AMERICAN ACADEMY of FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

by

Jen Brull, MD, FAAFP
Board Chair,
American Academy of Family Physicians

to

U.S. Senate Committee on Finance

on

"The Rising Cost of Health Care: Considering Meaningful Solutions for all Americans"

November 19, 2025

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Dear Chairman Crapo and Ranking Member Wyden:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,000 family physicians and medical students across the country, I write to applaud you for holding this hearing titled "The Rising Cost of Health Care: Considering Meaningful Solutions for all Americans."

The cost of health care is one of the most salient issues for family physicians and their patients today. A May 2025 poll found that health care costs are a top concern for Americans, with six out of ten adults saying they are "very" or "somewhat worried" about being able to afford these potential expenses.[i] Roughly one-third of adults say they have postponed or skipped getting necessary health care within the past twelve months due to the cost, and more than one in five adults have not filled a prescription because of the cost. Even having health care coverage does not exempt someone from these concerns. Nearly four in ten adults under 65 worry about paying their premiums, and many of those with employer-sponsored or Marketplace coverage rate their insurance as "fair" or "poor" when it comes to affordability.

As the entry point for many patients to the health care system, family physicians see firsthand how rising health care costs impact individuals and their health outcomes. We see patients come in with exacerbated chronic conditions that could have been prevented with earlier interventions. We have conversations with patients daily in which they express reticence or an inability to comply with a recommended course of treatment because the prescription is too expensive. Our health care system should not be forcing patients to decide between seeking care or buying their groceries for the week.

As you examine ways to lower health care costs and empower patients, the AAFP offers the following policy recommendations within the Committee's jurisdiction:

- **Increase our national investment in primary care and require tracking of primary care spending across payers;**
- **Waive Medicare cost-sharing requirements for primary care services;**
- **Address misaligned incentives that have accelerated health care consolidation, decreased competition, and raised costs for patients; and**
- **Extend expiring advanced premium tax credits (APTCs) for individuals enrolled in Marketplace plans.**

<u>Increased National Investment in Primary Care</u>

Access to longitudinal, coordinated, comprehensive primary care has been shown to increase utilization of preventive care, improve outcomes for patients with chronic conditions, and reduce costly emergency visits, hospitalizations, and unnecessary specialty outpatient visits. Yet the United States has continuously underinvested in primary care. In 2022, primary care spending dropped to less than five cents of every dollar, with Medicare spending the lowest at 3.4%.[ii]

The impact of this long-term underinvestment is evidenced in our nation's health. When we look at health outcomes across the world, we're not doing well by almost any measure.

Compared to other high-income, peer nations, the U.S. has higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.[iii] A common theme across countries with better health outcomes and lower health care costs is that they invest more in their primary care system with estimates placing primary care spending between 12 and 17% of total health care spending for these high-performing nations.[iv]

Our nation cannot afford to keep spending less than five cents of every dollar on primary care. Improving health outcomes and preventing a further explosion of chronic illness requires us to reallocate our existing resources away from expensive sick care and toward prevention, ensuring that patients are incentivized and can afford to seek appropriate care earlier on. As a starting point, the Academy has long advocated for all payers to be required to track and publicly disclose the amount they spend on primary care services. Specifically, **we're calling for consideration of legislation that would require commercial payers and federal health programs to track and annually report data on their primary care spending so we have a clearer picture of the current landscape.**

Many states already have such requirements in place for payers, with others going further to require that payers hit a certain target for primary care spending. For example, Oklahoma requires Medicaid managed care organizations to report their expenses related to primary care services and, by the fourth contract year, devote at least 11 percent to primary care.[v] Meanwhile, Arkansas just this year enacted legislation to establish the Arkansas Primary Care Payment Improvement Working Group, charged with producing a report that provides a recommendation for a primary care spending target.[vi] The Academy strongly encourages federal policymakers to consider such steps that would right-size our nation's primary care investments.

Misaligned Incentives and Anti-Competitive Practices

The rampant conslidation of the health care system – particularly acquisition of primary care practices by health systems, insurers, and corporate entities – has been a principal concern for the Academy in recent years. As was noted in the letter's introduction, family physicians are a trusted first contact for health concerns, allowing them to serve as the focal point of care for patients and provide referrals to other health care services and sites when necessary. Their significant influence and trust from patients have made primary care clinicians an appealing acquisition target for hospitals, health systems, and other corporate entities.

More than half of primary care practices are affiliated with a hospital (either by common ownership or joint management) compared to 38 percent in 2016. With fewer opportunities to join an independent practice, nearly three-quarters of all primary care physicians are now employed by hospitals or corporations (53 percent by hospitals and 20 percent by corporate entities). Hospitals are often motivated to acquire or control primary care practices to maximize the financial success of their organizations by securing referrals to high-margin services or facilities. Private payers and other corporate entities leverage them to manage care across settings, or to direct patients to other services they own.

Consolidation or private investment in primary care is not inherently bad. There is a tremendous amount of innovation taking place inside primary care, allowing primary care physicians to expand their capabilities, provide high-quality care to their patients and create a

more rewarding practice environment. There are a number of private equity-backed firms noted for making investments and providing resources that enable primary care practices to successfully participate in the rapidly expanding value-based payment landscape. These firms offer primary care practices the ability to not only survive but thrive in many instances. What distinguishes many of these organizations is that their revenue model is built primarily around expanding and investing in primary care to support value-based payment success.

The Academy has previously detailed the principal factors fueling the consolidation of primary care practices with health systems, plans, and other corporate entities, including financial instability, staffing challenges, administrative burden, and the need for more resources and capital. Physicians are often forced to choose between the stability offered by health systems, payers, or other physician employers, and the autonomy and community focus of independent practice. Increasingly, family physicians report that independent practice is simply unsustainable.

There may be circumstances in which market integration is beneficial. However, the research on the impact of these trends and consolidation more broadly has become increasingly clear. **Evidence has shown integration leads to higher prices and costs, including insurance premiums, without improving quality of care or patient outcomes**.[vii] One study found that hospital-owned practices incurred higher per-patient expenditures for commercially insured individuals when compared to physician-owned practices.[viii]

One of the key opportunities this Committee has to address inflated costs for patients is by addressing site-of-service payment differentials, including within Medicare. Currently, hospitals are directly rewarded financially for acquiring physician practices and other lower cost outpatient care settings. Medicare and other payers allow hospitals to charge a facility fee for providing outpatient services that can be safely performed in the ambulatory setting. However, 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.[ix] Patients should not be subject to higher costs simply because a hospital owns the outpatient office they visited, and physician practices should not be effectively penalized financially for remaining independent. The AAFP has long advocated for the advancement of policies to create payment parity across care settings for certain services, with careful consideration as to not unintentionally accelerate consolidation.

Primary Care Service Cost-Sharing for Medicare Beneficiaries

Statutorily, Medicare is required to charge patients a cost-sharing amount of 20 percent for many Part B services. While most preventive care is covered without cost-sharing, many primary care services delivered by family physicians remain subject to these requirements, resulting in financial barriers for patients and often low uptake.

Fee-for-service coding and billing, including within Medicare, has historically failed to capture much of the work provided by primary care physicians. However, CMS has taken steps to correct these errors in recent years. In 2015, Medicare began paying physicians for delivering non-face-to-face chronic care management (CCM) through separate codes. Additional coding advancements made have included implementation of the G2211 add-on code for many evaluation and management visits and the advanced primary care

management (APCM) code bundle. Overall, physicians have reported that being able to bill for these services has been a positive experience for them and their practices. However, cost-sharing requirements are limiting uptake by patients who would truly benefit from this type of additional support.

A 2022 study found that Medicare 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.[x] Family physicians regularly report patients opt out of receiving these services simply because the $15 or so a month they faced in cost-sharing was not financially feasible. In almost every case these are the very patients that would most benefit from CCM. 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.

In many ways, APCM, CCM, and other similar codes are preventive services in that they can reduce emergency department and other outpatient visits. This is a question that CMS themselves has begun to investigate, as indicated by their RFI about whether APCM should be considered a preventive service in the proposed CY26 MPFS. Removing cost-sharing for CCM and other primary care services increases access to these services without increasing overall health care spending.[xi] **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. Thus, the AAFP urges this Committee to consider legislation to remove cost-sharing barriers for APCM and CCM as a starting point.

Affordable Care Act (ACA) Marketplace Plans

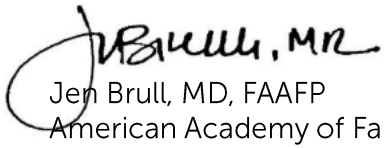
The upcoming expiration of the Advanced Premium Tax Credits (APTC) for ACA Marketplace plans will significantly increase health care costs for millions of Americans, unless Congress acts. If the APTCs are allowed to lapse after December 31, premiums will increase dramatically for many individuals who cannot otherwise afford coverage and many will discontinue their coverage, leading to a patient pool of sicker enrollees.[xii] If healthier enrollees leave the marketplace, the expected costs per enrollee will increase and premiums may rise to offset those costs.[xiii] Lapses in coverage are also likely to lead patients to utilize more expensive care downstream, resulting in additional costs to the federal government and our health care system.[xiv]

As noted above, the Academy recognizes that cost-sharing requirements and premiums impact patients' access to preventive and primary care. Even modest cost-sharing amounts—as little as $1 to $5—have been shown to reduce utilization of care, including essential and preventive services.[xv] Evidence indicates that such policies can lead to unintended and costly consequences, such as increased emergency department use and worsening health outcomes. For instance, studies have linked increased cost sharing with higher rates of uncontrolled chronic conditions, such as hypertension and hypercholesterolemia, as well as reduced treatment adherence among pediatric patients with asthma.[xvi] Cost-sharing also imposes a significant financial burden on families, often forcing individuals to forgo basic needs or incur debt in order to afford necessary medical care.

Furthermore, research consistently shows that state savings achieved through the implementation of premiums and cost-sharing mechanisms are minimal. Any short-term fiscal gains are often offset by higher rates of program disenrollment, increased utilization of costlier services like emergency care, higher expenditures for caring for the uninsured, and added administrative complexity. These policies also place additional strain on safety net providers, including community health centers and hospitals, which are critical to maintaining access to care for underserved populations.[xvii] As the Committee explores opportunities to lower health care costs for patients, **we strongly urge you to immediately extend APTCs for individuals and families enrolled in ACA Marketplace plans**.

Thank you for holding this timely and important hearing on one of the nation's most pressing issues. The AAFP shares the Committee's commitment to lowering health care costs and empowering patients, and we look forward to working with you to advance thoughtful reforms that will meaningfully improve the affordability of and access to health care. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,



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American Academy of Family Physicians, Board Chair

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