AMERICAN ACADEMY of FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

R. Shawn Martin
CEO and EVP
American Academy of Family Physicians

To

House Committee on Energy and Commerce
Health Subcommittee

On

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

March 18, 2026

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033

www.aafp.org

Chairman Griffith, Ranking Member DeGette, and distinguished members of the Subcommittee, thank you for the opportunity to testify today. My name is Shawn Martin, and I am the Executive Vice President and Chief Executive Officer of the American Academy of Family Physicians (AAFP). I am honored to be here today representing the 124,500 physicians and student members of the AAFP.

Health care affordability is the single biggest issue for many American families right now. According to two Gallup polls released last week, people across the country are driving less, skipping meals and putting off big life moves, such as buying homes or having children, to keep up with health care costs.[i] About one in three Americans are cutting back on daily spending to cover medical costs, and about half of middle-income households reported delaying a major life event, as premiums rise and changes to funding for the Medicaid program loom.

As the entry point for many patients to the health care system, family physicians see firsthand how these rising health care costs impact individuals and their health outcomes. They see patients come in with exacerbated chronic conditions that could have been prevented with earlier interventions. They 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.

These concerns are particularly pronounced for individuals with chronic conditions. In the U.S., roughly 90 percent of the nation's $4.5 trillion in annual health care spending is associated with people living with chronic and mental health conditions.[ii] Conditions such as diabetes, heart disease, hypertension and asthma require ongoing management over many years, and when they are not effectively controlled, they lead to costly hospitalizations, complications, and disability. For example, a recently published report found that patients with multiple chronic conditions accounted for more than half of inpatient admissions and generated about ten times more hospital and emergency department visits than those without chronic conditions in 2024.[iii]

Decades of evidence have made it clear that primary care is the most cost-effective part of the health care system for addressing these challenges. Health systems that invest more heavily in primary care consistently achieve better population health outcomes, lower rates of hospitalization and emergency department use, and lower overall health care spending. Yet despite its central role, the United States invests far less in primary care than many other high-income countries. Estimates suggest that only about five to seven percent of total U.S. health care spending is spent on primary care, a share that has been declining over time. In 2022, primary care spending dropped to less than five cents of every dollar, with Medicare spending the lowest at 3.4 percent.[iv]

This declining investment is attracting fewer prospective physicians to practicing primary care and contributing to a troubling trend: a growing number of Americans report not having a usual source of care. The number of American adults who do not have a usual source of care is the highest it has been in a decade of measurement, with almost a third (31 percent) reporting that they had no usual source of care in 2022.[v]

Research has consistently shown that patients with a regular primary care physician experience better health outcomes, higher quality of care and lower total health care costs. This includes patients with chronic conditions. Research released earlier this year by the AAFP's Robert Graham Center, in collaboration with the Milbank Memorial Fund and the Physicians Foundation, further confirmed this.[vi] The 2026 Health of US Primary Care report found that:

- Nearly all adults (95.5 percent) with a usual source of primary care received preventive services for chronic disease, compared to 67.6 percent of those without a usual source of primary care.
- For those adults who do develop chronic disease, having a usual source of primary care lowered their odds of going to the emergency department (ED) by 11 percent, and of hospitalization by 20 percent.
- Having a usual source of primary care was associated with having nearly 54 percent lower total health care expenditures for adults with chronic disease, and nearly 40 percent lower health care expenditures for children with chronic disease, compared to those who did not have a usual source of primary care.

Separating individuals and families from primary care has real consequences, which we are seeing today: a high prevalence of chronic disease, declining adherence to proven public health measures such as vaccination, low utilization of prenatal services, and growing numbers of unmanaged mental and behavioral health conditions.

Whether you call it "Making America Healthy Again" or simply good health policy, primary care is what keeps people healthy. Family physicians have been delivering comprehensive, continuous care since the earliest days of the profession – caring for patients across the lifespan, managing chronic illness, preventing disease and injury, and counseling patients on nutrition, physical activity, and other lifestyle

factors that shape long-term health. This broad scope of practice is precisely what allows primary care to improve outcomes while controlling costs.

Unfortunately, our policy environment is increasingly working against primary care's success. Payment rates undervalue the work of primary care or fail to capture much of the work altogether. Administrative burdens take already-limited time away from patient care. Rising rates of vaccine misinformation are further complicating often already complex primary care encounters. And recent federal actions to reduce state and federal financing for Medicaid and limit coverage eligibility are likely to further reduce resources flowing into primary care and create additional financial barriers that may discourage patients from seeking routine care.

In particular, I am concerned about the impacts these looming changes will have on access to continuous coverage and primary care for low-income children, pregnant and post-partum women, and individuals with disabilities. In response to reduced budgets, many more rural hospitals are likely to close labor and delivery units as well, given that Medicaid finances half of the births in these communities.[vii]

While the challenges facing primary care are significant, they are not insurmountable. With thoughtful policy reforms, Congress can reverse the above trends and ensure that primary care can serve as the backbone to our health care system that it is, while improving both outcomes and affordability of care for patients. I will describe the AAFP's specific recommendations below.

Consolidation within Primary Care and Independent Practice

Family physicians, like all physicians, are at their best when they are serving their patients and communities, not the financial interests of an employer or investment partner.

Over the past two decades, we have seen a dramatic shift in practice ownership among family physicians. Twenty years ago, about one third of family physicians were employed. Today, nearly 75 percent of family physicians are employed by hospitals, health systems, or corporate entities such as private equity. This shift has occurred for several reasons:

- Insufficient and unstable payment policies from all payers, including Medicare, have placed increasing economic pressure on physician practices. Over the past twenty years, physician payment rates have failed to keep pace with rising practice costs and inflation.
- Independent practices often lack the market leverage needed to fairly negotiate payment rates with large insurers and health systems.
- Current payment policies frequently reward ownership of physician practices, particularly by hospitals and large health systems, by providing higher payment rates to facilities.
- The regulatory and operational complexities created by the *Health Information Technology for Economic and Clinical Health (HITECH) Act* and ongoing challenges with health information technology and data exchange systems have created substantial administrative burdens for independent practices.
- Compliance requirements associated with quality reporting, utilization management protocols by payers, and quality improvement programs across Medicare, Medicaid, and commercial insurance plans have significantly increased the cost of running a practice. Many of these programs have created layers of overlapping administrative activity and supported industries that add costs to the system while producing only marginal (if any) improvements in outcomes.
- The COVID-19 pandemic accelerated aggressive merger and acquisition activity by hospitals and commercial insurers, further consolidating physician practices.

While private equity is often viewed unfavorably as an investment partner in health care, I would suggest that many of the business tactics associated with private equity are not materially different from those employed by hospitals or care delivery organizations owned by insurers. In many cases, these ownership models prioritize control over diagnostic, treatment, and referral decisions within primary care in ways that serve the financial interests of the parent organization, rather than always aligning with the best interests of patients.

While some family physicians have reported positive experiences with being acquired by a health system or corporation, citing access to advanced tools and technology, additional administrative support, and other experts, many more physicians experience moral injury as they cope with loss of clinical autonomy and requests to prioritize organizational priorities over those of their patients.

I want to be clear that consolidation overall is not inherently good or bad. However, our current environment disproportionately advantages corporate entities and larger health systems. A physician's choice to be employed or independent should be precisely that: an organic choice. To make that the reality, I urge Congress to:

- **Reform medical loss ratio (MLR) requirements so that insurers cannot game them to increase their market share**. MLR requirements were designed to ensure that most premium revenue – generally at least 80 percent – is spent on medical care and quality improvement activities. However, as insurers have acquired physician practices and other service companies, payments to affiliated entities can be counted as medical spending under current

rules even when the funds remain within the same corporate structure. This makes it more difficult to determine how much premium revenue is actually supporting patient care.

- **Address site of service payment differentials**. I applaud Congress for including a provision in the Consolidated Appropriations Act of 2026 that requires off-campus hospital outpatient departments (HOPDs) to use a unique national provider identifier when billing Medicare, helping distinguish what setting care is actually being delivered in. However, I urge lawmakers to go further. Medicare still pays significantly more for services that can be – and are – safely delivered in lower-cost settings like physician offices when they are provided in HOPDs and ambulatory surgical centers. This raises costs for patients and the Medicare program without any associated quality increases. Congress should extend the site-neutral payment policies applied to new off-campus HOPDs under the Bipartisan Budget Act of 2015 to apply to all off-campus HOPDs.

I would also like to acknowledge some practice models that Congress should further invest in, as they appropriately center the delivery of continuous, comprehensive primary care. Consolidation across the health care system and the decline of independent physician practices have forced innovation in primary care delivery and benefit design. One of the most promising of these innovations is direct primary care (DPC).

In the DPC model, financial intermediaries are removed and physicians and patients establish a direct contractual relationship for a defined set of primary care services with a fixed fee. This approach restores the physician–patient relationship as the central organizing principle of care. DPC is inherently patient-centered. It reduces the administrative burdens that limit physician autonomy and removes the financial barriers that often discourage patients from seeking timely primary care.

The AAFP has supported the development of the DPC model for more than a decade, and in recent years it has experienced substantial growth in family medicine and pediatrics. It is also gaining increasing interest from employers looking for alternatives to traditional insurance benefit designs that make primary care costly and difficult for their employees to access.

Additionally, community health centers (CHCs) and rural health clinics (RHCs) are the only primary care access points in many communities across the country. CHCs provide comprehensive primary care to nearly 34 million patients across the country, a number that has continued to increase over the years despite frequent financial uncertainty for these care settings. Family physicians are the most common physician type serving patients in these settings. CHCs have consistently proven themselves to be cost-effective, patient-centered care settings, delivering ten percent of the nation's primary care while only accounting for one percent of national health care spend.[viii] I applaud Congress for providing increased funding for this long bipartisan program in the *CAA of 2026*, but further investments should be made – including providing a longer funding runway beyond September of this year.

Medicare Physician Payment Reform

For years, the AAFP has described at-length the many flaws within fee-for-service (FFS) payment models, and more specifically the Medicare Physician Fee Schedule (MPFS), that have contributed to our national underinvestment in primary care. Briefly, some of the biggest factors are as follows:

- FFS payment is designed to pay for discrete services in ways that favor procedural service delivery.
- FFS coding and billing is incompatible with the continuous, comprehensive nature of relationship-based primary care.

- Budget neutrality requirements are unreasonably outdated and should not be narrowly focused only on physician services.
- The lack of an inflationary update means payment rates for physician services have declined substantially over the past two decades.

It is for these reasons that the AAFP continues to advocate for widespread adoption of value-based payment arrangements across payers. However, it cannot be ignored that FFS underpins and informs virtually all existing alternative payment models. Thus, the success of primary care physicians and practices in these arrangements is contingent upon comprehensive reforms being made to the MPFS and the *Medicare Access and CHIP Reauthorization Act* (MACRA).

I would like to acknowledge and applaud the Centers for Medicare and Medicaid Services (CMS) for taking important steps in recent years within the MPFS to better value and pay for the work being done in primary care. This includes implementing new codes to pay for work that was not previously captured by existing codes, providing monthly bundled payments for care management services with the advanced primary care management (APCM) codes, and using other empirical data sources to more accurately estimate the time it takes physicians to provide certain services and updating their associated relative value units accordingly.

However, the impacts of these positive policy changes are blunted by existing statutory requirements. For example:

- Extremely restrictive budget neutrality requirements – which haven't been updated since the inception of the MPFS – mean that, in most cases, new codes cannot be added without triggering an across-the-board payment cut to all services.

- The budget-neutral nature of the MPFS also means that the Merit-based Incentive Payment System (MIPS), which was intended to move more physicians successfully into value-based payment, has failed its intended goal. Penalties applied to "low-performing" clinicians pay for the awards provided to high-performers, creating a cycle whereby small, independent, and rural practices are consistently punished instead of offered a necessary helping hand.
- If CMS increases the valuations of any codes, it means that the valuations of other codes must be reduced or the conversion factor is cut.
- And finally, all of this is happening within the same pot of money that has existed since 1992 – despite a growing beneficiary population, increasing costs of running a practice, and significant innovations in medicine over the last several decades leading to more services and technologies being added to the MPFS. This policy framework has forced physician specialties to compete against each other for smaller and smaller pieces of the pie each year.

Ensuring widespread access to high-value, lower-cost primary care requires us to change how we pay for it. We need to pay family physicians for preventing disease, not incentivizing the delivery of more services to treat it. Comprehensively reforming Medicare payment for primary care must be a priority for this Subcommittee. I want to applaud Drs. Joyce, Miller-Meeks, Ruiz and Schrier on the Subcommittee for their steadfast leadership on these issues, and I urge Congress to:

- **Provide an annual inflationary update to physician payment.** There is no justification for why facilities like hospitals and skilled nursing facilities receive an annual update, but the physicians – the actual people providing care – do not. Payment for physicians is on an increasingly unsustainable path. If we think health care costs are out of control now, it will only

get worse unless Congress acts to ensure that the work of primary care physicians is adequately compensated and keeps pace with the actual costs required to deliver care.

- **Enact long-overdue reforms to budget neutrality requirements**. This includes providing CMS with the authority to correct over-or under-utilization assumptions when implementing new codes, ensuring that funds within the fee schedule are not irreversibly lost due to inaccurate assumptions.
- **Provide prospective, sustainable population-based payments for primary care.** Predictable per-patient monthly payments allow family physicians to focus on managing the health of their patient panels rather than maximizing billable encounters. This approach also reduces the need for extensive coding and billing documentation, which currently consumes substantial physician time and is inconsistent with the comprehensive, continuous nature of primary care. Instead, it gives practices the flexibility to tailor care in a way that best meet the needs of their communities – whether through expanded care management, more time to spend per patient visit, a wider array of staff, or proactive outreach to high-risk patients.
- **Make quality measurement more meaningful to physicians and patients**. Family physicians are disproportionately accountable for a growing number of disease-specific process measures that fail to capture the true nature and value of comprehensive, patient-centered primary care. While quality measurement is essential for moving toward a value-based system, our current approach fails to measure what matters to patients and clinicians or drive meaningful quality improvement. We must standardize quality and performance measures with a single universal set – across payers and programs – that meets the highest standards of validity and reliability and is derived from data extracted from multiple data sources. The measures should focus on outcomes that matter most to patients and that have the greatest overall impact on better health of the population, better health care, and lower costs.

Benefit and Coverage Design

For family physicians, affordability for their patients is not measured simply by the monthly premium. It is measured by whether a patient can actually come in for care, follow through on treatment and access the services their physician recommends.

Unfortunately, insurance benefits and coverage design are increasingly steering patients away from seeking care, including routine prevention and primary care services. Over the past decade, deductibles and other forms of cost-sharing have risen substantially. According to KFF (formerly the Kaiser Family Foundation), the average deductible for single coverage in employer plans has increased by more than 50 percent since 2013, and enrollment in high-deductible plans continues to grow.[ix] When patients must spend several thousand dollars before coverage meaningfully begins, many delay or skip care altogether. Higher cost-sharing reduces use of services, which in primary care often means patients postpone routine visits, chronic disease management or diagnostic testing until conditions worsen.

This is causing a detrimental cycle: cost-prohibitive plan designs lead to people not seeking care, which leads to a sicker population and risk pool, which leads to inflated actuarial values for plans who then increase deductibles and cost-sharing, and so on.

Reforming benefit and coverage design is one of the most tangible ways that Congress can make health care more affordable for patients enrolled in plans across payers and also increase our national investment in primary care. As a starting point, I recommend the following policies for consideration:

- **Waiving cost-sharing for chronic care management services under Medicare Part B**. Even relatively modest cost-sharing requirements can discourage patients from seeking the routine care that prevents illness and manages chronic disease. Family physicians see this play out with Medicare beneficiaries are currently required to pay a 20 percent coinsurance for many chronic care management services under Part B. Waiving cost-sharing for chronic care management and APCM codes – or at least providing the CMS clear authority to do so – would remove a meaningful barrier to the types of services that help patients stay healthy and avoid costly complications.
- **Require all plans to cover at least three primary care visits annually without patient cost-sharing**. As noted, evidence has shown that higher cost-sharing responsibilities leads to patients forgoing important primary and preventive care. I believe requiring all plans to cover at least three primary care visits annually without subjecting them to any form of cost-sharing would play an important role in connecting patients to high-value, low-cost care that would ultimately yield savings for the whole system.
- **Allow state Medicaid agencies to pay for DPC arrangements for beneficiaries**. As discussed above, DPC is a growing practice model that has been shown to yield cost savings, gives family physicians a meaningful alternative to traditional FFS insurance billing and, most importantly, centers the patient-physician relationship. The *Medicaid Primary Care Improvement Act* (H.R. 1162), led by Dr. Schrier and Rep. Crenshaw on this Subcommittee, would clarify that state Medicaid agencies may pay for these high-value arrangements if they choose. This bill unanimously passed the Committee last Congress and ultimately the House by a voice vote.
- **Require all payers to track and publicly disclose the amount they spend on primary care services**. I would encourage Congress to consider legislation that would require commercial and federal payers 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.[x] Meanwhile, Arkansas enacted legislation last year 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.[xi]

Allow Physicians to Actually Practice Medicine

In addition to declining primary care investment, family physicians are being bombarded by external factors that are disrupting their trusted relationships with patients, taking away already limited time for patient care, and undermining their medical decision-making.

Family physicians spend hours each day navigating electronic health record documentation rules, quality reporting programs across different payers, and utilization management protocols from insurers. These policies often delay necessary care, create frustration for patients and physicians alike, and require significant staff time to navigate – ultimately increasing costs across the health care system.

At the same time, growing confusion around vaccines and increasing vaccine hesitancy have placed additional demands on the primary care workforce. Family physicians are often the most trusted source of vaccine information for patients, yet addressing misinformation and counseling hesitant patients requires time that is increasingly scarce in already constrained clinical schedules. Vaccines are safe, effective and save lives. They are one of the most cost-effective public health interventions ever created.

If we want to make progress on health care affordability and outcomes, we must maintain ground covered. That includes Congress advancing policies that support and promote utilization of cost-effective, life-saving, evidence-based interventions including vaccines.

Further, insurers have been increasingly engaging in a practice known as "downcoding," which is quietly undermining the financial viability of primary care practices. Downcoding occurs when health plans assign a lower-level evaluation and management (E/M) code than the one that was provided by the physician and billed on the claim - without consulting the physician who provided the patient care. This results in lower payments that physicians are forced to either accept or pursue costly, time-consuming appeals, which take additional time and resources away from patient care.

Downcoding is often only discovered by practices when they notice underpayments for services rendered. In letters to specific payers and AHIP (formerly America's Health Insurance Plans), the AAFP has expressed its concern about this and other aspects of the downcoding programs. We have requested greater transparency regarding the methodologies for identifying targeted individuals and offered our assistance in educating family physicians regarding accurate coding criteria – something that the AAFP regularly offers to all of its members. However, to date, the AAFP has not been able to secure any guidelines, standards, or rules from payers with which physicians could educate themselves to improve their billing and documentation in order to avoid having their claims downcoded.

Each of these issues is directly interfering with the ability of family physicians to do what they are expertly trained in: practice medically-sound, evidence-based, undisrupted medicine. Time spent investigating downcoded claims and on the phone with insurance representatives trying to understand why a prior authorization request was denied is time not spent on delivering the care that keeps people

and families healthy. I urge this Subcommittee to allow family physicians to actually practice medicine by:

- **Passing the *Improving Seniors' Timely Access to Care Act* (H.R. 3514).** I appreciate recent commitments by insurers to streamline, simplify, and reduce prior authorization, but these efforts are voluntary and subject to no enforcement by anyone other than the plans themselves. Further action is necessary to meaningfully reform prior authorization across all plans. Passing this legislation would codify regulations from CMS to streamline prior authorization processes across Medicare Advantage plans.
- **Protect and support patient access to evidence-based, recommended vaccines.** Congress has a role to play in reinforcing and publicly supporting patient access to vaccines that we know to be safe based on the evidence.
- **Intervene in the unregulated practice of downcoding by health plans.** At a minimum, I urge consideration of legislation to require clear transparency into the processes and criteria insurers are using and prohibit the use of automatic algorithms to downcode claims. If these programs are designed to ensure accurate billing and prevent fraud, waste, and abuse then these policies should be transparent, fair, and uniformly applied regardless of practice ownership.

In closing, thank you again for the opportunity to provide this testimony. On behalf of the AAFP, family physicians look forward to working with the Subcommittee to advance policies that improve the health of patients while driving down costs – a goal which starts with appropriately investing in primary care.

[i] Gupta, G. (2026, March 12). *One-third of Americans skip meals or other needs to afford health care*. The Washington Post.
[ii] Centers for Disease Control and Prevention. (2024). *Fast facts: Health and economic costs of chronic conditions.* U.S. Department of Health and Human Services. https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html.
[iii] *Vizient: Chronic conditions drive demand for home health care and telehealth*. Modern Healthcare. Published 2026. Accessed March 14, 2026. https://www.modernhealthcare.com/providers/mh-vizient-chronic-condition-home-health-care-telehealth/.
[iv] Jabbarpour, Y., Jetty, A., Byun, H., Siddiqi, A., & Park, J. (2025, February 18). The Health of US Primary Care 2025 Scorecard: The Cost of Neglect – How Chronic Underinvestment in Primary Care Is Failing US Patients . Milbank Memorial Fund. https://doi.org/10.1599/mmf.2025.0218.
[v] Ibid.
[vi] Jabbarpour Y, Jetty A, Byun H, Siddiqi A, Park J. *Investing in Primary Care: The Missing Strategy in America's Fight Against Chronic Disease*. Milbank Memorial Fund; The Physicians Foundation; Robert Graham Center. Published February 12, 2026. https://www.milbank.org/publications/investing-in-primary-care-the-missing-strategy-in-americas-fight-against-chronic-disease/.
[vii] Ranji U, Salganicoff A, Tolbert J, Frederiksen B, Gomez I. *5 Key Facts About Medicaid and Pregnancy*. KFF. Published May 29, 2025. Accessed March 14, 2026. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-pregnancy/.
[viii] National Association of Community Health Centers. *Community Health Centers Provide Primary Care to Nearly 34 Million Patients*. Published August 4, 2025. Accessed March 14, 2026. https://www.nachc.org/community-health-centers-provide-primary-care-to-nearly-34-million-patients/.
[ix] *KFF.* 2025 Employer Health Benefits Survey. KFF. Published October 22, 2025. Accessed March 14, 2026. https://www.kff.org/health-costs/2025-employer-health-benefits-survey/.
[x] Oklahoma Health Care Authority. (2024, revised September 1). Okla. Admin. Code § 317:55 - 3- 14: Primary care requirements (317:55 - 3- 14). Retrieved from https://oklahoma.gov/ohca/policies - and - rules/xpolicy/managed - care/general - program - information/scope - and - administration/primary - care - requirements.html.
[xi] Arkansas General Assembly. (2025). Senate Bill 264: To establish the Arkansas Primary Care Payment Improvement Working Group (95th Gen. Assemb., Act 483). Retrieved from Arkansas Legislative website.

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033 www.aafp.org