AMERICAN ACADEMY of FAMILY PHYSICIANS

February 25, 2025

The Honorable Vern Buchanan
Chairman, Health Subcommittee
House Committee on Ways and Means
2210 Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Lloyd Doggett
Ranking Member, Health Subcommittee
House Committee on Ways and Means
2307 Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Buchanan and Ranking Member Doggett:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write in response to the Subcommittee's recent hearing, "Modernizing American Health Care: Creating Healthy Options and Better Incentives."

Nearly 95 percent of adults 60 years and older have at least one chronic condition, and nearly 80 percent have two or more.[i] This is only projected to get worse in the coming years as the number of adults 50 years and older with at least one chronic disease is estimated to increase by almost 100 percent from 71.522 million in 2020 to 142.66 million by 2050.[ii] Effectively meeting the current and future needs of our patients with chronic conditions requires our nation to better leverage primary care as the foundation of our health care system.

Family physicians provide continuing and comprehensive medical care, health maintenance and preventive services to each member of the family regardless of age or type of problem, be it biological, behavioral, or social. This includes helping patients prevent and manage chronic conditions, such as diabetes or arthritis, and serving as their usual source of care. Family physicians lead care teams; help patients set goals; prevent, understand, and manage acute and chronic illness; and navigate the complexities of the health system.

The Academy wholeheartedly shares the Subcommittee's goal of creating healthy options and better incentives to support Americans' health and wellbeing, which requires a robust primary care system. Unfortunately, our nation has historically underinvested in and failed to recognize the true value of primary care. This has skewed our physician workforce heavily toward non-primary care specialists, and we have fewer primary care physicians relative to the population than in other countries. This is having severe impacts on patient access. In a comparison of primary care access across ten peer countries, U.S. adults were the least likely (43 percent) to have a longstanding relationship with a primary care clinician and a growing number of adults have reported not having any usual source of care over the past decade.[iii] At the same time, three-quarters of U.S. adults (73 percent) say the health care system is not meeting their needs.[iv] This data is telling. People are losing their trusted relationship with a primary care physician and, in turn, their trust in the health care system.

Evidence makes clear that the longitudinal relationships primary care physicians foster with their patients leads to better control of chronic conditions, fewer emergency department visits and hospital

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stays, and improved health outcomes.[v] [vi] However, **cost barriers and insufficient coverage for high-value, low-cost services, inadequate access to primary care physicians, and increasingly limited resources to provide patients with access to nutritious foods are just some of the challenges that make it difficult for clinicians and patients to prevent and appropriately manage chronic disease**. Fortunately, this Subcommittee can advance policies that would meaningfully address these issues and work towards the stated goal of improving our nation's health and wellness.

Uptake of High-Value, Low-Cost Services by Medicare Patients

Congress has the opportunity to improve uptake of high-value, low-cost services that are covered by Medicare but underutilized, including chronic care management (CCM). In 2015, Medicare began paying physicians for delivering non-face-to-face CCM through separate codes. These services are fundamental to the delivery of patient-centered, comprehensive primary care, including for seniors with chronic conditions and those facing health-related social needs (HRSN).

Unfortunately, operational challenges such as patient cost-sharing requirements limit 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.[vii]

In other words, patients are informed of a copay and shared costs as required by Medicare, and subsequently many opt out of these services because of the financial barriers. Family physicians note that it is often the patients who stand to benefit most from these services that forgo them. This is also likely true for many of the other new codes Medicare has implemented, including G2211, social determinants of health risk assessments, and community health integration services. Many patients are living on fixed incomes and have not anticipated paying for these services and, understandably, are resistant or unable to do so. **If we want to incentivize usage of these high-value services, we must waive patient cost-sharing.**

Removing cost-sharing for chronic care management and other primary care services increases access without increasing overall health care spending.[viii] 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 and population health with long-term cost savings. While cost-sharing for most preventive services is currently waived across payers, many patients do not access all the preventive care recommended for them because they do not know what is or is not covered or they are concerned they might be charged for raising other health issues in the same visit. Therefore, as a starting point, **the AAFP calls for the reintroduction and passage of the Chronic Care Management Improvement Act, which would waive patient cost-sharing for chronic care management under Medicare**.

Coverage of Primary and Preventive Care by High Deductible Health Plans

Family physicians have seen an increase in the number of patients that are enrolled in high deductible health plans (HDHPs). Over the last decade, more Americans have opted for more affordable upfront coverage through HDHPs, which generally utilize lower premiums. From 2010 to 2021, enrollment in employer-sponsored HDHPs increased from 13% to 28%.[ix] However, the escalating costs of deductibles

have become increasingly problematic for patients, causing them to forgo needed health care due to upfront costs.

Research shows that the increased the use of HDHPs is associated with delays in care, testing, and treatment that can lead to avoidable disease progression. This can be particularly problematic for patients with chronic conditions, who often require more frequent and expensive care but face higher out-of-pocket costs. For example, a 2023 study found that patients with diabetes who experienced an employer-forced switch to HDHPs were significantly more likely to experience serious, but preventable, acute diabetes complications compared with patients who remained in conventional insurance plans.[x] Cost barriers like those associated with screenings, counseling, and chronic disease management discourages patients, especially those of lower socioeconomic status, from seeking necessary care.

In July 2019, the Internal Revenue Service (IRS) issued a notice expanding its interpretation of preventive care to include certain items and services that are prescribed to individuals with certain chronic conditions, if the items and services are low-cost and prevent the worsening of a chronic condition or development of a secondary condition. After the IRS issued their updated guidance, 76% of employers with over 200 employees and almost half of employers with over 5,000 employees chose to expand pre-deductible coverage, which did not result in significant premium increases.[xi]

Congress must take steps to keep this guidance in place and ensure continued access to care by addressing financial and coverage barriers for individuals with chronic conditions. Therefore, **the AAFP is pleased to see the reintroduction the Chronic Disease Flexible Coverage Act (H.R. 919) being led by Chairman Buchanan**, which codifies the IRS guidance. This legislation helps ensure that HDHPs can permanently provide patients access to critical chronic care services and treatments without cost-sharing before meeting their deductible.

Additionally, the AAFP supports direct primary care (DPC) and sees it as an innovative model of care that provides a pathway to continuous, comprehensive and coordinated primary care for patients. Individuals with chronic conditions may benefit from the enhanced access and touch points with their primary care physician that DPC arrangements enable. However, there are barriers that may prevent some patients with HDHPs from realizing the full potential of the DPC model.

One of those barriers is the prohibition on the permissible use of health savings accounts (HSAs) funds to pay for participation in a DPC practice. Under existing interpretation of the Internal Revenue Code, patients with HSAs are prohibited from engaging in DPC arrangements with a family physician or other primary care clinician. A growing number of family physicians are choosing to practice in the DPC model and patient demand for DPC practices is growing. Additionally, employers and labor unions are driving growth in the model, further necessitating changes in law that allow patients to benefit from this primary care delivery model.

In order to mitigate this issue, **the AAFP supports the Primary Care Enhancement Act (H.R. 1026).** This bipartisan bill would allow individuals with HSAs to use those funds to pay for DPC arrangements. The Academy applauded the Committee for favorably reporting out this policy as part of a larger package in the 118th Congress. We continue to urge Congress to take further action and ensure enactment of this legislation so that patients can more easily and affordably access primary care services suited to their unique needs, including management of chronic conditions.

Increasing Access to Services for Health-Related Social Needs

Even when healthy options, such as plant-forward, nutritious foods, exist within a community, HRSNs can constrain opportunities for people to access these resources that promote better health. Congress should advance additional policies to address food insecurity, unstable housing, and other health-related social needs and improve health outcomes at the community, family, and individual level. For instance, policies that support free or reimbursable public transit or improve the safety and accessibility of sidewalks and bike lanes help improve transportation access and can influence better health outcomes for both individuals and communities.

Many states have utilized existing funding streams or payer authorities to begin addressing HRSN, including Medicaid state plan authorities, section 1115 waivers, managed care in lieu of services and community reinvestment requirements. Specific reforms have included covering HRSN case management and nutrition supports as reimbursable services. Nutrition support may include nutrition counseling and education; medically tailored meals; meals or pantry stocking; fruit and vegetable prescriptions; and protein boxes. For example, under Massachusetts' section 1115 waiver, medically tailored meals may be provided to the whole household, not only the Medicaid beneficiary eligible for the service. This policy recognizes that a food-insecure caregiver will often give their nutrition supports to a hungry child, rather than feed themselves.

Much of this work in the states is just getting off the ground. Therefore, I strongly urge Congress and the Administration to support and further invest in these promising, innovative efforts that seek to address the root causes of poor health outcomes.

Within this Subcommittee's jurisdiction, there is opportunity to mirror many state innovations for Medicare beneficiaries. Broader Medicare coverage of and payment for services to address HRSNs within the context of a patient's usual source of primary care are likely to reduce downstream health care costs and improve outcomes for the chronically ill.

Specifically, the AAFP supported the Medical Nutrition Therapy Act in the last Congress, a bill that would expand Medicare coverage of nutrition services for seniors with certain diet-impacted chronic conditions, such as diabetes, HIV, and hypertension. We also supported the Medically Tailored Home-Delivered Meals Demonstration Pilot Act in the last Congress. This legislation would establish a four-year nationwide demonstration program through Medicare to provide medically tailored meals to eligible Medicare beneficiaries with diet-impacted conditions. We were heartened to see that this legislation was passed out of the Ways and Means Committee last Congress, and we strongly encourage the Committee to consider these policies as you continue to explore opportunities in the current Congress to improve health across the lifespan.the Medical Nutrition Therapy Act in the last Congress, a bill that would expand Medicare coverage of nutrition services for seniors with certain diet-impacted chronic conditions, such as diabetes, HIV, and hypertension. We also supported the Medically Tailored Home-Delivered Meals Demonstration Pilot Act in the last Congress. This legislation would establish a four-year nationwide demonstration program through Medicare to provide medically tailored meals to eligible Medicare beneficiaries with diet-impacted conditions. We were heartened to see that this legislation was passed out of the Ways and Means Committee last Congress, and we strongly encourage the Committee to consider these policies as you continue to explore opportunities in the current Congress to improve health across the lifespan.

While diet and exercise are critically important to health and wellness, we cannot ignore that these are not accessible choices for those who live in communities designed with them out of reach. Food and exercise can only be medicine if they are affordable, safe, and accessible. Family physicians can recommend working out and having a healthy diet – but it is up to you, our elected leaders, to ensure the resources and support are in place to fill that prescription.

Thank you for continuing to champion this important conversation. The Academy looks forward to working with the Subcommittee to advance innovative policies that invest in the health and wellbeing of individuals across the lifespan at the person, family, and community level. If you have any questions, please contact Megan Mortimer, Manager of Legislative Affairs at mmortimer@aafp.org.

Sincerely.

Steve Furr, M.D., FAAFP

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American Academy of Family Physicians, Board Chair
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