Statement of the
American College of Physicians
to the U.S. House Ways and Means Health Subcommittee Hearing
on
Modernizing American Health Care: Creating Healthy Options and Better Incentives for Patients
February 11, 2025

The American College of Physicians (ACP) is pleased to provide comments in response to the House Ways and Means Health Subcommittee hearing on "Modernizing American Health Care: Creating Healthy Options and Better Incentives." We thank Chairman Buchanan and Ranking Member Doggett for holding this hearing to examine ways to promote healthy living with more options, greater flexibility, and better incentives for patients. Our recommendations, outlined below, are consistent with ACP policy to improve incentives for patients to experience healthier living. These include enacting legislation to improve Medicare by aligning physician payment with the value of care provided, extend telehealth flexibilities improve chronic care management, lower prescription drug prices for patients, and extend the healthcare premium tax credits.

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.

Pass Payment Reforms to Ensure a Viable Transition to Value-Based Care

The Physician Fee Schedule (PFS) does not have an annual update based on inflation. As a result, when accounting for inflation, Medicare physician payments have declined 29 percent from 2001 to 2024. The Medicare Access and CHIP Reauthorization Act (MACRA) must be viewed within the broader context of the physician payment system. While physician services represent a very modest portion of the overall growth in health care costs, they are primary targets for cuts when policymakers seek to tackle spending. For years physicians have struggled with a broken Medicare payment system that does not allow them to keep up with practice expenses and rising inflation. That has made it much harder for physician practices to manage sharp increases in practice expenses or navigate staffing and supply shortages.

The modest statutory updates previously included in MACRA have ended and physicians are in a six-year period with no updates. The result is real reductions to payments when accounting for inflation

and budget neutrality requirements. Last Congress, ACP supported H.R. 2474, the Strengthening Medicare for Patients and Providers Act, to provide an annual Medicare physician payment update tied to inflation, as measured by the Medicare Economic Index (MEI). While the bill did not pass, we urge Congress to reintroduce and pass a MEI update legislation for the PFS to allow physicians to make needed investments in their practices and to help ensure that they are able to deliver high quality care to their patients.

Address the Medicare Physician Fee Schedule Cuts

The 2025 PFS includes a 2.83 percent cut to payment rates. As a result, patients and their physicians are left to deal with the uncertainty of cuts to Medicare payment rates each year. These cuts, especially when practice expense costs have markedly increased, further strain our nation's doctors, limiting patient access to care. Each year, physicians routinely face harmful payment cuts making it increasingly difficult to remain in practice and accept Medicare patients. Simply put, the current structure of the PFS does not provide sustainable, reliable and consistent payment rates for physicians who see Medicare beneficiaries.

We urge Congress to pass H.R. 879, the Medicare Patient Access and Practice Stabilization Act, bipartisan legislation that protects access to care for Medicare beneficiaries and enables small, rural and independent physician practices to remain financially viable. On January 1, 2025, a 2.83 percent Medicare reimbursement cut went into effect for physicians due to a rule finalized by the Centers for Medicare & Medicaid Services (CMS) in November of 2024. Compounded with CMS' own estimates of a projected 3.6 percent increase in practice cost expenses for this year, physicians are facing a 6.43 percent cut unless Congress acts. The Medicare Patient Access and Practice Stabilization Act, introduced by a bipartisan group of 10 House members, would stop the 2.83 percent cut to Medicare payments, while also providing a 2 percent payment update, aiming to stabilize physician practices and protect patients' access to care.

Pass the Value in Health Care Act to Extend APM Incentive Payments

ACP supports extending incentive payments for participation in eligible alternative payment models through 2026. Congress should introduce and pass legislation to extend the five percent bonus for physician participation in advanced APMs. In the last Congress, bipartisan legislation was introduced to make several important reforms to ensure that APMs continue to produce high quality care for the Medicare program and its beneficiaries. The Value in Health Care Act would have made a number of important reforms to strengthen Medicare's value-based care models and Accountable Care Organizations (ACOs) to ensure that these models continue to produce high quality care for the Medicare program and its beneficiaries as well as to generate savings for taxpayers. The bill would have extended MACRA's five percent advanced APM incentives that expired at the end of 2024. It would also have given CMS authority to adjust APM qualifying thresholds so that the current one-size-fits-all approach does not serve as a disincentive to including rural, underserved, primary care or specialty practices in APMs. This approach would help to maintain incentives that support physicians'

transition from a volume-based fee-for-service health care system to one that is based on the value and quality outcomes of health care delivered to the patient.

Extend Telehealth Flexibilities for Medicare Beneficiaries

Telemedicine as an important method of health care delivery that improves the health of patients with chronic conditions by enabling and enhancing patient physician collaborations, increasing access to care and members of a patient's health care team, and reducing medical and resource costs when used as a component of a patient's longitudinal care. Telehealth flexibilities from the pandemic-era public health emergency (PHE) have been instrumental in improving access to care for patients across the U.S.

ACP believes that the following existing flexibilities should be continued – and not allowed to expire – to support making telehealth an ongoing and continued part of medical care now and in the future. We urge you to ensure that these telehealth access and coverage policies are extended beyond their current March 31, 2025 expiration date.

- Expand originating sites and lift geographic requirements for telehealth services.
- Allow federally qualified health centers (FQHCs) and rural health clinics (RHCs) to continue to provide telehealth services.
- Allow the furnishing of audio-only telehealth services for evaluation and management services.

Several bills were introduced in the last Congress to extend these telehealth flexibilities for 2 years which ACP supported. They included the Connect for Health Act of 2023 to permanently expand access to essential telehealth services including expanding originating sites and lifting geographic requirements for telehealth services and allowing FQHCs and RHCs to continue to provide telehealth services. We also supported the Protecting Rural Telehealth Access Act, a bill that would ensure that seniors may continue to access audio-only telehealth consults with their physician after this option expired in 2024.

ACP strongly supports the use of audio-only telehealth as an effective modality to address gaps in health equity. Primary care and other evaluation and management services delivered via telephone have become essential to a sizable portion of Medicare beneficiaries who lack access to the technology necessary to conduct video visits. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks or have privacy concerns and do not feel comfortable using video visit technology or do not possess the digital literacy to use video technology.

Improve Chronic Care Management

Although the Chronic Care Act made important changes in improving care for seniors with chronic conditions, additional steps are needed to ensure that our patients have access to high quality chronic care. Six in ten American adults have at least one chronic disease and four in ten have two or more, and at $3.3 trillion in annual health costs, chronic disease is responsible for 75 percent of aggregate national health care spending and is the largest cause of disability and death. General internal

medicine physicians assume principal responsibility for coordinating and managing patients' overall care, particularly for those with multiple complex chronic conditions.

We remain concerned that many seniors have failed to access chronic care management services due to a patient cost-sharing requirement associated with this care. Current law mandates that Medicare beneficiaries are subject to a 20 percent coinsurance requirement to receive chronic care management services. This cost-sharing requirement creates a barrier to care, as beneficiaries are not accustomed to cost-sharing for care management services and may forego the services altogether as a result. The latest data reveals that only 4 percent of Medicare beneficiaries potentially eligible for chronic care management received these services. That amounts to 882,000 out of a potential pool of 22.5 million eligible beneficiaries.

We urge Congress to reintroduce and pass the Chronic Care Management Improvement Act. This legislation would have removed the cost sharing requirement for patients to access chronic care management services. We also support allowing the physician that performs chronic care management services to waive the requirement that the patient pay the 20 percent coinsurance fee associated with this service.

Make Prescription Drugs More Affordable

ACP urges Congress to introduce and pass legislation to lower the cost of prescription medications through Medicare drug price negotiations, lower out-of-pocket costs in Medicare Part D, cap Insulin costs in private plans and reform and improve pricing transparency of pharmacy benefit managers (PBM).

A. Lower Cost in Prescriptions through Medicare Drug Price Negotiations

We support provisions in the Inflation Reduction Act that allow Medicare to negotiate the cost of prescription drugs for seniors. In August of 2024, the Department of Health and Human Services (HHS) announced that it reached agreements for 10 drugs covered in Medicare that were selected for negotiations. These drugs are some of the most expensive and widely used by seniors to treat conditions such as heart disease, diabetes, and cancer. According to HHS data, about 9 million people with Medicare used at least one of these 10 drugs in 2023.

Medicare would have saved $6 billion had these negotiated prices been in effect last year; and, once the new lower prices are implemented in 2026, all Medicare enrollees are expected to save an estimated $1.5 billion. These savings will only increase over time as Medicare will negotiate prices for an additional 15 drugs in 2027, another 15 drugs in 2028, and 20 more drugs in 2029.

We are pleased that the IRA will finally start to curb continued increases in drug prices. Over the last several years, ACP has continued to express concerns over the rising cost of prescription drugs, particularly for patients as they struggle to afford basic and life-saving medications prescribed by their physicians to treat diseases and chronic conditions.

Prescription drug spending is projected to increase by almost 6 percent annually from 2024 to 2028—making it one of the fastest growing health care spending categories. Many Americans face the difficult choice of filling their prescriptions or paying for necessities such as food or housing. This can lead to serious health complications for patients as they find themselves having to resort to cutting back or skipping doses of their medicines to save money.

We urge Congress to consider passing legislation that would further strengthen the Medicare Drug Price Negotiation Program. ACP supports legislation introduced in the last Congress, the Lowering Drug Costs for American Families Act. This legislation would have built upon the historic drug pricing provisions in the IRA, by expanding the annual number of prescription drugs selected for negotiation in the Drug Pricing Program from 20 to 50, starting in 2029. By expanding the number of high-costs drugs that Medicare can negotiate, more Americans will have access to care, which is in alignment with ACP's goal to improve access to care for patients across the country.

B. Lower Out of Pocket Costs in Medicare Part D

ACP supports efforts to make prescription drugs more affordable in government and private health plans by reducing the out-of-pocket costs to consumers. Shifts in benefit design, including higher deductibles and a movement away from copayments to coinsurance, have increased patient out-of-pocket costs and put pressure on program budgets. The number of Part D enrollees with out-of-pocket drug spending above the catastrophic threshold in a given year has more than tripled from nearly 400,000 in 2010 to 1.5 million in 2019.

We strongly support provisions in the IRA that would cap annual out-of-pocket costs in Medicare Part D this year at $3,500 and $2,000 next year, with the option to break that amount into affordable monthly payments. These caps on out-of-pocket expenses for prescription drugs in the catastrophic phase of coverage protect vulnerable seniors from being exposed to increased financial burden and potentially putting their adherence to prescribed treatments at risk. It is beneficial to patients that the IRA includes the Extra Help or Low-Income Subsidy Program to cover additional drug costs for low-income seniors. This measure lowers drug costs for nearly 300,000 seniors this year who will not be required to pay any premiums or deductibles in Medicare Part D

C. Cap Insulin Cost at $35 a Month for Seniors

ACP strongly supports measures in the IRA that ensure that seniors pay no more than $35 for a month's supply of each covered insulin product in Medicare. We urge Congress to approve legislation to cap insulin costs at $35 in private plans as well and are disappointed that this provision was not included in the final version of the IRA. Insulin is a lifesaving drug for millions of people living with diabetes. For all people living with type 1 diabetes, insulin is the only option and must be taken for life. This life-saving medication remained unaffordable for many who rely on it. In the past 15 years, the price of insulin has nearly tripled making it difficult for people with diabetes to manage their care and more than one million people in the United States rationed their use of insulin in 2021 due to concerns about the high cost of this medicine.

D. Improve Transparency, Accountability, and Competition in PBM Practices

We support legislation to improve transparency, accountability and competition regarding the business practices of PBMs including how they determine the price and cost of prescription drugs. In the last Congress, legislation, the Modernizing and Ensuring PBM Accountability (MEPA) Act, was introduced that would have set out new requirements for PBMs to annually report drug prices and other information to Part D plan sponsors and to the Secretary of HHS. PBMs would have been required to include information related to several categories, such as information related to covered Part D drugs, drug dispensing, drug costs and pricing, generic and biosimilar formulary placement, PBM affiliates, financial arrangements with consultants, and potential PBM conflicts of interest.

The MEPA Act would also have required PBMs or their affiliates to provide Part D plans with a written explanation of contracts or arrangements with a drug manufacturer (or affiliate) that makes rebates, discounts, payments, or other financial incentives related the drug manufacturer's drug(s) contingent upon coverage, formulary placement, or utilization management conditions on other prescription drugs.

ACP supports the availability of accurate, understandable, and actionable information on the price of prescription medication. ACP urges health plans to make this information available to physicians and patients at the point of prescribing to facilitate informed decision making about clinically appropriate and cost-conscious care.

We favor measures to increase transparency and data collection regarding vertical integration and consolidation in the health care industry. Importantly, the MEPA Act would have required the HHS Office of Inspector General (OIG) to investigate the effect of vertical integration between Part D plans, PBMs, and pharmacies including effects on beneficiary out-of-pocket costs and Medicare spending under the Part D program. The OIG must submit a report with its findings to Congress within a specified timeframe.

ACP policy also urges more stringent oversight of PBM mergers/acquisitions. The consolidation of the PBM market raises concerns about potential antitrust issues and has been shown to increase prices for patients. Although many smaller regional PBMs exist, the large national PBMs that take up the vast majority of the market share continue to wield leverage with pharmaceutical companies. As consolidation continues, agreements between PBMs, insurers and other entities should undergo strict review for both antitrust implications and effects on other aspects of drug supply chain, such as generic and biosimilar market entry.

Extend Health Insurance Premium Tax Credit

ACP strongly supports the premium tax credits included in the IRA that have significantly reduced the cost of health insurance offered through the Patient Protection and Affordable Care Act (ACA) marketplace. Unless Congress acts, these tax credits will expire at the end of the year. We urge you not to let that happen and that Congress work toward making these tax credits permanent.

ACP is pleased that in 2024, ACA marketplace enrollment reached a record enrollment of more than 21 million people. This growth can be attributed to the premium tax credits helping make ACA marketplace plans more affordable for millions of American. Recent data shows that 95 percent of all enrolled in Healthcare.gov plans in the individual health insurance marketplace today receive enhanced tax credits that make their coverage affordable.

These tax credits have lowered net premium costs by an average of 44 percent this year – or $705 per enrollee – according to the Kaiser Family Foundation. We are deeply concerned that the Congressional Budget Office (CBO) projects that an estimated 3.4 million Americans will lose coverage if Congress fails to extend the ACA tax credits. We urge the Congress to pass legislation that would expand eligibility of taxpayers for the refundable tax credit for coverage under a qualified health plan and increases coverage under the ACA.

Conclusion

ACP commends you for working in a bipartisan fashion to identify ways to improve the provision of value-based care to patients. We support measures to improve chronic care, extend telehealth services and stabilize Medicare physician payments. We urge you to continue to advance reforms to improve transparency and increase accountability in the PBM industry and to lower prescription drug costs. If you have any further questions or if you need additional information from ACP, please contact George Lyons at (202) 261-4531 or glyons@acponline.org.