AMERICAN ACADEMY of FAMILY PHYSICIANS

February 18, 2026

The Honorable Rick Scott
Chairman
Senate Special Committee on Aging
United States Senate
Washington, DC 20510

The Honorable Kirsten Gillibrand
Ranking Member
Senate Special Committee on Aging
United States Senate
Washington, DC 20510

Dear Chairman Scott and Ranking Member Gillibrand:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,300 family physicians and medical students, I am writing this letter in response to the Committee's recent hearing, *The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine*. We applaud the Committee for centering the voice of family physicians in this important dialogue by having two testify as witnesses on the panel, and we would like to lift up their comments in addition to providing further policy recommendations.

Family physicians pursue a career in medicine because they want to care for their communities. However, the amount of time they're able to spend seeing patients is increasingly outweighed by the hours they spend between visits and outside of clinic navigating regulatory and administrative requirements. Primary care physicians in particular are overwhelmed with tasks such as appropriately documenting visits in an electronic health record (EHR); complying with billing and coding requirements; responding to patient portal messages; navigating prior authorization requests from nearly a dozen different payers; reporting on quality and performance measures; reviewing test results and coordinating referrals to specialists or other clinicians.

A 2024 study examined time constraints for primary care physicians and found that the structure of their work schedule did not match the work expected of them, a mismatch which creates "a constant experience of time scarcity."[i] Respondents described "having to make tradeoffs between maintaining high-quality patient care and having their work overflow into their personal lives." When physicians are having to spend as much time – if not more – on administrative tasks as they spend on patient care, there is a problem with our system.

These systemic issues are further evidenced by the shortage of primary care physicians nationwide. According to the Health Resources and Services Administration, there will be a shortage of 70,610 primary care physicians by 2038, particularly in non-urban areas.[ii] The administrative burdens described above play a central role in this shortage, leading to an increasingly consolidated health care market. When combined with other factors like inadequate payment and high student loan debt, more family physicians are opting to work for hospitals and health insurers, which can restrict clinical autonomy. Physicians that have

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owned an independent practice frequently see no other choice between selling to a corporate entity or closing their doors. Further, many family physicians are opting to leave the workforce altogether and retire early.

If Congress wants to ensure our nation has the strong, well-distributed primary care workforce it needs, lawmakers must take immediate steps to support physicians and their ability to practice medicine. We applaud the Committee for highlighting the legacy of Dr. Lorna Breen in this hearing and spotlighting the need to pass meaningful policies to improve physician wellbeing. The AAFP advocated alongside the rest of the physician community in support of the *Dr. Lorna Breen Health Care Provider Protection Reauthorization Act* (H.R. 929 / S. 266), which reauthorizes the only federal program to prevent suicide, occupational burnout, and support for mental health conditions for health care professionals. We appreciate that Congress passed this critical legislation earlier this month in the *Consolidated Appropriations Act of 2026*. Additional policies for Congress to consider include:

- **Prohibiting the use of noncompete agreements in physician employment contracts** to protect market competition and physician wellbeing;
- **Expanding patient access to services provided by direct primary care physicians**, including for Medicare and Medicaid beneficiaries;
- **Alleviating burdensome requirements placed upon physicians by the Merit-based Incentive Payment System (MIPS),** which has failed to meaningfully move the needle on quality improvement and the shift to value-based payment;
- **Streamlining and standardizing quality measurement requirements across federal programs and payers**;
- **Reining in the use of utilization management protocols, including prior authorization, by health insurers** that contribute to administrative burden and delay patient care;
- **Addressing the significant burden of student loan debt** that dissuades many prospective physicians from pursuing family medicine and other primary care specialties; and
- **Tax reforms that invest in independent and small family medicine practices**, ensuring community-based access in the communities with the greatest need.

**Health Care Consolidation**

As discussed above and extensively in the hearing, our policy and regulatory framework imposes significant burdens on physicians, accelerating both market consolidation and reports of moral injury for physicians. 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.

In March 2024, the AAFP conducted a survey of members requesting information about their experiences with consolidation. The survey asked about the impact on other aspects of practice, including staffing, management, clinical autonomy, access to resources such as

health IT infrastructure, and administrative requirements. Overall, most physicians felt some positive impact on their ability to access resources such as health information technology, billing and patient portals, and telehealth tools. However, these benefits come at a high cost, including diminished clinical autonomy, reduced job satisfaction, and negative impacts to the patient experience. Survey responses included:

- Examples of how post-transaction administrative policies prevented them from offering necessary patient care. For example, comments described scheduling mandates that prevent physicians from providing same-day visits to acute patients and result in month-long (or more) wait times for appointments.
- Several physicians felt that while their own personal productivity metrics increased, overall access and availability to patients decreased.
- Physicians also cited frustration with restrictions on their ability to make referrals to the specialist or entity that they believed would best meet the needs of the patient.
- Other commenters noted that acquisition by a health system resulted in centralized management decisions made without local primary care physician or practice input, resulting in increased administrative burdens, reduced quality, or in some cases, both.

Our survey results align with other external reports indicating physicians experience a drop in clinical autonomy and feel patient care declines post-acquisition. A 2023 survey conducted by NORC found that more than half of employed physicians experienced reductions in the quality of patient care as a result of a practice acquisition.[iii] Nearly half of survey respondents attributed the changes to reduced clinical autonomy and requirements that prioritize financial performance.

As the physician landscape shifts more toward employment, noncompete agreements in health care can also disrupt patient access to physicians, deter advocacy for patient safety, limit physicians' ability to choose their employer, stifle competition, and contribute to an increasingly concentrated healthcare market.[iv] Despite projected physician shortages, health care employers enforce noncompete agreements that intentionally restrict physician mobility and workforce participation. A survey of some AAFP members found that:

- 75 percent report that noncompete clauses have impacted their practice, career, or personal life;
- 46 percent said noncompete clauses limit their job options or mobility; and
- 32 percent said that noncompete 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. Noncompete 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. **The AAFP urges Congress to pass legislation that prohibits anticompetitive noncompete clauses in physician employment contracts.**

**Direct Primary Care**

In an increasingly consolidated market dominated by onerous administrative requirements, many family physicians have found success and joy by pivoting to direct primary care (DPC). DPC is an innovative practice and payment model in which patients contract directly with their physician or medical practice for primary care services. Under this model, patients pay a flat monthly or annual fee – typically through a written agreement – in exchange for access to a defined set of primary care and related administrative services.

A 2024 AAFP survey among DPC physicians found that 94 percent indicated they were satisfied with their overall practice, compared to 57 percent of those not in a DPC practice. Additionally, physicians working in a DPC practice were more likely to indicate no level of burnout than those not working in a DPC practice (49 percent versus 14 percent, respectively).

DPC practices are structured around the patient-physician relationship and are designed to replace the traditional reliance on third-party insurance reimbursement for primary care services. In many cases, the DPC model allows physicians to offer enhanced access and more personalized care than is typically possible under a traditional fee-for-service system. These services may include same-day or real-time communication with a personal physician through advanced technology, extended appointment times, coordinated care management, and, in some cases, home-based medical visits. By emphasizing a direct financial relationship and comprehensive primary care access, the DPC model can provide a more patient-centered, coordinated, and efficient care delivery.

An increasing number of family physicians are choosing to practice in the DPC model and patient demand for DPC practices is growing. Additionally, employers and labor unions are driving growth in the model. We appreciate that Congress took steps last year to address one of the biggest barriers to DPC growth by allowing patients with health savings accounts to use those funds to pay for DPC arrangements. However, we encourage the Committee to explore additional policies to expand access to DPC for more patients, while also preserving access to other services family physicians deliver in the community. These include:

- **Passing the Medicaid Primary Care Improvement Act (S. 3298 / H.R. 1162),** which would require the Centers for Medicare and Medicaid Services to issue guidance to states interested in paying for DPC arrangements for Medicaid beneficiaries, and
- **Amending the requirement that DPC physicians opt-out of the Medicare program entirely if they are seeing Medicare beneficiaries in their practice**, as this can leave access voids in communities where DPC family physicians also provide inpatient, skilled nursing facility, or other Medicare-covered services.

**Reforming the Quality Payment Program**

The Quality Payment Program (QPP), implemented as part of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015, has been a significant source of burden for practices, particularly small practices. MACRA was intended to serve as an on-ramp to value-based payment by giving physicians experience with being measured on their performance and quality. While the AAFP supported the intent of MACRA, it has not led to quality improvement

and has also not achieved its original goal to streamline Medicare's existing quality programs and simplify reporting requirements.

There is broad consensus that the QPP has increased administrative burden and complexity as its requirements change year after year. While all programs should be flexible and make improvements, the QPP has primarily changed the requirements without making improvements or reducing burden. For example, one qualitative study found that the average per-physician cost to participate in QPP's Merit-based Incentive Payment System (MIPS) was $12,811, and physicians and staff together spent 201.7 hours annually per physician on MIPS activities.[v] The costs were higher for small and medium primary care practices ($18,466 and $13,631, respectively). Importantly, this study only analyzed the time and financial costs for participating in MIPS. Previous studies have found that practices spend an average of 785.2 hours and $40,069 per physician per year on quality reporting requirements.

Since there is a dearth of alternative payment models (APMs) and the MIPS requirements do not closely align with any existing APM, MIPS is primarily a reporting program with arbitrary requirements that do not meaningfully contribute to improved patient outcomes. The significant burden associated with these programs forces practices to direct their time and resources on complying with reporting requirements rather than building the skills and infrastructure that would allow them to succeed in value-based payment.

In addition, MIPS must be budget neutral – meaning the total value of annual positive adjustments are equal to the total value of negative adjustments. This has led to many practices who met their performance requirements getting a negative adjustment, and for those that receive a positive one, it is very modest. Therefore, **MIPS adds administrative burden without leading to a meaningful increase in payment.** The program particularly disadvantages small and rural practices, who consistently have lower than average MIPS scores. As the performance threshold increases, it will become more difficult for small and rural practices to avoid a negative payment adjustment, which can be up to 9 percent, to their Medicare Part B services.

The inflexibility of the MACRA statute has created significant barriers to implementation of reforms aimed at moving physicians from payment on volume to value. Health care markets, value-based care models, and other factors can change quickly and additional flexibility is needed to ensure programs keep pace with these changes without awaiting congressional intervention.

For these reasons, we have strongly encouraged Congress to consider a new program in conjunction with efforts to address budget neutrality constraints, in lieu of merely reforming MIPS. However, absent a viable alternative, we continue to urge Congress to pass MIPS and QPP reforms to alleviate the administrative costs of reporting to the program, ensure it drives meaningful quality improvement, and assist physician practices in building the necessary competencies to transition into APMs.

**Quality and Performance Measurement**

Quality and performance measurement has proliferated in the past 25 years, leading to significant burdens on physicians. This is especially true for primary care physicians, who 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 health care system, our current approach fails to measure what matters to patients and clinicians or drive meaningful quality improvement. The eagerness to measure has burdened family physicians with the onerous task of capturing structured electronic data to feed an excessive number of measures, taken time away from patients, and led to loss of joy in practice. Quality measurement has become a high-burden, high-cost administrative exercise, focused on financial concerns with little benefit to patient care, population health, and cost reduction.

**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. Right now, it is a logistical nightmare to try and meet all the different quality measures across plans. On average, family medicine practices contract with about ten different payers. Keeping track of and successfully reporting different measures for each of these payers creates confusion and additional reporting burden and can actually undermine meaningful practice improvements. Aligning measures across payers will also help to identify disparities in care quality (and, in some cases, utilization and access) across different payers, states, and lines of service. Greater alignment will also drive improvements in data collection automation, which will reduce reporting burden on family physicians and other clinicians.

Importantly, measures must reflect things which a physician can control instead of penalizing them for the things they can't. For example, there is a code available for physicians to bill to indicate that they offered the patient a vaccine but they refused to take it. However, the measures only reflect that the patient chose not to get a recommended vaccine - the fact that the physician offered it has no impact. Performance measurement should focus on improving outcomes that matter most to patients and have the greatest impact on improving the health of the population, creating a better experience of care, and lowering the per capita cost of care, while also returning joy to the practice of caregiving for physicians and other clinicians.

**Utilization Management by Health Insurers**

Interactions with health plans consistently rank high on the list of sources for family physician burden, leading to alarming rates of moral injury and burnout. Utilization management tactics implemented by plans are one of the primary causes of this administrative burden. Specifically, many plans require authorization (prior authorization, or PA) before they cover a certain service or item for a beneficiary. Prior authorization is described by payers as a cost-containment mechanism, but many patients and physicians alike report that it largely serves to delay and deny appropriate, medically necessary care.

One study from the Department of Health and Human Services Office of the Inspector General (HHS OIG) found that Medicare Advantage organizations (MAOs) overturned 75

percent of their own prior authorization and payment denials upon appeal.[vi] Another study found that, of denied prior authorization requests, 13 percent met Medicare coverage rules and 18 percent of payment denials met Medicare coverage and billing rules.[vii] A July 2023 OIG report found that Medicaid Managed Care Organizations (MCOs) denied one out of every eight (12.5 percent) prior authorization requests in 2019 – a rate even higher than in Medicare Advantage (5.7 percent). Approximately 2.7 million Medicaid beneficiaries were enrolled in MCOs with prior authorization denial rates greater than 25 percent.[viii]

We appreciate recent commitments by insurers to streamline, simplify, and reduce PA, but these efforts are voluntary and subject to no enforcement by anyone other than the plans themselves.[ix] We believe further action is necessary to meaningfully reform PA across all plans.

In 2024, CMS issued final rules streamlining prior authorization processes across federal payers, including Medicaid and MA. However, Congressional action is still needed to enshrine these much-needed reforms into statute. In May, a bipartisan, bicameral group of lawmakers reintroduced the *Improving Seniors' Timely Access to Care Act* (H.R. 3514 / S. 1816), which would codify these changes to standardize prior authorization processes within MA plans. Specifically, it would require a standard electronic prior authorization process for MA prior authorization requirements and expand beneficiary protections to improve enrollee experiences and outcomes. It would also improve transparency across MA plans and address inappropriate coverage denials.

A previous version of this legislation passed the House in the 117th Congress but stalled in the Senate due to a high projected score from the Congressional Budget Office. The bill's sponsors crafted thoughtful changes to the bill in the 118th Congress to ensure the score will be low, if not zero. To meaningfully protect patients and ease burden on the physicians who care for them, **the AAFP urges Congress swiftly enact the *Improving Seniors' Timely Access to Care Act.*** We also strongly urge that these codified requirements be expanded to other health plans, including Medicaid.

Currently, minimal data collection and oversight of prior authorization denials and appeals is being done by state Medicaid agencies. This is largely because federal rules do not require states to collect and monitor data needed to assess access to care, monitor the clinical appropriateness of denials, or require that states publicly report information on plan denials and appeals outcomes. In March 2024, the Medicaid and CHIP Payment and Access Commission (MACPAC) convened to discuss denials and appeals within Medicaid managed care. They identified some of the challenges and barriers impeding the ability for individuals to pursue denials and appeals in Medicaid; for example, MCOs are required to mail denial notices, but beneficiaries do not always receive these denial notices in time to pursue an appeal within the allotted time frames.

In light of these findings, MACPAC put forward seven recommendations to improve the appeals and denials process for individuals enrolled in Medicaid. These suggestions included requiring states to establish an independent, external medical review process that can be accessed at the beneficiary's choice and providing beneficiaries with the option to receive electronic denial notices in addition to mailed notices. It also recommended requiring states

to collect and report data on denials, use of continuation of benefits, and appeals outcomes, and use the data to improve delivery of care to patients. **The AAFP strongly urges Congress to act upon these MACPAC recommendations to improve the denials and appeals processes for Medicaid beneficiaries and ensure patients have timely access to medically necessary care as recommended by their physician.**

In addition to supporting legislative efforts that aim to streamline the prior authorization process, the AAFP also supports the *Reducing Medically Unnecessary Delays in Care Act*, (H.R. 2433), which would ensure that prior authorization decisions across health plans are made by licensed, board-certified physicians who use scientific and evidence-based research to make their decisions. It would also require plans to create policies based on medical necessity and written clinical criteria. Through these reforms, clinicians and patients can be assured that prior authorization decisions are made by those with the necessary clinical training and subject matter expertise. This will reduce the incidence of illegitimate prior authorization denials and the need for numerous appeals, therefore reducing the administrative burden for physicians and ensuring that patients are receiving the care they need as soon as possible. We encourage the Committees to consider this proposal as they work on additional opportunities to reign in administrative burden for physicians.

**Medical School Debt and Loan Repayment**

Physicians are the professionals most likely to carry student loan debt. Eighty-one percent of those with Doctor of Medicine degrees have graduate school debt, and 80 percent owe debt from their undergraduate education.[x] The average student loan debt for four years of medical school, undergraduate studies, and other higher education is between $200,000 and $250,000.[xi] Unless we see medical schools nationwide lower current tuition rates, this number will only continue to rise. For first-year students in 2020-21, the average cost of attendance increased from the prior year for public medical schools by 10.3 percent, making it likely that medical students will have to carry even larger student loans to graduate.[xii]

The high burden of medical education debt contributes to worsening physician shortages and puts a career in medicine out of reach for many prospective physicians, further undermining progress toward achieving a robust national health care workforce. In addition, 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 average incomes compared to other specialties. In fact, when measuring debt as a ratio to income, primary care physicians have approximately double the debt burden as those entering surgical specialties.[xiii]

Therefore, the AAFP supports policies to decrease the cost of medical education for the learner, medical student debt accumulation, and the discrepancy in pay between primary care and other medical specialties. The AAFP also encourages innovation and the study of the effectiveness of existing and future systems of debt management, as well as alternatives, to determine which strategies are truly effective. Specifically, the AAFP recommends the following:

- **Exempting medical degrees from the $200,000 cap on loans for professional degrees**, especially since primary care physicians are more likely to come from low-income backgrounds;
- Requiring the Department of Education or Small Business Administration to **develop relationships with or contract with private lenders who agree to adhere to certain lending rules** and provide that "safe lender" list publicly;
- **Allowing medical residents to defer interest on their federal student loans while in residency**, as proposed by the *Resident Education Deferred Interest (REDI) Act* (H.R. 2028 / S. 942); and
- **Continued and additional support for loan repayment programs** that specifically assist primary care physicians during their training and early career.

Given the effect that student loan debt can have on the ability for physicians to start a practice, work in the communities of greatest need, or influencing specialty choice, lowering the burden for physicians and medical students is one essential step to improving our nation's health care system.

**Tax Reform to Support Independent Physicians**

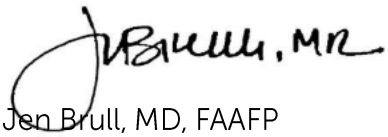
Family physicians have changed the way they practice significantly in recent years. In 2011, 37 percent of AAFP members surveyed reported that they are sole or partial owners of their practice. In 2024, that number fell to 21 percent.[xiv] In addition to addressing the aforementioned factors that contribute to physician burnout, maintaining or expanding existing small business tax credits (such as maximizing tax deductions for improvements to small businesses) can be crucial to maintaining the viability of independent ownership for family physicians.

Some provisions that were made permanent with the enactment of H.R. 1 – such as the deduction of pass-through income and expanded expensing – are important for independent physician practices. However, the pass-through deduction is capped for physicians and other "professional services." This cap should be eliminated.

Further, **lawmakers should consider other tax incentives that are targeted to encourage the growth of the primary care workforce**, especially for independent practices and in rural and underserved communities. Some of these ideas include: tax credits for independent primary care practices; Small Business Administration programs that provide zero to low interest loans for the establishment of a new independent physician practice; additional tax deductions for independent practice employers who provide student loan payments for their employee physicians; and the elimination of loan repayments from income tax, from which the savings could be used to invest in the formation of an independent practice.

Thank you for convening this important hearing. The AAFP looks forward to partnering with you to implement proposed reforms to better support physicians so that they can actually prioritize caring for patients over complying with paperwork. Should you have any additional questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,



Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

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