AANS/CNS Washington Committee

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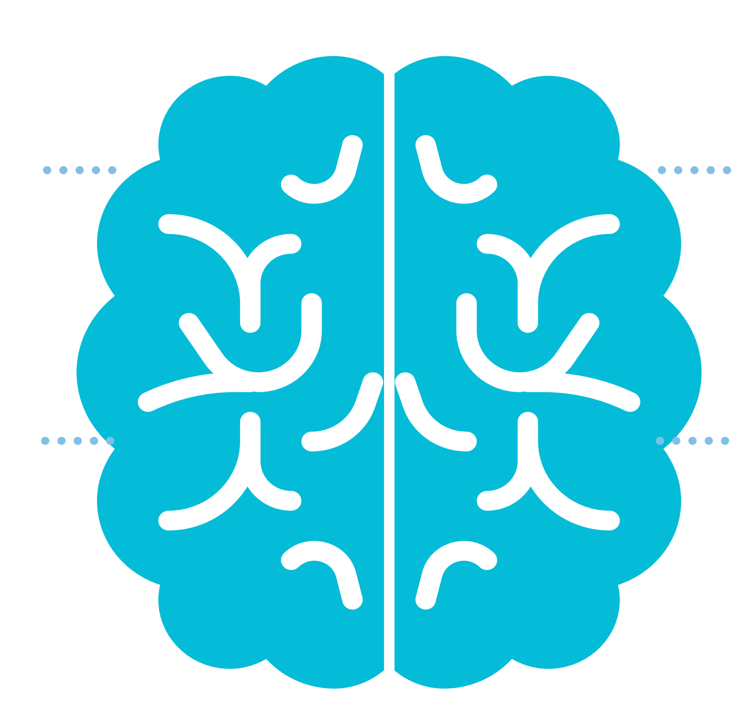
Neurosurgery's Federal Priorities

Reimbursement
Advance fair, sustainable physician payment policies across all payer markets.

Competition
Restore competition through physician-led care and stronger oversight of market concentration.

Workforce
Strengthen the neurosurgical pipeline through GME expansion, student loan reform, and training protections.

Public Health
Advance prevention and surveillance policy on neurological trauma, stroke, and congenital disease.



Utilization Management
Reform prior authorization and utilization controls to be faster, smarter, and frictionless.

Research
Secure federal investment in neurosurgical research, including NIH and defense-funded programs.

Liability
Advance balanced liability reform to stop defensive medicine and stabilize insurance.

Innovation
Accelerate safe access to new technologies and therapies by serving as a partner to the FDA and CMS.

Signed Into Law

Select Highlights of Neurosurgeon-Driven Leadership

Signed Into Law

The Washington Committee actively monitored and supported several must-pass legislative vehicles critical to neurosurgery and patient care. These included the NDAA, the SUPPORT Act, and continuing appropriations legislation that sustain funding for neurological research, Medicare accountability, opioid response programs, and essential VA and FDA operations.

National Defense Authorization Act for Fiscal Year 2026

Reauthorizes appropriations for the Department of Defense, including funding levels, and sets policies for military and defense priorities. This includes the Defense Health Program, which administers the CDMRP.

Support for Patients and Communities Reauthorization Act of 2025

Reauthorizes key public health programs that help prevent drug overdoses, provide access to treatment for those in need, and support opportunities for those recovering from substance use disorder.

Continuing Appropriations, Agriculture, Legislative Branch…and Extensions Act, 2026

Ended the government shutdown and provided appropriations through the end of FY2026 for agriculture (**FDA**), military construction, and veterans affairs, and legislative branch programs including No Surprises Act implementation costs for HHS.

Consolidated Appropriations Act, 2026

The annual Labor, Health and Human Services appropriations package funds major federal health programs, including NIH, CMS, and related public health agencies. Extends the Medicare Physician Fee Schedule **work geographic index floor** through January 1, 2027. Continues incentive payments under Advanced Alternative Payment Models, including a **3.1% bonus** for eligible clinicians in 2028. Maintains Medicare's COVID-era **telehealth flexibilities** through December 31, 2027, by removing geographic restrictions, expanding eligible originating sites and practitioners, and broadening telehealth services. **Increased funding for NIH** and Medicare programs and incorporates **select PBM reforms**. Blocked NIH **15% Indirect Cost Policy**. Preserved existing funding levels for CDC concussion surveillance and firearm injury prevention research.

Reimbursement

Addressing Federal and Commercial Reimbursement Policies

Medicare Physician Fee Schedule Reform

The Washington Committee has been working with the legislative champions, including those in the GOP and Democratic Doctor Caucuses, on bipartisan legislative reforms.

Efficiency Adjustment

Imposes a 2.5% cut based on assumed efficiency gains in procedural specialties.

Redirects payment toward E/M services.

Efficiency Adjustment Delay Act (H.R. 7520)

Delays cuts to work RVUs until 2030. Requires a report to Congress assessing whether this method is justified before it can move ahead. Does not impact primary care.

MEI

Payments are not tied to the Medicare Economic Index.

Practice costs rise annually, but payments do not.

Strengthening Medicare for Patients & Providers Act (H.R. 6160)

Replaces separate physician payment updates with a single CF. Provides an annual update tied to the Medicare Economic Index beginning in 2026.

Claims Data

Medicare claims data remain largely inaccessible.

Limits the ability to analyze care patterns, identify inefficiencies, and develop physician-led payment reforms.

Access to Claims Data Act (H.R. 4331)

Streamlines access for qualified and clinician-led registries to federal health program claims data. Allows registries to link claims data with clinical outcomes to support research, quality improvement, and patient safety analyses.

Budget Neutrality

Requires payment increases in one area to be offset by cuts elsewhere.

Forces specialties to compete over a fixed pool of funding.

Medicare Patient Access and Practice Stabilization Act of 2025 (S. 1640)

Increases certain payment adjustments under the Medicare physician fee schedule for services furnished between June 1, 2025, and January 1, 2026.

Budget Neutrality V2

Same

Provider Reimbursement Stability Act of 2026 (H.R. 8163)

Increases and indexes the budget neutrality threshold, corrects utilization-based payment errors, updates practice expense inputs, and limits year-to-year fluctuations in the conversion factor.

REP. ESTES INTRODUCES LEGISLATION TO DELAY EFFICIENCY ADJUSTMENT; BENEFITING KANSAS DOCTORS

Washington, February 12, 2026

Congressman Ron Estes (R-Kansas) introduced legislation, H.R. 7520, that addresses the efficiency adjustment in the Medicare Physician Fee Schedule by delaying the adjustment to ensure it is more targeted and thoughtful. Currently, the CY 2026 Medicare Physician Fee Schedule Final Rule introduced a new "efficiency adjustment" policy, and this mandate assumes perpetual efficiency gains in physician services, leading to recurring reimbursement reductions.

The policy reduces work Relative Value Units (RVUs) and intra-service time for all non-time-based codes by 2.5% in 2026, with additional cuts every three years. CMS assumes services are becoming faster, yet studies show 90% of procedures had the same or longer operative times in 2023 compared to 2019.

Additionally, the 2.5% cut is a flat rate based on general economy-wide labor productivity rather than actual clinical work or direct patient complexity. Because many physician employment contracts use work RVUs to calculate pay, these cuts will decrease compensation and threaten patient access.

"The Efficiency Adjustment Delay Act builds on Congress' recognition that cuts fuel consolidation to the detriment of physicians and their patients," **Alexander A. Khalessi, MD, MBA, Chair of the AANS/CNS Washington Committee for Neurological Surgery said**. "It helps ensure any future changes to work RVUs are grounded in empirical evidence and stakeholder input. We applaud Representatives Estes and Suozzi for their leadership and urge Congress to advance this legislation."

February 12, 2026

The Honorable Ron Estes
United States House of Representatives
2234 Rayburn House Office Building
Washington, DC 20515

The Honorable Thomas Suozzi
United States House of Representatives
203 Cannon House Office Building
Washington, DC 20515

Dear Congressmen Estes and Suozzi,

On behalf of the thirty-eight undersigned organizations, we would like to express our strong support for the *Efficiency Adjustment Delay* Act. This legislation is critical in ensuring patient access to medical care by delaying the flawed "efficiency adjustment" finalized in the Calendar Year 2026 Medicare Physician Fee Schedule until 2030. **This "efficiency adjustment" in the form of an across-the-board 2.5% reduction to work Relative Value Units (RVUs) will cause further decreases in reimbursement for physician services and have wide-ranging consequences, including significant financial pressures that could limit patient access to necessary medical services, particularly for the most vulnerable populations.**

This "efficiency adjustment" applies to all non-time-based codes in 2026 with additional reductions every three years indefinitely and is intended to address an incorrect assumption that non-time-based services become more efficient as the services become "more common, professionals gain more experience, technology is improved, and other operational improvements are implemented"[1]. In direct contradiction to this claim, a recent peer reviewed study published in the *Journal of the American College of Surgeons* (JACS) analyzing more than 1.7 million operations, spanning 249 CPT codes and eleven surgical specialties, found that 90 percent of CPT codes had the same or longer operative times in 2023 compared to 2019. Operative times have increased overall by 3.1 percent.[2]

Further, a recurring reduction in work RVUs every three years will have severe consequences for physician compensation, even beyond direct reimbursement from the Medicare Physician Fee Schedule. Many physician employment contracts are based on work RVUs or total RVUs, meaning that reductions in these values will decrease physician compensation despite no reduction in actual work performed. The inability to anticipate the magnitude of RVU reductions introduces ongoing uncertainty, making it increasingly difficult to structure fair and sustainable employment agreements, while extending another layer of financial unpredictability for private practice and solo practitioners. The likely response to this instability may be further consolidation.

Medicare Physician Fee Schedule

*Why does the **efficiency adjustment** systematically fail neurosurgical services?*

CMS' Rationale

CMS applied a **uniform 2.5% efficiency adjustment across *most* CPT codes** under the Medicare Physician Fee Schedule. The Agency believes that **technological advancement and practice evolution reduce the resources required** to deliver physician services over time. In aggregate, this may hold for some routine services. However, a blanket efficiency cut applied across heterogeneous codes **without differentiating** clinical characteristics, valuation recency, or empirical evidence of reduced inputs creates **systematic misvaluation.**

Key problem: *Uniform cuts applied without scrutiny risk misalignment between payment and resource costs, **especially for surgical services least amenable to efficiency gains.***

Irreducible Physician Work

Neurosurgical procedures require continuous, highly intense physician work that cannot be delegated or compressed without compromising patient safety.

High-Acuity, Unpredictable Cases

Many neurosurgical services are performed in emergent or life-threatening situations. Variability and clinical unpredictability inherently limit standardization and rule out efficiency gains.

Technology Hasn't Reduced Time in Aggregate

Advanced imaging and navigation tools have improved precision but not reduced operative time or cognitive complexity. In many cases, such tools have increased intraoperative duration and equipment overhead.

Administrative Burden Is Rising

Increasing documentation, quality reporting, and compliance requirements imposed by CMS offset any marginal efficiencies gained elsewhere in the neurosurgical care continuum.

Medicare Physician Fee Schedule

Comprehensive Code Inventory

- **Covered all 6 neurosurgical subspecialties:** spine, tumor, cerebrovascular, functional, trauma, pediatric
- Reviewed **10 years of RUC activity** for recently valued codes
- Solicited submissions
- Initial inventory: **~70 codes**

Clinical Prioritization

- **Volume:** annual code count billed by neurosurgeons
- **Practice Trends:** direction and pace of change in how services are furnished
- **Intensity & Complexity:** magnitude of physician work and irreducible clinical demands

Usability Screening (Exclusions)

- **Dominant Specialty:** codes where neurosurgery is not the primary biller were excluded
- **RUC Review Recency:** codes never reviewed or last reviewed before 2016 were excluded
- **Medicare Data Sufficiency:** codes with insufficient utilization data were excluded

Result: A defensible, evidence-based list of codes for targeted policy exemption.

Medicare Physician Fee Schedule

__11__ codes were identified through the three-step methodology.

CPT 61781

Add-On · ZZZ Global

Intraoperative Cranial Navigation

Recently valued by the RUC in September 2025 with CMS accepting the recommendation in full, making an efficiency adjustment redundant; as a time-only intraoperative add-on code, the physician work is irreducibly dependent on continuous presence and cannot be compressed or delegated.

CPT 61624

Cerebrovascular

Transcatheter CNS Embolization

CMS accepted the RUC-recommended valuation just two years ago in the CY 2025 MPFS, leaving no basis to assume resource requirements have changed; the procedure addresses vascular emergencies that are inherently unpreventable and represent high-acuity, technically demanding care.

CPT 63030

Spine · 90-Day Global · Outpatient

Lumbar Discectomy/Laminotomy

The efficiency adjustment compounds a pre-existing undervaluation, as CMS already assigned RVUs below the RUC recommendation in 2022, creating a double reduction inconsistent with the Agency's obligation to maintain payment accuracy.

CPT 22633

Spine · 90-Day Global · Inpatient

Combined Posterior Lumbar Interbody Fusion

CMS accepted the RUC valuation in 2021 and the clinical inputs remain unchanged, so an efficiency adjustment lacks empirical support; its 90-day inpatient global period encompasses extensive post-operative management that cannot be streamlined through productivity assumptions.

CPT 63052

Add-On · ZZZ Global

Extended Decompression During Lumbar Fusion

Like CPT 63030, an efficiency adjustment layers on top of a pre-existing below-RUC valuation, further distancing payment from actual resources required; as a time-only code, it captures intraoperative work that CMS has recognized warrants exemption from time-based efficiency reductions.

CPT 61863, 61864, 61867, 61868, 61885, and 61886

Deep Brain Stimulation

CMS already exempted these codes from the WISeR Model, affirmatively concluding they do not exhibit the characteristics of waste or declining clinical necessity that justify cost-reduction frameworks; applying an efficiency adjustment is directly inconsistent with that prior determination.

Medicare Physician Fee Schedule Reform

Joint Democrat and Republican Doctors Caucuses MACRA Reform Discussion Draft Released Last Week – **Feedback Due Monday**

- **Title I – Conversion Factor Update**
  - Updates the conversion factor using MEI while maintaining the split conversion factor structure
  - Limits annual adjustment so it may not exceed 0.75 of total MEI or fall below 0.25 of MEI in a given year
  - Primary care add-on payments during the five-year MIPS transition period – provides $500 million in budget neutrality-exempt.
- **Title II – MIPS Reform**
  - specialties lacking adequate measures and prioritizes them for Rebrands and modernizes MIPS
  - Temporarily reduces payment penalties from ±9% to ±2% during the transition period
  - Temporarily exempts QCRTF metric development
  - Establishes a CMS Quality Care Reform Task Force to develop specialty-relevant, outcomes-based metrics
  - Simplifies reporting through EHR auto-extraction and reduced provider burden
  - Aligns measures with clinical practice guidelines and registry-based reporting
- **Title III – APM / CMMI Reform**
  - Freezes the current APM threshold for three years
  - Requires greater transparency in CMMI model design and methodology
  - Establishes formal notice-and-comment requirements for mandatory models and material model changes
  - Requires regular reporting to Congress on model performance
  - Directs review of barriers to specialty participation in value-based models
- **Title IV – Budget Neutrality Reform**
  - Raises the budget neutrality threshold to $54.3 million and indexes it to MEI every five years
  - Allows retroactive conversion factor adjustments based on utilization estimates
  - Requires direct cost input updates at least every five years
  - Caps year-to-year conversion factor variance at 2.5%

Balance Billing

- The **No Surprises Act Enforcement Act** (S. 2420/H.R. 4710), was introduced by Senators Roger Marshall, MD (R-KS) and Michael Bennet (D-CO), and Representatives Greg Murphy, MD (R-NC), Jimmy Panetta (D-CA), John Joyce, MD (R-PA), Kim Schrier, MD (D-WA), Robert Onder, MD (R-MO), and Raul Ruiz, MD (D-CA).
- Holds insurers accountable and ensures compliance with federal arbitration rulings by:
  - Closing enforcement gaps through increased penalties for non-compliance with statutory payment deadlines.
  - Providing parity between penalties imposed against parties non-compliant with statutory patient protection provisions.
  - Increasing transparency in reporting requirements.
- **Washington Committee in Action**
  - Filed an **amicus brief in TMA III** (en banc) with 21 other state and specialty societies, supporting fair IDR rules and challenging flawed QPA methodology.
  - Ongoing meetings with original bill sponsors and coalition partners to coordinate Senate **HELP Committee hearing** on NSA implementation.
  - Working on **new campaigns** with a physician-led NSA-focused organization, INDEMED.

Utilization Management

Reforming Prior Authorization

POLITICO

Prior authorization panic

HHS pilot program raises Democratic concerns over Medicare red tape

The New York Times

Medicare Will Require Prior Approval for Certain Procedures

Medicare prior authorization pilot raises concerns among providers

Dr. Oz's new plan to root out Medicare 'waste' is actually a recipe for disaster

Newsweek

Medicare Update: Major Change Sparks Alarm from Lawmakers

NBC NEWS

Private health insurers use AI to approve or deny care. Soon Medicare will, too.

Medicare will test using AI to help decide whether patients get coverage — which could delay or deny care, critics warn

The WISeR Model

- Electrical Nerve Stimulators (NCD 160.7)
- Deep Brain Stimulation for Essential Tremor/Parkinson’s Disease (NCD 160.24)
- Vagus Nerve Stimulation (NCD 160.18)
- PVA for Vertebral Compression Fracture (L34106, L38201, L35130)
- Cervical Fusion (L39741, L39762, L39793)

Context

The CMMI WISeR model introduces prior authorization in Traditional Medicare for selected services beginning January 1, 2026, using third-party reviewers.

Scope

WISeR applies to multiple neurosurgical services, including DBS, VNS, vertebral compression fracture procedures, and cervical fusion, in six pilot states: **AZ, NJ, OH, OK, TX, and WA**.

Key Concerns

The model relies on flawed service selection, opaque third-party contractor payment based on denied care, and lacked gold carding or payment protections.

Washington Committee Position

Oppose expanding Medicare prior authorization without physician input, transparency, or administrative and payment safeguards.

Washington Committee in Action

1. **DBS** for Parkinson’s disease removed from the targeted services list.
2. **Percutaneous image-guided lumbar decompression** implementation delayed.
3. **Spinal arthrodesis (CPT 22585)** removed from the model’s procedure list.
4. **Vertically and horizontally integrated vendors** not selected.
5. **Documentation requirements revised** following specialty feedback.
6. **Professional claims protected** from automatic denial if facility claims fail authorization.
7. **CMMI committed to developing a gold-carding pathway** for physicians with strong approval histories.
8. **Greater transparency pledged** around clinical guidelines used to determine service selection.

Prior Authorization in Medicare Advantage

- The **Improving Seniors' Timely Access to Care Act** (S. 1816/ H.R. 3514) was introduced by Senators Roger Marshall, MD (R-KS), Mark Warner (D-VA), and Representatives Mike Kelly (R-PA), Suzan DelBene (D-WA), John Joyce, MD (R-PA), and Ami Bera, MD (D-CA).
- Reforms PA in MA by standardizing electronic transactions and clinical attachments, expanding CMS's authority to require more expedited determinations, increasing accountability and transparency in MA plans' use of PA, expanding beneficiary protections, and more.
- Has **69 Senate** and **280 House** cosponsors.
- **Washington Committee in Action**
  - Actively working to send this legislation to the **President's desk this Congress**.
  - Actively working with House Ways & Means Committee and House Energy & Commerce Committee staff to map out plan.
  - Driving toward **290 House cosponsors to trigger floor action** — replicating our 2022 strategy.

News | **Articles** | January 22, 2026

Congress challenges health insurers saying they put profits over patients

Neurosurgery
@neurosurgery

@RepBuddyCarter and the MANY other bipartisan members of @HouseCommerce @EnergyCommerce for standing up for patients and shining a light on the very real harm caused by prior authorization.

Some insurers may boast high #priorauth approval rates, but that's only part of the story.

What they don't say:

📞 Hours of staff time wasted on sham "peer" reviews
📠 "*We didn't get the fax or clinical documents*" 🤔 (even though they did)
📄 Appeals stacked with red tape
💸 Retroactive payment clawbacks days, months, and years after care is delivered

It's not just frustrating - it's disruptive, wasteful, costly, and for patients with cancer and other life-threatening conditions.... deadly.

⏰#fixpriorauth

@regrelief @councilsns @AANSNeuro @CNS_Update @CNSResidents @southernneuro

Energy and Commerce Committee @HouseCommerce · Jan 22
Doctors—NOT health insurance companies—know what's best for their patients.

When a doctor or pharmacist says a patient needs treatment, health insurance companies should listen. Denying lifesaving care after patients pay so much i...

12:47 PM · Jan 22, 2026 · **1,287** Views

Neurosurgery
@neurosurgery

At yesterday's @WaysandMeansGOP hearing, PA legislative champion @MikeKellyPA urged insurance CEOs to publicly support his bipartisan, bicameral bill — the Improving Seniors' Timely Access to Care Act.

👏 CVS Health endorsed it.
👏@Humana CEO Jim Rechtin is urging Congress to pass it.
🔇 Silence from the other CEOs — but the déjà vu was unmistakable, echoing pledges made in their 2018 industry-backed Consensus Statement...

There's a reason why Rep. Kelly and other lawmakers wrote this bill.
#fixpriorauth #MedicareAdvantage

🎯 Watch his remarks — he nailed it:

youtube.com
Rep. Mike Kelly to Health Insurance CEOs: Support the 'Im...
During a Ways & Means Committee hearing on January 22, 2026, U.S. Representative Mike Kelly (R-PA), a member of ...

Neurosurgery
@neurosurgery

🚨 One of my constituents had a stroke... the doctor said he needed to be in the hospital. UnitedHealth said no. Now he's stuck with the bill. So now we've got this senior who's in the hospital, can't go home, stuck with a huge bill. That is just unconscionable. – @RepKimSchrier

Rep. Schrier did our Washington State members and their patients proud!

It's time to #FixPriorAuth in #MedicareAdvantage

🎥 Watch the full clip 👇
@EnergyCommerce @councilsns @fredhutch @washumedicine @seattlechildren @ProvSwedish @regrelief @SpecialtyDocs @uwsomwwami

Last edited 2:14 PM · Jan 22, 2026 · **2,071** Views

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Increasing Competition

Ownership Matters

Physician-Owned Hospitals

- The **Patient Access to Higher Quality Health Care Act of 2025** (H.R. 4002) is led by Reps. Beth Van Duyne (R-TX) and Henry Cuellar (D-TX), joined by 8 additional bipartisan cosponsors. Fully repeals the ACA's moratorium on new or expanded POHs, restoring physicians' ability to open and grow facilities.
- The **Physician-Led and Rural Access to Quality Care Act** (S. 1390/H.R. 2191) is a narrowly tailored approach to restoring competition and physician leadership. Allows the establishment of new POHs in rural areas located more than 35 miles from an existing hospital or CAH (15 miles in mountainous or hard-to-reach areas).
- **Washington Committee in Action**
  - Ongoing **education with Democratic offices** on the role and benefits of physician-owned hospitals.
  - Sustained **coalition and stakeholder engagement** to expand organizational support for POH reform.
  - Collaborating with coalition partners to design a **CMMI demonstration model**. Following a productive initial meeting in 2025, CMMI staff invited a revised concept that could build off the TEAMS model structure.
  - In the IPPS Proposed Rule released in April, CMS included an RFI to participate in the TEAM model through a voluntary opt-in pathway, while maintaining safeguards to protect program integrity and Medicare spending.

Expanding Neurosurgery's Influence

Placing Clinicians in Positions of Power

Expanding Neurosurgery's Influence

Joshua Rosenow, MD
CPT Neurostimulator Workgroup – AMA
November 2025

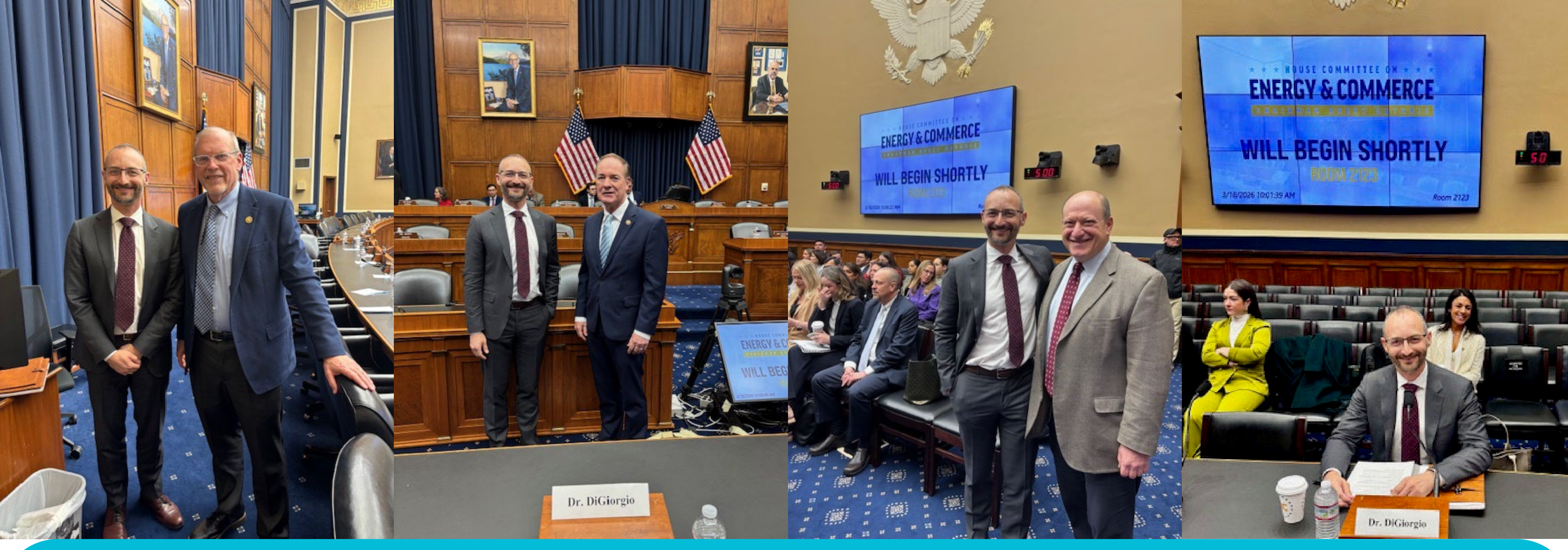
Anthony DiGiorgio, DO
National Committee on Vital and Health Statistics – HHS
December 2025

Ricardo Hanel, MD
Advisory Council on Alzheimer's Research, Care and Services – HHS
January 2025

Expanding Neurosurgery's Influence

Meeting with HHS Secretary Kennedy

Dinner with FDA Commissioner Makary



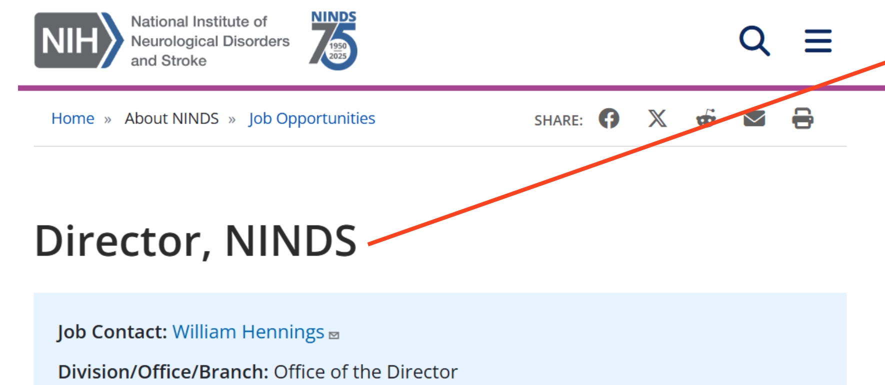
Energy and Commerce Committee Health Subcommittee Hearing

Patient Affordability, Competition, and Access Across the U.S. Provider Landscape

March 18, 2026

Expanding Neurosurgery’s Influence

Russ Lonser, MD


NIH National Institute of Neurological Disorders and Stroke

NINDS 75 1950 2025

Home » About NINDS » Job Opportunities

SHARE:

Director, NINDS

Job Contact: William Hennings

Division/Office/Branch: Office of the Director

The Director of NINDS leads one of the preeminent institutes for neurological science, advancing research to understand the brain and nervous system and reduce the burden of neurological disease. NINDS supports basic, translational, and clinical research, while fostering the next generation of neuroscience investigators. The Director also plays a key leadership role in major NIH-wide efforts, including the BRAIN Initiative®, NIH HEAL Initiative, and the NIH Blueprint for Neuroscience.

Who can apply
U.S. citizens with an M.D., Ph.D., or equivalent doctoral degree and senior-level research and leadership experience in neuroscience

Location
Bethesda, Maryland

Apply by
May 4, 2026, 11:59 p.m. ET

Apply now
https://hr.nih.gov/careers/open-positions/job-0c3fbf4b-104f-4d70-a9df-43a4ac918008

APPLICATION TO BE SUBMITTED SOON

Upcoming Events

Don’t Miss Out!!!

MARTY MAKARY, MD

CHARLES PLANTE LECTURE

Commissioner of Food and Drugs,
Food and Drug Administration
United States Department of Health
and Human Services

Friday, May 1 at 4:30 PM

AANS/CNS Washington Committee

Webinar: Surgeons as Entrepreneurs

Thursday, May 14, 2026 • 8:00–9:00 PM Eastern • Virtual / Recorded

MODERATORS

Moderator	Moderator
Paul Arnold, MD	**Faith Robertson, MD**

For more information, email Zahra Younoszai at zyounoszai@neurosurgery.org

AGENDA

Session	Time	Details
Opening Remarks	8:00 PM 5 min.	**Welcome & Introductions** Dr. Arnold & Dr. Robertson
Surgeon Perspectives	8:05 PM 25 min.	**Physicians as Innovators: Paths to Product Development** Carl Heilman, MD *Co-Founder, CereVasc* Amit Iyer, MD, MBA *Co-Founder, Rhaeos* Fred Liss, MD *General Partner, PhyCap Fund*
FDA Perspective	8:30 PM 15 min.	**TAP Overview & Regulatory Pathways for Physicians** Lea Drye, PhD *Epidemiologist, Total Product Lifecycle Advisory Program* *Office of the Center Director, CDRH* *US Food & Drug Administration*
Discussion	8:45 PM 15 min.	**Q&A** Moderators & all speakers

NeurosurgeryPAC Spotlight

John A. Cowan Jr., MD, FAANS

for Georgia's 11th Congressional District

Background

- Board-certified neurosurgeon with nearly two decades of clinical practice serving patients and families in Rome and the broader northwest Georgia region.
- Demonstrated commitment to advancing patient care and specialty as an innovator and inventor, with multiple US patents in neurosurgical and spinal device technologies.
- Received M.D. from Johns Hopkins School of Medicine. B.S. in Physics from Davidson College, cum laude. General surgery internship and neurosurgery residency at the University of Michigan.
- Longstanding participation in organized medicine, including membership in the AANS since 2002, past President of the Georgia Neurosurgical Society, service on the Board of Directors of the Medical Association of Georgia, and current member of NeurosurgeryPAC.
- Active volunteer leader in his church, civic organizations, and community service in Rome and Floyd County.
- Small business owner with direct experience in job creation and the operational challenges facing local businesses.
- Proud multigenerational Georgian raised on his family's cattle farm in Bartow County. Husband of board-certified anesthesiologist Anne Cowan, MD, and father of four children.

Earned endorsements from national physician organizations and Members of Congress.

Key Legislative Priorities

- Running for Congress to ensure patients come first by strengthening the physician voice in Washington and leading sustainable bipartisan solutions to America's health care challenges.
- Protecting physician-led care and opposing all threats that jeopardize patient safety and the integrity of surgical specialties.
- Restoring competition in health care by addressing vertical and horizontal consolidation that is undermining independent physician practice and prioritizing corporate profits over patient care.
- Committed to reforming prior authorization and other utilization management tools, and advancing administrative simplification policies that improve timely access to evidence-based care.

Key Endorsement by the Healthcare Freedom Fund, the PAC supporting members of the GOP Doctors Caucus.

Primary 05/19/2026

Thank You