AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

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To

U.S. Senate Committee on Finance

On

Hearing: “Lower Health Care Costs for Americans: Understanding the Benefits of the Inflation Reduction Act”

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Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, thank you for holding this hearing entitled "Lower Health Care Costs for Americans: Understanding the Benefits of the Inflation Reduction Act."

The cost of health care is one of the most salient issues for family physicians and their patients today. A February 2024 survey found that unexpected medical bills and health care costs are top concerns for Americans, with three out of four adults saying they are "very" or "somewhat worried" about being able to afford these potential expenses.[1] This includes insured individuals, half of whom say it is difficult for them to afford health care costs. One out of four adults say they have skipped or delayed getting necessary care in the last twelve months due to the cost; that number jumps to six out of ten when looking specifically at uninsured adults.[2]

The Inflation Reduction Act (IRA), signed by President Biden in August 2022, took important steps toward addressing escalating health care costs. The AAFP believes all people should have access to affordable health care coverage that provides access to evidence-based care, including comprehensive and longitudinal primary care. Because of this, we advocated strongly in support of several provisions that were ultimately enacted into law as part of this legislation. In particular, the Academy applauded that the IRA:

- Provided a three-year extension of the enhanced premium tax credits for individuals and families purchasing health insurance from the Patient Protection and Affordable Care Act (ACA) marketplace;
- Capped insulin costs for Medicare beneficiaries at $35 a month;
- Created parity between traditional Medicaid and Medicaid expansion programs by eliminating cost-sharing for all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) for adults; and
- Eliminated cost-sharing for ACIP-recommended immunizations covered under Medicare Part D.

As the Committee reflects on implementation of the IRA two years later, the Academy believes there are significant opportunities to build upon the groundwork it laid, as well as to advance other jurisdictional policies that would take further steps to meaningfully reign in health care costs. These recommendations include:

- **Expanding Medicare Part B coverage to include all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines;**
- **Limiting out-of-pocket insulin costs for individuals enrolled in private health plans and those who are uninsured;**
- **Permanently extending the ACA enhanced premium tax credits;**
- **Waiving Medicare cost-sharing for certain primary care services; and**
- **Addressing site of service payment differentials.**

Expanding Part B Coverage of Recommended Vaccines

As Benjamin Franklin said, "an ounce of prevention is worth a pound of cure." And prevention is an integral part of primary care. Every day, family physicians provide routine and lifesaving preventive health measures and interventions, such as immunizations, screenings for cancer or heart disease, and tobacco cessation counseling. To promote equitable utilization of cost-effective preventive care, the AAFP believes that all health plans should provide first-dollar coverage for low-cost, high value, evidence-based services such as recommended vaccines, screenings, and

preventive medications.

Vaccines are one of the safest and most cost-effective public health innovations we have. Current adult vaccination coverage yields an estimated 65 million averted disease cases and $185 billion in averted case costs over a 30-year period.[3] The COVID-19 pandemic was a real-time demonstration of the invaluable role that vaccines play in saving lives when they are affordable and accessible. Yet each year, the United States spends $27 billion on four vaccine-preventable illnesses in adults over the age of 50: flu, pertussis, pneumococcal (pneumonia), and shingles.[4]

This is in part due to remaining barriers that prevent many individuals from being able to readily access and receive all recommended vaccines in their physician's office. For example, Medicare currently splits vaccine coverage between Part B (outpatient care) and Part D (prescription drug coverage). New vaccines, such as RSV, are only covered under Medicare Part D, which was designed for pharmacies to submit claims and makes it particularly challenging for primary care physicians to deliver recommended vaccines in their office.

Approximately 8.5 million Medicare enrollees have Part B but not Part D coverage, leaving them without affordable access to Part D vaccines.[5] For those with Part D coverage, physicians can give patients a bill to submit to their Part D plan for reimbursement, but this forces patients to pay a potentially high out-of-pocket cost upfront, which creates barriers to access. There is an online clearinghouse that allows physicians to check Part D coverage and electronically submit an out-of-network Part D claim, but physicians must pay for this service by sharing a portion of their payment. Because of these barriers to administering the vaccine in-office, physicians can recommend or prescribe a Part D-only vaccine to a patient, who must then identify and secure a separate appointment at an in-network pharmacy on order to be vaccinated.

As mentioned above, the Academy strongly supported the IRA's provisions that made significant strides in improving access to vaccines for more populations, including eliminating cost-sharing for all ACIP-vaccines recommended for Medicaid beneficiaries and Medicare Part D beneficiaries. However, **additional legislative action is needed to ensure that physicians can easily provide all ACIP-recommended vaccines to Medicare beneficiaries.**

Specifically, the Academy urges the Committee to build upon the IRA by considering legislation to require Medicare Part B coverage of all vaccines, allowing beneficiaries to more readily access vaccines from their usual source of care and improving our nation's uptake of one of the most cost-effective public health measures.

Limiting Out-of-Pocket Insulin Costs

More than 38 million Americans have diabetes,[6] and an estimated one-quarter of people with diabetes in the U.S. ration their insulin due to costs.[7] Ensuring access to medications is an integral part of physicians' role as advocates for their patients. Unfortunately, and too frequently, family physicians encounter patients who cannot afford their medications and for that reason fail to adhere to treatment recommendations. Diabetes treatment is particularly important: unmanaged diabetes can lead to significant health complications and costly medical care, such as kidney damage and heart disease.[8] Patients affected by high insulin costs also are more likely to experience adverse health effects, including increased stress and anxiety, and may forgo other needs, such as transportation, utilities, housing, doctor's visits, or other medications, to afford insulin.[9]

The AAFP recognizes health as a human right for every person and believes that all people, regardless of social, economic, or political status; race; religion; gender; or sexual orientation, should have access to primary medical care and other essential health care services and

treatments. Care should be comprehensive and affordable and should include protections for those with financial hardships. Having both health insurance and a usual source of care (e.g., through an ongoing relationship with a family physician) contributes to better health outcomes, reduced disparities along socioeconomic lines, and reduced costs.[10] This applies to those with chronic diseases and their ability to access low-cost, high-quality medicines and treatment. Today, however, millions of patients cannot afford a basic medication. In 2021, diabetes deaths exceeded 100,000 in the United States for the second consecutive year.[11] One study found that cost-related nonadherence (or rationing) was associated with an 18% higher hazard of diabetes-related death.[12]

Widespread inability to afford essential medications is a symptom of broader dysfunction in the U.S. health care system, which is why the AAFP is committed to working with Congress to advance holistic reforms. However, the need to address insulin affordability is immediate. **The AAFP applauded the IRA for limiting co-pays for insulin to $35 a month for Medicare beneficiaries, but we continue to strongly urge the Committee to extend this policy and limit insulin costs for individuals enrolled in private health plans and uninsured individuals**. The Academy has endorsed the Affordable Insulin Now Act (S. 954), which would do just this.

Permanently Extending ACA Enhanced Premium Tax Credits

The IRA extended the ACA's advanced premium tax credits (APTCs) through 2025 and expanded eligibility, particularly for lower-income families and individuals. This has contributed greatly to enrollment in ACA plans, with an increase of lower-income enrollees by 115% since 2020.[13] APTCs also support access to health care for middle class families. In 2024, middle income families saved around $4,248 annually due to APTCs.[14] Because of our steadfast belief that all people should have affordable access to comprehensive health care, **the AAFP has supported the extension and expansion of APTCs. These tax credits ensure that millions of low- and middle-income families continue to have access to affordable health coverage.** Unfortunately, if there is no Congressional action to extend the APTCs beyond the end of next year, premiums will increase dramatically for the lowest-income enrollees and many will likely lose their coverage altogether.

Further, there are concerns about how allowing APTCs to lapse would affect insurers' premium rates in 2026. Without APTC enrollment, numbers are likely to decline thus leading to a patient pool of sicker enrollees.[15] If insurers anticipate losing their healthier enrollees, their expected costs per enrollee would increase and they may choose to raise their premiums to offset those costs.[16] Allowing the APTC to expire would not only result in lower- and middle-income families choosing to disenroll from ACA plans but could also increase the premiums for those that choose to stay enrolled.

Therefore, as we look ahead to next year's approaching expiration, the Academy strongly urges Congress to make the enhanced premium tax credits permanent. Specifically, the AAFP has endorsed the Improving Health Insurance Affordability Act (S. 8) which would make APTCs permanent while also increasing the value of cost-sharing reduction (CSR) assistance for people with income between 100 and 250% of the federal poverty level (FPL) and expanding eligibility for CSR assistance to people with income up to 400% of FPL.

Waiving Part B Cost-Sharing for Certain Primary Care Services

In general, Medicare beneficiaries are responsible for paying 20% of the cost associated with any Part B services they receive. The AAFP supports the provision of primary care services to patients without financial barriers, such as deductibles and cost sharing, if the services are provided by the patient's usual source of primary care. Primary care services provided by a patient's usual source

of primary care are proven to reduce downstream health care costs and improve patient outcomes, including those of the chronically ill. But despite the well-documented benefits of low-cost, high-value primary care services both to patients and the health care system, existing cost-sharing requirements dissuade or impede patients from utilizing them appropriately.

Removing cost-sharing for certain primary care services increases access to these services without increasing overall health care spending.[17] The available evidence indicates that reducing or removing cost barriers to primary care increases utilization of preventive and other recommended primary care services, which improves both individual beneficiary and population health. While cost-sharing is waived across payers for most preventive services, many patients don't access all the preventive care recommended for them because they don't know what is or isn't covered or they are concerned they might be charged for raising other health issues in the same visit.

In recent years, the Centers for Medicare and Medicaid Services (CMS) has implemented new codes in the Medicare Physician Fee Schedule intended to better capture high-cost, low-value services like chronic care management which, when utilized, have the potential to improve patient outcomes while reducing overall spending. However, patient cost-sharing requirements are limiting uptake by patients who would truly benefit from these additional supports. A 2022 study found that MPFS billing codes for preventive medicine and care management services are being underutilized even though primary care physicians were providing code-appropriate services to many patients. The median use of the preventive and care coordination billing codes was 2.3 percent among eligible patients.[18]

Many family physicians report that patients decline chronic care management services because the $15 or so a month they face in cost-sharing is not financially feasible. This rings true for many of the other new codes Medicare has implemented, including G2211, social drivers of health risk assessments, and community health integration services. Patients are not used to paying for these services and, understandably, are likely to be resistant to doing so. **If we want to incentivize usage of these high-value services, we must waive patient cost-sharing.** This is particularly critical when considering that the patients least likely to afford the out-of-pocket costs are those most in need of these services.

As a starting point, the Academy urges the Committee to advance legislation that would waive patient cost-sharing for chronic care management codes for traditional Medicare beneficiaries, yielding the potential to both improve patient outcomes and lower their health care costs.

Addressing Site of Service Payment Differentials

Site of service payment differentials contribute to increased health care spending despite no demonstrated differences in the quality of patient care and outcomes. Currently, hospitals are directly rewarded financially for acquiring physician practices, freestanding ambulatory surgical centers, and other lower cost care settings. Medicare allows hospitals to charge a facility fee for providing outpatient services that can be safely performed in the ambulatory setting. Unfortunately, there is little evidence that these additional payments are reinvested in the acquired physician practice, many of which are primary care practices. Thus, the hospital increases its revenue by acquiring physician practices and beneficiaries are forced to pay higher coinsurance.[19]

Medicare's increased payments for services performed in hospital outpatient departments (HOPDs) do not just impact the Medicare program and beneficiaries, however. Private health plans generally use Medicare's payment system as a basis for how much they pay physicians and hospitals, meaning that this influences and directs spending and resources among commercial plans and patients. Therefore, adopting comprehensive site neutral payment policies in Medicare

would have significant impacts in saving money across the health care sector, with one study estimating that it would lead to $471 billion in savings over the next 10 years.[20] **In terms of direct patient costs, Medicare patients collectively would save about $67 billion on Part B premiums and $67 billion on cost-sharing.** Premiums for private health insurance plans would be about $107 billion lower over that period, which would amount to a reduction in aggregate premiums of 0.75%. Privately insured patients would also save about $18 billion on cost-sharing due to lower payment rates.[21]

The AAFP has long supported the advancement of thoughtful site neutral payment policies that would establish payment parity across care settings with careful consideration as to not unintentionally accelerate consolidation. We have called for an expansion of payment parity to all on-campus and off-campus hospital-based departments, as well as other facilities. We support reducing payment differences between sites of service since it enables patients to make more informed healthcare decisions by making costs more transparent and would reduce patient cost-sharing. As such, site neutral payment encourages patient choice based on quality rather than cost.

Therefore, **we urge the Committee to consider advancing site neutral payment policies that will help address misaligned incentives fueling consolidation while lowering costs for patients**. This includes, as a starting point, ensuring payment for physician drug administration services will be the same when delivered in an off-campus HOPD as in a physician's office.

Thank you to the Committee for the opportunity to provide this feedback. The AAFP appreciates your continued examination of past efforts and exploration of future opportunities to lower health care costs for Americans. Should you have any questions or wish to discuss further, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Founded in 1947, the AAFP represents 130,000 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org.

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