

**American Association of Orthopaedic Surgeons  
Statement for the Record  
U.S. House Committee on Energy and Commerce  
Subcommittee on Health**

**Hearing on “Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape”  
March 18, 2026**

***Updated March 19, 2026***

On behalf of its 39,000 orthopaedic surgeon members, the American Association of Orthopaedic Surgeons (AAOS) is pleased to submit this statement for the record of the March 18, 2026 hearing, “Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape,” before the U.S. House Energy and Commerce Subcommittee on Health. We share the committee’s goal of addressing the core drivers working against health care affordability—namely inadequate Medicare reimbursement, onerous government interference, administrative burdens, waste, fraud, and abuse, and lack of competition and patient choices.

*As a result of an aging population, musculoskeletal diseases are an emerging cause of health and financial burden in the United States<sup>1</sup>, where they affect more than one in three people or approximately 127.4 million individuals.<sup>2</sup> Musculoskeletal care made up 9.4% of total medical services expenditure in 2021, highlighting the significant proportion of healthcare services dedicated to treating bone and joint diseases in the United States. This translates to an annual spend of \$244 billion.<sup>3</sup> Musculoskeletal care has an outsized impact on activities of daily living and productivity. Therefore, the impact of MSK diseases leads to a ripple effect on not just the patient, but the caregivers, family members, and larger community involved in the therapeutic recovery from acute and chronic disease. Reflecting this impact, employers rank musculoskeletal conditions among the top two health conditions driving their costs.<sup>4</sup> Proactive treatment led by expertly trained orthopaedic surgeons focused on the full continuum of care management is the best way to ensure quality care that treats the patient and by extension the entire community. The doctor-patient relationship must remain at the heart of MSK care, unincumbered by payment or administrative barriers.*

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<sup>1</sup> <https://pmc.ncbi.nlm.nih.gov/articles/PMC10788788/>

<sup>2</sup> <https://pmc.ncbi.nlm.nih.gov/articles/PMC10788788/>

<sup>3</sup> <https://www.kff.org/health-policy-101-health-care-costs-and-affordability/?entry=table-of-contents-what-factors-contribute-to-u-s-health-care-spending>

<sup>4</sup> <https://www.businessgrouphealth.org/resources/2024-large-employer-health-care-strategy-survey-intro>

### **Impact of Physician Payment Policies**

AAOS is grateful to Congress for enacting a 2.5% increase to physician payments in 2026. To ensure seniors continue to have access to the physicians they trust in their communities, Congress must act now to stabilize payments with long-term solutions. We strongly support policies that give physicians an annual, inflation-based payment update. Unlike hospitals and skilled nursing facilities, physicians receive no automatic inflation-based payment updates. This disparity forces many practices to either close their doors or consolidate with larger healthcare institutions – a trend that ultimately drives up healthcare costs for everyone.

Physicians are not only struggling to keep up with inflation, but they also face Medicare reimbursement cuts year-after-year due to budget neutrality constraints.

The Omnibus Budget Reconciliation Act of 1989 contained a provision which mandated that any upward payment adjustments or the addition of new procedures that will increase spending by \$20 million or more must be offset by cuts elsewhere in the MPFS. As a result, the various medical specialties are pitted against each other in competition over the size of their respective shares of the MPFS budget. It is not uncommon for a physician in one specialty to see their payments reduced because of policy decisions aimed at a completely different specialty that have little to do with their day-to-day practice of medicine.

This creates even more uncertainty for physicians and ultimately harms patients. A good first step would be to raise the MPFS budget neutrality threshold and index it to inflation going forward, as well as providing statutory guardrails to limit the year-over-year changes to the conversion factor (CF). Congress should permanently rationalize Medicare physician payments by requiring that the annual conversion factor update include the full amount of yearly inflation as measured by the Medicare Economic Index (MEI).

In addition to these ongoing challenges, certain issues arise because of CMS policy and have an outsized impact on the state of physician payment. For example, the Centers for Medicare & Medicaid Services (CMS) finalized an “efficiency adjustment” in the CY2026 Medicare Physician Fee Schedule. This policy, which took effect January 1, applies a 2.5% cut to procedural work Relative Value Units (RVUs) for most non-time-based codes — with additional reductions scheduled every three years indefinitely absent congressional action. Because work RVUs underpin surgeon compensation across practice settings, this policy would accelerate the decades-long decline in physician payment and intensify zero-sum pressures in Medicare that can force tradeoffs across specialties and primary care.

Orthopaedic surgeons, other specialists, and primary care clinicians are partners in patient care. **The *Efficiency Adjustment Delay Act (H.R. 7520)* would provide a prudent pause until 2030 to reassess CMS’s assumptions through a study and ensure that preserving access to surgical and specialty care does not come at the expense of patients’ access to front-line, preventive care.** We appreciate that H.R. 7520 would require any future adjustment to work RVUs deemed necessary by this

study be calculated without relying on a factor that is used to determine productivity relative to inflation, such as the Medicare Economic Index, unless the yearly update to the nonqualifying APM conversion factor is at least as large as the percentage increase in the Consumer Price Index for the previous year.

The premise underlying the efficiency adjustment is not supported by the evidence. A peer-reviewed study in the *Journal of the American College of Surgeons* found that 90% of procedures took the same or longer to perform in 2023 than in 2019 as patients grew more complex — contradicting the assumption that services will become more efficient indefinitely, or at the same rate across clinicians and settings. Specifically, within the realm of orthopaedics, our surgeon members have been at the forefront of patient optimization initiatives that have succeeded in improving care to make surgery as successful as possible. Even so, the data reflects the fact that the best patient outcomes are not simply equated with the fastest operative times. Physician work valuation reflects time, complexity, and intensity, not speed alone. An across-the-board reduction untethered from empirical data fails to account for high-risk cases; surgeons newer to a procedure, and teaching environments where additional time is appropriate and necessary.

The impact also extends beyond Medicare. Many employment contracts are tied to work RVUs or total RVUs, meaning cuts can reduce compensation even when the work performed does not change. A recurring reduction every three years adds uncertainty that undermines sustainable practice and employment arrangements.

In addition, CMS finalized a 50% reduction to the indirect Practice Expense RVU for facility-based services. Rising costs and constant policy churn are making the MPFS increasingly unstable for physicians caring for seniors. Until both the “efficiency adjustment” cut is delayed and Congress develops a remedy for this severe cut to indirect Practice Expense RVUs, physicians will continue to struggle with tremendous uncertainty, harming the health of our nation. Small, independent and rural practices will struggle most to absorb these cuts, potentially forcing them to consolidate into large systems; an outcome AAOS, Congress and CMS all want to prevent.

### **Administrative burdens implemented by payers hinder physicians’ ability to provide patient care**

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

**The Improving Seniors' Timely Access to Care Act (H.R. 3514) would prioritize patient care over paperwork by modernizing and streamlining the prior authorization process in Medicare Advantage.** This legislation would mandate electronic prior authorization for MA plans, standardize transactions and clinical documentation requirements, and increase transparency around MA prior authorization

practices. Additionally, it would empower CMS to establish clear timeframes for prior authorization decisions and require regular congressional reporting on program integrity efforts from HHS and other agencies.

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

### **Healthcare consolidation trends threaten patient choice and access**

The rising costs of running a medical practice disproportionately impact small, independent practices, and rural physicians, increasing the risk of access to care issues for some of our country's most vulnerable patients. As a result, the U.S. healthcare system continues to experience unprecedented consolidation as large hospital systems devour smaller facilities and independent physician practices at record rates, raising concerns about the creation of monopolies that could drive up healthcare costs and limit patient choice. The stress of running a medical practice, including amplified financial pressures and administrative burdens, is causing one in five physicians to consider leaving private practice within two years.<sup>5</sup> When private practices close, patients may struggle to find care elsewhere. They also may end up paying higher out-of-pocket costs if they now have no choice but to receive the same care, they were before from their local doctor in a more expensive hospital setting.

Rural hospitals provide essential healthcare services to millions of Americans, but they continue to face immense financial pressures and workforce shortages threatening their viability. On average, rural hospitals operate with margins of half that of urban hospitals, and over 130 rural hospitals have closed since 2010. The law limits who can own hospitals, which artificially limits options as to the type of entity that can rescue a hospital on the cusp of closure. Lifting the physician ownership ban would allow physician-led hospitals to provide care in these underserved rural communities.

**The Physician Led and Rural Access to Quality Care Act (H.R. 2191)** would preserve these critical facilities by allowing physicians to be a part of the ownership model of a rural hospital, provided it is not within the existing mileage requirements of an existing critical access hospital (CAH) (35 miles by primary road or 15 miles by secondary road) in order to ensure no new physician-led hospital interferes with a CAH's mileage-based eligibility. However, it also clarifies that this does not require a new physician-led hospital to be a CAH. This legislation provides a targeted solution to empower physician-led hospitals in underserved rural areas. It would represent an incremental and reasonable step that would expand options for maintaining access to care when a rural community is at risk of losing its hospital.

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<sup>5</sup> [https://www.mcpiqjournal.org/article/S2542-4548\(21\)00126-0/fulltext](https://www.mcpiqjournal.org/article/S2542-4548(21)00126-0/fulltext)

**AAOS also supports the Patient Access to Higher Quality Health Care Act (H.R. 4002)** which would repeal section 6001 of the Patient Protection and Affordable Care Act (PPACA) prohibiting the formation and expansion of physician-owned hospitals.

Physician-led hospitals have been shown to provide high-quality care at lower costs compared to other hospitals. Studies have found that they deliver savings to Medicare, feature lower prices for procedures, and operate more efficiently. Consolidation of rural hospitals into larger health systems reduces services and responsiveness to community needs. More competition from physician-led hospitals can provide needed alternatives to consolidation. Access to local emergency and inpatient care is crucial for rural communities. Passing H.R. 2191 will help keep rural hospital doors open and preserve health care access for rural Americans.

**Congress must continue to incentivize the adoption of value-based care**

The shift from fee-for-service (FFS) to value-based care systems of healthcare accelerated when the Center for Medicare and Medicaid Innovation (CMMI) was created by the Affordable Care Act in 2010. Since then, CMMI has generated numerous alternative payment models to spur this shift to paying for care that improves quality and reduces costs, instead of paying based on the volume of services delivered. Some of these models, like the Comprehensive Care for Joint Replacement (CJR) and Bundled Payments for Care Improvement Advanced (BPCI-A) have proven successful.

Much work remains to be done as most models have not produced the savings intended. Given the significant volume of orthopedic procedures paid for by Medicare along with the burgeoning Medicare-eligible population, orthopaedic surgery remains at the forefront of Advanced Payment Model development.

AAOS encourages Congress to work with CMS to expand physician-led Alternative Payment Model (APM) opportunities for independent and employed physicians.

**AAOS recommends a new generation of physician-led APMs that:**

- Focus on Comprehensive Condition-Based Care by encouraging primary care providers to partner with teams of specialty physicians who have expertise in specific conditions, including musculoskeletal care, with the support of CMS, to ensure that patients receive optimal care.
- Accelerate support for physicians, particularly those in private practice, who are eager to participate yet lack the resources to build the infrastructure required to participate in this model.
- Begin with upside incentives and allow progression to downside risk-sharing as experience is accumulated.

**Questionable hospital billing practices harm independent practices and their patients**

As orthopaedic surgeons, we witness firsthand how the lack of transparency in hospital billing practices impacts healthcare costs. Under the current system, it is often unclear to patients, insurers, and even

clinicians whether care is being delivered in a hospital or non-hospital setting. This opacity incentivizes large health systems to acquire independent physician practices, only to then bill routine office procedures at higher hospital-based reimbursement rates – despite no change in the location of service or actual care delivered. These acquisitions and subsequent billing practices increase costs across the board, with patients and payers bearing the burden of these inflated charges. The current payment system has contributed to rapid consolidation across the U.S. healthcare landscape. Today, nearly 80 percent of physicians are employed by hospitals or other corporate entities.<sup>6</sup> This trend has not resulted in improvements in the quality-of-care patients receive but rather has led to higher costs for both patients and the healthcare system. In fact, a 2022 report from the Medicare Payment Advisory Commission (MEDPAC) found that Medicare spent \$1.4 billion more than necessary due to site-of-service payment differentials, which underscores the need for reform.<sup>7</sup>

**AAOS endorsed the FAIR Act in the 118<sup>th</sup> Congress and was pleased to see certain provisions of this bill included in the government funding package that was signed into law in early February.** The FAIR Act's requirement for separate National Provider Identifier (NPI) numbers for off-campus hospital outpatient departments will create much-needed transparency in our healthcare system. Requiring unique identifiers, will clarify when services are being provided in a hospital versus non-hospital setting, allowing for appropriate reimbursement rates based on the site of care and helping to identify cost disparities between hospital-owned and independent physician practices. AAOS strongly supports efforts to bring greater transparency and fairness to medical billing practices.

### **Payers needs guardrails to preserve program integrity in Medicare Advantage**

The Medicare Advantage (MA) program currently enrolls 54 percent of Medicare-eligible beneficiaries.<sup>8</sup> Physicians and patients appreciate the choices MA plans provide regarding out-of-pocket cost protections and supplemental benefits. However, these MA plans should not be able to manipulate or exploit the risk adjustment system used to determine payment to receive higher payments from the federal government. **AAOS endorses the No UPCODE Act (S. 1105) to create guardrails within the MA program by requiring the Centers for Medicare & Medicaid Services (CMS) to use two years of diagnostic data in its risk adjustment methodology for MA payments.**

Strengthening the integrity of the MA program by prohibiting diagnoses collected from chart reviews or health risk assessments alone when adjusting payments based on health status, as well as requiring CMS to account for differences in coding patterns between MA and traditional Medicare when finalizing MA payment adjustments furthers our shared goals of increasing patient access to care and ensuring a strong and stable physician payment system.

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<sup>6</sup> <https://www.fiercehealthcare.com/providers/more-and-more-physicians-are-working-under-hospitals-corporate-entities-report-finds>

<sup>7</sup> [https://www.medpac.gov/wp-content/uploads/2022/06/Jun22\\_Ch6\\_MedPAC\\_Report\\_to\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf)

<sup>8</sup> <https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>

Prudent use of federal dollars is essential to improving healthcare access and quality of care. According to MedPAC, CMS overpaid MA plans by \$50 billion in 2024.<sup>9</sup> A Health Affairs study points out that the impact of upcoding by MA plans has a scaling effect on the entire market. Specifically, artificially increased revenue from upcoding leads the MA plan to offer more robust benefits and rewards to its enrollees compared with traditional Medicare or MA plans that upcode with less intensity. This subsequent increase in enrollees, attracted by these benefits, generates higher profits per enrollee and increased market share by these aggressively upcoding MA plans.<sup>10</sup>

### **Payers must be accountable for unnecessary downcoding**

It has come to our attention that several payers are implementing a new reimbursement policy to review professional claims billed with E/M codes 99204-99205, 99214-99215, and 99244-99245. We have seen provider bulletins stating that the policy is in alignment with the American Medical Association (AMA) E/M services guidelines, adjusting services by one level to reflect the appropriate reimbursement when AMA guidelines are not met. This policy is in fact against AMA's E/M service guidelines. We have seen reports that payers including Aetna, Anthem, Cigna, Humana, and Sunshine (Centene) have already begun implementing this policy.

AAOS is concerned this policy implies payers will automatically adjust the E/M CPT code level until medical records are submitted to substantiate the complexity and the medical decision making (MDM) or time associated with the reported E/M visit. However, the policy does not indicate how these coding adjustment determinations are made. For example, what are the criteria which trigger such a denial? Is downcoding of E/M charges based solely on the complexity of the diagnosis codes submitted? These questions raise many concerns as physician notes are not typically sent with E/M visits.

AAOS fears the policy will create an unwarranted burden to physicians and their staff, and barriers to patients' access to quality care. This coding adjustment practice sets out a dangerous precedent and raises several issues regarding the legality of this type of policy. We are also concerned that this policy will lead to under-coding to avoid having claims adjusted. There are several factors accounting for high-level E/M visits, such as the decision for surgery and ordering and interpretation of images. Physicians should be reimbursed appropriately for this work.

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<sup>9</sup> <https://www.medpac.gov/document/chapter-12-the-medicare-advantage-program-status-report-march-2024-report/>

<sup>10</sup> <https://www.healthaffairs.org/content/forefront/improving-medicare-advantage-accounting-large-differences-upcoding-across-plans>

### **Payers should not penalize a patient's choice of physician**

AAOS is deeply concerned about emerging trends of penalizing hospitals when out-of-network physicians are used in the provision of the care. For instance, Anthem recently announced the Facility Administrative Policy: Use of Nonparticipating Care Provider<sup>11</sup> in 11 states starting January 1, 2026. It is our understanding that Anthem Blue Cross and Blue Shield plans will begin penalizing hospitals with a 10 percent reimbursement cut for services provided by out-of-network physicians and will consider terminating hospitals from Anthem networks for continued use of nonparticipating physicians.

Anthem is attempting to bypass the negotiated bipartisan policy under the No Surprises Act (NSA) that protects patients from surprise medical bills when out-of-network care is provided at an in-network hospital. On average, a physician practice has 20.2 health plan contracts, and even small practices with under five physicians average 13.5 health plan contracts.<sup>12</sup> The NSA established a system by which patients do not pay more than in-network rates for out-of-network care at participating hospitals, and health plans and physicians engage in negotiations and potentially an independent dispute resolution process to determine a fair payment amount. We find it genuinely concerning that rather than working through the NSA, Anthem is choosing to implement a policy that circumvents the statute.

### **Conclusion**

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

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<sup>11</sup> [https://files.providernews.anthem.com/6740/MULTI-BCBS-CM-093315-25-Nonpar-provider-policy\\_FINAL.pdf](https://files.providernews.anthem.com/6740/MULTI-BCBS-CM-093315-25-Nonpar-provider-policy_FINAL.pdf)

<sup>12</sup> <https://www.caqh.org/hubfs/43908627/drupal/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf>