AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

May 23, 2024

The Honorable Jodey Arrington
Chairman
Budget Committee
U.S. House of Representatives
204 Cannon House Office Building
Washington, DC 20515

The Honorable Brendan Boyle
Ranking Member
Budget Committee
U.S. House of Representatives
507 Cannon House Office Building
Washington, DC 20515

Dear Chairman Arrington and Ranking Member Boyle:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write to thank you both for your bipartisan leadership in addressing issues impacting family physicians and their patients through today's hearing entitled "Breaking Up Health Care Monopolies: Examining the Budgetary Effects of Health Care Consolidation."

Family physicians – in fact, all physicians – are at their best when they are in service to their patients and communities, not the interests of institutions or corporations. Furthermore, the foundation of our health care system is the human interaction between patients and physicians inside exam rooms, not the business decisions made by executives in board rooms. However, consolidation has been rapidly accelerating over the last two decades, including within primary care, and in many instances has put what's "best" for business at odds with what's best for physicians and their patients.

A 2017 study found that from 2010 to 2016, the share of primary care physicians working in organizations owned by a hospital or health care system increased by a dramatic 57 percent – while the shares in independent solo practice or organizations owned by a medical group decreased.[i] A subsequent study published in 2020 found the share of primary care physicians affiliated with vertically integrated health systems increased from 38 percent to 49 percent from 2016 to 2018. In 2018, more than half of all physicians were affiliated with a health system.[ii]

However, Congress can take meaningful action to address these trends and advance policies that will support the success of practices of all sizes and ownership types, not just large practices owned by health systems and health plans with substantial capital. This includes policies such as:

- **Improving Medicare reimbursement for primary care and providing prospective, sustainable revenue streams to allow physicians to tailor their practices to their patients' needs;**
- **Reforming the administrative and regulatory compliance burden associated with Medicare's Quality Payment Program (QPP);**
- **Alleviating geographic payment differences that unfairly disadvantage rural practices;**

- **Addressing misaligned incentives such as site of service payment differentials that encourage consolidation;**
- **Minimizing payers' use of utilization management processes such as prior authorization and step therapy;**
- **Banning the use of overly-restrictive noncompete agreements that limit patient access to care; and**
- **Increasing federal regulators' enforcement authority of anticompetitive practices.**

What's Driving Consolidation in Primary Care?

Consolidation or private investment in primary care is not inherently bad. There is a tremendous amount of innovation taking place inside primary care, allowing primary care physicians to expand their capabilities, provide high-quality care to their patients and create a more rewarding practice environment. These new models are creating opportunities for primary care delivery organizations to not only survive but thrive as many of these groups bring important new resources to practices and are enabling primary care to be more readily available to historically underserved communities and populations. What distinguishes many of these organizations is that their revenue model is built primarily around expanding and investing in primary care – a space where our health care system has not performed well over the past several decades.

Many of the most successful primary care delivery innovations are led by primary care physicians. A growing body of evidence demonstrates that physician-led accountable care organizations (ACOs) achieve greater savings than their hospital-led counterparts.[iii] One key driver of success is primary care: more primary care physicians and visits lead to greater savings. Meanwhile, hospital-led ACOs may be unwilling to direct revenues away from hospital services to bolster primary care and perform better in ACO models.[iv]

The principal factors fueling the consolidation of primary care practices with health systems, plans, and other corporate entities are financial instability, staffing challenges, administrative burden, and the need for more resources and capital. Physicians are often forced to choose between the stability offered by health systems, payers, or other physician employers, and the autonomy and community focus of independent practice. **Increasingly, family physicians report that independent practice is simply unsustainable.** The available evidence supports their experiences: our current environment is driving and rewarding consolidation while at the same time draining resources from primary care.

Hospitals and corporate entities, including health plans and private equity, now own over half of physician practices (hospitals own 26.4 percent and other corporate entities own 27.2 percent). From 2019 to 2021, there was a 43 percent increase in the number of corporate-employed physicians and an 86 percent increase in the percentage of corporate-owned physician practices.[v] In 2021, UnitedHealth Group – which already owns the nation's largest commercial heath plan – became the largest employer of physicians in the country through its subsidiary company, Optum.[vi]

The proportion of family physicians who are employed continues to grow each year, with 73 percent of all AAFP members and 91 percent of new family physicians (one to seven years post-residency) working as employees in a wide range of organizations from small independent practices to Fortune 100 employers. This shift is dramatic considering only 59 percent of AAFP members reported being employed in 2011.

Providing high-quality, patient-centered primary care requires a multi-disciplinary team, technology that facilitates advanced data aggregation and population health analytics, and practice management staff to support functions such as patient communication, scheduling, and billing. All of this requires practices to make significant financial investments and commitments to remain competitive. While large health systems with revenue streams from multiple service lines may be able to afford these escalating practice costs, many independent primary care practices struggle to make ends meet as the physician payment system has failed to keep pace with the escalating demands and costs placed on primary care practices.

Many family physicians in independent practice report not taking home a paycheck themselves so that they could pay their staff and overhead expenses to keep the lights on. Ultimately, many of their stories end the same: they either close their doors or succumb to acquisition to avoid financial ruin, selling their practice for pennies. While some family physicians have reported positive experiences with being acquired by a health system or corporation, citing access to advanced tools and technology, additional administrative support, and other experts, many more physicians experience moral injury as they cope with loss of clinical autonomy and requests to prioritize organizational priorities over those of their patients.

The motivation behind the acquisition of primary care practices is the same for both hospitals and insurers – control of cash flow. Vertical integration can allow primary care to become a leverage point to maximize savings or profit somewhere upstream. For payers, controlling primary care allows them to oversee and manage care across a patient's care team and settings. For hospitals, it allows them to refer patients to their other employed specialists or seek treatments in their facilities that produce higher profit margins while also ensuring the patient's care (and costs) stay within a defined health system. In both situations, these organizations use primary care to meet other financial goals, redirecting revenue away from primary care and failing to invest in the primary care teams that patients benefit from most. Both hospitals and insurers are achieving their financial goals, but the patients and their primary care physicians, in many instances, are not benefiting from these financial windfalls.

There may be circumstances in which market integration is beneficial. However, the research on the impact of these trends and consolidation more broadly has become increasingly clear. **Evidence has shown integration leads to higher prices and costs, including insurance premiums, without improving quality of care or patient outcomes**.[vii] One study found that hospital-owned practices incurred higher per-patient expenditures for commercially insured individuals when compared to physician-owned practices.[viii]

Site-of-service payment differentials play a significant role in these inflated costs. Currently, hospitals are directly rewarded financially for acquiring physician practices and other lower cost outpatient care settings. Medicare and other payers allow hospitals to charge a facility fee for providing outpatient services that can be safely performed in the ambulatory setting. However, there is little evidence that these additional payments are reinvested in the acquired physician practice, many of which are primary care practices. Thus, the hospital increases its revenue by acquiring physician practices and beneficiaries are forced to pay higher coinsurance.[ix]

In March 2024, the AAFP conducted a survey of members requesting information about their experiences with health care consolidation. When asked specifically about the impact on compensation and benefits, responses were mixed, with 40 percent saying their compensation and benefits were somewhat or much better, 29 percent reporting no change, and 25 percent claiming compensation was worse or much worse after the transaction. Respondents who sold

their independent practice to a hospital generally felt compensation improved because their salary was now more reliable, compared to experiences in independent practice when they were unable to draw salary due to economic events (such as the COVID-19 pandemic or delayed payments, including the recent cyberattack on Change Healthcare). A 2021 study found that physicians in independent primary care practices acquired by a hospital or health system saw, on average, no difference in income after integration.[x]

The survey also asked about 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 and reduced job satisfaction**. 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 referrals outside the health system.
- 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**.[xi] Nearly half of survey respondents attributed the changes to reduced clinical autonomy and requirements that prioritize financial performance. The same survey found 61 percent of physicians felt they had moderate to low autonomy to make referrals to care outside the health system, which is reinforced by research showing hospital ownership of a physician practice dramatically increases the likelihood a patient will be admitted to the owning hospital.

Opportunities to Support the Future of Independent Medicine

Congress has the chance to reverse the concerning trends of consolidation in primary care by advancing policies that allow practices of all sizes to flourish. If we want to protect the viability of current and future independent family medicine practices, Congress must meaningfully overhaul how we pay for primary care, minimize administration burden, and reform our existing policy environment that is propelling consolidation.

Appropriately paying for primary care (and making it less burdensome)*:* One of the key drivers of financial instability for primary care practices is our nation's continued, systemic underinvestment in primary care. Evidence has shown time and time again that improving access to longitudinal, coordinated primary care reduces costs, improves utilization of recommended preventive care, and reduces hospitalizations. Yet only five to seven percent of our total national health care spending is on primary care.[xii] The consequences of this

underinvestment are particularly pronounced in rural communities which represent nearly two-thirds of primary care health professional shortage areas (HPSAs) in the country.[xiii]

In particular, the piecemeal approach fee-for-service (FFS) payment takes to financing primary care undervalues the whole-person approach integral to primary care and hinders the ability of family physicians to provide care in a way that is organic and responsive to their community. Primary care services are relatively undervalued in the Medicare Physician Fee Schedule (MPFS), which leads to further devaluation across virtually all other payers who peg their payment rates to Medicare's or use Medicare's relative values to set their rates.

The retrospective, volume-based nature of FFS also fails to account for the costs of longitudinally managing patients' overall health. It does not provide practices with the time and flexibility to invest in the care management staff and population health tools that enable practices to efficiently and effectively meet patients' individual evolving health needs.

In addition to primary care being undervalued, it is hard and confusing for physicians to get paid. A 2009 study found that physician practices collectively spend about $30 billion a year alone on administrative costs related to billing and coding.[xiv] One can assume that, when adjusted for inflation today, that number is significantly higher. To get paid, physicians must submit unique codes for each and every service they provide – documenting both what they did and why they did it. This is incompatible with the continuous, comprehensive nature of primary care which spans everything from basic preventive services to more complex services involving chronic care management, integrated behavioral health, and care coordination.

Every billing code has its own accompanying rules (some associated with the code set(s) and others created by Medicare and other payers) that govern when they may be reported either independently or in conjunction with other codes. This is true in almost any fee-for-service payment system, whether traditional Medicare, Medicare Advantage, or commercial insurance. Some research has concluded that creating additional billing codes for distinct activities in the MPFS may not be an effective strategy for supporting primary care, due to the burden associated with billing each one.[xv]

Rural communities are disproportionately impacted by insufficient FFS payments and the other pressure points fueling consolidation. They have smaller patient volumes that are older and more likely to have chronic illnesses, multiple health concerns, and be low-income. They see higher rates of uninsured and Medicare and Medicaid patients, meaning significantly lower payment rates and more expensive, uncompensated care. Because of the less-profitable patient population, studies have indicated that market concentration is higher in low-income areas.[xvi] For some rural practices and hospitals, the effects of consolidation may be different. Mergers and acquisition can play an important role in preserving existing sites of care (and oftentimes, the only site) with insufficient margins. However, it also often results in the closure of service lines not deemed highly profitable – including primary care – and may worsen access to care in these communities.[xvii]

For these reasons, **the AAFP has long advocated to accelerate the transition to value-based care using alternative payment models (APMs) that provide prospective, population-based payments to support the provision of comprehensive, longitudinal primary care**. We strongly believe well-designed APMs provide primary care a path out of the under-valued and overly burdensome FFS payment system that exists today, and in turn will better enable the Medicare program to meet the needs of its growing and aging beneficiary

population in new and innovative ways. Unfortunately, a dearth of primary care APMs and the inadequacy of FFS payment rates that often underlie APMs are undermining the transition to value-based care. Because most APMs are designed based on FFS payment rates, modernizing FFS payment for primary care is one essential strategy to support physicians' transition into value-based care.

Physician practices that struggle to keep their doors open cannot possibly transition into APMs or hire care managers and behavioral health professionals. Practice transformation and quality improvement require significant investment in practice capabilities including technology, people, and new workflows. Therefore, **the Academy continues to urge Congress to advance legislative solutions, including reforms to the Medicare Access and CHIP Reauthorization Act (MACRA), that would address unsustainable FFS payment rates for physicians and alleviate some of the associated administrative burden for practices, while promoting patients' access to continuous, comprehensive primary care**. This includes proposals such as providing an annual inflationary update for Medicare physician payment to give practices a fighting chance at keeping their doors open and reforming existing budget neutrality requirements that hinder CMS' ability to appropriately pay for all the services a beneficiary needs.

Finally, federal policymakers should provide more opportunities for primary care practices to participate in APMs that provide upfront or advanced payments and other supports to enable the investments required to be successful in value-based payment. While value-based payment does not eliminate the administrative burden associated with coding and billing *entirely*, prospective, population-based payments provide practices with the resources and flexibility needed to handle administrative functions more efficiently while delivering and investing in high-quality, patient-centered care.

Reforming Medicare's Quality Payment Program (QPP): The QPP, implemented as part of the passage of MACRA in 2015, have 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.[xviii] 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 $40,069 per physician per year on quality reporting requirements.

Since there is a dearth of 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 all these reasons, the AAFP continues to urge Congress advance 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.** Specific recommendations include:

- **Granting the Centers for Medicare and Medicaid Services (CMS) the authority to provide credit across multiple performance categories**. MIPS uses four siloed performance categories – all with different measures and reporting requirements. Despite multiple calls for consolidation and cross-category credit, CMS argues that they do not have the statutory authority to alter the program in that regard. One significant step toward reducing burden would be to give CMS the flexibility to provide cross-category credit. For example, a physician who reports a quality measure related to depression screening should automatically receive credit for the corresponding improvement activity.
- **Allowing practices to attest to using certified electronic health record technology (CEHRT) in place of reporting on Promoting Interoperability measures**. The AAFP has advocated for practices to be able to attest to their use of CEHRT rather than requiring multiple burdensome measures, but CMS does not have the authority to offer such an option. Years of policy changes to the legacy Meaningful Use program and now the promoting interoperability category have failed to move the needle on health information exchange. It is beyond time to move away from such burdensome requirements – doing so would be an important step toward reducing the burden of the MIPS program.
- **Providing CMS with the authority to modify the qualifying participant threshold through rulemaking to ensure advanced APM participation is attainable.** Existing thresholds set in federal statute are creating barriers for physician practices seeking to move into more advanced models. Providing CMS with the authority to modify the thresholds will help ensure the QPP is facilitating the transition to APMs instead of preventing it.
- **Providing technical assistance, shared learning collaboratives, and data infrastructure to support all primary care practices to transition to APMs.** Primary care's information needs are particularly complex which requires technical capabilities and a reliance on others to fill information gaps, including payers and other clinician organizations. Often, IT departments may be non-existent or staffed by non-IT

personnel, posing challenges when implementing new or updated hardware or software, connecting to regional health information exchanges, and setting up registries. Additionally, building and understanding reports from an EHR is time-consuming, burdensome, and can be costly if there is a need for custom reports. Safety nets also face additional reporting burden on top of payer reports due to other reporting requirements based on their funding streams (grants, Uniform Data System, etc.).

- **Funding technical assistance programs to support overall adoption of APMs by all practices in all settings**. MACRA provided funding to support small practices with direct assistance through tools and resources to help them navigate the complex MIPS reporting requirements. In response, CMS created the QPP Small, Underserved, and Rural Support (QPP SURS) program which provided small practices in rural and health professional shortage areas with technical assistance at no cost to them. Unfortunately funding for the QPP SURS expired in February 2022 and has not been renewed.

Alleviating geographic payment differences: In addition to already being insufficient, Medicare payments to physicians in rural areas are generally less than in suburban and urban areas, as reflected in the geographic adjustment factors associated with the Medicare Physician Fee Schedule (MPFS). This current structure of low payment can prevent physicians from being able to feasibly accept as many patients as urban and suburban physicians, further disadvantaging individuals living in rural areas and consequently reducing their access to primary care services. For this reason, the AAFP supports the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas). We appreciate that Congress has temporarily extended the floor of 1.0 for the physician work Geographic Practice Cost Index (GPCI) through the end of this year and continue to encourage consideration of a more permanent solution to more fairly value the work of rural physicians.

Addressing site of service payment differentials: Facility fees are one of the clearest advantages that hospitals have over small physician practices. It generates them significantly more revenue for providing the very same services and affords them the capital to give staff higher salaries, signing bonuses, and additional financial compensation such as contributions toward student loan payments. Patients should not be subject to higher costs simply because a hospital owns the outpatient office they visited, and physician practices should not be effectively penalized financially for remaining independent.

The AAFP has long supported the advancement of thoughtful site neutral payment policies that would establish payment parity across care settings and even the playing field for physician practices, with careful consideration as to not unintentionally accelerate consolidation. We have supported the Lower Costs, More Transparency Act (H.R. 5378), which would ensure payment for physician-administered drugs provided in an off-campus hospital outpatient department (HOPD) will be the same as those delivered in a physician's office. We have urged Congress to swiftly pass this measure, while also continuing to advocate for additional action to build upon and advance more substantial site neutral payment policies.

Reigning in utilization management processes: Administrative functions and regulatory compliance overburden family physicians at the point of care and after patient care hours. These functions include activities such as EHR documentation, submitting claims to get paid, reporting on quality and performance measures, and navigating prior authorization and step therapy requirements. Studies have estimated that primary care physicians spend nearly 50 percent of their time on cumbersome administrative tasks.[xix]

Utilization management processes by health plans are one of the greatest sources of administrative burden for physicians. Payers that use protocols such as prior authorization (PA) frequently describe them as a cost-control mechanism. However, repeated evidence has shown that many use prior authorization inappropriately, causing care delays and worsening patient outcomes and satisfaction. A 2022 report from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) confirmed that Medicare Advantage (MA) plans sometimes deny prior authorization and payment requests that meet Medicare coverage rules by using clinical criteria not in Medicare coverage rules and requesting unnecessary documentation, as well as making errors.[xx]

In addition to enrollees in MA plans, enrollees in other health plans needing care for their own chronic illness,[xxi] their children's chronic illness,[xxii] and rare diseases[xxiii] have experienced barriers to care from prior authorization requirements. In 2022, California-based L.A. Care, which administers Medicaid and other types of coverage, failed to address a backlog of more than 9,000 prior authorization requests and more than 67,000 complaints or appeals.[xxiv] Meanwhile, an OIG report published in July 2023 found that Medicaid managed care organizations (MCOs) denied one out of every eight prior authorization requests in 2019. Approximately 2.7 million Medicaid beneficiaries were enrolled in MCOs with prior authorization denial rates greater than 25 percent.[xxv] However, minimal data collection on and oversight of these practices is being done by state Medicaid agencies. This is largely because current 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 an American Medical Association (AMA) survey of physicians, 94 percent reported that prior authorization delays access to care, while 80 percent reported that it led to patients abandoning their treatment and 33 percent reported that it had led to a serious adverse event for their patient.[xxvi] Additionally, 86 percent of surveyed physicians reported that prior authorization sometimes, always, or often leads to higher overall utilization of health care resources, such as additional office visits, emergency department visits, or hospitalizations.

In March, the Medicaid and CHIP Payment and Access Commission (MACPAC) convened to discuss denials and appeals within Medicaid managed care. In their research, they noted the lack of federal requirements for collecting key data as described above. They also identified some of the challenges and barriers impeding the ability for individuals to pursue 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:

- States should be required to establish an independent, external medical review process that can be accessed at the beneficiary's choice;
- CMS should issue guidance to improve the clarity and content of denial notices and clarify how Medicaid funding may be used to support external entities, such as ombudsperson services;
- MCOs should be required to provide beneficiaries with the option to receive electronic denial notices in addition to mailed notices;
- CMS should extend the timeline for beneficiaries to request continuation of benefits and issue guidance to improve beneficiary awareness of their rights to continue receiving services while an appeal is pending;

- CMS should require states 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;
- States should be required to conduct routine clinical appropriateness audits of managed care denials and ensure access to medically necessary care; and
- CMS should publicly post all state Managed Care Program Annual Reports and require states to include denials and appeals data on their quality rating system websites to ensure beneficiaries can access this information when selecting a plan.

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.

Additionally, we applauded CMS for finalizing a regulation earlier this year that will streamline prior authorization processes, implement electronic prior authorization, and improve transparency across all of its payers, including Medicare Advantage and Medicaid managed care, as well as address inappropriate coverage denials. However, we continue to advocate for the passage of legislation to enshrine these necessary reforms into statute. Specifically, **the Academy continues to push for reintroduction and passage of the Improving Seniors' Timely Access to Care Act**, which passed the House last Congress and would codify many of the regulatory provisions by requiring implementation of an electric prior authorization program in MA and streamlining and standardizing of PA processes.

Step therapy is another utilization management protocol used by insurers, which requires patients to try one or more insurer-preferred medications prior to the medication their physician prescribed. This practice can take weeks or months and can result in patients not being able to access the treatments they need in a timely manner. Physicians can request exceptions to step therapy requirements, but insurers may not respond promptly to such requests, resulting in a further delay of treatment. Family physicians have reported seeing patients lose control of their previously well-managed diabetes and hypertension as a result of these tactics, in addition to requiring more office visits and in some cases emergency department visits and hospital stays. Therefore, **Congress should pass the Safe Step Act (S. 652 / H.R. 2630), which would require employer-sponsored health plans to provide a clear and transparent exception process for any step therapy protocol**.

Additionally, when medication coverage changes, physicians are often only told that the medication is not covered – they are not given any additional information, such as a list of alternatives that *are* covered. This means physicians spend a lot of time going back-and-forth with the pharmacy trying to figure out what medicine is covered by a patient's plan. They often find themselves prescribing a medication that is not covered, or not preferred by the patient's insurance company, which can lead to the patient not taking the prescribed medication. **We therefore urge Congress to pass the Real-Time Benefit Tool Implementation Act (H.R. 7512), which requires prescription drug plan sponsors to implement at least one electronic real-time benefit tool to allow physicians to see drug costs before prescribing.**

Further, the AAFP has and continues to strongly urge that the recently finalized regulation from CMS on electronic prior authorization be expanded to Medicare Part D plans and prescription drug coverage across other impacted payers.

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

- 75 percent report that noncompete clauses have impacted their practice, career, or personal life;
- 46 percent said noncompetes 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. We applaud the Federal Trade Commission's (FTC) final rule to ban noncompete clauses, but it is highly uncertain whether the rule will ultimately go into effect. Multiple cases have been filed challenging the FTC's constitutional and statutory authority to issue the rule. **Congress should address these challenges by passing legislation that prohibits anticompetitive noncompete clauses in physician employment contracts.**

Small practice owners have noted that noncompete clauses enable them to invest in training new physicians, but most believe there should be guardrails, such as buy-out clauses, to prevent coercive behavior. When non-profit health systems are allowed to implement highly restrictive noncompete clauses in employment contracts, independent practices face an unfair disadvantage when competing for physician and non-physician clinical talent. Even when the practice can offer competitive compensation, benefits, and working environment compared to the system, workers are unable to leave. As a result, health systems have little incentive to address physician and clinical workforce concerns linked to moral distress and burnout.

Congress should therefore pass legislation that ensures and clarifies FTC's jurisdiction to enforce any prohibition on anticompetitive noncompete clauses across the health care industry, including non-profit healthcare organizations. Without this jurisdictional clarification, non-profit health systems may be exempt from enforcement which will result in an unfair competitive advantage in recruiting and retaining physicians compared to independent practices. In 2020, Congress passed the Competitive Health Insurance Reform Act which, in addition to limiting the antitrust exceptions available to health insurers under the McCarran-Ferguson Act, also clarified the FTC's jurisdiction over all health insurers, including non-profit insurers. We urge Congress to make a similar clarification in future legislation to level the playing field across health care organizations and enforce antitrust laws evenly.

Improving federal regulators' enforcement authority of anticompetitive practices: This includes granting the FTC authority to address a wider range of anticompetitive behaviors, such as anticompetitive contracting clauses. The FTC should also have clear jurisdiction over all

health care entities including tax-advantaged hospitals. Non-profit health systems are required to provide charitable contributions to the community in exchange for valuable tax exemptions. Without adherence to requirements to produce community benefit or provide charity care, tax-exempt organizations have an unfair advantage that creates an uneven playing field and stifles fair competition in health care markets.

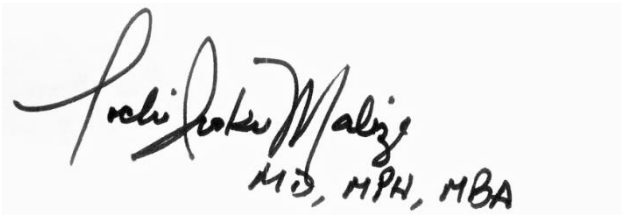
Research indicates non-profit hospitals have higher operating margins than for-profit hospitals, and these surpluses are used to increase cash reserve balances, not to provide charity care.[xxvii] The same study found that a one dollar increase in profit was not associated with a statistically significant increase in charity care for non-profit hospitals, while for-profit hospitals had a four-cent increase in charity care for every additional dollar of profit. While hospital financial reserves can help non-profit health systems maintain solvency during downturns or emergencies, large health systems direct cash reserves to launch venture capital funds.[xxviii,xxix] There is no evidence demonstrating that gains from these investment funds are used to maintain or expand charity care during economic downturns. For example, one system reporting operating losses in 2023 cited significant gains in an associated investment fund, but funding for charity care was still cut that year.[xxx]

Tax exemptions for hospitals, which generated an estimated value of $28 billion in 2020, provide them with even greater capital and financial resources to purchase physician practices.[xxxi] Although the FTC recently notified that organizations with 501(c) status with the Internal Revenue Service "are not categorically beyond the Commission's jurisdiction," we ask that Congress make clear and extend FTC authority to include all health care entities, regardless of tax-exempt status.

We also urge Congress to provide agencies with increased resources to effectively monitor consolidation, including transactions at a lower threshold. In 2024, pre-merger notification to federal antitrust authorities was required for transactions over $119.5 million. Small acquisitions, particularly of physician practices, often go unnoticed as a result. While these smaller transactions may not be of consequence individually, health systems and corporate entities often acquire and aggregate multiple physician practices in a single market, leaving FTC and other agencies unaware of merger activity until competition has been harmed. A lack of transparency about smaller health care transactions, including equity sharing, prohibits agencies from monitoring health care consolidation until long after a market is consolidated.

Thank you for your leadership to examine consolidation within the health care sector, including within primary care. We look forward to working with you to advance policies that will better support the success of practices of all sizes and ensure family physicians can continue to serve patients in the community. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams@aafp.org.

Sincerely,



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