Chairman Brett Guthrie Opening Statement
Subcommittee on Health
Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape
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As prepared for delivery.

Thank you, Chairman Griffith. And thank you to all of the witnesses for being here today for our third hearing examining health care affordability.

Today we'll explore the U.S. provider landscape and how payment policies, competition, transparency, and other incentives shape patients' cost of care.

According to U.S. national health expenditure data, more than half of all health care spending is attributable to hospitals and providers. Both play a vital role in the delivery of care to patients, but their significant share of overall spending necessitates today's conversation.

Over the last two decades, the provider landscape has evolved significantly. Today, the largest single employer of physicians is a health insurance company. According to GAO, in 2024, almost half of U.S. physicians were employed by, or affiliated with, hospital systems—up from less than 30 percent in 2012. For those physicians who remain independent, there is more and more pressure to consolidate into larger practices. There are many factors that contributed to this consolidation.

First, despite efforts in MACRA to move past annual "doc fixes" and shift Medicare toward value-based care, we've seen continued payment instability in the program, which Congress has addressed through temporary increases to physician fee schedule payments. This Medicare payment uncertainty and other regulatory burdens threaten the viability of independent medical practices.

Additionally, differing Medicare reimbursements for care delivered in a hospital rather than a doctor's office has created an incentive for big systems to acquire physician practices and bill those same services at the higher hospital rate.

Market power for providers looks slightly different than it does for health insurers or pharmacy benefit managers, as market control is more localized and regional for providers, rather than on a national scale.

In 2022, one in five MSAs were controlled by a single hospital system, and one in four markets were controlled by only two systems. That means roughly half of every U.S. market was dominated by – at most – two big hospital systems, and this trend was even more prevalent in lower-population rural areas.

Another key aspect to the affordability conversation is price transparency. The Trump Administration has led the charge to implement price transparency regulations up and down the health care supply chain, including hospital price transparency regulations in the first Trump Administration to empower patients with knowledge of the price of health care services before delivery. Last Congress, this Committee worked to put these advancements into law, and I hope that this is an area we can all come together on again.

We know competition and transparency can play a critical role in improving affordability of care for patients. However, I fear that well-intentioned decisions made in Washington have created a system that too often incentivizes the opposite. While this Committee has previously worked across the aisle to advance thoughtful, bipartisan policies to increase provider affordability, there is more work to do together to make health care affordable for all Americans.

Thank you, and I yield back.