STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives
Energy and Commerce Subcommittee on Health

Re: Lowering Health Care Costs for All Americans:
An Examination of the U.S. Provider Landscape

March 18, 2026

Chairman Griffith, Ranking Member DeGette, Chairman Guthrie, Ranking Member Pallone, and Members of the Subcommittee:

My name is David Aizuss. I am a board-certified ophthalmologist with an independent multispecialty ophthalmology practice in Calabasas, California, as well as the Chair of the American Medical Association (AMA) Board of Trustees. I greatly appreciate the opportunity to share insight on the growing health care affordability and patient access problem in the United States from the practicing physician's perspective.

As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA is committed to ensuring that there is proper access to physicians for all patients and that physicians are well supported in their role as leader of the health care team.

In this statement, I present the AMA's insight into patient access and identify opportunities that Congress should prioritize as you look to improve affordability and accessibility for American patients. From the physician perspective, affordability is inseparable from access. When physician practices face unsustainable financial pressures, patients ultimately experience the consequences through reduced access to care, longer wait times, and fewer local care options.

The issues surrounding patient access to physicians and health care affordability are multifactorial and include, but are not limited to, increasingly non-competitive health care marketplaces, physician payment cuts, rising practice costs, burdensome administrative requirements, patient access to affordable public and private insurance coverage options, and physician workforce shortages. The combination of these factors has resulted in patient access problems and a growing number of health care deserts in many communities across the United States. This contributes to higher costs for patients and the health care system.

As policymakers examine affordability across the health care system, it is essential to recognize that maintaining a stable physician workforce and sustainable physician practices are core components of controlling long-term health care costs. When physician practices close or consolidate due to financial pressures, patients are often pushed into higher-cost care settings, driving up spending for both families and federal health programs.

Competition, Consolidation, and Vertical Integration

Consolidation in Health Care Markets Threatens the Viability of Physician Practices

The AMA is deeply concerned that market forces emerging from increasing consolidation across the health care system are threatening physicians' ability to survive and interfering with the provision of the highest-quality care to patients. Consolidation in the health care industry exacerbates the vulnerability of independent physician practices. For example, independent physician practices find it difficult to compete for health insurance contracts in a consolidated health insurance market, as these practices need certain reimbursement rates to remain financially viable but often cannot negotiate rates effectively with insurers on their own.

The trend towards consolidation in health care has directly led independently operated private physician practices, which historically have provided personalized and locally responsive health care services, to close. In fact, AMA's 2024 Physician Practice Benchmark Survey shows that physicians increasingly work in practices owned by hospitals or other organizations and not by physicians. Between 2012 and 2024, the share of physicians who worked in private practices dropped by 18 percentage points from 60.1 percent to 42.2 percent, and other studies estimate the number of physicians affiliated with corporate entities to be even higher. In the same survey, physicians reported that the lack of negotiating leverage is a longstanding and important driver of this change.

Altogether, supportive measures are necessary to preserve the operation and integrity of private practices, ensure that health care remains accessible and tailored to community needs, and protect physician autonomy in providing high-quality, patient-centered care.

Highly Concentrated Health Insurance Markets Adversely Impact Physicians and Patients

Most health insurance markets in the United States are highly concentrated. A comprehensive study of U.S. markets found that 97 percent of commercial health insurance markets in metropolitan statistical areas (MSA) were highly concentrated in 2024, and there is high concentration in Medicare Advantage (MA) markets as well. High market concentration tends to lower competition and facilitates the exercise of market power. Where health insurers exercise market power, patient premiums tend to be higher, impacting health care affordability for patients.

Physicians also face challenges in highly concentrated health insurer markets because the presence of a dominant insurer limits their negotiating power. Where an insurer has market power in health insurance markets, it likely also has monopsony power as a buyer of physician services, meaning that physician practices may have no choice but to contract with that dominant insurer. Health insurers with buyer power may depress physician payments to less than competitive levels, and this both threatens physician practice viability and has the potential to diminish service or erode quality of care. Finally, ongoing challenges associated with underpayment by Medicare and Medicaid can further exacerbate the negative consequences of private insurer consolidation facing physicians. Even if a physician is willing to terminate their participation agreement with a health insurer that is depressing payment, doing so might be futile in a highly concentrated health insurance market if other health insurers are also exercising their buyer power to lower payments.

The AMA strongly contends that the federal government must protect physicians against the negative impact of health insurer mergers that may substantially lessen competition for the purchase of physician services. The AMA applauds the success of the Department of Justice (DOJ) in recent years in stopping anti-competitive health insurer mergers, e.g., the proposed Anthem-CIGNA and Aetna-Humana mergers

and encourages the federal government to continue taking aggressive enforcement action to ensure that monopsonistic health insurers are neither created nor further empowered.

Hospital Consolidation Can Harm Physicians while Raising Health Care Costs

Competition in hospital markets is critical for the U.S. healthcare system to function effectively. AMA research has found that most MSA-level markets have hospitals or hospital systems with large market shares, and the proportion of markets with large hospitals has been growing over time. Indeed, virtually all hospital markets are highly concentrated. In 2021, 99 percent of 389 MSA-level markets were highly concentrated. Only five markets were not. Additionally, cross-market hospital mergers are increasing and their impact on health care markets warrants continued study.

Hospital consolidation raises health care costs and creates a difficult environment for hospital-employed physicians. Research consistently shows that hospital mergers in concentrated markets can significantly raise hospital prices, both for the merged entity and for neighboring hospitals, with some estimates finding that hospital consolidation raised prices by as much as 65 percent. Altogether, hospital mergers have been found to increase health care prices, increase health care spending, and decrease health care wages; some evidence suggests hospital mergers may also be correlated with decreases in patient access to care, especially in rural settings. Further, in highly concentrated hospital markets, a hospital may take advantage of the fact that a hospital-employed physician may have few employment alternatives. Where little competition exists, hospitals may depress physician wages. These hospitals also have little incentive to compete with respect to practice conditions or respond to physicians' concerns about patient care.

Physician-Owned Hospitals

Physician-owned hospitals (POHs) provide high-quality care, expand patient choice, and introduce much-needed competition into increasingly consolidated health care markets. Unfortunately, statutory and regulatory barriers imposed by the Affordable Care Act and subsequent rulemaking have sharply restricted the formation of new physician-led hospitals and significantly limited the ability of existing facilities to expand. These restrictions have prevented physicians from developing innovative care delivery models and have reduced competitive pressure that could otherwise improve quality and lower costs for patients and federal health programs.

At a time when hospital consolidation continues to increase across the country, limiting physician ownership of hospitals reduces the availability of alternative care delivery models and further concentrates market power in large health systems. Research has consistently shown that greater competition in health care markets is associated with lower prices and improved quality. Physician-led hospitals can provide an important competitive counterbalance to highly consolidated hospital markets by introducing new options for patients, encouraging efficiency, and fostering innovation in care delivery.

Congress recognized the potential role of physician-led hospitals in improving access and care delivery by establishing statutory distinctions between different types of POHs, including "applicable hospitals" and "high Medicaid facilities." However, regulatory changes adopted in recent years have undermined this statutory framework by limiting expansion opportunities for facilities serving larger numbers of Medicaid patients and imposing discretionary approval standards that are inconsistent with the intent and structure of the law. These barriers disproportionately affect hospitals serving vulnerable populations and limit the ability of physicians to respond to community health needs.

The AMA strongly supports H.R. 4002, the Patient Access to Higher Quality Health Care Act of 2025, which would repeal the Affordable Care Act's restrictions on the whole hospital exception to the Stark

physician self-referral law. Enacting this legislation would restore physicians' ability to develop and expand hospitals that deliver coordinated, physician-led care. Removing these restrictions would promote innovation, expand patient choice, and strengthen competition in local health care markets without creating new federal spending programs. Allowing physicians to participate more directly in hospital ownership can also support integrated models of care that improve coordination, reduce unnecessary duplication of services, and enhance accountability for patient outcomes.

Vertical Integration and Market Dynamics

Integration across different parts of the health care system, including insurers, hospitals, and physician practices, has become increasingly common. These arrangements can allow providers to operate within more integrated delivery systems but also introduce financial and operational incentives that merit careful policy consideration.

When insurers or health systems own physician practices, those organizations may have greater ability to influence how services are priced and where care is delivered. In certain market environments, these structures may contribute to higher prices if competition is limited or if patients are directed toward higher-cost facilities within an integrated system. Vertical integration can also affect contracting relationships across health care markets. These dynamics can shape market competition, patient choice, and health care spending in local communities.

For these reasons, policymakers should continue evaluating the effects of vertical integration across the health care system so that market developments support accessible, affordable care while maintaining a competitive provider landscape.

The AMA urges the federal government to collect data and pursue research to assess the impact of vertical integration on the cost and quality of care. We also encourage the federal government to block vertical integration where it may have harmful effects on the health care industry, and to that end, we note that the 2023 DOJ and Federal Trade Commission Merger Guidelines provide a framework for evaluating a vertical merger.

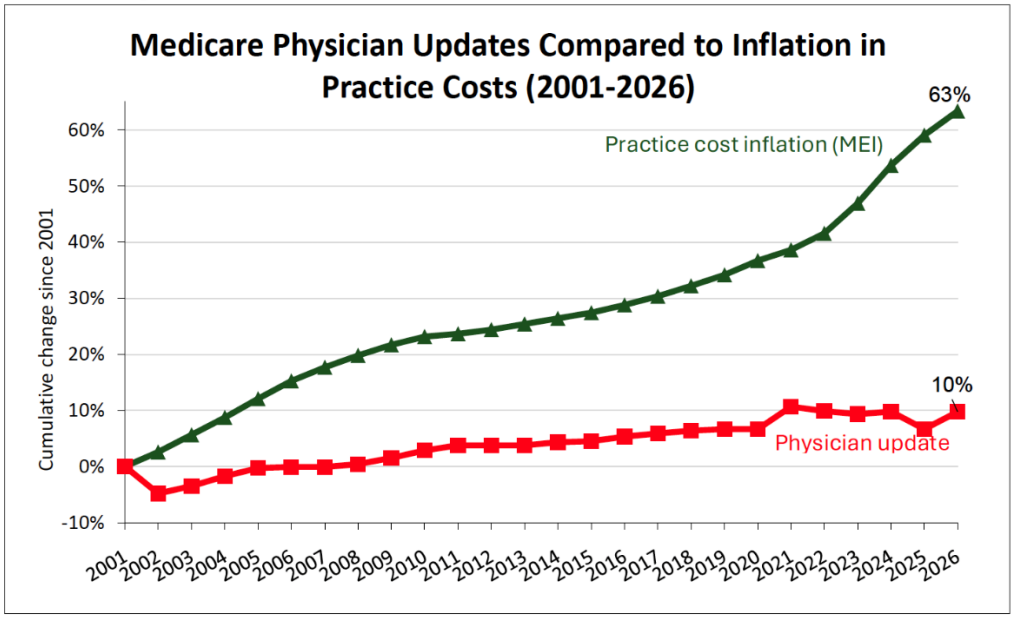
Medicare Physician Payment Cuts and Lack of Inflationary Updates

A strong physician workforce depends not only on adequate training capacity but also on a payment structure that supports physicians and their practices, particularly those serving seniors and patients in rural and underserved communities.

Medicare physician payment policy is fundamentally an affordability issue for both patients and taxpayers. When physician practices cannot remain financially viable, patients are often pushed into more expensive care settings, such as hospital outpatient departments or emergency departments. Strengthening the sustainability of community-based physician practices helps preserve access to care while preventing unnecessary cost growth within the Medicare program.

The current Medicare physician payment system is characterized by stagnant base payments, the absence of permanent annual inflationary updates, and excessive administrative burdens. Unlike hospitals and other Medicare providers, physicians do not receive automatic inflationary adjustments tied to rising practice costs. As a result, Medicare physician payments have declined by 33 percent when adjusted for inflation since 2001, even as expenses related to staffing, technology, compliance, and facility costs have steadily increased.

Medicare physician payment continues to fall further behind practice cost inflation

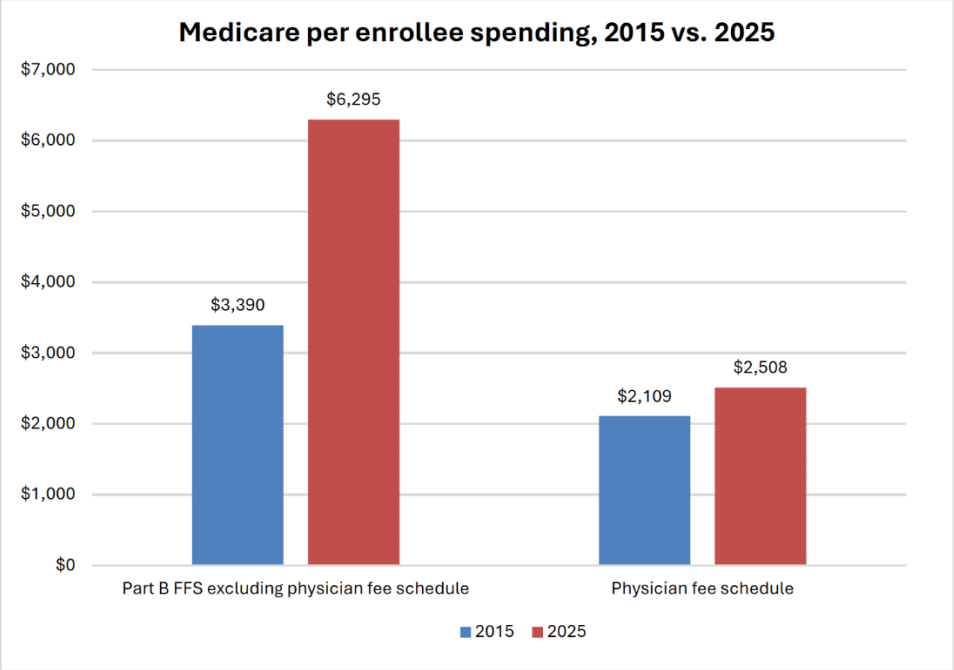


Sources: Federal Register, Medicare Trustees' Reports, Centers for Medicare & Medicaid Services (CMS) Market Basket Data, and Quality Payment Program (QPP) Experience Report.
Note: In 2026, qualified participants in an Advanced APM received a different update from non-qualified participants. Data from the PFS final rule and QPP report were used to construct a weighted average of the physician update for 2026.

According to data from the Centers for Medicare & Medicaid Services (CMS), Medicare physician payment rates have increased by approximately 10 percent over the last 25 years, representing an average annual increase of about 0.4 percent. During that same period, however, the cost of operating a medical practice has increased substantially. The Medicare Economic Index (MEI), which measures inflation in physician practice costs such as office rent, staff wages, medical supplies, and professional liability insurance, increased by approximately 63 percent between 2001 and 2026, or about 2.0 percent annually.

This widening gap between payment updates and practice cost inflation has significantly eroded the real value of Medicare physician payment. When adjusted for inflation in practice costs as measured by the MEI, Medicare physician payment has effectively declined by approximately 33 percent since 2001, an average real decline of about 1.6 percent per year. As a result, Medicare physician payment today supports substantially fewer resources than it did two decades ago, placing increasing financial strain on physician practices and threatening long term access to care for Medicare beneficiaries.

Medicare physician spending per enrollee is *stagnant*



Source: 2025 Medicare Trustees Report.
Note: Part B FFS (excluding physician fee schedule) consists of hospital (outpatient), physician-administered drugs, home health agency, lab, durable medical equipment, and other. The 2025 data reflect intermediate estimates provided in the Trustees report.

Between 2015 and 2025, spending under the Medicare Physician Fee Schedule increased by only 19 percent on a per enrollee basis, representing an average annual growth rate of approximately 1.7 percent. During the same period, the remainder of Medicare Part B fee-for-service spending per enrollee increased by 86 percent, with an average annual growth rate of 6.4 percent.

As a result, physician services now account for a significantly smaller share of overall Part B spending. In 2015, services paid under the Physician Fee Schedule represented approximately 38 percent of total Part B fee-for-service spending per enrollee. By 2025, that share had declined to 28 percent. Put differently, for every $100 spent in Medicare Part B on a fee-for-service enrollee in 2025, only about $28 is attributable to physician services under the Physician Fee Schedule.

This trend highlights a fundamental imbalance in Medicare payment policy. While physician payment has remained largely stagnant, spending growth in other parts of the Medicare program has accelerated, further eroding the relative share of resources devoted to physician services and contributing to the financial strain facing physician practices.

This pattern of recurring reductions and structural instability is undermining the financial viability of physician practices nationwide. Small, rural, and independent practices are particularly vulnerable. When practices are forced to close, consolidate, or limit the number of Medicare patients they can treat, access to care suffers. Expanding the physician workforce without stabilizing Medicare payment risks placing newly trained physicians into an environment where sustaining a practice is increasingly difficult.

To address this crisis, Congress must pass legislation that includes the following core reforms:

1. Physicians must receive an annual, permanent inflationary update tied to MEI. This is essential so that payments reflect the actual cost of delivering care. Unlike hospitals and other Medicare providers, physicians do not receive automatic inflationary adjustments, leaving practices vulnerable as staffing, technology, compliance, and operational expenses continue to rise. Legislation introduced in the previous Congress, H.R. 2474, the Strengthening Medicare for Patients and Providers Act, would have provided a permanent MEI-based update and garnered more than 170 bipartisan cosponsors. Congress should advance similar legislation, such as H.R. 6160, the Strengthening Medicare for Patients and Providers Act, in the 119th Congress to restore stability and predictability to Medicare physician payment.

2. Congress must reform Medicare's budget neutrality requirements to prevent arbitrary and destabilizing payment cuts. Current statutory thresholds and flawed utilization projections routinely trigger across-the-board reductions when services are revalued, or new services are added to the fee schedule. By raising the budget neutrality threshold and creating a more accurate and transparent adjustment process for newly unbundled codes that are assigned a utilization estimate, Congress can provide physicians with a more predictable payment environment. Legislation introduced last Congress, H.R. 6371, the Provider Reimbursement Stability Act, offers a clear framework for modernizing these outdated requirements. In fact, portions of H.R. 6371 were passed by the House Energy and Commerce Committee in the 118th Congress. We urge Congress to reintroduce and enact an updated version of this bill focused on targeted budget neutrality reforms.

3. The Merit-based Incentive Payment System (MIPS) must be overhauled to reduce administrative burden and better align performance measures with meaningful patient outcomes. The current structure imposes significant reporting obligations that disproportionately affects small, rural, and independent practices, often without demonstrable improvements in quality. Reforming MIPS, especially eliminating the steep nine percent penalties and requiring CMS to provide more timely access to data during the performance year, is necessary to allow physicians to devote more time and resources to patient care rather than compliance activities.

4. Congress should expand the availability and accessibility of Alternative Payment Models (APMs) to foster innovation in value-based care delivery. Many physicians, particularly specialists and those practicing in rural communities, lack opportunities to participate in advanced APMs. While Congress recently restored the 3.1 percent APM incentive payments and lowered the revenue threshold that entities need to reach to even qualify for these bonuses for the 2026 performance and 2028 payment year via the Consolidated Appropriations Act, 2026, these policy changes are only in effect for 12 months. Expanding model availability and maintaining appropriate financial incentive payments beyond the 2026 performance year would support broader participation in value-based arrangements, reward improvements in patient health, and preserve physician choice while moving the system away from volume-based reimbursement.

Site-of-Service Payment Differences

Differences in Medicare payment rates for the same services delivered in different clinical settings contribute to higher health care spending and accelerate consolidation across the health care system. Under current policy, services performed in hospital outpatient departments are often reimbursed at significantly higher rates than identical services delivered in physician offices or other community-based settings. These payment disparities are not typically tied to differences in the clinical service itself but instead reflect the setting in which the service is delivered.

These payment differentials create powerful financial incentives for hospitals and health systems to acquire physician practices and shift services into hospital outpatient departments, where reimbursement is higher. When physician practices are purchased by hospitals, depending on the type of service provided they may be billed at a higher rate which result in higher payments from Medicare and increased cost sharing for patients. This dynamic contributes to rising health care spending without necessarily improving quality or patient outcomes.

These payment disparities also place independent physician practices at a structural disadvantage. Community-based physicians must compete with hospital systems that receive higher reimbursement for providing the same services. Over time, this imbalance can drive additional consolidation as independent practices struggle to remain financially viable. Consolidation can reduce patient choice, weaken competition in local markets, and further increase health care costs.

Moving toward more consistent payment across sites of care when services are clinically comparable could help address these distortions. Aligning Medicare payments across care settings would reduce incentives for unnecessary consolidation and help maintain access to care in community-based physician practices. However, any site-of-service reforms should be implemented in a manner that does not further reduce already strained physician payment levels or diminish overall Medicare spending on physician services, while protecting the financial viability of community-based physician practices. Such reforms would also promote a more efficient Medicare program by focusing reimbursement on the value of the service delivered rather than the ownership structure or location of the physician.

Navigating Changes to Medicaid and the Affordable Care Act

Medicaid

For over 60 years, Medicaid has played a central role in providing millions of Americans with access to affordable health care. Medicaid is a critical safety net program for children, pregnant and postpartum women, seniors, and people with disabilities and serious health conditions. Accordingly, Medicaid provides coverage for almost 25 percent of individuals under age 65 who live in rural areas and for almost 40 percent of births in the U.S.

This is a pivotal moment for Medicaid policy. As states begin to implement major Medicaid reforms, the AMA urges policymakers to preserve the ability of eligible beneficiaries to access affordable care through the program. When patients cannot afford to access physician services, they become sicker, require more expensive treatments, and incur more costs, both as individuals and at the health system level. Even worse, lack of access to continuous physician care results in higher patient mortality. We believe these outcomes can be avoided if Medicaid leaders work to increase physician participation in the Medicaid program, with a particular emphasis on improving reimbursement for physician services and reducing the administrative burden on physician practices.

As policymakers consider future changes to the Medicaid program, the AMA encourages approaches that preserve coverage stability while also ensuring that physicians can sustainably participate in the program and care for Medicaid patients.

Like the Medicare physician payment system, payment for physician services under the Medicaid program has failed to keep pace with rising practice costs and the increasing administrative burdens that are placed on physicians. Indeed, Medicaid payment rates for physician services generally lag behind both Medicare and private insurance rates for the same services. Medicaid's lower payment rates have an impact on physician participation in the program. Physicians want to be able to provide care to all patients

and understand the vital importance of the Medicaid program. However, the current payment system has created an environment where physician practices cannot keep their doors open if they rely on inadequate Medicaid reimbursement. For example, over 1 in 3 US counties lack a single obstetric clinician and, as noted above, 40 percent of all births are paid for via Medicaid. To create a sustainable ecosystem where physicians can continue to operate in high need areas the AMA urges Congress, states, and the federal government to work towards establishing a Medicaid payment floor at a minimum of 100 percent of Medicare rates.

Additionally, the AMA is concerned that the implementation of new Medicaid requirements could lead to additional administrative burdens for patients and physician practices. Overly burdensome administrative processes can lead to eligible patients losing coverage and to physician practices dropping out of the program. It is crucial that states and the federal government work collaboratively to avoid this outcome by leveraging technology and data to maximize the number of administrative processes that can be undertaken without any involvement from either patients or providers.

Affordable Care Act

The AMA is also concerned that, alongside dramatic changes to Medicaid, changes to coverage through the Affordable Care Act (ACA) Marketplaces could threaten patient access to affordable health care. Higher premium costs and an increased reliance on high deductible, less comprehensive, catastrophic plans could undermine patients' ability to access meaningful coverage through the Marketplaces.

In September of 2025, the AMA led a sign-on letter calling for the extension of enhanced premium tax credits. With the expiration of the enhanced credits, millions of patients are now facing higher out-of-pocket premium costs, and sign-ups for the 2026 plan year have declined compared to 2025. Since, by law, individuals who are eligible for premium tax credits do not otherwise have access to affordable minimum essential coverage, it is likely that many individuals who chose not to enroll in an ACA metal tier plan for the 2026 plan year, due to increased premium costs, are currently uninsured or are enrolled in coverage that is not comprehensive.

Beyond the expiration of the enhanced premium tax credits, we are also concerned that recently proposed changes to ACA Marketplace requirements will undermine access and affordability by allowing issuers to offer bronze and catastrophic plans that exceed statutory limitations on cost-sharing. Even modest increases to cost-sharing, especially among low-income populations, has been shown to reduce utilization of health care services, which in turn leads to poor health outcomes and increased use of emergency departments and other, costlier forms of care.

CMS argues that allowing plans to exceed cost sharing limitations is a necessary measure to allow issuers to satisfy the ACA's actuarial value requirements because differing rates of increase in the factors that determine actuarial value make it impossible for issuers to abide by both the actuarial value requirements and the cost-sharing limitations. While we disagree with CMS's assessment that taking this action is necessary for the 2027 plan year, we acknowledge that the ACA's actuarial value requirements and cost-sharing limitations may ultimately be incompatible with each other. For that reason, we recommend that Congress amend the ACA so that patients are protected and continue to be able to access comprehensive coverage with reasonable limitations on out-of-pocket costs.

Physician Workforce Shortage

The physician workforce shortage is multifactorial and must be addressed to ensure long term access to patient care as well as manageable health care costs. Without an ample supply of qualified, highly skilled physicians, patients may not be able to get the care that they need in a timely manner. By the time patients

get the care they need, they may be sicker and the cost to both the patient and the health care system will undoubtedly rise precipitously.

The United States is suffering from a major physician shortage, with forecasts of a widening gap that will continue to grow over the next decade in part due to impending physician retirements, an aging and growing population, changes to the student loan system, and more. According to the latest data released by the Health Resources and Services Administration (HRSA), more than 75 million people in the U.S. live in Health Professional Shortage Areas (HPSAs). HRSA estimates that an additional 33,898 providers are required to eliminate all current primary care, dental, and mental health HPSAs. Furthermore, there is a projected shortage of up to 86,000 physicians by 2036. Therefore, sustained long-term investments in our physician workforce are needed to help mitigate current and impending physician shortages and preserve patient access to care. These policy investments are crucial to ensuring a lack of physicians does not lead to exorbitant increases in the cost of accessing care.

- AMA Statement for the Record for hearing entitled, "Advancing the Next Generation of America's Health Care Workforce"
- AMA Comments concerning health care workforce shortages

The cap on Medicare support for residency slots must be raised.

As U.S. medical schools have increased enrollment, residency training positions at teaching hospitals have not kept up with the larger pool of applicants, limited by the cap on Medicare support for graduate medical education (GME). Yet, while new medical schools are opening, and existing medical schools are increasing their enrollment to meet the need for more physicians, federal support for residency positions remains tied to an outdated cap from 1996 that falls dramatically short of the needs of the U.S. population. Though we are grateful that bipartisan Congressional leaders have worked together since 2021 to provide 1,200 new Medicare-supported GME positions–the first such increases in nearly 30 years–more slots are needed to adequately care for our population. As such, until the cap is significantly raised, the shortage of physicians will never be truly resolved. Therefore, it is essential that we invest in our country's health care infrastructure by providing additional GME slots so that more physicians can be trained and access to care can be improved.

- AMA Statement for the Record for hearing entitled, "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors"

Rural Health

Access to physicians is particularly challenging in rural areas. The more difficult it is for rural patients to get care, the more costly and less affordable the care is for both the patient and the health care system. In order to help curtail the current and projected shortage, more rural residency positions should be created, and overarching support for program development and longevity should be provided. Residents often continue to practice in locations where they complete GME training, which ultimately influences the distribution of the health care workforce. A 2020 study found that 56 percent of the residents who completed their training between 2010 and 2019 were still practicing in the state in which they trained at the end of 2019, and a 2015 study found that a similar portion of family medicine residents practiced within 100 miles of their training site after completing their training. Unfortunately, the physicians who are most likely to practice in rural regions, such as those graduating from medical schools in rural areas, declined by 28 percent between 2002 and 2017. This decrease is compounded by the fact that in 2016 and 2017 only 4.3 percent of incoming medical students were from rural backgrounds.

In order to encourage more individuals to be physicians and to serve in rural areas, holistic changes to the working environment need to be made. Students need to be recruited earlier in life. Communities that need physicians should be educated about medical education and encouraged to help groom and assist local students with getting into medical school. Moreover, pathway programs, and holistic outreach (mentors, interview prep, etc.) are necessary. Medical schools and residency programs should develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements and provide early and continuing exposure to those programs for medical students and residents. Finally, once individuals choose residencies in rural areas, long-term support systems are needed.

- AMA Response to Bipartisan Finance Members Outline Proposal to Improve Medicare Physician Training to Reduce Workforce Shortages
- AMA Issue Brief on Payment and Delivery in Rural Hospitals

Teaching Health Center Graduate Medical Education

Continued and increased support for Teaching Health Center Graduate Medical Education (THCGME) would help to decrease shortages for underserved populations, thus ensuring greater affordability of health care. "Teaching Health Centers are located predominantly (80 percent) in community-based health centers, such as Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, Rural Health Clinics, and Tribal Health Centers that provide primary care services in underserved areas. In Academic Year 2016-2017, the majority of THCGME residents (83 percent) spent part of their training in medically underserved and/or rural communities, and these residents provided more than 795,000 hours of patient care." Since 2022 THCGME has funded over 1,200 physicians and dentists training each year. Since there are so many positive benefits to THCGME this program should be expanded. One form of expansion would be to increase funding for THCGME to create more residency training slots, which would increase the overall pool of physicians.

National Health Service Corps

Continued and increased support should be provided for the National Health Service Corps (NHSC). The NHSC provides scholarships and loan repayment options for health care providers who are willing to serve in HPSAs for a designated period of time. The NHSC has three loan repayment programs and a scholarship program. Physicians are eligible for all of these programs, though each program has a different service commitment and amount that can be forgiven.

It has been shown that with additional federal funds more providers are hired, and thus more care can be provided at more affordable rates. Since scholarships help to diminish the financial burden of medical school from the outset, additional funding should be provided to bolster the scholarship aspect of the NHSC program. Additionally, more funding should be provided to expand the program overall, including by adding more programs and specialties to the NHSC, so that additional physicians and patients can benefit from this valuable program.

International Medical Graduates

International Medical Graduates (IMGs) play a critical role in helping to mitigate care shortages, especially in areas of the U.S. with higher rates of poverty and chronic disease. By helping to close the gap on the physician shortage, IMGs assist patients in getting care in a timely manner which is more affordable for the patient and the health care system. For example, in 2024, almost 25 percent of licensed U.S. physicians were IMGs, with the number of IMGs in active practice growing by nearly 18 percent

since 2010. These physicians play an irreplaceable role in our U.S. health care workforce and should be provided with supportive pathways to remain in the U.S. and care for their patients.

Currently, resident physicians from other countries working in the U.S. on J-1 visas are required to return to their home country after their residency has ended for two years before they can return. The Conrad 30 program allows these physicians to remain in the U.S. without having to return to their home country if they agree to practice in an underserved area for three years. However, the AMA is extremely concerned about the long-term viability of the Conrad 30 program given the pending rule that would eliminate duration of status. If IMGs are unable to successfully complete their residencies due to consistent interruptions in their visa, they will likely choose to go to other countries for training or will not want to remain in the U.S. and care for our rural and underserved populations. A loss of IMGs will only exacerbate the current physician shortage crisis with deleterious impacts on healthcare affordability nationwide.

Additionally, the $100,000 H-1B visa fee that resulted from the Proclamation entitled, "Restriction on Entry of Certain Nonimmigrant Workers" will further harm our physician workforce and U.S. patients access to care. H-1B physicians play a critical role in filling our current physician shortage, especially in areas of the U.S. with high-need populations as demonstrated by the fact that between 2001 and 2024 almost 23,000 H-1B physicians worked in underserved communities. However, the $100,000 fee is prohibitively expensive, especially for institutions operating on slim margins such as Federally Qualified Health Centers, small rural practices, and those in Medically Underserved Areas. Accordingly, these positions will remain vacant and our populations that are most in need will not have access to a physician. Therefore, the AMA asks that Congress exempt H-1B physicians from this fee so that these individuals can continue to be a reliable pipeline for U.S. health care.

- AMA Comments on Duration of Status Proposed Rule
- AMA Letter requesting exemption from H-1B fee
- AMA Statement for the Record for hearing entitled, "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce."

Federal Student Loans

The AMA believes that the cost of medical education should never be a barrier to the pursuit of a career in medicine and supports efforts to ensure that individuals are offered fair loan terms and are provided with the ability to make meaningful progress towards paying off their student loans. Moreover, the AMA supports the preservation of an American educational system that provides our students with the opportunity to successfully become physicians, which is especially important when taking into consideration our nation's current and impending U.S. physician shortage. However, the AMA is concerned that the recent changes to federal student loans will hinder educational achievement and successful student loan repayment and discourage students from becoming physicians. This reality runs counter to the goals of creating and maintaining a robust American pipeline of physicians. As such, we urge Congress to maintain PLUS loans for medical students, exempt physicians from loan caps, and allow physicians access to both the current and new federal student loan repayment plans. For more information on how the federal changes to the student loan system will impact current and prospective medical students please see our comments on this topic:

- AMA Comments on Reimagining and Improving Student Education: Docket ID ED-2025-OPE-0944

Physician-led team-based care is cost effective and should be preserved.

As Congress continues to debate ways to address health care affordability, it is crucial that federal lawmakers do not default to expanding the scope of practice of non-physician providers as a stopgap to address patient access to care issues. Put simply, patient safety is compromised and health care costs rise when policies permit allied health professionals to deliver services beyond their training and expertise. Therefore, physician-led teams should be preserved and any legislative efforts that inappropriately seek to expand the scope of practice of nonphysician providers beyond their clinical training must be rejected. The AMA strongly supports the team approach to patient care, with each member of the team serving in a clearly defined role as determined by his or her education and training. However, federal and state policymakers often seek to address the physician shortage, especially in rural areas, by turning to nonphysician personnel. We urge the Subcommittee to reject any efforts by nonphysician organizations to use claims of a diminished physician workforce as a rationale to support expanded scope of practice.

Despite claims to the contrary, expanding the scope of practice for nonphysician practitioners does not increase patient access in rural or underserved areas. In reviewing the actual practice locations of primary care physicians compared to nonphysician practitioners, it is clear that physicians and nonphysicians tend to practice in the same areas of a state. This is true even in those states where, for example, nurse practitioners can practice without physician involvement. These findings are confirmed by multiple studies, including state workforce studies. The data is clear—scope expansions have not led to increased access to care in rural and underserved areas. Please see our Health Workforce Mapper to find out more.

There is strong evidence that increasing the scope of practice of non-physicians results **in higher costs** and worse outcomes. For example, a high-quality study published as a working paper by the National Bureau of Economic Research in 2022 compared the productivity of nurse practitioners and physicians (MDs/DOs) practicing in the emergency department using Veterans Health Administration data. The study found that nurse practitioners use more resources and achieve worse health outcomes than physicians. Nurse practitioners ordered more tests and formal consults than physicians and were more likely than physicians to seek information from external sources such as X-rays and CT scans. They also saw worse health outcomes, raising 30-day preventable hospitalizations by 20 percent, and increasing length of stay in the emergency department. Altogether, nurse practitioners practicing independently increased health care costs by $66 per emergency department visit. The study found that these productivity differences make nurse practitioners more costly than physicians to employ, even accounting for differences in salary. The authors estimate that continuing to use the current staffing allocation of nurse practitioners in the emergency department results in a net cost of $74 million per year, compared to staffing the emergency department with only physicians. Not only does the increased resource use by nurse practitioners result in increased costs and longer lengths of stay, but it also means patients undergo unnecessary tests, procedures, and hospital admissions.

These findings are consistent with other studies as well, including a recent study from the Hattiesburg Clinic in Mississippi which found that allowing physician assistants and nurse practitioners to function with independent patient panels in the primary care setting resulted in higher costs, higher utilization of services, and lower quality of care compared to panels of patients with a primary care physician. Specifically, the study found that non-nursing home Medicare Accountable Care Organization patient spend was $43 higher per member, per month for patients on a nurse practitioner/physician assistant panel compared to those with a primary care physician.

These are just a few examples of how improperly expanding scope of practice can harm patients and increase health care costs. While all health care professionals play a critical role in providing care to patients and nonphysician practitioners are important members of the care team, their skill sets are not interchangeable with those of fully educated and trained physicians.

While there are numerous bills before Congress that inappropriately expand the scope of practice of non-physician providers, the AMA strongly opposes the following bills:

- S. 2426 and H.R. 3164, the "Equitable Community Access to Pharmacist Services Act (ECAPS) Act" which would inappropriately allow pharmacists to perform services that would normally only be authorized and covered if they were furnished by a physician, test and treat patients for certain illnesses and expand Medicare payment for pharmacists.
- S. 1996 and H.R. 2757, the "Medicare Audiology Access Improvement Act" which would reclassify audiologists as Medicare providers and expand their scope of practice beyond their educational training and clinical competencies.
- H.R. 3170, the "Improving Access to Workers' Compensation for Injured Federal Workers Act" which would allow nurse practitioners and physician assistants to diagnose, prescribe, treat, and certify an injury and extent of disability for purposes of compensating federal workers under the Federal Employees' Compensation Act.
- S. 106 and H.R. 539, the "Chiropractic Medicare Coverage Modernization Act of 2025," which would amend the Social Security Act's definition of physician to extend Medicare coverage for services furnished by chiropractors beyond the manual manipulation of the spine.

Physician Administrative Burden and Burnout

Administrative complexity continues to divert significant physician time and resources away from patient care. Reducing unnecessary administrative costs across federal health care programs represents an important opportunity to improve efficiency and reduce system-wide health care spending. Physicians and their staff spend substantial time navigating prior authorization (PA) requirements, reporting obligations under federal quality programs, and other regulatory processes that often provide little clinical value while imposing significant operational costs on physician practices. Reducing unnecessary administrative burden is essential to improving patient access to care and strengthening the sustainability of physician practices which in turn makes the care more affordable for patients and the health care system.

Recent federal efforts have recognized the need to reduce regulatory burden across the health care system. Executive Order 14192, *Unleashing Prosperity Through Deregulation*, directed federal agencies to identify and eliminate regulations that impose unnecessary costs and administrative complexity on providers. Consistent with this directive, the AMA has urged CMS to identify opportunities to streamline regulatory requirements and reduce administrative complexity within the Medicare program. The AMA has stressed that duplicative reporting requirements, inefficient PA processes, and complex quality reporting programs divert physician time away from clinical care and increase the administrative burden facing physician practices.

Congress can take an important step toward addressing these challenges by enacting H.R. 3514/S. 1816, the "Improving Seniors' Timely Access to Care Act of 2025." This bipartisan legislation would streamline and standardize PA requirements within the MA program by requiring the adoption of electronic PA processes, improving transparency regarding approval and denial rates, and establishing clearer timelines for PA determinations. These reforms would help reduce delays in medically necessary care while significantly decreasing the administrative workload associated with outdated and fragmented PA systems.

Congress should also pursue additional reforms to reduce the administrative burden associated with federal quality reporting programs, including MIPS. While improving quality measurement remains an important goal, the current structure of MIPS requires physicians to devote substantial time and staff

resources to complex reporting requirements that may not meaningfully improve patient outcomes to get paid. A *JAMA Health Forum study* found that it costs an estimated $12,811 and more than 200 hours per physician, per year to comply with MIPS requirements. Furthermore, the current structure disproportionately affects small, rural, and independent practices, subjecting them to up to nine percent penalties. Simplifying these requirements and better aligning federal reporting programs would protect these practices while allowing physicians in all practices to devote more time and resources to direct patient care.

Legislative action to streamline PA requirements and modernize federal quality reporting programs would allow physicians to spend less time on paperwork and more time delivering care to patients. Reducing these administrative burdens would improve patient access to timely, medically necessary, services and help sustain physician practices serving communities across the country, specifically those in rural and under resourced communities.

Permanent telehealth flexibilities are needed and will help in reducing overall health care costs as well as provider burnout.

The AMA strongly supports the permanent expansion of existing telehealth flexibilities as a primary way to retain healthcare affordability due to its ability to maintain patient access to physician services, especially in rural and underserved areas. The rapid expansion of telehealth and digital medicine during the COVID-19 pandemic provided an unprecedented, large-scale, real-time demonstration of how virtual care can improve access, enhance patient outcomes, and support an overstretched health care workforce, particularly among Medicare beneficiaries. As policymakers consider the future of these services, a growing body of evidence makes a strong case for making key Medicare telehealth flexibilities permanent.

Telehealth influences downstream health care utilization, workforce satisfaction, patient experience, access to care, and clinical outcomes, factors that may not generate immediate cost savings but can significantly shape long-term spending and program performance. These elements affect key drivers of health care costs, including clinician retention, care quality, patient engagement, and the avoidance of costly emergency or inpatient care. A more comprehensive approach to evaluating the economic impact of virtual care, including telehealth, should account for these indirect but meaningful effects on the sustainability and efficiency of federal health programs and the broader U.S. health care system.

More specifically, Congress should expeditiously pass H.R. 4206/S. 1261, the "CONNECT for Health Act", and H.R. 5081/S. 2709, the "Telehealth Modernization Act." Both bills, among other things, permanently repeal the antiquated geographic and originating site restrictions, eliminate the requirement for patients to see a physician in-person within six months of an initial telemental health visit, and preserve access to audio-only services. These crucial policy changes enable telehealth to remain a viable option for Medicare beneficiaries and physicians throughout the 21st century.

The AMA urges Congress to act swiftly. Continuing to operate under short-term extensions creates unnecessary instability that undermines innovation and discourages the long-term practice transformation needed to improve both access and affordability. Congress has an opportunity to cement telehealth as a permanent pillar of Medicare, and we urge you to seize it.

- AMA Issue Brief "The case for permanent telehealth policy and expanded access to virtual care"
- AMA Webpage Supporting telehealth

Conclusion

The AMA thanks the Subcommittee for this hearing and for its careful consideration of solutions to improve health care affordability, patient access, and physician workforce sustainability across the country. Addressing health care affordability requires a comprehensive approach that includes strengthening the physician workforce, preserving patient access to community-based care, and ensuring that federal health programs support sustainable physician practices.

We look forward to working with the Subcommittee and Congress to seek practical, bipartisan solutions that will ensure that patients are provided with the best care possible and that barriers are addressed to resolve the full spectrum of health care affordability issues so that physicians can keep providing patients with the care that they deserve.