AMERICAN ACADEMY OF FAMILY PHYSICIANS

April 26, 2023

The Honorable Brett Guthrie
Chairman
Health Subcommittee, House Committee
on Energy & Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
Health Subcommittee, House Committee
on Energy & Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write to express our appreciation for the Subcommittee's continued interest in transparency and competition in the health care sector by holding today's legislative hearing titled "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care." The AAFP shares your commitment to advancing policies that promote transparency and competition, and we write to offer our policy recommendations from the family medicine perspective.

The AAFP strongly believes that all individuals have a right to access timely, high quality, and affordable essential health care services, including comprehensive primary care. Unfortunately, family physicians encounter patients who struggle to make ends meet every day, and the escalating costs of health care have led many patients to delay or forgo needed care. Rising health care costs for patients have been driven in part by increases in anticompetitive practices and consolidation, which inflate health care prices without improving quality.

Last month, the AAFP provided recommendations in advance of the Subcommittee's initial hearing on this topic. The Academy has long advocated to Congress in support of policies that will strengthen our nation's investment in primary care and improve patients' access to affordable health care. We have also supported efforts to improve the patient experience through increased transparency. Building upon our previous recommendations, we continue to urge Congress to address health care costs and consolidation by supporting payment methods that promote competition, improving administrative burden through transparency, and limiting the use of anti-competitive contracting practices that harm clinicians and patients.

Physician Payment Reform

In comments submitted to the Federal Trade Commission (FTC) this month, the AAFP highlighted the drastic increase in physician employment over the last several years, which has been propelled in part by practice and hospital consolidation. There have been at least 1,600 known hospital mergers in the United States between 1998-2017.[i] Meanwhile, a significant shift from physicians as owners of independent practice has been occurring over many years across all medical specialties. The most recent American Medical Association (AMA) Physician Practice Benchmark Survey (2020) reported that for the first time, less than half of physicians (49.1%) delivered care in independent practice (meaning organizations wholly owned by physicians) and the proportion of physicians who have an

ownership stake in their practice is shrinking as well. Just 24% of AAFP members report that they are sole or partial owners in their practice setting. The proportion of family physicians who are employed continues to grow each year with 73% of all AAFP members and 91% of new physicians (1-7 years post-residency) working as employees in a wide range of organizations from small independent practices to Fortune 100 employers. This shift is dramatic considering that only 59% of AAFP members reported being employed in 2011.

Independently practicing physicians need an environment that allows them to thrive, but inadequate payment rates and the continuing consolidation of insurers and large health systems threatens their long-term viability. **Evidence indicates that consolidation increases health care prices and insurance premiums, as well as worsens equitable access to care for patients in rural and other medically underserved communities**.[ii,iii] Therefore, we appreciate the Committee's consideration of legislation that would require the Department of Health and Human Services (HHS) to consider, within the annual rulemaking process, the effect of regulatory changes to certain Medicare payment systems on provider and payer consolidation. **We urge Congress to go further, however, and take tangible action to reform the current Medicare payment structure that fails to appropriately pay physicians and spurs consolidation.**

The Academy continues to recommend that Congress promote payment methods that boost competition in the marketplace and create greater choice for patients. Despite evidence indicating that additional investments in primary care would improve population health and advance health equity, primary care has been historically underfunded in the U.S. Medicare and Medicaid have historically undervalued primary care. In the short-term, inadequate payment rates mean that primary care physicians lack the resources needed to provide comprehensive, continuous care for their patients and may be forced to accept fewer Medicare or Medicaid patients, close their practices, or sell to a health system or corporation. In the long-run, payment distortions between primary and specialty care will continue to drive more physicians to go into higher paid specialties, worsening the maldistribution of the physician workforce. A recent Medicare Payment Advisory Commission (MedPAC) analysis highlighted that the median compensation remains much lower for primary care physicians than for physicians in certain other specialties, such as radiology and surgical specialties – underscoring concerns about the mispricing of fee schedule services and its impact on the primary care pipeline.[iv]

Medicare's current physician payment system is undermining physicians' ability to provide high quality, comprehensive care – particularly in primary care. Statutory budget-neutrality requirements and the lack of annual payment updates to account for inflation will, without intervention from Congress, continue to hurt physician practices and undermine patient care. In October, the Academy submitted robust recommendations to Congress on ways to reform the Medicare Access and CHIP Reauthorization Act (MACRA) to address challenges affecting our members and their patients. Since then, both MedPAC and the Board of Trustees have raised concerns about rising costs for physician practices and impacts on patient care, with each body recommending that Congress provide payment updates for physicians. Specifically, the Board of Trustees warned that, without a sufficient update or change to the payment system, they "expect access to Medicare-participating physicians to become a significant issue in the long term."[v]

Congress should heed these warnings. **The AAFP strongly urges Congress to pass the Strengthening Medicare for Patients and Providers Act (H.R. 2474) to provide for an annual update to the Medicare Physician Fee based on the Medicare Economic Index (MEI).** This annual update is an important first step in reforming Medicare payment to help practices keep their doors open, resist consolidation, and ensure continued access to care for beneficiaries.

Additionally, the Academy strongly supports the Centers for Medicare and Medicaid Services (CMS) plan to implement a new add-on code for complex evaluation and management (E/M) visits: G2211. The G2211 code recognizes the inherent complexity of primary care office visits and provides commensurate Medicare payment. We were disappointed that Congress elected to delay implementation of that code, and **we urge Congress to support full implementation of G2211 in the CY 2024 Medicare physician fee schedule.**

The AAFP also supports site neutral payment policies that would establish payment parity across care settings and has called for an expansion of site neutrality to all on-campus and off-campus hospital-based departments, as well as other facilities. We have repeatedly urged Congress to build upon past efforts to increase site neutrality, including in our aforementioned remarks for last month's hearing. We support reducing payment differences between sites of service since it enables patients to make more informed healthcare decisions by making costs more transparent and would reduce patient cost-sharing. As such, site neutral payment encourages patient choice based on quality rather than cost. It is the AAFP's policy that patients should have reasonable freedom to select their physicians, other providers, and healthcare settings. Importantly, whenever making a choice, patients and caregivers must be well-informed on the options available and possible effects of, and responsibilities involved with, each option.

Therefore, we appreciate the Subcommittee's consideration of several discussion drafts today that would implement site neutral payment policies. The AAFP encourages Congress to continue exploring ways to advance site neutral payment policies with careful consideration so as not to further incentivize or accelerate consolidation.

Congress must also act to bolster the primary care physician pipeline by enacting Medicaid payment parity. On average Medicaid, pays just 66 percent of the Medicare rate for primary care services and can be as low as 33 percent in some states.[vi] This severely reduces the number of physicians who participate in Medicaid and limits access to health care for children and families. Increasing Medicaid payment rates will improve access to care for Medicaid patients, lead to better health outcomes, and reduce longstanding health disparities. **The AAFP urges Congress to pass the Kids' Access to Primary Care Act of 2023 (H.R. 952) to permanently raise Medicaid payment rates for primary care services to at least Medicare levels.**

Price Transparency and Administrative Burden

As acknowledged above, **the AAFP recognizes the value of transparency in health care and has long supported federal policies promoting price transparency**. These policies improve data collection and enable patients and their health care teams to compare prices across facilities and insurers. As our members seek opportunities to enter into value-based care arrangements, it is critical they have access to information on clinicians' and facilities' costs and quality performance to ensure they make informed decisions with their patients when making referrals.

The Academy appreciates and supports the Subcommittee's continued efforts to improve price transparency for patients. **However, primary care services, which are most often low-cost and high-value, are not the drivers of high, distorted health care prices.** The AAFP has repeatedly shared concerns regarding the administrative burdens imposed on primary care practices by the recently implemented good faith estimate (GFE) requirements and proposed advanced explanation of benefits (AEOB) requirements, resulting from the No Surprises Act (NSA). Congress did not intend for the NSA to impose burdensome regulatory requirements on primary care practices, which are already overwhelmed with administrative tasks. We urge Congress to ensure new price transparency reporting requirements are narrowly designed to target services and sectors that are driving price increases and do not impose burdensome new requirements on primary care practices.

One of the proposals considered during today's hearing seeks to promote transparency of common ownership interests under Parts C and D of the Medicare Program. We caution against moving forward with this legislation which may pose a similar risk once implemented.

Specifically, **the AAFP is concerned that the legislation as currently written would exacerbate already high rates of administrative burden among primary care physicians and subject them to undue reporting requirements.** Administrative burden is one of the leading causes of practice closures and physician burnout. Processes like prior authorization and step therapy already take up significant physician and staff time, with a 2022 American Medical Association survey reporting that physicians and their staff spend almost two business days each week completing prior authorizations.[vii]

The AAFP recently applauded CMS's 2024 Medicare Advantage (MA) and Part D final rule, which increases transparency of prior authorization under Medicare Advantage Plans. Instead of applying additional reporting requirements to physician practices contracting with MA plans and pharmacy benefit managers, **the AAFP strongly encourages Congress to build upon this momentum and prioritize codifying efforts to improve the transparency of and reduce overall use of prior authorization processes under Medicare Advantage plans, in addition to other insurers.** We also urge Congress to pass the Safe Step Act (H.R. 2630 / S. 652), which promotes transparency from health plans by requiring the development of a clear, transparent exception process to step therapy for patients and providers.

Finally, the AAFP supports policies such the Medical Loss Ratio (MLR) requirements on health plans offering coverage in the individual market, which requires they submit data on the proportion of premium revenues spent on clinical services and quality improvement. This helps ensure health care resources are focused on patient care rather than insurer profits or administrative expense. These federal policies have helped advance affordability and improve equitable access to comprehensive health care coverage in the individual market.

Stop Anti-Competitive Contracting Practices that Harm Clinicians and Patients

Congress should also prohibit the use of noncompete agreements in physician contracts. Noncompete agreements in health care impede patient access to physicians, deter advocacy for patient safety, limit physicians' ability to choose their employer, and stifle competition. Despite projected physician shortages, many health care employers still intentionally restrict physician mobility and workforce participation via noncompete agreements.

Currently, noncompete agreements are enforced through a patchwork of state laws. Twelve states deem noncompete agreements unenforceable and against public policy; however public awareness of these laws remains low, and employers still intimidate employees with the threat of legal action. Thirty-eight states allow noncompete agreements in some form, judging enforceability on factors including job type, legitimacy of business interests, and reasonableness of duration, scope, and distance. Family physicians from across the country have expressed deep concerns about how noncompete agreements are forcing them to remain in undesirable employment situations which harm their financial and mental health or abandon their patients and travel long-distances or uproot their families to practice in a new geographic area. **The AAFP urges Congress to pass legislation to ban noncompete clauses in physician employment contracts to ensure patients have access to their physicians and to allow physicians to freely practice medicine in their communities.**

Thank you for the opportunity to offer these recommendations. The AAFP looks forward to continuing to work with the Subcommittee on policies that support primary care physicians and their patients through improved transparency and competition. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

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