FOLLOW THE CUTS

One-Page Congressional Brief: Align Healthcare Cost Policy With Economic Control

THE PROBLEM. Congress attributes cost to the physician who orders or delivers care—even when manufacturers set product prices, insurers construct benchmarks and adjudicate claims, hospitals set facility economics, and corporations own the practice and retain the revenue. Visibility is not economic control.

WHAT THE EVIDENCE SHOWS	THE CORRECTION
• Physician fee updates rose ~14% while practice-cost inflation rose ~52–56% (MedPAC). • The 2026 conversion factor ($33.40) sits below its 2001 nominal value ($38.26). • Modeled MA excess payments—$84B (2025), $76B (2026)—approach the entire ~$92B physician fee schedule. • U.S. drug prices: 278% of 33 peer countries; brand-originator gross prices 422% (RAND). • 13% of audited MA prior-authorization denials met Medicare rules (OIG); Marketplace insurers denied 20% of in-network claims, <1% appealed (KFF). • CMS framed physician policy as "waste/efficiency" but insurer and drug policy as "access/stability/innovation"—in the same rule cycle.	• Require economic attribution before imposing cost containment. • Separate independent physicians from hospitals, private equity, and insurer-owned groups. • Require denominator, ownership, and actual-payment disclosure when citing outliers. • Label benchmark provenance; an insurer-calculated QPA is not an independent market price. • Publish denial, downcoding, repricing, reversal, appeal, and payment-delay data. • Index physician payment to practice-cost inflation. • Evaluate verified international net prices for identical drugs and devices.

THE FRAMEWORK: THE SCRUTINY–CONTROL INVERSION

Economic scrutiny and cost containment are directed toward the actor most visible at the point of care rather than toward the actors controlling price formation, payment methodology, market access, claims adjudication, ownership, and revenue capture.

Before Congress cuts payment, ask: Who set the price? Who built the benchmark? Who adjudicated the claim? Who owned the recipient? Who kept the money?

Clinical initiation is not economic control. | Visibility is not economic control.

Source framework: Klapper AM. Follow the Cuts: The Scrutiny–Control Inversion in American Healthcare, 2001–2026 (manuscript submitted for publication). Key sources: MedPAC 2025–2026; CMS CY2026 rules; RAND 2024; HHS OIG 2022; KFF 2025. Prepared for legislative education; views are those of the author.