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ONE HUNDRED NINETEENTH CONGRESS

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March 16, 2026

MEMORANDUM

To: Subcommittee on Health Members and Staff
From: Committee on Energy and Commerce Majority Staff
Re: Subcommittee on Health Hearing on March 18, 2026

I. INTRODUCTION

The Subcommittee on Health will hold a hearing on Wednesday, March 18, 2026, at 10:15 a.m. (ET) in 2123 Rayburn House Office Building. The hearing is entitled "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape."

II. WITNESSES

- **Richard Pollack**, President and CEO, American Hospital Association
- **David H. Aizuss, MD**, Chair, Board of Trustees, American Medical Association
- **R. Shawn Martin**, Executive Vice President and CEO, American Academy of Family Physicians
- **Elizabeth Mitchell**, President and CEO, Purchaser Business Group on Health
- **Anthony DiGiorgio, DO, MHA**, Neurosurgeon, University of California San Francisco Health
- **Barbara Merrill**, CEO, American Network of Community Options and Resources

III. BACKGROUND

This hearing is the third in the Committee's health affordability series and will examine the provider landscape. Hospitals, physicians, and other health professionals play an important role in the delivery of health care services to patients. The goal of this hearing is to explore how provider incentives and trends in the health care system shape patient affordability.

According to the most recent national health expenditures (NHE) data, as tracked by the Centers for Medicare & Medicaid Services (CMS), U.S. health care spending increased by 7.2 percent to $5.3 trillion in 2024, accounting for 18 percent of America's gross domestic product

in 2024.[1] Hospital spending represented 31 percent of total NHE in 2024, growing 8.9 percent to $1.6 trillion. Physician and clinical spending grew 8.1 percent to $1.1 trillion in 2024, representing 21 percent of the total NHE.[2] Overall, hospital and provider expenditures represented more than half of all U.S. health spending in 2024. Year-over-year spending growth in 2024 for hospital services (8.9 percent) and physician and clinical services (8.1 percent) outpaced overall national health expenditure growth (7.2 percent), as well as relative year-over-year growth for prescription drugs (7.9 percent) and nonmedical insurance expenditures (-2.4 percent).[3]

Consolidation in the provider sector has also become increasingly prevalent. Horizontal consolidation among hospitals and hospital systems has accelerated recently, after a brief lull during the COVID-19 public health emergency. Recent coverage has highlighted the trend of health systems "expanding across state lines, absorbing independent hospitals and reshaping regional care markets."[4]

A 2024 analysis by KFF found that in over 80 percent of all metropolitan areas, one or two health systems controlled more than 75 percent of the market, and 97 percent of metropolitan statistical areas had markets considered highly concentrated for inpatient hospital care when applying Herfindahl-Hirschman Index (HHI) antitrust guidelines.[5] Researchers have found strong evidence that horizontal consolidation among hospitals is associated with higher prices with no discernable change in quality of care delivered.[6] Moreover, according to the Government Accountability Office, in 2024, at least 47 percent of U.S. physicians were employed by, or affiliated with, hospital systems—up from less than 30 percent in 2012.[7]

A. Provider Payment and Sites of Service

According to the American Medical Association provider survey data from 2024, the share of physicians working in private practice varies by specialty. Doctors practicing in specialties like cardiology (30.7 percent) and radiology (46.9 percent) are less likely to be in private practice, compared to providers in specialties like orthopedic surgery (54 percent) and

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[1] Micah Hartman et al., *National Health Care Spending Increased 7.2 Percent In 2024 As Utilization Remained Elevated*, HEALTH AFFAIRS at 110 (Jan. 14, 2026), https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2025.01683.
[2] Micah Hartman et al., *National Health Care Spending Increased 7.2 Percent In 2024 As Utilization Remained Elevated*, HEALTH AFFAIRS at 112 (Jan. 14, 2026), https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2025.01683.
[3] *Id.*
[4] Alan Condon, *11 large health systems growing bigger*, Becker's Hospital Review (Mar. 5, 2026), https://www.beckershospitalreview.com/hospital-transactions-and-valuation/11-large-health-systems-growing-bigger/?origin=BHRE&utm_source=BHRE&utm_medium=email&utm_content=newsletter&oly_enc_id=2092I8261656G9G.
[5] Jamie Godwin et al., *One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2022*, KFF (Oct. 1, 2024), https://www.kff.org/health-costs/one-or-two-health-systems-controlled-the-entire-market-for-inpatient-hospital-care-in-nearly-half-of-metropolitan-areas-in-2022/.
[6] Jodi L. Liu et al., *Environmental Scan on Consolidation Trends and Impacts in Health Care Markets*, RAND Corporation (Sept. 30, 2022), https://www rand.org/pubs/research_reports/RRA1820-1.html.
[7] GOVERNMENT ACCOUNTABILITY OFFICE, *Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation,* GAO-25-107450 at 16 (Sept. 22, 2025), https://www.gao.gov/assets/gao-25-107450.pdf.

ophthalmology (70.4 percent).[8] The most common reason cited was inadequate payment rates among providers who have sold their practice over the past decade.[9]

Medicare plays an important role in influencing payment rates for physicians and other health professionals across the health care system. Under fee-for-service Medicare, the program pays for services furnished by these practitioners at payment rates established under the physician fee schedule (PFS). According to the Medicare Payment Advisory Commission (MedPAC), in 2023, the Medicare PFS paid for approximately 9,000 services, ranging from office visits and surgical procedures to imaging and tests.[10]

Medicare PFS payment rates are determined based on the relative costliness of the professional work, practice expense, and professional liability insurance.[11] Once these relative value units, which are adjusted for geographic factors, are established, they are multiplied by a conversion factor that ultimately yields a payment rate for the service.[12] The conversion factor is updated based on a statutory schedule established in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and further adjusted for any budget-neutrality adjustments. Beginning in 2026, the statute specifies PFS conversion factor updates of 0.75 percent for clinicians participating in advanced alternative payment models and 0.25 percent for other clinicians.[13] These updates were enacted as part of MACRA, which also repealed the Sustainable Growth Rate with the goal of transitioning Medicare toward value-based care through statutorily defined conversion factor updates, bonus payments for clinicians in alternative payment models, and payments adjusted for quality performance. Despite these efforts, between 2020 and 2023 and most recently in 2025 as part of the Working Families Tax Cuts Act, Congress has acted several times to provide further payment stability for physicians and health professionals through one-time conversion factor updates.[14]

When services are furnished to beneficiaries in certain facility settings, such as in a hospital or ambulatory surgical center, Medicare provides a separate facility payment for nonclinician costs, equipment, and supplies, among other expenses, in addition to payment for professional services under the PFS.[15] While facilities billing the Medicare PFS receive a reduced payment under the fee schedule, the separate facility payment—for example, under the outpatient prospective payment system or ambulatory surgical center payment system—results in

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[8] Press Release, American Medical Association, *More physicians move to practices owned by hospitals & private equity groups* (May 29, 2025), https://www.ama-assn.org/press-center/ama-press-releases/more-physicians-move-practices-owned-hospitals-private-equity.
[9] *Id.*
[10] Medicare Payment Advisory Commission (MedPAC), *March 2025 Report to the Congress: Medicare Payment Policy* at 103 (Mar. 13, 2025), https://www medpac.gov/wp-content/uploads/2025/03/Mar25_Ch4_MedPAC_Report_To_Congress_SEC-1.pdf.
[11] Medicare Payment Advisory Commission (MedPAC), *Payment Basics: Physician and Other Health Professional Payment System* (Nov. 2025), https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_Physician_FINAL_SEC.pdf.
[12] *Id.*
[13] *Id.*
[14] Medicare Payment Advisory Commission (MedPAC), *Reforming physician fee schedule updates and improving the accuracy of relative payment rates* at 2 (April 10, 2025), https://www medpac.gov/wp-content/uploads/2025/04/Tab-C-PFS-reform-April-2025.pdf.
[15] *Supra* note 10.

a combined payment that generally exceeds the rate at which a physician billing in the nonfacility setting is paid by the PFS for the same service.[16]

Many health care services can be performed in multiple sites of service. As described above, Medicare will, in many cases, reimburse providers at different rates based on the site in which the service was furnished, even if the type of health care procedure, the quality of the procedure, and the outcome of the procedure are all the same. This dynamic has garnered significant attention from Congress, MedPAC, and researchers. One review of expert and academic literature on the status and impact of site-neutral payment policies found that current Medicare payment policy differences by site of service generate higher costs for the Medicare program and beneficiaries, incentivize provider consolidation, and increase costs in the commercial insurance market without improvement in the quality of care for services that are routinely delivered in a physicians' office.[17]

B. Transparency

In 2019, under the Trump Administration, CMS issued a final rule requiring hospitals to post standard charges, including payer negotiated rates and minimum/maximum rates, for certain items and services provided through their facilities.[18] Notably, the American Hospital Association (AHA) sued the Department of Health and Human Services (HHS) to block the final hospital price transparency (HPT) rule.[19] Ultimately, the judge dismissed AHA's challenge, and the rule took effect in 2021.

In November 2024, HHS' Office of Inspector General issued a report estimating that 46 percent of all eligible U.S. hospitals were not complying with the hospital price transparency rule requirements.[20] Coverage from the *Wall Street Journal* following the effectuation of the rule found that several hospitals were allegedly blocking access to HPT data on their websites by leveraging "search-blocking" code embedded in the websites.[21] A recent analysis has shown that, while hospitals may generally be complying with the HPT final rule, a significant percentage of

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[16] *Id.*
[17] Zack Cooper et al., *Review of Expert and Academic Literature Assessing the Status and Impact of Site-Neutral Payment Policies in the Medicare Program*, YALE TOBIN CENTER FOR ECONOMIC POLICY (Oct. 30, 2023), https://tobin.yale.edu/sites/default/files/2023-10/Site-Neutral%20Payment%20Literature%20Review%2010302023.pdf.
[18] Final rule, 45 Fed. Reg. 180.50 (Nov. 27, 2019) (Requirements for making public hospital standard charges for all items and services, which was published on November 27, 2019, and was to be effective on January 1, 2021).
[19] The American Hospital Association v. Alex M. Azar II, Secretary of Health and Human Services (D.C. Cir. 2020) (Nichols, U.S. District Judge).
[20] OFFICE OF INSPECTOR GENERAL, *Not All Selected Hospitals Complied With the Hospital Price Transparency Rule,* (Nov. 2024), DEPARTMENT OF HEALTH AND HUMAN SERVICES, https://oig hhs.gov/documents/audit/10042/A-07-22-06108.pdf.
[21] Tom McGinty et al., *Hospitals Hide Pricing Data From Search Results*, Wall Street Journal (Mar. 22, 2021), https://www.wsj.com/health/healthcare/hospitals-hide-pricing-data-from-search-results-11616405402.

price transparency data is still inaccessible or unusable for the purposes of empowering patients to compare costs.[22] To date, CMS has assessed noncompliance penalties for only 28 hospitals.[23]

In February 2025, the Trump Administration issued an Executive Order building on their price transparency work by instructing the tri-agencies to enhance existing price transparency requirements, strengthen enforcement, and further patient access to meaningful pricing information.[24] In December 2025, CMS, in partnership with the Departments of Labor and Treasury, issued proposed changes to strengthen price transparency requirements with the goal of increasing the usability, accessibility, and impact of price transparency data.[25]

C. 340B Drug Pricing Program

The 340B Drug Discount Program (340B Program) was created by Congress in 1992. Under section 340B of the Public Health Service Act (PHSA), in order to receive Medicaid reimbursement for their drugs, pharmaceutical drug manufacturers must enter into Pharmaceutical Pricing Agreements (PPA) that provide discounts on covered outpatient drugs purchased by certain public health facilities (known as "covered entities").[26]

Participation in the 340B program is voluntary for covered entities and drug manufacturers, but there are strong incentives to participate. Covered entities are eligible to receive discounts on outpatient prescription drugs from participating manufacturers. Covered entities include hospitals owned or operated by State or local governments that serve a higher percentage of Medicaid beneficiaries, as well as Federal grantees such as Federally qualified health centers (FQHC), FQHC look-alikes, family planning clinics, State-operated AIDS drug assistance programs, Ryan White CARE Act grantees, family planning and sexually transmitted disease clinics, and others, as identified in the PHSA.[27]

While the 340B Program dictates the ceiling price at which drugs must be sold to covered entities, it does not specify the amounts that covered entities may, in turn, charge patients for the same drug. As such, covered entities are able to sell drugs at prices that significantly exceed the otherwise low acquisition cost in order to collect significant savings that can be used for any array of needs by the covered entity.

In August 2025, the Health Resources and Services Administration (HRSA) launched a 340B Rebate Model Pilot Program allowing participating drug manufacturers with drugs subject

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[22] Charles Ogles et al., *Compliance and Barriers in Hospital Price Transparency: A Cross-Sectional Evaluation of Alabama Hospitals With Emphasis on Spinal Surgery*, CUREUS (Feb. 27, 2026), https://www.cureus.com/articles/466707-compliance-and-barriers-in-hospital-price-transparency-a-cross-sectional-evaluation-of-alabama-hospitals-with-emphasis-on-spinal-surgery#!/.
[23] CTRS. FOR MEDICARE & MEDICAID SERVICES (CMS), Hospital Price Transparency, *Enforcement Actions*, https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/enforcement-actions (last accessed Mar. 9, 2026).
[24] Exec. Order No. 14,221, 90 Fed. Reg. 11005 (Feb. 25, 2025).
[25] Transparency in Coverage, 90 Fed. Reg. 60432 (proposed Dec. 23, 2025); *see also* Fact Sheet, CMS, *Transparency in Coverage Proposed Rule (CMS 9882-P)* (Dec. 19, 2025), https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-proposed-rule-cms-9882-p.
[26] Hannah-Alise Rogers, CONG. RSCH. SERV., IF12232, Overview of the 340B Drug Discount Program (2022).
[27] HEALTH RESOURCES & SERVICES ADMINISTRATION, *340B Eligibility* (June 2024), https://www.hrsa.gov/opa/eligibility-and-registration.

to the Medicare Drug Price Negotiation Program under the Inflation Reduction Act to provide 340B discounts through a rebate model intended to address potential duplicate discounts.[28] For covered entities, this model would shift certain drugs from an up-front discount to a post-sale rebate.

In September 2025, the Congressional Budget Office (CBO) released a report confirming the 340B Program encourages behaviors including the prescription of more and higher-priced drugs, the expansion of services, and the integration of hospitals and off-site clinics that tend to increase federal spending.[29] In addition, the CBO report found that from 2010 to 2021, spending on drugs purchased through the 340B program grew by an average of 19 percent annually, representing a $37.3 billion total increase and exceeding the growth rate for prescription drug spending market wide.[30]

In February 2026, in *American Hospital Association et al. v. Kennedy et al.*, the U.S. District Court for the District of Maine vacated and remanded to HHS the 340B Rebate Model Pilot Program.[31] In the same month and year, HRSA posted a Request for Information (RFI) to gather input from interested parties regarding manufacturer rebate models under the 340B Program, including the standards and procedures that should govern the approval of manufacturer plans and the impacts on stakeholders.[32]

D. Competition

Consolidation among providers can take different forms, including horizontally, vertically, or across markets.[33] This consolidation can reduce competition, which has the potential to increase health care costs for patients. Several dynamics, including contractual arrangements or federal and state regulations, for example, may encourage this consolidation and impede competition in health care markets.

Anti-tiering, anti-steering, and all-or-nothing contracting provisions are mechanisms prevalent in hospital system-health plan network contracts. Generally, these clauses prevent insurers from:

1. Excluding certain high cost/low quality facilities in larger health care systems from being included in their networks.
2. Leveraging financial incentives and plan design to encourage patients to select lower-cost, higher-quality health care facilities and providers over potentially higher-cost, lower-quality providers.

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[28] Notice, 90 Fed. Reg. 36163 (Aug. 1, 2025).
[29] CONGRESSIONAL BUDGET OFFICE, *Growth in the 340B Drug Pricing Program* (Sept. 2025), https://www.cbo.gov/system/files/2025-09/60661-340B-program.pdf.
[30] *Id.* at 13.
[31] American Hospital Association, et al. v. Robert F. Kennedy Jr., Secretary of the U.S. Department of Health and Human Services, et al., No. 25-cv-600 (D. Maine Feb. 10, 2026).
[32] Notice, 91 Fed. Reg. 7287 (Feb. 17, 2026).
[33] Zachary Levinson et al., *Ten Things to Know About Consolidation in Health Care Provider Markets*, KFF (Apr. 19, 2024), https://www kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/.

3. Tiering individual providers as a part of broader health care systems in a way that incentivizes patients to prefer lower-cost sites of care.[34]

Recently, several lawsuits have been filed concerning the presence of these anti-competitive contracting provisions, including *Cement and Concrete Workers DC Benefit Fund v. The New York and Presbyterian Hospital* and *UFCW Local 1500 Welfare Fund v. The New York and Presbyterian Hospital*. [35] Most notably, in February 2026, the U.S. Department of Justice sued the OhioHealth Corporation concerning their alleged use of anti-competitive contract restrictions "to force Ohio patients to pay higher prices for health care."[36]

The Department of Justice (DOJ) complaint alleges that OhioHealth leverages its market power to impose contractual restrictions that prevent insurers from designing and offering innovative and affordable health plan options. The DOJ highlights that, in the Central Columbus area, three hospital systems (OhioHealth, Ohio State, and Mount Carmel) account for more than 85 percent of total general acute care (GAC) discharges. OhioHealth accounted for more than 35 percent of all inpatient GAC discharges in 2023 and controls more than 35 percent of all inpatient GAC hospital beds in the Columbus, Ohio, market. The DOJ also notes that OhioHealth controls facilities outside of the Columbus region, which health plans must contract with in order to meet network adequacy and offer viable health insurance products.[37]

Additionally, section 6001 of the Patient Protection and Affordable Care Act (PPACA) prohibited the formation and expansion of physician-owned hospitals (POH).[38] The measure has largely been supported by hospital trade associations, including the American Hospital Association and the Federation of American Hospitals, while the American Medical Association and other provider groups have generally been supportive of lifting the POH ban prohibition.[39]

Critics of the POH ban have cited that it decreases hospital marketplace competition. Research from the Physicians Advocacy Institute (PAI) found "total payments in 2019 would have been reduced by approximately $1.1 billion if services for the 20 diagnostic related groups (DRG) were performed in POHs instead of traditional hospitals."[40] Additional research found

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[34] Center on Health Insurance Reforms, *Anti-Competitive Contract Restrictions*, Center of the American Experiment (last updated Oct. 2, 2025), https://chir.georgetown.edu/state-oversight-of-hospitals/anti-competitive-contract-restrictions/.
[35] Kabrick & Keith, *Challenges To Anti-Competitive Hospital Contracting Practices: The New York And Presbyterian Hospital*, HEALTH AFFAIRS (Mar. 3, 2026), https://www healthaffairs.org/content/forefront/challenges-anti-competitive-hospital-contracting-practices-new-york-and-presbyterian.
[36] Press Release, U.S. Department of Justice, *Justice Department Sues Ohio Health for Anticompetitive Healthcare Contracts That Increase Costs for Ohio Patients* (Feb. 20, 2026), https://www.justice.gov/opa/pr/justice-department-sues-ohiohealth-anticompetitive-healthcare-contracts-increase-costs-ohio.
[37] United States of America, U.S. Department of Justice, Antitrust Division and State of Ohio v. OhioHealth Corporation, No.: 2:26-cv-207 (D. Ohio Feb. 20, 2026).
[38] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6001 (2010).
[39] May & Thompson, *New Study: Physician-owned Hospitals Threaten Patient Access and Financial Viability of Full-service Sole Community Hospitals*, American Hospital Association (Nov. 18, 2025), https://www.aha.org/news/blog/2025-11-18-new-study-physician-owned-hospitals-threaten-patient-access-and-financial-viability-full-service-sole; *see also* Federation of American Hospitals, *Physician-Owned Hospitals are Bad for Patients and Communities*, https://fah.org/physician-owned-hospitals/ (last accessed on Mar. 9, 2026).
[40] Press Release, Physicians Advocacy Institute, *Physician-Owned Hospitals Promise Savings of More Than $1B a Year for 20 Expensive Conditions* (Oct. 19, 2023),

improved quality at lower or comparable costs for specialty POHs as compared to non-POH competitors.[41]

Lastly, certificate of need (CON) laws are state mechanisms regulating the construction of new health care facilities and expansion of existing facilities; to date, 35 states and Washington, D.C., operate CON programs. [42] CON laws are ostensibly meant to control health care costs by curtailing duplicative services and ensure that new health care facilities are meeting community needs.

In 2008, the DOJ and the Federal Trade Commission issued a joint statement criticizing CON laws, noting that they impede competition, undercut consumer choice, and weaken health care markets' ability to contain health care costs.[43] Research indicates that states with CON laws in place had 11 percent higher health care costs than states without CON laws in place. Additionally, the presence of CON laws was associated with roughly 30 percent fewer hospitals per 100,00 residents across the associated state. CON states also have fewer Ambulatory Surgery Centers than non-CON states.[44]

IV. STAFF CONTACTS

If you have questions regarding this hearing, please contact Annabelle Huffman of the Committee staff at (202) 225-3641.

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https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20PF%20Release%20POH%20Data%20-%20Final%2010-19-23.pdf?ver=4mcyYsgqjra4KP0gr1ygfg%3D%3D.

[41] Matthew C. Mandelberg et al., *Reconsidering the Ban on Physician-Owned Hospitals to Combat Consolidation*, 26 N.Y.U. J. LEGIS. & PUB. POL'Y 697 (2024), https://nyujlpp.org/wp-content/uploads/2024/07/JLPP-26-3-Mandelberg-et-al.pdf.

[42] National Conference of State Legislatures, *Certificate of Need State Laws* (Apr. 29, 2025), https://www.ncsl.org/health/certificate-of-need-state-laws.

[43] Press Release, U.S. Department of Justice and the Federal Trade Commission, *Competition in Health Care and Certificates of Need* (Sept. 15, 2008), https://www.justice.gov/archive/atr/public/press_releases/2008/237153a.pdf.

[44] Camille Walsh, *Certificate-of-need laws: Why they exist and who they hurt*, State Policy Network (Apr. 1, 2021), https://spn.org/certificate-of-need-laws/#:~:text=The%20Kaiser%20Family%20Foundation%20found,residents%20across%20the%20entire%20state.