American College of Physicians
Statement for the Record

The U.S. House of Representatives
Energy and Commerce Health Subcommittee Hearing
on
"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"
March 18, 2026

The American College of Physicians (ACP) is pleased to provide comments in response to the House Energy and Commerce Health Subcommittee's hearing on *"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape."* We thank Chairs Guthrie and Griffith and Ranking Members Pallone and DeGette for holding this hearing to discuss bipartisan policies that would make health care more affordable for our patients. **Our policy recommendations include Congress enacting legislation to bolster the primary care physician workforce, provide long-term payment stability for physicians, ensure patients' access to affordable health care coverage, and enhance transparency in the 340B Drug Discount Program (340B program).**

ACP members include 163,000 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. Additionally, internal medicine is the specialty with the largest number of active physicians specializing in primary care, with 120,342 internal medicine physicians being identified as specializing in primary care in 2021.

Fund and Reauthorize Programs that Bolster the Primary Care Physician Pipeline

Patients should have access to physicians who can deliver primary, whole-person, comprehensive, and longitudinal care. Congress should invest in federal programs that support and expand the internal medicine and primary care physician workforce. The United States faces a projected physician shortage of up to 187,140 by 2037, including more than 87,000 primary care physicians. Currently, over 77 million Americans live in areas without adequate numbers of health care clinicians, which is a matter for concern as an insufficient primary care practitioner supply is associated with negative outcomes, including higher rates of hospitalization, lower patient-rated health quality, and even higher mortality.

We are pleased that as part of the extenders addition to the recently enacted Consolidated Appropriations Act, 2026, Public Law No: 119-75, funding was authorized for investments in the primary care workforce through the National Health Service Corps (NHSC) and Teaching Health Center Graduate Medical Education (THCGME). ACP appreciates Congress' support in the primary care workforce through the NHSC with the $350 million authorized for Fiscal Year (FY) 2026 (through September 30, 2026) and $88.2 million for the remainder of calendar year 2026. **The NHSC will need to be reauthorized and funded by the end of this year, and it is critically important for NHSC**

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funding reauthorization to be at no less than $350 million per year for at least two fiscal years. Congress must act this year to ensure that NHSC funding does not lapse. The NHSC awards scholarships and loan repayment to health care professionals to help expand the country's primary care workforce and meet the health care needs of underserved communities.

Data from the Health Resources and Services Administration (HRSA) shows that in FY 2024, NHSC members provided culturally competent care to a target of over 22 million patients at more than 21,000 NHSC-approved health care sites in urban, rural, and frontier areas. Increased FY 2027 funding will help maintain NHSC's field strength by helping to address the health professionals' workforce shortage and growing maldistribution.

We also greatly appreciate the inclusion of more than $1 billion for the THCGME program funding reauthorization for fiscal years 2026-2029. The THCGME program has over a decade of bipartisan support and is the only federal program investing in the training of future physicians in community settings, rather than hospitals. This long-term investment in THCGME will go a long way in providing stability to these residency programs. **As the Committee examines policy solutions to address the physician workforce shortage, this is an exemplary program to invest in further to ensure patients in rural and underserved areas will have access to physicians in their communities.**

Additionally, the College urges Congress to pass the Resident Physician Shortage Reduction Act, H.R.4731/S.2439. This bipartisan bill is crucial to bolstering the physician workforce and ensuring that patients across the country will have access to well-trained physicians. The bill would invest in the physician pipeline by adding 14,000 new Medicare-supported residency slots over the next seven years. It provides a meaningful and targeted approach that would allow rural and underserved communities to train resident physicians who can provide high-quality health care to patients. Studies show that an overwhelming majority of physicians practice where they are trained, and this bill would direct a significant portion of slots to rural hospitals, hospitals serving health professional shortage areas (HPSAs), hospitals in states with new medical schools, and hospitals that are currently training above the existing resident caps.

Provide Long-term Payment Stability for Physicians

Patient care has been jeopardized as the Medicare Physician Fee Schedule (PFS) fails to provide physicians with the resources to keep up with rising expenses and the cost of caring for patients. ACP appreciates Congress providing additional funds for the PFS for 2026. However, it is important to recognize the longstanding problem that the PFS has not been updated to account for inflation. As a result, payment rates for physicians have actually decreased by a staggering 33 percent from 2001 to 2026, when adjusted for inflation. The lack of inflationary updates, coupled with the PFS statutory budget neutrality (BN) requirement, has led to increased financial instability for physicians. The BN requirement triggers physician payments to be withheld from the PFS when CMS overestimates utilization of new or modified codes in the fee schedule. CMS is not required to return the withheld funds to the fee schedule, resulting in physicians getting unnecessary payment cuts.

The lack of structural, long-term changes to the PFS has resulted in the closure of independent physician practices across the country, followed by a significant uptick in market consolidation. Emerging research shows that health care consolidation leads to worse health outcomes for patients and burnout for physicians. Without federal legislation that provides a payment increase reflecting rising inflationary pressures and changes to fix BN constraints, patients' access will be threatened, particularly in rural and underserved communities. **We urge Congress to pass legislation that would raise the threshold for**

triggering budget neutral cuts within the PFS from $20 million to $53 million. Further, we ask Congress to pass legislation that would return savings from any overestimation of new or modified codes in the PFS back to the PFS.

<u>**Ensure Patients' Access to Affordable Health Care Coverage**</u>

The College urges Congress to pass legislation that would make health care more affordable by lowering patients' cost-sharing for primary care and preventive health care services and addressing the expired enhanced health insurance premium tax credits. Healthcare affordability can be enhanced through legislative efforts to lower out-of-pocket costs for patients, including co-pays and deductibles for primary and preventive care services. Studies conclude that effective primary care reduces hospitalizations, improves patient health, and extends life expectancy more than other specialties. And yet, the U.S. allocates just 5 cents of every healthcare dollar to primary care. General internal medicine physicians assume principal responsibility for coordinating and managing patients' overall care, particularly for those with multiple complex chronic conditions. Nearly 95% of older adults in the U.S. have at least one chronic condition and nearly 80% have two or more chronic conditions. Chronic diseases, the leading causes of illness, disability, and death in the United States, are very costly to treat and manage. According to the Centers for Disease Control and Prevention (CDC), 90% of health care expenditures were spent on treating and managing chronic diseases.

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 avoid the services altogether as a result. 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 remove the cost-sharing requirement for patients to access chronic care management services. We also support allowing the physician who performs chronic care management services to waive the requirement that the patient pay the 20 percent coinsurance fee associated with such services. **Another piece of legislation that ACP supports, which would also lower out-of-pocket costs and cost-sharing for primary care and preventive health services, is the Chronic Disease Flexible Coverage Act, H.R.919.** This bill would provide employers with the option of offering first-dollar coverage of certain chronic disease treatments for employees with high-deductible health plans.

The College also urges Congress to extend the expired enhanced health insurance premium tax credits for the Health Insurance Marketplace or work on a bipartisan policy solution that would bolster health care coverage for people impacted by the expired tax credits. These tax credits made health insurance more affordable for low-income Americans who do not qualify for Medicaid, as well as for small business owners who are not on employer-sponsored health care plans. Since the open enrollment period ended on January 15th for most states, we are seeing lower enrollment in the Health Insurance Marketplace. Patients faced with steep premium increases opted to forgo health care coverage. According to recent data from the Centers for Medicare & Medicaid Services, approximately 1.4 million fewer people have signed up for health coverage in the Health Insurance Exchange this year. With more people opting out of health coverage, this could lead to increased health care costs.

Increase Transparency and Accountability in the 340B Program

The U.S. continues to spend significantly more on prescription drugs than any other country in the world. Prescription drug spending is projected to increase by almost 6% annually from 2024 to 2028 – making it one of the fastest-growing health care spending categories. Prescription drugs are a key part of a physician's comprehensive toolkit and have been crucial in improving the health and well-being of patients. As physicians, we see firsthand what happens when patients cannot get the drugs that they need because the drugs are not affordable. These patients are more likely to skip their medications. This can have negative downstream effects, placing lives at risk and increasing costs throughout the health care system. It is estimated that medication non-adherence results in roughly 125,000 deaths, 10 percent of hospitalizations, increased morbidity rates, and costs the U.S. healthcare system anywhere from $100-$300 billion a year.

ACP strongly supports the 340B program. Created by Congress in 1992, the program allows health care entities that provide outpatient care to uninsured and low-income patients to purchase prescription drugs at steep discounts directly from drug manufacturers. With savings from prescription drug discounts, qualified health care entities can reinvest the money into patient care and expand access to health care services for underserved patient populations. While we strongly support the program and would like to see it continue, we call on Congress to examine policies that would boost transparency and accountability, to ensure that the savings health care entities receive are directed toward patient care.

To enhance program integrity in the 340B program, ACP calls for covered health care entities to publicly report on the benefits received through the program and how the savings are used to expand access to care for low-income and uninsured populations. Additionally, we support the continued option for covered health care entities to contract with specialty or community-based pharmacies to help promote greater access to 340B drugs for eligible patients. However, we urge for oversight and auditing of contract pharmacies to ensure that discounts are going to uninsured and low-income patients, as the program intended. Furthermore, we urge Congress to provide relevant federal agencies with clear statutory authority and dedicated resources to promulgate necessary program regulations to conduct oversight and compliance activities.

Conclusion

Once again, we thank you for holding this important hearing to examine impactful, common-sense policy solutions to the rising cost of health care. We look forward to working with the Energy and Commerce Committee to accomplish these goals. Should you have any questions regarding the recommendations outlined in this statement, please contact Vy Oxman, Senior Associate of Legislative Affairs, at voxman@acponline.org.