SGIM
Society of General Internal Medicine

October 2, 2026

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Ranking Member Wyden,

On behalf of the Society of General Internal Medicine (SGIM), thank you for the opportunity to respond to this request for information (RFI) on "Health Coverage That Works for Everyone." We welcome the opportunity to work with the Senate Finance Committee ("the Committee") to develop policies that provide comprehensive health coverage and appropriate access to clinical services for all Americans. We are pleased to offer comments in response to all three sections: 1) Reversing Republican Cuts and Reimagining a Better Path; 2) Making Health Care Simpler for Families; and 3) Taking on Corporate Greed.

SGIM is a member-based medical association of more than 3,000 of the country's leading general internal medicine physicians, who are dedicated to delivering high-quality clinical care for adults of all ages, especially those with multiple chronic diseases who would benefit from having a physician deliver comprehensive primary care. Our members are committed to delivering high-quality care and ensuring patients have access to a well-trained physician workforce.

Our members see how gaps in coverage, utilization management practices like prior authorization, and business practices affect access to care and its delivery. Many of these gaps directly impact the health outcomes of the patients our members serve. The loss of the enhanced advance premium tax credits and the Medicaid cuts included in the *One Big Beautiful Bill Act* (P.L. 119-21) have already meaningfully reduced access to comprehensive health coverage. Utilization management practices, like prior authorization and step therapy, divert clinicians' time from practice and delay patients' access to treatment; this problem is particularly acute for general internal medicine physicians as the delivery of comprehensive primary care requires significant investment of face-to-face and non-face-to-face time treating patients and managing their care. Finally, we recognize and share your concerns about corporate ownership and consolidation in health care; however, we urge you to consider the policies and business practices of all ownership arrangements.

Reversing Republican Cuts and Reimagining a Better Path

Stable, affordable health care coverage is foundational to prevention, chronic disease management, and continuity of care – all key components of comprehensive primary care and a well-functioning health care system. Coverage losses do not eliminate the need for care; instead, they delay treatment, increase uncompensated care, and make it more difficult for patients and clinicians to manage health conditions before they become more serious and costly. Medicaid is an important safety net for low-income adults, people with disabilities, children and families, and patients with complex health and social needs who depend on consistent access to primary care. The reductions in federal Medicaid support and new eligibility and administrative barriers are already forcing states and hospitals to make difficult decisions about optional benefits and service reductions. Left unchanged, we anticipate costs will just shift from proactive to more costly reactive care, resulting in worsening health for many

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Americans. Further, we expect primary care physicians to bear significant responsibility for ensuring that their patients meet medical frailty eligibility requirements. This is additive to the already increasing amount of paperwork caused by utilization management discussed below. Combined, this extra reporting will ultimately divert resources away from direct patient care and chronic disease management.

SGIM, therefore, urges you to reverse the harmful Medicaid policies in the *One Big Beautiful Bill Act*, including the community engagement requirements, more frequent eligibility verification, and reductions in funding that goes to states and hospitals. Besides reversing these harmful Medicaid policies, the Committee should enact policies that provide stable financing sufficient to maintain benefits, provider participation, and access to care.

Besides the reductions in Medicaid, SGIM remains gravely concerned about the access barriers created by the expiration of the enhanced advance premium tax credits at the end of 2025. The Center on Budget and Policy Priorities reported that Marketplace enrollment in health plans has fallen by nearly 3 million Americans from 2025 to 2026.[1] According to the Kaiser Family Foundation, health premiums have increased by 58%, compounding concerns about health plan affordability and access to comprehensive coverage.[2] Just last week the Centers for Medicare & Medicaid Services (CMS) canceled Marketplace coverage for 760,000 Americans on account of alleged fraud.[3] Without intervention, the number of American who are uninsured and underinsured because they cannot afford more comprehensive coverage will continue to grow.

As the Committee considers long-term solutions to address the root causes of unaffordability, policies must be enacted to increase the availability of – and access to – primary care services, which help prevent chronic disease and reduce overall health care costs. Having health insurance does not necessarily ensure meaningful access to primary care and other medically necessary services, particularly when patients face high deductibles, cost-sharing, or other barriers that discourage them from seeking timely care**.**

Reversing recent coverage losses is essential, but Congress should also use this opportunity to address longstanding shortcomings in coverage that make it difficult for patients to access and maintain relationships with primary care clinicians and teams. This is a longstanding problem that pre-dates the *One Big Beautiful Bill Act*'s coverage losses and the expiration of the enhanced advance premium tax credits. Congress should require coverage of comprehensive primary care before application of a deductible and with no or minimal cost-sharing. Such policies should support the full range of primary care, including prevention, chronic disease management, care coordination, and other services necessary to maintain health and manage complex conditions, rather than just focusing on individual office visits. Reducing financial barriers to comprehensive primary care would make it easier for patients to establish and maintain an ongoing relationship with a primary care clinician or team and receive care before health conditions become more serious and costly.

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[1] https://www.cbpp.org/blog/aca-marketplace-enrollment-shrank-in-nearly-every-state-after-premium-tax-credit-enhancements

[2] https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/

[3] https://www.cms.gov/newsroom/press-releases/cms-cracks-down-fraud-waste-abuse-federal-health-insurance-marketplacer

Congress should also strengthen network adequacy standards to measure whether patients can obtain timely primary care and maintain continuity with a primary care clinician. Standards that rely primarily on the number of clinicians listed in a plan directory do not necessarily demonstrate that those clinicians are accepting new patients or are available within a reasonable time and distance. Network adequacy requirements should incorporate measures of actual appointment availability, geographic access, and patients' ability to establish and maintain an ongoing primary care relationship.

Making Health Care Simpler for Families

Prior authorization and other utilization management requirements create barriers for patients to clinically appropriate care. Delays extend beyond the time an insurer spends reviewing a request; physicians and practice staff must identify plan-specific requirements, assemble documentation, track a determination, pursue an appeal when necessary, and coordinate an alternative if coverage is denied. The cumulative burden is particularly significant for primary care practices caring for patients with multiple chronic conditions.

SGIM recommends that Congress ensure that there are consistent requirements across private insurance plans, including Marketplace and Medicare Advantage plans in the following areas. One important step toward this is passage of S, 1816, the Improving Seniors' Timely Access to Care Act, which SGIM supports and has overwhelming bipartisan support. This legislation would codify important protections for beneficiaries and clinicians.

Make coverage requirements available at the point of care. Plans should be mandated to provide accurate, patient-specific information through electronic health records, including whether prior authorization or step therapy applies; the clinical criteria for approval; covered alternatives that do not require prior authorization; required patient cost sharing; and clear next steps following a denial.

Move toward real-time determinations. For Medicare Advantage plans, CMS has sought feedback on the appropriate time frame for review of prior authorization requests for services and drugs. SGIM has recommended and continues to recommend that straightforward prior authorization requests that meet published criteria should be adjudicated in real time. More complex requests should receive a determination within 24 hours, with transparent status information and prompt access to appropriately qualified plan personnel for peer-to-peer review. Standards should account for the full period between a clinician's request and patient's receipt of care, not merely the plan's internal review time. Congress should mandate standardized requirements.

Limit repeat prior authorizations and step therapy for ongoing treatment. A prior authorization approval and step therapy protocol clearance should remain valid for the course of treatment and should continue absent a meaningful clinical reason for review for stable maintenance therapy. A patient who is doing well on therapy should not face disruption because of a new plan year or a formulary change. When limited reauthorization is clinically warranted, plans should use a brief attestation of continued need rather than resubmission of the full record. A policy directive to this effect would reduce burden on patients and their physicians.

Require evidence-based and current clinical criteria. Prior authorization and step therapy protocols should reflect current evidence, nationally recognized guidelines, and the needs of medically complex patients. Plans should be required to review these protocols regularly and provide a clinically

appropriate, readily accessible exceptions process when the preferred option is contraindicated, previously ineffective, or likely to cause harm.

Standardize denials and appeals. Patients and clinicians should receive prompt, understandable notices that identify the specific reason for the denial, the criteria applied, the information needed to obtain approval, and the available appeal options. Congress should promote standardized electronic appeals, prohibit duplicative documentation requests, and require expedited review when delay may jeopardize a patient's health or interrupt an established course of treatment.

Create consequences for noncompliance. The performance of Marketplace and Medicare Advantage plans should be audited, and penalties should be imposed for untimely, inaccurate, or clinically inappropriate determinations.

The reforms described above will ensure that patients do not bear the consequences of inconsistent plan rules. Requiring clear standards, interoperable processes, and enforceable accountability would reduce administrative burden and inappropriate delay while preserving appropriate oversight of care.

Taking on Corporate Greed

SGIM supports greater oversight of corporate practices that raise costs, reduce access, or compromise patient care. While private equity ownership has become pervasive and harmful and warrants careful examination, a policy framework focused only on it would miss similar conduct by other stakeholders, including health systems and management companies. Oversight should focus on the behavior of an entity and the effects of its decisions on patients and the health care workforce, not solely on the ownership label. Regardless of the ownership model, health care dollars should support clinical care.

For general internal medicine physicians and their patients, corporatization becomes harmful when financial targets replace clinical priorities. Practices may face pressure to shorten visits, increase volume, reduce staffing, prioritize services based on margins rather than patient needs, or consolidate practices into fewer physical locations, forcing patients to travel further for care. These pressures can weaken the patient-clinician relationship and make it more difficult to care for patients whose complex medical and social needs require time and coordination. **The Committee should consider policies that protect clinical independence by preventing non-clinical entities from interfering with physicians' professional judgement or exercising undue control over decisions that directly affect patient care.**

Additionally, the Committee should support federal research to better understand how changes in health care ownership and management practices affect patients, clinicians, and the health care system. Existing research has often focused on broad categories of ownership, which can obscure important differences in how organizations operate. Greater investment is needed in research that examines the specific financial and management practices that follow changes in ownership, including changes in staffing, service availability, clinical operations, and investments in care delivery and their effects on access, costs, patient outcomes, and the health care workforce. Such research should examine practices across ownership models, including health systems, insurers, private equity firms, and other corporate entities.

Thank you again for the opportunity to submit these comments. SGIM looks forward to working with you to support access to comprehensive health coverage and services. Should you have any questions or require further information, please contact Erika Miller at emiller@dc-crd.com.

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Sincerely,



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