



September 3, 2026

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

The Honorable John Thune
Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Chuck Schumer
Minority Leader
United States Senate
Washington, D.C. 20510

Dear Speaker Johnson, Minority Leader Jeffries, Majority Leader Thune, and Minority Leader Schumer:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 124,500 family physicians and medical students across the country, I write to express our strong support of key legislative priorities as Congress returns for the September work period. With the 119th session nearing its end in December, we believe there is urgency in advancing a number of provisions that have not only garnered bipartisan support, but which stand to improve the lives of family physicians and the patients they serve across the country.

Specifically, the AAFP urges Congress to swiftly pass:

- **Long-overdue reforms to the Medicare physician payment system, as proposed in the *Patients First Act* (H.R. 9693),** that would alleviate the looming 1.19 or 1.68 percent reduction to payment rates for 2027 (depending on advanced alternative payment model participation);
- Necessary reforms to the use of prior authorization processes by insurers, including the *Improving Seniors' Timely Access to Care Act* (H.R. 3514 / S. 1816)
- **Longer-term, robust funding for both community health centers and the National Health Service Corps,** as both face expiration on December 31; and
- **The H-1Bs for Physicians and the Healthcare Workforce Act (H.R. 7961),** which would protect patient access to primary care, especially in rural and underserved communities, by exempting foreign-born physicians from the new \$100,000 employer fee.

Modernizing Medicare Physician Payment for Primary Care

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), a landmark piece of legislation intended to reform physician payment after years of significant payment reductions under the sustainable growth rate. Unfortunately, while MACRA aimed to shift physician payment away from fee-for-service and towards value-based payment (VBP), it has largely failed to do so. Instead, family physicians across the country continue to face unprecedented financial and administrative pressures. This is because a number of

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foundational flaws remain embedded in the Medicare Physician Fee Schedule (MPFS) that have made it difficult for many physician practices to stay afloat financially, let alone make the necessary investments to move towards VBP participation.

Fee-for-service payment, such as the MPFS, has historically underinvested in primary care. On average, the United States only spends three to five cents of every health care dollar on primary care. Across payers, Medicare spends the least on primary care.ⁱ This has ripple effects, given that most other payers peg their payment rates to Medicare rates. This underinvestment is compounded by the fact that the MPFS is the only major Medicare provider payment system without a permanent inflationary update. What this has translated to in reality is a 33 percent decline in physician payments between 2001 – 2025, when adjusted for inflation. The need for reform remains evident as the Centers for Medicare and Medicaid Services (CMS) recently released the Calendar Year 2027 MPFS proposed rule, which includes a reduction to physician payment due to the lack of an inflationary update and an expiring Congressionally-provided increase.

Further, overly-restrictive budget neutrality requirements have hamstrung the ability for CMS to invest appropriately in all of the services that patients need and risk stunting coverage of innovative services or technologies. These requirements mean that adding new services or increases to existing codes result in either specific offsets to other services or across-the-board cuts.

Without meaningful reform, continued financial instability threatens patient access to comprehensive primary care services and will only further accelerate consolidation within the health care system. **Thankfully, the bipartisan *Patients First Act* (H.R. 9693), led by Drs. Kim Schrier, John Joyce and Greg Murphy, would take important steps to address these longstanding shortcomings.**

The legislation addresses five key categories of interest to family physicians:

- It stabilizes payment by providing an annual inflationary update equal to the Medicare Economic Index increase minus one percent, with a floor and a ceiling for updates;
- It establishes a five-year primary care pilot program that would provide a prospective, per-member-per-month payment to clinicians in independent practices;
- It replaces the Merit-based Incentive Payment System with a new program and establishes a physician-led quality measurement task force at the Department of Health and Human Services to ensure that each specialty has more clinically relevant quality measures, decided upon by their peers;
- It reforms long-outdated budget neutrality requirements for physician payment, which have not been changed since the 90's; and
- It freezes the existing advanced alternative payment model threshold for three years while giving the Secretary additional flexibility to further reduce thresholds if necessary to drive participation into new models.

While these reforms will not solve all of the problems with physician payment, they are essential first steps. The AAFP is pleased to support this legislation and applauds the introduction of this strong, bipartisan effort by physician champions. We urge Congress to follow the lead of these subject matter experts and ensure swift passage of the legislation.

Reforming the Use of Prior Authorization by Insurers

Family physicians care for patients across the lifespan, including older individuals and those with disabilities or other medical complexities. As a result, most of them contract with and/or otherwise interact with organizations that administer Medicare Advantage (MA) plans on a regular basis. A 2023 AAFP survey among family medicine practices found that 18 percent of their patients were covered by MA plans. At the same time, research is showing that parent companies of MA plans are playing a growing role in primary care practice acquisition and operation. A study from June found that payer-operated practices account for 4.2 percent of the national primary care market by service volume in 2023, compared to 0.78 percent in 2016. It also found that the prevalence of payer-operated primary care was positively associated with MA penetration; in 2022, payers operated 5.5 percent of the primary care market in counties with above-average MA penetration compared to 1.5 percent in counties with below-average MA penetration.ⁱⁱ

As MA enrollment and penetration has grown, however, so have concerns raised by family physicians about MA organizations (MAOs) and their tactics. MA plans are consistently cited as one of the biggest sources of burden by family physicians. Some MAOs subject physicians and patients to opaque, cumbersome prior authorization requirements and other onerous utilization management processes that lack medical justification and often only serve to delay necessary patient care. They include restrictive clauses in physician contracts that drag out payments for claims, impacting the financial stability of practices. They have gamed existing regulations and payment systems to reward themselves financially for adding unsubstantiated diagnoses to patient charts, without consulting the individual's primary care physician or providing the necessary services to care for said diagnoses.

To put it frankly: MAOs have taken it upon themselves to practice medicine, while at the same time making it increasingly difficult for trained, qualified physicians to do so. We believe Congress must pass policies to hold MAOs accountable and reform the program to better serve patients and alleviate the burden placed on physicians.

For years, the AAFP has [advocated](#) alongside the entire physician community in support of the *Improving Seniors Timely Access to Care Act* (H.R. 3514 / S. 1816). In 2024, CMS issued final rules streamlining prior authorization processes across federal payers, including MA. However, Congressional action is still needed to enshrine these much-needed reforms into statute. This must-pass legislation 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.

Final enactment of this legislation, which currently has more than 290 bipartisan cosponsors in the House, is long overdue. It has made significant momentum this year, with both the House Energy and Commerce and Ways and Means Committees advancing it unanimously. Now, the full Congress must act to meaningfully protect patients and ease burden on the physicians who care for them by enacting the *Improving Seniors' Timely Access to Care Act*.

Additionally, the Energy and Commerce Committee passed the below provisions (wrapped into an amended version of the *Lower Costs, More Transparency Act*), which are incremental but important steps toward improving accountability and transparency of health plans:

- The ***Prior Authorization Accountability Act*** (H.R. 9396) would require health plans and issuers that use prior authorization (PA) to publicly post and submit data to the U.S. Department of Health and Human Services on all items/services subject to PA, approval and denial rates by service, appeal rates and outcomes, processing times, and use of AI/decision-support tools.
- The ***Premium Transparency Act*** (H.R. 9397) would require private health insurers and MA plans to publicly disclose, in a consumer-friendly format, how premium dollars are spent beginning in 2027. Specifically, plans would have to report the percentage of premium revenue spent on medical claims, quality improvement activities, administrative costs, and the percentage retained rather than spent on patient care. MA plans would also have to disclose total revenue, claims spending, non-claims spending, and the portion of revenue remaining after medical loss ratio (MLR) calculations.
- The ***Medicare Advantage Cost Transparency Act*** (H.R. 9392) would require MA plans to report payment amounts, beneficiary cost sharing, and the use of affiliated versus independent in-home health risk assessments in their encounter data submitted to CMS, beginning in 2027.
- H.R. 5243, sponsored by Representative McClellan, would increase data transparency for supplemental benefits in MA by requiring plans to report detailed enrollee-level utilization and spending data to CMS and making that data available for research and public use.
- The ***Transparency in Medicare Advantage Steering Act*** (H.R. 9395) increases oversight of agents and brokers in MA by requiring detailed reporting on their role and compensation in enrolling beneficiaries. Specifically, MAOs must report whether each enrollee was enrolled by an agent, broker or third-party and, if so, the amount and form of compensation for said enrollment. It also requires aggregate reporting of total compensation paid to all agents, brokers and third parties for enrollments.

Congress should follow the Committee's movement and ensure final passage of these provisions in any year-end efforts, as well.

Ensuring Stable Funding for CHCs and NHSC to Support Primary Care Access

It is projected that the U.S. will face a shortage of up to 70,600 primary care physicians by 2038.ⁱⁱⁱ Waiting any longer to act will yield dire consequences for patient access to primary care by appropriately trained physicians. Congress must act *now* to address the current and projected primary care workforce shortages by funding federal programs that embed physicians in rural and underserved communities. Two of these programs – the Community Health Center (CHC) Fund and the National Health Service Corps (NHSC) – face funding cliffs at the end of this year, unless Congress intervenes.

CHC clinicians provide care to more than 52 million patients annually, and one in three Americans in rural areas receive their health care at CHCs. Further, family physicians make up

46 percent of clinicians in CHCs, which are often the only accessible health care setting for many individuals, including Medicaid beneficiaries and the uninsured.

CHCs have a significant economic impact. In 2021, they supported more than 500,000 direct or indirect jobs nationally with nearly \$85 billion in economic output. Unfortunately, CHCs operate on such thin margins that even a threat to funding can paralyze their ability to deliver all the care that is essential to meeting their patients' and community's needs.

The NHSC provides scholarships and loan repayment that support more than 18,000 primary care clinicians who serve more than 21 million patients annually. More than 56 percent of NHSC clinicians serve in health centers, and the remaining clinicians practice in high-need settings including rural health clinics, Indian Health Service facilities, tribal health programs, critical access hospitals, and outpatient sites in health professionals' shortage areas. Approximately 84 percent of NHSC participants who completed their NHSC service obligation in FY 2021 continued to practice in underserved areas for another year or more.

These programs have demonstrated success in bolstering the availability of primary care clinicians nationally and improving patient access to care, particularly in communities with the highest need. However, they have been consistently subjected to a patchwork of funding with unpredictable expiration dates, leading to uncertainty about their long-term outlook. **The AAFP urges Congress to enact a robust, multi-year reauthorization of the Community Health Center Fund and the National Health Service Corps.** Stable, predictable funding is critical to maintaining access to care in rural and underserved communities, strengthening the primary care workforce, and preventing disruptions for the tens of millions of patients who rely on these programs.

Expanding the Availability of Primary Care through Non-Citizen Family Physicians

Physicians born outside the U.S. are essential to the American physician workforce, particularly in primary care, rural communities, and underserved areas. Nearly 30% of physicians practicing in the U.S. were born in other countries, and about one-third of the primary care physician workforce (family medicine, internal medicine, and pediatrics) are trained in other countries outside of the United States.^{iv} In the last three National Resident Matching Program Main Matches, more than 2,500 non-U.S. citizen international medical graduates (IMGs) have matched in U.S. family medicine programs.^v That figure doesn't include those who matched through the Supplemental Offer and Acceptance Program.

Many non-US citizen physicians train in the United States on J-1 visas and remain in underserved communities through waiver programs that require them to practice in Health Professional Shortage Areas (HPSAs). The J-1 waiver program is one of the federal government's most successful physician retention tools. Notably, 84 percent of family physicians with J-1 waivers are still practicing in HPSAs three years after residency and nearly 70 percent remain in those communities for six years after completing training.^{vi}

After residency, many physicians transition from J-1 status to H-1B visas in order to continue practicing in the United States and caring for patients. More than 11,000 physicians currently practice in the U.S. on H-1B visas, helping address shortages in primary care, psychiatry, and other high-need specialties.^{vii}

Rural and high-poverty communities rely disproportionately on H-1B physicians. Rural counties have nearly double the percentage of H-1B physicians compared to urban counties, and those counties with the highest poverty levels rely on H-1B physicians at nearly four times the rate of counties with the lowest poverty rates.^{viii}

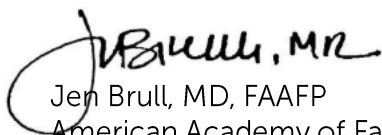
In September 2025, a new federal policy imposed a \$100,000 fee on H-1B visa applications, increasing the typical cost for employers from approximately \$3,500 to over \$100,000 per physician. This fee applies regardless of profession or workforce need and creates a major financial barrier for hospitals, clinics, and communities trying to recruit physicians. Rural hospitals and safety-net systems are especially vulnerable because they often operate on thin margins and already struggle to recruit physicians. The new fee will disproportionately discourage recruitment into lower-paying but critically important specialties like family medicine.

Physicians and trainees are also experiencing prolonged visa processing delays and adjudicative holds, disrupting residency programs and delaying patient care. Delays in physician visa processing can force residents to miss training start dates, leave positions vacant, and reduce access to care in communities already facing shortages. Supporting physician visa pathways is a direct investment in the primary care workforce and helps ensure patients can access timely care regardless of where they live.

The bipartisan *H-1Bs for Physicians and the Healthcare Workforce Act* (H.R. 7961), led by Representatives Mike Lawler and Sanford Bishop, seeks to address this new barrier to non-U.S. citizen physicians by exempting physicians' and other health professionals' sponsoring institutions from the new \$100,000 H-1B visa fee. We urge Congress to immediately enact this legislation and exempt physicians from this new fee, thereby preserving critical access to primary care in rural and underserved communities.

Thank you for your consideration of these high-priority, time-sensitive issues. The AAFP looks forward to continuing to partner with you to take meaningful steps toward improving the practice environment for primary care and access for patients in all communities. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,



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

ⁱ Jabbarpour Y, Jetty A, Byun H, Siddiqi A, Park J. *The Cost of Neglect: How Chronic Underinvestment in Primary Care Is Failing US Patients: The Health of US Primary Care, 2025 Scorecard Report*. New York, NY: Milbank Memorial Fund; 2025. Accessed August 28, 2026. <https://www.milbank.org/wp-content/uploads/2025/02/Milbank-Scorecard-2025-ACCESS-v07.pdf>.

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- ⁱⁱ Adler L, Crow S, Fiedler M, Frank R, Fernandez R, Lake D, Braun RT. The changing landscape of primary care: an analysis of payer-primary care integration. *Health Aff Sch*. 2025 Jun 11;3(7):qxaf120. doi: 10.1093/haschl/qxaf120. PMID: 40612500; PMCID: PMC12223493
- ⁱⁱⁱ Health Resources and Services Administration, Bureau of Health Workforce. *Health Workforce Projections*. Updated December 2025. Accessed August 28, 2026. Health Workforce Projections.
- ^{iv} [How immigrant doctors fill critical gap in U.S. healthcare system — Harvard Gazette](#)
- ^v National Resident Matching Program. *Charting Outcomes™: Characteristics of Non-U.S. Citizen International Medical Students/Graduates Who Matched to Their Preferred Specialty: 2026 Main Residency Match®*. Published July 28, 2026. Accessed August 28, 2026. NRMP Match Data webpage.
- ^{vi} "Retention of Family Medicine J1-Visa Waiver Recipients in Underserved Areas"
Anuradha Jetty, MPH; Jeongyoung Park, PhD; Yalda Jabbarpour, MD. Robert Graham Center 2026
- ^{vii} Liu M, Patel VR, Ramesh T, Vyas DA, Wadhera RK. Health Care Professionals Sponsored for H-1B Visas in the US. *JAMA*. 2025;334(22):2035–2038. doi:10.1001/jama.2025.20931
- ^{viii} Ibid.