Follow the Cuts

Aligning Healthcare Cost Policy With Economic Control

Prepared for members of Congress, legislative staff, regulators, and physician organizations

> **Core principle.** Economic attribution should precede economic regulation. Before assigning blame or imposing another payment cut, Congress should identify who set the price, who constructed the benchmark, who adjudicated the claim, who owned the entity that was paid, and who retained the revenue.

Executive Summary

Federal healthcare policy often treats the physician as the principal cost driver because the physician is visible: the physician orders the test, performs the procedure, prescribes the drug, and signs the claim. Visibility, however, is not economic control. Physicians frequently do not set the product price, the facility charge, the insurance premium, the network benchmark, the claims-payment rule, or the final destination of the revenue.

The **Scrutiny–Control Inversion** names the resulting policy error: economic scrutiny and cost containment are directed toward the actor most visible at the point of care rather than toward the actors exercising the greatest control over price formation, payment methodology, market access, claims adjudication, ownership, and revenue capture.

What the record shows	Source
Medicare physician fee updates rose ~14% (2000–2023) while practice-cost inflation (MEI) rose ~52%; through 2024, ~14% vs. ~56%.	MedPAC, June 2025 Report to Congress; 2026 update
The conversion factor fell from $38.26 (2001) to $33.40 (2026)—below its 2001 nominal level, and roughly 47% of its 2001 purchasing power after inflation.	CMS final rules; AMA conversion-factor history
Medicare Advantage payments ran an estimated $84B (2025) and $76B (2026) above traditional-Medicare equivalence—approaching the ~$92B paid annually under the entire physician fee schedule.	MedPAC, March 2025 and March 2026 reports
U.S. prescription-drug prices were 278% of prices in 33 peer countries; brand-originator gross prices were 422%.	RAND, 2024 (2022 data)
13% of audited Medicare Advantage prior-authorization denials and 18% of payment denials met the governing Medicare rules; Marketplace insurers denied 20% of in-network claims, and fewer than 1% were appealed.	HHS OIG, 2022; KFF, 2025
In the same rule cycle, CMS titled its physician rule around cutting “spending waste” while framing a 5.06% Medicare Advantage payment increase through access, affordability, and stability.	CMS newsroom, 2025–2026

Why this matters. If Congress attributes healthcare costs to the wrong economic actor, the consequences compound: physician shortages may worsen as real reimbursement falls; independent practices may disappear into hospital, private-equity, and insurer ownership; market concentration may increase; patients may pay more despite repeated physician payment cuts; and future legislation may miss the true drivers of spending entirely. Twenty-five years of physician unit-price compression have coincided with rising total costs—evidence that cutting the most visible price is not the same as containing the cost.

The Legislative Problem

Congressional cost debates routinely collapse distinct economic functions into a single label. The physician who initiates care is treated as though the physician also determined the price, controlled payment, and retained the revenue. Three recurrent errors follow.

Error	What Congress often sees	What must also be measured
Clinical initiation treated as economic causation	The physician ordered or performed the service.	Who set the drug, device, facility, or benchmark price attached to the episode?
"Provider spending" treated as physician income	The expenditure is coded as clinical or physician spending.	Who owned the practice—hospital, private equity, or the insurer itself—and retained the payment?
Outlier treated as profession-wide pattern	A dramatic charge, award, or denial appears in a report.	The denominator, payment distribution, ownership, and concentration among repeat corporate entities.

Evidence From the Three Ledgers

Ledger I — Who receives the cuts?

Physician payment is governed by a broad, annual, automatic, and inflation-insensitive architecture: budget neutrality, sub-inflation statutory updates, sequestration, recurring valuation changes, and—beginning in 2026—a recurring −2.5% "efficiency adjustment." Congressional relief is temporary and must be reenacted; the reduced baseline persists when it lapses. The major corporate-sector restrictions examined in the underlying analysis were more often selective, phased, suspended, repealed, or offset by payment growth: the medical-device excise tax and the health-insurer fee were both repealed, and Medicare drug negotiation—real and expanding—began only in 2026 with 10 products.

Ledger II — Who controls and captures the money?

Economic control lies in price setting, benchmark construction, prior authorization, claims editing, out-of-network repricing, payment timing, ownership, and retained revenue. A physician may decide that care is clinically necessary while manufacturers set product prices, insurers construct benchmarks and adjudicate payment, hospitals set facility economics, and vertically integrated corporations pay—and retain—revenue within their own walls. Payment recorded as "physician spending" is increasingly captured by insurer-, hospital-, and private-equity-owned entities.

Claims adjudication is price formation. The physician may complete a necessary service, but the insurer can still determine whether it was authorized, how it is coded, whether it is repriced, what documentation is accepted, whether a denial is reversed, and when payment occurs. The realized price of care is set at adjudication, not at the fee schedule.

Ledger III — Who receives the blame?

Official language can amplify the inversion. In matched CMS communications from the same policy period, physician payment was linked to waste, efficiency, and overvaluation; insurer payment was linked to access, stability, affordability, and sustainability; and pharmaceutical restraint was paired, in the headline itself, with innovation and certainty.

What the Evidence Does — and Does Not — Establish

Established or strongly supported	Not established
Long-standing real compression of Medicare physician unit prices. Substantial payer control over claims adjudication and realized payment. Large international product-price dispersion for identical products. Matched official-language asymmetry in the communications examined.	A coordinated campaign against physicians. That lobbying expenditures purchased specific votes. That every insurer denial or repricing decision is improper. That physician utilization and billing never contribute to spending.

This candor is deliberate: the framework classifies its own claims so that policy built on it rests only on what the record supports.

> **What this brief does not argue.** This brief does not argue that physicians never contribute to healthcare spending; that insurers, manufacturers, or device makers should be free of regulation; or that every denial or repricing decision is improper. It argues one thing: economic responsibility should be assigned according to measurable economic control. That is a governance principle, not a position for or against regulation.

Recommended Congressional Actions

1. Require economic attribution before cost containment. Every major healthcare cost proposal should identify who created the clinical need, who selected the service, who set the unit price, who constructed the benchmark, who adjudicated payment, who owned the receiving entity, and who retained the revenue.

2. Separate physicians from corporate medical entities. Federal reports should distinguish independent practices, hospital-owned groups, insurer-owned medical groups, private-equity-backed staffing organizations, management-services organizations, and revenue-cycle or arbitration firms. The single term “provider” is economically inadequate.

3. Require denominator and ownership disclosure. Reports describing outliers should disclose the number of entities involved, total eligible claims, distributional data, actual payment rather than billed charges, ownership, and concentration among repeat organizations.

4. Require benchmark provenance. Any benchmark used in legislation, regulation, or public reporting should be labeled as government-administered, insurer-calculated, contract-derived, charge-based, cost-based, survey-based, or adjudicated. An insurer-derived qualifying payment amount should not be presented as an independent market price.

5. Apply parallel economic language across sectors. If above-benchmark physician payments are called waste or overpayment, modeled insurer payments above fee-for-service equivalence should be described in comparable economic terms, with equivalent methodological caveats.

6. Create claims-management transparency and appeal accountability. Require reporting of denial, downcoding, repricing, reversal, appeal, and payment-delay rates; disclosure of automated and third-party repricing systems; and disclosure of compensation arrangements tied to claimed savings. Audit whether insurer-affiliated and independent practices are treated differently.

7. Index physician payment to practice-cost inflation. An administered national fee schedule that predictably trails practice-cost growth produces an automatic real cut. Permanent inflation-sensitive updates would force any intended real reduction to be made explicitly.

8. Evaluate international net-price comparison for globally marketed products. Direct a study of verified net prices for identical drugs and device models across comparable high-income countries—adjusting for rebates, volume, taxes, distribution, bundled services, and launch behavior—before any federal reference framework is designed.

Questions for Congressional Hearings

1. Who controls the benchmark used in this proposal, and can an independent auditor reproduce it?

2. What percentage of the total episode cost is professional physician payment?

3. Is the entity described as a "provider" an independent physician, a hospital, a private-equity-backed group, or an insurer-owned practice?

4. What are the denial, downcoding, repricing, reversal, and payment-delay rates for this payer or program?

5. Does the proposed cost control operate automatically each year, and is it indexed to input-cost inflation?

6. What restrictions on insurers, manufacturers, or device makers were delayed, narrowed, suspended, repealed, or offset during the same period?

7. Are outlier claims reported with denominators, medians, distributions, ownership, and concentration among repeat entities?

8. Who retains the revenue after the claim is paid?

Model Legislative Principles

> **Suggested statutory finding.** Congress finds that clinical initiation, price formation, claims adjudication, ownership, and revenue retention are distinct economic functions. Federal cost-containment policy should identify and measure the entity controlling each function before assigning responsibility or modifying payment.

> **Suggested reporting requirement.** Any federal report characterizing a healthcare sector as a cost driver should disclose benchmark provenance, ownership of the paid entity, actual payment distributions, professional payment as a share of total episode spending, and the economic actor capable of changing the price or retained revenue.

Implementation Path

1. Direct GAO or MedPAC to complete a dual-coded federal cost-containment census across physicians, insurers, pharmaceutical manufacturers, and device makers (2001–present).

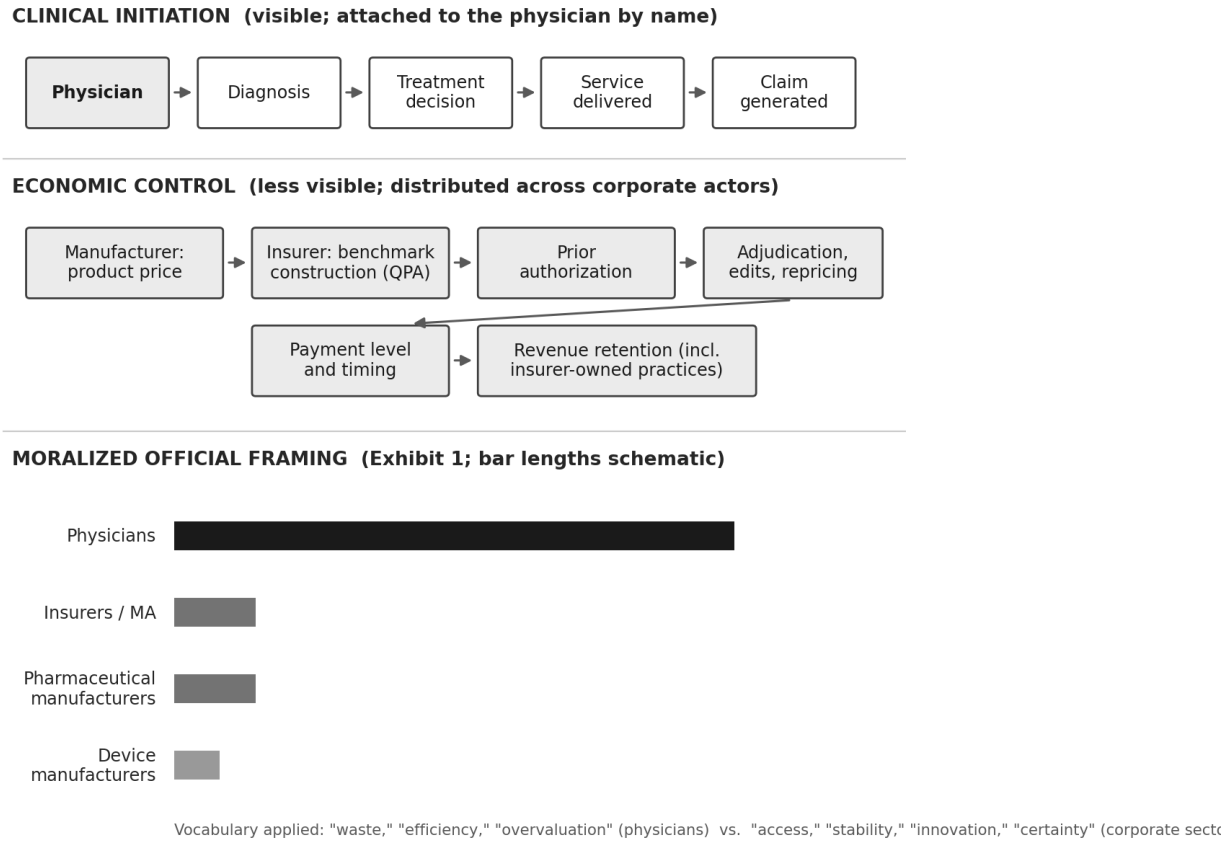
2. Require CMS to publish standardized claims-denial, downcoding, repricing, appeal, reversal, and payment-timing datasets.

3. Commission an international matched-product net-price audit for drugs and devices.

4. Require ownership-specific reporting for insurer-, hospital-, and private-equity-owned medical groups.

5. Apply the Scrutiny–Control framework prospectively to pending legislation and report whether the containment burden follows measurable economic control.

The Framework at a Glance



Upper panel: the visible clinical pathway. Middle panel: the less visible chain of economic control. Lower panel: the asymmetry of moralized official framing (bar lengths schematic). Adapted from the source manuscript, Figure 3.

Selected Evidence

1. MedPAC: Report to the Congress: Medicare and the Health Care Delivery System, Ch. 1 (physician fee schedule updates). June 2025; physician-adequacy update, 2026.
2. CMS: CY 2026 Physician Fee Schedule final rule (CMS-1832-F); CY 2026 Medicare Advantage and Part D Rate Announcement.
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5. Arnold DR, Fulton BD: UnitedHealthcare pays Optum providers more than non-Optum providers. Health Aff. 2025;44:1395-1403.
6. HHS Office of Inspector General: Medicare Advantage prior-authorization denial audit (OEI-09-18-00260). 2022.
7. Lo J, Long M, Wallace R, Salaga M, Pestaina K: Claims Denials and Appeals in ACA Marketplace Plans in 2023. KFF; 2025.
8. Duffy EL, et al.: No Surprises Act independent dispute resolution outcomes for emergency services. Health Aff Sch. 2024;2:qxae132.
9. Wouters OJ: Lobbying expenditures and campaign contributions by the pharmaceutical and health product industry, 1999–2018. JAMA Intern Med. 2020;180:688-697.

Prepared from: Klapper AM. Follow the Cuts: The Scrutiny–Control Inversion in American Healthcare, 2001–2026 (manuscript submitted for publication). This brief is for legislative education; views expressed are those of the author.