America's Health Care System Is at a Breaking Point. We Must Act Before Patients Pay the Price.

By Sandra Marchese Johnson, MD, FAAD

Have you heard that the Centers for Medicare and Medicaid Services better known as CMS is proposing changes that will reduce payments for services provided by 9% in 2027 unless we ask our representatives to act now to prevent this from happening. You can ask them to act now by clicking on this link:

https://www.votervoice.net/AAD/Campaigns/138934/Respond

When I began my career as a dermatologist nearly three decades ago, independent physician practices were the backbone of American medicine. Physicians built practices in their communities, cared for generations of families, trained future physicians, participated in research, and invested every dollar they could back into patient care.

That model is disappearing. In 2012, nearly 60 percent of all physicians practiced in independent, physician-owned practices. By 2024, that number had fallen to just 42.2 percent. Thousands of physicians have sold their practices to hospitals, private equity firms, or large health systems—not because they wanted to, but because the economics of independent medicine have become increasingly unsustainable.

This is not simply a physician problem. It is a patient problem. Patients are seeing the consequences every day: longer waits for appointments, fewer physicians accepting Medicare, higher facility fees after hospital acquisitions, reduced competition, and fewer choices about where they receive care.

The driving force behind this trend is a payment system that has steadily eroded the financial foundation of physician practices. Since 2001, Medicare's physician conversion factor—the foundation for physician reimbursement—has fallen from $38.26 to $32.35 per relative value unit, a nominal reduction of 15.5 percent. During that same period, the costs of running a medical practice have increased dramatically. Physician offices have absorbed rising salaries for nurses and medical assistants, escalating rent, medical supplies, electronic health record costs, cybersecurity requirements, malpractice premiums, and regulatory compliance.

When these practice costs are measured using Medicare's own Medical Economic Index (MEI), the picture becomes stark. Physician reimbursement has not merely failed to keep pace with

inflation—it has fallen dramatically behind it. Adjusted for practice-cost inflation, physicians now have only about 56 percent of the purchasing power they had in 2001.

Imagine asking any other small business to absorb nearly half of its purchasing power over twenty-four years while continuing to deliver the same—or better—service. No business could survive under those conditions without making difficult decisions. Medicine is no different.

The consequences extend far beyond physician offices. They affect every patient who depends on timely access to care. While physician payments have steadily declined, hospitals have experienced a very different reality. Between 2001 and 2025, hospital inpatient payments increased by more than 90 percent. After adjusting for inflation, hospitals ended the period with purchasing power approximately 26 percent above cost parity, while physicians finished more than 44 percent below it—a real difference of more than 70 percentage points.

This imbalance is not the result of market forces. It is the result of policy. Every year that physician reimbursement fails to keep pace with the cost of delivering care, independent practices become less viable. Many physicians reluctantly sell to hospital systems or large corporate organizations simply to survive. While consolidation may provide financial stability for practices, numerous studies have shown that it often increases overall health care spending and reduces competition, all while limiting patient choice.

As someone who has spent my career in private practice, academic medicine, research, and physician advocacy, I have witnessed extraordinary advances in dermatology. We now have treatments for psoriasis, eczema, hidradenitis suppurativa, melanoma, and many other diseases that were unimaginable when I entered medicine. Clinical trials continue to transform patients' lives, and physician-scientists across the country are developing tomorrow's therapies today.

Yet innovation alone cannot care for patients. Patients need physicians who can afford to keep their doors open.

My own career has been built around that mission. Together with my husband, we established an independent dermatology practice in Arkansas that has grown to serving thousands of patients each year. We have trained students, mentored residents, conducted hundreds of clinical trials, published research, participated in national leadership organizations, and invested in our community because we believe patients deserve access to high-quality care close to home.

But independent practices across America are under increasing pressure. Physicians cannot shorten a skin cancer surgery because reimbursement declines. We cannot reduce the time spent explaining a new melanoma diagnosis to an anxious family. We cannot eliminate nurses, medical assistants, laboratory personnel, or safety protocols without affecting patient care.

Eventually, something has to give.

The Centers for Medicare & Medicaid Services has proposed additional physician payment reductions at a time when practices continue to face rising costs and workforce shortages.

Continuing down this path risks accelerating physician consolidation, reducing access to care, and placing even greater strain on an already fragile health care system.

Congress has an opportunity—and a responsibility—to change course. Physician payment should include a permanent inflation-based update tied to the Medical Economic Index, just as other Medicare providers receive annual updates. Policymakers should reduce unnecessary administrative burdens that divert physicians from patient care and create a payment system that encourages independent practice, innovation, education, and research rather than penalizing them.

Most importantly, we must recognize what is truly at stake. This debate is not about physicians asking for more. It is about preserving access to care for America's patients.

The future of American medicine depends on whether we choose to strengthen the physicians who care for our communities—or continue a payment system that steadily weakens them.

The warning signs are already here. The question is whether we will act before the next independent practice disappears and before the next patient loses access to the care they deserve. The time to act is now. https://www.votervoice.net/AAD/Campaigns/138934/Respond

Exhibit 1

Key Statistics: Physician Payment, MEI, and Cross-Provider Comparison (2001–2025)

Sources: CMS OACT Market Basket Data 2025Q3; AMA Conversion Factor History; BLS CPI-U

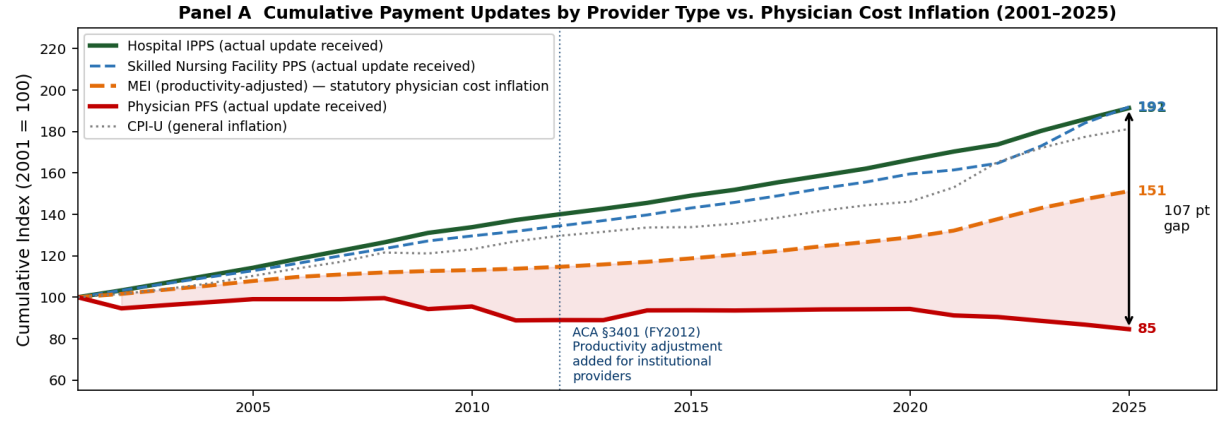
Year	MEI Adj. Update (%)	Physician CF Update (%)	Hospital IPPS Update (%)	Physician Deficit vs. MEI (pp)	Physician Real Index (2001=100)
2001	1.1	4.5	3.4	3.4	100.0
2002	1.6	−5.4	3.3	−7.0	94.3
2003	2.0	1.6	3.5	−0.4	93.0
2004	1.9	1.5	3.4	−0.4	91.8
2005	2.1	1.5	3.3	−0.6	90.6
2006	1.8	0.0	3.7	−1.8	88.8
2007	1.1	0.0	3.4	−1.1	87.8
2008	0.9	0.5	3.3	−0.4	87.4
2009	0.6	−5.3	3.6	−5.9	82.0
2010	0.4	1.3	2.1	0.9	82.6
2011	0.6	−7.0	2.6	−7.6	76.2
2012	0.8	0.2	2.0†	−0.6	75.7
2013	1.0	0.0	1.9	−1.0	74.7
2014	1.1	5.3	2.0	4.2	78.3
2015	1.4	0.1	2.4	−1.3	77.1
2016	1.5	−0.1	1.9	−1.6	75.6
2017	1.5	0.2	2.4	−1.3	74.5
2018	1.9	0.3	2.1	−1.6	73.2
2019	1.6	0.1	2.1	−1.5	72.2
2020	1.8	0.1	2.6	−1.7	71.1
2021	2.5	−3.3	2.4	−5.8	67.0
2022	4.2	−0.8	2.0	−5.0	63.5
2023	3.9	−2.1	3.8	−6.0	59.9
2024	3.0	−2.1	3.1	−5.1	56.6
2025	2.6	−2.5	2.9	−5.1	55.9
2001–2025 cumulative	**+51.2%**	**−15.5%**	**+91.3%**	**−54.3 pp**	**55.9**

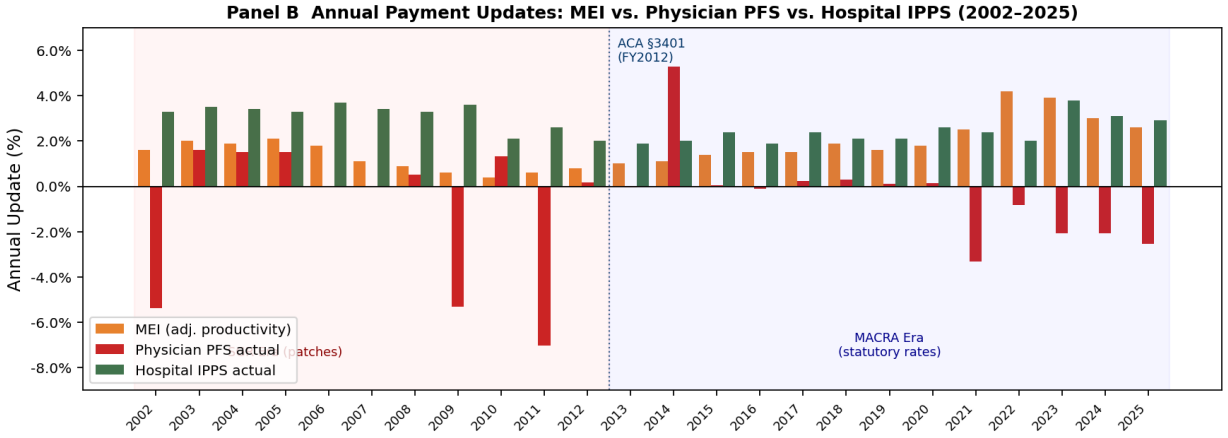
NOTES: MEI Adj. = productivity-adjusted Medicare Economic Index (Q4 four-quarter moving average percent change, CMS MEI17 2025Q3 release; 2001–2009 reconstructed from CMS summary table and published TFP estimates). Physician CF Update = year-over-year percent change in conversion factor (weighted annual average for years with mid-year changes). Hospital IPPS Update = market basket update for inpatient hospitals (full market basket through FY2011; market basket net of productivity from FY2012 per ACA §3401, indicated by † and thereafter). Physician Real Index = ratio of cumulative physician payment index to cumulative MEI-adjusted index, 2001=100. This figure of 55.9 in 2025 implies a 44.1 percentage point real decline; the AMA's commonly-cited "33 percent decline" benchmarks against the full (rather than productivity-adjusted) MEI and uses a nominal payment measure that does not fall as far as the statutory conversion factor used here. Both conventions describe the same underlying erosion (see Section 3.3). pp = percentage points.

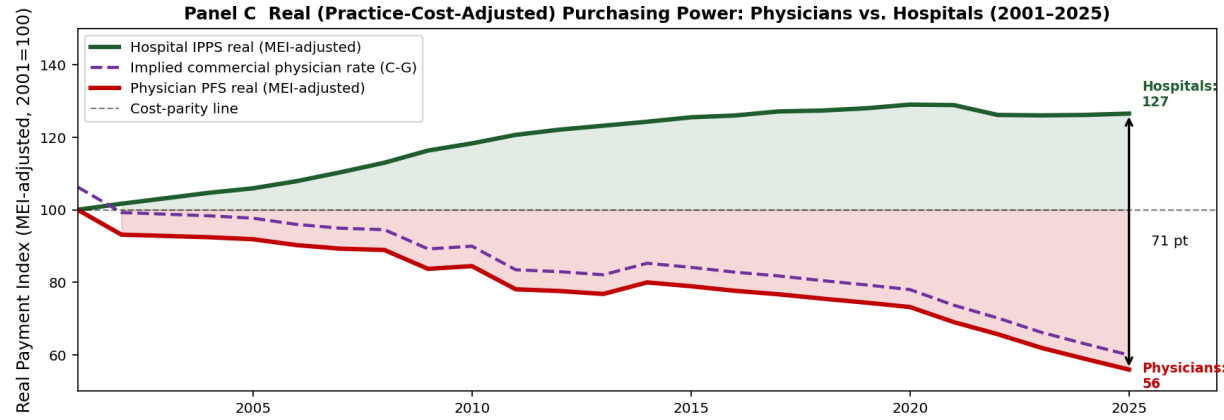
Exhibit 2
Comparative Provider Payment Statistics, 2001–2025
Source: CMS OACT Market Basket Data 2025Q3; AMA Conversion Factor History

Provider	Statutory update mechanism	Cumulative nominal update 2001–2025	Real index 2025 (MEI-adj., 2001=100)	Real surplus/deficit vs. cost parity
Physician PFS	SGR formula (2001–2014); MACRA statutory rates (2015–2025)	−15.5%	55.9	−44.1 pp deficit
Hospital IPPS	Full market basket (2001–FY2011); MB net of TFP (FY2012–2025)	+91.3%	126.5	+26.5 pp surplus
Skilled Nursing Facility	Full market basket (2001–FY2011); MB net of TFP (FY2012–2025)	≈+140%	≈150	≈+50 pp surplus
MEI (adj.) for reference	N/A (index of practice cost inflation)	+51.2%	100.0	Cost parity line
CPI-U for reference	N/A (general inflation)	+81.3%	N/A	N/A
Gap: Physician vs. Hospital (real index, 2025)		**71 percentage points**		

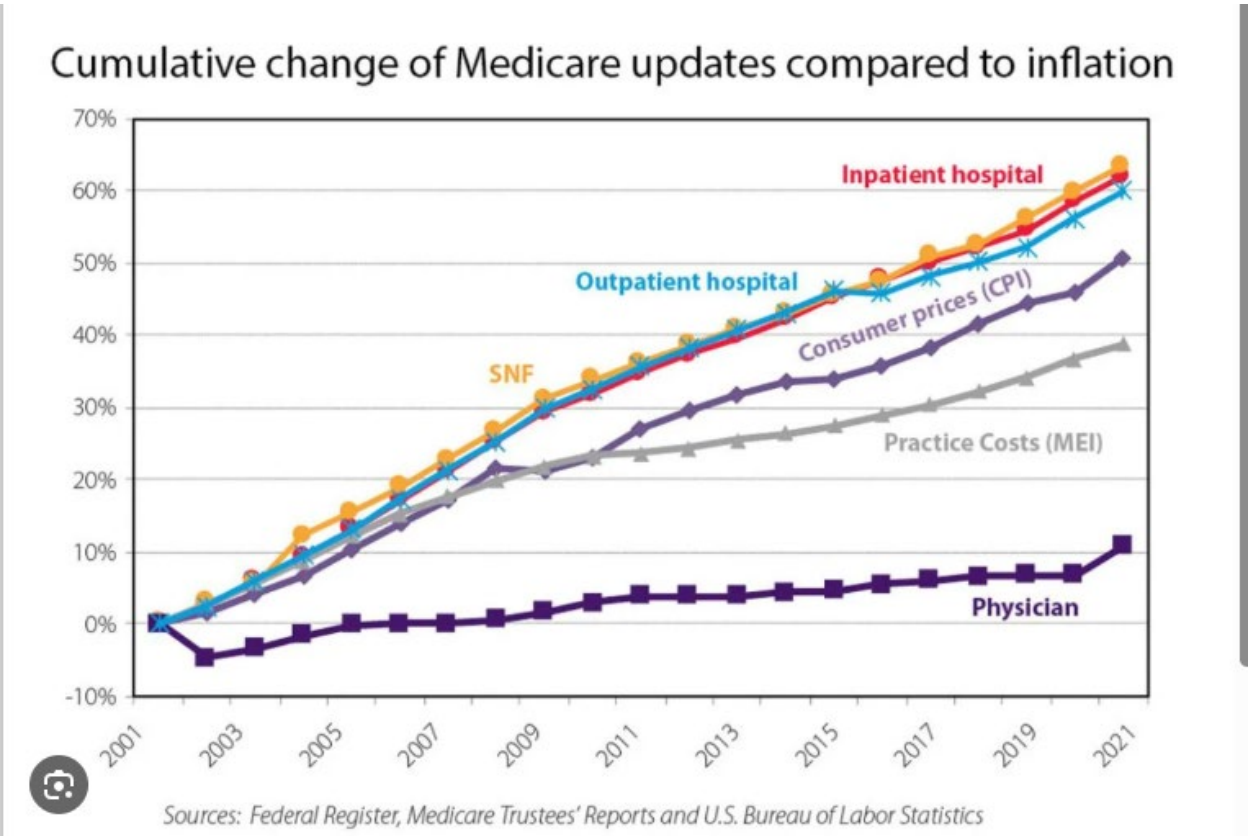
NOTES: Real index computed as ratio of cumulative nominal payment index to cumulative MEI (productivity-adjusted) index, 2001 = 100. SNF figure approximate due to forecast error adjustments in individual years. IPPS and SNF figures use fiscal year updates aligned to approximate calendar years. pp = percentage points.

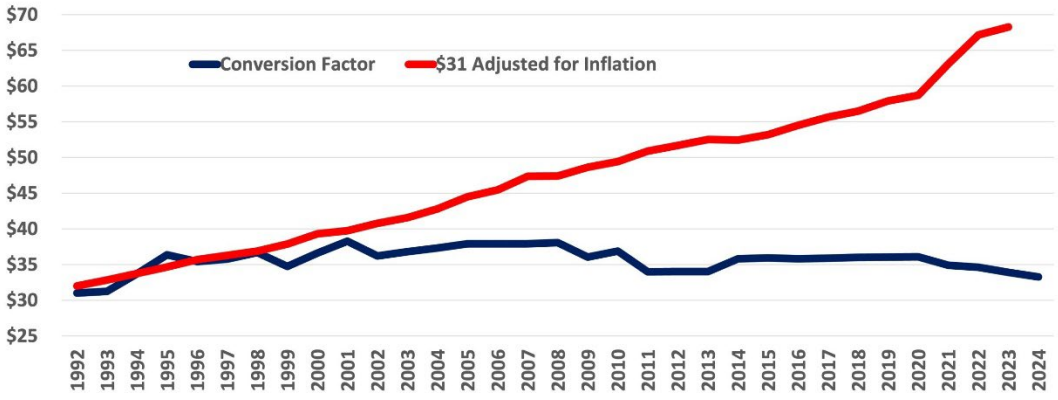


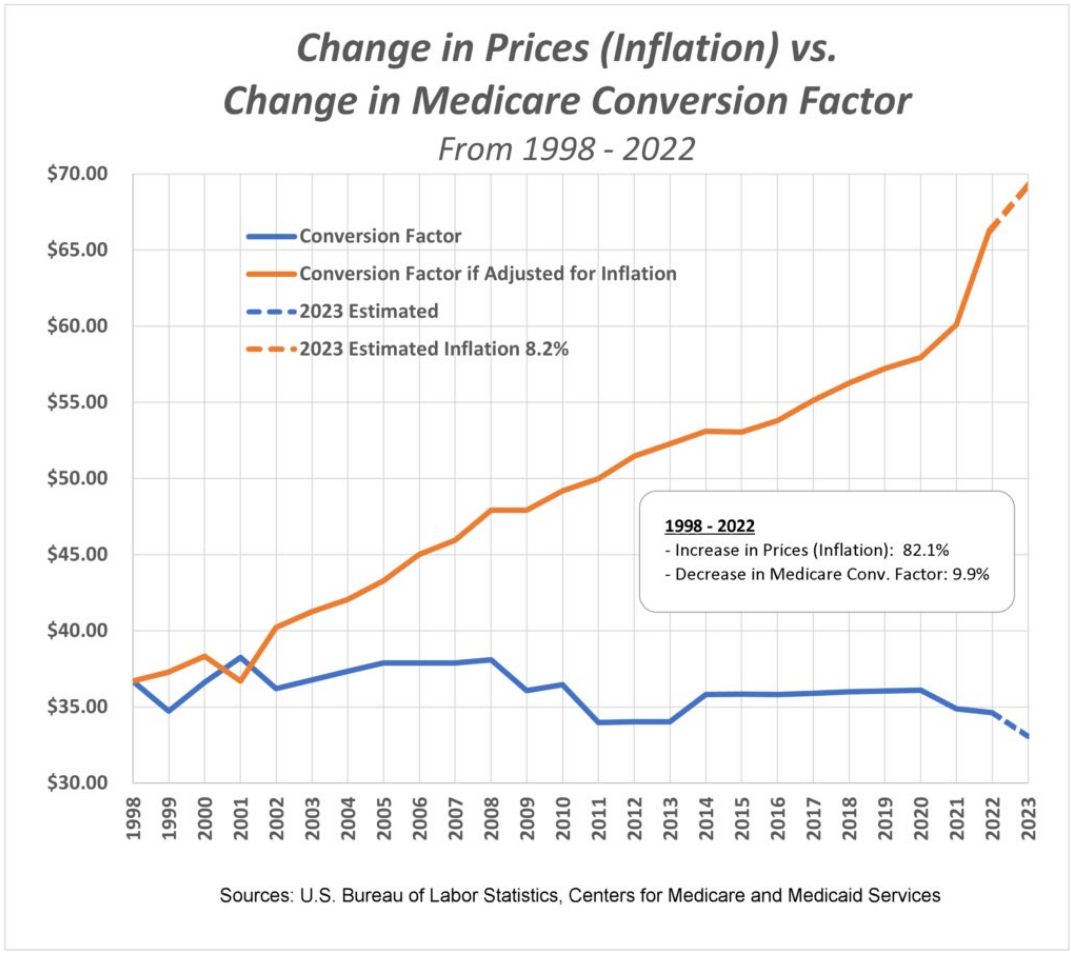




Sources: CMS Office of the Actuary, Market Basket Data 2025Q3 (released 2025-12-15); AMA Historical Conversion Factor Table (2001–2025); BLS CPI-U.
MEI = Medicare Economic Index (productivity-adjusted). IPPS = Inpatient Prospective Payment System. C-G = Clemens & Gottlieb (2017) transmission coefficient (β=1.16), anchored HCCI 2017.


Cumulative change of Medicare updates compared to inflation
70%
60%
50%
40%
30%
20%
10%
0%
-10%
2001
2003
2005
2007
2009
2011
2013
2015
2017
2019
2021
Inpatient hospital
Outpatient hospital
Consumer prices (CPI)
SNF
Practice Costs (MEI)
Physician
Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics


Medicare conversion rate vs. the value of $31 adjusted for inflation 1992 - 2024
$70
$65
$60
$55
$50
$45
$40
$35
$30
$25
Conversion Factor
$31 Adjusted for Inflation
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024



Dermatology Workforce in Arkansas