

**THE DOCTOR IS OUT:
HOW WASHINGTON'S RULES
DROVE PHYSICIANS OUT OF MEDICINE**

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THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIANS OUT OF MEDICINE

Wednesday, February 11, 2026

U.S. SENATE
SPECIAL COMMITTEE ON AGING
Washington, DC.

The Committee met, pursuant to notice, at 3:35 p.m., Room 216, Hart Senate Office Building, Hon. Rick Scott, Chairman of the Committee, presiding.

Present: Senator Scott, Moody, Gillibrand, Warnock, and Alsobrooks.

OPENING STATEMENT OF SENATOR RICK SCOTT, CHAIRMAN

The CHAIRMAN. The U.S. Senate Special Committee on Aging will now come to order. Across the country, older Americans are feeling that it is harder than ever to get timely access to the doctors and care they need to live happy, healthy lives and even when seniors do find a doctor, many feel rushed and disconnected from them.

Doctors aren't the villains here. Like their patients, they are victims of a broken system. Doctors want to care for and connect with their patients, but our rigid, top-down health care system is making that job nearly impossible.

This is especially true for doctors who see patients on Medicare or other government-run or subsidized health care programs. Federal mandates and administrative requirements pile on paperwork and paperwork, and force doctors to spend more and more time on compliance than on care, making patients face one obstacle after another just to get help. The results? Patients can't get the care they need from doctors, and doctors can't give patients the care they deserve.

Actually, no one benefits from this. We are forcing our doctors to operate in a system that prioritizes paperwork over patients and federal mandates over professional judgment. The demands on doctors to focus on compliance over care are higher than ever. Doctors must navigate unstable insurance and Medicare policies, different reporting standards, and excessive administrative burdens just to take care of their patients.

Again, no one benefits in this situation—not patients, and certainly not doctors who got into this profession because they want

to help patients and the result is less care, less access, and worse outcomes.

This is especially true in rural and underserved areas that already struggle to find and maintain health care providers, and the regulatory burden is especially tough for those who treat older Americans. It is no wonder that doctors regularly report feeling higher levels of burnout than other U.S. workers.

That burnout leads to more doctors quitting their jobs, which creates more doctor shortages, which leads to increased administrative burden, which creates a more disconnection and fewer rewarding interactions with patients, which results in more burnout. In the most serious cases, this burnout contributes to devastating mental health consequences for physicians and their families, including serious depression and even suicide.

We owe it to all of our constituents, but especially our aging population and those responsible for caring for them to stop this cycle. Today we will look at how Washington's regulations and red tape play into this crisis and what we can do to fix it so that our doctors can spend more time caring for patients and less time navigating bureaucracy.

We will hear from witnesses who interact with physicians at all levels. They train our doctors, they manage them in medical practices, they treat them, and they work with them as colleagues and our doctors themselves. They will tell us about their real-life experiences navigating and preparing doctors that deal with Washington's top-down, one size fits all approach to regulated medicine.

We will also share their experience working to solve these problems, what steps we can take to help our doctors and the patients they serve put the doctor-patient relationship back at the center of health care.

I look forward to a productive discussion today with our witnesses, and I would like to recognize Ranking Member Gillibrand for her opening statement.

**OPENING STATEMENT OF SENATOR
KIRSTEN E. GILLIBRAND, RANKING MEMBER**

Senator GILLIBRAND. Thank you, Chairman Scott, for holding today's hearing. Thank you to our witnesses. I really appreciate you being here to give us your testimony. Burnout within the health workforce has decreased since its peak during the pandemic but remains a prevalent issue plaguing our systems of care. It directly impacts the well-being and effectiveness of our workforce, and its consequences are grave for the patients, particularly older adults and people living in rural or underserved areas.

Burnout, which the American Medical Association defines as a long-term stress reaction including emotional exhaustion, depersonalization, and feeling of decreased personal achievement, causes physicians to leave the profession, making workforce shortages even worse and undermining access to care.

A wide range of factors drive physician burnout, including regulatory and administrative requirements, system level financial pressures, and realities of the profession's culture. Regulatory requirements play an important role in upholding a quality standard for patient care, safety, and privacy.

They allow providers to keep detailed track of patient treatment, and they also help prevent waste, fraud, and abuse. Simultaneously, it is clear that the current system has flaws. Requiring physicians to spend clinical time and energy fighting to convince insurance companies that their patient truly needs the procedure, treatment, or drug they prescribed is understandably aggravating and exhausting.

Time payment adjustments to extensive patient data entry with technology designed for billing compliance instead of clinical workflow understandably causes fatigue and frustration, especially when it consistently spills beyond normal working hours.

Reforms like streamlining the prior authorization process, approving the usability and interoperability of electronic health records, simplifying or standardizing payer forms would meaningfully reduce administrative burden that drives the burnout in physicians.

This can help delay early exit from the workforce and keep independent practices afloat. This is especially important as we continue to see unprecedented rise in smaller physician owned practices closing their doors, integrating with larger health care systems, or receiving private equity investment.

With these structural changes, physicians can face system level financial pressure that drive burnout through diminished agency and focus on profit. Under these circumstances, physicians can face business-oriented performance targets that require an increase in patient volume.

This means seeing a greater number of patients in shorter increased, frequent visits that create even more administrative work, which can be compounded by the reduction of clinical and administrative support staff. This drive toward profit can undermine the ability of these vital health care workers to secure their basic psychological or safety needs, and they experience less autonomy and input on key decision-making.

Particularly combined with the inability to practice elsewhere due to the rise of strict non-compete agreements, many physicians opt to leave the profession entirely. System leadership must drive operational level change.

Employers have an obligation to meet the needs of their employees, promote participation in relevant decisions, and implement evidence informed actions like those included in the NIOSH and the Dr. Lorna Breen Foundation Impact Wellbeing Guide.

Additionally, federal investigation into private equity investments in health care entities and federal action to ban anti-competitive terms in employment contracts are crucial to promoting autonomy at organizational and individual levels and reduce burnout. Despite the regulatory, administrative, and system level pressures that put enormous stress on the health workforce, there is a pervasive stigma against seeking mental health support and fear of medical license loss that prevents many from getting the help that they need.

It is important that clinician education includes training to handle not only these administrative burdens, but also psychological preparation to handle trauma like a patient death or distress. We must address burnout. The consequences and stakes are too high.

Healers are suffering. Providers are facing sky-high costs to replace each clinician that leaves.

Remaining staff are working at reduced capacity, putting themselves and their patients at greater risk. Patients are losing access to the care they need. These impacts only intensify in older, rural, and underserved communities, especially combined with enacted cuts to Medicaid that will exacerbate the provider closures and create medical deserts. There isn't an easy solution to any of this.

Moving the needle requires buy-in from all sectors that shape our workforce. Congress, academic institutions, regulators, and health system leaders must work together in a bipartisan way to create a system that supports, not exhaust, our essential workforce. I look forward to hearing from you and your proposals. Thank you.

The CHAIRMAN. Thank you, Ranking Member. Now, I would like to welcome today's witnesses. Our first witness leads one of the Nation's most mission-driven medical schools with a focus on training physicians to serve in rural communities.

Dr. Alma Little is the Dean and Chief Academic Officer of the Florida State University College of Medicine where she oversees medical education, workforce development, and physician training programs across the State of Florida.

Under her leadership, the FSU College of Medicine has emphasized primary care, community-based training, and addressing physician shortages in areas most affected by access challenges. Half my office went to FSU, so they are excited that you are here, so please begin your testimony.

**STATEMENT OF ALMA LITTLES, M.D., DEAN & CHIEF
ACADEMIC OFFICER, FLORIDA STATE UNIVERSITY COLLEGE
OF MEDICINE, TALLAHASSEE, FLORIDA**

Dr. LITTLES. Chairman Scott, Ranking Member Gillibrand, and distinguished Committee members, thank you for the opportunity to speak with you today to share a perspective on an issue that is becoming increasingly urgent across our Nation, physician burnout. An issue experienced by doctors who want nothing more than to care for their patients yet find themselves pushed to the brink by the very system meant to support them.

Physicians enter medicine with a clear purpose, to heal, to serve, and to stand with patients in their most vulnerable moments but today, that purpose is being overshadowed by unsustainable administrative burdens leading to record percentages of physician burnout.

We have already heard definitions of physician burnout, so I won't repeat that, but we know that physicians have a higher incidence of suicide when compared with other professionals in the United States. Around 400 take their lives each year and just as concerning, medical students and residents have rates of depression 15 percent to 30 percent higher than the general public.

This is a national crisis. To address it, the National Academy of Medicine, the Association of American Medical Colleges, and the American Medical Association are all actively developing resources to help. Physicians are leaving medicine not because they have lost their passion, but because the regulatory environment has made it nearly impossible to practice the way they were trained.

Physicians lose satisfaction when factors come between them and their patients. The issue is not regulation itself. Physicians understand the need for oversight, accountability, and patient safety. The issue is the volume and complexity of mandates, documentation requirements, reporting systems, compliance checklists, and insurance rules and regulations that grow year after year in the face of reduced reimbursement and without regard for the time they consume or the strain they impose in the form of the inability to make decisions based on training.

The consequences of burnout can be devastating. Think about this, one physician leaving practice potentially leaves 2,000 to 3,000 patients without access to care. Studies suggest that more than half of practicing physicians say they are burned out. We found this to be a real issue in Florida after becoming aware of several suicides among medical students, residents, and faculty.

Here is the hopeful part, this crisis is solvable. The medical schools in Florida came together to evaluate the support being to address the root causes of burnout. We use this data to share experiences and solutions. Programs were developed that support wellness activities and deliberate efforts were made to destigmatize seeking help in medical school, residency training, and practice.

This included lobbying for a change in the licensure application regarding how questions about prior mental illness were asked and addressed. The survey of medical schools and residency programs confirmed that the schools were actively engaged in a variety of activities including incorporating mandatory wellness topics into the curriculum, providing dedicated onsite counseling services, offering online resources, hosting financial aid and planning workshops, and incorporating activities that prepare students for the impact of administrative burdens.

Since our founding 25 years ago, Florida State University College of Medicine has recognized the threat of physician burnout and we hardwired into our curriculum and extracurricular activities, programs and activities to address it.

We provide resources on sleep and stress management, weekly fitness classes, campus walks, and improved our onsite fitness room. A major suicide awareness and prevention program featured film screenings and a live panel discussion. Our six regional campuses also developed their wellness programs.

All of this is helpful, but we cannot lose sight of key components of the American Medical Association's Physician Wellness Program that includes the reduction of administrative burdens, reduce of stress drivers in organizations, and removal of regulations and technology requirements.

We need your help. You have the power to make a positive impact by supporting regulatory reform, promoting administrative simplification, ensuring that federal policies strengthen not strain the physician workforce, and by recognizing that the best way to protect patients is to protect the people who care for them.

Addressing this issue is no longer an option. It is critical to ensuring access to care. I look forward to continuing the conversation. Thank you.

The CHAIRMAN. Thank you, Dr. Littles. Our next witness is a practicing family physician who left the traditional insurance driv-

en system to restore the doctor-patient relationship. Dr. Lee Gross is the Founder of Epiphany Health Direct Primary Care in Florida, a national leader in the direct primary care movement.

He spent more than two decades in private practice and has testified before Congress on how federal regulations and CMS mandates contribute to physician burnout and rising costs. Thank you for being here. Please begin your testimony.

**STATEMENT OF LEE GROSS, M.D., FOUNDER, EPIPHANY
HEALTH DIRECT PRIMARY CARE, NORTH PORT, FLORIDA**

Dr. GROSS. [Technical problems.] Sabotage the Florida guy.

Mr. Chairman, Ranking Member, members of the Committee, it is a pleasure to be back here at the Senate to give some testimony. Again, my name is Lee Gross. I am a practicing family physician in Southwest Florida—have been independent since 2002.

For disclosure, I serve on the Florida Board of Medicine. I am speaking on my own behalf and not on behalf of the Florida Board of Medicine, and I do not speak for the State of Florida. The name of my practice is Epiphany Health and Epiphany Health is a very strange name for a medical practice—and the timer is not running here. Epiphany Health is very strange for a very medical practice.

In fact, we had an epiphany and the epiphany was, why are we insuring primary care? Why are we taking relational and longitudinal care and funneling that through an insurance product, using tens of thousands of diagnostic codes, hundreds of thousands diagnostic and billing codes, filing an insurance claim for every single transaction, and then we are disappointed and surprised that it is cumbersome, it is impersonal, it is inflexible, and it is expensive.

I had a fully insured practice back in 2002. I took Medicare. I took all the insurances, and this was during the time of the sustainable growth rate formula and I would come to run up and down the halls of Congress saying, please don't cut our pay, please don't our pay. It is absolutely not survivable if Congress cuts the pay of primary care doctors.

I would walk out, and behind me the ophthalmologist would walk in, and they would say, please, don't come our pay and then behind them, the surgeons were standing there and this constant battle for a larger slice of a pie that was continually shrinking. It just became obvious to me that we shouldn't be fighting for a large piece of the pie, but we should be looking to explode the pie and looking for a better way to do this.

I was an early adopter of electronic health records, and I should say that in the sustainable growth rate debates, I would have to take out personal loans to make payroll because of the brinksmanship that would happen in Washington. I wouldn't know if we would have money coming in.

I didn't know how to finance supplies. I didn't know how to finance equipment purchases because I didn't know what we were going to get paid and so, the Federal Government became an unreliable business partner in the practice of medicine, and I felt like I needed to fire them. I was an early adopter of electronic health records. I loved that electronic health record. It maximized operational flow, workflow.

It was fantastic and then the Federal Governor came in and certified it and so, the electronic health record I had that did everything I needed it to do and made me more efficient was no longer certified, and they couldn't afford to certify.

I started getting Medicare penalties because I had a system that was efficient and worked for my practice, but I was getting penalized, so I had to purchase an additional system that didn't do anything I needed to do.

I had parallel systems, one for compliance and one actually to perform the function that I needed in my office. It essentially became that the electronic health record became a cash register. I used to get a one-page note from a consultant and I would know why my patient was there, what they did, what their recommendations were, what pertinent findings were.

I get 16 pages of computer-generated rubbish, and I have no idea what the patient was there for, but I know their pet was spayed or neutered. It is absurd and so, the medical record has become a cash register, the patient has become an ATM, and it had become all about volume.

You start rolling out all the alphabet soups of the MACRA and the MIPS, and the quality metrics, and the reporting. I would have to find other ways to generate revenue, because I wasn't going to do those things and so, every time I found a way to generate and support my practice, Medicare would make a rule change to undercut that and I was playing whack-a-mole with Medicare as to how my practice would survive.

We kind of joked in my practice that we were just going to go ahead and stop billing Medicare. We are just going charge \$100 for parking but effectively that is what we did. We created essentially in 2010 what became one of the first direct primary care practices in the country.

We charge a subscription for services. We charge \$93 a month right now for adults, \$30 for children, and after that we charge nothing for the services we provide in our office. No copays, no deductibles. I don't bill insurance for any services. Any testing that I do in my office is included, EKGs, halter monitors, cortisone injections, those are all included and I have a cash-based relationship for all the services outside of my office.

I buy everything wholesale and pass those savings along to the patient. I buy labs at 95 percent savings because the lab doesn't have to interact with the insurance company, and they don't have deal with coding and if you ask the lab, the most expensive thing that they do in the lab is interact with insurance companies and do the coding. If you eliminate all that and you just get the lab, it actually gets really cheap.

We have been doing that now for 15 years, operating outside of insurance companies. We have seen nearly zero inflation in the actual cost of purchasing health care. The cost of coverage has skyrocketed, but our cost of purchasing care and providing care has been nearly flat for 15 years.

Since we have started doing that, we were one of the first few practices in the country that have done that. Now, there are thousands of doctors around the country in all 50 States that have

stepped away from the system because we can do better at providing primary care, not going through third-party systems.

We are at a point now in our country where we can personalize health care down to somebody's individual DNA. We are taking a one size fits all approach to health care that has to be a broad brush across a massively enormous country that is so incredibly diverse as the United States of America.

What we don't need is mass production in medicine. We need mass personalization, and that is the kind of care that we deliver, and I am hoping that we can get to that through removing some of the overregulation in health care. Thank you.

The CHAIRMAN. Thank you. Our next witness brings a perspective of managing large, multi-specialty physician groups serving both urban and rural communities. Jeffrey Smith is the Chief Executive Officer of Piedmont Healthcare in North Carolina and is the incoming Board Chair for the Medical Group Management Association.

In his role, he oversees the operational, financial, and compliance challenges facing physician practices under Medicare and CMS regulation. Boy, it sounds like an easy job. Thank you for being here. Please begin your testimony.

**STATEMENT OF JEFFREY SMITH, CPA, MBA, FACMPE, CGMA,
INCOMING BOARD CHAIR OF MEDICAL GROUP
MANAGEMENT ASSOCIATION (MGMA), CHIEF
EXECUTIVE OFFICER, PIEDMONT HEALTHCARE, PA
STATESVILLE, NORTH CAROLINA**

Mr. SMITH. Chairman Scott, Ranking Member Gillibrand, and members of the Committee, thank you for the opportunity to testify on how administrative and regulatory red tape fuels physician burnout and undermines patient access to care.

I am honored to speak on behalf of Medical Group Management Association, MGMA, as its incoming Board Chair. MGMA has over 70,000 members across the United States representing 15,000 medical group practices and more than 350,000 physicians.

I am also the CEO of Piedmont Healthcare, a physician owned and led multi-specialty medical group based in Statesville, North Carolina, with over 230 physicians and providers and almost 1,200 employees.

I have over 40 years of health care experience and I feel deeply passionate about this issue, in part because I have seen its impact firsthand while working alongside my daughter, who is a primary care physician in my practice. MGMA has long advocated for reducing administrative burden and routinely surveys our members on administrative hurdles they face.

Their feedback makes clear the connection between regulatory burden, a broken payment system, and physician burnout. In our 2026 survey with over 230 responded physician practices, more than half of the practices report losing a physician to burn out in the past three years and among those, over 75 percent say regulatory burden played a substantial role.

This impacts patient access to care as it leads to longer wait times, shorter visits, and practices becoming unable to accept new patients. In my own practice, I have increasingly witnessed more physicians being driven toward early retirement. Burden related to

regulatory impacts, work-life balance as well, something I have seen with my daughter who often must complete these tasks at home after her children fall asleep.

While MGMA supports efforts to strengthen and expand physician training programs, addressing administrative and regulatory policies that are leading to physician burnout is critical to stem the tide on the front end and support physicians already in practice. I would like to highlight the following burdens that I and other MGMA members are facing that significantly contribute to physician burnout.

Medicare Advantage has allowed beneficiaries to access new benefits and can serve as an opportunity for innovation. However, as Medicare Advantage enrollment has increased, it has created daunting new challenges for many practices. MGMA members report audits, denials, prior authorization, and down-coding in Medicare Advantage as some of their top burdens in 2026.

There is also significant lack of standardization across Medicare Advantage plans. We have had to hire whole teams dedicated to value-based care just to interpret what quality really means.

For years, one of the top cited regulatory burdens for medical groups has been prior authorizations due to its impact on staffing demands, added cost, and impact on patient care. I oversee over 70 offices in the Charlotte metro area, and each practice has at least one staff member dedicated to prior authorizations.

MGMA members rank Medicare Advantage as the most burdensome payer. I appreciate the Chairman, Ranking Member, and many members of the Committee for co-sponsoring the Improving Seniors Timely Access to Care Act. It is important to pass this widely supported legislation that would streamline prior authorization for Medicare Advantage.

There are numerous additional opportunities to reduce duplicative and unnecessary regulatory hurdles. Reforming the Merit-Based Incentive Payment System, or MIPS, in Medicare would be welcomed. As complying with these requirements is a time-consuming and laborious process. Further, provider enrollment and credentialing in Medicare could be streamlined to better capture this data and lower practice costs.

All of this regulatory red tape is exacerbated by the continued under-reimbursement of Medicare Part B. Financial stressors were the second largest contributing factor to physician burnout in our 2026 survey. Given Medicare's reimbursement's frequent reductions due to outdated budget neutrality requirements and lack of an inflationary update, it is vital to pass legislation to comprehensively address these concerns.

The challenges discussed throughout this testimony coalesce to undermine the ability of independent medical groups to continue to operate and potentially lead many physicians to sell their practices. One MGMA member relayed selling their practice after being independent for over 100 years.

Enacting long-term reforms would help lead to a more robust practice environment. I sincerely appreciate the opportunity to testify today and share both my personal experience and other MGMA members' experiences on how regulatory burden contributes to physician burnout. I look forward to your questions.

The CHAIRMAN. Thank you. I now recognize Ranking Member Gillibrand to introduce the next witness.

Senator GILLIBRAND. Thank you, Mr. Chairman. I now want to introduce Corey Feist. Mr. Feist is the CEO and Co-Founder of the Dr. Lorna Breen Heroes Foundation and recently served as the CEO of the University of Virginia Physicians Group.

Mr. Feist has previously testified to support mental health legislation for health care workers in front of the House Energy and Commerce Subcommittee on Health. His advocacy efforts resulted in the passage of the first federal law focused on improving the well-being of health care workers, Dr. Lorna Breen Health Care Provider and Protection Act, in honor of his sister-in-law.

He was also awarded the Surgeon General's Medallion for Health in 2023 for the foundation's efforts. Mr. Feist, you can begin your testimony.

**STATEMENT OF COREY FEIST, JD, MBA, CO-FOUNDER
AND CHIEF EXECUTIVE OFFICER, LORNA BREEN
HEROES' FOUNDATION, CHARLOTTESVILLE, VIRGINIA**

Mr. FEIST. Chairman Scott, Ranking Member Gillibrand, and members of this Committee, thank you. My name is Corey Feist, CEO of the Dr. Lorna Breen Heroes Foundation.

On behalf of millions of health workers, thank you for the introduction and co-sponsorship of the Improving Seniors Timely Access to Care Act of 2025, and for reauthorizing the Dr. Lorna Breen Health Care Provider Protection Act. We now seek full funding of the Lorna Breen Act to ensure life-saving work continues. This is my third time testifying on this crisis.

Each time I carry the stories of those lost, not to a lack of resilience, but to a system that failed them. In 2021, I shared the story of my sister-in-law, Dr. Lorna Breen. She was a physician leader during the pandemic's first wave in New York City. Despite her bravery, she was terrified that seeking mental health care for her trauma that she witnessed on the job would cost her career that she spent her life building.

Lorna took her life April 26, 2020. In 2024, I shared the story of Tristan Kate Smith, a 28-year-old nurse whose father found a letter on her computer after her death. She wrote to the system she felt abused her, noting that instead of respect, they get pizza parties and pens for the health care heroes.

Today, I share the story of Dr. William West, a 34-year-old ophthalmology resident. His family called him Iron Will for his tenacity in rock climbing and endurance racing. In March 2024, the information ocean and pressures of medical training broke even Iron Will. In a devastating final note he wrote, I am simply exhausted and have nothing more to give.

He used his final moments to plead with administrators to support the residents rather than merely push them. William's story is a warning. Our health care system is claiming our brightest minds before they even finish their training. When we lose a resident, we aren't just losing one doctor.

We are losing 40 years of expertise meant to serve our aging population. The tragedy of losing clinicians like Lorna, William, and Tristan is compounded by the looming demographic shift. The number of Americans over 60 will increase by 46 percent in the next

decade. HRSA projects will cause a shortage of over 500,000 nurses, physicians, dentists, and pharmacists by 2038.

These projections do not fully account for those leaving due to systems failures, many of which you have already heard from. Forty-five percent of physicians say administrative pressures are pushing them toward career changes or early retirement. Administrative tasks like prior authorization are the number one driver of physician burnout. Nurses face a safety crisis with 80 percent experiencing workplace violence. Last year, 24 percent of Gen Z nurses left their roles.

Pharmacists are abandoning their roles due to excessively high workloads and hostile workplace climates. However, this is not a foregone conclusion. Thanks to the Lorna Breen Act funded Workplace Change Collaborative, we now have a proven national framework with several priorities for policy and practice to avert this crisis.

The Lorna Breen Act grantees have already supported over 250,000 health workers in states, and the results are undeniable with 35 percent reductions in staff turnover, 50 percent decreases in mental health conditions. The law also supported NIOSH's Impact Wellbeing Initiative, which provided 35,000 plus health care leaders with training to address the operational burdens that drive their workforce's burnout.

Our foundation created a technical assistance program to accelerate the initiative. We improved access to mental health care for more than three million health workers by supporting over 70 licensing boards and over 20—or 2,000 hospitals and care facilities and removing intrusive mental health questions from licensing and credentialing applications. We are also proving that administrative burden can be reduced while job satisfaction and patient experience improve.

One rural hospital decreased their workforce's cognitive burden addressing EHR alert fatigue. Their traveling nurses now want to stay in rural Virginia saying that this is the first place they have worked where they feel healthy, and they actually can get the help that they need. Reauthorization of the Lorna Breen Act is a historic win, but without funding, it is a hollow promise.

While billions are spent on workforce creation, the Lorna Breen Act programs are the only ones directly supporting retention. Investment in the pipeline is squandered if we don't stop the leaks.

For example, we currently face a two-year exodus in nurses, where 50 percent of new nurses leave the profession after two years.

This Committee can make a difference by ensuring the Lorna Breen Act is fully funded in Fiscal Year 2027, and for voting for the Improving Seniors Timely Access to Care Act.

I hope to return and report on the lives of health workers we have saved and how we are serving the aging community in the United States with the best and brightest among us, the Lornas, the Tristans, and the Williams. Thank you for your leadership.

The CHAIRMAN. I thank each of you for your testimony, and I will turn it over to Senator Moody for the first questions.

Senator MOODY. Thank you, Chairman Scott, Ranking Member Gillibrand for holding this hearing, and welcome to two of our wit-

nesses that are from Florida, for traveling up here and braving the ice on the ground. I know you wish you were back with the palm trees and flamingos. I do too. Welcome. This is such an important topic for our country, especially Florida. We have so many seniors in our state.

Some refer to us as not just the Sunshine State, but the Silver State. Discussing how we are going to provide efficient, quality health care is so important and so, this topic is of great importance and particular interest to me. Florida has some of the best hospitals and providers in the country.

We have world-renowned care, education, and training and we are so proud of these accomplishments, but we know they are only possible because we have hard working Floridians that have trained in health care and are part of our health care structure and show up to work, rain or shine, no matter what is happening.

Nationwide, the health care industry employs over 17 million people, making it one of the largest employment sectors in the United States, so it is understandable that we need a large health care sector and those that will work in this industry, but so much of that economy is tied up in billing, administration, and regulatory compliance and physicians are increasingly forced to spend nearly twice as much time on administrative work as they do in providing patient care.

I hear from Floridians all the time what they are experiencing on the job in these health care careers, and it is grinding and it feels burdensome. It is challenging and I think that is probably why a recent Mayo Clinic study found that 57.1 percent of physicians said they would choose to become a physician again, down from 72.2 percent just five years ago.

With endless prior authorization requests, sometimes combative patients, extreme working hours, it is no wonder that many providers step away from their traditional practices to transition to direct primary care practices, also known as concierge care.

Many of these practices allow physicians to see patients for longer, avoid cumbersome administrative processes, all while delivering a higher quality experience and giving doctors more time to live their lives.

We expect that segment of the health care industry to grow to nearly \$36 billion by 2030 and while there is a lot of good with that, and I certainly understand why there is that transition, we have to recognize that the exodus of providers from the mainstream health care system is a symptom of an underlying problem with that traditional system, and we as a Government have to figure out why that is.

I mean, it is no longer a free market in the health care system. Government has gotten so involved and so regulated, and we require so many things. Some seem nonsensical, like making you move to a different computer system when yours is working just fine, where you have to maintain two computer systems.

Unbelievably wasteful, and it sounds just like the Government but we are no longer a free market in our health care. I mean, supply and demand in health care is not driving costs anymore, and this is why we are seeing costs drive through the roof.

This is why it is so taxing now on consumers of health care, and I don't blame this mass exodus of people trying to move into what health care used to be, providing care to patients in a way where you feel like you have a relationship with them, you can spend time with them, high quality, maybe even cost efficient.

I am supportive of that but I am very nervous that concierge care or even direct care outside this, what we would now call the traditional health care or mainstream health care system, might not be accessible by everyday people who might not have a really, really high income. I worry about that.

Obviously, as we are seeing this mass exodus from the profession in general, I think we are going to have a projected shortage of 140,000 physicians by 2038. We are seeing a mass exodus of physicians, period. We have a mass exodus going into this more direct or concierge care. I am really worried about what happens for everyday Americans that might not be able to afford that direct care.

I think this is a great topic for us to talk about because I really think what has driven that is this just crazy, over-regulated, non-sensical approach by Government to—and the more and more we become involved in health care, the more and more complex and out of control, and chaotic, and unmanageable, not working for physicians, not working consumers, it becomes.

Dr. Gross, thank you for being with us. Congratulations on a successful career. I wanted to ask you how—you know, congratulations on all that you have been able to do to navigate around what we in government have created in the traditional health care system, but what would be your recommendations to—from where we find ourselves with a rapidly declining physician population, and out of that, add to it those moving out of a health care system that is more traditional, that many use government services or government assistance to access.

What would be your recommendations for those of us on this Committee to make sure that health care is not only quality, but cost efficient for Americans?

Dr. GROSS. Thank you, Mr. Chair. A lot to unpack in the statements there. I think one of the first things that I would like to do is just clarify a little bit between concierge medicine and direct primary care, because concierge medicine typically does charge an access fee and then bills a fee for service to a third-party payer, whereas the direct primary care charges a subscription fee, and everything is included in that, so there is a difference in the price points.

Senator MOODY. Different in the way you charge.

Dr. GROSS. Different in the way you charge and different in what is included, so we don't bill—it is not like a fast pass at Disney World, where you pay for access. You know, that is more of a concierge model.

Moving past that, I would say that a physician that leaves practice because they are overburdened, and they have moral injury sees precisely zero patients, so if you are forcing somebody out of practice because of the complexities of it, then you are not comparing it to a doctor that would see 3,000 patients and now they are shrinking it.

You are comparing it to a doctor that would see zero patients, so it is not an actual fair comparison, because I would not be practicing medicine today if I did not change my practice model. I just wouldn't have done it.

I would have found something else to do. I am forced by law to opt out of Medicare when I direct contract with these patients. That was not my decision. That was federal law that required—

The CHAIRMAN. Explain that—that you can't do both.

Dr. GROSS. Right. When I directly contract with a Medicare beneficiary for services that are covered by Medicare, I have to, by law, opt out. It is not just opt out in my direct care practice. It is across the board, under everything tied to my NPI. I can't moonlight as a hospitalist. I can't serve ER shifts. I can't do telemedicine through a traditional teledoc type service, because they all bill Medicare.

That locks me into saying, I can only accomplish this panel size by statute. I would love to see that change. I want to work with you to change that statute, because that has a disproportional impact on rural health care.

Because if I am putting a panel of a primary care doctor in rural America, in rural Alaska, rural Utah, I can make a direct primary care practice work and be profitable with 300 to 500 patients. I can't do that with a fee-for-service practice. If I come in with 300 to 500 patients, I am going to need massive federal subsidies.

I am going to need something to keep that practice afloat, and there is no way you are going to be able to do it, so and again, if statute requires me to opt out to do that—I may be the only doctor in your community serving in your emergency room.

I may be the only that might be able to care for you in the hospital, and statute has required me to opt out because I am providing more affordable and accessible care. It is important to, again, to have the maximum flexibility for physicians to shift to the needs of their community directly and not have that federally dictated.

For example, when we went into COVID, it took three months for Medicare to recognize the invention of the telephone, and we are still fighting over whether the telephone is appropriate access for physicians and whether the Federal Government should pay for it.

Just as recently as two weeks ago we are trying to decide this. I shifted my practice to a telemedicine on day number one. When you mentioned the rains falling, when Hurricane Ian tore the roof off the emergency room next to my office, I didn't need to wait for the insurance companies to convene a new code for me to provide parking lot care for my services. I put a tent in the front of my building.

We opened up to all comers, whether they were our patients or not. We provided free care to the community. Why? Because I am getting paid. I am being paid on a subscription basis and I have the flexibility and ability to provide the services to the care, to my community that they need.

Senator MOODY. Thank you.

The CHAIRMAN. Thank you. Ranking Member Gillibrand.

Senator GILLIBRAND. Thank you, Mr. Chairman. Mr. Feist, in your testimony, you discussed how administrative burden is an un-

derlying cause of physician burnout, impacting time with patients and pushing doctors beyond even extended working hours.

Your foundations, Impact Wellbeing Guide, provides guidance on how hospitals and health systems can address these burdens through quality improvement projects. Could you please share a brief example of how health care providers successfully reduce physician burnout by using your Impact Wellbeing Guide.

Mr. FEIST. Absolutely. The Lorna Breen Act created the Impact Wellbeing Guide, and NIOSH partnered with our foundation and our all-in national coalition of over 37 of the largest professional associations to create this leader retraining guide.

What we have done is we have implemented this guide across the United States, particularly in Virginia, North Carolina, now in New Jersey, and as well as in Wisconsin and, what we saw in Virginia after doing this were decreases in the amount of time that clinicians were spending in the electronic medical record before and after work by significant numbers.

In some cases, three to five minutes per patient, in some cases ten to fifteen minutes per patients. Huge decreases there. In addition, standing orders for pharmacy refills. Things that keep the pharmacists, the patients, as well as the physicians burdened with bureaucracy. All of those things, using the Impact Wellbeing Guide, decreased the amount of time that folks were spending outside of direct patient care, increased their well-being, increased—and decreased their burnout.

Senator GILLIBRAND. Thank you. Dr. Smith, your testimony describes how Medicare Advantage's burdensome prior authorization requirements significantly contribute to physician burnout and can harm patients.

Over 60 Senators, including myself, are pushing to pass the Improving Seniors Timely Access to Care Act to streamline the prior authorization process and help address some of these widespread concerns.

Yet, CMS's new Wasteful and Inappropriate Service Reduction model, also known as the WISeR model, expands prior authorization into traditional Medicare and utilizes a new non-standardized approach that is inconsistent with the existing federal regulations. How will the WISeR model increase administrative and patient burdens in traditional Medicare, and how might this drive burnout among physicians in states where this model is enacted?

Mr. SMITH. I think what you are going to see is more prior authorizations needed. That is going to add burden to the staff.

There will be more denials that will add burden to the physician to either fight the denial or just to decide it is just not worth the fight. Now, you have patients not receiving care. If patients don't receive care, I believe that they will get sicker, they will end up in the emergency room, and ultimately the hospital, which will drive the cost of health care up.

My dad is 94. He went to the doctor this week while I was up in Philadelphia visiting him, and the doctor decided that he needed a CAT scan. I would bet a lot of money that that would be denied if you did a prior-auth on that.

Senator GILLIBRAND. Right.

Mr. SMITH. You know, we spend a lot of time telling doctors, you know, you are in charge, you are the quarterback of care. We actually increased the E&M codes, but every step of the way we question what they do. I think we would just be contributing to the burnout of doctors if we move forward with it.

Senator GILLIBRAND. I agree. Dr. Gross and Dr. Littles. Dr. Gross, in your testimony, you highlight the mismatch between how physicians are trained and the regulatory environment that they practice in.

You say that when physicians enter the workforce, they are clinically competent but structurally unprepared to operate smaller rural practices. How does this mismatch drive physician burnout and contribute to consolidation?

Dr. GROSS. One of the things that I have noted is that when people are graduating from training—I am kind of old school. When I went into training, I had full practice management training in my practice.

That doesn't really happen to a degree. I mean, it is still sort of required. When people graduate, they do not have the full practice manager. How do you have compliance? How do you comply with OSHA? How do you hire? How do you fire? How do you set up your structure? How do you negotiate contracts?

That is all stuff that I learned in my training, but it is not really being taught to that degree. Because most people are being trained to be employees in an outpatient and ambulatory setting.

If you are trying to then go from training into a rural health care setting delivery where you need to be running your own practice, they are not prepared for that. People are just not even stepping into that environment, and it is leaving a huge void in the rural communities.

Senator GILLIBRAND. Thank you. Dr. Littles, in your testimony, you shared how medical schools and residency programs in Florida recognize this mismatch and are incorporating activities to help students prepare for the impact of the profession's administrative burdens. Please describe some of these initiatives and discuss how medical students and trainees have responded to these trainings.

Dr. LITTLES. Sure. We all know that medical school is a stressful environment, going through the process of training to become a physician, so we put in support systems, you know, for students to help guide them through this because we recognize that they are going to be facing stressful situations throughout their career, so having, you know, access to onsite counseling that they can, you know, access right there at the college without feeling that, you know, tension of is this going to affect my licensure later on and prohibit me from being licensed or practicing medicine, so activities like that.

Having wellness activities so that they learn to take breaks because at the end of the day we are all humans before we are physicians and they need to be able to, you know, to take breaks, make sure that they are, you know, eating properly, and getting rest, and maintaining connections to their support systems that they had even before they came, you know, to medical school.

Training them with those activities but also recognizing that these other stressors that they are going to face as practicing phy-

sicians are there as well and so, having them actually training with those physicians—I mean our students and our residents get to see what our attending physicians are facing in their practices.

When they are having to deal with these issues like, you know, prior authorization and denials, and you know, patients not being able to access the appropriate lab or the appropriate, you know, X-ray facility, they are seeing this as a part of their training, even in medical school.

As Dr. Gross said, those requirements for that practice management training is there for our resident physicians, but a lot of them are not focusing on it. Certainly not early on in their residencies they are not focusing on it because they are not having to be the ones ultimately responsible for it.

As they get closer to graduation, they tend to start paying a little bit more attention to it but it is true that more physicians are employed today than even, you know, 10 years ago and certainly more than, you know, 20, 25 years ago. More and more of them are entering employed situations which in many cases exacerbates a lot of these issues we are talking about.

Senator GILLIBRAND. Thank you.

The CHAIRMAN. Senator Warnock.

Senator WARNOCK. Thank you Chair Scott and Ranking Member Gillibrand. Communities in my state and all across the country face dire physician shortages as this panel has demonstrated.

Estimates are that in just a couple years we will be short by tens of thousands of doctors. Mr. Feist, what effect will additional workforce shortages have on our current health professionals many of whom are already facing?

Mr. FEIST. Reduction in staff are a force multiplier on the issues that we have been talking about on this Committee today. We have to look at what our clinicians are spending their time doing right now.

When you look at the fact that about 70 percent of a primary care physician's time and 50 percent of a nurse's time is spent away from the bedside, away from a patient, spending that time on administrative burden—as you decrease your staff, who else is left to do the administrative work? It is this vicious cycle that will impact access. It will impact quality. It will affect cost over time.

Senator WARNOCK. It is an impact, obviously, on the workers, including the physicians and their workplace, but it is a real effect on patients—

Mr. FEIST. Absolutely.

Senator WARNOCK [continuing]. and the quality of the health care that they are able to provide. For decades, Medicaid has helped fund doctor residency training through the Graduate Medical Education, or GME, Program.

This program has played a critical role in addressing physician shortages in states like Georgia, where more than 2.7 million Georgians live in a health professional shortage area. It is clear we need to do more.

That is why I was proud to introduce the bipartisan Resident Physician Shortage Reduction Act alongside my friend Senator Boozman. This bill would fund 14,000 new resident slots over the next seven years.

Mr. Smith, how would you increase—how would an increase in Medicare-funded graduate medical education slots help improve our seniors' access to health care services?

Mr. SMITH. I think any physician—any addition of physicians into the market would increase access to care. There would be more appointment time and more availability.

The challenge we have is convincing those doctors to go into primary care and internal medicine. Most of them, nowadays, they say, you know, become a neurosurgeon, or you know, I want to become an EP doc in cardiology, because there is more money there.

They are trying to pay off their student debts. They spend another year in fellowship. We don't see a significant amount of docs wanting to be family practice doctors anymore. I think somehow we have got to incentivize that in this program to make that more attractive, and the noble position that it used to hold in the community.

Take some of this administrative burden off of them and let them be doctors again. The numbers are great. We need the numbers. We know that the shortage by 38 is going to be staggering. I think the bill is——

Senator WARNOCK. They are making decisions then about the direction of their career and what they will be able to practice, not necessarily based on what they prefer to do. Some would love to go into primary care. It is an economic issue.

In that regard, Dr. Littles, in your experience, how often does the cost of higher education in the health professions dissuade people from entering the field?

Dr. LITTLES. Thank you for that question. We certainly believe that that is a factor. Because as I said, when students come into medical school, they come because they really want to be able to provide care and spend that time, you know, with their patients but they also need to be to make a living in doing that.

As has been said, it is the primary care specialties that are the hardest hit with that because they tend to be at the lower end of the pay scale already and if you are asking them to do more and more for less and less, at some point that just doesn't work, you know, for them.

If we are able to fix some of these other issues with those practices, I believe those students who come in wanting to take care of patients in a primary care setting will continue to want to do that and we will continue to do that.

Senator WARNOCK. Absolutely. I would imagine—well, not imagine. I know this is particularly difficult for first generation college students who have gone on to medical school and are—you know, they have the aptitude, but you have these barriers.

In the last few months, I have heard from thousands of Georgians about changes to federal loan limits under the big ugly bill, which capped the maximum amount of federal direct loans available to students pursuing a health profession. Most medical and nursing students in Georgia rely on federal loans to afford their education and when federal loans are capped, students seeking advanced degrees in health care still owe the rest of their bill.

Those who don't come from rich families have to then try and get risky private loans from banks, or worse, put their tuition balance

on high-interest credit cards, or even just give up their dreams of being a health professional altogether.

This is a concern that all of us share. I appreciate your work in this area, Dr. Littles, and also other members of the panel. I am deeply concerned that these changes to the federal student loans amid a growing health care workforce shortage and aging population is the exact wrong move at the exact long time. Thank you so much.

The CHAIRMAN. Thank you, Senator Warnock. Senator Alsobrooks.

Senator ALSOBROOKS. Thank you so much, Chair Scott, Ranking Member Gillibrand, and thank you so much as well to all of our witnesses for being here today. Across the country and in communities throughout Maryland, physicians are telling us the same story.

We hear that they are exhausted, overwhelmed, and increasingly unsure how long they can continue practicing in a system that demands more from them each year, while giving them less time, less support, and less autonomy to focus on patient care.

You know, I had a medical appointment just last week and had that experience. The doctor came in, collapsed basically on the chair and said, you know, I don't know what we are doing here. You know, one patient after the next.

Burnout is not simply about long hours. It is about physicians spending more and more of their time navigating layers of paperwork and trying to operate around complicated processes instead of caring for patients. It is shorter visits, heavier caseloads, and constant pressure to do more with less.

It is about working in environments where asking for help can still feel risky or discouraged. In Maryland, I hear from providers who want nothing more than to stay in their community and care for their patients, but who are struggling under administrative complexity, rising operating costs, and workplace structures that prioritize volume over quantity.

These pressures are driving talented physicians out of medicine, and patients are feeling the consequences. Appointments are hard to get, wait times are longer, and rural and underserved communities are losing providers altogether and exhausted clinicians face higher risks of medical error, directly affecting patient safety. This is not just a workforce issue.

It is a health care issue as well, an access issue. It is the quality of care and system sustainability issue. At the same time, the drastic Medicaid cuts in H.R. 1 threaten to further destabilize clinics and hospitals that serve as the backbone of primary and preventative care, forcing more patients into emergency rooms while placing even greater strain on an already stretched workforce.

We cannot afford to continue operating a health care system that is burning out the very professionals that we depend on. Now, I have a question, Mr. Feist, if I can start with you and you have spent years working with hospitals, health care systems, and policymakers on efforts like Dr. Lorna Breen Health Care Provider Protection Act to address physician mental health and burnout.

Much of the national conversation focuses on helping physicians manage stress, but far less on reforming the structural conditions

that drive burnout in the first place, so based on your work, can you tell us what are the most impactful preventative reforms that reduce burnout at its root?

Mr. FEIST. I appreciate the question because you highlight the issue. The well-intended response over the last few years to the workforce has been to flood the market with a message of you need to be more resilient to health workers, when they need the problems addressed at the root cause.

What we hear from the workforce by asking them the same question you asked me is that the administrative burden is the number one driver of their burnout. In addition, for nurses, the increasing issues around safety and threats and acts of violence against them are also driving them completely out of the workforce.

The workloads are manageable if you think about the fact that if you—I am sorry, the workloads can be manageable if you reduce the amount of administrative time that they are spending before and after work.

That in getting health workers back to the bedside and back to getting into the direct patient care that they went into the business to do, so we need to return them back to what they trained for and eliminate as much of the administrative burden and other operational inefficiencies that stand between them and their patients every day.

Senator ALSOBROOKS. As to workforce violence, I have heard a lot about workforce violence. How important is it that occupational safety and health administration develop clear federal standards to ensure that physicians, nurses, and other health care professionals can practice in environments that are physically safe, as well as adequately supported?

Mr. FEIST. A question back to me?

Senator ALSOBROOKS. Yes.

Mr. FEIST. I think about the Maslow hierarchy of needs. You have your essential needs of being able to be fed and watered, if you will, use the restroom but then right above that, you have safety and feelings of just being physically safe and emotionally safe. It is critically important for our workforce.

I mean, we don't walk in here every day without armed guards outside and yet, we send our health workers into an environment where they can be physically and verbally abused every day, and then we ask them to come back tomorrow and do it all over again. It is just an unsustainable environment for them to work in.

Senator ALSOBROOKS. One last question. My time is going here. Prior authorization, and this is for Mr. Smith, has become a routine gatekeeper in medical care, often requiring extensive paperwork, repeated appeals, and long delays before patients can receive treatment that their physicians deem medically necessary.

From your perspective running medical practices, how does the current prior authorization system contribute to physician burnout? What consequences do you see for patients when medically necessary care is delayed or denied, particularly for older adults and those in rural and underserved communities?

Mr. SMITH. Yes, thank you. Prior authorizations are delaying care. There is no doubt about it and just to back up for a second, burnout is not restricted to doctors. In some of our offices, we have

over 40 percent of our staff turnover every year because they cannot last in this environment. It is that difficult.

I try to see every class of incoming employees and I tell them, health care is not for the faint of heart. It is incredibly difficult, and I believe our front desk folks have the toughest job in health care. Not the doctors. It is the front desk. They need to be psychiatrists, insurance experts, best friends. I mean, it is incredibly challenging, all working under HIPAA obviously.

Prior authorization slows care. We see that, forcing folks to go to urgent care, in a lot of cases to the emergency room, because we haven't been able to get the authorization. We see delays in care. We haven't been able to quantify what that means in terms of additional dollars, but I think that would be worth looking at because I think that slowdown—we keep saying we need to get rid of the administrative burden, but we also recognize that the Government doesn't have unlimited money.

How do we work together to reduce those burdens so it reduces our costs, so we may not need as much of an increase as we had thought we did because now we can get rid some staff or rearrange some staff.

We can back to taking care of patients, because that is really—that is what doctors want to do. That is why they went to medical school. I believe that prior-auths are our biggest issue and truly need to be addressed quickly.

Senator ALSOBROOKS. Thank you.

The CHAIRMAN. Thank you, Senator Alsobrooks. Dr. Littles, what effect does documentation reporting requirements have on the willingness of new physicians to practice in rural or underserved areas?

Dr. LITTLES. Thank you. We have been talking about the stressor of dealing with the electronic health records and the number of electronic health record that physicians often have to go through in the course of taking care of their patients.

When you extend that out into rural communities, oftentimes even access to an electronic, you know, health record in and of itself—one, it is costly, but sometimes that is difficult for them to even have.

When they have that electronic health record, we know that, you know, the number of clicks that they have to go through to provide the documentation is directly related to the stress that they feel from that.

When you are asking about how the documentation specifically is affecting students wanting to go into rural practice, among the whole list of other factors that prevent them from doing that, that is certainly one of them.

The cost of the electronic health record, the complexity of using the electronic health record. The fact that the electronic health record isn't communicating with the physicians they are referring patients to in nearby urban areas.

All of that has a negative impact. I hear my faculty talking all the time about the pajama time that they are spending on their electronic health record, which has also been mentioned today. All of those are distractions from the care of the patient.

The CHAIRMAN. Thank you. Dr. Gross, tell me how your practice changed. How is your day different now from when you are running an insurance driven practice to a patient driven practice?

Dr. GROSS. Yes. When I have a fee for service practice, any slot in my schedule when I walk into my office that is not already filled is lost revenue, so when I walk in, the schedule is already full.

As the phones start to ring, then I have to start adding double booking, triple booking, quadruple booking, referring to the emergency room, sending to physician assistants, nurse practitioners, sending to other sites of care, because I don't have the capacity built within my schedule to accommodate for them. Which requires me to run an hour behind schedule, two hours behind schedule.

Five minute office visits, three minutes of those which are spent clicking the boxes to get paid and then the two-minutes, oh, you have got another problem. I am sorry, you got to rebook, and by the way, my next available appointment is in three months. My schedule that I have right now is I walk into my office, I have an hour before lunch blocked out for same day appointments an hour before lunch, at the end of my day blocked out for same-day appointments. As the phone rings, if you call me in the morning, you are seen in the morning. As you call in the afternoon, you are seen in the afternoon.

If I don't get a phone call, then I do administrative time, or I go home and spend some time with my family but people aren't referred to the emergency room simply because I am too busy and that opens up my schedule to actually practice to the full scope of my training.

I would argue that a lot of referrals in primary care is not because the doctor is not capable of handling the problem. It is because the doctor doesn't have time to handle the problem, so when the doctor now has the time and the administrative burden is lifted to perform the full scope of his or her practice, now you are stopping downstream referrals for endocrinology, for rheumatology.

You are managing things within your practice that are clearly within your purview as you are training and we see that in our data. That when we implement this into a health plan that is built around our practice model, our ER referrals are 35 percent less. Our specialty referrals are 35 percent less.

Our cost of total implementation of the health plan built around our model is a 52 percent reduction in health care in a rural health care setting and we sustain numbers like that over seven years because we are—not because we are better than anyone.

It is the structural design of the practice. It is the administrative design of the practice, the intent of that, which I think is completely changing how we care for patients.

The CHAIRMAN. Mr. Smith, how much of your budget goes to getting prior authorizations, compliance, paperwork versus patient care?

Mr. SMITH. Well that is a good question. I don't have a specific answer. I can tell you that in 75 offices, we have at least one employee, average employee, with benefits is making \$35,000 to \$50,000, so it is a significant amount and if we could reduce that by a quarter, by a half, it would significantly change the budget of the medical group.

The CHAIRMAN. Is it easy to stay up with all the changes by the insurance companies and by Medicare and by Medicaid?

Mr. SMITH. I am sorry. Say that—?

The CHAIRMAN. Is it easier to stay with all of the rule changes by Medicare, Medicaid, plus all the changes with the insurance company?

Mr. SMITH. It is not easy. I mean we do our best to educate. We have great staff. You know, our staff typically is high school educated. Working in the medical offices, we have in-house programs to allow them to become certified medical assistants.

We do everything we can to raise them up and to increase their knowledge, but it is a lot. You know, a one or two doctor practice, can't really have a business manager running that practice, so we are running it from afar and hoping that we can get information to them to allow them to be successful. Honestly, just to get paid for the work they are doing.

The CHAIRMAN. The people who run Medicare and Medicaid in your state, they are just out there to help you every day, aren't they?

Mr. SMITH. Yes, every day they come out. [Laughter.] No. It is a challenge.

The CHAIRMAN. Mr. Feist, how much of today's mental health crisis is driven not by patient care itself but by the constant pressure of bureaucracy and red tape?

Mr. FEIST. We hear—as we have discussed today, when you think about burnout as an occupational syndrome and burnout as driven by the workplace design, I think as we discussed today the vast majority of what we are experiencing in burnout is within our control to reduce by changing the operational environment that our health care workers work in every single day.

The CHAIRMAN. Well, I want to thank everybody for being here today. This was eye opening and hope all of our colleagues in the Senate see all this.

I think it is very difficult what physicians are going through and I think more and more physicians are doing what you are doing, Dr. Gross. They have got to opt out of the way the system is organized because it is just too difficult.

I am sure you deal with, Dr. Littles, all the time with, you know, the choices people are making, so thanks everybody for being here. It is clear that real reforms must start with cutting red tape and putting doctor-patient relationships at the center of health care so physicians can focus on healing rather than compliance.

I look forward to continuing to work with members across the aisle and down the dais. If any Senators have additional questions for the witnesses or statements to be added, the hearing record will be open until next Wednesday at 5:00 p.m. Thank you very much. It is adjourned.

[Whereupon, at 04:45 p.m., the hearing was adjourned.]

APPENDIX

Prepared Witness Statements

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF
MEDICINE"

FEBRUARY 11, 2026

PREPARED WITNESS STATEMENT

Dr. Alma Littles



Testimony from Dr. Alma Littles, Dean of the FSU College of Medicine

**"The Doctor Is Out: How Washington's Rules Drove Physicians Out of
Medicine,"
February 11, 2026
3:30 P.M.**

Chairman Scott, Ranking Member Gillibrand, and distinguished committee members, thank you for the opportunity to speak with you today to share a perspective on an issue that is becoming increasingly urgent across our nation—physician burnout—an issue experienced by doctors who want nothing more than to care for their patients, yet find themselves pushed to the brink by the very system meant to support them.

Physicians enter medicine with a clear purpose: to heal, to serve, and to stand with patients in their most vulnerable moments. But today, that purpose is being overshadowed by unsustainable administrative burdens leading to record percentages of physician burnout. The American Psychiatric Association defines three core components of burnout:

1. Overwhelming exhaustion;
2. Depersonalization, along with feelings of cynicism and detachment; and
3. A sense of ineffectiveness and lack of accomplishment

We know physicians have a higher incidence of suicide when compared with other professionals in the United States; around 400 take their lives each year. And just as concerning, medical students and residents have rates of depression 15 to 30 percent higher than the general public. This is a national crisis. To address it, the National Academy of Medicine, the Association of American Medical Colleges and the American Medical Association are actively developing resources.

Physicians are leaving medicine not because they have lost their passion, but because the regulatory environment has made it nearly impossible to practice the way they were trained to. Physicians lose satisfaction when factors come between them and their patients.

The issue is not regulation itself. Physicians understand the need for oversight, accountability, and patient safety. The issue is the volume and complexity of mandates—documentation requirements, reporting systems, compliance checklists, and insurance rules and regulations that grow year after year in the face of reduced reimbursements and without regard for the time they consume or the strain they impose in the form of inability to make decisions based on training and science.

The consequences of burnout can be devastating.

Think about this: One physician leaving practice potentially leaves 2-3,000 patients without access to care.

Studies suggest that more than half of practicing physicians say they are burned out. We found this to be a real issue in Florida after becoming aware of several suicides among medical students, residents, and faculty.

But here is the hopeful part: this crisis is solvable. The medical schools in Florida came together to evaluate the support being provided to address the root causes of burnout. We used this data to share experiences and solutions.

Programs were developed that support wellness activities, and deliberate efforts were made to destigmatize seeking help in medical school, residency training, and practice. This included lobbying for a change in the licensure application regarding how questions about prior mental illness were asked and addressed. The survey of medical schools and residency programs confirmed that the schools were actively engaged in a variety of activities including:

- Incorporating mandatory wellness topics into the curriculum;
- Providing dedicated on-site counseling services;
- Offering online resources;
- Hosting financial aid/planning workshops; and

- Incorporating activities that prepare students for the impact of administrative burdens.

Since our founding 25 years ago, the Florida State University College of Medicine has recognized the threat of physician burnout and we hard-wired into our curriculum and extracurricular activities programs and activities to address it. We provide resources on sleep and stress management, weekly fitness classes, campus walks, and improved our on-site fitness room. A major suicide awareness and prevention program featured film screenings and a live panel discussion. Our six regional campuses across the state of Florida added their own wellness programs.

All of this is helpful, but we cannot lose sight of key components of the AMA's Physician Wellness program that includes the reduction of administrative burdens, reduction of stress drivers in organizations, and removal of regulations and technology requirements.

We need your help. You have the power to make a positive impact:

- By supporting regulatory reform.
- By promoting administrative simplification.
- By ensuring that federal policies strengthen—not strain—the physician workforce.
- And by recognizing that the best way to protect patients is to protect the people who care for them.

Addressing this issue is no longer an option, it is critical to ensuring access to care!

Thank you for your time, your attention, and your commitment to the future of healthcare. The path forward is clear. We simply need the will to take it. I look forward to continuing this conversation.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF
MEDICINE"

FEBRUARY 11, 2026

PREPARED WITNESS STATEMENT

Dr. Lee Gross

**Written Testimony of Lee S. Gross, MD Founder, Epiphany Health – Direct Primary Care
North Port, Florida**

Before the United States Senate Special Committee on Aging

Hearing: The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine.

Date: February 11, 2026

I. Introduction and Credentials Chairman, Ranking Member, and Members of the Committee:

My name is Lee S. Gross, MD. I am a family physician and have practiced full time in Southwest Florida for more than twenty years.

I currently serve on the Florida Board of Medicine. This testimony reflects my personal experience and views and does not represent the official position of the Florida Board of Medicine or the State of Florida.

I am the founder of Epiphany Health, one of the earliest Direct Primary Care practices in the United States. I also serve as President of the Docs 4 Patient Care Foundation, a national physician-led organization focused on healthcare policy and workforce sustainability.

Thank you for the opportunity to testify on how Medicare's expanding regulatory framework is accelerating physician burnout, driving consolidation, and worsening access to care for America's seniors, particularly in rural and underserved communities.

II. The Collapse of Independent Medical Practice Independent physician practices have long served as the backbone of American medicine. They deliver continuity, accountability, and relationship-centered care that is especially critical for older adults managing chronic illness.

That foundation is rapidly disappearing.

Across the country, independent practices are closing or being absorbed by hospitals, private equity firms, and large corporate health systems. While many forces influence consolidation, Medicare's regulatory structure has become a dominant and accelerating factor for small and rural practices.

This shift is not being driven primarily by patient preference, quality concerns, or clinical outcomes. It is driven by federal payment structures and regulatory requirements that impose administrative costs unrelated to patient care and largely independent of practice size.

In my own community, my partner and I ultimately became the last remaining independent primary care practice in a rapidly growing city that has expanded to more than 90,000 residents. Every other practice either acquired or closed, overwhelmed not by lack of demand, but by compliance burdens that had little to do with medicine itself.¹

III. Medicare's Administrative Burden Medicare regulations now permeate nearly every aspect of clinical practice.

Physicians must comply with complex coding systems, documentation rules, multiple quality reporting programs, audit exposure, and continuously evolving compliance requirements. Each program may appear reasonable in isolation. In combination, they consume an extraordinary share of physician time and practice resources.

The consequences are well documented: · Physicians spend hours each day on documentation rather than patient care · Practices must hire staff whose sole role is compliance · Small offices face disproportionate financial strain · Burnout accelerates early retirement and reduced clinical hours

These pressures have intensified in recent years, accelerating early retirement, part-time practice, and physician exit.

For many primary care practices, the administrative cost of participation now exceeds the marginal clinical revenue generated by additional patient visits.

When each additional unit of work produces a net loss, increased volume accelerates failure rather than sustainability.

IV. Mismatch Between Medical Training and Practice Reality Compounding these pressures is a growing mismatch between how physicians are trained and the regulatory environment in which they are expected to practice.

Medical education prepares physicians to diagnose and treat illness, but provides little to no training in practice operations, regulatory compliance, billing systems, human resources management, or administrative risk mitigation.

New physicians enter the workforce clinically competent but structurally unprepared to operate small or rural practices under Medicare's expanding regulatory framework.

As complexity increases, and training costs rise, independent practice becomes not merely unattractive, but functionally inaccessible for early-career physicians. Employment within large health systems becomes the default path, not by preference, but by necessity.

This structural mismatch contributes directly to consolidation and explains why retiring physicians are not being replaced by new independent practices, particularly in rural and underserved communities.²

V. Medicare Payment Instability and Workforce Exit Administrative burden alone places enormous strain on independent practices. Payment instability compounds that strain.

During the years governed by the Sustainable Growth Rate formula, Medicare payment policy was characterized by repeated cycles of proposed deep cuts followed by last-minute

congressional intervention. While those cuts were often delayed or reversed, the uncertainty surrounding them created significant operational risk for small physician practices.

In my own practice, these recurring payment cliffs made long-term planning nearly impossible. The uncertainty forced me to take out personal loans simply to ensure payroll continuity while awaiting congressional action. Staff salaries, rent, and operating expenses could not be paused while Washington debated whether scheduled cuts would take effect.

Although many reductions were ultimately averted, the brinksmanship itself imposed financial risk that small offices were poorly positioned to absorb.

Compounding this instability, Medicare physician payments have not kept pace with inflation for more than two decades, steadily eroding the financial viability of independent primary care.³

Large health systems could manage this volatility across diversified revenue streams. Independent practices operating on narrow margins could not.

That instability ultimately became the decisive factor in my decision to leave Medicare participation. That decision reflected operational realities, not opposition to Medicare's mission or to caring for Medicare beneficiaries.

That experience marked what we later referred to as our "Epiphany" moment and forced a fundamental reassessment of why primary care is structured the way it is.

Why are we insuring primary care?

Primary care is a low-cost, high-value service, yet it is routed through complex insurance structures designed for catastrophic risk. Layers of billing intermediaries, tens of thousands of procedural codes, and hundreds of thousands of diagnostic codes are imposed on care that is fundamentally relational and longitudinal.

Somehow, we are surprised that it has become expensive, impersonal, and complex.

VI. Regulation as Fixed Overhead and the Structural Driver of Consolidation A critical feature of Medicare regulation is often overlooked. It functions as fixed overhead.

Compliance costs do not scale proportionally with patient volume. Certified electronic records, reporting platforms, billing systems, audit preparation, and administrative staffing impose similar expenses on a two-physician rural practice as on a multi-hundred-provider health system.

Large organizations can distribute these fixed costs across many clinicians and locations. Independent practices cannot.

As regulatory complexity increases, scale itself becomes a survival requirement.

Consolidation accelerates not because it improves care delivery, but because it allows administrative costs to be spread across a larger denominator.⁴

VII. Erosion of the Doctor-Patient Relationship Primary care depends on time, trust, and continuity.

Regulatory overload erodes all three.

As documentation demands expand, clinical encounters are increasingly shaped around billing and reporting requirements rather than patient need. Notes increasingly serve regulatory validation rather than clinical communication.

Older adults experience fragmented care, reduced continuity, and shortened visits.

The result is increased downstream utilization, higher total system spending, and diminished quality of care despite growing administrative investment.⁵

VIII. The Rural Access Crisis and Non-Scalable Compliance Costs The impact of fixed regulatory overhead is most severe in rural and underserved communities.

In these settings, access barriers rarely stem from lack of patient demand. They arise from systems that require administrative scale unrelated to the delivery of clinical care.

Under traditional fee-for-service Medicare participation, rural primary care practices often require patient panels approaching 3,000 individuals to generate sufficient billing volume to sustain certified electronic records, quality reporting programs, coding infrastructure, and compliance staffing.

Even at that scale, many practices remain dependent on supplemental subsidies or hospital support to offset administrative costs rather than clinical expenses.

These requirements bear little relationship to the actual clinical capacity of a primary care physician.

By contrast, when administrative design is simplified, the economics change entirely. In environments not dominated by billing and reporting infrastructure, primary care practices can remain financially viable with patient panels of approximately 300 to 600 individuals.

This contrast demonstrates that rural access failures are not caused by insufficient demand or physician shortages alone. They are driven by regulatory structures that impose fixed overhead costs incompatible with small-community medicine.

Physicians are not leaving rural communities because patients are absent. They are leaving because policy design has made independent practice economically untenable at the scale rural communities can support.⁶

IX. Scale as a Regulatory Artifact A frequent criticism raised in workforce discussions is that alternative practice models cannot “scale.”

In Medicare, scale has become a survivability mechanism rather than an indicator of clinical quality or efficiency.

When administrative overhead is reduced, the economic necessity for scale diminishes.

Scale is not an inherent requirement of primary care delivery.

It is an artifact of administrative design.

X. Observational Contrast: Direct Primary Care Direct Primary Care provides a real-world observational contrast demonstrating how primary care functions when administrative design is fundamentally altered.

Under DPC, practices do not bill insurance and are not subject to Medicare documentation, coding, or quality reporting programs. As a result, administrative overhead is dramatically reduced, allowing practices to remain financially viable with smaller patient panels and greater clinical capacity per patient.

This contrast is not presented as model advocacy, nor as a substitute for Medicare coverage. Rather, it illustrates a critical policy insight: when fixed regulatory overhead is removed, the economic necessity for scale diminishes and access can be preserved at the community level.

The relevance of this model is not its payment mechanism, but what it reveals about the underlying cost structure of primary care delivery.

Direct primary care is not a Medicare benefit and requires direct payment by beneficiaries. Its growth does not reflect a desire to exclude seniors, but a physician workforce adapting to regulatory conditions that have made traditional participation increasingly unsustainable.

Under current law, Medicare beneficiaries cannot freely contract with physicians for covered services without the physician fully withdrawing from Medicare participation. This statutory restriction limits flexibility for both seniors and physicians and represents a policy barrier rather than a clinical or ethical one.⁷

The lesson for policymakers is not that Medicare should be replaced, but that access collapses when administrative design overwhelms care delivery.

Medicare today guarantees coverage, not care. When physicians can no longer sustain participation, beneficiaries lose access regardless of what card they carry. Direct primary care has emerged not as a rejection of Medicare, but as evidence of how regulatory structure determines whether care can be delivered at all.

XI. Addressing the Panel-Size Workforce Concern Smaller patient panels are often viewed as incompatible with population-level access.

In practice, physician exit poses the far greater threat.

A physician who leaves practice provides care to zero patients. A sustainable practice that retains physicians in active clinical work preserves access even with smaller panels.

Reducing burnout and extending clinical careers is therefore central to workforce preservation.

XII. Conclusion Physicians are not leaving medicine because they lack commitment.

They are leaving because regulatory systems have made sustainable practice increasingly impossible.

If Congress wishes to preserve access for older Americans, particularly in rural and underserved communities, administrative simplification must be treated as workforce policy.

Without reform, consolidation will continue and the doctor-patient relationship will remain collateral damage.

Thank you for the opportunity to testify.

Footnotes ¹ Kaiser Family Foundation Health News. Doctors Raise Concerns for Small Practices in Medicare's New Payment System. September 6, 2016.

² American Medical Association. "Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties" (Policy Research Perspective, released 2025). Only 42.2% of physicians were in private practice in 2024 (down from 60.1% in 2012), with hospital-owned practices rising to 34.5% and private equity involvement increasing to 6.5%; MedPAC. March 2025 Report to the Congress: Medicare Payment Policy (March 13, 2025, Chapter 4 on physician services and workforce implications); MedPAC. June 2025 Report to the Congress: Medicare and the Health Care Delivery System (June 12, 2025, including recommendations for PFS reform to address sustainability and relative value accuracy).

³ When adjusted for inflation in practice costs, Medicare physician payment has declined approximately 33 percent from 2001 to 2025, despite a temporary one-time 2.5% statutory increase for calendar year 2026 (plus small MACRA updates, yielding overall conversion factor increases of approximately 3.77% for qualifying APM participants to \$33.57 and 3.26% for non-qualifying APM participants to \$33.40). This relief expires after 2026, with MedPAC and AMA emphasizing ongoing inadequacy, the need for permanent inflation-linked updates (e.g., a portion of the Medicare Economic Index), and projected cuts returning in 2027 absent structural reform. American Medical Association. "2025 Medicare updates compared to inflation chart" (updated January 2025, confirming 33% decline through 2025); Centers for Medicare & Medicaid Services. Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F), October 31, 2025 (Federal Register, November 5, 2025); MedPAC. March 2025

Report to the Congress: Medicare Payment Policy (March 13, 2025); MedPAC. June 2025
 Report to the Congress: Medicare and the Health Care Delivery System (June 12, 2025,
 recommending long-term PFS updates based on a portion of MEI growth); MedPAC vote
 (January 15, 2026) recommending +0.5 percentage points above current law for 2027.

⁴ Congressional Budget Office. Budgetary Effects of Aligning Payments for Services Provided in
 Hospital Outpatient Departments and Physician Offices. 2025–2034 projections.

⁵ Sinsky CA et al. Health Care Expenditures Attributable to Physician Burnout. Mayo Clinic
 Proceedings. 2022.

⁶ Health Resources and Services Administration. Health Professional Shortage Area data;
 MedPAC reports on access in rural America. 2025.

⁷ Social Security Act §1802(b)(1); 42 CFR Part 405 Subpart D.

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PREPARED WITNESS STATEMENT

Jeffrey Smith



Testimony

of Jeffrey Smith

to the

Special Committee on Aging

United States Senate

February 11, 2026

Chairman Scott, Ranking Member Gillibrand, and Members of the Committee:

Thank you for the opportunity to testify on the important subject of how administrative and regulatory red-tape fuels physician burnout and impacts patient access to care. I am Jeffrey Smith and I am honored to speak on behalf of the Medical Group Management Association, MGMA, as its incoming board chair. MGMA has over 70,000 members across the United States representing 15,000 medical group practices and more than 350,000 physicians. Our members include small independent practices, large integrated systems, and everything in between. I am also the Chief Executive Officer of Piedmont HealthCare, PA, a physician owned and led multi-specialty medical group with over 230 physicians and providers and 1,180 employees headquartered in Statesville, NC. I have over 40 years of healthcare experience and have also worked in the hospital setting as the Vice President of Finance, audited hospitals for Medicare, and worked in public accounting focusing on healthcare.

I feel deeply passionate about this issue in part because I have seen its impact firsthand while working alongside my wife earlier in my career, who is a nurse, and currently through my daughter, who now serves as a primary care physician in my practice. Having navigated years of escalating regulatory burdens and increasingly complex Medicare payment structures, I am intimately familiar with how these pressures lead to physician burnout and in turn, threaten the ability of physician groups to operate effectively.

MGMA has long advocated for reducing regulatory burden and advancing common-sense policy reforms, as our members consistently cite administrative requirements and documentation as primary challenges to practice sustainability. MGMA has conducted a long-standing regulatory burden survey with our members, receiving feedback on their top regulatory hurdles and how they impact practice operations and patient access. In our 2026 survey of over 230 medical group practices, there is a clear connection between regulatory burden, a broken payment system, and physician burnout.¹ Regulatory burden and

¹Findings referenced reflect preliminary insights from MGMA's forthcoming 2026 Regulatory Burden and Administrative Feedback Report, scheduled for release in the near term. For additional context, MGMA's 2023 Regulatory Burden Report is available at: <https://www.mgma.com/getkaiasset/423e0368-b834-467c-a6c3-53f4d759a490/2023%20MGMA%20Regulatory%20Burden%20Report%20FINAL.pdf>.

financial stress are the top two factors in physician burnout, which makes the increase in regulatory hurdles and the failure for Medicare payment to keep up with inflation especially dangerous in today's healthcare system. Over 90 percent of practices have seen an increase in administrative burden in the past three years, while the 2026 Medicare Part B conversion factor is barely above the 2024 level after years of continuous cuts.

Burnout is driving physicians out of practice, and regulatory burden is a major contributor with significant downstream effects. In my own practice, I have increasingly seen more physicians being driven towards early retirement who would have ordinarily stayed in the profession longer. For older physicians for whom retirement is not feasible or desirable, many are significantly reducing their availability as increasingly long work hours become detrimental to their health. The loss of these doctors and the reduction of their hours have a significant impact on patient access.

Extensive documentation requirements and full schedules leave physicians with limited time during patient visits and strain practice resources. Administrative burden related to regulations impacts work-life balance, something I've seen firsthand in my daughter, who often must complete these tasks at home after her children fall asleep. These pressures are driving physicians to leave their communities entirely, relocating to areas with higher reimbursement and predictable schedules to secure the practice infrastructure, and ultimately, the family support they need.

More than half of the practices in MGMA's 2026 survey report losing a physician to burnout in the past three years, and among those, over 75 percent say regulatory burden played a substantial role. Regulatory burden affects recruitment, as over half of practices indicate it makes attracting new physicians more difficult. Ultimately, burnout reduces patient access, leading to longer waiting times, shorter visits, and practices becoming unable to accept new patients. Staffing shortages intensify physician burnout, as remaining clinicians are forced to absorb the extra workload. One medical group relayed being unable to hire an interventional radiologist for over two years and for many, physician recruitment has become a persistent and ongoing challenge. Practices rely increasingly more on advanced practice providers (APP) to backfill physician shortages. While APPs play an important role in our healthcare system, there are limitations across specialties and scope of practice regulations, which can create administrative and patient access challenges.

Given the increasing physician burnout and ongoing workforce shortage, MGMA supports federal legislative efforts to strengthen and expand physician training programs including increasing the number of graduate medical education (GME) positions supported by federal funding. We appreciate the members of the committee who have cosponsored the bipartisan Resident Physician Shortage Reduction Act of 2025 (S. 2439), which aims to increase federal support for physicians' GME program. As I have seen firsthand with my daughter and son-in-law who are both physicians, medical school debt is substantial and can be a barrier to entry for many aspiring medical students. Student debt can shape where physicians may choose to practice as they may gravitate towards specialties and geographic markets that pay more in an effort to repay their loans sooner. MGMA also supports removing barriers in federal student loan programs and pathways for foreign doctors to train and work in the U.S., like H-1B and J-1 visa programs, to help ensure a more reliable supply of physicians, particularly in rural and underserved areas where shortages and recruitment challenges are most acute.

While we support these efforts to increase the physician workforce, addressing administrative and regulatory policies that are leading to physician burnout would help stem the tide of workforce shortages on the front end and support doctors already in practice. I would like to highlight the following burdens that I and other MGMA members are facing that significantly contribute to physician burnout and impede patient access to care, while also reviewing potential congressional solutions to mitigate these concerns and bolster the ability of this nation's medical groups to continue serving their communities.

Medicare Advantage Challenges Increasing

Medicare Advantage has allowed beneficiaries to access new benefits and can serve as an opportunity for innovation and value-based care. Many large medical groups find value for themselves and their patients in administering their own Medicare Advantage plans. However, as over half of Medicare-enrollees have opted for Medicare Advantage plans administered by commercial insurers, it has created daunting new challenges for many practices.² Audits and appeals, denials, prior authorization, and downcoding in Medicare Advantage all rank within the top 5 burdens reported by medical groups. Over 90 percent of practices have seen an increase in Medicare Advantage vs. traditional Medicare and of those, over 75 percent report this shift having a negative impact.

There is also a significant lack of standardization across Medicare Advantage plans. Blue Cross requirements differ from Cigna, which differ again from Aetna. In my practice, we have had to hire whole teams dedicated to value-based care just to interpret what "quality" means for each payer, yet often with no clear understanding of the true impact on quality or cost savings from these programs. Exacerbating these concerns are the frequent and lengthy delays of up to 18 months to receive final feedback from payers, which undermines the value of this information and leads to additional cost expenditures. Without standardization, administrative costs become unmanageable. Larger practices like mine can absorb more of the cost but for many practices, the cost is unmountable.

There are ample opportunities to ensure that the Medicare Advantage program does not add to unnecessary administrative and payment concerns. Legislation like the bipartisan, bicameral Medicare Advantage Prompt Pay Act (H.R. 5454, S. 2879), which would require Medicare Advantage plans to pay 95 percent of clean claims in 14 days for in-network providers and 30 days for out-of-network providers, would help ease issues with delayed payments and associated administrative headaches. Further, legislation to address unwarranted downcoding trends in Medicare Advantage would alleviate a substantial pain point for physician practices.

Prior Authorization

One of the top cited regulatory burdens for medical groups is prior authorization, a process that requires physicians, practices, and hospitals to obtain advance approval from health plans before patients can receive certain tests, treatments, or medications. Practices now rank Medicare Advantage plans as the most burdensome payer for obtaining prior authorization. Only roughly 12 percent of prior authorization denials for Medicare Advantage are appealed, of which, approximately 80 percent are ultimately

²Centers for Medicare & Medicaid Services. "Medicare Monthly Enrollment." CMS Data. <https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicare-reports/medicare-monthly-enrollment>.

overturned upon appeal.³ Medical group practices face a significant and uncompensated administrative workload for these unnecessary denials, and the greater harm is that many patients abandon efforts to obtain necessary care rather than navigate the appeal process after the initial denial. Not only do these unnecessary denials lead to delays in critical patient care and worsening health conditions, but they also create costly, burdensome, inefficiencies in our healthcare system.

We have seen federal efforts to reform prior authorization and increase transparency through recent rulemaking⁴ and an Administration-led pledge from some of the nation's largest insurers to simplify the process in June 2025.⁵ Although MGMA appreciates the pledged commitment from health insurance companies, prior experience has demonstrated the importance of pairing industry commitments with congressional oversight and statutory action to ensure meaningful, enforceable accountability. A similar pledge from the insurance industry in 2018⁶ failed to produce meaningful change, and prior authorization remains a top regulatory burden for medical group practices. In fact, in our recent survey, 95 percent of practices said that prior authorization is a significant burden for their practice and 85 percent report that the burden of prior authorization has increased in just the last 12 months. Over 35 percent of practices surveyed report employing at least three different employees per physician to assist physicians with regulatory and administrative tasks like prior authorization. I oversee 75 offices in the Charlotte metro area and each practice has at least one staff member doing prior authorizations alone. While hiring support staff is helpful for reducing physician burnout, it is still a poor use of resources that could otherwise go toward patient care, such as hiring nurses or expanding service hours.

Members continue to cite staffing demands, added costs, and negative effects on patient care from prior authorization:

- “Prior authorization remains one of the most significant administrative and financial challenges in our practice. Clinical staff and physicians spend substantial time navigating inconsistent payer requirements, duplicative documentation requests, and unclear approval criteria—often for services that are evidence-based and routinely provided. These processes delay care, frustrate

³KFF, “Medicare Advantage Insurers Made Nearly 53 Million Prior Authorization Determinations in 2024,” Kaiser Family Foundation, <https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024>.

⁴Centers for Medicare & Medicaid Services, “CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F),” <https://www.cms.gov/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f>. Requires Medicare Advantage plans, Medicaid and CHIP fee-for-service programs, Medicaid and CHIP managed care plans, and Qualified Health Plan issuers on the Federally-Facilitated Exchanges to adopt standardized electronic data-exchange and prior authorization APIs to streamline approvals, reduce burden, and improve timely access to patient information.

⁵Medical Group Management Association, “MGMA Statement on Health Plans’ Commitment to Simplify Prior Authorization,” June 23, 2025, <https://www.mgma.com/press-statements/june-23-2025-mgma-statement-on-health-plans-commitment-to-simplify-prior-authorization>. The pledge requires insurers to reduce the services needing prior authorization, provide 90-day continuity for existing authorizations during coverage transitions, improve denial and appeal explanations, expand real-time electronic prior authorization decisions, and implement standardized electronic systems that apply interoperability to prior authorization by 2027—extending key elements of the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) to commercial and employer plans and ultimately affecting most Americans.

⁶Medical Group Management Association, “Consensus statement on improving the prior authorization process, 2018,” https://www.mgma.com/getkaiasset/87f685d9-401e-4137-946b-761abc36c217/01.01.2018_PA-consensus-statement.pdf.

patients, and divert physician time away from clinical work, contributing directly to burnout. From a cost perspective, prior authorization has driven meaningful increases in practice overhead at a time when expenses across healthcare continue to rise. We have been required to add and reallocate staff to manage authorizations, appeals, and follow-up, absorb productivity losses when physicians and clinical teams intervene, and carry unreimbursed administrative labor that is not reflected in payer rates. These costs are compounded by rising wages, technology expenses, and compliance requirements, collectively placing downward pressure on margins and limiting our ability to reinvest in patient access and care delivery.”

- “In the last year, I have had to add two new staff dedicated to handle the growing volume of prior authorizations, bringing the team to a total of four working on them full-time. This was the only way to ensure prior authorizations were completed on time and to avoid rescheduling patients, since nearly all of our visits require authorization. As a result, our payroll and overall clinic costs have increased significantly.”
- “Patients often become upset while waiting for a prior authorization, and they frequently blame the provider. If a prior authorization is denied, the provider may have to complete a peer-to-peer review with the insurance company... The downtime spent on peer-to-peer calls—being placed on hold, rescheduling, and completing endless paperwork that may be sent to us three or four times—ties up my staff, only for us to receive a final letter saying the request is denied. It’s beyond frustrating.”

While the Administration has pledged to streamline prior authorization and reduce overall regulatory burden across the government, the launch of the Medicare Wasteful and Inappropriate Service Reduction (WiSeR) Model expands the use of prior authorization in traditional Medicare for 17 outpatient services in six states, and introduces a new, non-standardized approach that is inconsistent with federal regulations for prior authorization and the industry pledge. We harbor concerns that the WiSeR model may increase administrative and patient burdens in traditional Medicare and urged for the model to be delayed a year to avoid repeating well-documented problems with prior authorization.⁷

The Improving Seniors’ Timely Access to Care Act (H.R. 3514; S. 1816), which is sponsored by both the Chairman, Ranking Member, and many members of the committee, would make long-needed changes to prior authorization and allow practices to focus resources on clinical care instead of dealing with these administrative processes. A prior iteration of the bill passed the House unanimously, and the current version has a preliminary Congressional Budget Office score of \$0. This legislation has the support of hundreds of healthcare organizations, as well as insurers in the Better Medicare Alliance, as it would implement common sense reforms to improve the transparency surrounding prior authorization utilization and expediate an often-laborious process. MGMA considers this important legislation a must-pass in this Congress and has worked diligently with the Regulatory Relief Coalition to support this legislation.⁸

⁷Medical Group Management Association, “National Medical Organizations Applaud WiSeR Amendment and Seek Reforms,” <https://www.mgma.com/getkaiasset/ce980cc9-d7d7-4bd6-818b-e59ba2f2a06c/NatMedicalOrgsApplaud%20WiSeRamdtandSeekReforms.pdf>.

⁸The Regulatory Relief Coalition (RRC) is a group of national physician specialty organizations advocating for regulatory burden reduction in Medicare so that physicians can spend more time treating patients. <https://regrelief.org/>.

Regulatory Burdens Associated with the Quality Payment Program (QPP)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaced the sustainable growth rate formula with the QPP. This was intended to stabilize payment rates in the Medicare fee-for-service (FFS) system and incentivize physicians to transition into value-based payment models. The QPP created two reporting pathways to facilitate the transition to value-based care: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

Unfortunately, MIPS has been beset with issues as it requires clinicians to report on quality measures that are not clinically relevant to them. The cost reporting measure holds clinicians accountable for costs outside of their control. Complying with these requirements is a time-consuming and laborious process, as studies have shown the significant amount of staff time and money dedicated to MIPS reporting.⁹ Compounding these issues is the lack of adequate and timely feedback by CMS on measuring performance. Without receiving appropriate feedback about which patients are assigned to them and what costs outside of their practice they must account for, physicians are unable to correct issues.

Medical groups report that MIPS requirements detract from patient care efforts due to significant program compliance costs that could be more efficiently allocated to clinical priorities. The QPP reporting burden is substantial — 86 percent of MGMA members surveyed who participate in MIPS found reporting to lead to increased administrative burden with little clinical benefit. “MIPS is especially unworkable,” as one MGMA member succinctly put it in our 2026 survey. This aligns with what MGMA members have unfortunately said for years.

To address these significant concerns, we recommend Congress reform the MIPS program to improve its clinical relevance and reduce the cost and administrative burden of reporting. Specifically, Congress could pass legislation that aligns with the following policies developed in conjunction with physician specialty societies, the American Medical Association, and MGMA:

- **Reduce reporting burden and better align performance measures with clinical care.** CMS should remove the silos between the different performance categories; providing multi-category credit for MIPS measures that fulfill multiple categorical functions would avoid the duplicative steps of documenting and reporting on the same activities. The MIPS cost performance category has numerous issues related to measuring costs outside of a provider’s control and opaque scoring procedures; it is essential to revise this category significantly. Additional changes are needed to improve reporting on quality measures and allow providers reporting through clinical data registries to automatically satisfy Promoting Interoperability and Improvement Activities requirements.
- **Improve the performance threshold.** The current MIPS threshold of 75 points results in many providers being unnecessarily penalized. Congress should freeze the threshold at 60 points. Further, the Government Accountability Office (GAO) should submit a report to Congress and the Department of Health and Human Services (HHS) in consultation with physician organizations that details recommendations for a replacement performance threshold.
- **Reform how payment adjustments are calculated.** The current tournament-style model of

⁹Dhruv Kullar, MD, MPP; Amelia M. Bond, PhD; Eloise May O’Donnell, MPH, “Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System,” JAMA Network, May 14, 2021, <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947>.

MIPS needs to be eliminated to stop undermining the financial viability of practices participating in MIPS that receive a negative payment adjustment. A new model with payment adjustments tied to the annual payment update would be more equitable while continuing to incentivize groups to improve their performance. Groups who score below the performance threshold would receive a reduced payment update compared to those at or above the threshold. The penalties would fund bonuses for the high performers and go towards an improvement fund.

- **Ensure timely and actionable feedback from CMS.** Providers do not receive the timely and accurate feedback from CMS needed to understand their performance and be able to make changes to reduce costs or improve scores. A redesigned MIPS program must include this vital feedback in a digestible format, and if quarterly reports are not provided, then medical groups should be held harmless from any penalties.

The APM incentive payment has been essential to medical groups attempting to transition to value-based care models, allowing them to make the necessary infrastructure investments to succeed in these arrangements. The lapse of the incentive payment and increases to the qualifying APM participant (QP) thresholds in 2025 contributed to additional financial instability for practices and prevented them from making critical investments in value-based care operations and technologies. We thank Congress for passing the Continuing Appropriations Act, 2026, that reinstated the Advanced APM incentive payment at 3.1 percent for the 2026 performance year and freezing the 2026 QP thresholds at the 2024 level. We look forward to working with Congress to ensure that APMs offer a viable and stable pathway for medical groups to transition to value-based care while reducing reporting burden.

Administrative Simplification Opportunities under HHS

Numerous processes under HHS's purview could be standardized and simplified to reduce duplicative and unnecessarily time-consuming tasks that impact physician burnout. There are myriad opportunities to reduce the complexity of reporting for Medicare providers. Simplifying and streamlining healthcare transactions, documentation requirements, claims reviews, and audits would reduce administrative burdens and costs and allow medical groups to dedicate more time to patient care.

Provider enrollment and credentialing in Medicare is often a laborious, complex, and cumbersome process. Improving credentialing systems that CMS oversees, such as the Provider Enrollment, Chain and Ownership System (PECOS), should be a priority to offer needed relief. MGMA members have consistently ranked credentialing processes as adding regulatory burden to their practices; standardizing and aligning requirements across payers while reducing paperwork would help address this longstanding concern. Credentialing is important for medical groups – for payment, network participation, compliance, and improvements to the credentialing process would have added benefits beyond just administrative burden like potentially helping with delays to patient access and disruptions in revenue. Adding to this strain are the various websites and portals specific to CMS that practices have to use for enrollment, revalidation, changes of addresses, adding providers, etc. Navigating these various portals – NPPES, PECOS, HARP for example – all lead to increased staff time and increase the potential for administrative mistakes. One member with providers in reports having to complete the same application five times to enroll a provider in each of the five states. Streamlining Medicare systems would better facilitate the capture of this data, while simplifying these administrative processes and lower practice costs.

Inadequate Medicare Payment Amplifies Regulatory Burden and Physician Burnout

All of these administrative barriers and regulatory red tape are exacerbated by the continued under-reimbursement of the Medicare Part B payment system. Financial stressors, such as declining reimbursements and rising costs, were the second largest contributing factor to physician burnout in our 2026 survey. An essential factor to these financial stressors is the downward trajectory of Medicare Part B reimbursement for the past few decades.

Medical groups dealt with a 2.83 percent cut to the Medicare conversion factor for all of 2025 that has compounded other financial pressures such as staffing shortages and rising operating costs. While Congress thankfully enacted a 2.5 percent increase to 2026 Medicare reimbursement, CMS's recently finalized payment rates for 2026, that incorporated the 2.5 percent increase, are barely above 2024 reimbursement levels. This small increase is undercut by budget-neutrality policies that decrease reimbursement for certain specialties, while at the same time failing to keep up with inflation. In addition to failing to keep up with the costs of treatment for Medicare beneficiaries, given the centrality of Medicare rates to benchmarks for commercial payers and Medicaid, inadequate Medicare reimbursement has cascading effects across payers.

Members continue to express frustration and illuminate the negative effects of declining reimbursement to both physician well-being and patient access:

- "Physicians are exhausted trying to treat cancer patients in the office setting because Medicaid and Medicare reimbursement do not cover the cost of the chemotherapy. We are always looking for alternative treatments or specialty pharmacies to support our local patients and keep cancer care in our area."
- "Part of the burnout stems from declining reimbursement. It's difficult for providers to watch the value of their work consistently decrease over time while still being expected to deliver the same high level of care. Physicians are doing more work for less pay, which also makes it harder to recruit new physicians, all while contributing to the physician shortage."
- "Discussions about how a private practice can survive when inflation is going up, but our reimbursements are dropping. Evaluating lower-level providers (PAs/NPs) to see patients and cut costs. Constant scramble to cut costs and see more patients. VERY STRESSFUL to physicians who have dedicated their lives to medicine. "

Given the current path of Medicare reimbursement, with its frequent reductions due to outdated budget neutrality requirements and lack of an inflationary update, it is necessary to enact lasting reform. The Strengthening Medicare for Patients and Providers Act of 2025 (H.R. 6160) would make structural changes to the Medicare payment system that is needed to sustainably support medical groups and avoid these yearly threats to their financial viability. This legislation would provide an annual Medicare physician payment update tied to inflation, as measured by the Medicare Economic Index (MEI). This inflationary update is necessary to not only align with other CMS payment systems, but also adequately account for the cost of operating a medical group.

Antiquated budget neutrality policies in the PFS must be modernized; we urge Congress to institute changes to budget neutrality in unison with an annual inflationary update. The Provider Reimbursement Stability Act of 2023 (introduced last Congress as H.R. 6371) made common sense changes to Medicare

budget neutrality requirements such as increasing the low threshold for triggering cuts and allowing CMS flexibility to correct issues with erroneous budget projections. Similar legislation would help make much-needed modernizing changes.

A holistic approach would go a long way toward establishing an appropriate reimbursement system and stopping a major factor of physician burnout. Comprehensive reform is needed to avoid the detrimental effects of increased physician burnout due to inadequate reimbursement.

Increasing Consolidation

The challenges discussed throughout this testimony coalesce to undermine the ability of independent medical groups to stay in operation and ultimately lead many physicians to sell their practices and either become employed or retire. The trend in independent practices selling their practices is stark – according to the Physicians Advocacy Institute, 77.6 percent of physicians are employed by hospitals/health systems and other corporate entities.¹⁰ The GAO reported that 47 percent of physicians were affiliated or employed with a hospital system in 2024.¹¹

Of practices that have experienced an ownership change in the last three years that was affected by physician burnout and regulatory burden, many MGMA members report distressing stories of how burnout contributes to increased consolidation: “After being physician-owned for over 100 years, the practice sold to a hospital at the close of 2025.” The mounting regulatory burden and administrative work coupled with increasing costs and decreasing reimbursement has pushed physicians to leave independent practice and seek employment in health systems. Everyday our practice receives calls offering to buy us and take the burden off our hands. We are cannibalizing ourselves due to these pressures and making it extremely difficult for physician practices to stay independent, especially in rural areas.

Even when independent groups sell to systems, these practices are still often operating at a loss. MGMA has collected data for years that indicates health systems often operate medical groups at an annual loss of over \$200,000 per FTE physician. These practices are subsidized from hospital inpatient revenue, insurance plan revenue, and more. This demonstrates that payment and cost issues do not fully alleviate once a practice is acquired. Medical groups provide substantial additional benefits to systems, such as ancillaries like imaging and labs, referrals, and value-based care benefits such as controlling volumes and performance in capitated contracts. But unlike large systems, independent groups don't have large cash reserves and other revenue sources to weather the costs associated with increasing burden. Enacting long-term reforms, like those discussed in this testimony, would help lead to a more robust and dynamic practice environment.

Conclusion

¹⁰Physician Advocacy Institute, “PAI-Avalere Report on Physician Employment Trends and Acquisitions on Medical Practices: 2019-2023,” April 2024, <https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023>.

¹¹ Government Accountability Office, “Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation,” Sept. 22, 2025, <https://www.gao.gov/products/gao-25-107450>.

I sincerely appreciate the opportunity to testify today and share both my personal experience and MGMA members' experiences on how regulatory burden contributes to physician burnout. A confluence of administrative and financial pressures is driving physicians out of practice, increasing consolidation, and undermining patient access in communities across the nation. Thankfully, Congress has numerous opportunities to address these issues and help bolster medical groups' ability to provide high-quality, cost-effective care, and create a more satisfying experience for physicians and patients alike. I look forward to answering any questions you may have.

U.S. SENATE SPECIAL COMMITTEE ON AGING
"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF
MEDICINE"

FEBRUARY 11, 2026

PREPARED WITNESS STATEMENT

Corey Feist

Testimony of J. Corey Feist, JD, MBA
CEO & Co-Founder, Dr. Lorna Breen Heroes' Foundation

Presented Before the United States Senate Special Committee on Aging

Hearing on:
"The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine"

February 11, 2026

Chairman Scott, Ranking Member Gillibrand, and members of the Committee, thank you for the opportunity to address you today.

My name is Corey Feist, and I am the CEO and co-founder of the Dr. Lorna Breen Heroes' Foundation whose mission is to reduce burnout and improve the wellbeing of all health workers. I want to begin with a message of profound gratitude. On behalf of the millions of health workers across this country, thank you. Thank you for the introduction and co-sponsorship of the [Improving Seniors' Timely Access to Care Act of 2025](#), S.1816, and for most recently taking a historic step by reauthorizing the bipartisan [Dr. Lorna Breen Health Care Provider Protection Act](#), S.266, through September 2030. By reaffirming the value of this work in improving health workers' mental health and wellbeing, you have signaled to our workforce that their lives matter.

Now, we seek full and consistent annual funding so this life-saving work can continue.

We are at a crossroads: we can either make the necessary investments to support our caregivers and ensure the future of the workforce, or we can watch the backbone of our healthcare system continue to fracture as health workers head for the exits, just when the country will need them the most.

The Human Toll: Stories of a System that Failed

This is my third time testifying before Congress on this crisis. Each time, I carry with me the stories of those we have lost—not to a lack of "resilience," but to a system that failed them.

The first time, in October 2021, before the House Energy and Commerce Committee/Subcommittee on Health, I shared the story of my sister-in-law, Dr. Lorna Breen. She was a physician leader during the pandemic's first wave in New York City, working around the clock in an environment she described as "Armageddon" with limited PPE, insufficient beds, and patients dying in the hallways. Despite her bravery, she was terrified that seeking mental health support for the trauma she witnessed would cost her the medical license and career she had spent her entire life working for. Lorna died by suicide on April 27, 2020.

Last time, in February 2024, before the House Energy and Commerce Committee/Subcommittee on Health, I shared the story of Tristin Kate Smith, a 28-year-old nurse whose father found a letter on her computer after her death. She wrote to the system she felt had abused her, noting

that just when health workers think they will get the respect they deserve, they get "a pizza party and pens for the healthcare heroes."

Today, I share the story of Dr. William West, a 34-year-old ophthalmology resident at George Washington University. His family called him "Iron Will" for his tenacity in rock climbing and endurance racing. But in March 2024, the "information ocean" and evaluation pressures of medical training broke even Iron Will. In a devastating final note, he wrote: "I am simply exhausted and have nothing more to offer." He used his final moments to plead with administrators to guide and support residents rather than merely pushing them.

William's story is a warning: *our healthcare system is claiming our brightest minds before they even finish their training. When we lose a young resident like him, we aren't just losing one doctor; we are losing 30 to 40 years of expertise that would have served our aging population.* Our physicians, nurses, and pharmacists die by suicide more than the general population. Their absence ripples outward, exacerbating our workforce shortage and compromising the quality of care every American family relies on.

A Looming Crisis: Workforce Shortages and an Aging Population

The tragedy of losing clinicians like Lorna, William, and Tristin is compounded by a looming demographic shift. Over the next decade, we will see the share of Americans aged 60-90 years old increase by 46 percent. HRSA [projects](#) this "supply and demand" imbalance to result in a shortage of over 354,000 nurses, 141,000 physicians (including over 70,000 primary care physicians such as geriatricians), 53,000 dentists and dental hygienists, and 30,000 pharmacists by 2038.

For our seniors, these numbers are existential. In 2038, rural areas and small towns will experience a projected 39% shortage of primary care physicians. For an aging American, "rural" should not mean "uncared for," yet these statistics suggest that is exactly what is going to happen.

These projections do not fully account for the hundreds of thousands of clinicians deciding to leave their professions early because of system failures driving their burnout and distress.

Driving the Exodus: Loss of Autonomy, Safety, and Administrative Burden

According to The Physicians Foundation's [2025 Survey on Physician Autonomy and Impact on Patient Care](#), 73% of physicians report autonomy limits (the inability to make independent, evidence-based clinical decisions) are increasing their stress.

Of these physicians, 45% indicate these bureaucratic and administrative pressures are pushing them toward career changes or earlier retirement. Further, 91% of physicians say this loss of autonomy is a major threat to U.S. medicine and will worsen the physician shortage. Seven in 10 (71%) physicians know colleagues who have already left the profession due to loss of autonomy.

It is [estimated](#) that doctors spend two hours on administrative work for every hour they spend with patients; and tasks like charting and paperwork is the [number one driver of burnout](#) among physicians. One specific example of administrative burden is prior authorization, which delays care, harms patients, and hassles our healthcare workforce. The [average physician practice](#) completes 45 prior authorizations per physician per week, and doctors and their staff spend nearly two business days a week completing such authorizations.

The crisis among nurses is even more acute. In [2024](#), 17% of nurses left their roles, but for Generation Z nurses, that rate jumps to 24%. This is largely a safety crisis. ***Eight in 10 nurses have [experienced](#) at least one incident of workplace violence—including being punched, kicked, or slapped—in a single year.*** We cannot expect a new generation to remain at the bedside if we do not protect them. Currently, only 16% of registered nurses [practice](#) in rural areas. This exodus drastically impacts underserved communities where nurses are the linchpins of primary care, serving as the essential coordinators for the complex chronic conditions of our aging population. On top of all of this, nurses are also underwater with administrative burden; on average nurses spend about [40% of their shift on documentation](#) rather than patient care.

The pharmacy profession is experiencing similar fracturing. While 73.5% of licensed pharmacists remain [active](#), they are abandoning traditional retail roles due to excessively high workloads and performance quotas that compromise patient safety. The national average rate of occupational burnout for pharmacists has reached 64%. Like nurses, pharmacists face a hostile workplace climate where harassment from frustrated families has become a daily reality. When a local pharmacist leaves, a senior loses not just a provider, but their primary gatekeeper for medication safety.

A Proven Roadmap

The stories and the data paint a dire picture, but it is not a foregone conclusion.

Thanks to the evidence-based frameworks provided by the National Academy of Medicine (NAM) [National Plan for Health Workforce Well-Being](#) and the Lorna Breen Act's [Workplace Change Collaborative Burnout and Moral Injury Framework](#), we now have a proven approach to reverse this crisis.

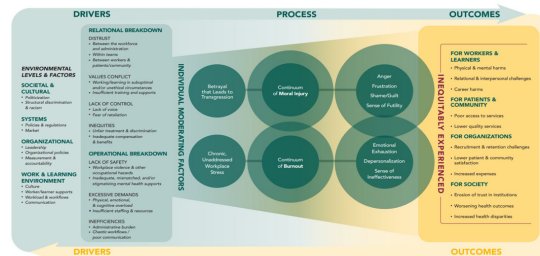
The NAM Plan, developed by over 200 organizations, provides a roadmap for collective action across our U.S. healthcare system to take a “systems approach that recognizes that no single variable in the health system is to blame for the problem of burnout. Addressing the issue from multiple angles is necessary to redesign environments, so that patients are met with a thriving health workforce that approaches them with all of the skills, expertise, care, and attention they have at their disposal.” These multiple angles include:

- **Creating a Positive Work Environment:** Instead of asking health workers to be “more resilient,” this area focuses on fixing the workplace. It’s about making sure hospitals and clinics are supportive, safe, and respectful places where staff feel valued and can do their best work without being overwhelmed by toxic cultures.

- **Measure What Matters:** You can't fix what you don't track. This area calls for organizations to regularly check in on how their staff are doing using scientifically proven tools. The goal is to move beyond simple surveys and actually use data to find—and fix—the specific things causing stress in each workplace.
- **Support Mental Health and Reduce Stigma:** Many health workers are afraid to seek help for anxiety or depression because they fear it might affect their license or job. This priority aims to change those rules and create a culture where getting mental health support is treated as a normal, healthy part of the job.
- **Cut the Red Tape:** Health workers spend hours on digital paperwork and administrative tasks that don't help patients. This goal pushes for changes in laws and insurance policies to reduce administrative burden so that clinicians can spend more time with patients and less time clicking buttons.
- **Make Technology Work for People:** Technology should help, not hinder. This area focuses on improving electronic health records (EHRs) and other tools so they are easier to use. The vision is for technology to allow healthcare teams to focus more of their time on the human side of medicine.

The Lorna Breen Act's [Workplace Change Collaborative Burnout and Moral Injury Framework](#) explains the drivers and process of burnout and moral injury. It [explains](#) how “burnout and moral injury are driven by a set of complex and intersecting factors. Overarching environmental factors contribute to relational and operational breakdown. Relational breakdown recognizes the distrust, values conflicts, lack of control, and inequities experienced in work and learning environments. Operational breakdown is seen in a lack of physical and mental health safety, excessive work demands, and inefficiencies. Often, operational breakdown has been the focus of interventions; however, burnout and moral injury will not be fully addressed without repairing distrust and other relational challenges.”

Burnout and Moral Injury in the Health and Public Safety Workforce



The Workplace Change Collaborative at the Fitzhugh Mullan Institute for Health Workforce Equity; Institute for Healthcare Improvement; Moral Injury of Healthcare; AFT Healthcare. *Burnout and Moral Injury in the Health and Public Safety Workforce*. Washington, DC: George Washington University, 2023. <https://wpschange.org>

The Framework also provides [actionable, practical strategies](#) to address burnout and moral injury for health organizations, public safety organizations, workers and learners, government, professional associations, and other private organizations.



The Workplace Change Collaborative at the Fitzhugh Mullan Institute for Health Workforce Equity; Institute for Healthcare Improvement: Moral Injury of Healthcare; AFT Healthcare. Addressing Moral Injury & Burnout in the Health & Public Safety Workforce. Washington, DC: George Washington University, 2024. <https://wpchange.org>

Evidence of Impact: Successes of the Lorna Breen Act

The Lorna Breen Act's program implementation and evaluation have proven this approach can lead to significant improvements for our healthcare workforce.

The law and its funding supported the Workplace Change Collaborative, two grant programs funded by HRSA, for hospitals, health systems, health professions schools, and community organizations to improve their workforce's wellbeing and mental health. The programs have already [supported](#) over 250,000 health workers across 24 states in improving the systems in which they are educated, trained, and practice. [Key successes include 35% reduction in staff turnover, 37% reduction in burnout rates, and 50% decrease in mental health conditions.](#)

The grantees' experiences also [point to several priorities](#) for policy and practice:

- Continued investment to help organizations embed wellbeing into their core operations;
- Leadership development and accountability structures to ensure that commitment to worker wellbeing is sustained;
- Shared learning platforms so that organizations can adapt successful approach to their own contexts while centering health worker voices in program design; and
- Future funding mechanisms that encourage sustainable infrastructure and measurement strategies.

The law and its funding also supported CDC NIOSH's [Impact Wellbeing™ initiative](#) to guide and equip hospitals, clinics, and other care facilities in building a thriving and sustainable workforce. The initiative has already provided 35,000+ healthcare leaders with training materials to address the specific operational factors and burdens that drive their workforce's burnout.

With philanthropic support and coalition-building, our Foundation created a national technical assistance center program to accelerate the implementation of the [Impact Wellbeing Guide: Taking Action to Improve Healthcare Worker Wellbeing](#).

Specifically, we [improved access to mental health care for more than 2.64 million licensed health workers and 438,000 credentialed health workers](#) by supporting 70 licensure boards; 1,194 hospitals, freestanding emergency departments, and freestanding surgery centers; and 921 urgent care centers and independent primary care clinics in auditing and removing stigmatizing, intrusive mental health questions from their licensing and credentialing applications. But we are only scratching the surface to make it safer and fully supportive to seek mental health care for the nearly 11 million licensed health workers caring for Americans every day.

Additionally, through leadership training on identifying and mitigating organizational drivers of burnout and building peer learning communities to support sustainable workplace transformation, we are [proving](#) that administrative burden can be reduced while workforce job satisfaction and patient experience improve.

For example, one participating rural hospital improved their staff retention and engagement while improving quality of work and patient experience/engagement scores. They even *saw their traveling nurses wanting to stay in their rural Virginia community and saying, “this is the first place I’ve been where I feel healthy, where I feel I can actually get the help that I need.”* During this rural hospital’s quality improvement project, they *decreased their workforce’s cognitive burden by addressing EHR alert fatigue—reducing unnecessary inpatient alerts by 52% and unnecessary ambulatory alerts by 73% per month.*

Another rural hospital reduced their workforce’s administrative burden by using Ambient Notes AI technology—reducing physicians’ documentation time by 10-15 minutes per patient visit, while improving patient experience ratings.

The Critical Path Forward: Investing in Retention to Protect Our Future

These results prove that the reauthorization of the Dr. Lorna Breen Act is a historic win, but reauthorization without funding is a hollow promise. Tens of billions of dollars are directed annually for healthcare workforce creation initiatives, but the Lorna Breen Act programs are the only ones to directly support workforce retention. *This massive federal investment in the pipeline is effectively squandered if we fail to stop the leaks at the other end. For example, we are facing a “two-year exodus,” where approximately [50% of new nurses](#) quit the profession within two years of graduation.*

This is fundamentally an aging issue. We cannot care for older adults if we do not care for those who care for them, and every dollar spent on the wellbeing of a doctor, nurse, or pharmacist is a dollar spent on retaining an already shrinking workforce.

We must move from a system that depletes our dedicated workforce, the very pressure that broke Iron Will, to a system that sustains them with the safety and operational support they require. *If*

we fail to invest in this retention work, the 46% increase in our senior population will face a healthcare system with no one left to answer the call.

This Committee – with your collective voice – can make a difference by making sure that the Loma Breen Act is funded in FY27 and beyond. Please also vote for the [Improving Seniors' Timely Access to Care Act of 2025](#), so we can take immediate action in reducing our workforce's administrative burden of prior authorizations and ensure patients can access the medicines and treatment they may need. I hope I can then return and testify to report on the lives of healthcare workers we have saved, the healthcare systems we have preserved and improved, and how we are serving the growing aging population by the best of those still among us, the Loma's, the Tristin's, and the Will's.

Thank you for your leadership and for protecting those who protect us.

Questions for the Record

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

QUESTIONS FOR THE RECORD

Dr. Alma Littles**Chairman Rick Scott****Question:**

You highlighted during the hearing that even modest reductions in documentation and administrative workload can meaningfully increase patient-facing time and reduce burnout. For small, independent, or rural practices that lack large IT departments, what types of digital infrastructure or workflow-support platforms are most practical and scalable to eliminate redundant documentation, streamline prior authorization, and improve care coordination?

Response:

For small, independent, or rural practices, the most practical approaches are hub and spoke digital infrastructure models, where core clinical and administrative capabilities are provided through a regional or system-level platform (Health System or State Entity), rather than requiring each practice to maintain its own IT department.

Examples of practical platforms include:

- Shared EHR instances or hosted environments (e.g., a regional Epic or Cerner/Oracle deployment) that allows rural practices and hospitals to plug into enterprise-grade documentation, ordering, and care coordination workflows without bearing full implementation or maintenance costs.

- Embedded workflow automation layers within those Electronic Health Records (EHR), such as native AI, standardized prior authorization modules, centralized referral management, and system-level clinical documentation templates, that eliminate duplicative charting and manual handoffs.

- Cloud-based care coordination and interoperability tools that leverage TEFCA (Trusted Exchange Framework and Common Agreement) and FHIR (Fast Healthcare Interoperability Resources) standards to ensure patient information flows seamlessly across sites in a regional network.

Sample incentives to support this model:

- Federal grants or enhanced matching funds for shared EHR hosting arrangements between larger health systems and rural or independent practices.

- CMS recognition of regional digital health hubs (e.g., "Certified Rural Integration Platforms") that meet interoperability, uptime, and governance standards.

- Reduced reporting or documentation requirements for practices that participate in an approved shared infrastructure model.

Payer Integration Incentive:

- Provide enhanced reimbursement rates, administrative cost-sharing, or preferred network status for payers that integrate directly into shared EHR platforms (e.g., Epic's Payer Platform) used by regional hubs and rural spokes, allowing real-time eligibility, authorization, care gap closure, and quality reporting. This reduces payer administrative overhead, improves risk adjustment accuracy, and lowers avoidable utilization through shared clinical visibility.

Question:

What federal policy changes would most accelerate adoption of such solutions while maintaining appropriate safeguards for patient privacy and program integrity?

Response:

Reward integration rather than fragmentation. Examples of policy changes:

- Clarifying regulatory safe harbors under Stark, Anti-Kickback, and Civil Monetary Penalty rules to explicitly allow health systems to subsidize or host digital

infrastructure for affiliated rural or independent practices, provided interoperability and patient choice standards are met.

- Standardizing privacy and governance frameworks for shared EHR and data platforms, so smaller practices are not forced to independently interpret HIPAA, state privacy laws, or cybersecurity requirements.

- Aligning federal quality and reporting programs (e.g., MIPS, Promoting Interoperability) so participation through a shared platform satisfies compliance requirements, instead of duplicating reporting at each site.

Sample incentives:

- A federal “integration bonus” applied to Medicare reimbursement for practices participating in validated regional digital infrastructure arrangements.

- Preferential eligibility for CMS innovation models or rural health demonstrations for systems that demonstrate multi-site EHR integration and shared workflows across urban and rural settings.

- Liability and audit protections for practices using federally recognized shared platforms that meet predefined security and integrity benchmarks.

Policy Safe Harbor for Payer Participation:

- Establish explicit federal safe harbors and demonstration authority allowing payers to co-invest in shared clinical and administrative infrastructure, such as hosted EHRs, payer-provider data platforms, or integrated utilization management tools, when tied to measurable reductions in administrative burden, duplicative services, and total cost of care, while maintaining strict governance and patient consent standards.

Question:

Additionally, how should federal payment or demonstration programs be structured to incentivize adoption of workflow-enhancing digital tools, including AI-enabled documentation, coding, or administrative support platforms that measurably reduce clinician time spent on non-clinical tasks?

Response:

One thing to consider with any demonstration program is whether or not small physician practices will be able to successfully participate. Physicians in small practices and those in rural areas spend inordinate amounts of time just requesting and waiting for patient records to reach them. Access to patient care documents from consulting physicians enhances efficiency and quality of care. Having systems that fully integrate between hospitals, consulting physician practices and primary care physician practices is critical. For that to happen, small practices will need to be able to receive adequate funding and support without the fear of costly recoupments or excessive program penalties. While costs are a crucial and necessary consideration for the government, if small practices are not equipped with the resources they need to acquire the software and potentially hardware needed, the demonstration may be effectively limited to larger hospital systems while excluding many smaller practices that could benefit the most from measures aimed at reducing administrative burdens.

Effective program design should move beyond merely “checking the box”:

- Tie incentives to outcomes, such as reductions in clinician documentation time per visit, faster prior authorization turnaround, or increased patient-facing minutes, rather than simply purchasing the technology.

- Encourage system-level deployment of AI-enabled tools (e.g., ambient documentation, automated coding, centralized prior authorization engines) that benefit multiple sites simultaneously.

- Allow savings from administrative efficiency to be shared between clinicians, practices, and hosting systems, reinforcing alignment.

Sample incentive structures:

- CMS demonstration programs that provide per-clinician or per-visit bonuses when validated AI or automation tools reduce time spent on documentation, coding, or administrative tasks.

- Shared-savings models where reductions in administrative cost or denied claims are partially returned to participating practices and hosting health systems.

- Temporary expense recognition or add-on payments for the first 2-3 years of enterprise-scale implementation of workflow-enhancing tools, particularly when deployed across rural networks.

Shared Payer Administrative Savings & Risk Alignment:

- Structure demonstrations so payers participating in integrated EHR and workflow platforms are eligible to share in documented reductions in administrative

costs, denial rates, and unnecessary utilization. For example, CMS could allow Medicare Advantage plans or Medicaid MCOs to retain a portion of savings generated through real-time clinical integration, automated prior authorization, and AI-enabled documentation-provided savings are reinvested into provider-facing workflow improvements.

Senator Elizabeth Warren

Question:

Insurance conglomerates and wholesale drug distributors are now major employers of physicians. For example, UnitedHealth Group (UHG) is the nation's largest employer of physicians, and McKesson owns the largest community oncology network.

Are you concerned about how these middlemen influence their physician employees and independent physician competitors, including graduates of your medical school, given their incentives to raise prices, lower quality, and drive independent providers out of business?

Response:

Organized medicine, in general, opposes the corporate practice of medicine because these types of arrangements can compromise patient care. Over the past decade or so, physician groups have been consolidating at an unprecedented pace. Medical groups keep growing larger as physician practices merge or sell out in the face of serious economic challenges and, as a result, there are now more physicians serving as employees than as practice owners. In short, the medical landscape has fundamentally changed and there are no signs that this change is set to reverse course. One critical reason for this shift is that it has become increasingly difficult to manage the cost and complexity of running an independent practice, particularly due to regulatory red tape and unfair insurance practices.

In addition, the conversion factor under the Medicare Physician Fee Schedule is not pegged to inflation and has fallen around 33% in real value since 2001, which poses a serious challenge for physicians who care for seniors. Given this reality, it is more important than ever to support physicians that want to remain in private practice, so that doctors who do not want to work for larger organizations will continue to have the opportunity to practice independently. To do this, we must cut down on burdens like prior authorization, end step-therapy or "fail first" protocols, eliminate unfair payment practices such as retroactive denials, ensure that payors maintain adequate networks of physicians, and provide annual Medicare payment updates that track inflation. Taken together, these measures would help make it easier for small medical practices to remain economically viable in this challenging environment and reduce the spread of the corporate practice of medicine.

It is important to distinguish care-aligned integration from middleman-driven consolidation.

Integrated delivery and financial systems like Kaiser Permanente and UPMC align insurance, care delivery, and population health accountability under unified governance. Their success depends on keeping patients healthy, reducing unnecessary utilization, and reinvesting in clinical infrastructure, creating a fundamentally different incentive structure.

By contrast, when insurance conglomerates or wholesale drug distributors employ physicians or acquire networks without direct accountability for care delivery, there is always the risk that financial incentives, not patient outcomes, drive decisions. That concern is heightened when those entities also compete with independent practices or control access points like drug purchasing, referrals, prior authorization, or data.

The concern is not physician employment itself, but who controls clinical decision-making and market leverage. At the same time, fragmentation is not the answer.

Ultimately, policy should encourage integration models that align financing, care, and accountability, while placing guardrails around consolidation that narrows competition or compromises clinical autonomy.

Examples:

- Risk-Bearing Requirement for Advanced Payment Models: Limit eligibility for top-tier shared-savings, global budget, or capitation programs to organizations that directly deliver care and assume downside clinical risk-favoring Integrated Delivery and Finance System (IDFS) over administrative intermediaries.

- System-Level Quality & Cost Accountability: Attribute outcomes, utilization, and total cost of care at the integrated system level (not subsidiary or vendor level), advantage organizations where financing and clinical operations are inseparable.

- Care-First Antitrust Presumption: Apply more permissive antitrust treatment to vertically integrated entities that both finance and deliver care (e.g., Kaiser), while applying stricter scrutiny to entities that control care pathways without delivering care themselves.

In addition to the support for physician practices, support for patient participation in digital support tools must be considered. In many rural areas, connectivity to the internet is a problem. Satellite internet is slow and expensive. Many patients do not have home internet. Telehealth and tele-consults are helpful when patients can get access to the internet; however, Medicaid apparently stopped paying for tele-consult services after the peak of the COVID-19 Pandemic.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

QUESTIONS FOR THE RECORD

Dr. Lee Gross**Senator Elizabeth Warren****Question:**

In 2010, you started a direct primary care practice. Direct primary care practices typically charge patients a flat fee to cover basic services and do not accept public or private insurance. This often requires insured patients to forgo their benefits and pay out of pocket.

1(a) What role did large insurance conglomerates play in your decision to start a direct primary care practice?

1(b) Would legislative reform that breaks up Big Medicine conglomerates make it easier for you to run your practice?

1(c) Would legislative reforms that prohibit prior authorization make it easier for you to run your practice?

Response to 1(a):

Large insurance entities were not the only factor in my decision, but they were part of a broader structural environment that increasingly shaped how care was delivered. Over time, payment architecture and administrative requirements began to exert growing influence on clinical workflows. Utilization management protocols, prior authorization requirements, and complex billing rules were originally introduced with the stated goal of protecting patients from inappropriate or excessive care. In practice, these systems gradually evolved into administrative layers that often operate independently of the clinical encounter itself.

As these processes expanded, they began to consume increasing amounts of physician time and practice resources. The cumulative effect made it harder to sustain a model centered on continuity, access, and individualized decision making. Policies intended to address isolated misuse became standardized requirements applied across the entire system. Tools designed to identify outliers came to shape routine care. Over time, the system shifted from targeting rare instances of misuse to treating every clinical decision as if it required preauthorization, effectively replacing professional trust with administrative permission.

Direct primary care allowed me to test whether removing administrative friction between physician and patient would change outcomes. By simplifying payment and eliminating intermediated approval requirements for routine care, the model reduced overhead and increased time available for clinical care. The objective was not to avoid insurers, but to evaluate what happens when administrative complexity is minimized and clinical decisions occur directly within the physician patient relationship.

My experience working with DeSoto Memorial Hospital illustrates this dynamic. The hospital implemented a self funded employee health plan that eliminated prior authorization and similar approval barriers for routine care within the plan's structure for employees that chose DPC. Removing those administrative layers allowed treating physicians to proceed based on clinical judgment rather than external authorization. The result was a substantial reduction in total health plan spending along with improved employee benefits. That outcome highlights an important distinction. When administrative intermediaries are removed from routine care decisions, both cost and access can improve simultaneously. This suggests that many inefficiencies attributed to medical care itself may instead originate within payment and oversight structures that sit between patients and clinicians.

Medical Expense Per Employee Per Year (PEPY) when hired was \$13,852:

- 2019 Medical Expense PEPY = \$4,549
- 2020 Medical Expense PEPY = \$5,595
- 2021 Medical Expense PEPY = \$7,294

The DPC 3-year averages:

	DPC	Non-DPC	% Difference
Paid by plan PMPM	\$350.83	\$569.28	38.6%
Total Out Of Pocket PMPM (Copay, Coinsurance, deductible)	\$44.55	\$64.73	31.2%
ER visits per 1,000 members	250	411	39.2%
Specialist spend PMPM	\$8.84	\$12.48	29.2%
PCP spend per visit	\$58.70	\$72.42	18.9%

Response to 1(b):

Market concentration in healthcare warrants serious scrutiny, particularly when corporate structures combine financing, delivery, pharmacy, and utilization oversight within the same enterprise. When a single entity is responsible for paying for care, determining whether care is approved, and in some cases delivering that care, structural conflicts of interest are not theoretical. From an incentive design standpoint, they are inherent. Such arrangements create powerful financial incentives to influence clinical pathways, access to services, and treatment approvals in ways that may not be transparent to patients or physicians.

These vertically integrated models can shift decision making authority away from the point of care and toward entities whose primary fiduciary obligation is financial performance rather than clinical outcomes. That dynamic can affect utilization policies, network design, reimbursement structures, and approval standards. When those levers are controlled within the same organization, the distinction between clinical management and financial management can become blurred.

At the same time, consolidation trends reflect multiple reinforcing forces, including regulatory complexity, reporting mandates, and compliance costs that disproportionately burden smaller practices. Many physicians have entered large systems not because of clinical preference, but because scale offers protection from administrative overhead that independent practices struggle to absorb. In that sense, consolidation is not purely a market phenomenon. It is often a rational response to policy design.

For that reason, structural breakups alone would not automatically restore a competitive physician led marketplace. If the regulatory environment that favors scale remains unchanged, new entities would likely reconsolidate to manage the same administrative demands. Structural remedies may therefore be necessary, but they will not be sufficient unless policymakers also address the underlying policy incentives that make consolidation economically rational.

Response to 1(c):

Yes. Prior authorization is among the most resource intensive administrative processes in clinical medicine. It requires time, staffing, and documentation that do not directly contribute to patient care. In many cases it delays treatment while approvals are obtained from third parties who are not directly involved in the clinical evaluation.

Reducing unnecessary prior authorization requirements would improve efficiency and timeliness of care. It would also redirect clinical staff time toward patient services rather than administrative processing. More broadly, it would help restore decision making authority to the point of care, where physicians are accountable for outcomes. Oversight mechanisms are important, but when approval processes become routine prerequisites for standard treatment, they can shift control of clinical decisions away from those directly responsible for the patient and toward entities whose primary role is financial administration.

Additional Concern: Expansion of Prior Authorization and Risk of Administrative Drift

Recent policy developments indicate that prior authorization requirements are being introduced into additional areas of public coverage through pilot programs that apply prospective approval requirements to selected services. These initiatives are intended to improve program integrity and reduce inappropriate spending. At the same time, they illustrate how administrative tools introduced for limited purposes can expand over time in both scope and operational impact.

Historical experience suggests that utilization management systems can evolve beyond their initial targets. In the private sector, some insurers previously used physician utilization scoring programs tied to prescribing or imaging patterns. Physicians with higher scores were exempt from certain administrative steps, while others faced increasing approval requirements. In practice, such systems often affected clinicians who treated more complex patients or who practiced in fields where higher utilization reflected appropriate care.

Another example of clinical guidance evolving into administrative constraint is the American Geriatrics Society Beers Criteria. Originally intended as a reference tool to help clinicians identify potentially inappropriate medications in older adults, the criteria have increasingly been incorporated into quality metrics, payer policies, and utilization controls. In some settings this has effectively turned a clinical guideline into a compliance standard, where deviation can trigger scrutiny even when medically appropriate. This illustrates a recurring policy pattern. Tools created to inform physician judgment can gradually be repurposed to regulate it.

The concern is not the existence of oversight mechanisms, but how they evolve. Safeguards that begin as targeted protections can, if not periodically reassessed, become generalized administrative requirements that influence routine care decisions.

Additional Policy Perspective for the Record

The central problem in healthcare is rarely who participates in the system. It is how the rules shape their incentives.

Certain statutory and regulatory structures can unintentionally influence institutional behavior through their design. Payment rules that tie allowable administrative margins to total spending levels, for example, may affect how organizations evaluate cost reducing innovations. While such policies may limit excessive overhead, they can also create situations in which lowering total spending alters financial calculations for participating entities.

Organizations generally respond predictably to the incentives embedded within policy frameworks. When those incentives reward volume, complexity, or administrative control rather than efficiency and outcomes, system behavior will reflect that structure. Policymakers therefore face an incentive design challenge rather than a choice between public or private delivery models. The key issue is whether payment policy aligns institutional incentives with the goals of affordability, access, and clinical quality.

Sustainable reform is most likely when those incentives are calibrated so that patients, physicians, employers, and payers all benefit from the same outcome: appropriate care delivered efficiently, transparently, and with minimal administrative friction.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

QUESTIONS FOR THE RECORD

Jeffrey Smith**Senator Elizabeth Warren****Question:**

The passage of the One Big Beautiful Bill Act, coupled with the expiration of the Affordable Care Act's enhanced premium tax credits, will likely lead to a significant increase in the number of uninsured Americans and a concurrent increase in uncompensated care, compounding the financial pressures on safety-net hospitals and independent physician practices.

How do you anticipate providers and safety-net hospitals will respond?

Response:

Medical groups will likely provide more uncompensated care and face new financial pressures as patients lose coverage due to the ACA enhanced premium tax credit expiration and Medicaid changes under the One Big Beautiful Bill Act. The response from medical group practices will depend on the ability of their respective states to intervene and offset some of these costs through state-level assistance and policy. Practices, especially in underserved and rural areas who serve a diverse payer mix, will face financial strain as they absorb more care without payment, threatening the stability of safety-net access points and independent practices.

As uninsured rates increase, medical group practices will be forced to take on a substantial administrative burden, such as increased eligibility verifications. Front-office staff will also shoulder the burden of helping patients who may have lost coverage and facilitating out of pocket payment options. As financial pressures intensify, group practices may be pushed toward selling their practices or closing entirely.

Question:

How will intensifying consolidation further erode physicians' autonomy over their patients' medical care?

Response:

Consolidation results from physician owners selling their practices and becoming employed in a health system or hospital. This change can impact physician autonomy because, unlike smaller practices, large health systems often operate in more structured environments and may lead to less physician control over their schedules, practice structure, and other operational activities. By contrast, independent groups can offer physicians meaningful control over their work, where partners may set their own schedules and adjust workloads, and shape operational decision-making.

2025 State of Private Medical Practice report speaks to how intensifying consolidation impacts autonomy. The survey was conducted online from April - May 2025 and received a total of 240 responses.

- Consolidation is a top driver of declining optimism: Among leaders who feel less optimistic about independent practice, 54% cite "increasing consolidation of healthcare".

- Autonomy is a central component of professional independence: 40% of members identify autonomy and independent decision-making as a key benefit of private practice, while 47% cite quality of care/patient focused as a key benefit of working in an independent practice.

- Financial and payer pressures are pushing groups toward mergers and acquisition, shifting governance away from physicians: When asked about necessary changes to ensure practices' sustainability, 28% of respondents selected "increasing practice size via mergers and acquisitions," signaling that many practices view consolidation as survival.

Question:

Following a February 2024 cyberattack on its subsidiary, Change Healthcare, UHG extended emergency loans to affected providers via its subsidiary bank, Optum Financial. Physician borrowers later reported that UHG was acting like a “loan shark,” abruptly demanding full repayment under threat of yet another subsidiary, the insurer UnitedHealthcare, and garnishing claim reimbursements as a means of repayment.

If applicable, can you provide examples of the way that Optum Financial and UHG are treating your members who were forced to take these emergency loans?

Response:

While we are aware of ongoing lawsuits related to the Change Healthcare cyberattack, we have not heard from members about their current interactions with Optum Financial.

Question:

Are any of your members still dealing with the financial fallout from this cyberattack and UHG’s response to it? If so, in what ways are they affected?

Response:

The Change Healthcare cyberattack had wide-ranging financial impacts for medical groups beginning in February 2024, that included:

- Substantial billing and cash flow disruptions, such as a lack of electronic claims processing. Both paper and electronic statements were delayed, with some groups going without any outgoing charges or incoming payments immediately following the cyberattack.
- Limited or no electronic remittance advice from health plans, groups had to manually pull and post from payer portals.
- Prior authorization submissions were rejected or were not transmittable at all.
- Lack of connectivity to important data infrastructure.
- Lack of ability to perform eligibility checks for patients.

Members continued to express residual financial concerns into 2025 related to unpaid claims, benchmarking and data issues, and more. While we have not heard from members recently given the amount of time that has passed, all of these disruptions amplified underlying systemic financial issues, such as staffing shortages and continued inadequate reimbursement from Medicare.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

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QUESTIONS FOR THE RECORD

Cory Feist**Chairman Rick Scott****Question:**

You highlighted during the hearing that even modest reductions in documentation and administrative workload can meaningfully increase patient-facing time and reduce burnout. For small, independent, or rural practices that lack large IT departments, what types of digital infrastructure or workflow-support platforms are most practical and scalable to eliminate redundant documentation, streamline prior authorization, and improve care coordination?

Response:

Thank you for the opportunity to respond to Chairman Scott's questions regarding the administrative burdens fueling the exodus of physicians from the medical profession. For small, independent, and rural practices, the "administrative tax" is a primary driver of burnout and distress. To support clinicians serving in these critical settings, we must prioritize digital infrastructure that is interoperable, automated, and low-friction.

Before implementing specific technologies, I urge all practice leaders to review and implement action steps outlined in the Impact WellbeingT Guide: Taking Action to Improve Healthcare Worker Wellbeing. This transformative resource, supported by the Dr. Lorna Breen Health Care Provider Protection Act, has already equipped over 35,000 healthcare leaders with evidencebased strategies to address the operational factors and burdens that drive their workforce's burnout.

Practice leaders can then take additional steps to reduce documentation burden, streamline workflow, and improve care coordination:

Reducing the Documentation Burden: Ambient Listening AI Technology

The Electronic Health Record (EHR) has transitioned from a clinical tool to a billing ledger, forcing physicians into "pajama time". For small practices, ambient listening AI technology or AI-driven scribes represent a significant leap in workload reduction. Recent implementation of the Impact Wellbeing Guide by one Virginia hospital showed that Ambient listening AI technology can reduce documentation time by 10-15 minutes per patient visit while simultaneously improving patient experience ratings. Another rural Virginia hospital decreased their workforce's cognitive burden by addressing EHR alert fatigue-reducing unnecessary inpatient alerts by 52% and unnecessary ambulatory alerts by 73% per month.

By automating the generation of structured clinical notes, ambient listening AI technology allows physicians and other care givers to return their focus to the patient rather than a screen.

Streamlining Workflow: Electronic Prior Authorization (ePA)

Prior authorizations are a source of profound administrative burden as clinicians spend nearly two business days a week completing these requirements. Similar to the legislative approaches in New Jersey and Virginia, we must move toward integrated ePA platforms that reside within the e-prescribing workflow. I strongly urge the Committee to support S. 1816 The Improving Seniors' Timely Access to Care Act of 2025 to reduce this administrative burden and ensure seniors can access the treatments they need.

Improving Care Coordination: Asynchronous Communication

Rural health is inherently collaborative, yet clinicians are often underwater with documentation and coordination tasks. We recommend the adoption of HIPAA-compliant asynchronous messaging hubs to replace the inefficiency of "phone tag". Furthermore, practices should address EHR alert fatigue. As noted above, we have seen evidence in Virginia that targeted quality improvement projects can reduce unnecessary ambulatory alerts by up to 73% per month, significantly decreasing the cognitive burden on the workforce.

Beyond technical infrastructure, we must address the “invisible” administrative barriers that prevent clinicians from seeking help. Many legacy licensing and credentialing applications ask intrusive, stigmatizing questions about a clinician’s mental health history. Consistent with recommendations in the Impact Wellbeing Guide, our Foundation and its coalition of national healthcare organizations has supported 70 licensure boards and 2,115 health care facilities in auditing and removing these questions, improving access to mental health care for more than 2.64 million licensed health workers. By shifting the focus from past diagnosis to current impairment, we create a culture where getting mental health support is treated as a normal, healthy part of the job.

For the independent physician, time is the most precious resource. The newly reauthorized Lorna Breen Act prioritizes projects that reduce administrative burden, freeing up clinicians to focus on patient care while supporting their wellbeing. I urge Congress to provide full funding of \$45M in FY27 for Lorna Breen Act programs. By funding these programs now and in the future, and by taking the steps outlined above, we can protect the backbone of our healthcare system. We must move from a system that depletes our workforce to one that sustains them with safety and operational support.

Question:

What federal policy changes would most accelerate adoption of such solutions while maintaining appropriate safeguards for patient privacy and program integrity?

Response:

To most effectively accelerate the adoption of these burnout-reducing technologies while maintaining program integrity and patient privacy, federal policy must transition from permissive to proactive support.

Based on the evidence-based framework of the National Academy of Medicine (NAM) National Plan for Health Workforce Well-Being and the operational successes of the Dr. Lorna Breen Health Care Provider Protection Act, we recommend the following federal policy changes:

Sustained Funding for Workforce Retention

Federal investment has historically focused on the pipeline (creating new clinicians) while ignoring the leaks (losing existing clinicians). As I referenced in my written testimony, tens of billions of dollars are directed annually for healthcare workforce creation initiatives, but the Lorna Breen Act programs are the only ones to directly support workforce retention. Congress must provide full and consistent annual funding for the newly reauthorized Lorna Breen Act, which ensures federal dollars are used for proven operational improvements rather than superficial wellness programs.

Standardizing Electronic Prior Authorization (ePA)

The administrative burden of prior authorizations currently consumes nearly two business days a week for physicians. By passing and implementing S. 1816 The Improving Seniors’ Timely Access to Care Act, we can ensure a standardized, real-time electronic prior authorization process for Medicare Advantage plans. Utilizing the HL7 FHIR (Fast Healthcare Interoperability Resources) standard will ensure secure and transparent data exchange that does not create new avenues for “upcoding” or fraudulent claims.

Codifying Documentation Relief through AI “Safe Harbors”

While Ambient Notes AI can reduce documentation time by 10-15 minutes per patient visit, small practices often hesitate to adopt it due to concerns over future audit scrutiny. By establishing CMS “Safe Harbor” guidelines that explicitly recognize AI-generated, physicianvalidated ambient notes as meeting medical necessity and documentation requirements for Medicare/Medicaid reimbursement, will give small practices the peace of mind they need to adopt this transformative technology. Requiring these platforms to maintain HIPAA-compliant, SOC2-certified data encryption will ensure patient conversations remain private and are not used for unauthorized secondary purposes.

Incentivizing “Low-Burden” EHR Configurations

Small practices often suffer from “EHR alert fatigue,” yet they lack the IT staff to optimize these systems. By establishing federal grants or “Wellbeing Meaningful Use” incentives for EHR vendors and practices that successfully reduce cognitive load, we can help small practices make the most of these systems, perhaps even achieving benchmarks like the 73% reduction in ambulatory alerts as demonstrated by quality improvement projects implemented in Virginia using the Lorna Breen Act

resources. This shifts the focus of technology from a billing ledger to a clinical tool that supports—rather than depletes—the workforce.

We cannot care for our aging population if we do not care for those who care for them. By removing the red tape and making technology work for people, we preserve the 30 to 40 years of expertise each clinician provides to the American public—an urgent priority given projected workforce shortages.

Question:

Additionally, how should federal payment or demonstration programs be structured to incentivize adoption of workflow-enhancing digital tools, including AI-enabled documentation, coding, or administrative support platforms that measurably reduce clinician time spent on non-clinical tasks?

Response:

To move the needle on clinician burnout, federal payment and demonstration programs must shift from rewarding volume of documentation to rewarding quality of care for patients and clinicians.

By funding newly reauthorized Lorna Breen Act grants, Congress can help support operational changes that reduce administrative burden. With resources from the Lorna Breen Act, hospitals have successfully improved the wellbeing of health workers by decreasing administrative burden. They have seen significant decreases in both diagnosed mental health conditions like depression and turnover.

Federal demonstrations should require the use of evidence-based or evidence-informed resources like the Impact WellbeingT Guide to ensure that digital tools are integrated into a supportive, safe workplace culture rather than simply added to existing workloads.

Mandating Interoperability for Prior Authorization

Federal policy must accelerate the adoption of electronic Prior Authorization (ePA) to eliminate the “clerical detective work” that currently consumes nearly two business days a week for physician staff.

Immediate passage and implementation of S. 1816 The Improving Seniors’ Timely Access to Care Act of 2025 would mandate a standardized electronic process for Medicare Advantage plans. Future payment models should penalize “manual-only” authorization processes that delay care and increase clinician distress.

Removing Legal and Regulatory Barriers to Wellbeing

Incentivizing use of effective technological tools is only half the battle; we must also ensure that clinicians feel safe enough to seek support while they manage these system transitions.

Federal programs should require participating health systems to audit and remove stigmatizing mental health questions from their credentialing applications. To date, this initiative has already improved access to care for more than 438,000 credentialed health workers.

Tiered Reimbursement Incentives for “Burden-Reduced” Care

Federal payment programs, particularly those within CMS, should provide enhanced reimbursement or bonus payments for practices that utilize certified ambient listening AI technology and other AI-enabled administrative tools.

A “Wellbeing Tier” within the Merit-based Incentive Payment System (MIPS) or Alternative Payment Models (APMs) could reward practices based on a number of factors such as measurably reducing time spent on non-clinical tasks. For one rural hospital in Virginia, the use of ambient listening AI has been shown to reduce documentation time by 10-15 minutes per patient visit, directly allowing for more patient-facing time.

Implementing these and other similar programs, we need to balance the federal investment between focusing exclusively on pipeline creation to prioritizing workforce retention. By providing full and consistent annual funding for Lorna Breen Act programs in FY27 and beyond, Congress can ensure that technology works for people, preserving our health workforce to care for our aging population.

Statements for the Record

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

American Academy of Dermatology



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**U.S. Senate
Special Committee on Aging**

Hearing:

The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine

February 11, 2026

**Statement for the Record
American Academy of Dermatology Association**

Chairman Scott and Ranking Member Gillibrand, on behalf of the more than 17,000 U.S. members of the American Academy of Dermatology Association (AADA), we thank you for the opportunity to submit a statement for the record regarding your hearing, *The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine*.

A board-certified dermatologist has extensive training, which allows them to accurately diagnose and properly treat more than 3,000 diseases of the skin, hair, and nails. Administrative burdens and declining Medicare physician payment amplify physician burnout and threaten patient access to care. Every closed practice, every second of delayed care, every unfilled job in a practice, all hampers coordination and threatens the viability of Medicare. Unfortunately, after more than twenty years of cuts to Medicare physician payment, these delays, closures, and unfilled roles are far too common.

Stabilizing Medicare Physician Payment

Stable and predictable Medicare reimbursement will help lead to greater access for patients and increase the bandwidth of health professionals to coordinate care. Medicare physician payment cuts threaten patient access as physician offices close or become consolidated within larger health systems with narrow networks to specialists and subspecialists. This results in reduced accessibility to affordable, high-quality dermatologic care and fewer options for patients to choose their own physician and health insurance that best meets their needs.

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To accomplish this goal, Congress must take action to advance Medicare physician payment reform by:

- Establishing a positive annual inflation adjustment; and
- Increasing the budget neutrality threshold.

We urge Congress to pass H.R. 6160, the Strengthening Medicare for Patients and Providers Act, which would provide for an inflationary update under the Medicare physician fee schedule tied to the Medicare Economic Index beginning in 2026. This legislation is a critical step toward ensuring financial stability in the Medicare physician payment system so that patients have continued access to high-quality care. The AADA also urges Congress to pass legislation like H.R.6371 – 118th Congress, Provider Reimbursement Stability Act of 2023, which would raise the outdated budget neutrality threshold in the Medicare Physician Fee Schedule (MPFS).

The failure of the MPFS to keep up with inflation is the greatest threat to access to care in physician offices. Stabilizing the MPFS is critical to fortify independent medical practice, combat consolidation and maintain access for patients. On January 16, 2025, the Medicare Payment Advisory Commission (MedPAC) voted to recommend tying Medicare physician payment for CY 2026 to the Medicare Economic Index (MEI) minus 1 percentage point. The MEI, which measures practice cost inflation, is projected to increase by 2.3% in 2026.

The AADA is appreciative of the 2.5% plus-up to Medicare physician payment for calendar year 2026 in *H.R. 1, One Big Beautiful Bill Act*. Additionally, the AADA was supportive of the policy included in the House-passed version of H.R. 1 that would have tied the MPFS to inflation by establishing a permanent, annual update based on a portion of MEI. This could have been a building block towards long-term, sustainable reform of predictable annual inflationary adjustments, but unfortunately this policy was not finalized and instead physicians have dealt with a cut for all of this year with looming challenges facing them in 2026 despite the increase passed by Congress.

Since 2001, the cost of operating a medical practice has increased 59%. During this time, Medicare hospital and nursing facility updates resulted in a roughly 70% increase in payments to these entities, significantly outpacing physician reimbursement. Adjusted for inflation in practice costs, Medicare physician reimbursement declined 33% from 2001 to 2025. This out-of-balance payment structure disproportionately threatens the viability of medical practices, especially smaller, independent, physician-owned practices, as well as those serving low-income or historically marginalized patients. Dermatologists are seeing the real effect of cuts. In the past 8 years, private insurance patients for dermatologists have increased by 21% while Medicare patients are down 27%.

The current Medicare physician payment system has led to increased consolidation and hospital ownership of physician practices resulting in higher expenses and reduced competition to the health care system. In considering the failure of the MPFS to keep up with the rising costs of delivering medical care, it is important to remember that physicians rely on reimbursement to cover a multitude of practice

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expenses. These expenses include staff salaries, benefits, federal and state regulatory compliance costs, and expenses associated with insurance mandates, such as step therapy and prior authorization. The impact of these burdens is unsustainable. Many physicians have already had to close their doors, leave their communities, retire early, or leave the practice of medicine. The inability to provide inflationary pay raises to practice employees is contributing to the current health care workforce crisis in which we are seeing increasing burnout rates and a mass exodus of our clinical, administrative, and clerical staff into other industries.

Fewer physicians in our communities means longer waiting times for patients to receive care. According to the Health Resources and Services Administration, currently, dermatology is only able to meet approximately 37.1% of patient demand in non-metro areas. When those patients do receive care, their only option may be non-physician providers of care with less training, or more expensive care in suboptimal settings including emergency departments and hospital-based practices. Medicare patients will suffer in the end with delayed and second-rate care at a higher cost. Declining reimbursement and increasing administrative burdens will exacerbate this shortage of physicians when offices close their doors.

Recently, MedPAC shared its concerns about whether beneficiaries will continue to have adequate access to care in the coming years as growth in physician practice operating costs is expected to exceed growth in Medicare payment rates by a greater amount than it did in the prior two decades. This larger gap could create incentives for physicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program.

Concerns in the CY 2026 MPFS

In the CY 2026 MPFS, CMS finalized a proposal to apply a 2.5 percent "efficiency adjustment" policy. The AADA is strongly opposed to this policy as it is not supported by valid data, is inconsistent with the Medicare statute, undermines the relativity of resource-based relative value scale (RBRVS), and most importantly, risks harming patient care.

CMS has not explained the rationale for selecting 2.5 percent for the efficiency adjustment beyond citing productivity adjustments in the MEI, which has no meaningful relationship to physician work. Applying an economy-wide productivity factor to physician services is arbitrary and ignores the realities of clinical care. Further, reliance on the MEI is particularly misplaced in this policy because, unlike hospitals and other Medicare payment systems that receive routine inflationary updates, physician services do not benefit from an automatic adjustment for rising costs.

There is no evidence that dermatologists, or physicians in general, are performing procedures more efficiently today than in the past. The time it takes for local anesthesia to become effective or for a patient to stop bleeding has not changed and cannot be made more efficient simply through repetition. In fact, many modern tools require additional physician time, including the use of artificial intelligence.

February 11, 2026

Advanced imaging systems and artificial intelligence tools produce far more data that must be carefully reviewed, interpreted, and documented. A recent national study of 1.7 million surgical procedures found that operative times have increased over the past five years, while patient complexity has also grown. The authors concluded that there is no evidence to support CMS's assumption that physicians are performing procedures more efficiently today.

Unsupported and meritless policies such as the "efficiency adjustment" destabilize the healthcare system by encouraging consolidation and further exacerbate the failures within Medicare, which reinforces the need for long-term sustainable reform. To address this flawed policy, Congress should enact recently introduced legislation, H.R.7520, the Efficiency Adjustment Delay Act, which is critical in ensuring patient access to medical care by delaying the flawed "efficiency adjustment" finalized in the Calendar Year 2026 Medicare Physician Fee Schedule until 2030. The AADA stands ready to work with CMS and Congress on an alternative path forward such as linking Medicare physician payment to a positive inflationary adjustment and reforming budget neutrality.

On behalf of the AADA, thank you for your leadership and help ensuring that Medicare meets the needs of Americans. The AADA is committed to excellence in the medical and surgical treatment of skin diseases; advocating for high standards of clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of disease. The AADA welcomes the opportunity to continue working with Congress to identify opportunities to maintain patient access to care and improve outcomes. Together, we can make a positive difference for patients across the nation.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

American Academy of Family Physicians Statement

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."¹ 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.² 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.¹⁸ 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.¹⁹ 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.⁹ 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.^{vi} 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.⁸ 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.^{iv} 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@aaafp.org.

Sincerely,



Jon Brull, MD, FAFAP
American Academy of Family Physicians, Board Chair

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U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

American Association of Orthopaedic Surgeons Statement

American Association of Orthopaedic Surgeons
Statement for the Record
U.S. Senate Special Committee on Aging
"The Doctor is Out: How Washington's Rules Drove Physicians Out of Medicine"
February 11, 2026

On behalf of its 39,000 orthopaedic surgeon members, the American Association of Orthopaedic Surgeons (AAOS) is pleased to submit this statement for the record of the February 11, 2026 hearing titled, "The Doctor is Out: How Washington's Rules Drove Physicians Out of Medicine". We share the committee's goal of addressing the core drivers working to drive physicians out of the workforce and impact patients' access to care.

Administrative burdens imposed by payers hinder physicians' ability to provide patient care

Prior Authorization (PA) requirements are put in place by Medicare Advantage (MA) plans to help ensure high-quality, cost-effective care while preventing unnecessary utilization. The current prior authorization system, however, imposes excessive administrative burdens on medical practices through complex requirements and electronic health record maintenance, reducing physicians' time with patients and increasing operational costs. It also regularly delays or completely prevents patients from receiving necessary care and negatively interferes with the all-important doctor-patient relationship.

The Improving Seniors' Timely Access to Care Act (H.R. 3514) would prioritize patient care over paperwork by modernizing and streamlining the prior authorization process in Medicare Advantage. This legislation would mandate electronic prior authorization for MA plans, standardize transactions and clinical documentation requirements, and increase transparency around MA prior authorization practices. Additionally, it would empower CMS to establish clear timeframes for prior authorization decisions and require regular congressional reporting on program integrity efforts from HHS and other agencies.

The Improving Seniors' Timely Access to Care Act codifies several key provisions of CMS's January 2024 final Interoperability and Prior Authorization rule (CMS-0057-F). Accordingly, the Congressional Budget Office gave the legislation a score of zero dollars. While this regulatory action represents progress, congressional action is still needed.

Inadequate Medicare reimbursement creates financial barriers for the surgical workforce

The recently finalized rule published by the Centers for Medicare & Medicaid Services (CMS) on October 31st (90 Fed. Reg. 32352 et seq.), reduces the work Relative Value Units (RVUs) and intra-service time for most non-time-based codes by 2.5 percent in 2026, with additional reductions expected every 3 years indefinitely. This "efficiency adjustment" causes further decreases in

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reimbursement for physician services and have wide-ranging consequences, including significant financial pressures that could limit patient access to medical care, particularly for the most vulnerable populations. This “efficiency adjustment” is intended to address an incorrect assumption that non-time-based services become more efficient as the services become “more common, professionals gain more experience, technology is improved, and other operational improvements are implemented”.¹ In direct contradiction to this claim, a recent peer reviewed study published in the *Journal of the American College of Surgeons (JACS)* analyzing more than 1.7 million operations, spanning 249 CPT codes and 11 surgical specialties, found that 90 percent of CPT codes had the same or longer operative times in 2023 compared to 2019. Operative times have increased overall by 3.1 percent.²

The policy from CMS assumes longitudinal efficiency for an individual physician and proposes the adjustment be applied in a cross-sectional manner to all non-time-based codes, including those that have been revalued within the past five years and are currently under review. Adding to the flawed implementation of this policy, the 2.5 percent reduction was calculated using only the productivity component of the Medicare Economic Index (MEI), which is not a valid measurement of physician-specific productivity, given that the MEI is based on changes in economy-wide productivity and does not reflect physician work. While advances in medical technology and treatment protocols allow more patients to survive severe illnesses, these same patients often later require complex, high-risk procedural intervention. Highly experienced physicians may improve time efficiency, but undertake the most challenging cases, whereas newly trained or teaching physicians may treat less complicated patients but typically require more time. Valuation is based on time and complexity/ intensity—not just time alone. Further, a recurring reduction in work RVUs every three years will have severe consequences for physician compensation, even beyond direct reimbursement from the Medicare Physician Fee Schedule. Many physician employment contracts are based on work RVUs or total RVUs, meaning that reductions in these values will decrease physician compensation despite no reduction in actual work performed. The inability to anticipate the magnitude of RVU reductions introduces ongoing uncertainty, making it increasingly difficult to structure fair and sustainable employment agreements, while extending another layer of financial unpredictability for private practice and solo practitioners. The likely response to this instability may be further consolidation. **AAOS urges Congress to take action to delay the implementation of this “efficiency adjustment” and to direct CMS to study a more targeted and thoughtful approach to physician work across specialties and nationwide.**

¹ 90 FR 32352

² Childers CP, Foe LM, Mujumdar V, et al. Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023. *J Am Coll Surg*. 2025.



Conclusion

The American Association of Orthopaedic Surgeons urges Congress to take immediate action to address the growing challenges facing physicians in the U.S. healthcare system. By removing administrative and financial burdens, and putting patient access as top priority, Congress can help to reverse the trend of consolidation and preserve patient access to affordable care. We stand ready to work with the Committee and other stakeholders to advance these critical priorities and ensure that our nation's healthcare system remains robust, innovative, and patient-centered for years to come. Thank you for the opportunity to submit this statement for the record, and we look forward to continuing to engage with the Committee on these critical issues.

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U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

American Clinical Neurophysiology Society Statement

Statement from the American Clinical Neurophysiology Society in response to the
U.S. Senate Special Committee on Aging Hearing:
"The Doctor is Out: How Washington's Rules Drove Physicians Out of Medicine"
February 18, 2026

The American Clinical Neurophysiology Society (ACNS) appreciates the opportunity to submit this statement for the record to the Senate Special Committee on Aging in response to their hearing on Wednesday, February 11 titled "The Doctor is Out: How Washington's Rules Drove Physicians Out of Medicine". Founded in 1946, ACNS represents more than 1,600 physicians, researchers, and allied health professionals dedicated to excellence in clinical neurophysiology in the practice of neurology, neurosurgery, and psychiatry. Our members diagnose and manage complex neurological conditions, including epilepsy, neuromuscular disorders, sleep disorders, and other diseases that disproportionately affect older Americans. A substantial portion of the patients we serve are Medicare beneficiaries.

ACNS is deeply concerned about the growing administrative and financial burdens placed on physicians and how those burdens directly affect older Americans' access to timely, high-quality care. Policies that increase paperwork, reporting complexity, and payment instability divert physician time away from patient care and contribute to workforce strain at a time when the Medicare population continues to grow.

Prior Authorization and Administrative Burden

Prior authorization requirements, particularly within Medicare Advantage, have become a significant source of delay and administrative burden. For patients with chronic neurological conditions such as epilepsy, timely access to electroencephalography (EEG) and other neurophysiologic testing is essential to accurate diagnosis and treatment. Delays in approval can result in worsened health outcomes and increased downstream costs.

While prior authorization can serve as a utilization management tool, its overuse and inefficient implementation require physicians and staff to devote substantial time to navigating approvals, submitting documentation, and appealing denials. This administrative workload reduces the time available for direct patient care and places additional strain on our members' practices already facing staffing shortages.

ACNS supports bipartisan efforts to modernize prior authorization, including adoption of electronic prior authorization systems, standardized requirements, improved transparency, and enforceable timeliness standards through the Centers for Medicare & Medicaid Services (CMS). Reducing unnecessary administrative friction will improve patient access while allowing physicians to focus on clinical care rather than paperwork.

Medicare Payment Stability and Program Complexity

Continued instability in the Medicare physician payment system compounds physician burden. Despite rising practice expenses, including investments in clinical staff,

technology, and compliance infrastructure, Medicare physician payments have remained largely stagnant. Annual uncertainty regarding payment cuts undermines practice sustainability and discourages long-term planning and innovation.

Moreover, quality reporting and value-based payment programs, while well-intentioned, have become increasingly complex and resource-intensive. Many practices must hire dedicated personnel solely to meet reporting requirements. When quality measures are not clinically meaningful or timely, they function as check-the-box exercises rather than tools to improve care. This complexity adds to burnout and detracts from the patient-centered practice of medicine.

ACNS urges Congress to pursue reforms that:

- Stabilize and modernize the Medicare physician payment system;
- Update outdated practice expense data and address structural budget neutrality constraints;
- Simplify quality reporting requirements and align measures with meaningful clinical outcomes; and
- Reduce unnecessary administrative burden across Medicare programs.

Reducing physician burden is not merely a workforce issue; it is critical to protecting access to specialty care for older Americans. A Medicare system that allows physicians to focus on patient care rather than administrative tasks will improve quality, enhance access, and strengthen the healthcare system for the aging population.

ACNS appreciates the Senate Aging Committee's leadership in addressing issues that affect older Americans and stands ready to work with Congress to advance policies that improve access to care while reducing unnecessary burdens on physicians.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF
MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

American Economic Liberties: Healthcare Middlemen Statement

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Congress Shouldn't Let Healthcare Middlemen Open Another Legal Loophole

What patients need is protection from corporate greed in all forms.



By Emma Freer, Senior Policy Analyst for Healthcare

Last fall, the House passed the [Seniors Access to Critical Medications Act](#), sponsored by Rep. Diana Harshbarger (R-TN). It's a seemingly innocuous piece of legislation, purporting to help Medicare patients access their cancer medications. In the view of its backers, it "simply ensures that ... patients have timely access to the appropriate oral medications, by allowing delivery ... or allowing family members or caregivers to pick them up on the patient's behalf," as Harshbarger said in [a press release applauding the bill's passage](#).

But closer inspection reveals its biggest cheerleaders are some of the largest healthcare corporations in the world: wholesale drug distributors that stand to profit at the expense of patients and taxpayers if this bill, expected to be reintroduced in the current session, becomes law. By allowing physician practices with in-house pharmacies, like some oncology clinics, to mail patients their medications, it would open up a lucrative, if unethical, new revenue stream for wholesalers, which are purchasing cancer care centers at a rapid clip. If Trump signs this legislation, he'll increase corporate profits at the expense of senior citizens – and exacerbate the corporate control of medicine.

That's a lot of trouble coming from a bill that sounds worthy enough at first glance. The Seniors Access to Critical Medications Act would amend the longstanding federal Physician Self-Referral Law, commonly referred to as the Stark law, which prohibits physicians from referring patients to entities in which they have a financial interest.

In 2021, the Centers for Medicare and Medicaid Services (CMS) [updated its interpretation](#) of the Stark law to prohibit physician practices with in-house pharmacies from mailing drugs to patients. The bill would undo this FAQ guidance within Medicare's Part D, or prescription drug, program.

Under the current guidance, specialty physician practices continue to benefit from an exemption to the Stark law that allows them to dispense medications via in-house pharmacies. This loophole is bad enough given that such a financial arrangement can distort physician decision-making, incentivizing

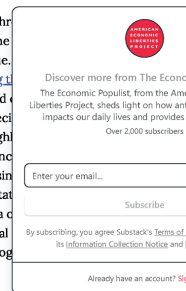
them to prescribe drugs that serve the in-house pharmacy's bottom line rather than patient health. But the legislation at hand would widen this loophole by also allowing practices to also mail medications to patients or release them to their caregivers.

Letting physician practices mail drugs to cancer patients sounds like a good thing since it would, presumably, offer convenience to patients. But seniors can *already* receive cancer medications by mail from stand-alone pharmacies, and there's nothing more convenient than [having a relationship](#) with an independent pharmacist who can provide individualized care. "In many ways it seems like a solution without a problem," Rep. Kim Schrier (D-WA) said at a Congressional hearing on the legislation last year.

But the legislation offers up even more profits to the largest drug wholesalers. This explains why a main supporter of the legislation is a supposedly grassroots group called the Community Oncology Alliance, which is, in reality, a front for the biggest drug wholesalers: the McKesson Corporation; Cencora, Inc.; and Cardinal Health. COA's physician leadership and board members largely hail from practices owned by the "Big Three," which were also among the top sponsors of COA's recent annual conferences.

The wholesaler market is extremely concentrated. The Big Three control 98% of the market, and each ranks among the Fortune 500. In 2023, they generated approximately \$830 billion in revenue, moreover increasingly vertically integrated as well, [acquiring](#) [specialty medical clinics](#) – specifically, oncology and other specialty clinics – at a rapid pace. In January 2024, the Big Three have proposed or completed special acquisitions totaling more than \$14 billion and spanning roughly across 35 states. McKesson owns US Oncology, the largest oncology network in the country, and is now in the process of purchasing Cancer Specialists, with more than 90 locations across the state. A \$1.2 billion deal that's still under federal antitrust review. Cencora completed its \$1.2 billion acquisition of the Integrated Oncology network, the second-largest such network. And Cardinal Health completed its \$1.2 billion acquisition of the Integrated Oncology network, with more than 55 locations in the U.S.

By owning specialty medical clinics, wholesalers can steer and incentivize their physician staff to prescribe the most profitable drugs, regardless of whether they are appropriate or affordable to patients. As a result, this legislation would pad the Big Three's already substantial profits by allowing their affiliated oncology clinics to mail specialty cancer drugs, whose costs are rising steeply, [increasing 169%](#) between 2018 and 2022, e. It would also open the door for a similar arrangement in other medical specialties. Indeed, [McKesson](#), Cencora, and Cardinal Health have all [recently announced plans](#) to



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For all of these reasons, it's critical not only to block this legislation; codify CMS' interpretation of the Stark law, which bolsters protections against conflicts of interest; and repeal other exemptions, but also to take on the consolidation of the medical industrial complex itself.

The American Economic Liberties Project recently launched a new campaign, [Break Up Big Medicine](#), focused on identifying the core policy problem of healthcare conglomerates and urging policymakers to pursue structural reforms to the sector. Congress needs to pass a [Glass-Steagall Act for health care](#), drawing on the New Deal-era reform that structurally separated commercial and investment banks in the wake of the Great Depression. Wholesalers and physician practices should likewise be separated because of the conflicts of interest inherent to their common ownership.

There is almost certainly bipartisan interest for this kind of legislation. Last session, Sens. Elizabeth Warren (D-MA) and Josh Hawley (R-MO) introduced the Patients Before Monopolies Act, which would structurally separate pharmacy benefit managers (PBMs) from pharmacies, for the same reasons why wholesalers should not own medical practices or the pharmacies located in them. One of the co-sponsors of that legislation? No one other than Harshbarger, a pharmacist and staunch advocate for PBM reform.

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Congress Shouldn't Let Healthcare Middlemen Open Another Legal Loophole

"I'm a proud conservative Republican, but we have antitrust laws for a reason," she said in a [press release](#). "That's why I'm joining my colleagues in introducing [this bill], which will protect consumers and taxpayers, and ensure fair competition by breaking-up these anticompetitive, conflict-of-interest arrangements."

Harsbarger has stated that the Ensuring Seniors Access to Critical Medications Act will spare patients from having to rely on PBMs to mail their drugs by allowing physician practices to do so for them. But her bill would actually sanction a different set of "anticompetitive, conflict-of-interest arrangements" driving up costs for taxpayers and patients – especially in oncology, where wholesalers are gobbling up physician practices. These patients' access to critical medications is already ensured. What they need is protection from corporate greed in all its forms – and that includes protection from the Ensuring Seniors Access to Critical Medications Act.

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EXECUTIVE SUMMARY

A new wave of health care consolidation is underway. Health insurance and retail conglomerates are rapidly acquiring providers, from primary care practices and surgery centers to home-based and post-acute care. UnitedHealth Group (UnitedHealth), for example, is now the nation's largest insurer and the largest employer of physicians. Humana is now the largest provider of "senior-based" primary care and in-home care. CVS Health, Walgreens, and Amazon, which have been aggressively consolidating the prescription drug supply chain, are now acquiring physician practices. And private equity investors—looking to consolidate industry segments and then sell to these conglomerates as an eventual exit—are accelerating these rollups.

With dominant market power, the new health care conglomerates can dictate which physicians patients can see, which medications are prescribed to them, and which insurance plans they enroll in. By acquiring medical practices, these corporate employers can shorten visit times, require more clinical coding and box-checking, and replace physicians with lower-cost clinicians. Meanwhile, by coordinating across lines of business, conglomerates like UnitedHealth can squeeze out independent practices and community pharmacies. They can also shuffle money between subsidiaries and use other financial tactics to skirt regulations and exploit payment loopholes, increasing health care costs.

This paper details the causes and costs of this new frontier of consolidation and offers a set of solutions to address it. In short, sweeping changes in health care financing policy are causing insurers and retailers to restructure as vertically integrated conglomerates. While technical, how the government pays providers and insurers fundamentally shapes the business strategies of health care companies. As the government continues to privatize Medicare and Medicaid, it is significantly overpaying insurance companies to administer benefits. With this excess capital, these insurers are acquiring providers, gaining control of key points in the delivery system that enable them to capture greater government payments and minimize spending on patient care. To take one prominent example, control over primary care clinicians allows these corporate owners to manipulate billing and coding practices to make patients appear sicker to the government, thereby increasing payments.

Part I of this paper explains how government policy over the last two decades has transformed health care financing. In an attempt to solve health care's value problem—high spending and poor health outcomes—policymakers have steadily abandoned "fee-for-service" financing, in which medical providers are reimbursed for each service that a patient receives. Instead, public programs have increasingly adopted "capitation-based" financing. In this model, the government pays a fixed budget to a "risk-bearing entity"—an insurance company, hospital system, or group of physicians—to manage the total health care costs for a patient. The risk-bearing entity turns a profit if it keeps costs below the

established budget, which is adjusted based on the perceived sickness of the population and metrics of care quality. In this paper, this policy agenda and its underlying ideological framework are referred to as health policy's "Capitation Consensus."

Medicare Advantage, the privatized version of Medicare that now covers more than half of Medicare beneficiaries, is the most prominent example of the Capitation Consensus. But this financing approach has spread across public health care programs: nearly all of Medicaid has moved to capitation-based financing, and Medicare's prescription drug benefit, Part D, operates entirely on capitation. In the last decade, traditional Medicare—the historically fee-for-service model of Medicare—has been integrating versions of capitation through accountable care organizations and other value-based care models. Despite high hopes, the shift to capitation has yet to deliver on its primary objective of cost reduction. Most concerning is that Medicare Advantage now costs taxpayers anywhere from \$75 billion to \$140 billion annually in over-subsidization relative to traditional Medicare.

Part II of this paper explains how the Capitation Consensus is driving vertical consolidation. With excess capitation payments, Medicare Advantage insurance conglomerates are plunging capital into provider acquisitions, and retailers and private equity investors are following suit. As noted above, owning physician practices enables conglomerates to inflate the perceived disease burden of patients, thereby enhancing capitation-based payments from the government. Vertical consolidation also enables patient steering: conglomerates can push patients to receive care at their own provider subsidiaries. In doing so, these companies squeeze out local providers, such as independent physician practices and community pharmacies. Steering also generates "captive revenue," which allows conglomerates to game federal regulations requiring that government payments are spent on patients, not profits. Further, these conglomerates use their insurance-side subsidiaries to pressure independent practices to sell to their provider-side subsidiaries, effectively "flipping" new patients to their own medical practices and insurance plans.

Turning to solutions, Part III of this paper argues for an alternative policy framework—aimed at a new "industrial policy" for health care—that would depart from the Capitation Consensus and center at least three principles. First, this approach would be suspicious of concentrated corporate power—whether horizontally or vertically combined—and would promote the autonomy and collective power of clinicians. Second, it would revive a legal and policy focus on the ownership structure and governance of health care providers, protecting the medical profession from corporate influence and minimizing financial strategies that increase prices and administrative costs. Third, a proactive health care industrial policy would emphasize the "supply side": how policymakers, particularly in Medicare, can exercise greater control of public money and directly rationalize the production and allocation of health care capacity.

The paper offers two sets of policy recommendations. The first would directly combat the emerging forms of vertical consolidation that are fueled by the Capitation Consensus. The second set of policies offers alternatives to large-scale, investor-driven health care. These proposals are geared toward building robust health care infrastructure—owned by clinical providers and local communities—that meets growing care needs and is insulated from corporate consolidation.

SUMMARY OF POLICY RECOMMENDATIONS

COMBATING VERTICAL CONSOLIDATION

- **Require Transparency in Ownership:** State and federal lawmakers could update transparency laws to illuminate the nature and extent of vertical consolidation and corporate ownership.
- **Reduce Medicare Advantage Overpayments:** Congress and the health agencies can pursue a range of options to stop over-subsidizing Medicare Advantage.
- **Update Medical Loss Ratio (MLR) Requirements:** Congress can raise the MLR requirement, now set at 85%, to align with other advanced countries. Policymakers can also require transparency in pricing to protect against MLR gaming.
- **Invest in Traditional Medicare:** Congress should use savings from Medicare Advantage reform to expand benefits and lower cost-sharing in Medicare. Medicare reform should also stop the emerging trend in which providers only accept Medicare Advantage, not traditional Medicare.
- **Enforce Antitrust Laws:** Congress and executive agencies can update and better enforce antitrust law, and states can pursue similar enforcement, as some already have.
- **A Glass-Steagall for Health Care:** Borrowing New Deal banking reform, Congress could bar insurance companies, or at least certain types, from owning providers.
- **Repurpose Bans on the Corporate Practice of Medicine:** States, with the support of the federal government, can update and repurpose dormant bans on the corporate practice of medicine (CPOM) to address various forms of corporate ownership and investment.
- **Regulate Facility Ownership:** Policymakers can better regulate ownership and governance of institutional providers, such as hospitals, nursing facilities, and home health providers.

- **Support Countervailing Power:** States and the federal government can ban certain contracting practices used to control clinicians, such as noncompete agreements. Lawmakers should also support health care union activity, including the surge in physician unionization.

BUILDING RESILIENT HEALTH CARE INFRASTRUCTURE

- **Produce and Allocate Physicians:** Medicare, as the largest payer for health care services and the direct funder of graduate medical education, should be far more active in increasing and rationally allocating physician supply.
- **Invest in Primary Care and Fix the Relative Value System (RVS) Update Committee:** Policymakers can drastically increase primary care investment and properly calibrate reimbursement disparities across specialties. This requires that Medicare claim the primary role of setting physician pay, rather than deferring to a specialist-dominated physician lobby.
- **Simplify Financing in Primary Care:** Reimbursement should move toward lump-sum payments (without total-cost risk-bearing) that support primary care teams. These payments would be standardized across payers, or removed from insurance and publicly financed, as part of much-needed integration with our public health system.
- **Promote Physician and Public Ownership:** States and the federal government can promote physician-led ownership through the tax code. States also have numerous tools, with historical precedent, to publicly acquire struggling practices and hospitals, and to publicly build where capacity is needed.
- **Hospitals as Public Utilities:** Hospitals, similar to primary care, should be viewed as critical infrastructure and protected from harms of corporate consolidation. They should also be the focus of cost containment through the regulation of prices and administrative costs. Policies could include strengthened conditions of participation and nondiscrimination laws, rate regulation, and all-payer rate-setting. Ultimately, payment should move toward “operational” global budgets, which would strictly fund operations, cap profits and administrative waste, and untether capital financing from operations.

I. THE RISE OF THE CAPITATION CONSENSUS

American health care has a well-known value problem. As a share of GDP, the United States spends nearly twice as much (17.8%) as the average OECD country. Yet high health care spending doesn't translate into better health outcomes. Affordability and access are also lackluster. Caretakers are underpaid and overworked, and physicians are increasingly burnt out.¹

In recent decades, policymakers have pursued a distinctive approach to enhancing value. In the government's two largest public health programs, Medicare and Medicaid, there has been a sweeping effort to move away from traditional fee-for-service financing and toward forms of capitation-based financing—referred to here as health policy's "Capitation Consensus." As argued in this part, financing models under the Capitation Consensus attempt to incentivize the private sector to better manage the total use of health care services, even though excess health care spending is largely driven by high prices and administrative costs, not excessive utilization. This helps explain capitation's underwhelming record on cost reduction, its primary objective.

A THEORY OF UTILIZATION MANAGEMENT

The Capitation Consensus is a departure from traditional fee-for-service financing, in which the government reimburses providers on a per-service basis. Under capitation-based models, the government delegates the management of total health expenditures to private "risk-bearing entities." In a traditional capitation arrangement, like Medicare Advantage (MA) or Medicaid managed care, this risk-bearing entity is a private insurance company that receives a flat per-member, per-month payment from the government. In accountable care organizations (ACOs) and other value-based care arrangements, the risk-bearing entity is a hospital or a group of physicians that similarly receive a total-cost budget to manage. If the patient's medical costs are lower than the capitated budget, the risk-bearing entity profits.

The theory behind the Capitation Consensus is that private-sector management of health care utilization will reduce aggregate health care spending. Under capitated budgets, insurance companies will manage the use of services through a host of familiar strategies—prior authorization, narrow networks, and forms of benefit design

¹ Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, "U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes," The Commonwealth Fund, January 31, 2023; Nada Hassanein, "A third of Americans don't have a primary care provider, report finds," *USA Today*, February 28, 2023.

that incentivize the patient to use certain types of services over others. In value-based care models, physicians and hospitals become the locus of utilization management. In theory, whereas providers under fee-for-service are incentivized to render excess care, capitation-based models incentivize providers to avoid unnecessary care, reduce referrals to expensive specialty and hospital care, and manage chronic conditions that lead to downstream costs.² Under these models, consolidation between hospitals, physicians, and insurers is not presumptively a problem—in fact it is potentially efficiency-enhancing.³ Instead of contracting at arm's length, firms will reduce the transaction costs, coordinate data and workflows, and ultimately lower costs.⁴

This theory of cost-containment rests on an empirical assumption: that Americans overuse health care services, and, therefore, controlling utilization is the obvious way to manage costs. But since the early 2000s, when capitation-based financing began to accelerate in government programs, evidence has shown that Americans do not, by and large, overuse health care services. Indeed, as explained in a landmark 2003 article by Gerard Anderson and colleagues, “It’s the Prices, Stupid,” health service use in the United States was below the median for OECD peer countries. High aggregate costs were attributed to high unit prices.⁵ This finding has been borne out repeatedly in the subsequent decades, including in 2019, when the authors of the 2003 study re-ran their analysis with updated data and concluded that “prices are the primary reason why the US spends more on health care than any other country.”⁶ Demonstrating America’s persistent price problem, the bulk of cost growth in the United States since 2004 is attributable to increased prices.⁷

A major driver of high prices is America’s unparalleled administration costs, including embedded profits, which far exceed our peer nations.⁸ These high costs are driven by the complexity of our system, with countless insurers and intermediaries, and profits accrued at every level. By a conservative estimate, the United States spends \$1,055 per capita on administrative costs, while the next highest, Germany, spends \$306 per capita.⁹ On the high end of estimates, a 2020 study found that administrative costs were \$2,497 per capita, or \$812 billion, and 34.2% of national health expenditures.¹⁰

² Elliott S. Fisher, “Medical Care—Is More Always Better?,” *New England Journal of Medicine*, October 23, 2003, (“[C]urrent incentives must change, since they contribute to the overuse of discretionary services.”).

³ Steven C. Salop, “Invigorating Vertical Merger Enforcement,” *Yale Law Journal*, May 2018.

⁴ Erin Fuse Brown and Jaime King, “The Double-Edged Sword of Health Care Integration: Consolidation and Cost,” p. 62, *Indiana Law Journal*, 2016.

⁵ Gerard F. Anderson et al., “It’s the Prices, Stupid: Why the United States Is So Different From Other Countries,” *Health Affairs*, June 2003.

⁶ Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan, “It’s Still the Prices, Stupid: Why the US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt,” *Health Affairs*, January 2019; Luca Lorenzoni, Annalisa Belloni, and Franco Sassi, “Health-care expenditure and health policy in the USA versus other high-spending OECD countries,” *The Lancet*, June 30, 2014; Irene Papanicolas, Liana R. Woskie, Ashish K. Jha, “Health Care Spending in the United States and Other High-Income Countries,” *JAMA*, March 13, 2018.

⁷ David Dranove and Lawton Burns, *Big Medi: Megaproviders and the High Cost of Health Care in America*, p. 82, University of Chicago Press, 2021.

⁸ “How Does the US Healthcare System Compare to Other Countries?,” The Peter G. Peterson Institute, July 12, 2023.

⁹ *Id.*

¹⁰ David U. Himmelstein, Terry Campbell, and Steffie Woolhandler, “Health Care Administrative Costs in the United States and Canada, 2011,” *Annals of Internal Medicine*, January 7, 2020.

These costs are incurred by both payers and providers, which devote substantial resources to their contracting interactions, to billing and coding for each encounter, and compliance with (and often gaming of) quality payments and reporting.¹¹ Fully insured private payers spent 15.3% of premiums on administrative costs in 2010-2012.¹² MA plans spent 13.6% on administrative costs in 2011.¹³ Meanwhile, the overhead for traditional Medicare in 2012 was 1.8%, similar to Canada.¹⁴ Hospitals spend over 26% of their revenue on administration, which is twice as much as in Canada, and hospitals retain another 6%-7% of revenue as profits, or “surplus” for nonprofit hospitals.¹⁵ In 2011, for every physician, practices spent \$83,000 on administrative costs, a number that is doubtless higher today with the increased compliance burdens of quality reporting and other value-based payments.¹⁶ Furthermore, like high prices, high administrative costs are nothing new: a 2004 study found that administrative costs in the United States were 26% of total expenditures.¹⁷

Nonetheless, overutilization concerns have been a feature of policy discourse since the 1980s. Beginning with concerns about the “moral hazard” of insurance, economists such as Kenneth Arrow and Mark Pauly promoted high-deductible insurance to incentivize patients to constrain their use of care.¹⁸ By the early 2000s, reformers would also look to the incentives of physicians to control utilization. Research from the highly influential Dartmouth Atlas Project showed that regions with high Medicare spending did not correlate with quality.¹⁹ The researchers, in publicly discussing their findings, would extrapolate and argue that all health care spending could drop by as much as 30% if providers across America adopted the practice patterns of the lower-spending regions.²⁰ Popularized by Dr. Atul Gawande of the *New Yorker*, this research became the centerpiece of the Affordable Care Act’s commitment to capitation-based models as the vehicle for cost control.²¹ However, as the *New England Journal of Medicine* and the *New York Times* would later report, this research made significant assumptions about modifiable utilization,

11 Matthew Fiedler, “Testimony Before the United States Senate Committee on the Budget,” October 18, 2023; Adam Gaffney et al., “Hospital Expenditures Under Global Budgeting and Single-Payer Financing: An Economic Analysis, 2021–2030,” *International Journal of Social Determinants of Health and Health Services*, January 30, 2023.

12 “Private Health Insurance Premiums and Federal Policy,” Congressional Budget Office, February 2016.

13 “Medicare Advantage: 2011 Profits Similar to Projections for Most Plans, but Higher for Plans with Specific Eligibility Requirements,” United States Government Accountability Office, December 2013.

14 “2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,” The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2021.

15 Adam Gaffney et al., “Hospital Expenditures Under Global Budgeting and Single-Payer Financing: An Economic Analysis, 2021–2030,” *International Journal of Social Determinants of Health and Health Services*, January 30, 2023.

16 “Physician Practices in the U.S. Spend Nearly \$83,000 Annually Per Physician on Administrative Costs, Nearly Four Times as Much as Canadian Practices Spend,” The Commonwealth Fund, August 4, 2011.

17 David U. Himmelstein, Steffie Woolhandler, and Sidney M. Wolfe, “Administrative Waste in the U.S. Health Care System in 2003: The Cost to the Nation, the States, and the District of Columbia, with State-Specific Estimates of Potential Savings,” *International Journal of Social Determinants of Health and Health Services*, January 2004.

18 Allison Hoffman, “Health Care’s Market Bureaucracy,” *UCLA Law Review*, 2019.

19 Elliott S. Fisher, “Medical Care—Is More Always Better?,” *New England Journal of Medicine*, October 23, 2003.

20 Reed Abelson and Gardiner Harris, “Critics question study cited in health debate,” *The New York Times*, June 2, 2010.

21 Erin Fuse Brown and Jaime King, “The Double-Edged Sword of Health Care Integration: Consolidation and Cost,” p. 57, *Indiana Law Journal*, 2016.

especially at the end of life.²² Further, subsequent evidence has shown that variation in Medicare spending should not be extrapolated to the private commercial market.²³ It also didn't appear as if other evidence at the time substantiated the Dartmouth team's theory of waste. A 2012 meta-analysis of 114,831 papers published over the period 1978-2009 found only 172 studies documenting overuse, concluding that "robust evidence about overuse in the United States is limited to a few services."²⁴ Notably, more recent articles on the sources of waste in America do not appear to cite the Dartmouth Atlas.²⁵

To be sure, many Americans receive low-value or excessive care that contributes to downstream costs. But given that uniquely high expenditures in the United States have long been driven by out-of-control prices, it's not obvious that the optimal way to manage costs is to manage the utilization of services. As discussed in the proceeding parts, policy schemes of private rationing of services come with significant risks, which must be weighed against sober projections of cost reduction and alternative approaches to enhancing value.

A FAILURE ON COST REDUCTION

Despite the foregoing evidence of persistently high prices, capitation-based models have become the consensus approach to improving value in health care. This section traces the formation of the Capitation Consensus within Medicare and Medicaid and discusses its fiscal performance. Medicare Advantage (MA), the "purest" form of capitation, now costs the government significantly more than traditional Medicare. Forms of capitation-based models within traditional Medicare are not nearly as fiscally problematic, but even the most successful models have achieved minimal savings. The same is true for Medicaid privatization, which has largely broken even, fiscally.

I. MEDICARE ADVANTAGE AND MEDICARE PART D

MA is the most prominent example of the Capitation Consensus. Known as "full capitation," the MA program furnishes monthly per-enrollee payments to private insurance plans to create and administer the Medicare benefit. The capitated payments are based on county-level per capita traditional Medicare spending levels (called "base payments") and adjusted for the disease burden of the population (called "risk adjustment"), and for the

²² Reed Abelson and Gardiner Harris, "Critics question study cited in health debate," *The New York Times*, June 2, 2010; Peter Bach, "A Map to Bad Policy — Hospital Efficiency Measures in the Dartmouth Atlas," *New England Journal of Medicine*, February 18, 2010.

²³ Zack Cooper et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *NBER*, December 2015.

²⁴ Deborah Korenstein et al., "Overuse of Health Care Services in the United States," *JAMA*, January 23, 2012.

²⁵ William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, "Waste in the US Health Care System Estimated Costs and Potential for Savings," *Health Affairs*, August 9, 2020.

insurer's performance on a set of quality metrics (called "Star Ratings").²⁶ In contrast to traditional Medicare, MA insurers manage costs in ways familiar to private managed care: constricting the network of providers, requiring prior authorizations, denying services, and designing premiums and cost-sharing to encourage certain utilization patterns.²⁷

MA is an outgrowth of health maintenance organizations, or HMOs. Prior to Medicare's passage in 1965, certain large employers began to make global payments to provider systems, HMOs, to cover all the care of their employees. As these patients retired, Medicare created a capitation option to replicate HMOs.²⁸ With the introduction of private health insurance companies to administer Medicare plans in 1982, this model began to transform into what we know as MA today. No longer reflecting organic, physician-led integrated delivery, HMOs in MA (and the commercial market) are now mostly insurance products with restrictive networks.

Contrary to its theory and legislative intent, MA has always cost more per person than traditional Medicare. MA payments were initially 5%-7% higher per person, on a risk-adjusted basis, than traditional Medicare because insurance plans selectively recruited healthier patients with historically low expenditures.²⁹ In 1997, Medicare sought to correct for selection by introducing "risk adjustment." But that, too, would generate a new form of gaming: MA plans, as explained in detail in Part II, could increase capitated payment from Medicare by making their enrollees appear sick via documentation of clinical diagnoses. By 2009, MA payments were 14% higher than traditional Medicare for populations with comparable health risk.³⁰ In 2010, though Congress reduced base-level capitated payments, it created a new source of arbitrage through geographic and quality bonuses, also explained in greater detail in Part II.

Today, the sum of overpayments in MA (relative to expenditures if the patients were in traditional Medicare) are estimated to range from 20%, or \$75 billion, to 35%, or \$140 billion annually.³¹ As detailed later, MA plans can selectively enroll patients who incur lower spending than expected based on their risk-adjusted benchmark. For the high-end estimations, selection effects account for 11% to 14% of the overpayments, or nearly \$60

²⁶ Erin C. Fuse Brown et al., "Legislative and Regulatory Options for Improving Medicare Advantage," *Journal of Health Politics, Policy and Law*, December 1, 2023.

²⁷ Laura Skopec, Robert A. Berenson, and Judith Feder, "Why Do Medicare Advantage Plans Have Narrow Networks?" The Urban Institute, November 2018.

²⁸ *Id.*

²⁹ Erin C. Fuse Brown et al., "Legislative and Regulatory Options for Improving Medicare Advantage," *Journal of Health Politics, Policy and Law*, December 1, 2023.

³⁰ January Angeles and Edwin Park, "'Upcoding' Problem Exacerbates Overpayments to Medicare Advantage Plans," Center on Budget and Policy Priorities, September 14, 2009.

³¹ Stuart Hammond, Andy Johnson, and Luis Serna, "The Medicare Advantage Program: Status Report," MedPAC, January 12, 2024; Steven M. Lieberman, Paul Ginsburg, and Samuel Valdez, "Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments," USC Schaeffer, June 13, 2023; "Our Payment, Their Profits," Physicians for a National Health Program, October 4, 2023.

billion in projected overpayments in 2023.³² Another 12% of overspending, at the least, results from risk adjustment arbitrage, and gaming of quality and geographic bonuses.³³ Some scholars contend that there is an additional source of overspending called “induced utilization.” This excess spending arguably arises because Medicare establishes MA capitation rates using the spending patterns of traditional Medicare patients, many of whom have purchased supplemental insurance and therefore have higher spending patterns.³⁴ Overall, such significant over-subsidization has caused Medicare to transform in strikingly short order: in 2007, MA was 20% of the program; today, it is over 50%.

In addition to MA, Medicare uses a capitation model to provide the prescription drug benefit, or Medicare Part D. As part of reforms in 2003, instead of providing the prescription drug benefit in the mold of traditional Medicare, Congress and the Bush administration opted for the privatized, MA-like capitated model.³⁵ Rather than directly reimbursing providers and pharmacies for drugs, Medicare would pay insurance companies to create prescription drug plans to offer to beneficiaries. The insurers, in turn, would pay pharmacy benefit managers (PBMs) to negotiate on their behalf. While there is no public option for comparison, Part D is infamous for having prohibited Medicare from negotiating prices after it approves a drug, fueling unparalleled prices for the drugs in the United States. Recently, the Biden administration took aim at this provision in a limited fashion, allowing Medicare to begin to negotiate for a select number of high-cost drugs. This modest reform is projected to save tens of billions in Medicare Part D over the next decade.³⁶

II. TRADITIONAL MEDICARE

While Republican policymakers have been the strongest advocates of MA and Part D, the Democratic Party has embraced the Capitation Consensus through recent reforms to traditional Medicare. In 2010 the Affordable Care Act (ACA) began to remake traditional Medicare in the image of MA, creating a flurry of capitation-based reimbursement models, often referred to as value-based care. These models were headlined by accountable care organizations (ACOs), a term first coined by Elliott Fisher of the Dartmouth Atlas.³⁷ The ACA established ACOs in the traditional Medicare program under the heading of the Medicare Shared Savings Program (MSSP) and established another office, known as the

³² Steve Lieberman and Paul Ginsburg, “Favorable Selection Ups the Ante on Medicare Advantage Payment Reform,” *USC Schaeffer*, June 13, 2023.

³³ “Medicare Status Report,” pp. 354, *MedPAC*, March 2023; “Our Payments Their Profits,” Physicians for a National Health Program, October 4, 2023.

³⁴ Richard Gillfillan and Donald M. Berwick, “Born On Third Base: Medicare Advantage Thrives On Subsidies, Not Better Care,” *Health Affairs*, March 27, 2023.

³⁵ “An Overview of the Medicare Part D Prescription Drug Benefit,” Kaiser Family Foundation, October 17, 2023.

³⁶ Juliette Cubanski, Tricia Neuman, and Meredith Freed, “Explaining the Prescription Drug Provisions in the Inflation Reduction Act,” Kaiser Family Foundation, January 24, 2023.

³⁷ Id.

Center for Medicare and Medicaid Innovation (CMMI), to facilitate other value-based financing experiments, including other forms of ACOs.

In ACOs and other value-based models, groups of physicians or hospitals become the financial risk-bearing entities. In this way, these models resemble health maintenance organizations (HMOs), which peaked in the 1990s, as well as many of the risk-bearing contracts that physicians enter into with MA insurance companies. In contrast to fee-for-service, value-based care models contain the familiar framework of the Capitation Consensus: Medicare establishes a risk- and quality-adjusted budget for a group of traditional Medicare patients who are “attributed” to the ACO, and the ACO profits if costs are kept below that budget.³⁸ Notably—and this is where parallels to MA and HMOs can cause confusion—most ACOs are still reimbursed under traditional Medicare on a fee-for-service basis, rather than receiving monthly capitated payments. At the end of the year, Medicare measures whether the ACO’s health spending is below what would be expected for the ACO’s patients; if it is, the ACO receives a share of the savings as profits. ACOs assuming “upside risk” face no consequences if aggregate spending is above the benchmark. By contrast, an ACO taking “downside” risk may have to pay money back to the government if total spending is sufficiently below their benchmark.

As noted, in addition to codifying the MSSP ACO program in statute and housing it in CMS’ Center for Medicare, the ACA established CMMI as the “innovation center” for value-based care experimentation. Since its inception, CMMI has rolled out dozens of capitation-based models. Some of these models have been variations on ACOs, such as the Pioneer ACO Model, which included more up-front capital for ACOs to invest in care transformation. In the Trump administration’s Direct Contracting model, CMMI more closely tried to emulate MA by experimenting with lump-sum capitated payments and more discretion for ACOs to constrict the network for beneficiaries. The Biden administration addressed numerous concerns about the Direct Contracting model and rebranded it ACO REACH. As another example of the push toward capitation-based models, CMMI recently began to move coverage for hospice care into the MA program, a benefit that has historically been retained in traditional fee-for-service Medicare.³⁹

Policymakers across the political aisle have taken additional steps since the ACA to reaffirm the Capitation Consensus within traditional Medicare. In 2015, as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress created an across-the-board 5% increase in the Medicare fee schedule for all providers who voluntarily enter capitation-based models, such as ACOs. As of 2021, roughly 42% of traditional Medicare patients were in ACOs and other “accountable care” relationships.

³⁸ Tianna Tu et al., “Origins and Future of Accountable Care Organizations,” Leavitt Partners, May 2015.

³⁹ “VBID Model Hospice Benefit Component Overview,” Centers for Medicare & Medicaid Services, September 26, 2023.

Mostly recently, the Biden administration has announced its goal to have all traditional Medicare patients in an accountable care relationship by 2030.⁴⁰

Roughly a decade in, value-based care models within traditional Medicare are not the cost driver that is MA, in part because of tighter regulation. For example, Medicare ACOs cap the amount that a patient's risk score can grow over a contract period at 3%. The Medicare ACO program also prohibits the use of diagnostic codes from in-home risk assessments in calculating risk scores, which, as discussed later, is a pervasive tactic used in MA to increase capitated payments.⁴¹ In addition, there are no Star Rating bonuses, and, compared to MA, there are fewer selection issues, in which the risk-bearing entity selectively enrolls low-spending beneficiaries.

But at the same time, ACOs are still not delivering on the high hopes of cost saving envisioned by their early proponents. A 2023 report from the Office of Inspector General concluded that CMMI, the agency created to administer a range of value-based payment models, cost Medicare \$10 billion in its first decade of operation.⁴² The MSSP, which is the largest value-based program and is housed outside of CMMI, has also struggled to realize significant, if any, savings. Most favorably, the MSSP in 2022 saved Medicare \$1.8 billion, or 0.24% of Medicare spending, but these savings are measured against performance benchmarks, which do not represent counterfactual spending (nor do they purport to). A 2018 study found that physician-led Medicare ACOs were associated with savings of \$250 million annually, while hospital ACOs resulted in net losses.⁴³

Less favorably, a 2023 study examining MSSP performance between 2012 and 2021 found that the program was associated with net losses to traditional Medicare of \$584 million and \$1.4 billion. However, the study found that ACOs were associated with savings in MA, due to spillover effects.⁴⁴ This follows a study published in 2021 by researchers at the University of California San Francisco (UCSF), which found that all four CMS ACO programs from 2005 to 2018 “roughly broke even” for CMS.⁴⁵ In a 2022 report assessing the performance of the MSSP, MedPAC concluded that Medicare spending growth for beneficiaries in an MSSP treatment group was 1%-2% lower than it would have been if those patients were not in MSSP,⁴⁶ but MedPAC noted that it ignored bonus payments, which, if included as they were in the UCSF study, would limit or eliminate any savings.⁴⁷ Finally, other researchers

40 “Medicare ACO Participation Flat in 2022,” NAACOS, January 26, 2022.

41 “Policy Brief: Applying Risk Adjustment Caps in an Equitable Manner,” Aledade, January 27, 2023.

42 “Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid,” Congressional Budget Office, September 28, 2023.

43 Michael McWilliams et al., “Medicare Spending after 3 Years of the Medicare Shared Savings Program,” *New England Journal of Medicine*, September 20, 2018.

44 Andrew Ryan and Adam Markovitz, “Estimated Savings From the Medicare Shared Savings Program,” *JAMA Health Forum*, December 15, 2023.

45 James Kahn and Kip Sullivan, “Promise vs. Practice: the actual financial performance of Accountable Care Organizations,” *Journal of General Internal Medicine*, August 13, 2021.

46 “Assessing the Medicare Shared Savings Program’s effect on Medicare spending,” *MedPAC*, June 2019.

47 Id.

have focused on selection effects in ACOs, in which participating providers have built-in benchmark “tailwinds” that bake in savings irrespective of performance. These studies have found muted savings, or even losses.⁴⁸

III. MEDICAID

Though less the emphasis of this paper, Medicaid’s near-wholesale privatization over the last few decades further illustrates the force of the Capitation Consensus. Medicaid is larger, in terms of enrollees, than Medicare, covering roughly 90 million Americans, compared to Medicare’s 65 million. It costs roughly \$700 billion annually, relative to Medicare’s \$900 billion.⁴⁹ While the majority of enrollees are low-income adults and children, Medicaid pays for supplemental Medicare coverage for 12.5 million Americans and funds roughly 40% of nursing home care.⁵⁰ Known as “Medicaid managed care,” Medicaid privatization began to accelerate in the 1990s and continues today. Currently, 41 states have Medicaid managed care, and as of December 2022, 70% of Medicaid beneficiaries were enrolled in this privatized form of Medicaid. Five for-profit, publicly traded companies cover over half of the Medicaid managed care market: UnitedHealth Group (UnitedHealth), Elevance (formerly Anthem), Aetna/CVS, Centene, and Molina.⁵¹ In 2021, payments to Medicaid Managed Care Organizations (MCOs) totaled more than \$376 billion.

In Medicaid managed care, similar to MA, states pay a capitated payment to MCOs, which assume financial responsibility for enrollees. Medicaid capitated payments are typically modified based on risk adjustment and quality performance. Quality payments in Medicaid managed care operate in a variety of ways, including financial bonuses or penalties, or capitation “withholds,” in which the state retains a portion of the capitated payment unless and until the MCOs meet certain quality targets. Many states—14 as of 2021—are experimenting with Medicaid ACOs, in which Medicaid providers, such as physician practices, participate in capitation-based reimbursement models, assuming varying levels of financial risk. Some states directly contract with providers, similar to the Medicare ACO programs, while others allow or mandate their managed care organizations (MCOs) to develop ACO contracts with clinicians.⁵²

48 Mariétou H. Ouayogodé et al., “Estimates of ACO savings in the presence of provider and beneficiary selection,” *Healthcare*, March 2021; Adam Markovitz et al., “Performance in the Medicare Shared Savings Program After Accounting for Nonrandom Exit,” *Annals of Internal Medicine*, June 18, 2019.

49 “NHE Fact Sheet,” Centers for Medicare & Medicaid Services, September 6, 2023.

50 Maria T. Peña, Maiss Mohamed, and Alice Burns, “Medicaid Arrangements to Coordinate Medicare and Medicaid for Dual-Eligible Individuals,” Kaiser Family Foundation, April 27, 2023.

51 Elizabeth Hinton and Jada Raphael, “A Closer Look at the Five Largest Publicly Traded Companies Operating Medicaid Managed Care Plans,” July 6, 2023.

52 Meredith B. Rosenthal et al., “Realizing the Potential of Accountable Care in Medicaid,” The Commonwealth Fund, April 12, 2023.

Despite the wholesale transformation of Medicaid in recent years, the evidence to support these changes is sparse. In the late 1990s, reformers were so bullish on the efficiency of managed care privatization that they projected significant budget-neutral coverage expansions.⁵³ However, there have been over 60 peer-reviewed studies over the past three decades analyzing the effects of Medicaid managed care; most have shown that managed care has had either no impact, or a negative impact, on cost and quality, while only a few have shown improvements.⁵⁴ According to Kathleen Adams, health economist and co-author of a 2022 literature review on Managed Medicaid, “research clearly says that the goal [of lower costs and better care] has not been reached.”⁵⁵ Further, an oft-touted benefit of managed care is that, even if it doesn’t save costs, states obtain budget predictability. But because managed care tends to include the subset of patients with the most predictable spending patterns, this benefit also seems to be oversold.⁵⁶

Nonetheless, states continue to move toward capitation-based financing in Medicaid. The one exception is Connecticut, which successfully reversed its managed care program in 2011. Costs went down; access to primary care, specialist physicians, and other providers increased; and the number of participating physicians went up 33%.⁵⁷

Taken together, health reform since the turn of the century has emphasized moving away from fee-for-service financing. As a result, the prevalence of capitation-based payment, especially in Medicare, has accelerated considerably. In 2012, 20% of Medicare beneficiaries were in a capitation-based payment model. Today, when combining the growth of both MA and ACOs, that number is over 70%. As discussed next, rather than fostering value in health care, the tidal shift toward capitation in publicly funded health care programs is fueling another wave of health care consolidation.

II. A NEW FRONTIER OF CONSOLIDATION

The under-told story of the Capitation Consensus is how it is transforming the provider ownership landscape. MA insurance companies and pharmacy retailers are purchasing providers and restructuring as vertically integrated conglomerates (“vertical conglomerates”). These acquisitions further the decades-long trend of corporate

⁵³ Colleen Grogan, *Grow and Hide*, p. 322, Oxford University Press, 2023.

⁵⁴ “Has Medicaid Managed Care Delivered On Its Promise?” *Tradeoffs*, November 4, 2021.

⁵⁵ “Has Medicaid Managed Care Delivered On Its Promise?” Transcript, *Tradeoffs*, November 4, 2021.

⁵⁶ Victoria Perez, “Does capitated managed care affect budget predictability? Evidence from Medicaid programs,” *International Journal of Health Economics and Management*, October 14, 2017.

⁵⁷ Joseph Burns, “Connecticut Bucks the Medicaid Managed Care Trend,” *Managed Healthcare Executive*, January 13, 2023.

consolidation in health care—the process of centralizing power in health care within large corporate entities and financial investors, rather than clinicians and patients.⁵⁸ As discussed in this part, this new form of consolidation is particularly profitable under capitation-based financing, but it poses risks for patients, clinicians, and the public.

MARKET OVERVIEW OF RECENT CONSOLIDATION

Recent trends in physician ownership reflect the rise of non-hospital corporate entities, such as vertical conglomerates and companies owned by private equity (PE). At the end of 2021, non-hospital corporate entities owned 27% of physician practices, an increase of 86% from three years prior.⁵⁹ After a flurry of transactions in 2022 and 2023, this percentage of practice ownership is likely higher today. In addition, a substantial amount of consolidation includes non-physician providers, such as in-home and post-acute providers, and pharmacies.

Capitation-based financing is supplying the capital and the incentive structure for these acquisitions. In 2023, the MA program was projected to make \$473 billion in payments, primarily to a handful of insurance companies: UnitedHealth (26%), Humana (18%), BCBS (14%), and CVS Health (11%).⁶⁰ In Medicaid, in 2021, payments to MCOs totaled more than \$376 billion, and five for-profit, publicly traded companies have over half of the Medicaid managed care market.⁶¹ And in traditional Medicare, ACOs and other value-based payment programs were projected to place another roughly \$175 billion “at risk,” which can only be captured by provider entities.

As recently stated by Andy Slavitt, the former EVP of Optum / UnitedHealth and head of CMS in the Obama administration, MA insurers are so flush with government money that they effectively have no choice but to buy up physicians to increase their valuations:

This [Medicare Advantage] is a business that generates a tremendous amount of cash, some might argue too much cash, and you either have to spend that cash to grow. ... So when you're generating literally billions, in the case of United, 25 billion in cash flow per year ... there's a growth imperative. ... So ... United was early to it ... but everyone is moving there because they see that is where the “risk dollars” are, and because they need to continue to grow.⁶²

⁵⁸ Joe Bruch, Colleen Grogan, and Victor Roy, “The Financialization of Healthcare in the United States,” *New England Journal of Medicine*, January 11, 2024.

⁵⁹ “PAI-Avalere Health Report on Trends in Physician Employment and Acquisitions of Medical Practices: 2019-2021,” Physicians Advocacy Institute, April 2022.

⁶⁰ Nancy Ochieng et al., “Medicare Advantage in 2023: Enrollment Update and Key Trends,” Kaiser Family Foundation, August 9, 2023.

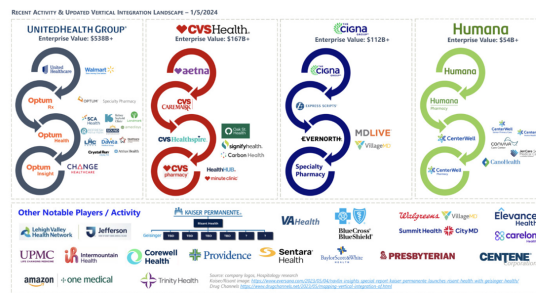
⁶¹ Elizabeth Hinton and Jada Raphael, “A Closer Look at the Five Largest Publicly Traded Companies Operating Medicaid Managed Care,” Kaiser Family Foundation, July 6, 2023.

⁶² Jacob Effron, “Optum’s Evolution and Lessons from Obamacare and COVID: In Conversation with Andy Slavitt,” *Vital Signs*, April 18, 2023.

These vertical acquisitions are frequently framed as value-based care (VBC) investments. In primary care alone, it is estimated that \$50 billion has been invested by these corporate entities in recent years, with similar activity in home-based and post-acute care. And private equity is lubricating these rollups, increasing investment in VBC-aligned companies by more than 400% between 2019 and 2021. As one PE investor recently said, “All roads lead to Optum.”⁶³

The following market overview, summarized in Figure 1, illustrates the push to vertically consolidate. Vertical conglomerates see a population aging into Medicare and the commitment from policymakers to adopt capitation-based financing. In turn, they are restructuring to capture a greater proportion of capitation payments by owning more of the care delivery system and the drug supply chain.

Figure 1⁶⁴



UnitedHealth. As the leader in this space, UnitedHealth now comprises both the nation's largest insurance company and the largest employer of physicians. Through Optum, UnitedHealth employs or is affiliated with over 90,000 physicians and 40,000 advanced practice providers (e.g., nurse practitioners) at more than 2,300 locations,⁶⁵ focusing on practices that operate in MA and across the range of capitation-based models (ACOs, Medicaid, and even ACOs in the commercial market).⁶⁶ Its bigger recent deals include a \$236 million acquisition of Atrius Health in 2022,⁶⁷ a network of over 600 primary care providers, and the \$4.6 billion acquisition of DaVita Medical Group in 2018, a network of

⁶³ "Privatization in Health Care," Senate Interim Committee on Health Care, September 26, 2023.

⁶⁴ Blake Madden, "Vertical Integration Dominates the Payer Landscape," *Workweek*, January 5, 2024.

⁶⁵ Jakob Emerson, "Optum now has 90,000 physicians," *Becker's Payer Issues*, February 16, 2023.

⁶⁶ Rylee Wilson, "15 things to know about ACO REACH," *Becker's Payer Issues*, February 23, 2023.

⁶⁷ Susan Morse, "Massachusetts AG agrees to \$236 million Optum and Atrius Health merger," *Healthcare Finance*, April 25, 2022.

300 clinics and their primary care physicians.⁶⁸ Signaling the growing consolidation and PE investment in behavioral health,⁶⁹ UnitedHealth bought PE-backed Refresh in 2020, a network of outpatient providers.⁷⁰ It also purchased AbleTo, a virtual behavioral health provider.⁷¹ In addition, UnitedHealth began its spree into specialty care with its 2017 purchase of Surgery Care Affiliates for \$2.3 billion, which it has rebranded SCA Health.⁷² It now owns over 320 surgery centers and brands itself as the leader of value-based specialty care—for example, operating as a convener for bundled payment models.⁷³

UnitedHealth is also moving into in-home care, with both primary and post-acute providers. In 2021, it bought PE-backed Landmark Health for \$3.5 billion and recently merged Landmark with Prospero Health, after acquiring it in 2022.⁷⁴ UnitedHealth also acquired LHC Group for \$5.4 billion in 2022 and is currently seeking to purchase Amedisys, a home health and hospice company, for \$3.3 billion.⁷⁵ These home-based assets complement UnitedHealth's 2020 purchase of PE-backed NaviHealth, which is one of a handful of post-acute “conveners” that have emerged within capitation-based models, particularly MA. Similar to PBMs on the drug side, conveners interface with both hospitals and insurance companies and attempt to manage post-acute spending, often by taking financial risk. NaviHealth has recently faced public scrutiny and is being sued for its use of algorithms to terminate or deny medically necessary but expensive care in skilled nursing facilities (SNFs).⁷⁶

On the prescription drug side, UnitedHealth is the owner of OptumRx, one of the three nationally dominant PBMs, which are middlemen in the drug supply chain that work on behalf of insurers to negotiate between drug manufacturers and pharmacies. In addition to being an insurer and a PBM, UnitedHealth also operates a mail-order pharmacy, a “specialty” pharmacy, and an in-person pharmacy for infusion therapies. In 2022, UnitedHealth entered into a 10-year “value-based care” arrangement with Walmart, which operates 5,000 pharmacies nationwide, now provides primary care in 27 clinics,⁷⁷ and is rumored to be the acquisition of MA-based primary care chain, ChenMed.⁷⁸ Finally, UnitedHealth also has a data and analytics services arm, OptumInsight, which recently

68 Ilene MacDonald, “Optum’s \$4.9B deal to buy DaVita Medical Group further expands UnitedHealth’s care delivery portfolio,” *Fierce Healthcare*, December 6, 2017.

69 Sharon Fry et al., “Global Healthcare Private Equity and M&A Report, Value-Based Care: Opportunities Expand,” Bain & Company, April 10, 2023.

70 Chris Larson, “UnitedHealth Group’s Optum Acquires Refresh Mental Health,” *Behavioral Health Business*, March 24, 2022.

71 “OptumHealth Names AbleTo Vet Trip Hofer CEO of Behavioral Health Solutions,” *Behavioral Health Business*, June 23, 2022.

72 Bob Herman, “UnitedHealth is on a buying spree of outpatient surgery centers,” *Stat News*, March 11, 2024.

73 Riz Hattori, “SCA Health grows to 320+ ASCs: 3 things to know,” *Becker’s Payer Issues*, July 10, 2023.

74 “Landmark Health Lands Investment From General Atlantic,” *Wall Street Journal*, March 28, 2018.

75 Eileen Appelbaum, Rosemary Batt, and Emma Curchin, “Profiting at the Expense of Seniors: The Financialization of Home Health Care,” *Center for Economic and Policy Research*, September 26, 2023.

76 Casey Ross and Bob Herman, “UnitedHealth faces class action lawsuit over algorithmic care denials in Medicare Advantage plans,” *Stat News*, November 14, 2023.

77 “Walmart and UnitedHealth Group Collaborate To Deliver Access to High-Quality, Affordable Health Care,” *Walmart*, September 7, 2022.

78 Heather Landi, “Walmart exploring buying majority stake in primary care company ChenMed: media report,” *Fierce Healthcare*, September 11, 2023.

closed a controversial acquisition of Change Healthcare, the billing clearinghouse for the vast majority of medical claims in the nation. All told, UnitedHealth's Optum subsidiaries are now as much of a profit driver as their insurance arm.⁷⁹

Humana. As the second largest MA payer, Humana is now the nation's largest provider of Medicare-focused primary care, directly operating over 250 clinics nationwide.⁸⁰ In 2018, Humana rebranded its primary care practices as Conviva, which operates primary care practices as well as a management services organization (MSO) for over 300 affiliated practices operating in capitation-based contracts, such as MA and ACOs. In 2020, Humana began the first of two joint-venture investments with private-equity firm Welsh, Carson, Anderson & Stowe (WCAS) to build out another primary care practice chain, now called CenterWell. In 2022, the parties announced a second joint venture to deploy \$1.2 billion to open 100 new primary care practices between 2023 and 2025.⁸¹ Like Conviva, CenterWell has a management services arm, which operates in standard Medicare ACOs and now ACO REACH.⁸² Humana is in another joint venture with MA-based primary care practice, ChenMed, and it recently acquired numerous practices from CANO health, another practice chain that has long focused on MA and Medicare ACOs as both a direct provider and an MSO affiliate.⁸³

Humana has also been quickly moving into in-home and post-acute care.⁸⁴ In 2023, it launched an in-home primary care program through CenterWell, incorporating its acquisition of Heal, which focuses on in-home visits for the Medicare population. Humana became the largest home health provider with its \$5.7 billion purchase of PE-backed Kindred at Home in 2021.⁸⁵ Also in 2021, Humana purchased hospice provider Curo Health Services for \$1.4 billion, alongside investors WCAS and TPG Capital. As part of its "value-based care offerings," Humana also purchased PE-backed OneHome in 2021, which is now a vertically integrated conglomerate of home health agencies, infusion services, durable medical equipment, and pharmacies that also coordinates post-acute care for MA plans.⁸⁶ It is also a convener, similar to NaviHealth, and Humana has announced that it plans to have OneHome be the "coordinating agency" for half its own insurance members by 2027.⁸⁷ This acquisition of OneHome also bolstered Humana's pharmacy offerings, as well as its "In-Home Assessment" program, complementing its acquisition of Heal.

⁷⁹ "UnitedHealth Group hits a milestone in vertical integration," *Gist Healthcare*, April 7, 2023.

⁸⁰ "CenterWell Care Solutions," *CenterWell Senior Primary Care*, 2023.

⁸¹ "Humana's CenterWell Senior Primary Care and Welsh, Carson, Anderson & Stowe Announce Second Joint Venture to Develop and Operate Value-Based Primary Care Clinics for Medicare Patients," *Humana*, May 16, 2022.

⁸² "CenterWell Care Solutions," *CenterWell Senior Primary Care*, 2023.

⁸³ "Cano Health sells substantially all of its Primary Care Centers in Texas & Nevada to CenterWell Senior Primary Care," *PR Newswire*, December 26, 2023.

⁸⁴ Paige Minemyer, "Humana completes acquisition of Kindred at Home," *Fierce Healthcare*, August 18, 2021.

⁸⁵ "Humana to buy out remaining stake in Kindred for \$5.7B," *Fierce Healthcare*, April 28, 2021.

⁸⁶ Eileen Appelbaum, Rosemary Batt, and Emma Curchin, "Profiting at the Expense of Seniors: The Financialization of Home Health Care," *Center for Economic and Policy Research*, September 26, 2023.

⁸⁷ *Id.*

CVS Health. The recent investment activity of CVS Health also illustrates the vertical consolidation occurring under the Capitation Consensus. For CVS, like all these corporate investors, entering and growing in the MA market as a payer and provider is the highest priority, while other capitation models, such as ACOs, layer on synergies. CVS' biggest move as a capitation-based conglomerate came in 2018 with its acquisition of Aetna, the nation's third-largest MA insurance company. This immediately complemented its pharmacies, its PBM, Caremark, and its network of 1,100 light-touch MinuteClinics.⁸⁸

In 2023, CVS moved into traditional and home-based primary care. It purchased Oak Street Health for \$10.6 billion, then a chain of roughly 170 Medicare-focused primary care practices across 21 states.⁸⁹ In 2024, it plans to build more than 50 clinics and expand its footprint to 25 states.⁹⁰ Similar to Optum and Humana clinics, and affiliates such as ChenMed and CANO, Oak Street was developed in close alliance with MA payers and now also operates in Medicare's ACO program and ACO REACH. In addition to Oak Street, CVS also purchased private-equity-backed Signify for \$8 billion, which, like Humana's Heal and UnitedHealth's "House Calls" programs, specializes in MA-based home visits to risk code patients.⁹¹

The Signify and Oak Street acquisitions fueled CVS' continued investment in the ACO business in 2023. Prior to selling to CVS, Signify had purchased Caravan Health, an MSO that operates Medicare ACOs with affiliate practices, for \$250 million. At the end of 2023, CVS announced "CVS Accountable Care," combining Caravan with Oak Street and its existing ACO REACH business and ACO MSO partnerships. CVS Accountable Care is managing \$10 billion and 1 million patients.⁹²

Cigna. Like UnitedHealth, insurance conglomerate Cigna also contains the prescription drug trifecta as an insurer, a PBM, and a pharmacy. It owns the third of the "big three" PBMs, Express Scripts, as well as the specialty pharmacy Accredo. Cigna also owns and invests in provider care assets through its subsidiary, Evernorth. Evernorth has been focused on behavioral health, including its telehealth platform, MDLIVE.⁹³ It also made a \$2.5 billion investment in VillageMD, a senior-focused primary care chain now majority owned by Walgreens (more below).⁹⁴ Cigna, which has a larger presence in commercial insurance than Medicare, recently sold its MA business to Health Care Service Corporation

⁸⁸ *Id.*

⁸⁹ Heather Landi, "CVS closes \$10.6B acquisition of Oak Street Health to expand primary care footprint," *Fierce Healthcare*, May 2, 2023.

⁹⁰ Bruce Japsen, "CVS To Build More Than 50 Oak Street Senior Clinics In 2024," *Forbes*, August 2, 2023.

⁹¹ Robert King, "CVS closed \$8B deal for health services company Signify Health," *Fierce Healthcare*, March 29, 2023.

⁹² "CVS Health Investor Day 2023," CVS, December 2023.

⁹³ Chris Larson, "What Potential Humana-Cigna Tie Up Means for Behavioral Health," *Behavioral Health Business*, November 9, 2023.

⁹⁴ Bruce Japsen, "Cigna's \$2.5 Billion Stake In VillageMD's Summit Venture To Grow Evernorth Provider Portfolio," *Forbes*, November 8, 2022.

for \$3.7 billion.⁹⁵ Signaling a complete crossover to the provider and prescription drug side, Cigna explained that it will focus its Medicare investments in Evernorth.

Walgreens. Walgreens is quickly mimicking CVS Health's vertical consolidation efforts. In 2021, Walgreens made a \$5.2 billion investment in VillageMD "to advance its strategic position in the delivery of value-based primary care, a \$1 trillion, fast-growing segment of the healthcare system."⁹⁶ It now has a majority stake, while Cigna is a minority owner. VillageMD declared plans to scale from 230 practices in 2021 to 1,000 in 2027, although it recently announced a spate of closures.⁹⁷ Last year VillageMD purchased Summit Health for \$9 billion, which was one of the largest independent physician groups, operating 680 provider locations.⁹⁸ Walgreens also moved into post-acute and home care in 2021, acquiring CareCentrix, a home health convener that manages 19 million members through over 7,400 provider locations.⁹⁹ As of September, Walgreens purchased Pearl Health, a tech-focused aggregator of primary care practices that is focused on ACO REACH, with ultimate plans to move into MA.¹⁰⁰

Amazon. Amazon's latest foray into health care targets pharmacy services and primary care. It purchased PillPack in 2020, an online pharmacy, and it recently launched Amazon clinic, a platform for low-acuity virtual care. In 2022, Amazon purchased the primary care chain, One Medical. Prior to the acquisition, One Medical had bought Iora Health, another MA-based primary care company, for \$2.1 billion.¹⁰¹ At the time of Amazon's acquisition, One Medical was booking half its revenue from Iora, primarily from capitation contracts with MA payers, as well as Medicare ACOs and ACO REACH.¹⁰²

Other Players. Finally, Medicaid insurers and hospital systems are also pursuing a vertical integration playbook under capitation. Elevance (previously Anthem), which is the second largest Medicaid plan, has recently built out its provider subsidiary, Caredon. It now provides palliative care, behavioral health, and home-based care, including another large post-acute convener, myNEXUS.¹⁰³ It also owns a PBM and recently signaled its plans to invest more heavily in primary care.¹⁰⁴ Centene, the largest Medicaid insurer, acquired Community Medical Group, a large risk-based practice in Florida, in 2018; in 2022, Centene made further investments in CMG with the goal of bringing the model to other

⁹⁵ Paige Minemyer, "Cigna inks deal to sell Medicare business to HCSC for \$3.7B," *Fierce Healthcare*, January 31, 2024.

⁹⁶ "Walgreens Boots Alliance Makes \$5.2 Billion Investment in VillageMD to Deliver Value-Based Primary Care to Communities Across America," *Walgreens*, October 14, 2021.

⁹⁷ *Id.*

⁹⁸ Blake Madden, "VillageMD Ties The \$9 Billion Knot With Summit Health," *Hospitalogy*, November 7, 2022.

⁹⁹ *Id.*

¹⁰⁰ Heather Landi, "Pearl Health clinches \$75M backed by a16z to scale up value-based care tech," *Fierce Healthcare*, January 30, 2023.

¹⁰¹ Paige Minemyer, "One Medical to acquire Iora Health in \$2.1B all-stock deal," *Fierce Healthcare*, April 28, 2021.

¹⁰² Soleil Shah, Hayden Rooke-Ley, and Erin Fuse Brown, "Corporate Investors in Primary Care — Profits, Progress, and Pitfalls," *New England Journal of Medicine*, January 12, 2023.

¹⁰³ "Anthem, Inc. To Acquire myNEXUS, Home Health Benefits Manager," *Business Wire*, March 24, 2021.

¹⁰⁴ Kate Fisher and Dan Stanek, "Payersiders' Moving to the Front Door of Healthcare," *Wayfind*, 2023.

markets.¹⁰⁵ As for hospitals, a recent survey found that 60% of hospital systems reported that they planned to become MA plans in 2022.¹⁰⁶ This trend is highlighted by the recent merger between Geisinger Health, a large hospital system, and Kaiser, which now has 6% of the MA market.¹⁰⁷ Other large integrated systems include UPMC in Pennsylvania, and Providence Health in the Northwest.

RISKS OF VERTICAL CONSOLIDATION UNDER CAPITATION-BASED MODELS

Consolidation allows these vertical conglomerates to use capitated payment structures in ways that drive profits without creating value. As noted above, corporate consolidation in health care has existed for decades, largely driven by hospitals. The primary result: hospitals can negotiate higher prices in the commercial market, cut labor costs and demand more of clinicians, and exploit various loopholes in the fee-for-service Medicare system.¹⁰⁸ In addition, private equity (PE) rollups in health care have risen dramatically over the decades, also exploiting fee-for-service reimbursement and threatening patient care.¹⁰⁹

Today, as policy moves away from fee-for-service, analogous patterns of corporate consolidation are emerging under capitation-based financing. While vertical conglomerates promise clinical integration, familiar harms are emerging, such as the push toward “productivity” medicine and the replacement or supplementation of physicians with less expensive advanced practice providers.¹¹⁰ Moreover, as detailed below, consolidation under capitation presents a new set of risks, centered on payment gaming, patient steering, and anti-competitive coordination between sister subsidiaries of the same parent company.

I. GAMING CAPITATED BENCHMARKS

Vertical conglomerates in capitation-based models are keen on controlling primary care physicians, who are essential for inflating risk-adjustment payments and quality

¹⁰⁵ Paige Minemyer, “Here’s how Centene is thinking about M&A as it tackles its value creation plan,” *Fierce Healthcare*, May 11, 2022.

¹⁰⁶ Robert King, “Nearly 60% of health systems aim to become ‘payviders’ in 2022, survey finds,” *Fierce Healthcare*, November 9, 2021.

¹⁰⁷ Nancy Ochieng et al., “Medicare Advantage in 2023: Enrollment Update and Key Trends,” Kaiser Family Foundation, August 9, 2023.

¹⁰⁸ Karyn Schwartz, Eric Lopez, Matthew Rae, and Tricia Neuman, “What We Know About Provider Consolidation,” Kaiser Family Foundation, September 2, 2020; Corey Capps et al., “The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending,” Northwestern Institute for Policy Research, February 2015 (concluding that vertical integration was associated with a 13.7% increase in physician prices); Sylvia A. Allegretto and Dave Graham-Squire, “Monopsony in Professional Labor Markets: Hospital System Concentration and Nurse Wages,” Center for Economic and Policy Research, January 5, 2023; Jessica Silver-Greenberg and Katie Thomas, “They Were Entitled to Free Care, Hospitals Hounded Them to Pay,” *New York Times*, December 22, 2022; Christopher Whaley, Sebahattin Demirkan, and Ge Bai, “What’s behind losses at large nonprofit health systems?” *Health Affairs Forefront*, March 24, 2023.

¹⁰⁹ Anaeze C. Offodile II et al., “Private Equity Investments in Health Care: An Overview Of Hospital And Health System Leveraged Buyouts, 2003-17,” *Health Affairs*, May 2021; Atul Gupta et al., “How Patients Fare When Private Equity Funds Acquire Nursing Homes,” NBER, August 2023.

¹¹⁰ Joseph Dov Bruch et al., “Workforce Composition In Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices,” *Health Affairs*, January 2023.

bonuses. In MA alone, gaming of risk adjustment is responsible for at least \$23 billion in annual overpayments to insurers, while quality payments amount to another \$10 billion in subsidization without demonstrated value.¹¹¹ In addition to increasing costs, the preoccupation with risk-coding and box-checking wastes scarce time with patients and contributes to dissatisfaction among clinicians.

As explained in Part I, in capitation-based financing, the government modifies payments to risk-bearing entities, such as MA insurers and ACOs, based on the estimated disease severity of patients. This is intended to discourage favorable selection, in which risk-bearing entities enroll mainly “healthy” patients who systematically incur lower-than-average medical expenditures. In addition to fixed demographic factors, a patient’s “risk score” is determined by the number and severity of clinical diagnoses that are communicated to the government. The arbitrage opportunity exists because patients in fee-for-service have not been maximally “coded.” When patients move into MA, insurers and providers drastically increase their risk scores, often by more than 20%.¹¹² In concrete terms, a patient with a risk score of 1.0 is given an annual Medicare “budget” of roughly \$10,000. If that patient’s risk score is 1.2, the insurance entity now has a \$12,000 budget, per patient, against which to make a profit.

Risk coding has become a significant area of abuse under capitation-based financing. All of the ten largest MA companies have been accused of fraud by a whistleblower or the US government.¹¹³ Similar allegations were recently made against one of the largest ACO companies in a whistleblower suit.¹¹⁴ One form of fraud is through the retrospective addition of diagnosis codes. For example, a whistleblower case that was brought and settled against Sutter Health, a California MA plan, alleged that Sutter and its affiliate providers were inaccurately coding conditions as chronic, rather than acute, and that they were employing a “pit crew” to go behind the physician to add diagnoses to patient records after the encounters.¹¹⁵ Recent reporting from a UnitedHealth clinic depicted the same process facilitated by nurses and billers.¹¹⁶

Moreover, ownership of practices allows vertical conglomerates to embed technology, workflows, and compensation structures that maximize coding. For example, the lawsuit against Sutter alleged that managers were pressuring physicians to add codes by sending

111 Steven M. Lieberman, Paul Ginsburg, and Samuel Valdez, “Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments,” USC Schaeffer, June 13, 2023; Laura Skopec and Robert Berenson, “The Medicare Advantage Quality Bonus Program,” Urban Institute, June 2023.

112 Michael Geruso and Timothy Layton, “Upcoding: Evidence from Medicare on Squishy Risk Adjustment,” *Journal of Political Economy*, March 2020; Fred Schulte, “Researcher: Medicare Advantage Plans Costing Billions More Than They Should,” *Kaiser Health News*, November 11, 2021.

113 Reed Abelson, “‘The Cash Monster Was Insatiable’: How Insurers Exploited Medicare for Billions,” *New York Times*, October 8, 2022.

114 Fred Schulte, “Whistleblower Accuses Aledade, Largest US Independent Primary Care Network, of Medicare Fraud,” *KFF Health News*, March 5, 2024.

115 “United States’ Complaint-In-Intervention,” *United States of America ex rel. Kathy Ormsby v. Sutter Health*, March 4, 2019.

116 Adam Stone, “Whistleblower Releases Audio, Files Complaint: Cites Medical Billing Plot at Optum,” *The Examiner*, March 18, 2024.

them algorithmically generated daily alerts suggesting missed codes for MA patients. They were also accused of pre-populating patient records with codes and meeting with physicians one-on-one to encourage them to add codes to their patient records. At UnitedHealth practices, as with Sutter, the medical record is pre-populated with codes for each visit, and the clinician is barred from closing the note until all the suggested codes are addressed. Further, managers reportedly confront clinicians to inquire about missing codes and require that they attend mandatory coding training, rather than seeing patients.¹¹⁷

Another coding practice, as the Office of Inspector General recently documented, is in-home health risk assessments (HRAs).¹¹⁸ Here, clinical providers will visit the home to gather information about the patient's health status and document diagnoses for risk adjustment. Vertical conglomerates are therefore building and purchasing companies specifically devoted to this practice.¹¹⁹ These include UnitedHealth's "House Calls" program, CVS Health's purchase of Signify, and Humana's acquisition of Heal and OneHome. Notably, Medicare ACOs do not allow in-home HRAs to contribute to risk coding, and for traditional Medicare patients who are not in capitation-based models, there is no financial advantage to risk coding. As a result, a recent Health Affairs study found that an annual home visit was 31 times more likely to occur in MA than traditional Medicare.¹²⁰

The centrality of data in diagnosis coding puts vertical conglomerates in the driver's seat. It helps contextualize UnitedHealth's recent \$13 billion acquisition of Change Healthcare, the nation's largest billing clearinghouse, which, according to the Department of Justice, would give UnitedHealth a near monopoly (94% market share) over the clearinghouse market.¹²¹ Through the prism of risk coding, as well as other financial strategies discussed below, the business case was obvious: acquiring Change gives UnitedHealth visibility into the claims, diagnosis codes, and provider IDs of tens of millions of patients.

Beyond risk adjustment, the quality component of capitation-based payments appears to be subject to similar gaming as risk-coding. Under MA's quality payment program (QPP), or Star Rating program, Medicare made bonus payments amounting to \$10 billion in 2022, even though MedPAC and other researchers concluded that care quality and care

¹¹⁷ Interview with anonymous Optum physician.

¹¹⁸ "Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments,"

Office of Inspector General, September 20, 2021.

¹¹⁹ Eileen Appelbaum, Rosemary Batt, and Emma Curchin, "Profiting at the Expense of Seniors: The Financialization of Home Health Care,"

Center for Economic and Policy Research, September 26, 2023.

¹²⁰ Jeffrey Marr et al., "Home-Based Medical Care Use in Medicare Advantage And Traditional Medicare in 2018," *Health Affairs*, September 2023.

¹²¹ Amy Y. Gu, "DOJ's Challenge of the UnitedHealth and Change Healthcare Merger: What Went Wrong and What Does it Mean?" *The Source*, October 17, 2022.

improvement is largely uncorrelated with MA Star Rating performance.¹²² Nonetheless, MA plans receive a bonus of 5% on their total capitated payments if they receive four stars, accounting for 4%-5% of earnings for some major MA plans.¹²³

As with risk adjustment, vertical conglomerates can inflate quality scores with greater control of clinicians. They can, for example, game medication adherence quality measures by pushing providers to put their patients on 90-day refills, mail-order prescriptions, and automatic refills, even if patients never take the medications. Similarly, they can discourage or prohibit clinicians from giving samples to patients and allowing them to use lower-cost alternatives.¹²⁴ Further, Star Ratings and other quality programs require significant administrative efforts, placing small practices at a disadvantage. Staff at primary care practices have entire teams devoted to tracking and managing performance. They must mine the fragmented health care system for paperwork or records proving that a given test was administered, and then report this documentation through a unique software portal for Medicare or the private insurance company.¹²⁵ For vertical conglomerates, the burden on smaller practices creates an acquisition opportunity.

These two arbitrage opportunities—risk scoring and quality gaming—illustrate the obvious business case for vertical consolidation of primary care and in-home providers. Already, abuse of risk adjustment and quality programs is causing tens of billions in subsidies, further supplying the capital for provider acquisitions. With greater ownership and control of providers, vertical conglomerates can reproduce overpayments in MA and employ the same tactics as the risk-bearing entity in ACOs. Beyond fiscal waste, these financial strategies divert from scarce time in the exam room, undermining patient care and driving clinician burnout.¹²⁶

II. PATIENT STEERING AND “CAPTIVE” REVENUE

Next, consolidation allows vertical conglomerates to steer revenue to their sister subsidiaries, such as primary and specialty care, post-acute care, and pharmacies. This not only enables them to skirt federal regulations intended to cap profits; it also drives out independent providers and allows conglomerates to steer patients away from expensive yet medically necessary care.

122 Jeannie Fuglesten Bliniek, Anthony Damico, and Tricia Neuman, “Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least \$12.8 Billion in 2023,” Kaiser Family Foundation, August 9, 2023; Laura Skopec and Robert Berenson, “The Medicare Advantage Quality Bonus Program,” Urban Institute, June 2023; “The Medicare Advantage program: Status report,” MedPAC, March 2023.

123 “2023 Medicare Advantage and Part D Star Ratings,” Center for Medicare and Medicaid Services, October 6, 2022; Blake Madden, “CVS, Oak Street, and the Great Payor Vertical Integration War,” *Workweek*, February 9, 2023.

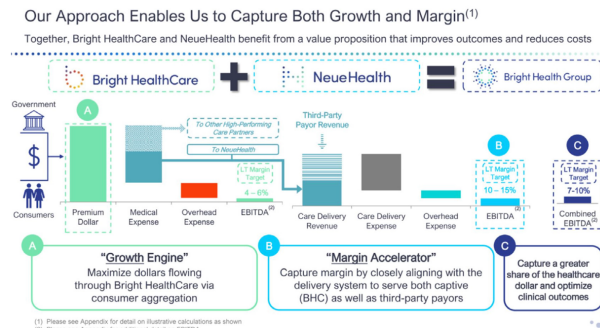
124 C. Annette DuBard et al., “Why The Star Ratings Medication Adherence Measures Must Go,” *Health Affairs*, January 10, 2024.

125 Kelsey Waddell, “The Fundamentals of Medicare Advantage Star Rating Methodology,” *Health Payer Intelligence*.

126 Noam Scheiber, “Why Doctors and Pharmacists Are in Revolt,” *New York Times*, December 23, 2023.

Steering care generates “captive revenue” for vertical conglomerates.¹²⁷ Bright Health, an MA insurance company that recently sold to Molina, depicted this strategy to investors. As shown in Figure 2, insurers see provider ownership as the “margin accelerator.” This is because ownership of the practice unlocks revenue from all third-party payers (i.e., other insurance companies and government payers with patients served by that provider), and it allows the insurance companies to retain more of their capitation payments through captive revenue.

Figure 2



UnitedHealth is increasingly relying on this captive revenue—or “intercompany eliminations”—with its growth of its provider subsidiary, Optum. UnitedHealth has increased intercompany eliminations by over 80% in five years, reaching \$108 billion in 2022.¹²⁸ It now sends over 25% of its medical claim revenue to its own subsidiaries.¹²⁹ Its market presence shows why: UnitedHealth exists in 87% of insurance markets, only rivaled by Humana at 90%.¹³⁰ Further, UnitedHealth has over 50% share in more than 140 MA markets.¹³¹

These captive revenue strategies enable regulatory arbitrage. Medical Loss Ratios (MLRs) were established in the Affordable Care Act to cap insurance administrative costs and profits and to ensure that a minimum percentage of capitation payments and private

¹²⁷ Joe Connolly, “This graphic shows...,” X, July 14, 2021.

¹²⁸ “UnitedHealth Group hits a milestone in vertical integration,” Gist Healthcare, April 7, 2023.

¹²⁹ Editorial Board, “Elizabeth Warren Has an ObamaCare Epiphany,” *The Wall Street Journal*, November 24, 2023.

¹³⁰ Meredith Freed, “Medicare Advantage 2024 Spotlight: First Look,” Kaiser Family Foundation, November 15, 2023.

¹³¹ “TCF Analysis Shows UnitedHealthcare Holds 50% or Greater Share in 140 Medicare Advantage Markets,” *The Capitol Forum*, September 18, 2023.

insurance premiums were spent on medical care. However, insurance companies can circumvent this regulation by paying themselves, directing above-market payments and end-of-year bonuses to their own sister subsidiaries. This is referred to as “transfer pricing” and has been best documented with PBMs.¹³² For example, UnitedHealth can evade the MLR requirement by paying higher-than-cost fees to its Optum PBM, booking that fee as a medical cost.¹³³ The same is possible with medical providers: insurers can increase fees to their sister primary care or post-acute providers to conceal profits as costs and to therefore evade the MLR constraint.¹³⁴

In addition to increasing profits, steering squeezes independent providers and other competitors. In the prescription drug space, the gaming of medication adherence, explained above, diverts business away from unaffiliated pharmacies while gaming quality metrics. As another example, vertical conglomerates that own PBMs can devise formularies and copays that funnel patients to their own pharmacies, squeezing independent pharmacies.¹³⁵ The proliferation of “specialty” pharmacies embeds these anti-competitive practices. Vertical conglomerates, all of which now own specialty pharmacies, increasingly require that certain drugs be dispensed through this alternative channel. Specialty pharmacies now account for over half of prescription drug spending. Another concern is on the prescriber side. As conglomerates own more providers, such as traditional primary care offices and MinuteClinics, they can configure prescribing technology and workflows to favor their own pharmacies, even if cheaper options exist for independent pharmacies.

Vertical consolidation in the post-acute setting presents similar steering risks. MA insurers have increasingly been under scrutiny for limiting or denying care through narrow networks, “ghost networks,” and onerous prior authorization.¹³⁶ Recent reporting revealed that UnitedHealth and Humana are using artificial intelligence with their conveners, specifically NaviHealth, to drive “clinical” prior authorization decisions and override clinical judgment.¹³⁷ This NaviHealth scandal is part of a larger vertical consolidation story. Vertical conglomerates are rapidly consolidating conveners, such as NaviHealth and OneHome, which focus on diverting care from the hospital and skilled nursing facilities. This reduces costs for their insurance subsidiaries, and it also drives revenue to home-based providers that they own, again generating “double margins” for the parent company.

¹³² Eileen Appelbaum, Rosemary Batt, and Emma Curchin, “Profiting at the Expense of Seniors: The Financialization of Home Health Care,” Center for Economic and Policy Research, September 26, 2023.

¹³³ Richard Frank and Conrad Milhaupt, “Profits, medical loss ratios, and the ownership structure of Medicare Advantage,” Brookings, July 13, 2022.

¹³⁴ Eileen Appelbaum, Rosemary Batt, and Emma Curchin, “Profiting at the Expense of Seniors: The Financialization of Home Health Care,” Center for Economic and Policy Research, September 26, 2023.

¹³⁵ Eric Elliott, “Why Independent Pharmacies Remain a Pillar for Access, Community Health,” *Pharmacy Times*, June 30, 2023.

¹³⁶ Jakob Emerson, “Hospitals are dropping Medicare Advantage plans left and right: 13 updates,” *Becker’s Hospital CEO Report*, November 16, 2023; “Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks,” Senate Committee on Finance, May 3, 2023.

¹³⁷ Elizabeth Nappitano, “UnitedHealth uses faulty AI to deny elderly patients medically necessary coverage, lawsuit claims,” *CBS News*, November 20, 2023.

Another way to steer patients in post-acute care is to effectively bring the prior authorization function “in house.” By directly employing physicians, the risk-bearing entity can cut costs by prohibiting or discouraging clinicians from authorizing expensive care. In a 2020 whistleblower lawsuit reported by *The Prospect*, Maxwell Ollivant, a UnitedHealth-employed nurse practitioner in a nursing home, alleged that his supervisor denied requests to transfer UnitedHealth-MA patients with exacerbations to the hospital.¹³⁸ This, Ollivant alleged, was consistent with UnitedHealth’s compensation structure, which gave bonuses to their clinicians who kept patients in the nursing home and out of the hospitals.¹³⁹

Taken together, these steering practices will look familiar to antitrust observers across sectors. Amazon, for example, will steer customers to purchase its own goods on its marketplaces by preferentially placing those products under search queries.¹⁴⁰ Similarly here, vertical conglomerates, like the Amazon marketplace, are directing business to their own products, such as pharmacies and physician practices. As depicted above, however, this captive revenue strategy carries grave risks.

III. PATIENT “FLIPPING” AND ENROLLMENT ARBITRAGE

Consolidation also provides vertical conglomerates with powerful leverage to “flip” patients into their insurance plans and ACOs, a more extreme version of the steering documented above. In addition to increasing overall enrollment, flipping gives conglomerates a tool to drive “favorable selection,” or the practice of enrolling patients who are systemically profitable, even after risk-adjustment. In MA, favorable selection is responsible for another 11%-14% of overspending, or as much as \$56 billion annually.¹⁴¹ Selecting enrollees also allows insurers in MA to game county benchmark bonuses, which excessively rewards insurers with patients in areas of low Medicare spending, to the tune of another roughly \$10 billion in excess MA payments.¹⁴² As vertical conglomerates increasingly own physicians and operate in ACOs, similar risks of selection may arise.¹⁴³

With vertical consolidation, conglomerates can capitalize on more touch points to patients. For example, CVS Health has recently launched initiatives to increase MA and ACO enrollment by targeting specific patients at specific CVS pharmacies. The goal is to sell them on an in-home evaluation or a visit to CVS’ primary care office, which will boost the patients’ risk scores and increase the likelihood of enrollment in their insurance plan

¹³⁸ “Complaint,” *United States of America, et al. ex rel. Maxwell Ollivant, v. Optum, UnitedHealth Group*, May 13, 2020.

¹³⁹ *Id.*

¹⁴⁰ Julie Creswell, “How Amazon Steers Shoppers to Its Own Products,” *New York Times*, July 23, 2018.

¹⁴¹ Steve Lieberman and Paul Ginsburg, “Favorable Selection Ups the Ante on Medicare Advantage Payment Reform,” USC Schaeffer, June 13, 2023.

¹⁴² “Our Payment Their Profits,” Physicians for a National Health Program, October 4, 2023.

¹⁴³ Adam Markovitz et al., “Performance in the Medicare Shared Savings Program After Accounting for Nonrandom Exit,” *Annals of Internal Medicine*, June 18, 2019.

(Aetna) or their ACO.¹⁴⁴ As another example, practice ownership allows conglomerates to send representatives to do “Medicare 101” information sessions in the clinic. Ostensibly, these representatives neutrally educate elderly patients on their Medicare options, but they are paid on commission for each patient they enroll.

More direct than marketing, provider acquisitions allow conglomerates to “flip” patients into MA plans or ACOs by coordinating efforts with sister provider subsidiaries. Conglomerates can initiate the flipping strategy by using some of the steering tactics discussed above.¹⁴⁵ In a recent lawsuit, UnitedHealth was accused of terminating contracts with unaffiliated physicians in order to force the patients to establish care at nearby Optum practices.¹⁴⁶ In another suit, UnitedHealth, with 50% of the MA and commercial insurance markets, allegedly attempted to force the sale of local practices to Optum. UnitedHealth was accused of cutting insurance reimbursement and steering members away from the target practice, and as a condition of insurance contracting, forcing the target practice to give UnitedHealth the first right of refusal upon sale.¹⁴⁷

Once the physician group is acquired by the vertical conglomerate, it can contract exclusively with the sister insurance subsidiary.¹⁴⁸ Patients who want to continue seeing those physicians are all but forced to be part of the MA plan or other capitation model. Short of such exclusive contracting, the conglomerate can achieve a similar objective by contracting less favorably with other insurers. Another tactic is to begin rejecting traditional Medicare patients and only accept MA, undermining the bedrock open-network guarantee of Medicare.

Consolidation of health care data infrastructure, such as the Change-UnitedHealth merger, elevates concerns about enrollment and selection arbitrage. Already, insurers possess troves of information with which to identify prospective patients. As 10,000 Americans age into Medicare daily, vertical conglomerates can leverage their data across lines of business to target practices with profitable patients.¹⁴⁹ Similarly, with greater ability to select their enrollees, they can exploit the aforementioned bonuses provided to plans in low-spending geographies.

These flipping and selection strategies again extend beyond fiscal waste. As with the broader harms of the new frontier of consolidation, patients and clinicians experience

¹⁴⁴ Blake Madden, “CVS Health Bets the House,” *Workweek*, August 10, 2023; “Weekly Health Tech Reads,” Health Tech Nerds, December 10, 2023.

¹⁴⁵ Brittany Trang, “Antitrust lawsuit alleges UnitedHealth’s Optum pressured a California hospital to stop competing over physicians,” *Stat News*, November 23, 2023.

¹⁴⁶ “An insurance titan is dropping hundreds of N.J. physicians to enrich itself, doctors and patients charge,” *NJ.com*, February 2023.

¹⁴⁷ Brittany Trang, “Antitrust lawsuit alleges UnitedHealth’s Optum pressured a California hospital to stop competing over physicians,” *Stat News*, November 23, 2023.

¹⁴⁸ Blake Madden, “CVS, Oak Street, and the Great Payer Vertical Integration War,” *Workweek*, February 9, 2023.

¹⁴⁹ “Complaint,” *U.S. and Plaintiff States v. UnitedHealth Group, Inc. and Change Healthcare Inc.*, February 24, 2022.

fewer and worse options, and more control in health care is centralized within large vertically integrated conglomerates.

III. TOWARD HEALTH CARE INDUSTRIAL POLICY

Addressing emerging consolidation—as well as analogous trends in the hospital context—will require moving beyond the Capitation Consensus. As discussed in Part I, capitation-based financing relies on private-sector utilization management to improve value. In theory, properly incentivized insurance companies and risk-bearing providers will profit by managing the population's use of services, generating lower-cost, high-quality care. However, as the foregoing parts demonstrate, adopting capitation-based models is not delivering on cost-saving promises—and the MA program in particular has become a substantial cost driver. Instead, the Capitation Consensus is transforming the provider landscape, fueling a new frontier of corporate consolidation.

An alternative policy paradigm would orient around health care “industrial policy,” joining the post-neoliberal thinking across other policy domains.¹⁵⁰ This approach would emphasize at least three principles, briefly outlined here. First, it would combat consolidated corporate power and promote the autonomy and collective power of clinical providers. Health policy has long been solicitous of integration, without proper attention to the costs of market power to patients and the health care workforce. The anemic response to decades of hospital consolidation counsels for swift action today against obvious forms of vertical consolidation, even if it is framed as “value-based care” or “alignment.” This approach would also be attentive to the relationship between privatization of public programs and the creation of corporate behemoths, such as today's MA conglomerates.

A second principle would revive concerns about the ownership structure and governance of health care providers, understanding how control by clinicians and the public can shape the ethical valence of care delivery. This approach would challenge a core conceit of the Capitation Consensus—that physicians and other medical professionals are cold economic actors, just like corporations and investors, whose for-profit incentives merely need proper channeling. The emerging harms of vertical consolidation within capitation-based models illustrate the limits of economic incentivization to produce policy outcomes.

¹⁵⁰ K. Sabeel Rahman, “Saving Bidenomics,” *Boston Review*, January 4, 2024; Amy Kapczynski and Joel Michaels, “Administering a Democratic Industrial Policy,” *Harvard Law & Policy Review*, forthcoming.

Such an outlook, which blurs the competing loyalties of business and patient care, may ultimately reduce medical providers to financial instruments, with the “asset” of a patient panel and the capacity to practice “productivity” medicine. Regulation of ownership structure and governance is also critical for minimizing gaming and other financial tactics that are unconnected to patient care. Fully formulated, this policy approach would allow policymakers to rely less on private-sector utilization management to contain costs and instead apply tenets of public utility law to regulate prices, profits, and private-sector administrative bloat.¹⁵¹

A third principle would focus on the “supply side”: how policymakers can exercise greater control over public money and rationally dictate how we produce and allocate capacity in the system. By embracing the government’s central role in designing the system—taxpayers now finance nearly 70% of the health care economy—policymakers can increase the supply of clinicians and redistribute them towards areas of underinvestment, like primary care. In addition to labor, similar thinking is needed in capital policy—our system of allocating and financing infrastructure like clinics and hospitals, which is another area of significant state subsidization with little rational organization. In addition, strengthening control over public money would revive once-lively debates about direct public provisioning of care and direct financing of capital projects.

The following recommendations seek to roll back the harms of the Capitation Consensus and build toward alternatives to corporate consolidation.

COMBATING VERTICAL CONSOLIDATION

The first set of policies is aimed at combating emerging forms of vertical consolidation. Most pressing, policymakers should address the vertical consolidation that is being fueled by the MA program. These policies range from near-term and most feasible, to more structural.

Require Transparency in Ownership: Nontraditional corporate entities, such as insurance companies and private equity, increasingly use complicated and obscure corporate structures that are difficult for patients, the public, and researchers to track. To address this, the Biden administration recently finalized rulemaking that requires nursing homes to disclose information related to ownership, management, and financial control.¹⁵² This sort of transparency should be applied sector-wide. In Congress, the Lower Costs, More Transparency Act, which was recently released but not passed by Republican

¹⁵¹ Nicholas Bagley, “Medicine as a Public Calling,” *Michigan Law Review*, 2015.

¹⁵² Tonya Williams Scharf and Abbey Mansfield Ruby, “CMS Issues Final Rule on Ownership Transparency,” Holland & Knight, November 20, 2023.

House leaders, only requires ownership transparency for providers owned by MA plans.¹⁵³ However, it excludes similar requirements for all providers, including disclosure of the sophisticated contracting arrangements often used by private equity owners that enable them to exert functional control over medical practices without direct ownership (more on this below).¹⁵⁴ States could also take up these transparency efforts.

Reduce MA Overpayments: Scholars have mapped out at least a dozen ways to address these overpayments through regulatory and legislative action, the savings of which could be used to reinvest in Medicare.

To rein in risk adjustment, CMS could, for the first time, increase the “coding intensity adjuster” beyond the statutorily required 5.9% adjustment to correct for risk-score inflation. This would be the most straightforward solution for CMS and reduce payments by roughly \$600 billion in the next eight years.¹⁵⁵ But it would be a blunt instrument that retains the incentive for individual plans to risk code as much as possible and seek overpayments. A more targeted approach would be to alter the risk adjustment model to rely less on traditional Medicare as the risk comparator, or by specifically removing certain abusive risk scoring tactics from measurement, such as chart reviews and home-based risk assessments.

CMS could also build on its 2023 rulemaking to address wholly fictitious risk documentation. Unlike the solution above, which addresses (generally) valid diagnoses from physicians, risk adjustment data validation audits (“RADV audits”) are meant to capture diagnoses submitted by plans that are entirely erroneous and unsupported by the clinical record. The current rule was a modest step in the right direction, and CMS could significantly bolster the impact of these audits by extending the retrospective lookback period, devoting more resources to allow for more audits, and imposing penalties for erroneous submissions (rather than merely requiring repayment).¹⁵⁶

With respect to quality bonuses, CMS could make it more difficult for the plans to achieve the 4-star level, at which they receive their 5% bonus. To address overpayments that result from favorable selection, CMS could vary risk adjustment by geography, or alter the geographic region that is used to calculate MA benchmarks on the basis of traditional Medicare spending in that “local area.”¹⁵⁷

¹⁵³ Yashaswini Singh and Erin C. Fuse Brown, “The Missing Piece In Health Care Transparency: Ownership Transparency,” *Health Affairs*, September 22, 2023.

¹⁵⁴ Id.; Jane Lucas, Scott Kummer, and Rob Stone, “How Is Congress Trying to Regulate Private Equity in Health Care?” *Alston & Bird*, August 21, 2023.

¹⁵⁵ Erin C. Fuse Brown et al., “Legislative and Regulatory Options for Improving Medicare Advantage,” *Journal of Health Politics, Policy and Law*, December 1, 2023.

¹⁵⁶ Id.

¹⁵⁷ Id.

However, legislative action would be the superior intervention for cost savings because Congress could directly capture savings generated from MA. In addition, Congress could make fundamental changes to the way that CMS calculates benchmarks, or the way that plans bid for them. Congress could also make the quality payment program budget neutral, or do away with it.

Update Medical Loss Ratio (MLR) Requirements: In addition to reducing MA over-subsidization, policymakers should more tightly regulate MA plans to protect against gaming and vertical consolidation. To limit the MLR gaming described above, Congress can require disclosure of transfer prices and establish benchmarks to ensure that conglomerates are paying market rates to sister companies.¹⁵⁸ In addition, Congress should consider raising the MLR, now set at 85%, to require that public money is spent on care, not profits and consolidation. While raising the MLR in the commercial market could have unintended consequences (e.g., insurers raising prices), the same concern ought not to apply in MA. Under MA's bid structure, benchmarks are established based on fee-for-service spending, and if bids increase above the benchmark, then plans are required to pay the government. Therefore, there is a built-in price constraint that does not exist in the employer or individual market.

Invest in Traditional Medicare: Policymakers should use savings from MA reform to directly invest in Medicare. Such savings, which could be upwards of \$100 billion annually, would be significant "pay-fors" to, for example, lower premiums and other cost sharing for beneficiaries, implement an out-of-pocket cap, cover hearing and dental, and invest in primary care. In addition, providers are increasingly denying traditional Medicare patients and are instead only contracting with MA plans. This directly undermines the guarantee of traditional Medicare—that patients have an open network to see any provider. This pattern is especially concerning as primary care practices are increasingly sister companies of MA insurance plans. Congress can ban the practice of denying traditional Medicare.

Enforce Antitrust Laws: In December of 2023, the FTC and DOJ updated their merger guidelines, signaling greater agency emphasis on vertical consolidation and more rigorous standards for merger review.¹⁵⁹ Beyond stronger guidelines, the antitrust agencies need more enforcement power. Compared to 1979, the Department of Justice antitrust division has over 200 fewer staff, which Congress could rectify with greater funding for the DOJ and the FTC; this could be general funding or directed to health care specifically, as proposed in the Hospital Competition Act.¹⁶⁰ Congress could also strengthen the antitrust

¹⁵⁸ Richard G. Frank and Conrad Milhaupt, "Related businesses and preservation of Medicare's Medical Loss Ratio rules," Brookings, June 29, 2023.

¹⁵⁹ "FTC and DOJ Release Finalized Merger Guidelines," Hall Render Blog, December 27, 2023.

¹⁶⁰ Andy Forman, "Deputy Assistant Attorney General Andrew J. Forman Delivers Remarks to Capitol Forum: Health Care Competition Conference," United States Department of Justice, October 26, 2023; "Senator Klobuchar Introduces Sweeping Bill to Promote Competition and Improve Antitrust Enforcement," US Senator Amy Klobuchar, February 4, 2021.

statutes to make large mergers and vertical mergers more presumptively unlawful, as well as overturning bad case law on the Sherman Act.¹⁶¹

State AGs and other enforcement bodies can also scrutinize transactions. In the past decade, seven states have established enforcement agencies specifically dedicated to scrutinizing health care transactions beyond the traditional domain of nonprofit hospitals.¹⁶² Requirements range from simple notice to approval from the state.¹⁶³ Notably, these bodies need not be solely focused on antitrust. In Oregon, which is thought to have the most expensive regulatory authority, the Health Care Market Oversight (HCMO) board can block transactions if they pose risks to controlling costs or improving access, equity, and quality.¹⁶⁴ However, across the states, it remains too early to tell whether enforcement will be sufficient to slow corporate consolidation. Notably, Oregon undertook an extensive review of Amazon's One-Medical purchase but ultimately approved it.¹⁶⁵

A Glass-Steagall for Health Care: Under current statute, to address the harms of vertical consolidation, the antitrust agencies must work within the statutory confines of the Clayton Act, which primarily prohibits mergers where the effect “may be substantially to lessen competition, or to tend to create a monopoly.”¹⁶⁶ Enforcing limits on vertical consolidation this way requires repeatedly proving its negative effects on competition through litigation. But Congress itself faces no such constraints when addressing vertical mergers. One idea would be to simply outlaw payer-provider integration—a sort of Glass-Steagall for health care. The Glass-Steagall Act, passed in 1933 in response to the Great Depression but repealed in the late 1990s, prohibited banks from being both commercial and investment banks because it was thought to pose a systemic risk. A Glass-Steagall for health care would take a structural position against the vertical consolidation of insurers and providers, recognizing the inherent conflict and risk associated with being on both sides of this relationship. This proposal would ban insurers and PBMs from owning pharmacies, including mail-order and specialty pharmacies, and it would ban insurers from owning medical providers.

Update and Repurpose Prohibitions on the Corporate Practice of Medicine: States, with the assistance of the federal government, can update bans on the corporate practice of medicine (CPOM) to prohibit or limit insurance, private equity, and other forms of corporate ownership of physicians. Historically, CPOM bans have barred lay corporations

161 For example, *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2 (1984), permitted exclusive contracting between different medical providers (a hospital and its anesthesiologists), assuming that such contracting is efficient and benefits patients. Such precedent, however, may give greater authority to exclusive contracting of insurance conglomerates.

162 Brett R. Friedman, Benjamin Wilson, and Natalie LaRue, “Value-based Care Collides with Competition: Recent Developments on the East Coast,” *Ropes & Gray*, May 31, 2023.

163 *Id.*

164 Robin Davison, “A Step Forward for Health Care Market Oversight: Oregon Health Authority’s Health Care Market Oversight Program,” *Milbank Memorial Fund*, March 13, 2023.

165 “Transaction 005 Amazon & One Medical 30-Day Review Summary Report” Oregon Health Authority, December 28, 2022.

166 “15 U.S. Code § 18 - Acquisition by one corporation of stock of another,” *Cornell Law School Legal Information Institute*.

from owning, employing, or controlling medical practices. In the 1970s and 1980s, however, with the rise of the managed care movement and mistrust of the AMA's monopoly power, regulators at the state and federal level began to erode CPOM bans. Most importantly, lawyers crafted a workaround, known as the “friendly” or “captive” professional corporation (PC) model, to allow lay management corporations to exert de facto control over medical practices.¹⁶⁷ States could close these loopholes and workarounds with properly drafted legislation—and some are beginning to try. Legislators in Oregon have recently introduced a first-in-the-nation bill to specifically regulate the friendly PC model as used by private equity, insurance conglomerates, and national retailers.¹⁶⁸

At the federal level, congressional leaders could pressure their states to enforce these laws, and the agencies could update guidance that has, for the past number of decades, been suspicious of CPOM.¹⁶⁹ Further, Congress could repeal the HMO Act, which pressured states to create managed care exceptions to their CPOM laws. Though not historically the purview of the federal government, Congress could establish a federal CPOM ban, as was recently debated by the AMA House of Delegates.¹⁷⁰

Regulate Facility Ownership: While CPOM bans can combat the encroachment of management companies and require physician ownership of medical practices, they do not address ownership of facilities and non-physician providers. For example, CPOM bans—as historically understood—do not regulate ownership of hospitals, nursing homes, dialysis clinics, or home health agencies. However, states and the federal government can, and historically have, directly regulated the ownership and governance of these providers. Specific to emerging forms of vertical consolidation, Medicare used to ban for-profit entities from existing as home health or hospice providers.¹⁷¹ Similarly, Medicare did not initially allow for-profit entities into the Program of All-Inclusive Care for the Elderly (PACE).¹⁷² Renewed scrutiny of ownership also would also apply to hospitals and nursing homes. For example, regulators could ban PE ownership of nursing homes, or revoke the nonprofit distinction for nonprofit hospitals that employ predatory financial tactics while stinting on charity work.¹⁷³

Support Countervailing Power: Federal and state officials can also take steps to empower physicians and other clinicians. Corporate owners routinely use noncompete agreements, gag clauses, and other restrictive covenants to control physicians and bind

167 Jane M. Zhu, Hayden Rooke-Ley, and Erin Fuse Brown, “A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine,” *The New England Journal of Medicine*, September 14, 2023.

168 Jake Thomas, “Bill seeks to curb corporate control of health care in Oregon,” *The Lund Report*, October 31, 2023.

169 Carl F. Ameringer, “Organized Medicine on Trial: The Federal Trade Commission vs. the American Medical Association,” *Journal of Policy History*, 2000.

170 Maureen Tkacik, “The AMA Debates a Federal Ban on Corporate Medicine,” *The American Prospect*, November 13, 2023.

171 Eileen Appelbaum, Rosemary Batt, and Emma Curchin, “Profiting at the Expense of Seniors: The Financialization of Home Health Care,” Center for Economic and Policy Research, September 26, 2023.

172 David Dayen, “Patient Zero,” *The American Prospect*, August 1, 2023.

173 “US: Nonprofit Hospitals Chase Low-Income Patients on Debts,” Human Rights Watch, June 15, 2023.

them in place. The FTC proposed a ban on noncompete agreements in January 2023, which would apply across industries, but final rulemaking was delayed until 2024. States could do this, as well, and some already do. The federal government and the states can also provide due process protections for physicians who are fired by lay corporations that do not formally employ them but that exert de facto control over them through contracting. This issue has direct application to the hospital setting, as well. For example, an emergency room physician working for a PE-owned staffing company may be removed, without due process, via coordination between the PE firm and the hospital.¹⁷⁴ Finally, there is a growing desire for physicians and health professionals to unionize, as seen with nurses, pharmacists, and physicians working for UnitedHealth, private equity companies, and large hospital systems.¹⁷⁵ Physician unionization offers a vehicle for collective power, providing an institution for physicians to reclaim control of medical practice and to engage in policy transformation. Federal and state legislators can support the growing unionization efforts of physicians and other medical professionals by enacting legislation that makes it easier to unionize.

BUILDING RESILIENT HEALTH CARE INFRASTRUCTURE

Ultimately, combating corporate consolidation requires more than just “defense.” Practicing medicine independently today is an immense challenge. Our fragmented, multi-insurance system, with its labyrinth of payment and compliance policies, has made every physician-run clinic vulnerable to acquisition. Today, these physician practices generally have one option: sell to the corporate giant, whether a hospital, insurance conglomerate, or PE investor. An adequate policy response therefore requires alternatives. Though far from comprehensive, the following recommendations offer first steps, with an emphasis on primary care, the backbone of any strong health care system.

Produce and Allocate Physicians: Because the government directly funds medical residency slots, it is well positioned to dictate the scale and specialty distribution of the physician supply. The current primary care physician shortage is worsening by the day. By 2034, it is estimated that there will be a shortage of up to 48,000 primary care physicians.¹⁷⁶ This can be rectified with a significant increase and reallocation of primary care residency slots. Medicare should also use its bargaining power to ensure that there is an adequate pipeline of medical students to place into primary care and other underserved specialties. This would require coordination with medical schools, prior to residency, to ensure that

¹⁷⁴ Greg Jasani and James Maloy, “Emergency department physicians should have the right to due process protection. Many don’t,” *Stat News*, December 16, 2020.

¹⁷⁵ Arielle Dreher, “More physicians unionize in the face of burnout, consolidation,” *Axios*, November 7, 2022.

¹⁷⁶ Andis Robeznieks, “Doctor shortages are here—and they’ll get worse if we don’t act fast,” *American Medical Association*, April 13, 2022.

their admissions practices align with societal needs. These questions of access will also implicate debates around telemedicine and scope of practice, which deserve serious policy attention and evidence-based solutions made in the interest of patients and the public.

Invest in Primary Care and Fix the RUC: Attracting physicians into under-supplied specialties like primary care calls for increased investment and for compressing the range of physician reimbursement. Indeed, evidence indicates that a significant driver of specialty choice is the pay disparity between possible specialties.¹⁷⁷ Here, again, Medicare plays a central role in organizing the physician supply through its control over reimbursement rates for services, known as the Medicare Physician Fee Schedule (MPFS). Not only does the MPFS set rates for Medicare, three-quarters of the services physicians billed to commercial insurers are pegged to Medicare's relative prices, and numerous Medicaid programs use the Medicare rates as a benchmark.¹⁷⁸ Medicare policy is moving in the right direction with recent MPFS increases to primary care, but the magnitude is wholly insufficient. As recently recommended by the National Academies of Sciences, Engineering, and Medicine (NASEM), pay rates for primary care should increase by 50%.¹⁷⁹

One perennial barrier to compressing pay disparities between primary care and specialists is that the American Medical Association (AMA) all but sets the MPFS through its control of the RVS Update Committee, or RUC. Shortly after Medicare implemented the MPFS, the AMA created the RUC to provide recommendations to CMS in setting reimbursement rates for physicians. Between 1994 and 2010, CMS accepted 87.4% of the RUC's recommendations, unaltered. The RUC has minimal primary care representation, and research shows that the RUC inflates the relative value, and hence the reimbursement, of specialty services.¹⁸⁰ While it is useful to have physician input from their institutional representations, it should be just that—input. Medicare ought to have its own version of the RUC within CMS, which would independently determine the relative value of physician services as the basis for reimbursement. One modest proposal put forth by a group of Medicare experts is to establish an expert advisory panel (EAP) within CMS to provide advice for adopting more accurate relative values.¹⁸¹

Simplify Financing: Training more physicians and properly allocating and paying them will begin to address shortages, but reforms must address the “push” factors that cause many physicians to opt for corporatized medicine. Radical simplification is needed. In primary care, payers should pay providers per-patient, lump-sum payments, with minimal,

177 Michelle Andrews, “Report suggests compensation is key to fixing primary care shortage,” *Kaiser Family Foundation Health News*, November 24, 2023.

178 “Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care,” National Academies of Sciences, Engineering, and Medicine, 2021.

179 *Id.* at p. 373.

180 “Composition of the RVS Update Committee (RUC),” American Medical Association, June 29, 2023.

181 Robert A. Berenson, “Comment on NPRM Calendar Year 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Program Requirements,” September 2, 2022.

easily measured quality metrics.¹⁸² While providers would receive lump-sum payments, they would not assume the total-cost-of-care “risk-bearing” function that characterizes capitation-based models. That is, primary care providers would not assume the insurance function of managing total costs; they would be paid the 5-10% of an individual’s total health spending that goes toward primary care. Further, risk adjustment would be based on demographic and other factors, not diagnostic coding. Omitting these two elements would protect against the corporatization of primary care seen today. While this sort of financing could be integrated into insurance, a more ambitious alternative is to remove primary care from private insurance and provide it directly for all. Irrespective of the direct payer, this primary care reimbursement model would go to practices of diverse organizational types, including small private practices, group practices, community health centers, county clinics, and other types of primary care practices.¹⁸³

Promote Physician and Public Ownership: States and the federal government can promote physician-led ownership through direct investment and through the tax code. For example, Indiana recently enacted a tax credit for independent physician-led practices.¹⁸⁴ States also have numerous tools to publicly acquire struggling practices (and hospitals). For example, health and hospital districts exist in localities across the country as a means of locally financing and owning health care infrastructure. These districts are locally governed, often directly elected or appointed by the county, and they have the authority to issue bonds and raise revenue for the purpose of financing or providing health care. For struggling practices or hospitals, this could be an alternative to selling to private equity or a national conglomerate. Further, states and the federal government should increase funding for local public health departments, which would support efforts to directly provide medical care.

Health Care as a Public Utility: As noted above, health care industrial policy means moving away from private utilization rationing as the primary means of cost containment—that is, placing less reliance on private insurance (e.g., MA) and risk-bearing primary care providers (e.g., ACOs) to be managers of total costs. Instead, cost-containment should emphasize the main drivers of excessive spending: high (and disparate) prices, as well as administrative bloat and profits. This necessarily implicates the regulation of hospitals, which are the largest source of health care spending and which have also become corporatized and profit-driven. By incorporating tenets of public utility law, policymakers can effectively contain cost and, similar to primary care, correct the maldistribution of capacity. While a full account of hospital policy is beyond the scope of this paper, the following proposals outline a path forward.

¹⁸² Kevin Grumbach, *Forging a Social Movement to Dismantle Entrenched Power and Liberate Primary Care as a Common Good*, *Annals of Family Medicine*, March 2023.

¹⁸³ Eyal Press, “The Moral Crisis of America’s Doctors,” *New York Times*, June 15, 2023.

¹⁸⁴ “House Bill 1004,” *Indiana General Assembly*, 2023.

Medicare can strengthen nondiscrimination laws and the conditions of participation to ensure that hospitals serve all patients and do not desert less profitable geographies. The more systemic fix to disparate access is to standardize payment rates. States can begin to do this by pegging commercial prices to Medicare rates, as some recently have.¹⁸⁵ Even better, states and the federal government should move toward all-payer rate-setting, which would eliminate the differences in reimbursement between providers. Ultimately, payment should move toward “operational” global budgets. Unlike Maryland’s financing programming, which is often referred to as global budgeting, true operational global budgets would capture significant savings by moving away from per-service billing and coding.¹⁸⁶ In addition, operational budgets would strictly fund operations, capping profits and administrative waste. It would also remove the expansionist impulses of current hospital systems by untethering capital financing from operations.

185 Michael E. Chernew, David M. Cutler, and Shivani A. Shah, “Reducing Health Care Spending: What Tools Can States Leverage?” The Commonwealth Fund, August 18, 2021.

186 Adam Gaffney et al., “Hospital Expenditures Under Global Budgeting and Single-Payer Financing: An Economic Analysis, 2021–2030,” *International Journal of Social Determinants of Health and Health Services*, January 30, 2023.

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By Emma Freer, Sr. Policy Analyst for Healthcare

Earlier this month, Community Hospital in McCook, Nebraska, [announced](#) it will close a rural clinic in nearby Curtis, home to about 900 people. The reason? The One Big Beautiful Bill's cuts to Medicaid.

Community Hospital and other independent safety-net providers – including rural hospitals and clinics, community health centers, and nursing homes – are already in a [battle for survival](#). These cuts will make their situation worse, while also making it easier for Big Medicine to capitalize on their distress by acquiring them. As a result, vulnerable patients will suffer, finding themselves stranded in either a care desert or at a corporate-owned entity that charges more for worse-quality care.

In exchange for further destabilizing the U.S. healthcare system, President Donald Trump and congressional Republicans got \$4.5 trillion in tax breaks for the richest Americans. Even Sen. Josh Hawley (R-MO), who ultimately voted along party lines in support of the bill, [described](#) this deal as "morally wrong and politically suicidal."

Lawmakers from both parties who want to resuscitate safety-net providers – and perhaps their own political futures – must not only restore Medicaid

funding but also rebuild our healthcare system to prioritize patients and practitioners over corporate interests.

The largest Medicaid cut in U.S. history

The new law results in the [largest cut](#) in Medicaid's 60-year history, slashing spending by nearly \$1 trillion. It accomplishes that in part by curtailing states' ability to fund Medicaid, which they finance alongside the federal government. More specifically, the law restricts states' ability to tax hospitals, nursing homes, and other healthcare providers. Every state except Alaska has used these [provider taxes](#) for decades to generate their share of Medicaid funding, as well as to increase the federal matching dollars they receive, which are based on state contributions. Providers [support](#) these taxes because they ensure the financial stability of their state's Medicaid program, without which they would face higher uncompensated care costs and lower reimbursement rates.

The law also imposes new Medicaid work and reporting requirements. Research [shows](#) that such requirements don't promote increased employment – most non-disabled recipients under the age of 65 are already employed. Instead, unable to keep up with the bureaucracy that work requirements impose, they are unjustly cut from the rolls, which is why the CBO Budget Office [estimates](#) nearly 12 million people will lose Medicaid as a result.

When combined with cuts to Medicare and premium subsidies under the Care Act (ACA) plans, these policy changes threaten to eliminate providers' profit margins, which are already thin due to [increasing rates of un- and undercompensated care](#). This will devastate both patients and [safety-net providers](#) that disproportionately rely on Medicaid pay for care. The Groundwork Collaborative [estimates](#) 338 rural hospitals and 579 nursing homes could close as a result of the law's passage. Private Medicare insurers – which administer private Medicaid, Medicare Advantage plans – will see their profits [pinched](#).

A big win for Big Medicine

Safety-net providers that don't close will still be extremely at risk and thus easy targets for Big Medicine insurance conglomerates and private-equity firms, whose ongoing acquisition sprees and, in some cases, predatory lending practices, have intensified healthcare consolidation and its attendant harms.

For instance, UnitedHealth Group has a long track record of buying distressed medical assets. During the COVID-19 pandemic, which [devastated](#) physician practices, United's [publicly reported acquisitions](#) included several large practices in Massachusetts, New York, [Oregon](#), and Texas. In fact, by 2023,



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United was the largest [physician employer](#) in the country, with 10% of the workforce – roughly 90,000 doctors – under its control.

More recently, after a February 2024 cyberattack on its subsidiary claims processor Change Healthcare forced practices into a months-long cash-flow crisis, United bought at least one of them, Oregon's [Corvallis Clinic](#), prompting an exodus of physicians and steep price hikes for patients. United also extended emergency loans to more than [10,000 providers](#) impacted by the attack – and is now demanding immediate repayment, threatening to withhold future reimbursements via its insurance arm. As a result, loan recipients are facing yet another United-generated cash-flow crisis that could force them to close their doors – or sell them in a fire sale.

Private-equity firms also pose a threat to patients, especially in rural areas, where they have acquired at least [130 hospitals](#) seeking quick infusions of capital, according to the Private Equity Stakeholder Project. The acquiring firms, in turn, seek a quick profit by hiking prices and cutting costs, often through chronic understaffing, critical service closures, and looting. Although these transactions may keep rural hospitals open in the short term, investors' business model "gamble[s] with the lives of patients and the livelihoods of practitioners," according to a [May 2025 article](#) published in the *AMA Journal of Ethics*. To make matters worse, many hospitals ultimately [close](#) once their private-equity investors cash out.

Investing in "small" medicine

Trump's law is only the [latest federal policy](#) to favor Big Medicine at the expense of patients, providers, taxpayers, and health plan sponsors like employers and unions. Correcting this embedded imbalance will require more than just patching the fiscal holes created by the One Big Beautiful Bill.

Policymakers must rebuild the U.S. healthcare system to be friendlier to practitioners of independent, or "small," medicine, like safety-net providers, rural hospitals, private physician practices, and independent pharmacies. One important step: Congress should standardize prices in both federal healthcare programs and the commercial market. Doing so would level the playing field, ensuring that independent providers are paid fairly for their services and eliminating Big Medicine's unfair advantage in reimbursement negotiations.

We also need a bigger structural action. We must take steps to [Break Up Big Medicine](#) conglomerates by enacting legislation that structurally separates their business lines, which would eliminate inherent conflicts of interest that drive costs up and quality down.

There's precedent for this, both in other industries and in health care. During the New Deal era, Congress passed the Glass-Steagall Act, which structurally

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The One Big Beautiful Healthcare Crisis

separated commercial and investment banks given the systemic risks inherent to their common ownership. Much more recently, in April 2025, Arkansas passed a first-in-the-nation law that prohibits pharmacy benefit managers from owning pharmacies, paving the way for a similar ban on the national level – and a broader Glass-Steagall for health care that would prohibit any kind of payer from owning any kind of provider. The next month, Oregon also passed landmark legislation that aggressively limits private-equity ownership of physician practices.

Neither of these solutions would prevent future Medicaid cuts. But they would ensure safety-net providers – and their vulnerable patients – have a chance at surviving the injury.

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U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

American Economic Liberties: United Health Group Statement

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UnitedHealth Group Is a Bank: How Policymakers Can Protect Independent Physician Practices from Becoming Loan Shark BaitDECEMBER 18, 2025
HEALTHCARE

BY EMMA FREER

FULL BRIEF (PDF)

Most people know UnitedHealth Group through its subsidiary UnitedHealthcare, the nation's largest health insurer. Some might know it through its other major subsidiary, Optum Health, the nation's largest physician employer. But few are familiar with its bank.

In addition to being one of the nation's largest providers of health savings accounts (HSAs), Optum Financial extends loans to physician practices, increasing their reliance on UnitedHealth Group not only for reimbursement, employment, and claims processing but also for capital. For these reasons, former UnitedHealth Group CEO Andrew Witty promised in 2023 that Optum Financial would be a "very, very material-scale business for us" over the next decade, akin to Optum Health, which, until very recently, investors considered the company's "crown jewel."

Optum Financial briefly made headlines in spring 2025 for putting the squeeze on medical practices. A year earlier, it had extended emergency loans to more than 10,000 practices after a cyberattack on its sister subsidiary, Change Healthcare, the nation's largest health insurance claims processor, paralyzed claims payment processes "for a substantial portion of the

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medical sector" for several months. Without payment, countless practices faced financial ruin unless they received a monetary lifeline, which Optum Financial provided — until, suddenly, it didn't. Physician borrowers told CNBC, The New York Times, and The Wall Street Journal that the company demanded they repay hundreds of thousands of dollars in a matter of days; if they did not comply, another subsidiary, UnitedHealthcare, would withhold reimbursements for health care services rendered to cover their debts.

"Optum, in my opinion, is acting like a loan shark trying to rapidly collect," a pediatric neurologist in New Jersey who received a \$535,000 loan told the Times.

But Optum Financial soon lost the media spotlight to its scandal-plagued and increasingly financially challenged parent company. Although UnitedHealth Group deserves the scrutiny, it shouldn't overshadow deeper questions about Optum Financial. To start, why does a health insurance conglomerate even have a bank?

This policy brief attempts to answer that question by recounting the history of Optum Financial and exploring its growing importance to UnitedHealth Group. It also issues policy recommendations. In the short term, federal policymakers must protect independent physician practices from UnitedHealth Group and other insurance conglomerates, whose anticompetitive business practices drive them to close, sell, or borrow on unfair terms, ultimately driving health care prices higher for patients, health plan sponsors, and taxpayers. In the long term, they must restore the financial viability of independent physician practices and break up the platforms squeezing them out of business.

FULL BRIEF (PDF)



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December 18, 2025



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U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF
MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

American Hospital Association Statement



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Statement

of the

American Hospital Association

for the

Special Committee on Aging

of the

United States Senate

"The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine"

February 11, 2026

On behalf of our nearly 5,000 hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide the hospital perspective on the issues impacting health care workforce burnout.

We appreciate Congress' recent efforts to address health care workforce challenges and urge continued action to advance additional legislative initiatives that strengthen and sustain the nation's physicians. These efforts include the recent reauthorization of the Dr. Lorna Breen Health Care Provider Protection Act as part of the Consolidated Appropriations Act of 2026. This legislation aims to reduce and prevent suicide, burnout and behavioral health disorders among health care professionals and authorizes grants to health care providers to establish programs that offer behavioral health services for front-line workers.

Hospitals and health systems are currently facing national physician shortages that threaten access to high-quality care for the patients and communities they serve. The factors that create these workforce challenges — some of which are highlighted below — affect every part of the care continuum and are especially acute in underserved and rural communities.



Commercial Insurance Policies and Practices

Hospitals and health systems have long raised concerns that the administrative practices that some commercial insurers rely on — especially the improper application of prior authorization in the Medicare Advantage (MA) program — have very real consequences for patients and providers. Inefficient prior authorization requirements remain a pervasive problem among certain plans in the MA program that result in delays in care and add financial burden and strain to the health care system. Plans vary widely on accepted methods of prior authorization requests and how to submit supporting documents. Many insurers continue to rely on fax machines and call centers to process prior authorization requests. This heavily burdensome process contributes to patient uncertainty regarding their care plan, creates harmful delays in care, and leads to health care worker burnout.

It is not unusual to hear from physicians about how they spend hours of their day away from the bedside while sitting on the phone urging a patient's insurance company to cover essential medical care. It is no surprise that administrative burden is one of the top contributors to clinician burnout. Nearly 90% of physicians report that prior authorization somewhat or significantly increases physician burnout, which adds to the workforce shortages facing hospitals across the country.¹

Workplace Violence

For the past several years, health care workers across the nation have experienced a sharp increase in incidences of workplace violence, with no sign that this trend is receding. Despite the diligent efforts of hospitals and health systems to prevent violence and protect their staff, health care workers remain five times more likely than any other type of worker to be physically attacked on the job, according to the U.S. Bureau of Labor Statistics.

Violence in health care settings has implications beyond the injuries sustained by the workforce. Our member hospitals and health systems report that workplace violence and intimidation make it more difficult for clinical staff to provide quality patient care. Providers cannot deliver attentive care when they are afraid for their personal safety, distracted by disruptive patients or family members, or traumatized from prior attacks. In addition, violent attacks at health care facilities can delay urgently needed care for other patients and increase the likelihood of adverse events.

The United States faces a projected shortage of up to 86,000 physicians by 2036 due to the nation's growing and aging population and a significant portion of the physician

¹ <https://www.aha.org/testimony/2026-01-21-aha-statement-house-wrm-committee-hearing-health-insurance-ceos>

workforce approaching retirement age.² This has created a workforce crisis characterized by immediate staffing shortages and a long-term, insufficient talent pipeline. The projected shortages of physicians, nurses, and allied health and behavioral health professionals will further strain our health care system and disproportionately impact vulnerable and underserved populations.

POLICY RECOMMENDATIONS

Prior Authorization Reform

We urge Congress to pass the Improving Seniors' Timely Access to Care Act (H.R. 3514/S. 1816). This bill would streamline prior authorization requirements under MA plans by making them simpler and more uniform and eliminating the wide variation in prior authorization methods that frustrate both patients and providers. It also would require MA plans to report on their use of prior authorization, including the use of artificial intelligence in prior authorization and the rate of approvals and denials.

Curbing Violence in the Workplace

We urge Congress to pass the Save Healthcare Workers Act (H.R. 3178/S. 1600). This bill — modeled after the federal statute protecting aircraft and airport workers — would make it a federal crime to assault a hospital employee, with enhanced penalties applicable to acts that involve the use of a deadly or dangerous weapon, inflict bodily injury, or are committed during an emergency declaration.

Strengthening Graduate Medical Education

We urge Congress to pass the Resident Physician Shortage Reduction Act of 2025 (H.R. 3890/S. 2439). This bipartisan bill would add 14,000 Medicare-funded residency positions over seven years, thereby helping to alleviate ongoing physician shortages that threaten patients' access to care.

CONCLUSION

Thank you for examining the challenges facing physicians. The AHA stands ready to provide additional input as you continue to explore these important issues.

² <https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage>

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF
MEDICINE"

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STATEMENTS FOR THE RECORD

American Physical Therapy Association Statement



U.S. Senate Special Committee on Aging

Hearing "The Doctor is Out: How Washington's Rules Drove
Physicians Out of Medicine"

February 18, 2026

Statement by the American Physical Therapy Association



Chairman Scott, Ranking Member Gillibrand, and Members of the U.S. Senate Special Committee on Aging:

On behalf of the approximately 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments in response to the Committee's hearing, *"The Doctor is Out: How Washington's Rules Drove Physicians Out of Medicine."* APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

APTA applauds the Committee for holding this hearing to examine the various factors contributing to the burnout and shortage of healthcare providers, which impedes access to care and drives up healthcare costs for millions of Americans. We further commend the Committee for reviewing existing, burdensome laws and regulations to alleviate such pressures on the healthcare profession. For the Committee's consideration, APTA offers the following legislative and regulatory policy recommendations.

We also direct the Committee's attention to two relevant and complementary APTA publications: First, ["The Economic Value of Physical Therapy in the United States,"](#) a recently released APTA report, showcases the cost-effectiveness and economic value of physical therapist services for a broad range of common conditions. The report compares physical therapy with alternative care across a suite of health conditions commonly seen within the U.S. health care system. The report underscores and reinforces the importance of including physical therapists and physical therapist assistants as part of multidisciplinary teams focused on improving patient outcomes and decreasing downstream costs. The committee should [consider the insights provided in this report](#) to support access to, coverage of, and payment for physical therapist services in rural and underserved areas, and to support policies that position physical therapists as entry-point providers to ensure beneficiaries have timely access to proven, cost-effective care as outlined in our recommendations below.



Second, APTA's publication, "[The Impact of Administrative Burden on Physical Therapist Services](#)," published in 2025, expounds on sources of burden plaguing physical therapists. The findings of APTA's 2025 survey confirm the problems of timely care and cost to both patients and physical therapists due to administrative burden remain ever-present. The survey results demonstrate not only that prior authorization delays care for patients in need but also that it leads to worse outcomes for patients and increases the likelihood that they will abandon seeking care altogether.

APTA Responses to the Centers for Medicare & Medicaid Services (CMS) RFI: "Unleashing Prosperity Through the Deregulation of the Medicare Program."

As members of the Committee are aware, last year, CMS published an RFI ("Unleashing Prosperity Through the Deregulation of the Medicare Program") seeking input regarding current regulations that may be burdensome, outdated, or unnecessary, and should be reviewed for potential elimination or significant modification. In response to the RFI, APTA submitted extensive comments on acutely burdensome regulations, recommending the following measures be implemented to better aid in the delivery of healthcare to Medicare patients and ease burdens on providers:

- **Expand the Plan of Care Signature Exception to Direct Access Patients:** Previously, in addition to submitting the plan of care (POC) to the referring provider within 30 days of initial treatment, a PT was required to have that provider return a signed and dated copy of the POC as evidence of certification. However, in the CY 2025 Physician Fee Schedule rule and codified under the new 424.24(c)(5), once the PT has transmitted the POC, the onus now is on the referring provider to either return the signature or indicate changes. However, one major caveat is that only claims for services provided to patients with an order or referral are eligible for the exception. APTA recommends that this policy be expanded and applied to direct access patients to expedite delivery of care for all Medicare beneficiaries.
- **Replace Medicare's 8-Minute Rule:** Under Medicare's 8-Minute Rule, introduced in Dec. 1999, rehabilitative therapists are required to add all service minutes across different CPT codes during a therapy session and apply a tiered decision matrix to determine unit billing. The rule is both confusing and time-consuming; the instructions and examples on applying the policy cover three pages in the Medicare Claims Policy Manual and are an oft-cited source of significant strain and uncertainty among therapy providers. APTA recommends adoption of the AMA's Midpoint rule, a similar, but administratively simpler standard. Under the Midpoint Rule, each timed service is evaluated individually based on its time threshold, simplifying calculations and reducing billing errors.



- **Eliminate Enforcement of the KX Modifier:** Section 50202 of the Bipartisan Budget Act of 2018, P.L. 115-123 amended Section 1833(g) of the Social Security Act to repeal the application of the therapy caps. While APTA supported this removal, in lieu of the caps, Congress added limitations to the delivery of therapy services via the KX modifier threshold. Despite removal of the hard cap on payment for therapy services, the SSA still requires the KX modifier to be appended to any claims exceeding the KX threshold, which is adjusted annually for inflation using the Medicare Economic Index. For physical, occupational, and speech therapists, if services delivered in a year exceed the annual threshold amount, the therapist must include the KX modifier on the patient's claims to confirm that services were medically necessary and are justified by the appropriate documentation. Claims for services over the KX modifier threshold without an appended KX modifier are automatically denied. Appending the KX modifier to claims to support medical necessity for the purposes of payment is redundant and should be removed, or at least no longer be enforced.
- **Create Consistent and Uniform Credentialing Procedures in Medicare Advantage:** Under 42 CFR 422.204, a Medicare Advantage Organization (MAO) is required to have written policies and procedures for the selection and evaluation of providers for network participation and follow this documented process with respect to initial credentialing. Likewise, commercial and other health plans are required under state law to follow similar requirements essentially requiring the same information and data points from providers who enter into contracts to participate in their networks. Physical therapists credentialed by Medicare therefore undergo redundant credentialing by each MAO or other health plan they contract with for network participation. In addition to the extensive wait time and resulting impediment to access to care, physical therapy practices and facilities expend significant time and resources managing multiple credentialing applications all collecting essentially the same duplicate documentation. Applying Medicare credentialing recognition across all MAOs and commercial insurance plans would result in faster patient access, lower administrative costs, greater provider mobility, improved continuity of care, and more robust networks in underserved areas.
- **Make the Merit-Based Incentive Payment System (MIPS) Participation Voluntary for Physical Therapists:** The Quality Payment Program (QPP) established a model of funding that was intended to reward high-value, high-quality Medicare clinicians with payment increases – while at the same time reducing payments to those clinicians who weren't meeting performance standards. The MIPS program is one way to participate in the QPP. Physical therapists who meet certain benchmarks are required to report under the MIPS program. In the case of physical therapists, the QPP has failed to meet its objectives, and imposes requirements developed primarily with physicians in mind. Ten years into the program it still lacks quality measures that are reflective of the impact of physical therapy. Additionally, physical therapists are expected to meet interoperability requirements that threaten the financial viability of most practices without any support



as was provided to physician practices. APTA believes CMS should use its authority to make MIPS participation optional for physical therapists.

- **Allow Therapists to Conduct the Initial and Comprehensive Assessment for Home Health Episodes of Care:** Under current regulations, physical therapists are permitted to perform the initial and comprehensive assessments, which are required at the start of care for a home health episode when therapy is the only discipline requested on the order. When the order requests both therapy and skilled nursing services, the therapist is not permitted to open the case and begin care, regardless of whether the patient's primary need is for therapy or not. APTA recommends making permanent the COVID-19 public health emergency waiver flexibility to allow rehabilitative therapists to initiate episodes of care when both therapy and nursing are ordered, sometimes referred to as "some therapy" orders.
- **Remove the Three-Day Inpatient Stay Requirement for Skilled Nursing Facilities:** Section 1861(i) of the Social Security Act and 42 CFR 409.30 require covered Part A SNF services be preceded by a qualifying inpatient stay of at least three consecutive calendar days starting with the admission day but not counting the discharge day, excluding time spent in the emergency room or under observation. This policy has inadvertently contributed to an increased number of hospital stays and created an unnecessary burden for patients since they cannot use their Medicare Part A Extended Care Benefit (SNF) unless they have met the three-day qualifying hospital stay requirement.
- **Standardize Patient Assessment Items Across the Medicare Program:** Section GG is a standardized data assessment tool found in the various patient assessment instruments used across all four post-acute care settings under traditional Medicare. This section tracks patients' functional abilities and progress in SNFs, IRFs, LTCHs, and HHAs. Section GG standardizes functional reporting of a patient's self-care and mobility at both admission and discharge, and the results of Section GG directly influence a patient's care plan and serve as the primary inputs for numerous PAC quality measures. Section GG however does not account for patients who are enrolled in Medicare Advantage plans, which are permitted to set their own policies regarding patient assessment. For this reason, MA plans often take varying approaches to patient assessment with the sole purpose of guaranteeing payment. The burden, however, is passed to the PT or PTA, who are required to understand and follow the requirements laid out in each MA plan's guidelines. To relieve provider burden and allow for comparison across all Medicare enrollees, APTA recommends adherence to the intentions of the IMPACT Act by requiring MA plans to use Section GG to report functional assessments.
- **Revisit the Inpatient Rehabilitation Facility (IRF) 60% Rule Qualifying Diagnoses:** The 60% rule requires each IRF to discharge at least 60 percent of its patients with one of



13 qualifying conditions. Failure to maintain this status means losing IRF status and ability to bill under the IRF PPS. In 2015, the list of qualifying conditions was reduced after ICD changes, yielding a 20% reduction in contributing diagnoses to the compliance threshold. Before that, the introduction of the 60% rule led to tens of thousands of fewer IRF visits between 2004-2013. Physical therapists and their employers have a vested interest in patients being directed to appropriate post-acute care (PAC) facilities. Appropriate placement is often determinative of the clinical staff's ability to provide adequate therapy services to meet the patient's needs. Thus, the 60% rule is direct threat to placing patients in the most clinically appropriate setting. CMS should consider reevaluating the qualifying diagnoses and codes for the 60% rule.

Reform Prior Authorization Practices

APTA is concerned that current prior authorization policies, notably those used by many Medicare Advantage plans, have needlessly led to delays in patient access to care and unnecessary administrative burdens on healthcare providers. Private insurers, including those that offer Medicare Advantage products, require health care providers, including physical therapists, to submit an authorization request and receive approval prior to delivering care to their patients. These prior authorization requirements are increasingly creating barriers to accessing medically necessary care for patients nationwide.

While prior authorization may be appropriate in limited circumstances, the use of such requirements have become increasingly routine, overly broad, and function as a means to withhold payment for medically necessary care rendered to plan enrollees. This is particularly well documented in the Medicare Advantage program. Since plans often routinely approve certain services for which they require prior authorization, the purpose of such utilization control is questionable if not entirely inappropriate.

APTA believes that when prior authorization is universally imposed on a given service, it merely acts as a barrier to care and adds no value to the health care system. In 2026, more than half of Medicare-aged patients are enrolled in a Medicare Advantage plan, and the Congressional Budget Office projects that approximately 64% of Medicare beneficiaries will be enrolled in Medicare Advantage by 2030. These plans employ prior authorization as a cost-control mechanism, resulting in delays to medically necessary care. Medicare Advantage plans can require enrollees to receive prior authorization before a service will be covered.

To illustrate the pervasiveness of the issue, in 2015, MA enrollees represented one-third of the total Medicare population, which increased to 54%—more than half of all beneficiaries—in 2024 and remained this way in 2025, only a decade later. Further, according to Medicare's Part B national summary data file, in 2022, including physical therapy, occupational therapy, and speech-language pathology, Medicare allowed charges for more than 4 million unique evaluations, and approximately 150 million claims across the top four modality codes alone.



(97110, 97530, 97112, and 97140). As MA grows among Medicare beneficiaries, so does its impact on access to services; nearly four out of five Medicare Advantage enrollees (79%) are in plans that require prior authorization for some services in 2019, according to a 2019 Medicare issue brief from the Kaiser Family Foundation, and in 2024, KFF identified that 73% of physical therapy services are subject to prior authorization in MA plans. This is among the highest rate for any single clinical specialty administering Part B covered services.

Currently, Medicare Advantage enrollees must undergo a prolonged, burdensome process to obtain treatment authorizations. A delay in authorization may severely hinder a patient's recovery, requiring physical therapists and other providers to decide between furnishing a noncovered service at their own expense, abiding by their ethical obligations, or risking the patient's health and well-being by waiting for a plan to authorize medically necessary care. In an [APTA survey](#) conducted survey, the results were alarming:

- 80% of respondents agreed or strongly agreed that PA requirements negatively impact patients' clinical outcomes.
- 86.3% of providers agree or strongly agree that administrative burden contributes to burnout.
- 80.9% of facilities had to hire nonclinical staff to accommodate administrative burden.
- 25% or more of clinician and staff time would be saved if policymakers required standardization of PA forms and processes.
- 47.94% of appealed denials are overturned.
- 65% of respondents say more than 30 minutes of staff time is spent preparing an appeal.

The statistics above demonstrate just how much waste is attributable to administrative burden — clinics are forced to hire staff to obtain authorizations and appeal denials — many of which are eventually overturned. Meanwhile patients languish and suffer detrimental health outcomes.

To address this issue, APTA urges Congress to pass *H.R. 3514/S. 1816 – the Improving Seniors' Timely Access to Care Act*. This legislation would advance and streamline the current prior authorization system by establishing an electronic prior authorization process that will help ensure timely processing for items and services that need to be approved. Additionally, this bill would require the Secretary of the US Department of Health and Human Services to establish a process for "real-time decisions" for items and services that are routinely approved. With these changes, health care providers will have more time to do what they were trained to do — attend to their patients and provide them with the care that they deserve. The Improving Seniors' Timely Access to Care Act also would prevent plans from requiring prior authorization on any additional surgical or other invasive procedure if this procedure is furnished during the perioperative period of an already approved procedure. Endorsements This legislation, introduced in the previous Congress, was endorsed by over 500 healthcare institutions, including numerous provider associations, patient advocacy groups, and hospitals.



We also ask the Committee to consider urging CMS to take contemporaneous and complementary action on existing regulations that they have existing authority to modify. In particular, CMS must take great caution as it repeals and modifies regulations for MAOs. In its recent MA proposed rule, CMS did not give significant attention to the fact that lessening burden on MA plans only shifts the burden to patients and providers. By enabling these entities to freely use prior authorization practices and proprietary internal coverage criteria, providers are left to navigate unjustified programs and patients suffer as a result. Only the insurers are left unscathed.

Medicare Payment Reform

The most critical issue facing healthcare providers is the uncertainty and instability of the current structure of the Medicare payment and reimbursement system. With declining or flat payment rates, and the rapidly increasing cost of owning and operating a healthcare practice, APTA is deeply concerned that many providers may give up a private practice or possibly exit the profession.

It is imperative that Congress enact meaningful reforms to the Medicare Physician Fee Schedule (MPFS) to improve payment and provide stability for practices. Congress must take action to reform this unsustainable system to ensure that Medicare payments to providers accurately reflect the cost of practice and ensure timely access to care for Medicare beneficiaries. The following are five policy solutions that will reform the fee schedule to help provide stability to therapy providers and the patients they serve.

- **Provide an Annual Payment Update Based on Inflation:** Step one is for Congress to ensure that Medicare payments to providers in 2025 and beyond are adjusted annually with an inflationary update. The MPFS is the only Medicare payment system lacking an annual inflationary update. Physical therapy practices, many of which are small businesses, face rising costs for office rent, clinical and administrative staff wages, and administrative burden. APTA strongly supports the enactment of an annual payment update under the fee schedule tied to the Medicare Economic Index. This reform would provide an annual payment update, helping to stabilize practices and enable long-term planning, investment in practices, and the delivery of high-quality, patient-centered care.
- **Increase the Budget Neutrality Trigger:** Cuts to the MPFS are triggered by a policy known as budget neutrality, which mandates that any estimated increases of \$20 million or more to the Medicare fee schedule —resulting from upward payment adjustments or the addition of new procedures or services — must be automatically offset by cuts elsewhere. This rigid \$20 million threshold has not been updated since 1992, despite a growing beneficiary population and the increasing number of medical procedures formerly performed in the inpatient setting that are now performed in the outpatient setting and billed to the fee schedule. Increasing the threshold would reduce the



triggering of automatic, across-the-board fee schedule cuts, permitting needed spending flexibility to address beneficiary needs without imposing cuts on all providers.

- **Require Regular Update to Practice Expenses:** Congress should direct the Centers for Medicare & Medicaid Services, or CMS, to update the direct inputs for practice expense relative value units at least every five years. Direct inputs include clinical wages, costs of supplies, and prices of equipment, which increase with inflation. In the past, direct inputs were reviewed by CMS only after many years, resulting in significant redistribution of payments and cuts to some providers.
- **Repeal the Multiple Procedure Payment Reduction Policy:** In 2013, Congress implemented the Multiple Procedure Payment Reduction, or MPPR, for physical, occupational, and speech-language therapy services under Medicare Part B. This decision was made without solid evidence, primarily to offset costs related to the sustainable growth rate, or SGR, which has since been repealed through the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2). As a result, average therapy claim payments dropped by 8.5% in 2013 compared to 2010, despite the lack of justification for these cuts. MPPR applies excessive and unnecessary payment reductions to specific "always therapy" codes, significantly impacting the financial viability of therapy practices and limiting access to vital therapy services.
- **Reform the Quality Payment Program:** The Quality Payment Program, or QPP, comprises two payment tracks: the Merit-based Incentive Payment System, or MIPS, and Advanced Alternative Payment Models, or APMs. In its current form, the QPP poses significant challenges to non-physician providers, including physical therapists. Therapists have struggled to meaningfully participate in MIPS or engage in APMs. One reason for this difficulty is that CMS has failed to pilot or implement several alternative payment and delivery models applicable to therapy providers. Additionally, the cost of participating in these programs often outweighs any potential payment adjustments, and the interoperability requirements for participation are an insurmountable burden for most providers. Congress must enact meaningful reforms to the QPP that recognize the value of therapy providers and facilitate their meaningful participation.

APTA appreciates the Committee holding this hearing and for the opportunity to provide comments on these issues. Should you have any questions, please contact Steve Kline (stevekline@apta.org) with APTA Congressional Affairs. Thank you for your time and consideration.

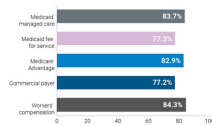
The Impact of Administrative Burden on Physical Therapist Services



APTA members report that medically necessary physical therapist services are delayed – ultimately impacting patients' clinical outcomes – because of the amount of time and resources they must spend on documentation and administrative tasks. The volume and time spent on these tasks also leads to dissatisfaction and burnout. APTA urges policymakers and both commercial and public payers to minimize administrative burden including, but not limited to, prior authorization, appeals, documentation, and unnecessary mandates. Distributed in the summer of 2025, the APTA Administrative Burden Survey received responses from 856 APTA members across various facility and institutional settings. The objective survey results offer important insight into how administrative burden impacts patient clinical outcomes.

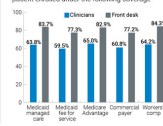
Prior Authorization

Percentage of front desk staff who spend more than 10 minutes to complete a prior authorization for each patient enrolled under the following coverage



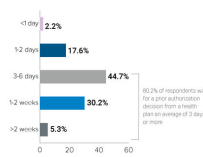
Continued Visits

Percentage of clinicians and front desk staff who spend more than 10 minutes when requesting approval for continued visits for each established patient enrolled under the following coverage



Nearly 3/4 of respondents indicated that prior authorization requirements delay access to medically necessary care by more than 30%.

Average Wait Time



30.2%

30.2% of respondents noted a 1-2 week waiting period for a prior authorization approval in 2025.

85% of Respondents agreed or strongly agreed that prior authorization requirements negatively impact patients' clinical outcomes.



58%

of respondents say more than 30 minutes of staff time is spent preparing an appeal for one claim.

2 in 5 Respondents

say that even after a payer has said prior authorization isn't required, claims are later denied for lack of prior authorization more than 25% of the time.



For the first time in 2025, APTA measured whether delays in care caused patients to abandon treatment. Nearly 85% of respondents agreed or strongly agreed that prior authorization has caused patients seeking care to abandon treatment.

90.8%

of providers agree or strongly agree that administrative burden contributes to burnout.



56.7%

of respondents agreed or strongly agreed that administrative burden has led their practice to discontinue participation with a payer or network.



75%

of facilities have added nonclinical staff to accommodate administrative burden.

Ultimate Outcome of Denied Claims



Data is from a web-based survey administered July-August 2025. Sample size: 18,888 | Respondents: 856

Respondents were screened to ensure that every participant met at least one of these criteria:

- Is an owner/partner of a physical therapy practice
- Is an administrator/supervisor
- Provides at least some direct patient care

Of these:

- 77.2% practice in outpatient settings
- 40.7% are owners/partners of a practice
- 78.6% are administrators/supervisors
- 92% provide at least some direct patient care

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF
MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

American Podiatric Medical Association Statement



American Podiatric Medical Association
Written Testimony of Brooke Bisbee, DPM, President
to the
U.S. Senate Committee on Aging
The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine

February 11, 2026

Dear Chairman Scott and Ranking Member Gillibrand,

On behalf of the American Podiatric Medical Association (APMA), I thank you for the opportunity to submit written testimony for the Senate Committee on Aging's February 11, 2026, hearing, titled "The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine." APMA represents the vast majority of the more than 15,000 licensed podiatric physicians and surgeons—also known as doctors of podiatric medicine (DPMs)—in the United States. Our members diagnose and treat conditions of the foot and ankle that affect millions of Americans, including individuals with diabetes, circulatory disorders, and other chronic conditions.

Reducing the Burden of Prior Authorization

APMA remains deeply concerned about the ongoing overuse and abuse of prior authorization (PA) by Medicare Advantage Organizations. A major barrier to affordable coverage, PA results in a significant administrative burden for physicians, including podiatrists, and their practices. APMA members regularly navigate outdated systems, which rely on manual, paper-based labor to submit PA requests and appeals. Instead of addressing the needs of vulnerable patients, podiatrists dedicate unnecessary amounts of time to this outdated and inefficient structure.

Long wait times for PA claim prolong access to foot and ankle care and increase the risk of health complications like infections, wounds, and lower-limb amputations. Despite strong approval rates for previous services, podiatrists must go through the PA process each time. PA appeals demand additional time, with insurance companies using in-house health professionals to review claims. Although peer-to-peer reviews are intended to support clinical decision-making, payors employ non-physicians or physicians from unrelated specialties than the physician submitting the PA request, leading to incorrect denials. In all, this burdensome red tape increases administrative costs and forces practices to dedicate staff to claim processing, all of which drives up health-care costs and increases physician burnout.

The lack of transparency in the PA process leaves podiatrists without the clear information needed to navigate PA denials. APMA members frequently report confusion and frustration with the often unclear and opaque PA processes. This includes the use of AI, which can employ generalized, biased data to incorrectly deny claims. Insurance companies provide very little or no information about their internal AI claim policies.

APMA urges Congress to pass H.R. 3514, the *Improving Seniors' Timely Access to Care Act*, which would implement significant reforms to the Medicare Advantage (MA) prior authorization (PA) process. The bipartisan legislation would establish a mandatory electronic PA program for MA plans that would streamline transactions for providers, strengthen MA PA transparency to better help providers navigate the process, and clarify MA PA decision timeframes to ensure efficient access to care.

This legislation is especially important for patients with urgent needs, such as diabetic foot ulcers or fractures. Patients who are denied treatment or not treated promptly will suffer from intensifying pain and be at higher risk of infection or amputation. It also enables podiatrists to focus on providing cost-effective care for all seniors.

Addressing Documentation Burdens in the Therapeutic Shoes for Patients with Diabetes Program

Diabetic shoes—defined as extra-depth shoes with inserts or custom-molded shoes with inserts—are a critical, evidence-based intervention for patients living with diabetes. These specialized shoes are proven to reduce the incidence of foot ulcers, prevent avoidable hospitalizations, decrease the risk of lower-extremity amputations, and ultimately help patients live longer, healthier lives.

Since 1987, therapeutic shoes have been a covered benefit under Medicare. Originally launched as a demonstration program, the benefit was made permanent after it demonstrated significant cost savings and improved health outcomes for beneficiaries. Yet despite major advances in medical practice, health information technology, and fraud prevention safeguards over the past four decades, the statutory and regulatory framework governing this benefit has not been meaningfully modernized.

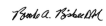
Today, nearly one-third of Medicare beneficiaries are living with diabetes, making timely access to therapeutic footwear essential to preventing devastating and costly lower-extremity complications. [85 percent](#) of amputations caused by diabetes-related complications are preventable, underscoring the critical role of early intervention and consistent preventive care.¹ However, current documentation requirements within the Medicare Therapeutic Shoe benefit create unnecessary and harmful delays. Before a patient can receive shoes, podiatrists must obtain certification paperwork from the physician (MD/DO) managing the patient's diabetes. In practice, podiatrists often wait months for the required documentation—if it is returned at all. Orders frequently expire before paperwork is completed, forcing repeated outreach and restarting the process. These delays leave vulnerable patients without medically necessary preventive care, increasing the risk of infection, worsening circulation, hospitalization, and ultimately avoidable, life-altering amputations.

¹ Todd W. F., David G. Armstrong & P. J. Liewood, "Evaluation and Treatment of the Infected Foot in a Community Teaching Hospital," *Journal of the American Podiatric Medical Association* 86, no. 9 (1996): 421–426, doi:10.7547/87507315-86-9-421.

The administrative burden has become so significant that many podiatrists have opted out of providing the benefit altogether, limiting patient access and undermining the program's original intent. Congress must act to modernize the statute, reduce unnecessary documentation barriers, and strengthen podiatrists' authority within the certification process. Streamlining these requirements will preserve program integrity while ensuring timely access to care—protecting patients, reducing long-term Medicare costs, and ultimately saving limbs and lives.

APMA looks forward to assisting you with this and other initiatives aimed at reducing regulatory burdens for physicians. Please contact Chad Appel, JD, APMA Vice President, Advocacy at cappel@apma.org with any questions. Thank you for considering our views.

Sincerely,



Brooke A. Bisbee, DPM
President

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

The American Society of Health-System Pharmacists Statement



February 11, 2026

The Honorable Chairman Rick Scott
The United States Senate
Special Committee on Aging
G 16 Dirksen Senate Office Building
Washington, DC 20510-6050

The Honorable Ranking Member Kirsten Gillibrand
The United States Senate
Special Committee on Aging
G 16 Dirksen Senate Office Building
Washington, DC 20510-6050

Re: ASHP Statement on the Senate Special Committee on Aging Hearing, *The Doctor is Out: How Washington's Rules Drove Physicians Out of Medicine*.

Dear Chair Scott and Ranking Member Gillibrand:

Thank you for holding this hearing on how federal regulations can lead to administrative burdens for health care providers, causing burnout and affecting private and rural practices. The American Society of Health-System Pharmacists (ASHP) is the largest association of pharmacy professionals in the United States, representing more than 65,000 pharmacists, student pharmacists, and pharmacy technicians in all patient care settings, including hospitals, ambulatory clinics, and health-system community pharmacies. There are federal regulations that cause frustration in pharmacists' training as well as practice.

Importance of the Dr. Lorna Breen Health Care Provider Protection Act: Prior to exploring areas of regulatory frustration, it is important to highlight the recent passage in the continuing resolution of the reauthorization of the Dr. Lorna Breen Health Care Provider Protection Act. Stress and occupational burnout are pervasive across all health care providers, but it is particularly acute among pharmacists and pharmacy technicians. A recent study found that pharmacists and female pharmacy technicians are at higher risk of suicide than their counterparts from the general population.¹ The Dr. Lorna Breen Health Care Provider and Protection Act is essential to helping organizations, like ASHP, assist health care team members in managing stress and occupational burnout. ASHP was one of 45 organizations selected by the Health Resources and Services Administration (HRSA) to receive funding inspired by the Dr. Lorna Breen Health Care Provider and Protection Act from the 117th Congress. Through the HRSA Health and Public Safety Workforce Resiliency Training grant, we reached over 5,000 pharmacists, pharmacy technicians, pharmacy residents, and student pharmacists in a curriculum-based, virtual learning community aimed at empowering local action to mitigate occupational burnout and create cultures of well-being in healthcare organizations. With the reauthorization, ASHP and other grantees can continue to enable providers to manage the stress of the modern health care marketplace. **We support fully funding the Dr. Lorna Breen Health Care Provider Protection Act.**

¹ Makhija H, Davidson JE, Barnes A, et al. National trends in pharmacist and pharmacy technician suicide: Incidence and associated features, *American Journal of Health-System Pharmacy*, 2026; , zxa006, <https://doi.org/10.1093/ajhp/zxa006>
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ASHP Statement on the Senate Special Committee on Aging Hearing, *The Doctor is Out: How Washington's Rules Drove Physicians Out of Medicine*.
February 11, 2026

Enable Physicians to Bill for Pharmacists on the Care Team: Pharmacists work as medication specialists on interprofessional care teams, improving patient outcomes while reducing workload burdens of their colleagues. Medicare recognizes the critical collaborative role pharmacists play by allowing physicians to bill for services provided by pharmacists under their supervision — a practice known as “incident-to” billing. Unfortunately, federal regulations hamstringing physicians’ ability to fully utilize pharmacists’ education, training, and experience. The CY2021 Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule final rule stated that pharmacists’ patient care services provided incident-to a physician or nonphysician practitioner must be billed at the lowest evaluation and management (E/M) service code (99211), eliminating the ability for pharmacists to bill incident-to for complex services that would generally be reimbursed under the higher level E/M codes (99212 – 99215) for other qualified health professionals (QHPs).² This policy undermines care models that enable pharmacists to support physicians and the care teams in which they participate in providing comprehensive care to seniors, thereby frustrating both physicians and pharmacists in their collaborative care of patients and threatening patient access to critical services. **We support legislation that would require CMS to allow physicians to bill, incident-to the physician, across all levels of medical decision making for E/M services provided by a pharmacist practicing within their scope of practice, while under the general supervision of such physician.**

Safeguard Pharmacy Residency Programs: Pharmacy residencies are postgraduate training programs that equip pharmacists to meet the challenges of today’s complex healthcare environment and ensure tomorrow’s stable and well-prepared pharmacy workforce. Unfortunately, the CMS has refused to tell residency programs sponsored by hospitals that are part of health systems or academic medical centers how they should comply with agency requirements. Despite this lack of guidance, CMS alleges that standard hospital business and training practices are noncompliant, resulting in funding clawbacks from many residency programs. The Rebuild America’s Health Care Schools Act (S. 1087/H.R. 1708) would require CMS to clarify the requirements health systems must meet to receive Medicare reimbursement for operating pharmacy, nursing, and allied health residency programs, and halt the clawbacks of these critical funds that frustrate administrators and participants in these programs. **We support passage of the Rebuild America’s Health Care Schools Act that would help the next generation of America’s pharmacy workforce.**

Removing Administrative Barriers to Pharmacists Providing Services in Medicare Advantage Plans: While pharmacists are not QHPs under Medicare Part B, they can and do provide state-authorized patient care services to Medicare beneficiaries. This care is often disrupted because CMS does not provide a clear administrative mechanism for pharmacists to enroll in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) (Form CMS-855i) as a provider. While there is an option for a “pharmacy” to register, this fails to account for the patient care role that pharmacists play

² Centers for Medicare & Medicaid Services, Physician Fee Schedule CY 2021 Final Rule, 85 Fed. Reg. 84592-3 (Dec. 28, 2020), available at <https://www.fda.gov/content/1016/FR-2020-12-28/pdf/2020-26815.pdf> (Limiting physicians supervising pharmacist-provided incident-to services to billing code 99211 for those services, despite the fact that many of the services provided by pharmacists meet the complexity and duration criteria set forth for code 99212-14).

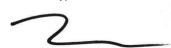
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February 11, 2026

in ambulatory clinical settings and results in care disruptions for Medicare beneficiaries. For example, because Medicare Part B only covers prescription claims issued by providers enrolled in PECOS, Medicare rejects prescription claims even for beneficiaries with a valid prescription initiated by pharmacists, as authorized by their state. Limiting Medicare beneficiaries in this way is in direct conflict with state scope of practice and collaborative practice laws that allow pharmacists to initiate or modify prescriptions medications for certain conditions. Beneficiaries experience similar coverage barriers for laboratory testing and durable medical equipment ordered by pharmacists acting within their state scope of practice. Lack of a mechanism for pharmacists to register as a provider in PECOS and obtain a provider transaction access number (PTAN) from a Medicare Administrative Contractor also interferes with the ability of Medicare Advantage (MA) plans to include pharmacists in their provider network despite statutory authority (42 CFR § 422.2) intended to allow MA plans to contract with "any individual who is engaged in the delivery of health care services in a State and is licensed or certified to engage in that activity in the State." **We support requiring CMS to provide an administrative mechanism for pharmacists to enroll as a provider in the Medicare PECOS as a non-physician specialty type and obtain PTAN.**

Address The Impact of the Inflation Reduction Act (IRA) on Pharmacies and Pharmacists: The prescription drug provisions of the IRA were meant to ensure Medicare beneficiaries have access to affordable medications. Unfortunately, CMS implementation has undermined this goal and will actually increase medication purchasing costs for pharmacists and pharmacies by allowing manufacturers to sell medications intended for Medicare beneficiaries at much higher prices than the negotiated price. This places immense financial pressures on pharmacies and pharmacists, clearly not the intent of the IRA. **We support amending the IRA to clarify that drug price discounts must be provided upfront rather than through rebates that allow manufacturers to game the system and increase purchase prices for pharmacies and their patients.**

ASHP thanks you for your efforts to address regulatory impediments that place undue strain on the health care workforce and prevent team based collaboration. We look forward to continuing to work with you to address the impediments to pharmacists' ability to serve America's seniors. If you have questions or if ASHP can assist your office in any way, please contact Frank Kolb at fkolb@ashp.org.

Sincerely,



Tom Kraus
American Society of Health-System Pharmacists

Enclosed: Makhija H, Davidson JE, Barnes A, et al. National trends in pharmacist and pharmacy technician suicide: Incidence and associated features, *American Journal of Health-System Pharmacy*, 2026, [zxag006](https://doi.org/10.1093/ajhp/zxag006), <https://doi.org/10.1093/ajhp/zxag006>

National trends in pharmacist and pharmacy technician suicide: Incidence and associated features

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Purpose: Pharmacists and pharmacy technicians are essential healthcare professionals with limited data on their risk for suicide.

Methods: Using the National Violent Death Reporting System, pharmacist, pharmacy technician, and general population suicides (for individuals 25 years of age or older) were identified. Suicide incidence was estimated from 2011 to 2022 due to data limitations, while suicide characteristics (preceding circumstances, method, and toxicology) were analyzed in adjusted Firth logistic regression models from 2005 to 2022.

Results: A total of 369 pharmacist (87 [24%] female), 243 pharmacy technician (149 [61%] female), and 245,114 general population (52,890 [22%] female) suicides were found for the period from 2011 to 2022. When data were standardized by sex, pharmacists had a higher risk of suicide (incidence rate ratio [IRR], 1.21; 95% confidence interval [CI], 1.09-1.34) while pharmacy technicians had a lower risk (IRR, 0.86; 95% CI, 0.74-0.99) than individuals in the general population during the 2011-2022 study period. Male pharmacists had a higher risk of suicide than other males (IRR, 1.25; 95% CI, 1.11-1.41) while female technicians had a higher risk than other females (IRR, 1.22; 95% CI, 1.04-1.44) during the 2011-2022 study period. In terms of the features associated with suicide, compared to the general population, pharmacists had higher odds of preceding job problems, while pharmacy technicians had higher odds of mental health problems. Pharmacists also had higher odds of using poisoning as a method.

Conclusion: Our findings suggest that pharmacists and female pharmacy technicians are at higher risk of suicide than their counterparts from the general population, possibly indicating that increased awareness and prevention are warranted.

Keywords: healthcare worker suicide, occupational health, occupational stress, pharmacists, pharmacy technicians, suicide prevention

Am J Health-Syst Pharm. 2026;00:1-11

Address correspondence to Dr. Lee (kellylee@health.ucsd.edu).

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<https://doi.org/10.1093/ajhp/zxag006>

Suicide is the 11th leading cause of death in the US, with a reported age-adjusted rate of 14.12 per 100,000 in 2023, occurring most commonly by firearm for males and by poisoning for females.¹ The first US study on pharmacist suicide, published in 2022, reported that their age-standardized rates of suicide ranged from 18.2 to 20.1 per 100,000 during 2004, 2009, and 2014, exceeding that of the general population.² Associated circumstances involved in pharmacist suicides included

a history of mental illness and job problems, with use of benzodiazepines, antidepressants, and opioids more frequent among pharmacists than in the general population.² International studies with small sample sizes found similar trends. A study from New Zealand reported an age-standardized mortality ratio of 2.5 (95% confidence interval [CI], 0.8-5.9; $P < 0.05$) for female pharmacists for the period from 1973 to 2004.³ A study from Denmark found that pharmacists

were 91% more likely to die by suicide than teachers, with sex-specific increases in pharmacist suicide risk compared to sex-matched teachers for the period from 1981 to 2006.⁴ The most recent study in Austria observed sex-based differences for pharmacists from 1991 to 2020, noting a 73% higher age-adjusted risk of suicide for female pharmacists compared to other women, while male pharmacists had risk comparable to that of other men.⁵ The incidence of suicide among other healthcare professionals, specifically physicians and nurses, has also been reported to be higher than in the general population.⁶⁻⁸ Additionally, the association of job problems and mental health disorders with suicide is similar among the healthcare professions, along with the substances that were involved.^{6,9-11}

Pharmacists and pharmacy technicians play vital roles in the delivery of safe and effective healthcare; increasingly, however, they face overwhelming stressors such as high workloads, lack of autonomy, corporate-driven metrics, understaffing challenges, and difficult patient interactions, especially for those working in community pharmacy settings.¹²⁻¹⁴ Before the coronavirus disease 2019 (COVID-19) pandemic, the prevalence of burnout in pharmacists was estimated to be as high as 61%.¹⁵⁻¹⁹ During the COVID-19 pandemic, pharmacies became the frontline centers for testing and vaccination and the prevalence of burnout during this time period was estimated to be as high as 75%.²⁰⁻²² Little is known about the prevalence of burnout among pharmacy technicians; however, in a study from Singapore, burnout was reported in more than half of pharmacy technicians due to workload and other job-related factors.²³ To our knowledge, there is also no literature on their risk of suicide or preceding circumstances.

Since our first publication on pharmacist suicide,² the roles of pharmacy professionals have changed drastically in response to the COVID-19 pandemic

KEY POINTS

- Pharmacists have a greater risk of suicide than the general population after controlling for sex.
- Female pharmacy technicians have a greater risk of suicide than females in the general population.
- Job problems within the pharmacist occupation and mental health problems within the pharmacy technician occupation represent possible targets for suicide prevention, as multimodal and comprehensive strategies remain warranted.

with increased workforce pressures.¹² The current study advances our prior work by including pharmacy technicians, an occupation not previously examined in the literature, and by evaluating sex as a possible confounder. We also built on our previous methodologies by using the most recent National Violent Death Reporting System (NVDRS) data, extending through 2022 and covering 47 states and the District of Columbia, and by employing multivariable modeling techniques. Our objective with these changes was to estimate the sex-specific suicide risk among pharmacists and pharmacy technicians and to compare associated circumstances, methods, and substances involved in suicide to those in the general population.²⁴

Methods

This retrospective cohort study utilized US suicide decedent data from the NVDRS for the years 2005 to 2022. The NVDRS is an anonymous database that collects information from death certificates, coroner/medical examiner reports, and law enforcement reports. The Centers for Disease Control and Prevention (CDC) approved use of the data, and the University of California San Diego institutional review board deemed the study to not be human

subject research in accordance with the Declaration of Helsinki (170165).

Population estimates. In the NVDRS, the jurisdictions for which data are available vary by year, so this study used all available jurisdictions with full jurisdiction-wide reporting except for Puerto Rico, Illinois, Pennsylvania, and Washington were also excluded until reporting accounted for 100% of the state's population (further clarification about the included jurisdictions can be found in eTable 1). Pharmacists and pharmacy technicians were identified using free-text occupations from the decedents' death certificates, CDC modified 2017 US census occupation codes, and 2018 standard occupation classifications (eTable 2). Two independent investigators used each variable to flag occupations (Cohen's $\kappa = 0.95$ for pharmacists and 0.99 for pharmacy technicians). Decedents aged 24 years or younger as well as those without data for sex or age were excluded. General population suicides were identified as suicides by individuals who were not pharmacists or pharmacy technicians.

Occupational employment and wage statistics from the Bureau of Labor Statistics (BLS) were used to estimate each state's pharmacist and pharmacy technician populations for incidence analysis.²⁵ National occupation-specific sex and age percentages from the Current Population Survey were applied to estimate sex-specific populations (age of 25 years or older).²⁶ For pharmacy technicians, missing yearly sex and age percentages were imputed with the mean for available years. The US Census Bureau's American Community Survey Public Use Microdata Sample was used to obtain denominators for incidence for the general population, estimating each state's population per year (age of between 25 and 99 years).²⁷ Although data were available from 2005 (16 states) to 2022 (47 states and the District of Columbia), incidence and incidence rate ratio (IRR) estimates were calculated only for the years

2011 to 2022. During this later time-frame, the BLS began reporting age group percentages for detailed occupations, which we needed to calculate denominators.²⁸

For both the pharmacist and pharmacy technician occupations and the general population, sex-standardized rates and rate ratios were estimated using the direct method of standardization, with the 2022 general population as the standard (age of between 25 and 99 years; jurisdictions unavailable in the NVDRS for 2022 were excluded). This process was used to account for differences in sex distributions between the specific pharmacy occupations and the general population. Further sex-specific age data were unavailable for sex and age standardization.

Covariates. While the incidence analysis was restricted to 2011 to 2022, we chose to use the full data from 2005 to 2022 to analyze associations with suicide characteristics (eg, preceding circumstances, methods involved, and toxicology findings) due to the rarity of healthcare worker suicide. To estimate adjusted odds ratios (aORs), Firth's penalized logistic regression was utilized to minimize bias in maximum-likelihood estimates, address rare event bias, account for possible separation issues, and help counteract overfitting due to large sample imbalance. The variables used as covariates included age, sex, race/ethnicity, and marital status. Two separate univariate analyses were completed to compare pharmacists or pharmacy technicians to the general population. All decedents missing data for the adjusting variables were excluded.

Preceding circumstances to suicide. Of the 14 different preceding circumstances to suicide that were analyzed, the following 4 were created by combining the variables in parentheses: substance problems (alcohol problem or other substance use), mental health problems (mental illness treatment history or current mental health issue), legal problems (criminal or noncriminal problem), and death or

suicide of friend, family, or other (suicide of a family member or friend combined with death of a friend, family member, or other person).

Primary method of suicide. All methods were analyzed in separate adjusted models followed by post hoc Holm-Bonferroni correction. Methods included poisoning; firearm use; hanging, strangulation, or suffocation; sharp instruments; and all other methods.

Toxicology-reported substances. Using substances noted in the NVDRS toxicology field, a pharmacist investigator organized all substances into 22 categories.^{1,8} This categorization included a specific category labeled "not prescribed for home use," which represented medications potentially diverted from the workplace, given pharmacy professionals' knowledge of and access to such substances.²⁹⁻³¹ Analysis was completed for any substance found during toxicology investigations.

Analysis. STATA Version 17.0 (StataCorp, College Station, TX) and SAS Version 9.4 (SAS Institute, Cary, NC) were used to analyze the data, keeping a 2-sided α level of 0.05. Categorical variables were analyzed with a χ^2 or Fisher's exact test, while continuous variables were analyzed with Welch's one-way analysis of variance, using a Games-Howell test for multiple pairwise comparisons. Multivariable modeling was done using Firth's penalized logistic regression adjusted by age, sex, race/ethnicity, and marital status.

Results

In the analysis of suicide characteristics from all available jurisdictions in 2005 to 2022, we found 438 pharmacist (100 [23%] female), 281 pharmacy technician (173 [62%] female), and 296,190 general population (64,162 [22%] female) suicides (Table 1). Pharmacist decedents were older (mean [SD] age, 55 [16] vs 51 [16] years; $P < 0.001$) and more likely to be married or in a domestic partnership (no. [%], 229 [52%] vs 107,581 [36%]) than decedents in

the general population (Table 1). Pharmacy technician decedents were younger (mean [SD], 42 [13] vs 51 [16] years; $P < 0.001$) and more likely to be single or never married (no. [%], 118 [42%] vs 84,360 [29%]) than decedents in the general population.

As denominators were not available for 2005 to 2010, the incidence analysis was completed for the period from 2011 to 2022 and comprised 369 pharmacist (87 [24%] female), 243 pharmacy technician (149 [61%] female), and 245,114 general population (52,890 [22%] female) suicides (Table 2).

Incidence of suicide in pharmacists from 2011 to 2022. After sex standardization, pharmacists had a higher risk of suicide than individuals in the general population during the 2011-2022 study period (IRR, 1.21; 95% CI, 1.09-1.34), with elevations specifically in 2013 to 2014 (IRR, 1.36; 95% CI, 1.00-1.84), 2015 to 2016 (IRR, 1.37; 95% CI, 1.07-1.76), and 2017 to 2018 (IRR, 1.31; 95% CI, 1.03-1.65). When data were stratified by sex, compared to the male general population, male pharmacists had a higher risk of suicide during the 2011-2022 study period (IRR, 1.25; 95% CI, 1.11-1.41), with elevations specifically in 2015 to 2016 (IRR, 1.37; 95% CI, 1.02-1.83) and 2017 to 2018 (IRR, 1.40; 95% CI, 1.08-1.82) (Figure 1). Compared to the female general population, female pharmacists had comparable suicide risk (all rates can be found in eTable 3).

For the 2011-2022 study period, suicide incidence for male pharmacists vs the male general population was 37.33 vs 29.84 per 100,000 person-years. For female pharmacists vs the female general population, the incidence was 8.02 vs 7.66 per 100,000 person-years (eTable 3).

Incidence of suicide in pharmacy technicians from 2011 to 2022.

After sex standardization, pharmacy technicians had a lower risk of suicide than the general population during the 2011-2022 study period (IRR, 0.86; 95% CI, 0.74-0.99). When data were stratified by sex, compared to the male general population, male

Table 1. Demographics of Pharmacist, Pharmacy Technician, and General Population Suicides for 2005 to 2022

Characteristic	Pharmacists	Pharmacy technicians	General population ^a	P value ^f
Total suicides, No.	438	281	296,190	NA
Sex, No. (%)				
Male	338 (77)	108 (38)	232,028 (78)	<0.001
Female	100 (23)	173 (62)	64,162 (22)	
Age, mean (SD), years	55 (16)	42 (13)	51 (16)	<0.001
Race and ethnicity, No. (%) ^{ab}				
Asian or Pacific Islander	22 (5)	11 (4)	5,450 (2)	<0.001
American Indian or Alaska Native	S ^d	S ^d	3,326 (1)	
Black	19 (4)	23 (8)	17,473 (6)	
Hispanic	S ^d	10 (4)	14,359 (5)	
White	381 (87)	232 (83)	251,626 (85)	
Other ^e	7 (2)	S ^d	3,660 (1)	
Unknown	1 (0)	1 (0)	296 (0)	
Marital status, No. (%) ^a				
Married or domestic partnership	228 (52)	69 (25)	107,581 (36)	<0.001
Never married or single	76 (17)	118 (42)	84,360 (29)	
Separated, widowed, or divorced	133 (31)	93 (33)	100,847 (34)	
Unknown	1 (0)	1 (0)	3,402 (1)	

Abbreviations: NA, not applicable; S, suppressed.

^aCategorical variables were compared using a χ^2 or Fisher's exact test; continuous variables were compared using Welch's one-way analysis of variance.^bRace and ethnicity data were collected from the National Violent Death Reporting System and are reported as both variables were significant in suicide rates.^cGeneral population includes individuals who were not pharmacists or pharmacy technicians.^dPossibly identifiable counts less than 10 are suppressed per the National Violent Death Reporting System user agreement.^eValues under the "other" category included multiple races and the National Violent Death Reporting System coding of other.^fThe threshold for significance was set at 0.05.

pharmacy technicians had a lower risk of suicide during the 2011-2022 study period (IRR, 0.76; 95% CI, 0.62-0.93), with lower risk specifically in 2019 to 2020 (IRR, 0.61; 95% CI, 0.38-0.97). Compared to the female general population, female pharmacy technicians had a higher risk of suicide during the 2011-2022 study period (IRR, 1.22; 95% CI, 1.04-1.44), with elevations specifically in 2019 to 2020 (IRR, 1.40; 95% CI, 1.01-1.95).

For the 2011-2022 study period, suicide incidence for male pharmacy technicians vs the male general population was 22.69 vs 29.84 per 100,000 person-years. For female pharmacy

technicians vs the female general population, the incidence was 9.36 vs 7.66 per 100,000 person-years (eTable 3).

Preceding circumstances to suicide. A total of 436 pharmacist, 278 pharmacy technician, and 290,069 general population suicides had data available on circumstances. Compared to the general population, pharmacists were found to have higher odds of job problems (aOR, 2.05; 95% CI, 1.56-2.70; $P < 0.001$) and leaving a suicide note (aOR, 1.39; 95% CI, 1.14-1.70; $P < 0.001$) (Table 3). Pharmacy technicians were found to have higher odds of a history of previous suicide attempts (aOR, 1.47; 95% CI, 1.13-1.92; $P = 0.004$)

and mental health problems (aOR, 1.38; 95% CI, 1.05-1.81; $P = 0.02$).

Primary method of suicide. A total of 432 pharmacist, 272 pharmacy technician, and 285,263 general population suicides had data available for the primary method of suicide (weapon type most implicated in death). The most commonly used method of suicide for male pharmacists was a firearm, while poisoning was the most commonly used method for female pharmacists. For pharmacy technicians, firearms were the most used method for both males and females.

Compared to the general population, pharmacists were found to have

Table 2. Suicides among Pharmacists, Pharmacy Technicians, and the General Population from 2011 to 2022^a

	Male sex				Female sex			
	Pharmacists	Pharmacy technicians	General population ^b	P value ^c	Pharmacists	Pharmacy technicians	General population ^b	P value ^c
Total suicides 2011-2022, No.	282	94	192,224	NA	87	149	52,890	NA
Suicides by years, No. (%)								
2011-2012	25 (9)	4 (4)	16,921 (9)	0.58	12 (14)	13 (9)	4,927 (9)	0.45
2013-2014	29 (10)	6 (7)	18,575 (9)		13 (15)	14 (9)	5,534 (11)	
2015-2016	45 (16)	13 (14)	28,352 (15)		18 (21)	21 (14)	8,557 (16)	
2017-2018	56 (20)	20 (21)	35,766 (19)		16 (18)	27 (18)	10,282 (19)	
2019-2020	54 (19)	18 (19)	42,261 (22)		11 (13)	36 (24)	11,006 (21)	
2021-2022	73 (26)	33 (35)	50,349 (26)		17 (19)	38 (26)	12,584 (24)	
Age, mean (SD), years	58 (16)	39 (13)	51 (17)	<0.001	46 (13)	44 (13)	50 (15)	<0.001

Abbreviation: NA, not applicable.

^aBecause denominators were not available for pharmacists and pharmacy technicians from 2005 to 2010, this table displays the suicide demographics for the incidence analysis using 2011-2022 data.^bGeneral population includes individuals who were not pharmacists or pharmacy technicians.^cThe threshold for significance was set at 0.05.

higher odds of using poisoning (aOR, 2.28; 95% CI, 1.82-2.86; $P < 0.001$) (Table 3).

Toxicology-reported substances.

A total of 346 pharmacist, 217 pharmacy technician, and 220,471 general population suicides had data available from toxicology reports. Compared to the general population, pharmacists were found to have higher odds of using antidepressants (aOR, 1.45; 95% CI, 1.07-1.97; $P = 0.02$); antidiabetic agents (aOR, 3.09; 95% CI, 1.22-7.81; $P = 0.02$); anxiolytics, nonbenzodiazepine sedatives, or hypnotics (aOR, 2.49; 95% CI, 1.66-3.74; $P < 0.001$); barbiturates (aOR, 2.41; 95% CI, 1.47-3.95; $P < 0.001$); cardiovascular agents (aOR, 1.78; 95% CI, 1.13-2.79; $P = 0.01$); and opiates or opioids (aOR, 1.79; 95% CI, 1.35-2.38; $P < 0.001$) (Table 4). Pharmacy technicians were found to have higher odds of using anticonvulsants (aOR, 1.69; 95% CI, 1.11-2.56; $P = 0.02$) and anxiolytics, nonbenzodiazepine sedatives, or hypnotics (aOR, 2.24; 95% CI, 1.39-3.60; $P = 0.001$).

Discussion

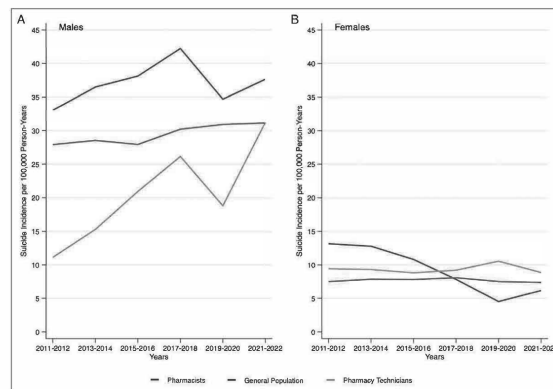
From 2011 to 2022, in sex-standardized analysis, pharmacists had a higher risk of suicide, while pharmacy technicians had a lower risk of suicide, than the US general population. However, both occupations had crude sex-specific risk patterns. Male pharmacists had a higher risk of suicide than other males, while female pharmacists had comparable risk to other females. Male pharmacy technicians, on the other hand, had a lower risk of suicide than other males, while female pharmacy technicians had a higher risk than other females.

Several prior studies have examined sex-specific and overall suicide rates among pharmacists.³⁻⁵ The most recent of these from Austria found that pharmacists had a comparable risk of suicide to the general population from 1991 to 2020, with female pharmacists having a higher risk of suicide than other women.⁵ Our findings likely differ from previous studies because

these studies used international data and analyzed small samples of pharmacist decedents, ranging from 8 to 231 deaths.³⁻⁵ Pharmacist training requirements and practice roles may also differ in these countries compared to the US, possibly leading to differences in suicide rates. The current study is most consistent with the first US study of suicide in pharmacists, which showed that pharmacists had a higher age-adjusted suicide risk than the general population in 2004, 2009, and 2014.² Our current analysis advances this previous work by refining the methodology, including more recent data, and evaluating pharmacy technicians.

Interestingly, in sex-matched comparisons to the general population, the suicide risk of pharmacists differed from that of US physicians and nurses: females in those occupations had higher risk than other females, while males had lower or comparable risk to other males.^{2,8} This may be due to males being less likely to seek and receive mental health treatment²²⁻³⁴ or the use of

Figure 1. Incidence of pharmacist, pharmacy technician, and general population suicides biannually for males (A) and females (B). The analysis used data only from 2011 to 2022 as pharmacist and pharmacy technician denominators were not available from 2005 to 2010. Information on the number of jurisdictions included and specific rates can be found in eTable 1 and eTable 3.



more lethal means by males,^{1,35} consistent with trends seen in the general population. Further, although most pharmacy graduates are female, male pharmacists are disproportionately represented in pharmacy ownership and academic leadership.^{12,36-40} Whether these differences in roles lead to higher stress, lower job satisfaction, mental health problems, and potentially increased risk of suicide is unknown. However, the features associated with overall pharmacist suicides were consistent with the characteristics of physician and nurse suicides as well as previous studies on pharmacist suicide; these occupations had higher odds of preceding job problems and use of poisoning as a method, likely due to ease of access to highly lethal agents in the workplace.^{2,3,11}

Research on pharmacists has consistently shown elevated levels of burnout

throughout the profession.^{15-18,21,22} More recently, attention has shifted to combatting burnout by addressing the organizational culture, improving the work environment, and providing resources to support employees.^{14,41-43} In line with this, pharmacy professionals have recommended analyzing the root causes of burnout and moral injury, improving pharmacy efficiency, and adopting more flexible workplace models.^{14,41,44} In 2025, the Accreditation Council for Pharmacy Education also updated its standards to prioritize student, faculty, and staff well-being and to require pharmacy institutions to provide supportive resources.⁴⁵ While there is limited evidence that burnout leads to suicidal ideation, burnout has been associated with depressive symptoms and represents a future area of research to better explore prolonged burnout, mental health, and suicide.⁴⁶

Few data are available regarding pharmacy technician suicide rates along with the occupation's rates of burnout, depression, and other possible suicide contributors. However, this study showed that mental health issues and suicide attempt history could be targets for prevention. As female pharmacy technicians, like female physicians and female nurses, were found to have a higher risk of suicide than other women, there may also be an intersection between employment in healthcare and facing female-specific stressors (eg, dual roles in work and personal life) that is contributing to this increased risk.^{7,8,47} It is unclear why female pharmacists did not similarly show increased risk as these stressors would apply similarly. Although only female pharmacy technicians had a significantly higher risk of suicide than the general population, male pharmacy

Table 3. Preceding Circumstances to and Method Involved in Suicide from 2005 to 2022^a

	General population No. (%)	Pharmacy technicians			Pharmacists		
		No. (%)	aOR ^a	P ^d	No. (%)	aOR ^c	P ^d
Circumstances							
Physical health problem	62,508 (22)	53 (19)	1.35 (0.99, 1.85)	0.06	108 (25)	0.85 (0.67, 1.08)	0.19
Job problem	28,022 (10)	30 (11)	1.26 (0.85, 1.87)	0.24	71 (16)	2.05 (1.56, 2.70)	<0.001
Suicide attempt history	49,297 (17)	92 (33)	1.47 (1.13, 1.92)	0.004	74 (17)	1.05 (0.81, 1.36)	0.74
Left suicide note	84,313 (29)	100 (36)	1.19 (0.92, 1.53)	0.18	162 (37)	1.39 (1.14, 1.70)	<0.001
Mental health problem	130,881 (45)	174 (63)	1.38 (1.05, 1.81)	0.02	217 (50)	1.20 (0.98, 1.48)	0.08
Substance problem	78,520 (27)	68 (24)	0.68 (0.51, 0.89)	0.006	82 (19)	0.72 (0.56, 0.92)	0.009
Depressed mood	93,547 (32)	88 (32)	0.91 (0.7, 1.18)	0.46	168 (39)	1.23 (1.00, 1.51)	0.05
Intimate partner problem	72,891 (25)	68 (24)	0.96 (0.71, 1.3)	0.79	88 (20)	0.77 (0.59, 1.01)	0.06
Family problem	18,713 (6)	24 (9)	1.22 (0.8, 1.86)	0.36	26 (6)	0.98 (0.66, 1.46)	0.93
Prior argument or conflict	34,290 (12)	30 (11)	0.84 (0.56, 1.27)	0.42	43 (10)	1.09 (0.76, 1.54)	0.65
Disclosed suicide intent	64,809 (22)	61 (22)	0.91 (0.68, 1.21)	0.51	89 (20)	0.89 (0.71, 1.13)	0.34
Financial problem	25,319 (9)	22 (8)	0.95 (0.61, 1.48)	0.82	33 (8)	0.66 (0.46, 0.95)	0.02
Criminal or noncriminal legal problem	30,150 (10)	20 (7)	0.76 (0.48, 1.19)	0.23	39 (9)	1.01 (0.73, 1.42)	0.94
Death or suicide of friend, family, or other	22,246 (8)	23 (8)	1.10 (0.72, 1.67)	0.67	29 (7)	0.82 (0.56, 1.20)	0.30
Method ^b							
All other methods	14,414 (5)	S ^e	0.83 (0.49, 1.41)	0.49	22 (5)	1.08 (0.71, 1.66)	0.71
Poisoning	43,135 (15)	81 (30)	1.39 (1.06, 1.82)	0.02	114 (26)	2.28 (1.82, 2.86)	<0.001
Firearm	154,124 (54)	124 (46)	1.22 (0.96, 1.56)	0.10	219 (51)	0.77 (0.63, 0.94)	0.01 ^f
Hanging, strangulation, or suffocation	72,245 (25)	55 (20)	0.61 (0.45, 0.82)	0.001 ^f	70 (16)	0.64 (0.49, 0.83)	<0.001 ^f
Sharp instrument	6,151 (2)	S ^e	0.91 (0.36, 2.29)	0.83	11 (3)	1.27 (0.71, 2.27)	0.43

Abbreviations: aOR, adjusted odds ratio; S, suppressed.

^aAnalysis was done using Firth logistic regression adjusted by age, sex, race/ethnicity, and marital status. Analysis included data from 2005 to 2022 and all data were available to complete regression analysis. The total number of suicides with data on circumstances was as follows: general population, 900,069; pharmacy technicians, 276; pharmacists, 436. The total number of suicides with data on circumstances was as follows: general population, 285,263; pharmacy technicians, 272; pharmacists, 432.

^bMethods of suicide were analyzed as an adjusted model per method.

^cAll odds ratios were produced by comparing a single occupation (pharmacist or technician) to the general population.

^dThe threshold for significance was set at 0.05.

^eValues less than 10 are suppressed per the National Violent Death Reporting System user agreement.

^fOnly for methods: significant after post hoc Holm-Bonferroni correction; values shown are original P values.

Abbreviations: aOR, adjusted odds ratio; S, suppressed.

^aAnalysis was done using Firth logistic regression adjusted by age, sex, race/ethnicity, and marital status. Analysis included data from 2005 to 2022 as all data were available to complete regression analysis. The total number of suicides with data on circumstances was as follows: general population, 290,060; pharmacy technicians, 278; pharmacists, 456. The total number of suicides with data on methods was as follows: general population, 285,263; pharmacy technicians, 272; pharmacists, 432.^bMethods of suicide were analyzed as one adjusted model per method.^cAll odds ratios were produced by comparing a single occupation (pharmacist or technician) to the general population.^dThe threshold for significance was set at 0.05.^eValues less than 10 are suppressed per the National Violent Death Reporting System user agreement.^fOnly for methods: significant after post hoc Holm-Bonferroni correction; values shown are original P values.

technicians' rates of suicide were still notably high. Therefore, this study highlights an immediate need to fill this knowledge gap and to further study the wellness of both male and female pharmacy technicians.

Regarding substances, it is likely that the following substances found

on the toxicology reports of decedents from both or only one pharmacy occupation may have been used for the purpose of treating a mental health problem (eg, depression, anxiety, and/or sleep disorders): antidepressants, barbiturates, and anxiolytics; nonbenzodiazepine sedatives; and

hypnotics. The presence of cardiovascular and antidiabetic agents may also correspond to treatments for chronic conditions that often coexist with depression or possibly β -blocker usage for anxiety.⁴⁸⁻⁵² Opiates, however, from the toxicology reports of pharmacists could indicate treatment for

Table 4. Substances on Toxicology Reports After Suicide from 2005 to 2022*

Substance	General population No. (%)	Pharmacy technicians		Pharmacists	
		No. (%)	aOR ^b	No. (%)	aOR ^b
Antidepressant	28,496 (13)	54 (25)	1.21 (0.85, 1.73)	70 (20)	1.45 (1.07, 1.97)
Anticonvulsant	11,495 (5)	29 (13)	1.69 (1.11, 2.58)	26 (8)	1.21 (0.79, 1.84)
Acetaminophen	8,249 (4)	17 (8)	1.42 (0.86, 2.36)	20 (6)	1.09 (0.67, 1.76)
Antidiabetic agent	1,018 (0)	S ^d	1.08 (0.25, 5.13)	S ^d	3.09 (1.22, 7.81)
Antihistamine	16,997 (8)	32 (15)	1.19 (0.86, 1.75)	30 (9)	0.86 (0.58, 1.27)
Antipsychotic	7,490 (3)	11 (5)	0.72 (0.40, 1.3)	11 (3)	0.70 (0.38, 1.27)
Alcohol (ethanol)	61,389 (28)	60 (28)	0.94 (0.70, 1.26)	91 (26)	1.01 (0.75, 1.29)
Anxiolytic, nonbenzodiazepine sedative, or hypnotics	6,718 (3)	20 (9)	2.24 (1.39, 3.6)	29 (8)	2.49 (1.66, 3.74)
Barbiturate	34,122 (15)	50 (23)	0.97 (0.68, 1.39)	73 (21)	1.15 (0.84, 1.56)
Barbiturate	9,949 (5)	12 (6)	1.16 (0.61, 2.23)	27 (8)	2.41 (1.47, 3.95)
Cardiovascular agent	6,005 (3)	10 (5)	1.37 (0.74, 2.55)	21 (6)	1.78 (1.13, 2.79)
Muscle relaxant	5,437 (2)	15 (7)	1.57 (0.92, 2.67)	0.1	S ^d
Opiate or opioid	38,101 (17)	57 (26)	1.35 (0.95, 1.92)	93 (27)	1.79 (1.35, 2.38)
Other analgesic or NSAID	4,384 (2)	S ^d	0.44 (0.15, 1.25)	S ^d	0.35 (0.14, 0.86)
Tetrahydrocannabinol or marijuana	22,276 (10)	25 (12)	1.08 (0.71, 1.66)	18 (5)	0.39 (0.23, 0.67)
Caffeine	14,766 (7)	16 (7)	0.81 (0.47, 1.38)	24 (7)	1.05 (0.69, 1.64)
Drug not prescribed for home use	2,966 (1)	S ^d	0.86 (0.31, 2.4)	S ^d	0.87 (0.38, 2.01)
All other drugs	8,949 (4)	10 (5)	0.63 (0.34, 1.17)	16 (5)	0.91 (0.54, 1.53)
Nicotine	10,743 (5)	12 (6)	1.02 (0.56, 1.86)	0.94	S ^d
Poison	14,655 (7)	17 (8)	1.33 (0.82, 2.16)	29 (8)	1.27 (0.86, 1.88)
Stimulant	17,612 (8)	21 (10)	1.36 (0.81, 2.27)	25	29 (8)
Illicit substance use	25,200 (11)	17 (8)	0.33 (0.16, 0.60)	<0.001	28 (8)

Abbreviations: aOR, adjusted odds ratio; NSAID, nonsteroidal anti-inflammatory drug; S, suppressed.

*Analysis was done using Poisson logistic regression adjusted by age, sex, race/ethnicity, and marital status.

†Values less than 10 are suppressed per the National Violent Death Reporting System user agreement.

‡All odds ratios were produced by comparing a single occupation (pharmacist or technician) to the general population.

§The threshold for significance was set at 0.05.

||Values less than 10 are suppressed per the National Violent Death Reporting System user agreement.

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chronic pain due to difficult working conditions or possible misuse, which can be highly lethal. The indication for anticonvulsants in the toxicology reports for pharmacy technician is less clear. Yet, anticonvulsants, such as gabapentin and pregabalin, are increasingly being used for anxiety, which is consistent with the observed patterns of increased mental health disturbances for individuals in this occupation.^{63,64} Additionally, the use of anticonvulsants has been linked to suicidal ideation.⁶⁵ Another notable finding was the lower odds of illicit substance use (eg, of methamphetamines) among both pharmacists and pharmacy technicians and of marijuana use specifically among pharmacists. These findings may be related to the occupations' easier access to prescription medications as compared to the general population. Given the small sample of both pharmacist and pharmacy technician decedents for which toxicology reports were available, further analysis into which medications were being utilized at lethal concentrations could not be completed.

In recent years, organizations have increasingly recognized the risk of death by suicide in these two occupations. In 2023, the American Pharmacists Association and the American Society of Health-System Pharmacists recognized September 20 as Pharmacy Workforce Suicide Awareness Day to highlight the need to improve workforce wellness and incorporate suicide prevention programs.^{66,67} This work was coupled with acts by the Lorna Breen Foundation, which has been fighting against institutional mental health stigma and calling for the removal of intrusive licensure questions that hinder healthcare professionals from seeking care.⁶⁸ The findings of this study reinforce the importance of these initiatives and identifying professional, workplace, and individual factors that increase the risk of mental health disorders and suicidality within these occupations. It will be necessary to redesign professional and workplace policies to instill a culture of well-being for our pharmacy

workers. Strategies such as offering flexibility in work schedules, reducing unnecessary regulatory burden, removing stigmatizing questions in licensure applications, and improving workflow efficiency by use of technology have been recommended.¹⁴ Increased vigilance is required to protect the pharmacists and pharmacy technicians who serve our communities.

Limitations. This study had several limitations. First, our study may not be nationally representative as we were limited to jurisdictions that had comprehensive reporting to the NVDHS and each jurisdiction likely had different resources or protocols for coding.²⁸⁻⁴¹ Further, as shown in eTable 1, each year of data included a different total number of jurisdictions based on availability; as the years progressed, our incidence analysis showed a more national and comprehensive picture. Second, due to the retrospective nature of this study as well as the underreporting in the NVDHS of preceding circumstances, the circumstances we identified cannot be interpreted as precipitating factors.⁶³ Third, as licensure is not reflected in BLS statistics, there is a chance that our pharmacist and pharmacy technician denominators were underestimates.⁶⁹ Fourth, as age and sex percentages were available for pharmacy technicians only in 2020, 2021, and 2022, our estimates for prior years may have been biased.

Future research on workplace interventions aimed at reducing job problems and preventing suicide among pharmacy professionals remains warranted. Increasing awareness and education surrounding this heightened suicide risk is essential, along with ensuring access to supportive resources.⁶³ Addressing barriers to mental healthcare, including stigma, also represents an area for future research and intervention.

Conclusion

This study suggests that pharmacists are at higher risk of suicide than the general population and that female

pharmacy technicians are at higher risk than other females. Multimodal suicide prevention programs remain warranted for these occupations.

Data availability

The data underlying this article cannot be shared publicly due to need for approval by the Centers for Disease Control and Prevention for National Violent Death Reporting System access.

Disclosures

Dr. Lee is a consultant for LexiDrugs and has received honoraria for speaking on ADHD from WebMD Health Corp. Dr. Zisook reports grants from Compass Pathways. The other authors have declared no potential conflicts of interest.

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U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

American Society of Hematology Statement

American Society of Hematology

Helping hematologists conquer blood diseases worldwide

Statement for the Record

From the American Society of Hematology
For the Senate Special Committee on Aging**"The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine"**
Held on February 11, 2026

The American Society of Hematology (ASH) thanks the Senate Special Committee on Aging ("the Committee") for holding this hearing to examine the impact of administrative and regulatory burdens on physician burnout, workforce shortages, access to care for aging adults, and for the opportunity to submit this statement for the record.

ASH represents more than 18,000 clinicians and scientists worldwide who are committed to the study and treatment of blood and blood-related diseases. These disorders encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma, as well as classical (non-malignant) hematologic conditions such as sickle cell disease, thalassemia, bone marrow failure, venous thromboembolism, and hemophilia. In addition, hematologists are pioneers in the treatment of various hematologic diseases and continue to be innovators in the fields of stem cell biology, regenerative medicine, transfusion medicine, and gene therapy. Our mission is to foster high-quality, equitable care, transformative research, and innovative education to improve the lives of patients with blood and bone marrow disorders.

As this Committee knows, prior authorization is one of the single most burdensome administrative activities within Medicare Advantage. Prior authorization requires an inordinate amount of physician and clinical staff time, is directly responsible for endless paperwork, and contributes to physician burnout, while leading to excessive costs, delays in treatment, and beneficiary dissatisfaction. While ASH recognizes that prior authorization is intended to be used as a tool to ensure that care is medically necessary, meets certain standards, and controls costs, it frequently creates needless barriers to patients accessing timely and medically necessary care and generates excessive administrative burden.

Some of the most common prior authorization requirements include step therapy and other utilization management (UM) techniques which frequently exacerbate these challenges. Accordingly, the Society advocates for reforms to step therapy and other UM practices by focusing on three key improvements: (1) transparent use of prior authorization policies, (2) prior authorization policies rooted in clinical guidelines, data driven best practices or standards of care, and the latest literature, and (3) shorter turnaround times for any prior authorization practices.

In addition to administrative burden, inadequate and unsustainable physician payment further strains the health care system. As discussed during the hearing, Medicare physician

payment has been eroding for more than three decades, declining by 33 percent when adjusted for inflation from 2001 – 2026. The Medicare Access and CHIP Reauthorization Act (MACRA) only provided statutory updates to the conversion factor from 2015 – 2019 and then established a differential conversion factor for physicians in participating in the Merit-based Incentive Payment System and Advanced Alternative Payment Models. This differential conversion factor was implemented first in 2026. Therefore, the lack of positive updates and the Medicare Physician Fee Schedule's (MPFS) budget neutrality requirements have resulted in a series of statutorily required cuts to the conversion factor over the last several years.

The continued erosion in Medicare physician reimbursement is distinctly acute for hematologists. Hematology, particularly classical hematology, is facing a severe workforce shortage¹, limiting access to much needed expertise in complex hematological disorders, like sickle cell disease. This shortage is driven by new physicians' concerns of balancing the eroding Medicare reimbursement rates that cover physician and staff salaries and supplies, and significant medical school debt. At the same time, the practice of hematology is rapidly evolving and becoming increasingly complex, requiring physicians to stay current with the latest innovations as they evaluate and recommend new therapies to their patients, such as recently approved cellular and gene therapies and the expanding availability of bone marrow transplantation. The proliferation of these new and complex therapies comes at a time when the costs of practicing medicine are growing, while Medicare reimbursement, accounting for inflation, is shrinking.

Furthermore, without positive updates to the MPFS conversion factor, the budget neutrality requirements exert even greater downward pressure on Medicare reimbursement and exacerbates the impression that specialties are pitted against one another when new codes are added to the MPFS, or a family of codes is recommended for an increase in valuation, due to the redistributive impacts for other payments under the MPFS. Therefore, ASH supports reform to the budget neutrality requirements including increasing the outdated budget neutrality threshold of \$20 million and encourages Congress to consult with health economists to determine the most appropriate update. Additionally, Congress should provide an increase every 5 years equal to the cumulative increase in the Medicare Economic Index (MEI). By raising the threshold in this manner, redistribution of funds across the MPFS will be more equitable, preempting a cycle of drastic cuts to the conversion factor when new services are added to the MPFS or when high-volume services, like evaluation/management (E/M) services, are revalued.

¹ Go LT, Go LT, Gunaratne MDSK, Wolanskyj-Spinner AP, Ashrani AA, Elliott MA, Godby RL, Hook CC, Padmos LJ, Pruthi RK, Rivera CE, Rouse RL, Shah S, Shaikh ME, Siddiqui MA, Sridharan M, Wysokinska EM, Go RS, Abeykoon JP. Assessment of classical hematologists and classical hematology fellowship programs at NCI-designated cancer centers. *Blood Adv*. 2025 Oct 28;9(20):5343-5346. doi: 10.1182/bloodadvances.2025016644. PMID: 40795177; PMCID: PMC12597626.

Taken together, rising administrative burden and continued erosion in Medicare physician payment are accelerating workforce shortages in hematology and other cognitive specialties. These pressures discourage trainees from entering the field, push experienced physicians toward early retirement or reduced clinical hours, and threaten the sustainability of community-based practices that care for aging and medically complex patients. As access to specialized hematology services declines, patients face longer wait times, fragmented care, and delayed diagnosis and treatment.

To meaningfully address workforce shortages, ASH urges Congress to pursue policies that stabilize and strengthen the physician workforce by ensuring predictable, inflation-adjusted Medicare payment updates, reducing unnecessary administrative burden, and modernizing statutory constraints that limit care delivery innovation. Without action to address these underlying drivers, workforce shortages will continue to worsen, undermining access to high-quality, timely care for Medicare beneficiaries.

Thank you for the opportunity to provide these comments. ASH looks forward to working with the Committee to address administrative and regulatory burdens that contribute to physician burnout and workforce shortages and protect aging adults' access to timely, high-quality care. Should you have any questions or wish to discuss these issues further, please contact Carina Smith, ASH Health Care Access Policy Manager, at casmith@hematology.org.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

American Society of Retina Specialists Statement

Statement for the Record

U.S. Senate Special Committee on Aging

Hearing: "The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine"

Submitted by the American Society of Retina Specialists (ASRS)

February 11, 2026

Chairman Scott and Ranking Member Gillibrand,

The American Society of Retina Specialists (ASRS) appreciates the Committee's focus on the physician workforce crisis and the federal policies that threaten the viability of independent physician practices.

ASRS is the largest retina organization in the world, representing over 3,500 board certified ophthalmologists who have completed fellowship training in the medical and surgical treatment of retinal diseases. The mission of the ASRS is to provide a collegial open forum for education, to advance the understanding and treatment of vitreoretinal diseases, and to enhance the ability of its members to provide the highest quality of patient care.

Retina specialists deliver critical, highly specialized care for patients with vision-threatening conditions such as age-related macular degeneration (AMD), diabetic retinopathy, and retinal detachments. These diseases predominantly affect Medicare beneficiaries, making Medicare payment and oversight policies central to practice sustainability and patient access. Our comments here focus on strategies to strengthen the Medicare program so retina specialists can continue to deliver sight-saving care. Our key recommendations include:

- **Establish predictable annual Medicare physician payment updates tied to the Medicare Economic Index (MEI)** to reflect the real costs of delivering care and stabilize practice viability.
- **Raise the threshold that triggers budget neutrality adjustments** to reduce arbitrary payment cuts unrelated to clinical service value.
- **Reverse the Centers for Medicare and Medicaid Services (CMS) implementation of the 2026 efficiency adjustment and reductions in practice expense valuations** that threaten procedural specialists.
- **Encourage CMS to establish an Ophthalmic Emergency Activation policy** under the Hospital Outpatient Prospective Payment System (OPS) and Ambulatory Surgical Center (ASC) payment system to support standby operating room capacity for vision-threatening emergencies.
- **Reform quality reporting programs** such as MIPS to meaningfully improve outcomes while reducing unnecessary administrative burden.

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- **Strengthen federal oversight of Medicare Advantage utilization management** by curbing inappropriate step therapy and prior authorization barriers for medically necessary care.
- **Establish a statutory out-of-pocket (OOP) cap for physician-administered drugs under Medicare Part B** to align beneficiary financial protections with those already in place under Part D.

Our full comments on these recommendations are below.

Federal Payment Policies Driving Physicians Out of Independent Practice

Medicare Physician Payments Lag Inflation

Foundational to ensuring retina specialists can continue to provide care to patients in community-based practices is adequate Medicare physician reimbursement. Retina specialists need the support of specialized staff and must invest in equipment to keep their practices functioning. They have increasingly struggled to do that, however, with Medicare reimbursements that not only do not keep up with inflation but have been cut year after year.

According to the AMA, retina specialists are not the only physicians facing this issue. Over the last two decades, national data show that Medicare physician payment rates have declined by approximately 33% from 2001 through 2025 on an inflation-adjusted basis, even as practice costs continue to rise. Research indicates that physician payments have lost ground relative to the Medicare Economic Index (MEI) and broader inflation, contributing to financial strain on physician practices.¹ For retina specifically, average reimbursements in real dollars for the most commonly performed procedures fell 8.2% between 2011 and 2020, or 20.7% adjusted for inflation.² **ASRS strongly supports aligning physicians with other Medicare providers and implementing an inflation-based annual update to the physician fee schedule (PFS).**

Arbitrary Budget Neutrality Cuts Compound Reductions

Coupled with the lack of stable, annual updates, budget neutrality requirements in the PFS force CMS to redistribute payments across services when valuations change, leading to unpredictable cuts unrelated to clinical value. This has compounded the decline in physician payment across specialties, including retina care, and threatens practice sustainability. ASRS continues to urge Congress to raise the threshold that triggers budget neutrality adjustments.

Efficiency Adjustment and Practice Expense Reductions Threaten Surgical Access and Independent Retina Practices

ASRS strongly opposes two Medicare policies CMS implemented for 2026: the arbitrary 2.5% efficiency adjustment and reductions to indirect practice expense payments, which together significantly reduce

¹American Medical Association; "Updated AMA Analysis: Medicare Physician Payment Continues to Lag," *Medicare Payment Reform Advocacy Update*; January 30, 2026, <https://www.ama-assn.org/health-care-advocacy/advocacy-update/jan-30-2026-medicare-payment-reform-advocacy-update>

²DeRuyter NP, Patel S, Chen Q, Leder H, Leung E, Reddy R, Blim J, Awh CC, Hahn P; Health Economics Committee, American Society of Retina Specialists. Trends in Medicare Reimbursement for Common Vitreoretinal Procedures: 2011 to 2020. *Ophthalmology*. 2022 Jul;129(7):829-831. doi: 10.1016/j.ophtha.2022.01.019. Epub 2022 Jan 24. PMID: 35085660.

reimbursement for retina procedures without evidence that care delivery has become less resource-intensive. These policies risk reducing patient access to vision-saving surgery and accelerating the loss of independent physician practices.

Efficiency Adjustment Ignores Clinical Reality and Patient Complexity

Retina surgery already operates at near practical efficiency limits due to the complexity and unpredictability of retinal disease. While surgeons gain efficiency early in their careers, improvements typically plateau after several years. The current Relative Value Scale Update Committee (RUC) process already accounts for these improvements by surveying physicians across career stages and valuing services conservatively. CMS' across-the-board efficiency reduction bypasses this evidence-based process and assumes uniform efficiency gains across all specialties and procedures.

Retinal detachment repair illustrates the limitations of further efficiency gains. Cases complicated by proliferative vitreoretinopathy (PVR) or giant retinal tears require substantially longer and more technically demanding surgery. A study of more than 700 retinal detachment cases found these complex cases required an additional 20 to 30 minutes of operating time on average.³ Evidence also shows that delayed surgical treatment increases disease severity and complication rates, requiring more complex and prolonged procedures.⁴ Payment policies that reduce surgical capacity risk worsening outcomes and increasing downstream Medicare costs.

Recently introduced bipartisan legislation in the House, the Efficiency Adjustment Delay Act (H.R. 7520), will prevent these negative impacts by delaying implementation of the efficiency adjustment and requiring CMS to conduct a comprehensive, evidence-based evaluation with meaningful consultation with physician specialties before any future adjustment is considered. We recommend Senators introduce and act on similar legislation.

Practice Expense Reductions Misrepresent Retina Practice Costs

CMS' reduction of indirect practice expense payments assumes that physicians increasingly work in hospital settings and therefore no longer incur office overhead costs. However, workforce data contradicts this assumption. The 2025 ASRS Preferences and Trends (PAT) Survey found that more than 76% of U.S. retina specialists remain in office-based practice.⁵ Similarly, AMA benchmark data shows ophthalmology has the highest private practice participation of any specialty at approximately 70%.⁶

Retina specialists continue to incur substantial indirect costs regardless of where procedures are performed. These costs—including rent, technology infrastructure, compliance requirements, and billing operations—have risen sharply in recent years. Staffing costs have been particularly significant. One large retina practice reported that staffing costs increased by 63% between 2019 and 2024, with annual turnover exceeding 30%. Another practice reported a 26% increase in employee benefit costs during the

³ Angermann R, Huber AL, Hofer M, et al. Efficiency benchmarks in the surgical management of primary rhegmatogenous retinal detachment: a monocentric register cohort study of operating room time metrics and influential factors. *BMJ Open* 2021;11:e052513. doi:10.1136/bmjopen-2021-052513

⁴ Awad M, Poostchi A, Orr G, et al. Delayed presentation and increased prevalence of proliferative vitreoretinopathy for primary rhegmatogenous retinal detachments presenting during the COVID-19 pandemic lockdown. *Eye* 2021;35:1282–1283. <https://doi.org/10.1038/s41433-020-1056-0>

⁵ American Society of Retina Specialists, 27th Annual Preferences and Trends Survey, July 2025, <https://www.asrs.org/clinical/pat-survey>

⁶ American Medical Association, Physician Practice Benchmark Survey, June 2025, <https://www.ama-assn.org/about/ama-research/physician-practice-benchmark-survey>

same period. Smaller practices report increasing difficulty competing with hospital wage levels despite annual salary increases.

At the same time, demand for office-based treatment has grown rapidly. Anti-vascular endothelial growth factor (anti-VEGF) therapy has become the primary treatment for age-related macular degeneration and diabetic retinopathy, requiring retina practices to maintain expanded clinical and administrative staffing. Some practices now employ more than 15 staff members per physician to manage patient volume, safety requirements, and payer authorization processes.

Reducing indirect practice expense payments for surgical care creates a financial disincentive for retina specialists to perform urgent surgery. Retina physicians must frequently leave fully scheduled clinics treating chronic disease to perform emergency procedures such as retinal detachment repair. If reimbursement reductions cause surgical care to operate at a financial loss, physicians may be forced to reduce surgical availability, placing patient vision at risk.

There is some evidence that this may begin to occur soon. The 2026 PAT survey is currently in the field and early results indicate that because of these practice expense reductions, nearly 40% of respondents are considering changes to their practice patterns or structure including, reducing surgical volumes, retiring early, or selling to a corporate entity or health system. CMS indicated in the 2026 PFS final rule that this policy was intended to maintain independent practices, but in reality, it will have the opposite effect. We urge Congress to act and reverse this harmful payment reduction.

Inadequate Medicare Reimbursement Threatens Beneficiary Access to Retina Surgical Care

Medicare payments to hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) do not adequately cover the standby resources required to respond to ophthalmic emergencies such as retinal detachment, open globe injuries, intraocular foreign bodies, and endophthalmitis, creating access challenges for beneficiaries whose vision is acutely threatened.

When these emergencies arise, ophthalmic surgeons must scramble to identify a willing hospital or ASC, secure operating room time, and abandon scheduled patients to provide unscheduled surgical care. According to ASRS's 2025 Preferences and Trends Survey (PAT) survey, more than 71% of retina specialists reported difficulty accessing sufficient operating room time, particularly for urgent procedures such as retinal detachment repair.⁷

A primary driver of this access problem is inadequate reimbursement for ophthalmic emergencies. Under the CY 2026 Hospital Outpatient Prospective Payment System (OPPS), Medicare payment rates fall approximately \$659 below cost for retinal detachment repair (CPT 67108) and \$262 below cost for complex retinal detachment repair (CPT 67113). In fact, a 2024 cost analysis found that retinal detachment procedures repairs requiring scleral buckling had a mean cost of \$7,674.64—approximately \$2,200 higher than Medicare payment, demonstrating the magnitude of underpayment for these

⁷ American Society of Retina Specialists, 27th Annual Preferences and Trends Survey, July 2025, <https://www.asrs.org/clinical/pat-survey>

emergency services.⁸ Additional time-driven activity-based costing studies consistently show retinal detachment surgeries are frequently performed at a loss across care settings.^{9, 10, 11} The financial risk to ASCs is even greater: even assuming ASC costs are 30% lower than HOPDs, Medicare payment rates are approximately \$1,200 below the estimated cost for emergency retinal detachment repairs.

When Medicare payment rates fall significantly below the cost of care, community hospitals and ambulatory surgical centers are less willing to maintain standby operating room readiness or accept unscheduled emergency cases, and may limit access for complex or lower-margin patients. As community capacity diminishes, ophthalmic emergencies are increasingly concentrated at tertiary hospitals and Academic Medical Centers (AMCs) that are already operating under significant capacity constraints. For example, a study conducted at Bascom Palmer Eye Institute at the University of Miami Miller School of Medicine found that retinal detachment surgery volumes grew to approximately 240% of its 2018 level by 2025 – outpacing local population growth and physician staffing, and illustrating the growing concentration of emergency retinal care at tertiary centers.¹² This centralization contributes to delays in time-sensitive, vision-saving surgery and forces many beneficiaries to travel long distances for care, often requiring overnight stays and repeated travel for post-operative follow-up. At the same time, retina specialists face escalating call demands, workflow disruption, and moral distress when unable to secure timely care for patients, all of which contribute to workforce strain in a specialty already managing high emergency coverage obligations.

Unlike trauma care, where Medicare recognizes the costs of rapid-response readiness through a trauma activation payment, no analogous mechanism exists for ophthalmic emergencies. To address this gap, ASRS has proposed an Ophthalmic Emergency Activation (OEA) policy option to preserve operating room access at remaining community HOPDs, support AMCs that are absorbing this care, and encourage ASCs to make operating room capacity available for these cases. **We request that the Committee encourage CMS to establish an OEA policy using its existing regulatory authority to preserve timely access to vision-saving emergency care.**

MIPS Contributes to Physician Burnout Without Improving Retina Care

The Merit-based Incentive Payment System (MIPS) imposes significant administrative burden on retina specialists without evidence that it improves patient outcomes. Since the implementation of MACRA, retina specialists have consistently performed well under MIPS; however, this achievement largely reflects reporting on measures that are not clinically meaningful to retina care. Participation requires

⁸ Blumenthal J, Meshkin RS, Hoyek S, Feng Y, Patel NA. Operative Times in Scleral Buckle Surgery: Influencing Factors and Cost Analysis. *J Vitreoretin Dis.* 2024;9(1):18-25. Published 2024 Nov 22. doi:10.1177/24741264241293904

⁹ Haliyur R, Portney DS, Pan WW, Mian SI, Rao RC. Cost drivers of pars plana vitrectomy for retinal detachment: time-driven activity-based costing analysis. *J Vitreoretin Dis.* 2025;9(1): 11-17.

¹⁰ Hwang MW, Bommakanti N, Young BK, Besirli CG. Time-drive activity-based cost analysis of pars plana vitrectomy in rhegmatogenous retinal detachment at a large academic center. *J Vitreoretin Dis.* 2025;9(1):26-30.

¹¹ Berkowitz ST, Sternberg P Jr, Patel S. Cost analysis of routine vitrectomy surgery. *Ophthalmol Retina.* 2021;5(6):496-502.

¹² Berrocal AM, Zhang C. The centralization of emergent retina surgery: causes and consequences. *Retina Times.* Winter 2025. American Society of Retina Specialists. <https://www.asrs.org/publications/retina-times/details/6484/the-centralization-of-emergent-retina-surgery-causes-and-consequences>.

substantial physician and staff time, costly reporting infrastructure, and ongoing administrative effort—resources that could otherwise be devoted to patient care.

Uniformly high performance on existing MIPS measures suggests that retinal care is already delivered at a consistently high standard nationwide. Once physicians demonstrate adherence to established consensus standards, continued annual reporting becomes a repetitive administrative exercise rather than a quality improvement tool. This dynamic contributes directly to physician burnout and disproportionately burdens small and independent practices that lack the administrative capacity of large health systems.

Retina specialists are actively engaged in advancing clinical care through research and innovation, yet MIPS does not reflect the pace or complexity of these advances. Measures should only evolve when there is clinical consensus that standards of care have changed. Absent evidence of meaningful gaps in retinal care, across-the-board reporting requirements add strain to the workforce without improving outcomes.

ASRS urges Congress to direct CMS to refocus the Quality Payment Program on identifying real gaps in care and addressing structural or systemic barriers that delay or prevent access to timely retinal treatment. Quality improvement should shift away from broad reporting mandates and toward targeted, clinically valid interventions proven to improve outcomes. Reducing unnecessary administrative burden within MIPS is an essential step toward retaining physicians in practice and preserving patient access to vision-saving care. CMS' attempts at improving or streamlining the program have been largely unsuccessful with half-measures such as the "MIPS Value Pathways" (MVP) that retain the rigid reporting structure and, in the case of the ophthalmology-focused option, inappropriately group and compare sub-specialists who are taking care of different patient populations. A full re-imagining of the program is warranted.

Inadequate Oversight of Medicare Advantage Plans Burdens Physicians and Patients

As enrollment in Medicare Advantage (MA) grows—now covering more than half of all Medicare beneficiaries—plan utilization management policies increasingly drive care delivery, often without sufficient federal standards to protect access to clinically appropriate care. Most frequently, plans have mandated step therapy, or "fail first" protocols—and MA beneficiaries with chronic retinal disease have taken the brunt of those demands. Currently, nearly every MA insurer requires beneficiaries that require intravitreal injections of anti-vascular endothelial growth factor (anti-VEGF) drugs for chronic diseases such as neovascular (wet) age-related macular degeneration and diabetic retinopathy to begin and fail treatment with bevacizumab, which is off-label and must be repackaged for ocular use, before covering an FDA-approved drug.

To provide care to these patients, retina specialists and their practice staff must jump through multiple hoops to determine the patient's plan's specifically required step therapy protocol and obtain prior authorization at each step. This leads to unnecessary delays in care that is almost always approved. A study of retina practices found that requests for authorization were approved 96% of the time. Yet the work involved in obtaining authorization amounted to a median time of 100 minutes of clinical staff time and more than half of patients experienced a delay in care.¹³ Beyond the unnecessary delay, these

¹³ Dang, et. al. "Anti-VEGF Pharmaceutical Prior Authorization in Retina Practices" *JAMA Ophthalmol.* 2024;142(8):716-721. doi:10.1001/jamaophthalmol.2024.2217

requirements disrupt the relationship and shared decision-making between physician and patient. They also contribute to burnout by constantly overruling the physician's clinical judgement.

To help alleviate the burden of payers' utilization management policies, we request Congress provide oversight of CMS to ensure necessary care is not being delayed or denied, and physician practices are not overly burdened with administrative demands. In addition, Congress should enact key pieces of bipartisan legislation that ASRS and others in the medical community have long supported:

- S. 2903, the Safe Step Act
- S. 1816, the Improving Seniors' Timely Access to Care Act

While these bills do not eliminate insurers' ability to impose utilization management, they are an important first step in establishing patient protections and rights to repeal step therapy decisions, as well as streamlining and providing transparency on the prior authorization process.

Establishing a Part B Drug Out-of-Pocket Cap

Many Medicare beneficiaries rely on physician-administered prescription drugs covered under Part B to treat complex, chronic conditions, exposing them to high out-of-pocket (OOP) costs for these therapies. These drugs include infused cancer treatments, biologics for autoimmune disorders, and injectable therapies for retinal conditions such as age-related macular degeneration.

Unlike prescription drugs covered under Part D, which are subject to a statutory annual OOP cap, no comparable protections exist for physician-administered drugs under Part B. In Original Medicare, beneficiaries are responsible for 20% coinsurance with no annual maximum, and because cost-sharing is due at the time of administration, patients without supplemental coverage (i.e., Medigap) may face thousands of dollars in OOP costs for their Part B drug after a single visit. Beneficiaries enrolled in Medicare Advantage (MA) also face substantial financial exposure, as the overall Part A and Part B OOP limit is significantly higher than the Part D drug cap.

In its June 2012 *Report to the Congress*, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress address substantial financial risk facing beneficiaries under Part B and has continued to highlight the need for benefit design reform, including during the current 2025–2026 cycle. Building on MedPAC's recommendation, ASRS has proposed a statutory OOP cap for Part B drugs – similar to the Part D cap – to protect beneficiaries that rely on physician-administered drugs to manage chronic conditions from catastrophic costs. Not only would this promote more consistent financial protections across Medicare programs, it would also alleviate a burden on physician practices that are too often placed in the position of explaining and managing unaffordable drug costs that they do not control.

Aligning financial protections for physician-administered drugs under Part B with those already established under Part D would correct a gap in Medicare's benefit design and serve as a meaningful “on-ramp” toward broader Part B reforms. **ASRS urges Congress to consider legislation establishing a statutory out-of-pocket cap for Part B drugs to ensure consistent beneficiary protection across Medicare programs while allowing physicians to focus on providing the individualized care each patient needs.**

Conclusion

Thank you again to the Committee for holding this hearing and investigating the effect Washington's policy decisions are having on physicians and their patients. These federal payment trends and utilization management practices have real consequences for the physician workforce. National studies have documented that independent physician practices are consolidating or shifting to hospital or corporate employment due in part to payment inadequacy and administrative burdens—trends making independent practice increasingly untenable. This consolidation reduces patient choice, increases overall system spending, and can limit timely access to retina care—especially in rural and underserved communities. Vision loss from inadequate access to retina care has broad public health implications. Delays or barriers to treatment for AMD, diabetic retinopathy, and other retinal diseases increase the risk of irreversible vision loss, fall risk, depression, and loss of independence among older adults.

We urge the Committee to continue this line of inquiry and begin work on the recommendations we have made above so those negative outcomes do not come to pass. If you have questions or need additional information, please contact Allison Madson, vice president of health policy, at allison.madson@asrs.org.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

Primary Care Collaborative Statement

**Statement for the Record
by the
Primary Care Collaborative
for the
Senate Special Committee on Aging
on
"The Doctor Is Out: How Washington's Rules
Drove Physicians Out of Medicine"**

February 18, 2026

On behalf of the Primary Care Collaborative (PCC), thank you for the committee's attention to how federal regulations and administrative burdens contribute to burnout of physicians, advanced practice practitioners and all members of the primary care team.

The PCC is a nonprofit, nonpartisan, multi-stakeholder coalition of 66 organizational members, including clinicians, patient advocates, employer groups, and health plans. PCC members are dedicated to a high-quality health care system rooted in primary care, with a focus on comprehensive, ongoing relationships and addressing underlying factors to enhance patient experience and health outcomes.

The Problem

Primary care clinicians in the United States are increasingly strained by nonclinical work. Rising regulatory complexity and administrative demands are steadily siphoning time away from direct patient care and intensifying burnout. Primary care carries the frontline responsibility for managing chronic disease, coordinating care across specialists and navigating transitions of care. These care management responsibilities are rarely reimbursed and often invisible to patients, but they are essential to improving patient outcomes. Evidence shows that an ongoing primary care relationship is vital to improving population health outcomes; nearly all adults (95.5%) with a usual source of primary care received preventive services for chronic disease, compared to 67.6% of those without a usual source of primary care.¹ For those living with a chronic disease, having a usual source of primary care was associated with a nearly 54% reduction in total health care expenditures, and reduced the odds of hospitalization by 20%.²

¹ Milbank Memorial Fund, "Investing in Primary Care: The Missing Strategy in America's Fight Against Chronic Disease; 2026 Primary Care Scorecard." Available [online](#).

² *Ibid.*

Primary care is uniquely exposed to administrative burden. Compared to many specialists, primary care clinicians shoulder a disproportionate share of documentation, compliance and care coordination tasks, frequently with fewer support resources and lower compensation. The result is a growing mismatch between what primary care is asked to deliver and what clinicians are equipped to sustain.

Administrative pressure is also being driven by increasingly complex, often misaligned requirements across payers. These include growing prior authorization demands, unaligned quality reporting requirements that do not add value and inefficient electronic health records that too often add steps instead of streamlining care. This pressure is exacerbated by chronic underinvestment in primary care, which limits practices' ability to hire staff, modernize workflows or reroute routine administrative tasks.

There are systemwide benefits when quality measures are evidence-based, standardized and publicly reported. To be effective, however, the federal government and payers must act to streamline and align metrics, avoid duplication and unnecessary measurement burden, and incorporate new measures that better reflect the value of primary care.

This is not a clinician resilience problem; it is a system design problem that is rationing the time clinicians can spend with patients.

The PCC's Solution

Burnout is being driven, in large part, by inefficient workflows and unaligned data requests that pull time and practice resources away from the patient. When considering legislative reforms to address administrative burden, the PCC respectfully urges lawmakers to:

- Correct the historic under-reimbursement of primary care and remove barriers to whole-person primary care. (For more on needed payment reform, see the PCC's [response to a recent RFI from the House GOP Doctors Caucus and Congressional Doctor's Caucus](#))
- Transition to payment and delivery models that support advanced primary care (e.g., hybrid payment or primary care-centric ACOs) to help sustain primary care relationships and improve health outcomes, and ensure rural, independent and small practices are able to participate.
- Streamline metrics, avoid duplication and unnecessary measurement burden, and incorporate new measures that better reflect the value of primary care. Federal programs — Medicare, Medicare Advantage, and Medicaid — must harmonize measures while assuring appropriateness for the reporting entities

and populations served. If Medicare and Medicaid use their authorities to standardize and streamline processes, this will help other payers follow suit and adopt simplified and standardized features in the commercial insurance market.

- When primary care practices participate in APMs with accountability for population outcomes and costs, they should be provided relief from documentation demands and regulatory “safe harbors,” such as waivers of audits or other oversight.
- Utilize health information exchanges (HIEs) to improve care coordination, enhance patient safety and reduce service duplication and direct the Department of Health and Human Services (HHS) and the subagencies to offer clearer guidance and stronger enforcement of information-blocking rules so data can move predictably and safely.
- Enable responsible adoption of artificial intelligence (AI) with risk-based oversight that distinguishes background automation from semi-autonomous decision tools. Any use of AI tools must facilitate and support the ongoing partnership between and among a patient, their caregivers, a primary care clinician and the broader care team — the exact continuity of care relationship that drives improved outcomes and lower costs.^{3 4}

³ Otto R. Maarsingh, “The Wall of Evidence for Continuity of Care: How Many More Bricks Do We Need?,” *The Annals of Family Medicine* 22, no. 3 (May 1, 2024): 184–86, <https://doi.org/10.1370/afm.3116>.

⁴ Dilara Sonmez, George Weyer, and Daniel Adelman, “Primary Care Continuity, Frequency, and Regularity Associated With Medicare Savings,” *JAMA Network Open* 6, no. 8 (August 21, 2023): e2329991, <https://doi.org/10.1001/jamanetworkopen.2023.29991>.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

Regulatory Relief Coalition Statement

*Protecting patients' timely access to care.*

February 10, 2026

The Honorable Rick Scott
Chairman
Committee on Aging
United States Senate
G16 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Kirsten Gillibrand
Ranking Member
Committee on Aging
United States Senate
G16 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Scott and Ranking Member Gillibrand:

On behalf of the Regulatory Relief Coalition (RRC), a coalition of national physician specialty organizations seeking to reduce regulatory burdens that interfere with patient care, we welcome the Senate Committee on Aging's February 11, 2026, hearing, titled "The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine".

This hearing presents an excellent opportunity to examine the significant administrative burdens imposed by prior authorization and the resulting increase in physician burnout, an issue that the RRC has long advocated addressing through the *Improving Seniors' Timely Access to Care (Seniors') Act* (S. 1816). We also applaud the Committee for selecting Jeffrey Smith, CPA, MBA, FACMPE, CGMA, Incoming Board Chair of the Medical Group Management Association (MGMA), as a witness, as MGMA is a valued member of the RRC and brings critical expertise on how regulatory burdens affect physician practices.

The *Seniors' Act* would modernize and streamline the prior authorization (PA) process for over 35 million Americans currently enrolled in Medicare Advantage (MA) plans, and it stands as the most widely supported and endorsed zero-cost health care bill in the 119th Congress. The bill's broad support is reflected in its [65](#) Senate cosponsors and [255](#) House cosponsors, including a majority of this Committee (7). We applaud you and your Committee members for your strong leadership on this critical issue. Additionally, more than [300](#) organizations representing patients, health care physicians and other clinicians, the medical technology and biopharmaceutical industry, health plans and other organizations have endorsed the bill.

Regulatory burdens, including abusive PA practices by MA plans, increase administrative red tape, present serious physician workflow challenges, and contribute significantly to physician and other clinician burnout. These burdens divert physicians' time and resources away from direct patient care and can delay medically necessary treatment. The 2024 American Medical Association (AMA) Prior Authorization Physician Survey¹ demonstrates these impacts, finding, among other things, that:

¹ [AMA prior authorization \(PA\) physician survey | AMA](#)

Senate Committee on Aging Chair Scott and Ranking Member Gillibrand
 RCC Letter RE Hearing "The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine"
 February 10, 2026
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- 89% of physicians report that PA somewhat or significantly increases physician burnout;
- Physicians and their staff spend an average of 13 hours each week competing PAs;
- Practices complete an average of 39 PAs per physician, per week with 40% of physicians having staff who work exclusively on PA;
- 93% of physicians report that PA always (15%), often (42%), or sometimes (36%) delays access to necessary care.

Enacting the *Seniors' Act* has the potential to significantly reduce administrative burden while improving health care outcomes. Research clearly demonstrates that the delays and denials resulting from onerous PA requirements are hurting medical practices and reducing quality of care for patients. For example, a 2023 MGMA survey² found the following:

- 89% of medical practices find prior authorization "very or extremely burdensome."
- 92% of medical practices "hired or redistributed staff to work on prior authorization due to the increase in requests."
- 83% of practices said a top challenge is prior authorization for routinely approved items and services.
- 97% of medical practice reported that patients "experienced delays or denials for medically necessary care due to prior authorization requirements."

Physician practices are also experiencing challenges getting paid for pre-approved services, as some health plans are refusing to pay claims or are recouping payments after approved health care services have been rendered. For example, a neurosurgical practice recently analyzed its claims to determine the scope of the post-service payment recoupment process, discovering more than \$3 million in payment denials and/or recoupments over a 2 ½ year period. The combination of administrative costs and lack of payment is a one-two punch — a significant contributor to physician burnout and a catalyst for increased health care consolidation as physicians can no longer remain in independent practice in the face of these administrative burdens.

Prior authorization delays exacerbate physician burnout and disrupt clinical workflows, ultimately compromising patient care. Reducing these administrative burdens is critical to supporting physicians and ensuring patients receive timely, medically necessary treatment.

The RRC looks forward to assisting you with this and other initiatives aimed at reducing regulatory burden. Please contact Peggy.Tighe@PowersLaw.com or Natalie.Keller@PowersLaw.com with any questions. Thank you for considering our views.

² [2023 MGMA Regulatory Burden Report FINAL](#)

Senate Committee on Aging Chair Scott and Ranking Member Gillibrand
RCC Letter RE Hearing “The Doctor Is Out: How Washington’s Rules Drove Physicians Out of Medicine”
February 10, 2026
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Sincerely,

RRC Members

American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Osteopathic Association
Association For Clinical Oncology
Congress of Neurological Surgeons
Heart Rhythm Advocates
Medical Group Management Association
Society for Cardiovascular Angiography & Interventions

RRC Allies

American Podiatric Medical Association
The National Association for Proton Therapy

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

Ryan McClenahan Statement

Ryan McClenahan
February 10, 2026

The United States Senate Special Committee On Aging
G16 Dirksen Senate Office Building
Washington, D.C. 20510

RE: How Washington's Rules are Still Driving Physicians Out of Medicine

Dear Senate Special Committee On Aging,

I am writing to you as a current medical student and a proud American who believes deeply in public service and in the values of discipline, sacrifice, and individual responsibility. I also write as someone who is grateful for your leadership for our nation, and especially for your unwavering advocacy for healthcare and constitutional governance.

I want to first express my appreciation for your work on and attention to the challenges the great physicians of this country are facing. It is a step toward restoring responsibility, reining in unnecessary federal oversight, and ensuring that the next generation inherits a freer, stronger, and more sovereign America.

That said, I hope you will consider this letter as a concerned voice from within our field that is still facing an unfit and broken system, due much in part by Washington's rules. Specifically, I would like to raise awareness about how the new federal graduate loan caps, financial aid restrictions, and lack of support for increasing residencies unintentionally harm the very future physicians we will rely on to care for our country, especially our aging and underserved populations. This, in turn, is creating future generations of physicians at increased susceptibility of marginalization, burnout, and withdrawal from the art of medicine.

Under the new loan limits, thousands of medical students—especially those enrolled in private medical schools and osteopathic (D.O.) programs—face unprecedented financial challenges. We students often rely heavily on federal graduate loans to cover the full cost of tuition, living expenses, and other essential costs during our training as employment to cover bills is not an option while in our studies. Unfortunately, the new graduate loan caps fall significantly short of the actual cost of attendance at many of these institutions, which frequently charge higher tuition than public schools. As a result, us students will be left with two difficult choices: take on private loans that come with substantially higher interest rates and less borrower protection or face the risk of abandoning our medical education altogether. This creates a dangerous financial barrier that may discourage talented and committed individuals from pursuing careers in medicine, particularly those from modest or working-class backgrounds.

The rapidly growing field of osteopathic medicine is integral to our healthcare system, especially in providing primary care and serving rural and underserved communities, those who are the backbone of this great country. Osteopathic students, who make up a vital portion of the future physician workforce, are disproportionately affected by these restrictions. Our schools often lack the same level of federal and state support enjoyed by many allopathic programs, leading to

higher tuition costs that exceed the new loan limits. This will lead to a reduction in D.O. physicians just as the nation increasingly depends on our contributions to meet growing healthcare needs. Furthermore, the rising cost of living, especially in the cities where many residency programs are located, compounds the financial strain. Medical students and residents often find themselves juggling intense workloads with financial stressors, including housing, food, and transportation costs that continue to climb faster than wages or stipends.

While it is reasonable and necessary to encourage medical schools to control tuition growth and improve cost transparency, these reforms will take time to implement. In the interim, students bear the brunt of the financial squeeze. The result is a precarious situation where future physicians enter the workforce burdened by overwhelming debt, with fewer financial resources available to support their training. This threatens not only individual careers but also the stability of the entire healthcare system as fewer qualified candidates are able to afford to enter or complete medical training.

Additionally, current loan repayment plans are often ill-suited for residents who earn relatively modest stipends while working understandably demanding schedules, making managing debt repayment an ongoing struggle. More flexible, residency-friendly repayment options would greatly alleviate this pressure.

Moreover, residency programs and teaching hospitals continue to generate substantial revenue from the labor of residents, often funded through significant government Graduate Medical Education (GME) subsidies. Medicare alone pays out an estimated \$12-\$14 billion annually to support GME programs, yet residents are compensated modestly despite their critical contributions. There is limited transparency or accountability regarding how these government funds are used, allowing institutions to benefit financially while residents face significant financial challenges—a dynamic that raises concerns about fairness and sustainability.

At the same time, the number of medical schools and medical student enrollment has steadily increased across the country, expanding the pipeline of future physicians prepared to serve the American people. However, residency positions have not expanded at the same pace, in part due to longstanding federal funding structures and statutory caps established through Medicare Graduate Medical Education (GME) policy. These policies, while originally intended to ensure responsible stewardship of taxpayer dollars, have unintentionally limited hospitals' ability to create new residency positions despite clear and growing workforce needs. As a result, a bottleneck has formed between medical education and independent practice, leaving qualified graduates competing for a limited number of training opportunities. Additionally, because resident physician compensation is closely tied to federally structured GME funding formulas, resident salaries have not consistently kept pace with inflation, rising living costs, or the increasing demands placed on trainees. Residents serve as essential frontline providers and contribute meaningfully to patient care and hospital operations, yet their compensation often reflects funding constraints rather than the full scope of their responsibilities. Thoughtful modernization of these federal policies could help ensure that residency growth and compensation more accurately reflect the needs of both patients and the physician workforce, strengthening the long-term stability and sustainability of American healthcare.

This is especially troubling when you consider that federal student loans for many undergraduate programs—often for degrees with no direct benefit to the public—are still fully subsidized or come with far lower costs, totaling billions of dollars of government waste. Meanwhile, future physicians, who will dedicate their lives to public service, pay steep interest from day one. This imbalance sends the wrong message and distorts national priorities.

If these trends continue, we risk shrinking our pipeline of American-trained physicians. Fewer students will be able to afford medical education. Those who do will increasingly avoid lower-paying but high-need specialties like family medicine, psychiatry, and OB-GYN that are significantly lacking in rural areas. This will be further exacerbated by osteopathic schools declining enrollment and increasing dropout rates. And over time, we will be forced to rely more heavily on internationally trained physicians to fill domestic gaps—not because of a lack of interest among Americans, but because of Washington’s direct actions creating barriers we failed to address. I want to be clear: I value the contributions of international doctors. However, if we neglect our own future generations of physicians, American healthcare will lose its self-sufficiency, and American patients will lose providers. In essence, American medicine will cease to be American.

Beyond workforce shortages, these policies and structural limitations are contributing to a growing crisis of physician burnout and attrition. Physicians are increasingly leaving clinical practice—not because of a lack of passion for medicine, but because of prolonged training, financial strain, administrative burden, and diminished professional autonomy. Many are choosing instead to create private businesses in consulting, medical education, technology, wellness, and entrepreneurship, seeking stability, independence, and sustainability outside of traditional clinical roles. While these physicians continue to contribute meaningfully to society, their departure from direct patient care represents a significant loss to the healthcare system. This trend reflects a deeper structural challenge in retaining highly trained professionals within clinical medicine. Thoughtful reforms that support physicians during medical school, training, and practice can help preserve the strength, stability, and longevity of the American healthcare workforce.

We need practical solutions—grounded in responsibility, sustainability, and less oversight—that will both protect taxpayers and invest in the future of our healthcare workforce. Service-linked interest relief programs, for example, could reward physicians who commit to practicing in rural or underserved areas by offering subsidized or reduced interest rates, tying federal and state support to measurable public benefit. Residency-friendly repayment plans could defer or cap payments based on a resident’s actual income, easing financial pressure during training years without increasing principal balances. States could be empowered to administer flexible aid programs or create tuition-matching incentives for students who pledge to serve in high-need communities. Transparency requirements for both medical schools and GME programs would encourage more responsible spending and ensure that government funds are being used to train—not exploit—our next generation of doctors. Additionally, incentivizing public-private partnerships to expand residency slots would allow for workforce growth without relying on federal expansion. These approaches promote efficiency, reward service, and ensure taxpayer dollars are used effectively—all without growing government bureaucracy or imposing unnecessary and unsightly federal control.

Now is the time to protect and strengthen the physician workforce and protect against the continued exodus of the people who we depend on every day. I ask for your leadership and support in ensuring that the next generation of physicians can train, serve, and thrive—without being penalized for choosing a life of service in medicine.

Thank you again for your continued leadership, and for all you do for our great country. I remain hopeful that with your guidance, we can make the necessary adjustments to protect future physicians and save American healthcare.

God Bless You and God Bless America,

Ryan McClenahan
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U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE DOCTOR IS OUT: HOW WASHINGTON'S RULES DROVE PHYSICIAN'S OUT OF MEDICINE"

FEBRUARY 11, 2026

STATEMENTS FOR THE RECORD

Society of General Internal Medicine Statement

Statement for the Record
 From the Society of General Internal Medicine
 For the Senate Special Committee on Aging
The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine
 Held on February 11, 2026

The Society of General Internal Medicine (SGIM) thanks the Senate Special Committee on Aging ("the Committee") for holding this hearing to discuss legislative reforms that would address the physician burnout and for the opportunity to submit this statement for the record. SGIM is a member-based medical association of more than 3,300 of the world's leading academic general internal medicine physicians, who are dedicated to delivering high-quality clinical care and improving access to care for all populations.

Access to timely, high-quality primary care is essential to healthy aging, effective management of chronic disease, and the sustainability of the Medicare program. Yet today, older adults across the country, particularly those in rural and underserved communities, are increasingly unable to find or retain a primary care physician. Inadequate and misaligned payment for primary care services is a central driver of this crisis. The administrative burden associated with delivering primary care services only exacerbates reimbursement issues.

Primary care physicians provide longitudinal, relationship-based care that is foundational to preventing avoidable hospitalizations, coordinating complex care, managing multiple chronic conditions, and addressing behavioral health needs. Despite this central role, Medicare payment policies systematically undervalue cognitive, non-procedural care. Evaluation and management or office visit services have failed to keep pace with inflation, rising practice costs, and the growing complexity of the care required by an aging population. As a result, many primary care practices operate on razor-thin margins, while physicians face increasing administrative burden and uncompensated work.

The consequences of this underinvestment are clear. Medical students are increasingly deterred from entering primary care, mid-career physicians are leaving practice or reducing clinical hours, and independent practices are closing or being absorbed into larger systems. For older adults, this translates into longer wait times, fragmented care, increased reliance on emergency departments, and worsening health outcomes.

Improving reimbursement for primary care services must be a central solution to reversing these trends. Medicare policy should better reflect the value of comprehensive, team-based primary care by:

- Strengthening reimbursement for evaluation and management services and other cognitive care using a technical expert panel or technical advisory committee as outlined in the *Pay PCPs Act of 2024* (S. 4338);
- Supporting prospective, per-beneficiary payments that recognize care coordination, chronic care management, behavioral health integration, and non-face-to-face work;
- Ensuring payment updates keep pace with inflation and practice costs; and
- Reducing administrative burden that diverts clinician time away from patient care as addressed in the *Improving Seniors Access to Timely Care Act of 2025* (S. 1816/H.R. 3514).

Importantly, investing in primary care is not only a workforce strategy. It is a fiscal and health improvement strategy. Robust evidence shows that strong primary care systems improve quality and lower total health care spending, particularly for older adults with multiple chronic conditions. Medicare cannot achieve its goals of better health outcomes and cost containment without a stable, well-supported primary care workforce. As the population ages, the need for accessible, comprehensive primary care will only grow. Addressing the payment inequities that drive physicians out of primary care is essential to ensuring that older Americans can receive the care they need, when and where they need it. We urge Congress to prioritize reforms that place primary care at the center of Medicare payment policy and recognize it as the backbone of care for older adults. To do this, Congress must realign Medicare's reimbursement incentives and reduce the administrative burden associated with delivering care, particularly office visits and related services, to support a primary care workforce that can meet beneficiaries' health care needs.

Thank you for your leadership and attention to this critical issue.