AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

July 31, 2025

The Honorable Bill Cassidy
Chairman, Committee on Health,
Education, Labor and Pensions
United States Senate
428 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Bernie Sanders
Ranking Member, Committee on Health,
Education, Labor and Pensions
United States Senate
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Cassidy and Ranking Member Sanders:

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 to applaud you for holding this hearing titled "Making Health Care Affordable: Solutions to Lower Costs and Empower Patients."

The cost of health care is one of the most salient issues for family physicians and their patients today. A May 2025 poll found that health care costs is a top concern for Americans, with six out of ten adults saying they are "very" or "somewhat worried" about being able to afford these potential expenses.[i] Roughly one-third of adults say they have postponed or skipped getting necessary health care within the past twelve months due to the cost, and more than one in five adults have not filled a prescription because of the cost. Even having health care coverage does not exempt someone from these concerns. Nearly four in ten adults under 65 worry about paying their premiums, and many of those with employer-sponsored or Marketplace coverage rate their insurance as "fair" or "poor" when it comes to affordability.

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

As you examine ways to lower health care costs and empower patients, the AAFP offers the following policy recommendations.

- **Increase our national investment in primary care and require tracking of primary care spending across payers;**
- **Address misaligned incentives that have accelerated health care consolidation, decreased competition, and raised costs for patients, including site of service payment differentials and non-compete agreements;**

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- **Strengthen price transparency requirements across the system so that both patients and physicians can make informed decisions and recommendations;**
- **Ensure that patients can continue to access up-to-date, science-informed preventive care without cost-sharing requirements;**
- **Extend expiring advanced premium tax credits (APTCs) for individuals enrolled in Marketplace plans; and**
- **Provide robust and permanent funding for community health centers.**

Increased National Investment in Primary Care

Access to longitudinal, coordinated, comprehensive primary care has been shown to increase utilization of preventive care, improve outcomes for patients with chronic conditions, and reduce costly emergency visits, hospitalizations, and unnecessary specialty outpatient visits. Yet the United States has continuously underinvested in primary care. In 2022, primary care spending dropped to less than five cents of every dollar, with Medicare spending the lowest at 3.4%.[ii]

The impact of this long-term underinvestment is evidenced in our nation's health. When we look at health outcomes across the world, we're not doing well by almost any measure. Compared to other high-income, peer nations, the U.S. has higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.[iii] A common theme across countries with better health outcomes and lower health care costs is that they invest more in their primary care system with estimates placing primary care spending between 12 and 17% of total health care spending for these high-performing nations.[iv]

Our nation cannot afford to keep spending less than five cents of every dollar on primary care. Improving health outcomes and preventing a further explosion of chronic illness requires us to reallocate our existing resources away from expensive sick care and toward prevention, ensuring that patients are incentivized and can afford to seek appropriate care earlier on. As a starting point, the Academy has long advocated for all payers to be required to track and publicly disclose the amount they spend on primary care services. Specifically, **we're calling for consideration of legislation that would require commercial payers and federal health programs 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.[v] Meanwhile, Arkansas just this year enacted legislation 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.[vi] The Academy strongly encourages federal policymakers to consider such steps that would right-size our nation's primary care investments.

Misaligned Incentives and Anti-Competitive Practices

The rampant acceleration of the health care system – particularly acquisition of primary care practices by health systems, insurers, and corporate entities – has been a principal concern for the Academy in recent years. As was noted in the letter's introduction, family physicians are a trusted first contact for health concerns, allowing them to serve as the focal point of care for patients and provide referrals to other health care services and sites when necessary. Their significant influence and trust from patients has made primary care clinicians an appealing acquisition target for hospitals, health systems, and other corporate entities.

More than half of primary care practices are affiliated with a hospital (either by common ownership or joint management) compared to 38 percent in 2016. With fewer opportunities to join an independent practice, nearly three-quarters of all primary care physicians are now employed by hospitals or corporations (53 percent by hospitals and 20 percent by corporate entities). Hospitals are often motivated to acquire or control primary care practices to maximize the financial success of their organizations by securing referrals to high-margin services or facilities. Private payers and other corporate entities leverage them to manage care across settings, or to direct patients to other services they own.

Consolidation or private investment in primary care is not inherently bad. There is a tremendous amount of innovation taking place inside primary care, allowing primary care physicians to expand their capabilities, provide high-quality care to their patients and create a more rewarding practice environment. There are a number of private equity-backed firms noted for making investments and providing resources that enable primary care practices to successfully participate in the rapidly expanding value-based payment landscape. These firms offer primary care practices the ability to not only survive but thrive in many instances. What distinguishes many of these organizations is that their revenue model is built primarily around expanding and investing in primary care to support value-based payment success.

The Academy has previously detailed the principal factors fueling the consolidation of primary care practices with health systems, plans, and other corporate entities, including financial instability, staffing challenges, administrative burden, and the need for more resources and capital. Physicians are often forced to choose between the stability offered by health systems, payers, or other physician employers, and the autonomy and community focus of independent practice. Increasingly, family physicians report that independent practice is simply unsustainable.

There may be circumstances in which market integration is beneficial. However, the research on the impact of these trends and consolidation more broadly has become increasingly clear. **Evidence has shown integration leads to higher prices and costs, including insurance premiums, without improving quality of care or patient outcomes**.[vii] One study found that hospital-owned practices incurred higher per-patient expenditures for commercially insured individuals when compared to physician-owned practices.[viii] To address the factors fueling consolidation of primary care practices and realign our health care system to one that prioritizes patients, we urge the Committee and your colleagues in Congress to:

- **Address site-of-service payment differentials, which play a significant role in inflated costs for patients**. Currently, hospitals are directly rewarded financially for acquiring physician practices and other lower cost outpatient care settings. Medicare

and other payers allow hospitals to charge a facility fee for providing outpatient services that can be safely performed in the ambulatory setting. However, there is little evidence that these additional payments are reinvested in the acquired physician practice, many of which are primary care practices. Thus, the hospital increases its revenue by acquiring physician practices and beneficiaries are forced to pay higher coinsurance.[ix] Patients should not be subject to higher costs simply because a hospital owns the outpatient office they visited, and physician practices should not be effectively penalized financially for remaining independent. The AAFP has long advocated for the advancement of policies to create payment parity across care settings for certain services, with careful consideration as to not unintentionally accelerate consolidation.

- **Strengthen price and billing transparency so that patients and physicians can make more informed decisions.** Family physicians work closely with their patients to make shared decisions about appropriate, personalized care. Understanding the costs of services across care settings is imperative to helping family physicians make informed referrals. Improving transparency also allows policymakers, researchers, and other stakeholders to better understand the environment in order to advance meaningful solutions. For these reasons, the AAFP has continued to support efforts to advance price transparency within health care. We encourage federal lawmakers to codify and build upon existing price transparency regulations to require all hospitals and health plans to disclose their negotiated rates in dollars and cents. The Academy also urges Congress to advance legislation that would increase billing transparency by requiring HOPDs to use NPIs and claim billing forms that are distinct from the hospital's.

- **Prohibit the use of overly-restrictive non-compete agreements as part of physician employment contracts.** Despite physician shortages, health care employers enforce non-compete agreements that intentionally restrict physician mobility and workforce participation. A survey of some AAFP members found that:
    - 75 percent report that non-compete clauses have impacted their practice, career, or personal life;
    - 46 percent said non-competes limit their job options or mobility; and
    - 32 percent said that non-compete clauses make them feel trapped in their current job.

  Many family physicians have reported that geographic restrictions in noncompete clauses combined with the highly consolidated nature of most markets force them to choose to uproot their family, commute more than two hours away, or stop practicing entirely should they resign from their position. Non-compete clauses not only reduce competition – they also harm patients by reducing or in some cases, eliminating access to care. The AAFP believes restrictive covenants in physician employment contracts disrupt the patient-physician relationship. No physician employment contract should include restrictions which interfere with the continuity of the patient-physician relationship or patient access to care. Congress should pass legislation, such as the *Workforce Mobility Act* (S. 2031), that prohibits anticompetitive non-compete clauses in physician employment contracts.

Coverage Changes and Potential Impacts on Patient Costs

The Advisory Committee on Immunization Practices (ACIP) is an independent body that develops recommendations on how to use vaccines to control the spread of infectious disease in the United States. Once adopted by the Director of the Centers for Disease Control and Prevention (CDC), these recommendations become official CDC policy. Current statute requires that all payers, including commercial plans, cover all ACIP-recommended vaccines. Any changes to the body's existing recommendations threaten to sow confusion among patients about what vaccines they can or cannot access, and confusion amongst plans about what they do or do not have to cover. We have seen this play out recently with the recent changes to COVID-19 vaccine recommendations.

In May, the CDC removed the COVID-19 vaccine from the recommended immunization schedules for healthy children and pregnant women. The CDC then updated its existing materials and resources to reflect guidance that the COVID-19 vaccine may be administered if desired by parents and informed by shared decision making with their clinician. However, coverage requirements for shared medical decision-making recommendations is unclear across payers. Plans interpret coverage mandates for vaccines with clinical decision-making recommendations differently – some cover these vaccines while others do not or require patient cost-sharing.[x] This disjointed interpretation of coverage requirements creates confusion for patients and physicians and limits access to preventive care.

Separately, the United States Preventive Services Task Force (USPSTF) is an independent body comprised of volunteer experts in prevention and evidence-based medicine, working to improve the health of Americans nationwide. Many current and former USPSTF members have been family physicians. The body's recommendations are based on a rigorous review of existing peer-reviewed evidence and are intended to help primary care clinicians and patients decide together whether a preventive service is right for a patient's needs. Payers, including commercial plans, are required to cover Grade A or B recommendations from the USPSTF without cost-sharing requirements for patients – a requirement that was recently upheld by the Supreme Court in its ruling on *Braidwood Management, Inc. et al. v. Xavier Becerra et al.*

USPSTF recommendations span the spectrum of preventive care. Examples of current Grade A recommendations from the task force include screening for colorectal cancer in all adults aged 50 to 75 years; screening for hepatitis B infection in pregnant women at their first prenatal visit; and screening for hypertension in all adults over the age of 18.

This administration has positioned prevention and primary care a cornerstone of its health care agenda. The AAFP has strongly applauded this positioning, but we believe protecting the independence and scientific integrity of bodies like ACIP and USPSTF is necessary to truly support this platform. First-dollar coverage and minimal cost-sharing has proven to be impactful in improving patient uptake of high-value, low-cost preventive and primary care.[xi] While these types of policies require upfront spending by payers, they are largely offset by prevented illnesses, well-managed chronic conditions, and reduced utilization of more expensive care later down the line. This saves costs for both the health care system and patients in the long-run.

As the administration considers additional changes to the structure and/or recommendations put forward by ACIP, USPSTF, and other bodies with similar duties, **we urge the Committee**

and your colleagues in Congress to examine their potential impacts on health care costs and access for patients. If necessary, we implore you to utilize oversight authorities to ensure that any actions being undertaken do not impede the delivery of low- or no-cost, science-informed preventive care.

Affordable Care Act (ACA) Marketplace Plans

The upcoming expiration of the Advanced Premium Tax Credits (APTC) for ACA Marketplace plans will significantly increase health care costs for millions of Americans, unless Congress acts. If the APTCs are allowed to lapse after December 31, premiums will increase dramatically for many individuals who cannot otherwise afford coverage and many will discontinue their coverage, leading to a patient pool of sicker enrollees.[xii] If healthier enrollees leave the marketplace, the expected costs per enrollee will increase and premiums may rise to offset those costs.[xiii] Lapses in coverage are also likely to lead patients to utilize more expensive care downstream, resulting in additional costs to the federal government and our health care system.[xiv]

Relatedly, individuals who qualify for APTCs, are enrolled in silver Marketplace plans, and who meet certain income requirements are also eligible for cost-sharing reductions (CSRs). This type of assistance helps reduce an individual or family's expenses related to cost-sharing requirements, such as deductibles, copayments, or coinsurance.

As noted above, the Academy recognizes that cost-sharing requirements and premiums impact patients' access to preventive and primary care. Even modest cost-sharing amounts—as little as $1 to $5—have been shown to reduce utilization of care, including essential and preventive services.[xv] Evidence indicates that such policies can lead to unintended and costly consequences, such as increased emergency department use and worsening health outcomes. For instance, studies have linked increased cost sharing with higher rates of uncontrolled chronic conditions, such as hypertension and hypercholesterolemia, as well as reduced treatment adherence among pediatric patients with asthma.[xvi] Cost-sharing also imposes a significant financial burden on families, often forcing individuals to forgo basic needs or incur debt in order to afford necessary medical care.

Furthermore, research consistently shows that state savings achieved through the implementation of premiums and cost-sharing mechanisms are minimal. Any short-term fiscal gains are often offset by higher rates of program disenrollment, increased utilization of costlier services like emergency care, higher expenditures for caring for the uninsured, and added administrative complexity. These policies also place additional strain on safety net providers, including community health centers and hospitals, which are critical to maintaining access to care for underserved populations.[xvii]

As the Committee explores opportunities to lower health care costs for patients, **we strongly urge you to work in collaboration with your Senate Finance Committee colleagues to permanently extend APTCs and ensure that CSRs remain available to patients**. The AAFP supports the *Health Care Affordability Act* (S. 46), which would make APTCs permanent, and we strongly urge its enactment.

Robust Funding for Community Health Centers

Nationally, community health centers (CHCs) provide care for more than 31 million patients, with nearly half of all CHC physicians being family physicians.[xviii] CHCs are often the *only* accessible source of primary care in many communities, especially for low-income and rural residents. Ninety percent of CHC patients have incomes that fall below the federal poverty level and 31 percent of all CHC patients live in rural areas.[xix]

CHCs are also excellent stewards of money, with research showing that CHC patients have lower overall medical expenditures than non-CHC patients.[xx] CHC patients have fewer emergency department visits or hospital stays[xxi], and CHCs consistently meet or exceed benchmarks for controlling chronic diseases such as hypertension and diabetes.[xxii] Unfortunately, CHCs are reliant upon a patchwork of inconsistent funding to keep their doors open. They operate on increasingly thin margins and any cuts or instability threaten their ability to deliver the care their community needs. If a CHC closes its doors, patients are likely to feel significant impacts on their health care costs as a result. Without the ability to easily access primary and preventive care, patients may forgo or delay services until their condition is exacerbated, forcing them to utilize more expensive care settings and services.

Current federal funding for CHCs is set to expire on September 30. **To preserve patient access to these affordable, cost-effective care settings, the Academy urges the Committee to advance stable, robust funding for CHCs.**

Thank you for holding this timely and important hearing on one of the nation's most pressing issues. The AAFP shares the Committee's commitment to lowering health care costs and empowering patients, and we look forward to working with you to advance thoughtful reforms that will meaningfully improve the affordability of and access to health care. Should you have any questions, please contact Megan Mortimer, Manager of Legislative Affairs, at mmortimer@aafp.org.

Sincerely,

Steve Furr, M.D., FAAFP

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

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[i] Sparks, G., Lopes, L., Montero, A., Presiado, M., & Hamel, L. (2025, July 11). *Americans' challenges with health care costs*. Kaiser Family Foundation. Retrieved from https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/ KFF

[ii] 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

[iii] Turner A, Miller G, and E Lowry. "High U.S. Health Care Spending: Where Is It All Going?," The Commonwealth Fund. Published October 4, 2023. Available online at:

https://www.commonwealthfund.org/publications/issuebriefs/2023/oct/highus-health-care-spending-where-isit-all-going.

[iv] Baillieu R, Kidd M, Phillips R, et al. The Primary Care Spend Model: a systems approach to measuring investment in primary care BMJ Global Health 2019;4:e001601.

[v] 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

[vi] 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.

[vii] Schwartz K et al. "Issue Brief: What We Know About Provider Consolidation," Kaiser Family Foundation. September 20, 2022. https://www.kff.org/health-costs/issue-brief/what-we-know-about-providerconsolidation/.

[viii] Robinson JC, Miller K. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. JAMA. 2014 Oct 22-29;312(16):1663-9. doi: 10.1001/jama.2014.14072. PMID: 25335148.

[ix] Pst, B et al. Hospital-physician integration and Medicare's site-based outpatient payments. Available at: https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13613

[x] Hughes IV, R. (2019, May 7). *Vague vaccine recommendations may be leading to lack of provider clarity, confusion over coverage*. Health Affairs Forefront. Retrieved from https://www.healthaffairs.org/do/10.1377/forefront.20190506.172246.

[xi] Ma, Q. Sywestrzak, G. Oza, M. Garneau, L. DeVries, A. "Evaluation of Value-Based Insurance Design for Primary Care." (2019). The American Journal of Managed Care. 25: 5. https://www.ajmc.com/view/evaluation-ofvaluebasedinsurance-design-for-primary-care.

[xii] Kaiser Family Foundation. *Inflation Reduction Act Health Insurance Subsidies: What Is Their Impact and What Would Happen If They Expire?* 26 July 2024, Kaiser Family Foundation, www.kff.org/affordable-care-act/issue-brief/inflation-reduction-act-health-insurance-subsidies-what-is-their-impact-and-what-would-happen-if-they-expire/.

[xiii] Peterson-KFF Health System Tracker. (2022, July 18). *An early look at what is driving health costs in 2023 ACA markets*. Retrieved from Peterson-KFF Health System Tracker website Health System Tracker.

[xiv] McGough, M., Ortaliza, J., Cotter, L., & Cox, C. (2025, June 3). *Early indications of the impact of the enhanced premium tax credit expiration on 2026 Marketplace premiums*. Peterson-KFF Health System Tracker. Retrieved from Health System Tracker website.

[xv] Artiga, S., Ubri, P., & Zur, J. (2017) The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. The Henry Kaiser Foundation.

[xvi] Ibid.

[xvii] Ibid.

[xviii] Crowley, C. (2018, August 1). *Health Centers and the Recruitment of Family Physicians*. *American Family Physician*. Retrieved from https://www.aafp.org/pubs/afp/issues/2018/0801/p146.html.

[xix] Pillai, A., Corallo, B., & Tolbert, J. (2025, January 6). *Community Health Center patients, financing, and services*. Kaiser Family Foundation. Retrieved from Kaiser Family Foundation website KFF.

[xx] National Association of Community Health Centers. (2023). Economic impact of community health centers in the United States: 2023 report. National Association of Community Health Centers. Retrieved February 8, 2025, from https://www.nachc.org/wp-content/uploads/2023/06/Economic-Impact-of-Community-HealthCenters-US_2023_final.pdf.

[xxi] Bureau of Primary Health Care. (2025, April 2). *Impact of the Health Center Program*. U.S. Department of Health and Human Services, Health Resources and Services Administration. Retrieved July 29, 2025, from https://bphc.hrsa.gov/about-health-center-program/impact-health-center-program.

[xxii] Horstman, C., & Commonwealth Fund. (2024, August 8). *Community health centers' progress and challenges in meeting patients' essential primary care needs: Findings from the Commonwealth Fund 2024 National Survey of Federally Qualified Health Centers*. https://doi.org/10.26099/wmta-a282.