

September 15, 2026

**Hearing of the United States House Energy and Commerce Committee
Subcommittee on Health
on
“Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster
Health Care Cybersecurity”**

Statement for the Record by the American College of Rheumatology

Chairman Guthrie, Ranking Member Pallone, and Members of the Subcommittee:

The American College of Rheumatology (ACR) appreciates the opportunity to provide this statement for the record for the hearing “Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity.” The ACR represents over 10,000 rheumatologists and rheumatology interprofessional team members and is committed to improving the American health care system for clinicians and patients. We support the Subcommittee on Health’s efforts to improve health care affordability and expand seniors’ access to care. To that end, we have outlined our support for two of the bills included in the legislative hearing.

The ACR strongly supports H.R. 9693, the Patients First Act, introduced by Representatives Joyce and Schrier. Importantly, this legislation ties physician reimbursement to inflation and increases the budget neutrality threshold to mitigate automatic, year-over-year cuts.

Reimbursements for physicians treating Medicare patients have been cut by 29% over the last twenty years, while in that same period the average costs to operate a medical practice have increased by 41% (when adjusted for inflation). Other Medicare providers (hospitals, etc.) have not seen this divide because the MPFS is the only Medicare fee schedule without an automatic annual inflationary update. So, treating Medicare patients becomes less economically feasible each year and puts patient access in jeopardy. To preserve and expand patient access to care, the ACR supports updating the MPFS annually for inflation, like the other Medicare schedules in accordance with the MEI.

For too long physician practices have been expected to pay competitive wages to their care team and support staff, stay current on technology, while also covering rent, malpractice insurance,

medical supplies, marketing, and getting adequate legal advice on five fewer dollars per services rendered from Medicare than we earned in 2001, and those dollars are worth 105% less now.

This has led to smaller physician-owned practices merging with larger multispecialty groups or selling to hospital systems or financial firms. Other practices opt out of the Medicare payment system and only accept private insurance or cash for services. This leaves the most vulnerable Americans, including seniors, the disabled, and those living in underserved communities with the longest waits and the fewest options for medical care.

The ACR also strongly supports H.R. 8163, the Provider Reimbursement Stability Act, led by Representative Murphy. This legislation would:

- Increase the budget neutrality threshold from \$20 million to \$54.3 million and indexes the threshold to the cumulative percentage increase in the MEI every five years.
- Provide for budget neutrality corrections related to the estimated utilization of codes.
- Provide for updates to direct costs used to calculate practice expense relative value units (RVUs) not less often than every 5 years.
- Limit year-to-year variance in the conversion factor by 2.5%.

Annual cuts to the conversion factor are the result of a provision in the Omnibus Budget Reconciliation Act of 1989 which mandates that any increase exceeding \$20 million (a number that has not changed with inflation) to the MPFS — created by upward payment adjustments or the addition of new procedures or services—must be offset. Therefore, each time a procedure code or other service is reviewed to reflect the updated (higher) value; the conversion factor is cut to offset that increase. As procedure codes are reviewed more often than in-office codes, these cuts disproportionately affect office-based specialties like rheumatology. The outcome? Physician practices are never certain what the Medicare reimbursement rate will be each year, so they squeeze more patients into their schedule every day to make up for the new cuts, leaving both physicians and patients dissatisfied. The resulting physician burnout threatens the sustainability of medical care for all Americans.

The ACR appreciates the Subcommittee's consideration of H.R. 9693 and H.R. 8163. We welcome the opportunity to work with Members of the subcommittee and staff as these bills move forward.

Respectfully submitted,

Amanda Myers, MD, FACR
Chair, Government Affairs Committee