AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

May 20, 2025

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Speaker Johnson and Minority Leader Jeffries:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,300 family physicians and medical students across the country, I write regarding the House's budget reconciliation package and to provide our perspective on provisions within the legislation that would impact family physicians, their patients, and the communities they serve.

This cross-jurisdictional legislative undertaking touches upon virtually every area of interest for our members and the people they care for, such as health care coverage, physician payment, nutrition programs, financial incentives that support small physician practices, and medical student debt. We appreciate that Congress has identified these issues as priorities to take action on early in the 119th session. As the budget reconciliation process proceeds, we would like to share our endorsement of certain provisions as well as concerns and opportunities to strengthen other existing provisions, which as written have the potential to harm the family physician workforce and patients' access to essential, comprehensive primary care.

House Committee on Energy and Commerce:

We sincerely appreciate that champions on the Committee fought to include Section 44304, which provides an inflationary update to Medicare physician payment beginning in 2026. This proposal as drafted would provide an update equal to 75% of the Medicare Economic Index (MEI) for 2026 and then annual updates beginning in 2027 equal to 10% of the MEI. We recognize the significance of including a provision that invests $8.9 billion in the Medicare Physician Fee Schedule in a piece of legislation that has such a high savings floor. However, **family physicians faced a 2.83% cut in the beginning of 2025 that has not been addressed by Congress and remains unresolved in this provision.** Practices can't sustain in this financial environment, which requires them to somehow keep their doors open, continue seeing more patients, and provide more services with significantly fewer resources and lower payment. Further, we are concerned that providing an increase of only 10% of MEI to the conversion factor (CF) moving forward will provide little relief from the inflationary pressures that practices continue to face.

Further, current statute – which this provision would replace – provides a .75% increase to the CF for qualifying advanced alternative payment model (APM) participants beginning in 2026. The AAFP has been a steadfast champion of accelerating the transition to value-based payment, and we are concerned that this proposal eliminates one of the few remaining

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incentives for practices to make the shift, particularly given that the advanced APM incentive payment expired without Congressional action last year.

Therefore, we will continue to advocate for long-term, comprehensive payment reform for physicians. Short-term patches limit meaningful investment in primary care and reduce the appetite for federal policymakers to advance true change that will sustain and grow our primary care workforce. More permanent reforms, including an ***adequate*** annual inflationary update to Medicare physician payment based upon the MEI, remain necessary.

Further, we are concerned about the dynamics of including Section 44304 in legislation that is largely financed by Medicaid reforms that will lead to coverage losses, reduced eligibility, and lower physician payment rates. Last week, the AAFP joined more than 40 physician and other health care stakeholder groups in expressing our deep concerns with the Committee's proposals to limit eligibility for, increase administrative complexity of, and hinder state financing for Medicaid, as included in the legislation it passed.

As family physicians, we see the important and often life-saving role that Medicaid and the Children's Health Insurance Program play for more than 80 million individuals across the country. The AAFP has long opposed changes to the Medicaid program that seek to further restrict eligibility or impede access to coverage. Thus, **we write in opposition to Sections 44101, 44102, 44108, 44110, 44111, 44141, 44131, 44132, and 44142 as currently written** .

In particular, **we are deeply concerned about the mandatory work reporting requirements imposed in Section 44141** . Empirical evidence has consistently shown that work reporting requirements do not achieve their stated goal of increasing employment.[i,ii] Instead, they merely achieve "savings" by increasing onerous paperwork requirements that lead to eligible, compliant individuals being kicked off the rolls and fewer people having health insurance. The Congressional Budget Office has concurred with this in their own estimations.[iii]

Data from 2023 found that 92% of Medicaid-covered adults were working full or part-time (64%), or not working due to caregiving responsibilities, illness or disability, or school attendance. The remaining 8% reported that they are retired, unable to find work, or were not working for another reason.[iv] This proposal would only implement additional barriers to maintaining coverage for individuals who are working or otherwise unable to, largely for explicitly allowed exceptions. Onerous work reporting requirements are counterproductive to the intended goals of increasing employment and societal productivity, as increased barriers to coverage will make it difficult for individuals in need of care to be able to maintain employment. If we want to truly promote gainful employment, making it easier – not harder – for eligible Medicaid beneficiaries to maintain their coverage is the right approach.

Further, while we appreciate the inclusion of exceptions for certain individuals from the work reporting requirements, we are concerned that they will be difficult to operationalize or for patients to prove. For example, the exemption for individuals with a substance use disorder (SUD) is for those individuals who are participating in a drug addiction or alcoholic treatment and rehabilitation program as defined in section 3(h) of the Food and Nutrition Act of 2008

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(*any such program conducted by a private nonprofit organization or institution, or a publicly operated community mental health center, under part B of title XIX of the Public Health Service Act (42 U.S.C. 300x et seq.) to provide treatment that can lead to the rehabilitation of drug addicts or alcoholics*). Unfortunately, the reality in too many communities across the country is that individuals with a SUD do not have access to formal treatment or do not receive clinically-identified diagnoses. Stigma, broad variation of coverage for SUD services across states, an insufficient behavioral health workforce and other factors lead to what are likely significant undercounts of SUD rates. Some research estimates that the prevalence of alcohol and opioid use disorders are at least four times higher than what is reported.[v]

Congress should not make it harder for those getting on their feet to stay there. However, work reporting requirements, increased eligibility checks (Section 44108), and added financial barriers in the form of cost-sharing for Medicaid expansion enrollees (Section 44142) will do that. Several proposals (Section 44110, 44111, 44131, and 44132) will also decrease federal investments and place additional financial pressures on states, forcing them to make difficult decisions to reduce clinician payment rates, restrict eligibility, and limit covered benefits.

Medicaid is a foundational leg of the stool that is our health care system, and decreased investment in the program risks the stability of the entire structure. **The health care needs of disenrolled Medicaid beneficiaries won't just disappear.** Without access to affordable coverage or care, patients will delay prevention, early intervention, and primary care. Their chronic conditions will become exacerbated and unmanaged. They will be forced to utilize emergency departments more and levels of uncompensated care will rise. It will not just be Medicaid beneficiaries who are impacted when rural and safety-net hospitals close, physicians retire or practices shut their doors; it will be those who are privately insured or on Medicare that also feel the far-reaching impacts on access to care.

The Academy shares the interest in reforming Medicaid to ensure program sustainability and integrity so that it can continue to serve generations to come. However, the proposals discussed above are not the solutions. Instead, we encourage Congress to advance reforms that achieve these aims without significantly jeopardizing access to care for beneficiaries. For example, the AAFP is a strong supporter of advancing policies that would increase access to direct primary care (DPC) arrangements for those enrolled in Medicaid. The bipartisan *Primary Care Improvement Act* (H.R. 1162), led by the Committee's Representatives Crenshaw and Schrier, would require clarification from the Centers for Medicare and Medicaid Services (CMS) that state Medicaid agencies can pay for DPC arrangements for Medicaid patients if they choose to.

<u>House Committee on Ways and Means:</u>

The AAFP appreciates the Committee's inclusion of the *Primary Care Enhancement Act* (H.R. 1026) in their reconciliation language. This important provision would allow individuals enrolled in high-deductible health plans to use their health savings accounts to pay for DPC arrangements, which current Internal Revenue Service interpretation prohibits. As more primary care physicians choose to participate in DPC arrangements with their patients,

removing the barriers to that prevent that choice will only further foster patient-physician relationships. We have long supported this legislation and believe that DPC is a model of care that provides a pathway to continuous, comprehensive and coordinated primary care for patients.

We were also encouraged to see the extension of small business tax credits and deductions that many independent family medicine practices utilize. In a recent survey of our members, over 40% of respondents identified as an independent practice owner or partner. Of those respondents, 89% reported taking advantage of small business tax credits.[vi] We therefore appreciate the Committee's continued commitment to supporting small businesses. However, we are concerned by one provision and its potential impacts on independent practices.

The elimination of the Pass-through Entity Tax (PTET) state and local tax (SALT) deduction for specified service trades or businesses (SSTBs), including independent physician practices, may be detrimental to these small businesses. This elimination of PTET would disallow certain independent practices from being able to deduct their state and local business taxes as is currently allowed by their state laws. Again, we appreciate the Committee's increase of the pass-through deduction for small businesses up to 23% and the increased flexibility under section 179. Unfortunately, much of the benefit to our independent practices through those changes could be greatly negated if the PTET provisions remain in the final reconciliation package.

Family physicians that choose practice ownership must balance the responsibilities of providing care to their patients and all that comes with owning and running a small business. Most of these small practices rely on tax policies that support their independent practice choice. In addition, maintaining independent practices in rural and underserved communities is already difficult given the strains of administrative burden, repeated payment cuts, and lower than average salaries for primary care specialties. Undermining an independent practice's ability to utilize small business tax deductions and credits will likely only further weaken the desire to practice in independent business models and in communities of greatest need.

The AAFP also encourages Congress to extend the Patient Protection and Affordable Care Act's (ACA) advanced premium tax credits (APTCs) in the reconciliation package, which was not included in this Committee's marked up legislation. Because of our steadfast belief that all people should have affordable access to comprehensive health care, **the AAFP has long supported the extension and expansion of APTCs. These tax credits ensure that millions of low- and middle-income families continue to have access to affordable health coverage, which has been shown to have a positive influence on a nation's economic growth and alleviate economic burdens.**

Given that the APTCs expire at the end of this year, we are concerned that Congress has little time to address this issue. **Therefore, we again encourage Congress to incorporate APTCs**

extension into the reconciliation package and, longer-term, prioritize making them permanent.

In addition to the expiration of APTCs, we are concerned with a provision included in the reconciliation text that could potentially undermine ACA participation. Section 112201 would require all exchange enrollees – both when they first enroll and annually thereafter – to verify their income and end the exchange's current practice of passive enrollment. Eliminating automatic passive enrollment would disrupt continuity of coverage and generate unnecessary administrative burden for enrollees who are satisfied with their health coverage. We urge Congress to reconsider the inclusion of this provision.

Finally, the AAFP has concerns with some of the language dealing with the tax-exempt status of nonprofits. Specifically, we are concerned by the inclusion of language that would allow the administration to more easily revoke an organization's nonprofit status. Section 112209 allows the Department of the Treasury to revoke an entity's tax-exempt status by designating it a "terrorist supporting organization" with very little due process, transparency, or public accountability. Moreover, the criteria for determining that an entity is a terrorist supporting organization are unclear and do not consider the devasting effects to an organization's reputation, staff, finances, and other operations when wrongfully accused. Current federal law already makes it illegal to provide material support or resources to a designated terrorist organization, directs financial institutions to freeze related funds, and allows the government to suspend the tax-exempt status of any designated terrorist organization, thus making this provision redundant.

House Committee on Education and the Workforce:

The AAFP was pleased to offer comments to the Committee immediately following the markup of the *Student Success and Taxpayer Savings Plan.* We appreciate the inclusion of Section 30022, which would allow medical residents to defer interest on their federal student loans. This is a policy the Academy has long advocated in support of alongside numerous other medical and dental organizations. However, other provisions in the bill raise significant concerns for the primary care workforce and would potentially mitigate any savings medical residents receive from interest deferment.

The AAFP has long raised the alarm about the shortage of primary care physicians in the U.S., particularly the supply of family physicians, who provide comprehensive, longitudinal primary care services for patients across the lifespan, including chronic disease management, treatment of acute illnesses, and preventive care. We believe there are significant opportunities to partner with the Committee to strengthen and expand upon programs that incentivize individuals to work in primary care, particularly those programs that encourage physicians to practice in geographic areas with the greatest need. Unfortunately, we are concerned that many provisions in this bill would further erode the primary care workforce and disproportionately affect rural and underserved areas who are already experiencing physician shortages.

Specifically, the AAFP is concerned with the proposal to cap student loan borrowing (Section 30011) and restrict participation in Public Service Loan Forgiveness (PSLF) (Section 30024). We wholeheartedly agree that the cost of higher education should be thoroughly examined and that comprehensive policy discussions at both the federal and state level are necessary to reduce the cost of tuition. However, capping federal student loans will only further contract the already diminishing primary care workforce as students from lower income backgrounds are more likely to go into primary care. It is projected that we will face a shortage of up to 40,400 primary care physicians by 2036.[vii] Yet primary care is the only health care component where an increased supply is associated with better population health and improved patient outcomes.[viii] Restricting the ability of low-income students – who are more likely to choose primary care – to borrow what they need to complete their training will only exacerbate the shortage of primary care physicians.

Physicians incur the same cost for their medical education whether they enter primary care or other specialties, but once they complete their training, primary care physicians have more difficulty managing their debt due to lower income. When measuring debt as a ratio to income, primary care physicians have approximately double the debt burden as those entering surgical specialties.[ix] Research has also shown that loan forgiveness or repayment programs directly influence physicians' choices about whether to choose primary care specialties.[x] Family physicians in particular have relatively low salary averages ($221,419) in comparison with other non-primary care specialties ($413,915). Loan repayment programs can be effective in reducing these salary disparity concerns and give family physicians some financial incentive to stay in the field.

In addition to specialty choice, student loan debt can also affect decisions related to where a resident chooses to train and practice. This is especially important in rural areas, as evidence shows a direct correlation between where a resident trains and where they end up practicing.[xi] While 20% of the U.S. population lives in rural communities, only 12% of primary care physicians and 8% of subspecialists practice in these areas.[xii] However, this bill's proposal to disallow residents to participate in PSLF will further disincentivize residents and physicians from practicing in rural areas, thus exacerbating an already severe access to care issue in those communities.

Family physicians utilize PSLF at high rates. In a recent survey of AAFP members, more than 75% of respondents that are in a loan repayment program said they either were currently or had previously been enrolled in the PSLF program. In that same survey, many members shared stories of returning to practice in their rural hometowns — choosing public service careers they love — because PSLF made it possible. Without it, many would have been forced to leave public service for the private sector, leaving critical health needs unmet.

Supporting debt relief for family physicians doesn't just strengthen our health care system — it also boosts entire local economies. Studies have shown that a rural primary care physician generates an estimated $1.4 million in annual economic activity and over 26 local jobs.[xiii] Clinic employment, inpatient and outpatient services, and purchasing of local goods and services all contribute to these impacts. Given the number of health care workers who have

left the field post-pandemic, it is crucial for the U.S. to explore how we can motivate physicians and support staff to stay in health care, particularly in rural and underserved communities. **Preserving and strengthening avenues for loan repayment such as PSLF could give family physicians who want to practice in rural areas greater financial freedom to start businesses, employ others, and provide invaluable health care and economic activity in their communities** .

The *Student Success and Taxpayer Savings Plan* also includes a few other provisions that may further undermine the recruitment and retention of physicians into primary care. This includes determining the level of federal student aid one can receive based on a "median cost of college" (Section 30002) which does not take into account the need for many students to use federal student loans to pay for their living expenses. Given the increased cost of living in certain areas, capping loan amounts based on a median cost of tuition will only force students to make education choices based on financial viability, not on where and in what type of specialty they would like to practice.

House Committee on Agriculture:

The AAFP supports easy, widespread access to affordable and nutritious foods, particularly among populations vulnerable to food insecurity. The AAFP has consistently advocated to protect the Supplemental Nutrition Assistance Program (SNAP) and other nutrition programs as they provide a lifeline for millions of Americans struggling with food insecurity. Family physicians play an important role in counseling patients on nutrition and healthy behaviors across the lifespan. We are also uniquely positioned to identify individuals in need of support and connect them to valuable community resources like SNAP.

Prior to the Agriculture Committee markup, the AAFP joined 167 other organizations in sending a letter expressing support for SNAP and school meal programs. In addition to providing food assistance to the most vulnerable Americans, SNAP and other United States Department of Agriculture (USDA) nutrition programs provide a reliable market and steady revenue for retailers, food manufacturers, distributors, and farmers. In 2023, 260,000 American retail businesses directly received $124.3 billion in sales from people shopping with SNAP.[xiv]

The AAFP is concerned by the inclusion of Section 10001, which prevents future revaluations from increasing the cost of the Thrifty Food Plan and therefore will not account for updates to dietary guidelines and recommendations. SNAP benefit amounts are updated based on the cost of the Thrifty Food Plan, which is a USDA food plan that estimates the cost of groceries needed to feed a family of four a healthy, budget-conscious diet. Prior to 2021, the Thrifty Food Plan had not been updated for roughly 50 years, resulting in SNAP benefits not keeping pace with the rising costs of groceries and eating according to current dietary guidelines. The 2021 update to the Thrifty Food Plan benefitted more than 40 million people and kept 2.9 million people out of poverty, including 1.3 million children.[xv,xvi] The 2018 Farm Bill required the Thrifty Food Plan to be updated every five years to ensure that SNAP benefits would properly meet beneficiaries' needs without requiring as large of an

update as 2021. In order to ensure low-income American children and families can afford a healthy, nutritious diet in years to come, we strongly encourage reconsideration of this provision.

Thank you for the opportunity to provide this feedback. We look forward to working with you and your colleagues in Congress to ensure that the final reconciliation package includes provisions that both ensure financial sustainability of important federal programs, while also protecting and strengthening our nation's primary care system for all patients. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,

Steve Furr, MD, FAAFP
American Academy of Family Physicians, Board Chair

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