Opening Statement of Chairman Sheldon Whitehouse
Senate Committee on the Budget
How Primary Care Improves Health Care Efficiency
March 6, 2024

Members of the Committee may recognize this chart, which I've used for years to show the opportunity we have in health care in America. It graphs America's health care spending as a percent of GDP against Americans' life expectancy, one measure of health care success. As you see, there's lots of room for improvement compared to peer nations.

It's big. U.S. health spending makes up 17% of GDP; as you can see, a far higher percentage than in peer nations. Yet U.S. life expectancy is below peer nations, and even falling; it's now fallen to its lowest in two decades.

By contrast, Germany's health spending represents 12.5% of that nation's GDP, with longer life expectancy. If America's health care spending went from 17% to 12.5% of GDP, it would save our budget nearly a trillion dollars a year — ten trillion dollars in our customary ten-year budget window. It's big.

Why is American health spending so inefficient? One answer is how badly we fund primary care.

In our Budget Committee hearing last October, we heard that – despite overwhelming evidence that primary care is associated with longer life expectancy and lower downstream health costs – the U.S. continues to spend less on primary care, as a share of total health spending, than any other peer OECD country. In fact, average primary care spending across our peer nations is nearly double ours.

U.S. percentage spending on primary care actually declined from a sad 6.5% in 2002, to a woeful 4.7% in 2019. Today, three in ten Americans report not having a usual source of primary care. In some areas, often rural areas, the situation is much worse.

At our October hearing, we also heard how accountable care organizations — ACOs — and other payment models have improved the quality of care while lowering the cost of care. We've seen that in Rhode Island through two primary care ACOs, Coastal Medical and Integra. So today's hearing is about how to do more of that: how to deliver better care, at a lower cost, with better outcomes for patients.

This is pretty straightforward stuff. Primary care doctors and nurses know their patients. They know what they need to stay healthy, whether it's home visits, or tele-health options, or coordinating their medications, or better diets, or moving that slippery rug at the bottom of the stairs. Letting primary care doctors and nurses out of the handcuffs of fee-for-service payment frees up these simple innovations. And patients love it.

We will hear from experts today how to get there. Not complicated: first, make high-quality primary care more available; second, fix how we pay for primary care.

Today, I released a discussion draft of a bill tasking CMS to accelerate value-based primary care by creating hybrid payment models for Medicare primary care providers. Hybrid payments start the move away from the failed fee-for-service treadmill, by at least partially paying primary care providers based on their patient mix. These hybrid payment models reward providers who provide the best care to their patients — care that reduces patients' emergency visits, hospitalizations, excess specialist services, and other big cost drivers — and these hybrid payment models reward patients with better health.

My discussion draft proposes a technical advisory committee to improve how CMS sets Medicare's physician fee schedule. The existing fee schedule has under-resourced both primary care services and primary care provider pay, leading to too few primary care physicians. One report projects that in a decade the U.S. will face a shortage of between 17,000 to 45,000 primary care doctors. If good primary care reduces overall costs, as the data suggests, that will be a very expensive shortage — one to which the existing fee schedule is leading us.

On the reform side, even good alternative payment models stand on the existing fee schedule, hampering the new models' ability to hit that triple aim of better patient experience, better outcomes and lower costs.

Fee schedule reforms could head off a very expensive primary care shortage; and at the same time help current primary care providers lower health costs by improving Medicare beneficiaries' health outcomes. I encourage my colleagues to work with me as we develop these policies further.

Today, we'll hear from Chris Koller, the nation's first state health insurance commissioner, who put primary care at the center of health spending in Rhode Island, and saw lower costs and better outcomes result. He'll explain how reliance on a broken fee-for-service health care system limits our potential to scale primary care reforms.

We'll hear from Dr. Amol Navathe about how hybrid payment models can strengthen primary care, by helping providers innovate, improve care and lower costs.

And we'll hear from Dr. Bob Rauner, a front-line primary care physician, about how payment models affect the care he provides his patients.

We've learned a lot since passing the Affordable Care Act about how delivery system reforms can unlock improvements in our health care system that drive meaningful cost savings from better care. Now we can use that learning to make improved care for patients and lower costs for the budget an everyday thing.

The reforms contained in my discussion draft would help doctors deliver high-quality primary care to many more Americans; and improve their health outcomes; and lower total health care spending, because more and better primary care reduces the need for expensive specialty and hospital care.

These are savings we achieve with no — none, zero — benefit cuts. Let's be very clear about that. These are savings we achieve because patients are healthier. Patients are healthier because

they get better primary care. And doctors provide better primary care because we reward them for doing that. Simple tools, but we need to put them to work.