STATEMENT

of

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Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape

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Introduction

Chairman Griffith, Vice-Chair Harshbarger, Ranking Member DeGette, and Members of the Subcommittee, thank you for the opportunity to testify today on provider affordability.

I am Anthony DiGiorgio, a practicing physician and Assistant Professor of Neurological Surgery at the University of California, San Francisco. I also serve in the federal advocacy arm of the American Association of Neurological Surgeons and Congress of Neurological Surgeons. I appear today in my personal capacity. The views I express are my own and do not necessarily reflect those of UCSF, its Department of Neurological Surgery, the Institute for Health Policy Studies, Zuckerberg San Francisco General Hospital, the AANS, or CNS.

Americans do not experience health care affordability as an abstraction. They experience it when a premium deduction rises faster than their paycheck, when a deductible resets before the last bill is paid off, and when the exact same outpatient service suddenly costs more because the sign on the building changed. Polling from earlier this year found that health care costs top the list of

worrisome household expenses, with 66 percent saying they worry about affording health care for themselves and their family.[1]

If Congress is serious about provider affordability, it must look squarely at hospital-centered cost growth and the policy choices that have accelerated it. Hospital care remained the largest category of national health spending in 2024 at 31 percent. Physician and clinical services accounted for another 21 percent. Those are distinct categories, but hospital ownership of physician practices means the economic pull of hospital systems extends well beyond the hospital campus. And just this month, the Census Bureau reported that seasonally adjusted revenue for tax-exempt hospitals in the fourth quarter of 2025 was 11.8 percent higher than in the fourth quarter of 2024.[2] That statistic is not proof of wrongdoing. But it is a reminder that hospital-based cost growth is not theoretical. Patients, employers, and taxpayers are paying for it now.

The answer is not weaker hospitals. Our country needs strong hospitals for emergency care, trauma care, teaching, transplant services, and true safety-net functions. But we also need something that federal policy has steadily diminished: a strong, independent physician sector. Independent physicians and physician-led facilities are one of the last practical checks on consolidation in American health care. They preserve patient choice, create local price competition, keep routine services in lower-cost settings, and maintain accountability with a personalized relationship between physician and patient rather than inside a distant corporate hierarchy.

Independent physicians are not frustrated by competition, but rather by the unfair playing field. Too many current policies pay more for the same care when a hospital owns the site, impose fixed compliance burdens that large systems can spread across departments but small practices cannot, and restrict physician-led entry even where patients would benefit from more options.

Provider Consolidation

A 2025 U.S. Department of Health and Human Services (HHS) report prepared in consultation with the U.S. Department of Justice (DOJ) and U.S. Federal Trade Commission (FTC) concluded that consolidation of health care providers has led to higher prices, reduced access, and lower quality care.[3]

According to American Medical Association (AMA) research, physician ownership of practices was 76 percent in the 1980s, declining to 61 percent in the mid-2000s, and then to 35 percent in

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[1]Shannon Schumacher et al., "KFF Health Tracking Poll: Health Care Costs, Expiring ACA Tax Credits, and the 2026 Midterms," KFF, January 29, 2026, https://www kff.org/public-opinion/kff-health-tracking-poll-health-care-costs-expiring-aca-tax-credits-and-the-2026-midterms/.

[2] U.S. Census Bureau, "Quarterly Selected Services Estimates, Fourth Quarter 2025 – Advance Report," March 2026, accessed March 15, 2026, https://www.census.gov/services/qss/qss-current.pdf.

[3] U.S. Department of Health and Human Services, "HHS Consolidation in Health Care Markets RFI Response," January 2025, https://www hhs.gov/sites/default/files/hhs-consolidation-health-care-markets-rfi-response-report.pdf.

2024[4]. One analysis of five subspecialties (cardiology, gastroenterology, oncology, orthopedics, and urology) found that only 12 percent of physicians were not affiliated with a hospital, corporate entity, or private equity.[5] In 2016, 39 percent of Metropolitan Statistical Areas (MSAs) were highly concentrated for primary care and 65 percent for specialty care.[6]

On the hospital side, the AMA found that of 389 metropolitan areas, only five are not highly concentrated by FTC standards.[7] Multi-hospital systems owned 81 percent of hospital beds in 2020, up from 58 percent in 2000.[8]

Just like any industry, this consolidation has led to significant price increases. Prices at monopoly hospitals are 12 percent higher than in more competitive markets.[9] When hospitals merge in concentrated markets, numerous studies have shown large price increases, even increasing in neighboring hospitals, or cross-market hospitals as well.[10, 11, 12, 13, 14, 15] Hospital acquisition of independent practices and vertical integration are associated with higher prices and higher Medicare spending, with one national study finding a 14.1 percent post-acquisition increase[16] for

[4] American Medical Association, "Policy Research Perspectives: Physician Practice Characteristics in 2024," 2024, https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf.
[5] Avalere Health, "Medicare Cost and Utilization Across Physician Affiliation Models," Avalere Health, accessed March 15, 2026, https://advisory.avalerehealth.com/insights/medicare-cost-and-utilization-across-physician-affiliation-models.
[6] Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," *Health Affairs* 36, no. 9 (September 2017): 1530–38, https://doi.org/10.1377/hlthaff.2017.0556.
[7] American Medical Association, "Policy Research Perspectives: Competition in Hospital Markets," accessed March 15, 2026, https://www.ama-assn.org/system/files/prp-competition-in-hospital-markets.pdf.
[8] Elena Andreyeva et al., "The Corporatization of Hospital Care" (working paper, SSRN, 2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4134007.
[9] Zack Cooper et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *The Quarterly Journal of Economics* 134, no. 1 (February 2019): 51–107, https://doi.org/10.1093/qje/qjy020.
[10] Daniel Arnold et al., "New Evidence on the Impacts of Cross-Market Hospital Mergers on Commercial Prices and Measures of Quality," *Health Services Research* (April 2024), https://doi.org/10.1111/1475-6773.14291.
[11] Richard M. Scheffler, Daniel R. Arnold, and Christopher M. Whaley, "Consolidation Trends in California's Health Care System: Impacts on ACA Premiums and Outpatient Visit Prices," *Health Affairs* 37, no. 9 (September 2018): 1409–16, https://doi.org/10.1377/hlthaff.2018.0472.
[12] Cory Capps and David Dranove, "Hospital Consolidation and Negotiated PPO Prices," *Health Affairs* 23, no. 2 (March/April 2004).
[13] Leemore Dafny, "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," *The Journal of Law and Economics* 52, no. 3 (August 2009).
[14] Matthew Lewis and Kevin Pflum, "Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions," *The RAND Journal of Economics* 48, no. 3 (Fall 2017).
[15] Leemore Dafny, Kate Ho, and Robin S. Lee, "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry," *The RAND Journal of Economics* 50, no. 2 (Summer 2019): 286–325, https://doi.org/10.1111/1756-2171.12270.
[16] Cory Capps, David Dranove, and Christopher Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics* 59 (May 2018): 139–52, https://doi.org/10.1016/j.jhealeco.2018.04.001.

acquired physicians' services, with larger systems showing higher increases.[17, 18] Additionally, the shifts in the site of service and volume of services also increase total Medicare spending following hospital acquisitions of physician practices.[19]

These prices are reflected in increasing insurance premiums. Since 1999, health insurance premiums have increased 342 percent, with worker contributions increasing 308 percent while earnings are only up 119 percent.[20] Meanwhile, hospital-service prices have risen faster than premium growth and faster than physician-service prices, suggesting that hospital prices are an important driver of insurance price increases.[21]

This also affects wages for health care workers. Skilled workers see a four percent drop in wages after a hospital merger that increases concentration, and nurses see a nearly seven percent drop.[22] Physicians are also locked in by non-compete clauses. In 2018, 45 percent of primary care doctors in group practices were subject to these restrictions. This severely limits their ability to change jobs, move to areas of greater need, or negotiate wage increases when their employer is a large system with a wide geographic reach.[23]

Aside from the wage effects, the loss of control and autonomy drives burnout, and U.S. physicians are at higher risk of burnout than other U.S. workforce categories.[24, 25] This has also stagnated innovation, as Bureau of Labor Statistics stats over the past two decades show that productivity growth has been weak and, in recent years, negative for hospitals.[26] Physicians are profoundly frustrated by this stagnation. The nationwide epidemic of physician burnout is not

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[17] J. Godwin et al., "The Association Between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 58 (2021), https://doi.org/10.1177/0046958021991276.
[18] Vilsa Curto, Anna Sinaiko, and Meredith Rosenthal, "Price Effects of Vertical Integration and Joint Contracting Between Physicians and Hospitals in Massachusetts," *Health Affairs* 41, no. 5 (May 2022): 741–50.
[19] Christopher Whaley et al., "Higher Medicare Spending on Imaging and Lab Services After Primary Care Physician Group Vertical Integration," *Health Affairs* 40, no. 5 (May 2021): 702–9, https://doi.org/10.1377/hlthaff.2020.01006.
[20] Salpy Kanimian and Vivian Ho, "US Medical Prices and Health Insurance Premiums, 1999–2024," *JAMA Network Open* 8, no. 12 (December 2025), https://doi.org/10.1001/jamanetworkopen.2025.47462.
[21] Salpy Kanimian and Vivian Ho, "Why Does the Cost of Employer-Sponsored Coverage Keep Rising?," *Health Affairs Scholar* 2, no. 6 (June 2024), https://doi.org/10.1093/haschl/qxae078.
[22] Elena Prager and Matt Schmitt, "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review* 111, no. 2 (February 2021): 397–427, https://doi.org/10.1257/aer.20190690.
[23] Kurt Lavetti, Kosali Simon, and William White, "The Impacts of Restricting Mobility of Skilled Service Workers: Evidence from Physicians" (working paper, 2018), http://kurtlavetti.com/UIPNC_vf.pdf.
[24] National Academies of Sciences, Engineering, and Medicine, *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being* (Washington, DC: The National Academies Press, 2019), https://doi.org/10.17226/25521.
[25] Tait D. Shanafelt et al., "Changes in Burnout and Satisfaction With Work-Life Integration in Physicians and the General US Working Population Between 2011 and 2023," *Mayo Clinic Proceedings* 100, no. 7 (July 2025): 1142–58, https://doi.org/10.1016/j.mayocp.2024.11.031.
[26] U.S. Bureau of Labor Statistics, "Private Community Hospitals Labor Productivity," accessed March 15, 2026, https://www.bls.gov/productivity/highlights/hospitals-labor-productivity.htm.

driven by treating patients; it is driven by the relentless loss of clinical autonomy to corporate administrators and Byzantine compliance metrics that penalize independence.

When hospitals consolidate and raise prices, commercial insurers pass those increases through as higher premiums. Employers absorb those premiums by suppressing wages, reducing headcount, or shifting costs to employees through higher deductibles and coinsurance.

A study by economists at the University of Chicago, Yale, and the University of Wisconsin-Madison shows these economic effects, tracking hundreds of hospital mergers.[27] The researchers estimate that a one percent increase in health care prices lowers payroll and employment at non-health-care employers by 0.4 percent. Hospital mergers also decrease tax revenue. In other words, rising provider prices function like a tax on wages and jobs. Americans are right to be angry about affordability. The hidden victims are not just patients at the point of service, but workers whose raises never arrive because more of their compensation is being diverted into health benefits.

The counterargument often touted is that consolidation improves quality of care for patients via efficiency and coordination. Research does not support this. One study found that hospital mergers were associated with higher treatment intensity and higher inpatient mortality among patients with heart disease.[28] Another found modestly worse patient experience and no significant improvement in readmissions or mortality after hospital acquisitions.[29] Consolidation may create larger organizations. The evidence does not show that it reliably creates better care.

Policy Solutions

Restore Physician-Led Entry: Repeal ACA Section 6001 and Modernize Stark Law

Congress should revisit the policies that have choked off physician-led entry. Section 6001 of the Affordable Care Act (ACA) largely froze physician-owned hospital (POH) entry and expansion by prohibiting POHs from increasing the number of operating rooms, procedure rooms, and beds beyond the March 23, 2010 baseline, absent a narrow exception. This has removed one of the few physician-led entry pathways that could have checked consolidation.[30],[31]

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[27] Zarek Brot-Goldberg et al., "Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers" (working paper no. 32613, National Bureau of Economic Research, June 2024), https://doi.org/10.3386/w32613.
[28] Tyler B. Hayford, "The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes," *Health Services Research* 47, no. 3, pt. 1 (June 2012): 1008–29, https://doi.org/10.1111/j.1475-6773.2011.01351.x.
[29] Nancy D. Beaulieu et al., "Changes in Quality of Care after Hospital Mergers and Acquisitions," *New England Journal of Medicine* 382, no. 1 (January 2020): 51–59, https://doi.org/10.1056/NEJMsa1901383.
[30] American Medical Association, "Report 4 of the Council on Medical Service (I-23): Physician-Owned Hospitals," November 2023, https://councilreports.ama-assn.org/councilreports/downloadreport?uri=%2Fcouncilreports%2Fi23_cms_report_4.pdf.
[31] Mercatus Center at George Mason University, "Cost and Quality of Care at Physician-Owned Hospitals: A Systematic Review," accessed March 15, 2026, https://www.mercatus.org/research/research-papers/cost-and-quality-care-physician-owned-hospitals-systematic-review.

However, there is ample evidence that POHs provide high-quality care. Many of the focused-factory POHs exhibit lower inpatient mortality, reduced hospital risk-standardized mortality rates, lower complication rates, reduced readmission rates, and vastly superior patient satisfaction, at lower or comparable costs, when rigorously matched against non-POH corporate competitors. General acute care POHs (community hospitals which offer emergency care, primary care, and labor and delivery services), which make up roughly 55 percent of all POHs, perform equally as well as their non-profit and investor-owned counterparts regarding cost and quality, while improving access in underserved communities. [32] That is enough to justify repealing Section 6001 and replacing it with modern guardrails.

As an example, a colleague of mine is part owner in an independent spine hospital. Their prices are 50-80 percent of what neighboring hospitals charge. They achieve those savings by having about 1/3 of the total staff of similarly sized non-POHs, and, since the surgeons are owners, they keep a close eye on expenses. Of note, POH leadership is not separated from patient care, as the same surgeon who helps guide operational decisions will spend several days a week in the operating room caring for patients. That model stands in contrast to the prevailing belief that running a hospital requires handing the job entirely to administrators far removed from the bedside. Patients see that. This physician-owned spine hospital has a Net Promoter Score of 93 from patients, when similar hospitals tend to hover in the mid-teens. Yet despite its strong outcomes and lower costs, federal law prevents POHs like this one from expanding to meet demand from Medicare patients.

The same principle should guide Stark reform. Fraud and anti-kickback rules are necessary. But Congress should stop writing those rules as though every physician-led ownership arrangement is presumptively suspect, while large systems can internalize referral streams through common ownership and employment. Independent physicians should be able to build lawful ancillary capacity, participate in bona fide joint ventures, and coordinate care without hiring a battalion of lawyers just to understand whether ordinary business planning is allowed (the most recent combined regulations sit at hundreds of pages).[33, 34] The legal costs to comply with these regulations are so high that few independent practices can navigate the burden.

If policymakers are worried about weak utilization control in fee-for-service (FFS) billing, a legitimate concern given the levels of fraud that are coming to light, an exception to Stark could be made within a managed care setting. While physicians despise prior authorization and other methods of utilization review that come with managed care, allowing an exception to Stark law

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[32] *Ibid.*

[33] Centers for Medicare & Medicaid Services, "Medicare and State Health Care Programs: Fraud and Abuse; Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements," *Federal Register* 85, no. 232 (December 2, 2020): 77684–895, https://www.govinfo.gov/content/pkg/FR-2020-12-02/pdf/2020-26072.pdf.

[34] Centers for Medicare & Medicaid Services, "Medicare Program: Modernizing and Clarifying the Physician Self-Referral Regulations," *Federal Register* 85, no. 232 (December 2, 2020): 77492–682, https://www.govinfo.gov/content/pkg/FR-2020-12-02/pdf/2020-26140.pdf.

for Medicare Advantage and Medicaid Managed Care Organizations (MCOs) would soften that blow.[35]

Section 6001 and Stark create an untenable double standard: corporate health systems are granted broad safe harbors that allow them to functionally pay primary care doctors for lucrative downstream referrals simply by employing them. Research has shown that acquisitions by health systems can also provide economic leverage to anti-competitively steer referrals within their system.[36] Why should independent doctors be subjected to prohibitions on self-referrals when corporations aren't? This severely restricts independent physicians from entering into innovative, value-based joint ventures or sharing in the savings generated by efficient care coordination.

Enact Site-Neutral Payment for Routine Outpatient Care

Currently, the U.S. Centers for Medicare and Medicaid Services (CMS) pays vastly different amounts for the same clinical service depending solely on the ownership structure of the building where the service is rendered. This structural flaw transforms health care delivery into a massive exercise in payment policy arbitrage.

For just these standard office visits on Medicare patients, the hospital industry generates $2 billion in facility fees annually, with an extra $480 million in beneficiary cost-sharing.[37] For procedures, hospitals generate about $38 billion by doing procedures in hospital outpatient departments over independent ambulatory surgery centers (ASCs).[38] The Medicare Payment Advisory Commission (MedPAC) has been blunt about the consequences, noting that from 2015 to 2021, the volume of chemotherapy treatments given in freestanding clinician offices fell 14.2 percent, while volume in hospital outpatient departments grew by 21 percent. They also noted price distortions, and as an example, showed that a transthoracic echocardiogram was reimbursed 194 percent more in a hospital than in a freestanding office.[39]

Hospitals use the promise of a portion of this inflated reimbursement to entice or pressure independent physicians into selling their clinics. The stark economic reality is that an independent medical practice is often worth significantly more to a corporate hospital system than it is to the independent physician owner, strictly due to the hospital's ability to exploit the

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[35] Brian J. Miller, Jesse M. Ehrenfeld, and Albert W. Wu, "Competition or Conflict of Interest—Stark Choices," *JAMA Health Forum* 2, no. 2 (February 2021), https://doi.org/10.1001/jamahealthforum.2021.0150.
[36] David Cutler et al., "Vertical Integration of Healthcare Providers Increases Self-Referrals and Can Reduce Downstream Competition: The Case of Hospital-Owned Skilled Nursing Facilities" (working paper no. 28305, National Bureau of Economic Research, December 2020), https://www nber.org/papers/w28305.
[37] Medicare Payment Advisory Commission (MedPAC), "Report to the Congress: Medicare Payment Policy," March 2020, https://www medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch3_sec.pdf.
[38] Ambulatory Surgery Center Association, "Commercial Insurance Cost Savings in ASCs," accessed March 15, 2026, https://www.ascassociation.org/asca/about-ascs/savings/private-payer-data/shifting-procedures-to-ascs/commercial-insurance-cost-savings-in-ascs.
[39] Medicare Payment Advisory Commission (MedPAC), "Report to the Congress: Medicare and the Health Care Delivery System," June 2023, https://www medpac.gov/wp-content/uploads/2023/06/Jun23_arCh8_MedPAC_Report_To_Congress_SEC.pdf.

site-of-service differential. The ultimate victims of this regulatory loophole are the patients, who are burdened with substantially higher Part B coinsurance liabilities resulting from the artificially inflated facility fees, and the taxpayers who fund the Medicare program.

CMS deserves credit for beginning to tackle this problem with the 2026 Outpatient Prospective Payment System (OPPS) final rule. In this, the agency expanded site-neutral payment for drug-administration services in excepted off-campus provider-based departments.[40]

This is not an anti-hospital argument. MedPAC itself makes the right distinction. Hospitals should continue to be supported for services tied to true standby capacity, including emergency and trauma care, and any legitimate concerns about specific hospital categories should be addressed through targeted assistance rather than by overpaying routine ambulatory services across the board. Congress should finish what CMS has only begun and enact real site-neutral payment across routine outpatient care. That would not weaken hospitals' unique missions. It would stop using inflated routine-service payments to subsidize everything else.

MedPAC has an outline on how to equalize payments. Medicare should not just bring all facility fee payments down to the Physician Fee Schedule (PFS) level, but there should be equalization between the PFS, ASC fee schedule, and OPPS.[41] Independent economic estimates by the Committee for a Responsible Federal Budget project that equalizing Medicare payments regardless of the site of care would generate between $217 billion and $279 billion in deficit reduction for the Medicare program over a ten-year period.[42]

Stabilize Payments and Reduce Administrative Burdens

For a truly independent physician practice, Medicare compliance is a permanent operating layer made up of enrollment maintenance, claims coding, documentation, coverage checks, certified-Electronic Health Record (EHR) upkeep, security/interoperability work, prior authorization, and annual quality/payment reporting. Just documenting enough to meet CMS documentation requirements for billing is onerous. For example, one study showed that over one year, a single trauma surgeon spends over 9 full 24-hour days just on billing documentation.[43]

Quality metric reporting is another large burden. The four most common types of independent physician practices demonstrate an estimated $15.4 billion annual metric reporting cost, with the

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[40] Centers for Medicare & Medicaid Services, "Calendar Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule," accessed March 15, 2026, https://www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-opps-ambulatory-surgical-center.

[41] MedPAC, "Report to the Congress," June 2023, https://www medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf.

[42] Committee for a Responsible Federal Budget, "Equalizing Medicare Payments Regardless of Site-of-Care," February 23, 2021, https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care.

[43] J. F. Golob Jr., J. J. Como, and J. A. Claridge, "The Painful Truth: The Documentation Burden of a Trauma Surgeon," *Journal of Trauma and Acute Care Surgery* 80, no. 5 (May 2016): 742–45, https://doi.org/10.1097/TA.0000000000000986.

true cost likely higher. Outpatient physicians spend 2.6 hours weekly on metric reporting and nonphysician staff spend another 12.5 hours weekly.[44] It costs an average of $12,800 per physician to participate in the Merit-based Incentive Payment System (MIPS).[45]

Additionally, Medicare's conditions of participation actively prohibit price transparency for practices. Under current rules, a physician who wants to privately contract with a Medicare beneficiary generally must opt out of Medicare for an initial two-year period.[46] In practice, this means that physicians are not allowed to offer cash prices to Medicare beneficiaries. These prohibitions stifle the ability of physicians to innovate on payment design. That all-or-nothing structure makes patient-centered payment innovation harder than it should be. Congress should allow more flexible private contracting, more transparent cash pricing, and more direct care arrangements with strong patient protections. Independent physicians are often the clinicians most willing to experiment with simpler, more transparent ways of delivering care. The law should stop treating that instinct as a threat.

Without the ability to enter creative private contracts, many physicians are left billing traditional Medicare using its FFS formulations. Facilitating a broader use of private contracting, direct primary care models, and transparent, upfront pricing mechanisms empowers patients to act as true consumers of health care, allocating capital based on value rather than network limitations. It frees the independent physician from the FFS model. Additionally, private contracting with utilization management protects against the very fraud that the POH prohibition and Stark law were meant to stop.

I do not believe the long-term answer is to perfect Medicare's physician fee schedule. The better direction is more flexible private contracting and payment models that move physicians off the fee-for-service treadmill. But as long as Congress keeps physicians inside the PFS, it should at minimum stop using that schedule in ways that destabilize independent practice. After adjusting for inflation in practice costs, Medicare physician payment declined 33 percent from 2001 to 2025.[47] The 2026 PFS final rule again illustrated the problem: two conversion factors, temporary statutory patches, budget-neutrality offsets, and a new efficiency adjustment to work RVUs for most non-time-based services. Small independent practices cannot plan around that kind of volatility.

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[44] Lawrence P. Casalino et al., "US Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures," *Health Affairs* 35, no. 3 (March 2016): 401–6, https://doi.org/10.1377/hlthaff.2015.1258.
[45] Dhruv Khullar et al., "Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-Based Incentive Payment System: A Qualitative Study," *JAMA Health Forum* 2, no. 5 (May 2021), https://doi.org/10.1001/jamahealthforum.2021.0527.
[46] 42 C.F.R. pt. 405, subpt. D.
[47] American Medical Association, Medicare Physician Payment Updates vs. Practice Cost Inflation, 2001–2025, 2025, https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf.

These distortions do not hit every specialty the same way. Commercial insurers pay only modestly above Medicare in some fields such as ophthalmology,[48] while other specialties receive much larger markups. Other specialties, such as primary care, also have more room to experiment with direct or concierge models, which have grown rapidly in recent years.[49] Hospital-based specialties have a much harder time opting out of Medicare and the PFS. The point is not that Congress should make the PFS the centerpiece of reform. The point is that if Congress insists on administered pricing, it should stop using that pricing system as a consolidation accelerator while opening more room for private contracting and lower-burden alternatives.

CMS must implement sweeping regulatory reforms to simplify clinical documentation and streamline convoluted quality reporting programs. Policymakers should evaluate whether Advanced Alternative Payment Models (APMs) or MIPS Value Pathways (MVPs) can be restructured to simplify the administrative burden rather than compound it. Quality metrics should have a lifecycle, being continually re-evaluated and retired.[50] Many physician organizations also track quality metrics for their members. For example, in neurosurgery, we have the Quality Outcomes Database (QOD), which members use as internal quality tracking.[51] Those registries should serve as viable substitutes for CMS metrics, contributing to a decentralized metric landscape.

Doctors want to spend time healing patients, but current regulations force independent physicians to spend hours acting as data-entry clerks to keep their doors open. The system effectively starves independent practices of revenue while burying them in paperwork, making selling to a hospital the only viable way out.

Course Correct the 340B Drug Pricing Program

Congress must confront distortions and abuses in the 340B Drug Pricing Program. Whatever its original purpose, it is no longer a small program. The Health Resources and Services Administration reports that 340B covered entities purchased $81.4 billion in covered outpatient

[48] Stephen McMorrow, John Holahan, and Robert Berenson, *Commercial Health Insurance Markups over Medicare Prices for Physician Services Vary Widely by Specialty*, Urban Institute, October 2021, https://www.urban.org/research/publication/commercial-health-insurance-markups-over-medicare-prices-physician-services-vary-widely-specialty.

[49] Jane M. Zhu et al., "Growth in Number of Practices and Clinicians Participating in Concierge and Direct Primary Care, 2018–23," *Health Affairs* (2025), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2025.00656.

[50] Anthony M. DiGiorgio, Jesse M. Ehrenfeld, and Brian J. Miller, "Improving Health Care Quality Measurement to Combat Clinician Burnout," *JAMA* 330, no. 12 (September 2023): 1135–36, https://doi.org/10.1001/jama.2023.15512.

[51] Anthony L. Asher et al., "Research Using the Quality Outcomes Database: Accomplishments and Future Steps Toward Higher-Quality Real-World Evidence," *Journal of Neurosurgery* 139, no. 6 (May 2023): 1757–75, https://doi.org/10.3171/2023.3.JNS222601.

drugs in 2024,[52] which is up from just $6.6 billion in 2010.[53] The Government Accountability Office (GAO) found that the current Medicare payment structure creates financial incentives for participating hospitals to prescribe more drugs or more expensive drugs to Medicare beneficiaries.[54]

The availability of the 340B discount to hospital child sites, and not to independent practices, creates another means of financial leverage for hospital systems to acquire oncology, neurology, rheumatology clinics, and other specialty practices that prescribe high volumes of expensive specialty drugs. By converting these independent specialty practices into hospital outpatient departments, the hospital seamlessly extends its 340B discount eligibility to the acquired clinic's entire patient panel, generating large arbitrage margins. The independent oncologist, who cannot access 340B pricing, is fundamentally unable to compete with the purchasing power of the acquiring hospital.

Patients who live in areas with 340B hospitals are significantly more likely to receive their cancer drug administration in a hospital outpatient department than in an independent clinic.[55] Furthermore, commercial prices for outpatient procedures are nearly 20 percent higher at large 340B hospitals compared to large non-340B hospitals, translating into an estimated $36 billion annual penalty in extra hospital spending borne directly by employers and commercially insured patients.[56] Newer data confirms that, in concentrated markets, the 340B savings are not passed on to commercial payers, and a 2024 report suggested that commercial insurance prices are 4.2 percent higher than they otherwise would be if the program didn't exist due to loss of manufacturer rebates.[57, 58]

The program distortions are highlighted in a New York Times investigation into Richmond Community Hospital in Virginia, an institution originally founded and sustained by Black

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[52] U.S. Department of Health and Human Services, Health Resources and Services Administration, "2024 340B Covered Entity Purchases," December 2025, https://www hrsa.gov/opa/updates/2024-340b-covered-entity-purchases.

[53] Congressional Budget Office, "Growth in the 340B Drug Pricing Program," September 2025, https://www.cbo.gov/publication/60661.

[54] U.S. Government Accountability Office, *Medicare Part B Drugs: Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals*, GAO-15-442 (Washington, DC, June 2015), https://www.gao.gov/products/gao-15-442.

[55] Jeah Jung, Wendy Y. Xu, and Yamini Kalidindi, "Impact of the 340B Drug Pricing Program on Cancer Care Site and Spending in Medicare," *Health Services Research* 53, no. 5 (October 2018): 3528–48, https://doi.org/10.1111/1475-6773.12823.

[56] National Alliance of Healthcare Purchaser Coalitions, "The 340B Premium: New Data Shows Program Inflates Prices for Working Families," March 31, 2025, https://www nationalalliancehealth.org/resources/the-340b-premium-new-data-shows-program-inflates-prices-for-working-families/.

[57] Sunita M. Desai et al., "The 340B Drug Pricing Program, Hospital Prices, and Competition in Commercial Markets," *Health Services Research* 61, no. 1 (February 2026), https://doi.org/10.1111/1475-6773.70085.

[58] IQVIA, "The Cost of the 340B Program Part 1: Self-Insured Employers," March 12, 2024, https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-part-1-self-insured-employers.

physicians to serve patients who were excluded from segregated hospitals.[59] The hospital was acquired by the Bon Secours Health System and the intensive care unit was closed, diagnostic equipment such as the MRI machine frequently went out of service, and patients were often forced to travel elsewhere for specialized care. At the same time, Bon Secours expanded investments in wealthier suburban facilities within the same system. This was driven by 340B, as the Richmond hospital generated tens of millions of dollars each year through the program. Yet, many of those funds were effectively redirected elsewhere in the system.

If Congress wants a safety-net subsidy, it should create a safety-net subsidy openly. I support replacing the current drug-arbitrage-based 340B model with a transparent, capped safety-net grant[60] tied to measurable obligations: uncompensated care, Medicaid burden, rural service lines, direct patient assistance, and audited reporting. If policymakers want to align with some of those dollars to flow directly to patients rather than institutions, they should say so and design that support explicitly. What Congress should not do is keep pretending that an opaque drug arbitrage system is the cleanest way to fund the safety net.

Leverage FMAP to Incentivize Pro-Competition State Policies

Congress should create a competition adjustment in the Federal Medical Assistance Percentage (FMAP). States that continue to protect incumbents through certificate-of-need laws, broad physician non-competes, pro-consolidation state directed payments, or other barriers to physician-led entry should not receive the same federal matching treatment as states that permit real competition.

As of early 2026, 35 states and the District of Columbia have Certificate of Need (CON) laws,[61] where new health care facilities need to undergo a costly and protracted process to secure state regulatory approval before building new facilities, expanding bed capacity, offering new clinical services, or purchasing advanced medical technology. By artificially suppressing the supply of health care facilities and preventing the introduction of competitive alternatives, CON laws directly contribute to higher prices and reduced access to care. Analysts within the Department of Justice recognized that CON laws raise costs and reduce access to care.[62]

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[59] Katie Thomas and Jessica Silver-Greenberg, "How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits," New York Times, September 24, 2022, https://www nytimes.com/2022/09/24/health/bon-secours-mercy-health-profit-poor-neighborhood.html.

[60] Anthony M. DiGiorgio and Deborah Williams, "Reform the 340B Drug Pricing Program as a Capped Safety-Net Grant," *Health Affairs Forefront* (October 30, 2025), https://doi.org/10.1377/forefront.20251029.834131.

[61] National Academy for State Health Policy, "50-State Scan of State Certificate-of-Need Programs," accessed March 15, 2026, https://nashp.org/state-tracker/50-state-scan-of-state-certificate-of-need-programs/.

[62] U.S. Department of Justice and Federal Trade Commission, "Competition in Health Care and Certificates of Need: Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform," September 15, 2008, https://www.justice.gov/archive/atr/public/press_releases/2008/237153a.htm.

A National Bureau of Economic Research (NBER) report concluded that CON laws reduce competition and limit services, especially MRI access and ASC entry.[63] Another study found that repealing CON increases ASCs per capita by nearly 50 percent, with increases reaching 100 percent in rural areas.[64]

Furthermore, many states have laws prohibiting the corporate practice of medicine, but in practice those laws often impede physicians from partnering with physician-led management services organizations (MSOs). These physician-led MSOs centralize administrative and compliance functions, providing capital, scale, and expertise without requiring physicians to sacrifice clinical autonomy. While lawmakers might be claiming a desire to stop private-equity-backed MSOs, blanket restrictions like Oregon's Senate Bill 951 risk eliminating a legitimate tool for physician independence. [65] The problem is better solved through ownership transparency requirements and clinical autonomy protections than through outright prohibition.

Because the Federal Government pays such a large share of the Medicaid burden, if states insist on preserving regulatory moats around incumbent providers, federal taxpayers should not have to subsidize that choice at the same rate as states that allow competition.

Conclusion

Independent physicians are asking Congress to stop rewarding consolidation at their expense. Hospitals are indispensable, but so is a viable independent physician sector.

Congress can reverse the trends decimating independent physician practices. Pay the same for the same routine service regardless of who owns the building. Reopen physician-led entry where patients would benefit. Replace opaque safety-net cross-subsidies with transparent ones. Reduce the administrative burdens that fall hardest on small practices. And use federal leverage to reward states that permit competition rather than protect incumbents.

That is how you lower costs without weakening hospitals' unique missions, improve affordability without reducing access, and make room again for independent physicians to do what they do best: care for patients, close to home, with accountability that no corporate org chart can replicate.

If Congress continues to kick the can down the road or rely on band-aid solutions, the U.S. health system will continue consolidating into a top-down market dominated by a handful of vertically

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[63] Charles J. Courtemanche and Joseph Garuccio, "How Do Certificate-of-Need Laws Affect Hospitals? A Review of the Evidence" (working paper no. 34026, National Bureau of Economic Research, July 2025), https://www.nber.org/system/files/working_papers/w34026/w34026.pdf.

[64] Thomas Stratmann, Matthew Bjoerkheim, and Christopher Koopman, "The Causal Effect of Repealing Certificate-of-Need Laws for Ambulatory Surgical Centers: Does Access to Medical Services Increase?," *Southern Economic Journal* 92, no. 1 (2025): 63–86, https://doi.org/10.1002/soej.12710.

[65] Center for Medical Economics and Innovation, "Why Tightening Corporate Practice of Medicine Laws Weakens Independent Physicians, Empowers Hospitals, and Raises Healthcare Costs," February 2026, https://medecon.org/wp-content/uploads/2026/02/CMEI_PhysicianConsolidation_F_web.pdf.

and horizontally integrated systems. A healthcare system composed exclusively of corporate conglomerates and employed physicians is not a resilient market; it is a monopoly, and the American patient will be the one paying the price.