help reverse this trend and move forward. The American Rescue Plan Act (ARP) includes provisions that temporarily make Marketplace subsidies more generous and available to more Americans. Under the ARP, anyone who earns up to 150% of the FPL or who received an unemployment insurance payment in 2021 will have no cost-sharing requirement. Those with incomes above 400% FPL will contribute no more than 8.5% of their income towards premiums, regardless of their income. These enhanced subsidies are currently available through 2022 but the proposed American Families Plan would extend them permanently.

The AAMC encourages Congress to take additional steps to strengthen and expand upon the ACA to increase access to coverage, including by permanently extending these subsidies to help more low and middle-income individuals and families afford high-quality health insurance. We also urge Congress to eliminate the "family glitch," which affects an estimated 5.1 million people who would otherwise qualify for premium assistance through the ACA[3], and to take steps to reduce out of pocket costs for low and middle-income people on the Marketplaces.

Additionally, we support increased and steady funding for ACA outreach and educational activities to ensure that people are aware of their coverage options, especially those in rural and other underserved areas, as well as navigators to help consumers enroll in coverage through the Marketplace or Medicaid.

Address Gaps in Medicaid

The ACA expands Medicaid coverage for most nonelderly adults with incomes up to 138% of the FPL. While the law anticipated nationwide implementation, the Supreme Court's decision in

[1] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/
[2] Ibid.
[3] https://www.commonwealthfund.org/blog/2021/eliminating-family-glitch

2012 effectively made expansion optional for states. To date, 39 states (including Washington, DC) have opted to expand their Medicaid program to cover this population.[4] Medicaid expansion has provided nearly 15 million low-income adults with low-to-no-cost, affordable, comprehensive coverage.[5]

Despite this progress, 2.2 million adults in the remaining 12 non-expansion states fall into the coverage gap and are uninsured because they have incomes too low to qualify for subsidized health insurance coverage in the Marketplace but too high to qualify for their states' Medicaid program.[6] An additional 1.8 million uninsured adults in these states with incomes between 100-138% of the FPL are eligible for Marketplace coverage but are not enrolled and would be eligible for Medicaid if their state adopted the expansion.[7]

It is critical to cover this population since the consequences of remaining uninsured continue to be well-documented. As a result of having little or no preventative care, those without health coverage are more likely to suffer declines in their overall health and have poorer health outcomes. They also face delays in care due to cost barriers that can result in health emergencies and hospitalizations. Additionally, they have less financial security due to the cost of these hospitalizations.[8]

Continuing the effort to expand high quality, comprehensive, and affordable health care coverage is a priority to ensuring healthy and productive communities and remains an issue of advancing health equity. Communities of color are disproportionately uninsured, especially in non-expansion states. Black and Latino adults represent more than half of all adults that remain uninsured in the Medicaid coverage gap in non-expansion states, despite representing only 36% of adults within these states.[9]

To address the coverage gap, the ARP provides a 5-percentage point increase in the federal medical assistance percentage (FMAP) to incentivize new states to adopt Medicaid expansion. The AAMC supports this investment, as well as policies that would provide new expansion states with the same three years of a 100% federal matching rate as states that expanded in 2014 received.

Since, to date, no new states have decided to expand Medicaid even with the ARP incentives, we urge Congress to adopt a federal coverage option for the remaining uninsured population in non-expansion states. This could involve the federal government offering "look alike" Medicaid coverage or leveraging the Marketplace for adults with incomes less than 138% of the FPL in states that have not yet expanded Medicaid.

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[4] https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/
[5] https://data.medicaid.gov/Enrollment/2021-1Q-Medicaid-MBES-Enrollment/379c-k6ss/data
[6] https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial
[7] https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/. This data does not account for the coverage provisions included in the American Rescue Plan.
[8] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/
[9] https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial

Additionally, we urge Congress to make the FMAP more responsive to economic changes so that it automatically increases during periods of economic downturns. This would be beneficial to both individuals and states during any future downturns.

Improve Health Care Coverage Quality

The ACA made critical improvements to the quality of health insurance coverage offered in the U.S. by requiring qualified health plans to incorporate ten Essential Health Benefits (EHBs) and setting limits on out of pocket expenses. However, these standards do not apply uniformly across all health plans, leaving some individuals underinsured. These individuals have insurance coverage that does not meet their medical needs while requiring them to absorb more of the financial liability for treatment. Underinsurance is a growing problem – affecting more than 43% of adult Americans, and while people purchasing coverage through the individual market are most likely to be underinsured, the rate of growth in underinsurance is increasing, particularly as employers seek to cut premium costs and contributions.[10]

Relatedly, an increasing number of Americans find themselves in narrow network plans – whether the affordability of their coverage is at issue or not. This trend is accelerating in the individual market: at the inception of the marketplace exchanges in 2014, nearly half of all plans were broad-network PPOs – in 2019, that dropped to just 21%.[11] Narrow network plans can lead to delays in specialty care and can subject patients to unexpected medical bills. These plans also increasingly carve providers out of networks in the name of cost savings, leaving patients with persistent access issues to high quality care.

Poor health care coverage leads people to delay or avoid seeking care or medications, largely out of concern for the possibility of receiving a high medical bill. Americans should have access to a high-quality plan that covers what they need, when they need it, and without fear of high medical bills. The AAMC urges Congress to ensure that this type of coverage – which includes critical EHBs and ample access to a comprehensive network of providers – is accessible to all.

Increase Health Equity and Improve Data Collection

Over the past year, the COVID-19 pandemic's disproportionate impact on communities of color has laid bare pervasive health inequities, exposing the structures, systems, and policies that create social and economic conditions that lead to health inequities, poor health outcomes, and lower life expectancy. Though the ACA helped to narrow health care coverage inequities, these gains have been eroding since 2017.[12] Coverage rates among Hispanic, Black, Native American and Alaskan Native, Native Hawaiian or Other Pacific Islander, and nonelderly people remain below their White counterparts.[13] Though Medicaid and CHIP coverage help to alleviate these gaps, coverage rates across all racial and ethnic groups remain lower in states that have not

[10] https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial
[11] https://www.modernhealthcare.com/article/20181204/NEWS/181209976/most-aca-exchange-plans-feature-a-narrow-network
[12] https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/
[13] Ibid.

expanded Medicaid.[14] The AAMC is appreciative of actions that Congress and the Biden Administration have taken throughout the pandemic to increase coverage rates, but more must be done to ensure that racial and ethnic minority populations have access to high quality, comprehensive health care coverage. A federal fallback for low income adults living in non-expansion states would be an important step forward.

While increasing coverage rates is imperative, in order to close the gap in health inequities, we need higher quality and more expansive publicly held and managed data to better understand which health inequities exist (and persist). The COVID-19 pandemic also highlighted inconsistent data collection and reporting, resulting "in confusion and creat[ing] information voids…. [which] may lead to deepening social disparities that have already been further exacerbated by the pandemic."[15] Efforts to expand coverage should include setting federal standards for collecting and reporting data on social determinants of health (SDOHs) that could help alleviate local and state government inconsistencies. Without standardized, valid, inclusive data collection on the social needs and social determinants of health for under-resourced populations, we will not be able to target policy efforts to the communities that need them most. While it is widely recognized that more must be done to connect individuals to local services and programs, we must also work to identify and use data to better understand the social and economic contexts in which under-resourced populations live and seek care.

The AAMC believes that further investment is also needed to address SDOHs, which include access to clinical care, but also encompass myriad other factors such as secure housing, access to nutritious food, transportation, and financial stability. Current bipartisan legislation before Congress, the Social Determinants Accelerator Act of 2021(H.R. 2503), would provide funding for planning grants that would help states and communities develop innovative, evidence-based approaches to coordinate services and to improve the health of high need Medicaid populations, like homeless individuals or women diagnosed with postpartum depression. Additionally, the legislation would establish an interagency technical advisory council on SDOHs which would include program experts from across the federal government to help grantees implement their plans. The AAMC supports this legislation and believes that passing it is an immediate, actionable step that Congress can take to help address health equity.

The AAMC also urges you to continue your efforts to address inequities in maternal morbidity and mortality. As you are aware, the U.S. has a high rate of maternal deaths when compared to other, similar, countries. While this high rate of death on its own is deeply troubling, the outcomes are even worse for black, American Indian, and Alaskan Native women. Non-Hispanic black women are three to four times more likely to die from pregnancy-related causes than non-Hispanic white women.[16] Additionally, it is estimated that, in the U.S., over 60% of pregnancy related deaths are preventable.[17] The AAMC applauds both the Senate HELP and

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[14] Ibid.
[15] Oak, J. and Srinivasan, J, Ph.D., "Policy Inconsistencies Magnify COVID-19 Data Voids," Boston University Institute for Health System Innovation & Policy (September 2020).
[16] Callaghan WM. Overview of maternal mortality in the United States. Semin Perinatol. 2012 Feb;36(1):2–6.
[17] Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs

House Energy & Commerce Committees for their efforts to address maternal morbidity and mortality. In particular, we were pleased to see the passage of the Maternal Health Quality Improvement Act (S. 1675/H.R. 4387) in both Committees and continue to advocate for its final passage and enactment.

The AAMC also was pleased to see Congress provide a state plan option to expand Medicaid and CHIP coverage for pregnant women to one-year post-partum from the current 90 days in the ARP. Access to care is a critical component to improving outcomes for any and all patients, not just new birthing persons; but it is clear that this loss of post-partum coverage in particular imposes a hurdle to accessing needed care. More than 70% of new birthing persons experience complications in the year after child birth, and while not all complications result in a fatality, of the fatalities that do occur, approximately three in five were preventable.[18] Rates of severe morbidity are significantly higher in racial and ethnic minority women than in white women.[19] Coupled with the fact that nearly 50% of births are to women covered by the Medicaid program, and that Medicaid covers a greater share of births in rural areas and among minority women, it is clear that expanded Medicaid coverage for new birthing persons up to one year postpartum could have marked effects on preventing maternal deaths.[20] The AAMC urges you to make this a permanent requirement for all states.

The AAMC appreciates your interest in ensuring that all Americans have access to health care coverage, and we look forward to continuing to work with you to achieve our common goal of improving the health of all. If you have any additional questions, please feel free to contact me directly or my colleagues Jason Kleinman (jkleinman@aamc.org) or Ally Perleoni (aperleoni@aamc.org).

Sincerely,

Karen Fisher, J.D.
Chief Public Policy Officer
Association of American Medical Colleges

[18] Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;68:423–429. DOI: https://dx.doi.org/10.15585/mmwr.mm6818e1

[19] Howell E. A. (2018). Reducing Disparities in Severe Maternal Morbidity and Mortality. Clinical obstetrics and gynecology, 61(2), 387–399. https://doi.org/10.1097/GRF.0000000000000349

[20] https://www.macpac.gov/wpcontent/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf