AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

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The Honorable Brett Guthrie
Chairman, House Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Frank Pallone
Ranking Member, House Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Jason Smith
Chairman, House Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member, House Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairmen Guthrie and Smith and Ranking Members Pallone and Neal:

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 thank you for holding what we hope are the first two in a series of hearings on how we can make health care more affordable for all Americans with commercial insurance coverage. Given the significance of this issue to family physicians and the patients they serve, I want to offer the following recommendations and insights from the family physician perspective.

Most Americans are enrolled in health insurance plans administered by commercial insurers. The nation's ten largest insurers cover over half of enrollees in private insurance, Medicaid Managed Care and Fee-for-Service (FFS) programs, and Medicare Advantage plans.[i] As of 2025, the three largest insurance parent companies in the United States are UnitedHealth Group (UHG), Elevance Health (formerly known as Anthem), and CVS Health – all of whom have been invited to be represented here today.

The intent of health insurance is to provide individuals and families with financial protection, improve access to care that may otherwise be unaffordable, and keep consumers' costs down. However, that intent is currently not being realized. More than 90 percent of Americans have health insurance, yet 42 percent report worrying about their ability to pay medical bills. In 2023, one in four insured adults reported delaying or skipping necessary care due to the cost. Additionally, 28 percent of insured adults reported a problem with their plan that directly led to a barrier in accessing care or a negative health outcome; that number is even higher when broken out across employer-sponsored (33 percent) and Marketplace plans (35 percent).[ii] Reported impacts include paying more for a treatment than expected, significant delays in receiving care or being unable to receive the recommended care at all, and a decline in their health.

These stark data points beg the question: if insurance companies aren't meeting their intent of providing financial protection and improved access to care for their enrollees, then what are they doing? Other data might suggest the answer to that is reaping as much profit as

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possible, to the detriment of clinicians, consumers, and the American health care system writ large.

UHG is the largest health care company in the country, earning $14.4 billion in profit in 2024. The company's newly appointed CEO Mr. Stephen Hemsley, one of today's invited witnesses, earns a $1 million base salary but also received a $60 million equity award in non-qualified stock options.[iii] Meanwhile, numerous investigative reports have detailed the lengths to which UnitedHealth will go to achieve cost savings through care denials.[iv,v,vi] In one example, a student with crippling but managed ulcerative colitis (thanks to his physician-recommended medications) had his infusions reviewed because of "a high dollar amount" and then ultimately denied for being "not medically necessary."[vii]

In 2024, Elevance Health made nearly $6 billion in profit. Ms. Gail Boudreaux, also invited to testify today, earned nearly $20.5 million from her role as CEO. The median salary for employees at Elevance during the same year was $55,372 – a pay ratio of 370:1.[viii] CVS Health earned a profit of more than $4.6 billion in 2024[ix] and owns Caremark, the nation's second largest pharmacy benefit manager (PBM) by market share, behind UHG's OptumRx and ahead of Cigna's Express Scripts in third place. A Federal Trade Commission (FTC) report released last year found that these three PBMs marked up certain specialty generic drugs dispensed at their affiliated pharmacies by thousands of percent, and many others by hundreds of percent.[x] These markups allowed them and their affiliated pharmacies to earn more than $7.3 billion in revenue from dispensing drugs at prices far beyond their acquisition costs.

Multi-billion dollar companies delaying and denying medically necessary care simply because of the price tag is deplorable, especially when these same parent companies play a role in inflating those prices. The Academy strongly urges the Committees to use their oversight authorities to closely scrutinize health insurance companies, which are failing to serve the best interests of their enrollees, and take actions to reign in the anti-competitive, anti-patient, and profit-driven practices discussed below.

Insurers Acquiring Primary Care Practices to Maximize Profit

The health care market has become overwhelmingly consolidated in the last decade. In addition to the insurance products and PBMs already mentioned, the parent companies represented here today have their hands in virtually every sector of health care – including owning physician practices and employing clinicians.

Corporate entities, including health plans, now own 27.2 percent of physician practices. From 2019 to 2021, there was a 43 percent increase in the number of corporate-employed physicians and an 86 percent increase in the percentage of corporate-owned physician practices.[xi] In 2021, UHG – in addition to already owning the largest health insurance plan and PBM – became the largest employer of physicians in the country through its subsidiary company, Optum.[xii]

The principal factors fueling the consolidation of primary care practices with health systems, plans, and other corporate entities are 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

like me report that independent practice is simply unsustainable. The available evidence supports our experiences: the financial incentives driving and rewarding consolidation, including among payers, are, in many cases, directing resources away from primary care.

Providing high-quality, patient-centered primary care requires a multi-disciplinary team, technology that facilitates advanced data aggregation and population health analytics, and practice management staff to support traditional operational functions such as patient communication, scheduling, prior authorizations, and billing. All of this requires practices to make significant financial investments and commitments to remain competitive. Corporate entities, including payers, have revenue streams from multiple service lines and are better able to afford these escalating practice costs, many of which are created by burdensome requirements from the payers themselves. This creates an environment in which independent primary care practices struggle to make ends meet with the escalating administrative burdens and subsequent costs placed on primary care practices.

The motivation behind the acquisition of primary care practices is the same for both hospitals and insurers – control of cash flow. **Vertical integration can allow primary care to become a leverage point to maximize savings or profit somewhere upstream.** For payers, controlling primary care allows them to oversee and manage care across a patient's care team and settings. With these acquisitions, payers can use primary care services to meet other financial goals, redirecting revenue away from patient care. Although this allows insurers to meet their financial goals, the patients and their primary care physicians, in many instances, are not benefiting from these financial windfalls.

In March 2024, the AAFP conducted a survey of members requesting information about their experiences with health care consolidation. Among other issues, 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.[xiii] Nearly half of survey respondents attributed the changes to reduced clinical autonomy and requirements that prioritize financial performance.

Acquiring physicians also enables vertically integrated plans to bypass or soften Medical Loss Ratio (MLR) requirements that cap profit. UHG's vertical integration of UnitedHealthcare (UHC) with Optum enables UHG to collect both insurance profits and any profits earned by employed physician groups. Put simply, if UHC pays its owned Optum provider groups more than other contracted providers for the same services and diagnosis codes, UHG would see increased profit. In fact, a recent analysis found that UHC pays Optum providers 17 percent more than non-aligned competitors.[xiv] The same analysis found that in markets where UHC has a higher market share, the payments to Optum physicians are 61 percent higher. This approach games the MLR system by allowing UHC to direct profit beyond the MLR requirements to its parent, UHG, and creates disadvantages to non-Optum physicians by paying its own providers more. This further fuels consolidation as financial concerns are a primary driver of physicians leaving independent practice, as discussed above.

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. 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. Congress should pass legislation that prohibits anticompetitive noncompete clauses in physician employment contracts.

Anti-Competitive "Downcoding" Practices Undermining Physician Practice Viability

Insurers have been increasingly engaging in a practice known as "downcoding," which is quietly undermining the financial viability of primary care practices, to the detriment of patients who rely on these physicians for their care. Downcoding occurs when health plans, assign a lower-level evaluation and management (E/M) code than the one that was actually provided by the physician and billed on the claim - without consulting the physician who provided the patient care. This results in a lower payment that physicians are forced to either

accept or pursue costly, time-consuming appeals, which takes additional time and resources away from patient care.

The most recent example of a downcoding program to be implemented was launched by Cigna on October 1. Their new "E/M Coding Accuracy" policy (R49) downcodes visits reported with 99204-99205, 99214-99215, and 99244-99245. Cigna states that downcoding occurs when the insurer believes the primary diagnosis and other claim-based criteria do not indicate that level of E/M reported on the claims.[xv] Two example diagnoses Cigna gives are "earache" and "sore throat."

The AAFP is concerned that automatic downcoding policies fail to reflect the continuity and complexity of care family physicians provide, which often includes managing multiple chronic conditions, coordinating with specialists, addressing behavioral health needs and considering social drivers of health, all within a single visit. These activities are not a function of the diagnosis alone but are representative of the comprehensiveness and complexity of family medicine. This is consistent with Current Procedural Technology (CPT) guidance that clearly states, "The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition."[xvi] Taken together, these policies illustrate how downcoding practices can undervalue the comprehensive and relationship-based care that family physicians provide.

The concerns are further compounded by the practical challenges physicians face when attempting to identify and respond to downcoding activity. Downcoding is often only discovered by practices when they notice underpayments for services rendered. In letters to specific payers and AHIP, the AAFP has expressed its concern about this and other aspects of the downcoding programs. We have requested greater transparency regarding the methodologies for identifying targeted individuals and offered our assistance in educating family physicians regarding accurate coding criteria – something that the AAFP regularly offers to all of its members. The Academy strongly supports accuracy in coding and billing practices, and believes that both physicians and health plans should abide by the principles of CPT, especially in a fee-for-service payment system. For physicians, this means selecting the code that most accurately identifies the service performed and documented. For health plans, it means payment for covered services should be based on the codes documented and billed by the physician.

To date, AAFP and its members have not been able to secure any guidelines, standards, or rules from payers with which physicians could educate themselves to improve their billing and documentation in order to avoid having their claims downcoded. Rather, these programs appear to be using algorithms that lack transparency and are applied without full clinical context. **If these programs are designed to ensure accurate billing and prevent fraud, waste, and abuse then these policies should be transparent, fair, and uniformly applied regardless of practice ownership.**

The AAFP sent a letter in November to the FTC, Department of Justice, and Centers for Medicare and Medicaid Services (CMS) urging them to investigate whether these likely anti-competitive practices. We similarly urge the Committees to provide oversight over this

growing practice and pass legislation that, at a minimum, requires clear transparency into the processes and criteria insurers are using and prohibiting the use of automatic algorithms.

In addition to examining the insurance companies using downcoding programs, we strongly urge Congress to investigate the third-party companies that seem to be behind this trend. Why have nearly all insurers suddenly prioritized this particular tactic? What if this isn't an independent, organic effort to improve payment integrity but rather a coordinated revenue strategy driven by a single company in partnership with dozens of payers?

Cotiviti is the data and analytics engine behind many of these so-called "payment integrity" and "downcoding" programs. The self-described mission is as follows: "Cotiviti helps ensure pre- and post-pay claim accuracy by efficiently correcting inappropriate claim coding while validating other suspect claims against medical records, contract terms, and other data."[xvii] The company proudly reports that it "reduced inappropriate spend by more than $9.5 billion in 2024." Here is what their work produces, according to Cotiviti's own materials:

- Identify millions of dollars in prepay "savings"
- Reduce costs from clinically complex claims
- Detect and correct "billing compliance" issues
- Save an estimated 3–4 percent on inpatient spend

And who are Cotiviti's clients? The company is transparent about this as well: "A trusted partner with 23 of the top 25 national payers, and more than 100 unique payer clients in total."[xviii]

Let's be clear: this isn't solely about coding integrity. It's about profit maximization, achieved through opaque algorithms, not transparent processes. There's no defined methodology, no meaningful appeals process, and no regulatory oversight. Everything depends on Cotiviti's proprietary systems, which the company says have been "honed over 20+ years to drive exceptional value for clients."

So why this shift and why now? In recent years, there has been a great deal of scrutiny rightly focused on claims denials, utilization management, and prior authorization. These processes are frustrating and time-consuming for both patients and physicians – and costly for insurers as well. Yet, overturn rates remain high: about 70 percent of denied claims are ultimately overturned and paid.[xix] Appeals drain insurers' resources, and every overturned decision cuts into their revenue.

Enter downcoding: a clever workaround. Instead of denying a claim outright (which can spark an appeal and potential reversal), insurers simply pay it at a lower rate. The decision often comes from a black-box algorithm, with little to no physician input and, importantly, no formal appeals pathway for physicians. In short, this new tactic avoids regulatory scrutiny while preserving some of the financial gains of denial.

Underpayments to Physicians by Medicare Advantage Organizations

Downcoding is just one of the ways that insurers are underpaying physicians. Another way they undermine the financial stability of physician practices is through continuously delaying payments within their Medicare Advantage (MA) lines of business. Each of the parent companies invited to be represented at today's hearings is currently or has previously been a

Medicare Advantage organization (MAO), meaning they contract with CMS to administer Part C plans to eligible individuals.

There are currently no statutory or regulatory requirements dictating the type of payment arrangements MA organizations must have with contracted physicians. While this has the potential to encourage payment model flexibility and innovation, such as capitated payments for primary care, we hear more often from family physicians that they are struggling to get on-time payments from MA plans. As discussed further below, MA organizations use aggressive prior authorization and other utilization management processes that lead both to delayed care for patients and delayed payments for physicians.

One way that Congress can help to address this issue is by implementing prompt payment requirements for MA plans to in-network physicians and other clinicians. We applaud Representatives Doggett and Murphy for their leadership in introducing the bipartisan *Prompt and Fair Pay Act* (H.R. 4559) that would do just this. Specifically, the bill stipulates that MAOs must pay clean claims received within 14 days (if submitted electronically) or 30 days (all other claims). If the MAO does not pay the claim within the defined timeframe, they are also required to pay interest on the claim. Additionally, it provides HHS with enforcement authority and establishes a payment floor of traditional Medicare for MA plan payments to physicians. We support this legislation and encourage its swift passage.

A related issue that we frequently hear from family physicians is that MAOs require them to waive their right to interest on delayed claim payments as part of their contracts. We also encourage Congress to prohibit this unfair practice as it considers opportunities to reform the MA program.

Increased Primary Care Spending Across Payers Can Reduce Health Care Costs

We know that prioritizing primary care not only improves patient health outcomes, but it saves money. Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes, leading the National Academies of Sciences, Engineering, and Medicine to call it a "common good."[xx] However, despite the decades of evidence showing that primary care improves population health and saves money, our national investment in it continues to lag.

Although actual amounts vary by payer and across states, research has consistently found unsustainably low levels of primary care investment when using a commonly agreed upon definition of primary care spend. Across all payers, primary care spending has decreased or remained stagnant at low levels over the last decade. In 2021, all payers spent an average of 4.7 or less than five cents of every dollar on primary care. Commercial payers averaged 5.6 percent, while Medicaid and Medicare remained shortly behind at 4.7 and 3.9 percent respectively.[xxi] This pervasive underinvestment in primary care – which evidence frequently shows is high-value and low-cost – is one of the reasons that health care costs continue to skyrocket while health outcomes are not matching the high level of dollars spent.

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.[xxii] 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 percent of total health care spending for these high-performing nations.[xxiii]

Our nation cannot afford to keep these spending trends up. 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.[xxiv] Meanwhile, Arkansas enacted legislation last year to establish the Arkansas Primary Care Payment Improvement Working Group, charged with producing a report that provides a recommendation for a primary care spending target.[xxv] The Academy strongly encourages federal policymakers to consider such steps that would right-size our nation's primary care investments.

Utilization Management as a Means to Delay Care and Increase Administrative Burden

Interactions with health plans consistently rank high on the list of sources for family physician burden, leading to alarming rates of moral injury, burnout, and mental health challenges. Insurer administrative burden has become such an acute issue that there are legislative efforts recognizing the role it plays in mental health issues for clinicians. The *Dr. Lorna Breen Health Care Provider Protection Reauthorization Act* (H.R. 929 / S. 266), a bill supported by AAFP and numerous other clinician organizations, reauthorizes the only federal program to prevent suicide, occupational burnout, and support for mental health conditions for health care professionals. This bill has been updated to include a provision that highlights the deleterious effects that administrative burden can place on clinicians' mental health and further illustrates the seriousness of this problem.

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 will 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.[xxvi] 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.[xxvii] 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.[xxviii]

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.[xxix] 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, 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 accountability measures for insurers.

Further, the Academy has growing concerns about the use of artificial intelligence (AI) to process prior authorization requests. According to a recent survey conducted by the American Medical Association, 61 percent of physician respondents expressed concerns with the expanded use of AI by MA plans for prior authorization. [xxx] Although MA plans claim that the use of AI in this context is intended to expedite the processing of claims, there is evidence to suggest that plans are actually utilizing AI to unduly increase denial of prior authorization requests.[xxxi]

We appreciate that some lawmakers have begun to examine these practices. An October 2024 report released by the Senate Homeland Security Permanent Subcommittee on Investigations found that, after implementing the use of AI to process requests, UHG's PA denial rate increased by over 12% in just two years.[xxxii] The report provided recommendations to CMS to mandate increased transparency by MA plans in their utilization of AI for prior authorization. However, CMS has not formally implemented that recommendation. The AAFP encourages your Committees to continue this examination and build upon this work.

Another common utilization management protocol used by plans is step therapy, whereby patients are required to try one or more insurer-preferred medications or treatments prior to implementing a physician recommendation. Plans claim that step therapy is used to bring down the cost of care for the treatment of numerous conditions. However, the AAFP is concerned that health plans may be prioritizing their financial interests when developing step therapy protocols, which instead delay patients' access to treatments and can result in severe side effects and disease progression for patients. This practice can take weeks or months and can result in patients not being able to access the treatments they need in a timely manner. Physicians can request exceptions to step therapy requirements, but insurers may not respond promptly to such requests, resulting in a further delay of treatment.

Research has demonstrated that step therapy requirements prevent patients from adhering to effective medication regimens, which can lead to worse health outcomes.[xxxiii] In addition to its impact on patients' timely access to necessary medication, step therapy places significant administrative burden on physicians, who must navigate different and inconsistently applied protocols and requirements across health plans.

The AAFP believes that step therapy should not be mandatory for patients already on a working course of treatment and that generic medications should not require prior authorization. **We have endorsed the *Safe Step Act* (H.R. 5509), which would reform the inconsistent and opaque use of step therapy practices by insurers.** Specifically, it

would implement transparency guidelines to prevent inappropriate use of step therapy in employer-sponsored health plans and create a clear process for patients and physicians to seek reasonable exceptions to step therapy. We encourage the Committees to work with your colleagues in Congress to advance these necessary reforms.

MA Coding Intensity and Fragmentation of the Patient-Physician Relationship

At the same time that insurance companies are implementing policies to deliberately underpay physicians, many reputable sources have reported that MA plans are receiving substantial overpayments in federal taxpayer dollars through the MA program. Payments from CMS to MA plans are partially determined by a system of risk adjustment that depends on the health status of each enrollee. Accordingly, MAOs are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources than to healthier enrollees, who would be expected to require fewer health care resources.

The AAFP recognizes that risk adjustments are important for ensuring payments to MAOs accurately reflect patient complexity and support access to coverage and care for patients. However, the MA program lacks corresponding incentives to improve the health of its enrolled members, and a growing body of evidence suggests that some MAOs may be overly focused on recording health conditions. As the health status of the MAOs member population worsens, risk scores increase and the MAOs monthly payments increase. This happens regardless of the level of care provided to those plan enrollees.

There is mounting evidence that the expected level of care required for the health status of the plan's enrollees is not being delivered by some MAOs. For example, plans have reported diagnosis codes that are not fully supported by patients' medical records, an indication that patients aren't receiving related or indicated care.[xxxiv] A report released by the Senate Judiciary Committee and Chairman Grassley last week summarized UHG's approach to risk adjustment as a "major profit centered strategy, which was not the original intent of the program."[xxxv] It found that UHG uses "aggressive strategies to maximize [...] risk adjustment scores" and "appears to be able to leverage its size, degree of vertical integration, and data analytic capabilities to stay ahead of CMS's efforts to counteract unnecessary spending related to coding intensity."

An October 2024 HHS OIG report found that diagnoses reported only in enrollees' health risk assessments (HRA) and HRA-linked chart reviews led to an estimated $7.5 billion in MA risk-adjusted payments in 2023. Of that amount, in-home HRAs and HRA-linked chart reviews accounted for nearly two-thirds of the payments. To be clear, in-home HRAs are separate and distinct from home-based primary care (HBPC) delivered by a patient's usual source of care. Many family physicians provide comprehensive, continuous HBPC for often medically complex patients. These visits are both medically necessary and patient-centered, and Congress must ensure that reforms taken to address misaligned incentives in the MA program do not unintentionally impede the delivery of high-value HBPC.

All of these findings raise significant concerns about the validity of diagnoses obtained via in-home HRAs and HRA-linked chart reviews, as well as the ways in which MA plans are fragmenting existing patient-physician relationships. Family physicians frequently report that they had no knowledge of the in-home HRA being conducted or of the diagnoses identified during the HRA. They often only learn of it when their patient mentions a nurse or other

clinician coming to their residence at a later service visit. These experiences are verified by the OIG report finding that most in-home HRAs are conducted by third-party vendors that MAOs partnered with rather than the enrollees' own primary care providers, which may create gaps in care coordination. MedPAC has also questioned the accuracy of diagnoses only obtained through in-home HRAs, noting that diagnoses are often based on enrollee self-reporting or may require verification by diagnostic equipment not present during the visit.[xxxvi]

The OIG report further found that MAOs relied mainly on in-home HRAs to collect certain diagnoses associated with some of the top thirteen health conditions by volume. For example, MAOs used in-home HRAs to diagnose secondary hyperaldosteronism for 74 percent of all enrollees with this diagnosis obtained via an HRA or HRA-linked chart review. Meanwhile, only 3 percent of enrollees received this diagnosis during a facility-based HRA. **For thousands of MA enrollees, the in-home HRA was their only encounter recorded in 2022.** Specifically, the report found that 77 MA organizations generated $60.6 million in payments for 14,103 enrollees who did not have any recorded encounter of receiving tests, supplies, or services other than an in-home HRA. This is particularly concerning as it suggests that MA plans may be adding diagnoses to a patient's chart and maximizing risk-adjusted payments without actually connecting the patient to services and improving their care – *or*, that the diagnoses are inaccurate and thus follow-up services are not required for the patient. Neither of these strategies benefit patients or are a wise use of taxpayer dollars.

The AAFP believes the accuracy of data used for risk adjustment purposes is paramount and that the physicians and other clinicians who serve as the patient's usual source of continuous primary care are best positioned to provide these data. **Third-party assessments or encounters designed solely to identify patient risk factors do not serve the best interest of the patient as they focus on identifying illness over treating it and are potentially disruptive to established patient-physician relationships.** We have encouraged CMS to consider additional guardrails to prevent the use of such third-party assessments and, in the absence of regulatory action, we urge the Committees to consider legislation that would implement such guardrails.

MedPAC projected the federal government would overpay MA plans by $88 billion in 2024. The AAFP is strongly supportive of comprehensive and accurate documentation of all patient's diagnoses and advises members that all coding should comply with the ICD-10-CM coding guidelines. If reports of overpayment are accurate, the AAFP is concerned that significant funding that could support broader, more widely available access to high-quality primary care is being diverted with no benefit to MA enrollees. Some proponents of the MA program argue that the quality of care and patient outcomes are better, but evidence has not consistently supported that. A comprehensive literature review by the Kaiser Family Foundation compared MA and traditional Medicare based on measures of beneficiary experience, affordability, service utilization, and quality. It found "few differences [...] that are supported by strong evidence or have been replicated across multiple studies."[xxxvii]

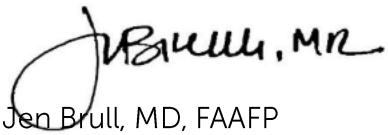
Therefore, the Committees should consider advancing policies to address incentives that create unintended consequences and ensure that payments to MA organizations are being used to connect MA enrollees to high-value services, including comprehensive, continuous

primary care that can help to reduce health care expenditures in the long run. At a minimum, MA plans must be required to coordinate with and disclose any in-home HRAs to a patient's PCP.

In implementing any of the above recommendations or related reforms, Congress should also take actions to prevent MA organizations from failing to invest in and support the provision of high-quality primary care. Specifically, we recommend additional guardrails that will ensure MA organizations do not pass potential revenue reductions onto the physician practices they contract with. Primary care practices continue to struggle with inadequate physician payment rates, staffing shortages, and overwhelming administrative burden. Additional payment cuts, costly system updates, and other downstream effects of these changes could further destabilize the primary care practices Medicare beneficiaries depend on.

Thank you for convening today's hearings and holding health insurance companies accountable for better serving consumers. The AAFP appreciates your attention to these deeply concerning practices and looks forward to partnering with you to implement the proposed reforms to reign in health care costs and prioritize patients and their health outcomes. Should you have any additional questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,



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American Academy of Family Physicians, Board Chair

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