An Attack on the Medical Establishment Buried in an 1,800-Page Regulation

If approved, a new rule could end the entrenched pay advantages for specialists like surgeons over other doctors.


By Reed Abelson and Margot Sanger-Katz
The authors have covered Medicare policy together for more than a decade.

July 21, 2025

For decades, the prices Medicare pays doctors for different medical services have been largely decided not by Medicare itself, but by a powerful industry group, the American Medical Association.

An A.M.A. committee meets in secret to determine the difficulty and time demands of each type of medical visit, test and procedure, and then recommends to Medicare how much doctors should be paid for performing them.

And for decades, critics have complained that this process unfairly rewards surgeons and other specialists, at the expense of primary care physicians and other generalists.

Medicare officials have been loath to change it because it has spared them from needing their own staff and budget to make such pricing decisions, along with the unpleasant politics of adjudicating conflicts between competing groups of physicians.

But a change buried inside a 1,803-page proposed regulation published last Monday suggests the Trump administration would like to move away from this longstanding system. If finalized, it could begin overturning a process that has entrenched pay advantages for certain kinds of doctors.

“We’re modernizing Medicare by correcting outdated assumptions in how physician services are valued,” said Chris Klomp, a deputy administrator of the Centers for Medicare and Medicaid Services, in an email.

Robert F. Kennedy Jr., the secretary of Health and Human Services, has emphasized that medicine should focus more on primary care and prevention, and less on the treatment of advanced diseases. He has also crusaded against “corporate medicine,” and has specifically criticized the American Medical Association. Stat News reported in November that Mr. Kennedy was considering policies to disempower the A.M.A. committee.

Dr. Bobby Mukkamala, the A.M.A.’s president, was highly critical of the proposed change.

“The American Medical Association believes that proposals to exclude or limit the input of expert practicing physicians and health care professionals in the development of Medicare payment policy would ultimately harm patients and represents a radical departure from the time-tested C.M.S. decision-making process,” he said in a statement.

The current A.M.A. committee, known as the RUC, uses data gathered in surveys of doctors to set formulas for every kind of medical care. The committee suggests payment rates to Medicare’s regulators, who almost always adopt them. The system is effectively zero-sum — any increases for one kind of doctor represents decreases for others. While private insurers are free to develop their own formulas for paying doctors, they tend to follow Medicare’s lead, making the committee very influential on what kinds of medical care get the largest (and smallest) financial rewards.

The estimates are often outdated. Existing payments are reviewed on average only once every 17 years. A Washington Post investigation in 2013 reported on numerous gastroenterologists who had billed Medicare for more than 24 hours' worth of colonoscopies a day. The reason wasn't fraud. Medicare was still paying the doctors as if each test took 75 minutes to complete, when most doctors were able to complete one in 30 minutes. (The colonoscopy payment has since been adjusted.)

Under the new proposal, Medicare would pay 2.5 percent less for every procedure, operation and medical test in 2026, based on data suggesting there have been improvements in "efficiency" over the years. Payments for treatments based only on time, like a consultation with a family physician or neurologist, would not be cut. Such adjustments would be repeated every three years.

The proposal also looks to change the kind of data Medicare should consider instead of the relatively small surveys, noting that new sources of health data from hospitals and electronic billing systems could offer more accurate information.

The effort to adjust what doctors are paid for their work is just one part of the large rule, which also contains provisions to broaden coverage for telemedicine, pay for more mental health care, and reduce overpayments for a new and expensive type of skin bandage.

One other provision, meant to better account for the costs of running a medical practice, also affects the relative pay of different medical specialists. In some cases, those changes would reduce payments to the types of medical specialists whom the efficiency adjustments are meant to benefit.

That policy would adjust payments to doctors based on whether they offer services on a hospital campus or in a private practice office, effectively lowering payments in the hospital and boosting those elsewhere.

Taken together, the overall proposal would do more than just increase the salaries of primary care doctors. It would also increase the average pay of an allergist next year by 7 percent, and decrease pay for a neurosurgeon by 5 percent, according to

estimates published by Medicare. It would lower pay by 6 percent for infectious disease specialists, who tend to earn low salaries and perform few procedures — and increase average pay for vascular surgeons by 5 percent.

Dr. Adam Bruggeman, a spine surgeon in San Antonio who leads the council on advocacy for the American Academy of Orthopaedic Surgeons, said he was sympathetic to arguments that the current system may be paying for some medical procedures inaccurately. But he said the proposal — which would cut payments for all procedures next year — was too crude a solution to that problem. He described the "efficiency" changes as "taking an ax to the whole thing."

"We're just fighting an arbitrary number with another arbitrary number, and that doesn't help," he said.

But when it comes to a longer-term replacement for the current A.M.A.-led committee, the proposal is less clear. The rule asks for suggestions about what data Medicare should use instead of the current surveys, but does not identify a clear strategy. Any new system would need a way to calculate prices for more than 11,000 individual medical services, a huge and costly undertaking. Medicare has made similar requests for such suggestions several times over the last decade.

But many longstanding critics of the pricing system expressed enthusiasm that the administration was starting to think about a different approach.

"This is kind of a dream come true for me and other people who have been raising these issues for years," said Paul Ginsburg, a health policy professor at the University of Southern California, who was involved in an overhaul to Medicare's physician payment system in the 1980s, and has disapproved of the role the A.M.A. has come to play in updating prices.

Those working in medical specialties that would benefit from the change were also positive. "We're producing a lot of expensive health care services, and I think we need to try some new ideas to produce health," said Ann Greiner, the chief executive of the Primary Care Collaborative. "This proposed rule is moving us in that direction."

The proposal isn't yet a final policy. Interested parties will have 60 days to offer comments, and regulators will make their final decisions in October. If it is finalized, it will start affecting Medicare payments in January 2026. Many physician specialist groups said they were still reading and digesting the rule.

Shawn Martin, the chief executive of the American Academy of Family Physicians, said he was encouraged by the proposed rule, which he said "sends a pretty strong statement about how you're thinking about the valuation of physician services." But he added that the policy's adoption was not guaranteed. "I assume there will be strenuous pushback on these proposals over the next 90 to 180 days."

Reed Abelson covers the business of health care, focusing on how financial incentives are affecting the delivery of care, from the costs to consumers to the profits to providers.

Margot Sanger-Katz is a reporter covering health care policy and public health for the Upshot section of The Times.

A version of this article appears in print on , Section A, Page 1 of the New York edition with the headline: Medicare Pay Rule Would Favor Primary Care Over Specialists