

Statement of the American Academy of Family Physicians

By

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

To

The Honorable Ron Wyden
Ranking Member,
U.S. Senate Committee on Finance

On

Request for Information: "Health Care Coverage that Works for Everyone"

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AAFP Headquarters

11400 Tomahawk Creek Pkwy.
Leawood, KS 66211-2680
800.274.2237 • 913.906.6000
fp@aafp.org

AAFP Washington Office

1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033 • Fax: 202.232.9044
capitol@aafp.org

Dear Ranking Member Wyden:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 124,500 family physicians and medical students across the country, thank you for the opportunity to respond to your request for information on meaningful, long overdue reforms to the American health care coverage system that would improve access and affordability for patients. This issue continues to be top of mind for family physicians and the communities, families, and individuals they care for all across the country.

Many of the existing challenges and complexities in our health care coverage system stem from our failure to appropriately position primary care as the foundation that it should be. Patients and physicians currently play a guessing game when determining what is or isn't covered by their benefit plan. Patients with a well-managed chronic condition often start back at square one when their coverage changes, be it due to a new job, marriage, or loss of income, because there is such variability in what each plan covers. Physician offices have resorted to hanging signs in the exam or waiting room warning that asking about a new or separate medical issue during a preventive visit will trigger a separate copay. This is driven by existing payment policies that fail to recognize comprehensiveness as a fundamental aspect of primary care. This inconsistent, opaque coverage across our system leads many patients to delaying necessary care or forgoing it altogether out of fear that they won't be able to afford the mystery bill that awaits them on the other side.

In many ways, existing insurance benefit design treats coverage for primary care services similar to coverage for other more specialized and often episodic procedures and services. Plans frequently apply cost-sharing to primary care visits, albeit often with lower copays. In addition to the office visit copay, plans frequently impose utilization management requirements as blunt cost-containment mechanisms, often intended to discourage utilization of higher-cost, lower-value care. However, copying and pasting this approach for primary care coverage overlooks several important factors about why it is different:

- Primary care, prevention, and early intervention are precisely the type of care that we as a nation should be incentivizing if we truly want to improve outcomes at the individual, community, and population level.
- Every person needs and should have access – both geographically and financially – to primary care.
- Primary care is, by definition, comprehensive and intended to treat the whole person. This is incompatible in many ways with our existing patchwork of coverage and payment policies that seek to neatly describe what happened at any given visit.
- Continuity remains a core tenet of primary care, but differing insurance networks and varying plan coverage often interrupt established patient-physician relationships. This is evident in data showing that American adults are the least likely to have a longstanding relationship with a primary care clinician compared to nine peer countries.¹

To that end, **we would like to begin this response by strongly urging this Committee and your colleagues in Congress to enact a national standardized primary care benefit.** All insured individuals, regardless of their source of coverage, would have access to a uniformly defined primary care benefit without the application of cost-sharing for a defined set of core services when delivered by their physician-led primary care team. One option for structuring clinician payment is that physicians be paid uniformly (with geographic and risk adjustments) by all public and private payers, including self-insured employers, using a blend of capitation and fee-for-service payments, and services within the defined core set would not be subject to prior

authorization or other utilization management strategies.

National Standardized Primary Care Benefit

Numerous other developed countries have successfully implemented a national standardized primary care benefit using a variety of approaches that could serve as guides for the United States. For example:

- **Canada** has established national standards for insurance coverage, with provincial and territorial administration of plans. Plans are required to offer insured residents access to medically necessary physician services, including primary care, without cost. Primary care is defined as first-contact care, management of illnesses and injuries, prevention and treatment of common conditions, referrals, and care coordination.
- In **Denmark**, all citizens have free access to a general practitioner (GP), who functions as the gateway to much of the health care system. Danish GPs provide preventive care, treatment, and coordination with specialists and other services. In Denmark, 90 percent of all medical cases are handled by the GP.
- The government of the **Netherlands** defines a standard package of coverage that every insurer must offer, which includes GP services that are exempt from the deductible.

Eligible population: Every insured individual, regardless of their source of coverage (public, private, employer-sponsored, or other), will have access to the same primary care benefit. Primary care benefits should be portable across coverage sources, meaning that any coverage transition wouldn't require patients to change their usual source of primary care, restart treatment plans, or lose access to primary care services. All payers would be required to maintain continuity-of-care protections during transitions resulting from plan changes, employment changes, or network modifications.

Enrollment: The authors seek feedback on a number of questions related to enrollment simplification for patients. The AAFP strongly believes that eligibility and enrollment systems should be simplified and coordinated. When feasible, policymakers should prioritize automatic and ex parte enrollment or renewal approaches, and existing federal data sources should be leveraged to reduce paperwork burdens. To prevent individuals from falling through the cracks during transitions in coverage, eligibility and enrollment systems should be interoperable regardless of the source of their coverage. Strong consumer protections should ensure that primary care access continue during eligibility reviews, appeals, coverage transitions, and administrative processing periods. Artificial intelligence and other technologies may support patient outreach, data matching, and identification of individuals at risk of losing coverage. However, eligibility, enrollment, and renewal decisions must remain subject to appropriate human oversight, transparency, and appeal rights.

Covered core services: The core services covered within a national primary care benefit should include those that are foundational to comprehensive, whole-person care and prevention. Family physicians can and do deliver a variety of services depending on their patient's needs, with some being more unique and less specific to primary care (e.g.: in-office procedures such as toenail or skin lesion removals). Thus, we would recommend the following core services be covered under a uniform, national primary care benefit:

- Primary care evaluation and management visits, whether they are furnished in an office, the patient's residence, or via telehealth;
- An annual comprehensive assessment or wellness visit;
- Chronic disease management;
- Transitional care management;

- Behavioral health integration;
- Medication management;
- Care coordination;
- Preventive services, including recommended screenings and immunizations;
- Health-related social needs assessments and referrals;
- Patient education; and
- Technology-based communications with a patient and/or their caregiver.

The high-quality delivery of this core service set requires support by a physician-led care team, and therefore the design of and payment for a national standardized primary care benefit must ensure coverage of services when delivered by the appropriate care team member. We discuss below in the “clinician payment” section how payment could be structured to ensure it supports the delivery of care by a team, not just a single clinician.

Associated cost-sharing: The AAFP [believes](#) patient cost-sharing for the above list of primary care services should be waived or significantly reduced when provided by a patient’s usual source of care. Reducing or removing cost-sharing for primary care is essential for improved uptake and outcomes. Research has consistently shown a positive association between reduced cost-sharing, utilization of preventive and primary care services, and improved health outcomes. Conversely, research also confirms that outpatient cost-sharing for basic services serve as barriers for those who need primary care services the most.^{2,3,4}

This proposal would include reduced or waived copays, as well as excluding core primary care services from the requirement that patients meet their deductible before benefits kick in. Preventive services wouldn’t count toward meeting the patient’s deductible (meaning no change in how they’re currently treated), but non-preventive services provided by a patient’s primary care physician would count toward their deductible. Research has shown that high-deductible health plans (HDHPs), which have become increasingly prevalent over the last decade, are associated with lower health care utilization, including preventive and primary care.⁵ While all plans – including HDHPs – are required to cover preventive services without any cost-sharing, uncertainty about what is considered “preventive” and what would trigger a separate office visit charge results in many patients forgoing even the preventive care due to possible costs.

Quality measurement: Quality and performance measurement programs vary significantly across payers and benefit plans. The current measurement environment often requires practices to use limited resources to hire dedicated quality measurement staff or take physician time away from direct patient care in order to stay on top of compliance. Primary care physicians are held 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.

The eagerness to measure has burdened family physicians with the onerous task of capturing structured electronic data beyond what is already part of their normal workflows to feed an excessive number of measures, taking time away from patients, and leading to a loss of joy in practice. Performance measurement has become a high-burden, high-cost administrative exercise with limited benefit to patient care, population health, and cost reduction.

Under our proposed framework for a national primary care benefit, measures would be standardized across all public and private payers (including self-insured employers) using a

single universal set. A universal set of primary care measures should meet the highest standards of validity and reliability and be derived from data extracted from multiple data sources. Consistent with the AAFP's [criteria for performance measures](#), 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. 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.

Coverage design and financing: Authors of the RFI pose a number of questions about implementation of a single-payer system, a federal public option, or other approaches to coverage. The AAFP is agnostic to the specific approach, so long as it adheres to the AAFP's policy and the framework described in this response regarding coverage of a uniform primary care benefit.

In any system of universal coverage, the ability of patients and physicians to voluntarily enter into direct contracts for a defined or negotiated set of services (e.g., direct primary care by individuals or direct contracting by employers) will be preserved. Additionally, individuals should always be allowed to purchase additional or supplemental private health insurance.

Clinician payment: One of the key barriers to widespread adoption of value-based payment arrangements, including full or partial capitation, has been the lack of multi-payer alignment. **Our proposed approach to a national, standardized primary care benefit would also ensure that payment to primary care clinicians across plans and payers is consistent, stable, and reflects adequate investment.** As noted above, we encourage the use of a hybrid payment approach with most of the defined suite of services being paid for in a capitated, per-member-per month payment and the remainder of covered services being paid for on a fee-for-service basis.

Perhaps most importantly: the payment amount would need to reflect an increased investment in primary care. While we acknowledge that increasing the payment amount of primary care services may lead to a small premium increase in the short-term, we believe this is a necessary tradeoff in order to improve patient access and outcomes, while also lowering costs in the long-term due to a reduction in high-cost services associated with increased preventive and primary care utilization.

One of the other primary distinctions between the United States and peer countries highlighted above is how much we spend on primary care. Despite the United States spending twice the OECD average on total health care, only 4.7 percent of our total health care spending in 2021 was on primary care, compared to an average of 14 percent in other high-income countries.⁶ Many peer nations waive patient cost-sharing for primary care services. Most other nations have somewhere between one-quarter and one-half of all physicians practicing primary care, while only 12 percent of U.S. physicians are in primary care.⁷ A significant factor influencing the higher concentration of specialists in America is disparities in payment and compensation, another symptom of our national underinvestment of primary care.

This underinvestment leads to notable differences in health outcomes. For example:

- The U.S. only outperforms OECD averages on three out of ten key indicators measuring health status and risk factors and only half of the key indicators measuring access to and quality of care.⁸

- Australia, Italy, Israel and the Netherlands (all of which exempt primary care from cost-sharing) have roughly half the rate of avoidable mortality as the U.S., and the U.S. rate is about 40 percent higher than the OECD average.
- The U.S. rate of avoidable hospitalizations is roughly 55 percent higher than the OECD average, in large part due to conditions like congestive heart failure and diabetes complications – many admissions of which could be avoided through primary care utilization.

Increasing primary care payment rates and utilizing a hybrid payment approach should be designed to pay for the delivery of primary care by a multidisciplinary, physician-led team – something which the existing fee-for-service payment system fails to do adequately. Traditional fee-for-service was designed around face-to-face physician services and office overhead, not the full range of personnel needed for modern team-based primary care. As practices increasingly employ additional staff such as care managers, pharmacists, behavioral health specialists, community health workers, and population health staff, many of those costs are inadequately supported by the fee-for-service system. Existing billing codes for care management or other team-based services require patient cost-sharing, which often deters patients from consenting to receive the services.

Shifting to a hybrid capitated payment model with increased investments affords primary care practices a flexibility that is not available in current FFS arrangements, allowing them to employ the necessary clinical or administrative staff as the needs of their patients and communities shift.

Physician networks: The AAFP believes that payers should be required to allow network participation by any willing qualified clinician to preserve continuity of care and existing patient-physician relationships. This would allow patients to keep their preferred primary care physician who knows their medical history, ongoing treatments, and health-related social needs, regardless of the source of their health care coverage.

Furthermore, the AAFP [urges](#) adoption of a single, nationally standardized health care professional credentialing application across payers and plans as one way to support administrative simplification. Family physicians regularly report challenges being granted timely credentialing by payers, including significant loss of revenue as some payers take up to six months to process applications.

The AAFP believes that payers:

- who require board certification as a requirement should permit physician participation for residents who have evidence of completing the required training and are actively pursuing meeting the requirements for board certification;
- should not use hospital privileges as an absolute requirement for decisions involving insurance participation nor use lack of specific hospital privileges as cause to deny credentialing;
- should make final physician credentialing determinations within 45 calendar days of receipt of a completed application;
- should grant provisional credentialing, pending a final credentialing determination, if the credentialing process exceeds 45 calendar days;
- should provide an electronic means for the physician to track the application;

- should retroactively compensate physicians for services rendered from the receipt date of physicians' completed credentialing application upon final, successful credentialing determination; and
- should provide an electronic copy of the fee schedule to the physician upon being successfully credentialed.

Electronic health record (EHR) interoperability: While the authors expressly acknowledge that EHR reform is outside the scope of this RFI, the AAFP feels it is important to recognize that it is critical to the success of any such standardized primary care benefit. Our current EHR landscape inhibits effective information sharing and care coordination across the patient's care team. Without advancements to interoperability and data sharing standards, primary care physicians will continue to face obstacles in sharing information with their patients and other members of their patients' care team.

All-payer claims data (APCD): As with EHR interoperability, the establishment of a comprehensive national all-payer claims database will be essential to ensuring the success of a standardized, nationwide primary care benefit.

APCDs generally combine medical, pharmacy, dental, eligibility, and provider data from public and private payers. These longitudinal data sets can be used to conduct health care spending and utilization analysis, provide price transparency, provider and insurer market analysis, quality measurement, and health equity research, among other potential uses. For primary care, APCD sets can be used to examine:

- Primary care spending as a percentage of total spending or per capita rates,
- Primary care utilization and payment rates by payer, and
- Geographic variation in primary-care access.

Unfortunately, several challenges exist with our current APCD landscape that have hindered their utility. Currently, existing APCD sets are operated at the state-level and vary widely in which payers contribute, who has access, information collected, and whether participation is voluntary or mandatory. Only about half of states currently have an APCD in place, leaving significant gaps when trying to do geographic comparisons. Further, "all-payer" is really a misnomer – most glaringly, a United States Supreme Court decision in *Gobeille v. Liberty Mutual* led to self-funded employer plans being exempt from having to contribute their claims data due to *Employee Retirement Income Security Act* (ERISA) preemption.⁹ Self-funded employer plans have grown to cover a significant population of Americans (about 39 million individuals in 2023¹⁰), meaning that this gap in data distorts the picture of total health care spending, estimating commercial prices, assessing market concentration, and measuring utilization among other questions.

However, Congress can solve this problem through much-needed ERISA reform that compels self-funded employer plans to report their claims data to an APCD. Creating a national APCD also resolves challenges with the lack of standardized data collection and state funding barriers, one of the major reasons why remaining states have not yet implemented an APCD.

Affordability

The above sections outline the AAFP's strong position regarding the application of cost-sharing for primary care services. However, we acknowledge that health care affordability does not operate in a silo. We know that an individual's ability to access other specialty care or services often influences their health care behaviors and utilization in other ways, such as primary care

uptake. For example, patients with health savings accounts (HSA) and HDHPs may be more likely to forgo primary care and instead invest more money in their HSA for more expensive specialty or emergency care.

Therefore, we encourage the authors to consider some additional parameters as it relates to broader coverage affordability:

- Patient affordability should be assessed using total out-of-pocket exposure, not premiums alone.
- Consumers should be protected from cumulative financial obligations arising from premiums, deductibles, copays, and coinsurance.
- Financial protections should be structured to ensure that primary and preventive care remain accessible irrespective of income.

Utilization Management, Claims Denials, and Administrative Waste by Insurers

Authors of the RFI requested comments and analysis on certain approaches and concepts related to utilization management and claims denials, practices which insurance companies have increasingly used to generate profits and impede patients' access to medically necessary care. This section highlights the fundamental disconnect between the mission of insurance, which is to provide financial protection to patients, and the business operations of for-profit plans, which employ practices that intentionally delay or deny care to patients and payments to physicians in order to generate greater profits.

The AAFP supports efforts to ensure claims and utilization management decisions are based on transparent, evidence-based, and clinically appropriate criteria, and has long advocated for greater transparency in utilization management programs, fair appeal processes, independent review mechanisms, and administrative simplification. We have encouraged federal policymakers to explore approaches that promote consistent review standards across payers, reduce variation in denial practices, strengthen external review processes, and improve transparency regarding coverage determinations and appeals. Any framework should ensure that decisions are grounded in objective clinical standards, protect physician clinical judgment, reduce unnecessary administrative burden, and provide clear pathways for patients and physicians to challenge adverse determinations.

Prior authorization (PA): As the Centers for Medicare and Medicaid Services (CMS) has acknowledged, requesting prior authorizations costs clinicians an estimated \$20–50 per hour and takes an average of 13 hours per week – approximately \$34,000 and 700 hours of administrative time per clinician each year that could otherwise be used to take care of patients.¹¹ **The AAFP believes the growing number of PAs, including for services and treatments such as prescription drugs, should be scrutinized for appropriateness and impact on patient care by an independent body – not left to those who stand to gain financially by denying or delaying appropriate care.** PAs that remain should be standardized, including reliance on evidence-based criteria, and converted universally to more efficient electronic processes throughout the industry to promote conformity, improve timeliness, and reduce administrative burdens on practices and patients.

As noted above, **the AAFP believes that all primary care services should be exempt from prior authorization when they are delivered by a patient's usual source of care.** Additionally, one of the biggest prior authorization burdens faced by family physicians involves prescription drugs, particularly through step therapy requirements. Step therapy is a specific type of PA requiring patients to try one or more insurer-preferred medications or treatments prior to implementing a physician recommendation. This tool, primarily designed to contain the cost of American Academy of Family Physicians

prescription drugs, is used for many conditions such as cancer, arthritis, diabetes, skin conditions, heart disease, mental illness, and more.

The AAFP [believes](#) step therapy protocols delay access to treatments and hinder adherence while risking severe side effects and disease progression for patients. Therefore, the AAFP maintains step therapy should not be mandatory for patients already on a course of treatment. Ongoing care should continue while PA approvals or step therapy overrides are obtained. Patients should not be required to repeat or retry step therapy protocols conducted under previous benefit plans. We also [support](#) the elimination of PA requirements for generic drugs.

Further, increased transparency and accountability from payers is necessary. **All payers should be required to publicly report their PA denial rates, as well as appeals and overturn data.** They should be required to publicly detail their utilization management practices and provide detailed denial rationales and standardized appeal information that is readily accessible to both the patient and their physician. Plans – especially Medicare Advantage organizations – are increasingly using retrospective PA denials, post-payment audits, and recoupments.

Claims denials and payment delays: Instead of denying a claim, commercial payers have been increasingly using a tactic known as downcoding. Downcoding occurs when health plans, without consulting the physician who provided the patient care, assign a lower-level E/M code than the one that was actually provided by the physician and billed on the claim. This results in a lower rate of payment that physicians are forced to either accept or pursue costly, time-consuming appeals, which only further reduces time and resources available for patient care. There is currently no requirement to directly notify a physician that a service has been downcoded, so when it happens, the onus is on practices to track each claim for accurate payment.

In letters to specific payers, AHIP (formerly America's Health Insurance Plans), and the Department of Justice and Federal Trade Commission, the AAFP has [expressed](#) its concern about this and other aspects of the downcoding programs. We have requested greater transparency regarding the methodologies for identifying targeted individuals and offered our assistance in educating family physicians regarding accurate coding criteria – something that the AAFP regularly offers to all of its members.

To date, the AAFP and its members have not been able to secure any guidelines, standards, or rules from payers with which physicians could educate themselves to improve their billing and documentation to avoid having their claims downcoded. Rather, these programs appear to be using algorithms that lack transparency and are applied without full clinical context. For example, these programs frequently appear to make decisions based solely on the diagnosis listed on claims, without reviewing medical records or consulting with physician practices which does not adhere to the Current Procedural Terminology (CPT) guidance, the industry accepted standard. This uptick in downcoding by payers is happening at the same time that many payers have made “voluntary commitments” to decrease the number of services they subject to prior authorization requirements. What this means in reality is that payers are just shifting more of the administrative burden to physicians *after* care is provided.

Attempting to appeal denied or downcoded claims has become increasingly onerous for primary care physicians, who on average contract with more than ten different payers – each of whom have their own unique appeal processes. Most states have legal requirements establishing timeframes by which insurers must pay or deny a claim, but there are generally few enforcement mechanisms to ensure compliance with those requirements. Further, many

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insurers will require that physicians waive their right to interest on any delayed claim payments as a part of contract negotiations.

At the federal level, there are no statutory or regulatory requirements dictating the type of payment arrangements Medicare Advantage (MA) organizations must have with contracted physicians. While this has the potential to encourage payment model flexibility and innovation, such as capitated payments for primary care, we hear more often from family physicians that they are struggling to get on-time payments from MA plans. MA organizations notoriously use aggressive PA and other utilization management processes that lead to delayed patient care and hinder the physician's ability to deliver timely, evidence-based treatment.

However, it is patients that feel the brunt of claim or prior authorization denials more than anyone. In 2024, ACA Marketplace plans denied roughly 85 million out of 451 million in-network claims, or about one out of every five. Notably, "medical necessity" is the least common reason (five percent) for claim denials; 36 percent were for "other reasons," 25 percent for "administrative reasons," 13 percent for "excluded service," and nine percent for lack of prior authorization or referral.¹² This data points to an alarming theme: administrative burdens and unnecessary complexity – not clinical justifications – are the reason that the overwhelming majority of claims are denied, leading to delayed or forgone patient care.

A survey of American adults with private insurance coverage published this year found that only half of those who experienced a claim denial appealed that decision due to uncertainty about their right to appeal, whether it would make a difference if they did, and confusion about who to contact.¹³ The above analysis of ACA Marketplace plan data found that less than one percent of the 85 million denied claims were appealed by patients, with insurers holding up two-thirds of their original denials.¹⁴ Nearly 60 percent of patients who had a claim denied indicated that it delayed them receiving physician-recommended care, and half of the individuals said that their health got worse as a result.¹⁵

To remedy the existing challenges with downcoded and denied claims, the AAFP offers the following policy recommendations:

- All payers should be required to transparently disclose when a claim has been downcoded or denied, including the original and modified CPT codes, the diagnosis code(s) reviewed, and the specific clinical, coding, or coverage criteria applied.
- Payers should also make available the diagnosis-to-service edits, algorithms, and coverage logic used to support downcoding and denial decisions, allowing physicians to understand, validate, and appeal adverse payment determinations.
- In their denial notices, all payers should be required to include the specific coverage policy, LCD/NCD equivalent, medical necessity standard, or internal guideline applied, as well as any alternative diagnosis coding, documentation, or clinical information that could support reconsideration.
- Congress should prohibit the unfair practice whereby insurers require physicians to waive their right to interest on delayed claim payments as part of their contracts.
- The AAFP supports the proposal to establish a standard national appeals framework so that patients and families can access and easily navigate the process.
- We also support the proposal to implement automatic external review when adverse determinations involve medically necessary services.
- Payers should not be able to conduct post-payment audits for services that received a prior authorization approval, and there should be reasonable timeframes limiting retrospective auditing and payment recoupments by plans. Extended lookback periods

undermine payment finality and expose practices to substantial retroactive financial risk. We have heard from family medicine practices that have faced audits looking back four years and requesting thousands of dollars in recoupments, when this is simply not feasible for physician practices operating on already thin margins.

Billing and coding: Despite most all payers and plans utilizing the American Medical Association's (AMA) Current Procedural Terminology (CPT) codes as the underlying language for describing medical services and procedures, there remains substantial variation in *how* and *what* payers and plans require when billing for those codes. As mentioned previously, this becomes particularly onerous and confusing for family physicians given their contracts with ten or more payers. **The AAFP therefore recommends that all payers and plans be required to adhere to standardized billing and coding requirements**, instead of forcing physicians to track down varying documentation requirements or try to understand why their claim got denied by one plan and not another. Further, health plans cannot be allowed to threaten to or actually restrict, terminate, or exclude a family physician from plan participation based on their coding pattern if the family physician provides medically necessary services and conscientiously abides by the principles and rules of CPT coding.

Taking on Corporate Greed

The Academy agrees with the RFI's premise in Section 3 that a greater share of taxpayer dollars and premiums paid by consumers and employers should be spent on patient care, not corporate profits. We believe misaligned incentives reward consolidation and allow primary care to be leveraged to maximize profits rather than patient care. Family physicians see firsthand how corporate consolidation and vertically integrated financial arrangements can interfere with clinical decision-making, disadvantage independent practices, and divert resources away from patient care.

Across numerous [comments](#), [testimony](#), and [letters](#), the AAFP has described how increasing consolidation and vertical integration in health care undermines clinical autonomy by shifting decision-making authority away from physicians and toward centralized corporate structures. Whether acquired by hospitals, health systems, insurers, or other corporate entities, family physicians frequently report a loss of control over scheduling, staffing, referral patterns, service offerings, and other operational decisions that directly affect patient care. Family physicians have reported they are being asked to prioritize organizational financial goals over the needs of patients and communities.

We understand the focus of this RFI section is for-profit corporate entities; however, it should be acknowledged that non-profit, vertically integrated health systems also engage in similar tactics that maximize revenue, increase prices for employers and patients, and reduce physician autonomy. While beyond the purview of this RFI, we encourage this Committee to also consider approaches to ensure non-profit entities provide community benefits commensurate with the tax benefits they receive.

Corporate Practice of Medicine (CPOM) laws: Corporate ownership or affiliation of physician practices should not interfere with the delivery of high-quality patient care. The AAFP has previously provided [extensive comments](#) noting that consolidation can erode physician autonomy and shift control of business operational decisions that ultimately affect access and quality. At the same time, the AAFP would approach federal corporate practice of medicine legislation cautiously to avoid unintended consequences. Corporate and private investment is not inherently harmful. Some arrangements provide capital, technology, advisory support, and other resources that help primary care practices expand access, improve quality, and participate

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successfully in value-based care. Moreover, many independent practices view corporate investment as an alternative that will allow them to retain control over the practice compared to selling their practice to a non-profit health system.

Accordingly, the AAFP is generally supportive of approaches similar to Oregon Corporate Practice of Medicine (CPOM) laws (Senate Bill 951 and House Bill 3410). Oregon's CPOM laws restrict management service organization (MSO) from owning or controlling a majority equity stake in a physician practice or controlling administrative or managerial operations in such a way that they impact clinical decision-making or the quality of care provided. Oregon law essentially limits corporate entities from making decisions which have downstream impact on patient care, even if the decision is not clinical in nature. For example, many family physicians have anecdotally noted how administrative policies such as appointment timing can have a significant impact on clinic access and ultimately, health outcomes. Additionally, Oregon's CPOM laws ban noncompete contracts between MSOs and licensed clinicians in the practice, with some exceptions for physician practice owners. We support these approaches.

Recent legislation introduced in Congress, the *Stop Corporate Takeovers of Physicians Act* (H.R. 10444 / S. 5419), is similar to Oregon's CPOM laws in that it would ban MSOs from having majority ownership or control over a physician practice and clinical operations, and it also blocks noncompete, nondisclosure, and nondisparagement clauses. Again, the AAFP is supportive of requirements that preserve physician control over not only clinical decisions, but also staffing, practice operations, and coding, as these can greatly impact patient care. We also applaud the provisions establishing protections for physician practices negotiating an MSO agreement with the support of an independent advisory. However, it is also important to ensure that any CPOM laws do not inadvertently block partnership with entities that seek to provide value-based care infrastructure while leaving clinical operations, ownership, and medical decision making with the physician practice.

Federal CPOM laws should be structured to allow physician owners to continue to work with enablement partners who do not seek equity or ownership control over the practice but who may provide additional practice staff or disburse quality incentives based on shared contracting arrangements. There are many value-based care enablers or aggregators who work with family physician practices to provide the infrastructure to participate in accountable care organizations (ACOs) and other alternative payment models while leaving clinical operations, ownership, and medical decisions to the practice. Independent practices should continue to have the opportunity to work with such groups if they retain majority ownership, governance, and control over practice operations.

Noncompete agreements: Overly restrictive noncompete clauses can prevent physicians from continuing to care for patients in the community or choosing another employer. Noncompete agreements can also interfere with the continuity of the patient-physician relationship and access to care, which is why we [oppose](#) them. However, we recognize certain exceptions may be necessary for small, physician-owned practices who have invested in training costs, relocation expenses, or other resources that cannot be repaid without undue burden. Oregon's CPOM laws allow noncompete agreements if the physician owns 1.5 percent or more of the practice, but the federal *Stop Corporate Takeovers of Physicians Act* would only provide an exception for physician with a 25 percent or more greater stake in practice ownership. This would make noncompete agreements for owners in small practices with 5-15 physicians unenforceable, creating financial risk for small practices seeking to expand.

The AAFP strongly [supported](#) the Federal Trade Commission (FTC) proposed rule that would

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ban overly restrictive noncompete agreements, but the proposed rule included exclusions for “senior executives” with significant operational or policy control over the business. Further, while the AAFP is very supportive of banning noncompete agreements, any such ban must be applied to all employers – including non-profit hospitals and health systems. Continuing to allow non-profit health systems to enforce overly restrictive noncompete contracts while banning them in for-profit organizations creates an unfair advantage and could encourage further physician consolidation.

Ownership transparency: Policymakers need clearer, more consistent information about ownership structures and the effects of acquisitions on patients, physicians, and communities. Requiring pre- and post-acquisition reporting on cost, quality, access, staffing, and other relevant performance measures would help researchers and policymakers better assess the impact of physician practice acquisitions by private equity-backed firms, publicly traded companies, and other corporate entities. These entities often face pressure to demonstrate rapid growth or profitability, which can lead to staffing reductions, reduced access, diminished care quality, and increased strain on the primary care workforce.

At the same time, some private equity-backed or corporate-affiliated organizations serve as value-based payment enablers by providing practices with capital, technology, data analytics, administrative support, or care management infrastructure that can help them expand innovative primary care models and improve the practice environment. Greater transparency is necessary to distinguish between arrangements that support physician-led, patient-centered care and those that extract value at the expense of access, quality, or physician autonomy. The AAFP recommends requiring more transparent and detailed disclosure of health care ownership and investment relationships, including ownership stakes, debts, transaction fees, affiliate transactions, governance structures, and relevant performance metrics such as cost, quality, access, staffing, and patient outcomes.

Vertical integration: The AAFP remains concerned that insurer and hospital acquisition of physician practices can allow primary care to become a leverage point for financial objectives elsewhere in the organization. Because primary care services are chronically undervalued, the motivation behind the acquisition of primary care practices is often to maximize savings or profits upstream rather than support primary care itself. Acquiring primary care practices can also provide a lever to steer patients to high-margin services and care provided by the parent organization. For insurance plans, owning primary care practices provides a mechanism to blur medical loss ratios. Many family physicians have linked burnout to requirements that force them to prioritize organizational goals over patient care. This problem is only compounded by overly restrictive noncompete agreements which prohibit physicians from seeking other employment opportunities or to start their own practice in the community.

At a minimum, stronger transparency and oversight of vertically integrated entities are needed. This should include disclosure of ownership or affiliation, governance structures, how payment is determined relative to non-owned providers, and whether physicians have the autonomy to direct how investment or incentive payments are used or distributed. Greater transparency about ownership and governance within vertically integrated MA organizations may help identify organizations which allow affiliated providers to direct how investment or incentive payments are used, an indicator that patient care is truly physician-directed. Relevant reporting requirements might include the percentage of equity (if any) an affiliated practice retains after joining a vertically integrated organization, or an affiliated practice’s involvement in selecting performance goals.

More transparency is also needed regarding payment differentials between owned and affiliated clinicians vs. non-affiliated clinicians. An analysis found that UnitedHealthcare (UHC) pays Optum physician practices approximately 17 percent more than non-Optum practices in the same market, and this gap increased to 61 percent when focusing on markets where UnitedHealthcare has greater market share.^{16,17} This increased payment enables UHC to increase profit by gaming medical loss ratios (MLR) and ultimately increases costs for individuals and employers. Payment differentials also create a financial disadvantage for non-Optum practices, who may feel pressured to affiliate or sell their practice to Optum to secure higher payment rates and stay afloat.

If a vertically integrated organization chooses to pay owned or affiliated practices higher rates, both the amount and reason for the payment differential should be transparent. For example, are payment differentials to Optum-owned practices simply bolstering Optum's profit margins, or are the additional payments being reinvested in patient care? Alternatively, if payers have negotiated a lower payment rate with owned and affiliated practices, these savings should be clear to the public. Anecdotally, reports from family physicians suggest any increased payment generated by the owned or affiliated practice is not reinvested in patient care or physician compensation.

We are also concerned that vertically integrated payers do not enforce operational and financial policies consistently across all clinicians, regardless of ownership or affiliation. As the AAFP noted above in the prior sections, we are deeply concerned that insurers are applying downcoding programs to unaffiliated physician groups and we continue to urge federal policymakers to require that any downcoding policies be transparent, fair, and uniformly applied regardless of practice ownership.

Addressing issues such as disparate clinician payment rates or delayed/downcoded payments to unaffiliated physicians would help mitigate some (but certainly not all) of the harms caused by vertical integration. A more comprehensive approach might be to ban vertical integration by payers entirely, as proposed in the *Break Up Big Medicine Act* (S. 3822) and *Patients Over Profit Act* (S. 2836). While S. 2836 is more limited in scope (focusing on insurer ownership of physician practices), S. 3822 also targets pharmacy benefit managers (PBMs) and prescription drug and medical device wholesalers. Many years of research have shown mixed reviews on whether vertical integration improves quality, but clear findings that vertical integration increases prices consistently. Given that the benefits are inconsistent but the harms are both consistent and significant, we believe legislation prohibiting vertical integration may be beneficial. However, both bills appear to only target vertical integration by payers and exclude vertically integrated non-profit health systems. Again, we remain concerned that broad bans on vertical integration that are only applied to one group of entities will only further consolidation by entities excluded.

Investing in independent physician practices: It is important to recognize that more than a quarter of physician practices are owned by corporate entities and more than 80 percent of physicians are employed by a hospital or corporate entity. We have provided [testimony](#) about the [drivers of consolidation](#) that have led to independent physician practice closures or sales to vertically integrated entities, and we applaud efforts by policymakers to address these drivers, including site-differential payments and unnecessary administrative burden. However, we also recognize that family physicians who choose to work in a small or independent practice environment have unique needs and need additional, specific, and targeted support to be successful. The AAFP therefore encourages Congress to consider policies that would support the creation of new independent practices, particularly if legislation establishing federal CPOM

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laws is passed. Otherwise, physicians who are currently employees of corporate entities will have little choice but to pursue hospital or health system employment, furthering physician consolidation.

With respect to primary care, investments by Congress are needed to provide the support and incentives necessary to make the financially difficult and risky decision to start an independent practice. Many physicians, especially recent graduates, may not have access to the financial capital needed to start a new practice. Additionally, many independent practices have shared that recruiting recent graduates is difficult in markets where a local health system dominates because they are unable to compete with loan repayment programs offered by the health system. Independent practices need support to successfully compete with large, well-resourced employers for physician talent.

Policy recommendations to encourage new independent practices and support their growth include:

- Developing specific Small Business Administration (SBA) loan programs and resources for independent primary care physician practices, especially in rural and underserved areas;
- Allowing outstanding federal student loan balances to be rolled into any SBA loan used by a primary care physician to open or expand an independent physician practice, thereby lowering the interest rate on those student loans; and
- Providing loan repayment programs for independent primary care physicians who use SBA loans to open practices in rural and underserved areas.

Large, consolidated health systems are tax-exempt because of the community benefit they are supposed to offer. Independent practices should also have the opportunity to receive tax incentives aligned with the benefits they provide the community, including job creation and care for the under- or un-insured. **The AAFP strongly supports tax policies to encourage and support independent practices, including:**

- Removing the cap on 199A (pass through income tax deduction) for independent physician practices;
- Unique tax credits or deductions for independent physician practices in rural and underserved areas and/or that treat a significant number of Medicaid and/or Medicare-eligible patients; and
- Tax credits for the purchase of personal property, housing, childcare, or education for physicians who establish a practice in a rural or underserved area.

Further, the AAFP has previously offered recommendations – including in the above sections – to ensure independent practices remain independent and are not forced into acquisition, including:

- Improving physician payment for primary care and creating prospective, sustainable revenue streams that allow physicians to tailor care to their patients' needs;
- Addressing misaligned incentives, including site-of-service payment differentials that encourage consolidation; and
- Reducing administrative burdens that require additional staff, time, and resources to manage.

Medical loss ratio (MLR): Because MLR is structured as a ratio without benchmarking, there are incentives to increase the cost of care regardless of actual utilization. Increasing medical expenditures increases the total amount of profit firms may accrue. In the case of vertically

integrated entities, increasing medical expenditures allows them to accrue increased profit at both the provider and insurer level, with no accountability for improved health outcomes or patient experience. Further, the current system rewards insurers for delaying care and payment for as long as possible during the year, as they accrue interest on the premiums already collected. Payers may also attempt to categorize utilization management techniques as a “quality improvement activity,” allowing them to further adjust MLR calculations in their favor. In addition to greater transparency of the actual expenses and calculation of the MLR, payers should also be accountable for increases in medical spending that is not proportionate to increases in utilization.

We recommend lawmakers ensure CMS has the authority necessary to fully audit and verify payer reporting of MLR and consider penalties that would force payers to repay any profits generated as a result of inaccurate MLR reporting. Further, vertically integrated organizations should have additional reporting requirements to ensure payments to owned and affiliated clinicians are not higher than non-affiliated practices for the sole purpose of capturing profit that would otherwise be unallowable because of MLR requirements. We would encourage additional transparency regarding transfer payments between vertically integrated payer-provider organizations, including requirements for reporting of incentive payments and administrative costs embedded in payments to affiliated clinicians.

Quality improvement activities and supplemental benefits: Some vertically integrated payers also own entities that provide supplemental benefits or quality improvement activities. Because they own these entities, they set the price, creating another opportunity to potentially generate or redirect profit to an owned vendor instead. Further, **the AAFP supports excluding indirect overhead expenses from MLR quality improvement calculations, which will further help to prevent artificial inflation of MLRs.** We also support requiring greater transparency around incentive payments and administrative costs tied to quality improvement activities. Finally, any bonuses or incentive payments paid to owned clinicians or services should be tied to specific performance metrics to ensure they are not simply being used to inflate MLRs or avoid remittances. We also encourage policies that would require plans to be more transparent and accountable for increases in medical expenditures that are not proportional to increases in utilization or annual inflation.

Direct contracting and direct primary care (DPC): We agree with the observation that generally, third-party administrators (TPAs) in the self-insured market operate with limited transparency and may increase costs with hidden fees and conflicts of interest. As we have noted in [previous comments](#), self-funded employers face rising costs and limited control over negotiated rates. In a self-funded plan, employers typically rely on TPAs to negotiate rates with clinicians, design benefits, and process claims. Self-insured employers generally aim to minimize costs, but TPAs have less incentive to reduce claims spending when it’s linked to their revenue. In fact, a recent study found that employers in self-funded plans often pay higher rates for health care services than those in fully insured plans.¹⁸ Recent lawsuits have further highlighted common TPA practices that make it difficult for employers to comply with fiduciary requirements set forth in the ERISA.¹⁹ As a result of the limited transparency and conflicts of interest, a growing number of employers are considering direct contracting strategies.

Direct contracting allows employers to contract directly with physician groups or health systems to provide care to employees and their families. The AAFP supports physician and patient choice to participate in any ethical care delivery or payment model, including direct contracting. **The AAFP believes that, when priced and contracted appropriately, direct contracting can enable physicians to spend more time with their patients and provide**

numerous benefits for employers, including reduced health care costs and increased employee satisfaction and productivity.

Perhaps the fastest growing direct contracting model is [direct primary care](#) (DPC). In a DPC model, patients (or employers) pay a flat monthly or annual fee in exchange for access to a defined set of primary care and related administrative services. 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. For example, the AAFP's 2024 DPC [study](#) found that 98 percent of DPC practices offer same-day appointments and phone/text consults, and over 80 percent provide nutritional counseling and weight management services as part of the membership fee.²⁰

In addition to improving access to primary care and preventive services, DPC models increase physician satisfaction and reduce burnout. Among family physicians working in a DPC practice, 94 percent said they were satisfied with their overall practice, compared to 57 percent of those not in a DPC practice²¹. Physicians working in a DPC practice were also more likely to indicate no level of burnout than those not working in a DPC practice (49 percent versus 14 percent, respectively).²² Administrative burden is a major driver of burnout; DPC models likely increase satisfaction by reducing administrative burden, allowing physicians to spend more providing care to patients.

Because of the many benefits to physicians and patients, an increasing number of family physicians are choosing to practice in the DPC model. As noted above, a growing number of employers are exploring DPC models to bolster employee access and utilization to high-value primary care and preventive services. Already, two-thirds of family physicians in DPC practices report they participate in employer-based contracts.²³ While most (71 percent) employer contracts for DPC offer the same bundle of services, over a quarter of employers have opted to customize their contract based on the needs of their employee population.²⁴ Customizations could include services tailored to the employee population, such as occupational health screenings specific to the industry or worksite urgent care clinics.

H.R. 1 eliminated the prohibition on using health savings account (HSA) funds to pay for a DPC arrangement. In response to this legislation, the Internal Revenue Service (IRS) issued [Notice 2026-5](#), which clarifies that direct primary care services arrangements (DPCSAs) should not be treated as a health plan for the purposes of defining HSA eligibility. However, while the guidance resolves individual HSA use, it does not resolve whether employers may pay DPCSA fees on behalf of employees without jeopardizing HSA eligibility.

As the AAFP and others noted in a recent [letter](#) to the Department of the Treasury, we believe Congress intended to expand access to DPC not only for individuals, but to employers who want to offer DPC models to their employees. Unfortunately, the IRS has stated in Notice 2026-5 that employers may not pay the DPCSA periodic fee on behalf of employees enrolled in a high-deductible health plan (HDHP) paired with an HSA. This guidance is a barrier to employers who want to contract directly with family physicians to offer DPC care to their employees and their families.

Additionally, employer-sponsored arrangements provide the stability and scale DPC practices

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need to fund investments in service expansion to provide care for an entire workforce. For example, an employer may want a DPC practice to open an onsite worksite clinic or offer unique occupational screening services. If employees must enroll and pay individually, participation is less predictable, making it harder for DPC practices to make the upfront investments needed to open a worksite clinic or hire and train staff to provide unique services. **Therefore, we urge Congress to fix this problem by establishing a safe harbor for DPCSA fees paid by employers so that employers may pay DPCSA periodic fees on employees' behalf without affecting their HSA eligibility.**

Congress should also examine whether incentives for insurance agents and plan designers discourage employers from considering DPC models and consider reforms to ensure DPC models are equally considered.

Finally, CMS currently requires physicians who see Medicare beneficiaries as part of a DPC practice to opt-out of the Medicare program entirely in order to directly contract with those patients and provide Medicare-covered services. Importantly, CMS is explicit that opt-out is not selective. This means that a physician cannot opt-out for some Medicare beneficiaries and remain participating for others – it's all or nothing. With the exception of emergency and urgent care services, opted-out physicians may not furnish any Medicare-covered services to any Medicare beneficiary, even beneficiaries who are not in a DPC contract. This restriction can leave access voids in communities where DPC family physicians also provide inpatient, skilled nursing facility, or other Medicare-covered services outside their DPC practice model. **Expanding the exceptions allowed would permit opted-out physicians to care for Medicare beneficiaries who are not in a DPC contract, ensuring seniors can maintain access to necessary services within a community.**

Thank you for issuing this RFI and laying the groundwork for an important conversation regarding insurance coverage design and reforms. The AAFP looks forward to continuing to partner with you to take meaningful steps toward improving the practice environment for family physicians and access to comprehensive, whole-person care 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, FFAFP
American Academy of Family Physicians, Board Chair

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