



Physicians Caring for Texans



House Select Committee on Health Care Affordability
Written Testimony from the Texas Medical Association
by Andrew James "Jimmy" Widmer, MD, Council on Legislation Chair
April 30, 2026

Honorable Chair Frank and members of the committee,

Thank you for the opportunity to submit testimony on behalf of the Texas Medical Association (TMA), a private, voluntary, nonprofit association representing more than 60,000 Texas physicians and medical students, and the undersigned physician specialty societies. Our members practice in every medical specialty, in every part of the state, and in settings ranging from solo practices to large health systems. We support the committee's goal of improving affordability for Texas patients, families, and employers. We believe that meaningful reform must address the true drivers of cost growth while preserving access to timely, physician-led care.

Texas physicians share the legislature's interest in affordability. Patients are struggling with higher premiums, higher deductibles, rising drug costs, narrower networks, and increasing difficulty obtaining timely care. To find solutions that actually lower costs without worsening access, Texas must accurately identify the problem. The evidence points not to one single cause, but to a combination of administrative complexity, declining population health, insurance and payment policies that shift costs and delay care, and market structures that reward consolidation.

1. Health care cost drivers, including statutory, regulatory, and administrative burdens, and the impact of fraud, waste, and abuse

National health expenditure estimates reached \$5.3 trillion in 2024, or about \$15,474 per person, representing 18% of the U.S. gross domestic product. Hospital care accounted for 31% of spending, physician and clinical services 21%, and prescription drugs 9%. On the financing side, private insurance accounted for 31%, Medicare 21%, Medicaid 18%, and out-of-pocket spending 11%. These figures are important, but they can be misleading if read too simplistically. For instance, the physician and clinical services category includes outpatient care centers, services independently billed by medical and diagnostic laboratories, and physician

offices; each of which includes the costs of staff, technology, rent, compliance, and the hidden costs of operating in a highly burdened administrative environment.

For that reason, TMA urges the committee to focus on the forces underneath “prices” rather than merely looking at the “prices” themselves. Recent Centers for Medicare & Medicaid Services (CMS) backed analysis found that national spending growth in 2023 and 2024 was driven primarily by **nonprice factors**, especially increased **utilization and intensity of services** across hospital care, physician and clinical services, and prescription drugs.ⁱⁱ In plain terms, the affordability problem is not just what services cost; it is also how much care is needed, how complex that care (or patients’ need) has become, and how much friction the system adds before and after the patient ever receives treatment.

Administrative burden is one of the clearest examples. The American Medical Association’s (AMA) 2024 prior authorization survey found that physicians complete an average of **39 prior authorizations per week**, and physicians and their staff spend roughly **13 hours per physician per week** on that process alone.ⁱⁱⁱ Despite the fact that **the vast majority of prior authorizations are approved upon appeal**, the Medical Group Management Association’s (MGMA) 2026 Regulatory Burden Report found **95%** of practices reported higher burden over the past three years, and **40%** reported needing **three or more full-time administrative staff members per physician** to handle prior authorization, denials, and reporting requirements.^{iv} These are real costs that add payroll and overhead without adding clinical value. They also divert resources like physician time, technology investment, nurses, and front-office staff away from patient care, ultimately raising costs for employers, taxpayers, and patients. Accordingly, administrative simplification should be treated as a cost-containment strategy in its own right.

TMA strongly supports protecting taxpayer dollars and eliminating fraud wherever it exists. Fraud is a criminal act that should be identified and prosecuted. But fraud and abuse should not be treated as a singular explanation for the affordability problem when we also see broad-based premium growth, high deductibles, and insurance products that only seem to innovate new ways to increase complexity and reduce patient and physician recourse. The larger structural problem is waste embedded into the system itself, including prior authorization for routine treatment and procedures, duplicative reporting, payment denials that must be appealed, fragmented coverage rules, and regulations that consume time without improving quality. The committee should certainly address fraud, waste, and abuse, but it should not stop there. Truly affordable health care will only come from tackling the underlying structural problems in our current health care system, such as excessive complexity, payment friction, and misaligned incentives. A great start would be to address the administrative and regulatory burdens that make care more expensive without making it better.

A Note on the Impact of Population Health on Costs:

In any policy discussion about health care cost drivers, it is important to not only understand prices but also to understand why utilization and intensity are so high. On that question, Texas’ population health challenges cannot be ignored. America’s Health Rankings places Texas 40th overall and Texas continues to have the highest uninsured rate for children in the country – more than twice the national average – contributing to delayed diagnosis, fragmented care, over-

utilization of emergency departments, and avoidable downstream spending.^v The state's burden of preventable disease is also economically significant: smoking causes an estimated \$10.29 billion in direct health care costs in Texas each year, including about \$2.10 billion in Medicaid costs.^{vi} Research cited by Partnership for a Healthy Texas indicates food insecurity adds up to \$2 billion annually in health care costs in Texas.^{vii} These are not abstract social concerns; they are major cost drivers embedded in the state's risk pool. Put simply, population health, coverage stability, and access to timely care are affordability policies, because a risk pool with more unmanaged diabetes, untreated hypertension, tobacco-related disease, preventable cancer, behavioral health crises, and gaps in childhood immunization will always be more expensive to insure and treat than a healthier one.

The same is true for underuse of prevention and primary care. Chronic undervaluation and underutilization of preventive care through primary care clinics leads to downstream costs to the health care system. When complex chronic diseases are not managed effectively and timely, this leads to higher acuity of illness, and these patients often seek care in higher cost settings such as emergency departments and hospitals. Furthermore, a Mayo Clinic Proceedings study estimates the cost of primary care physician turnover to be nearly \$1 billion annually.^{viii} These dynamics reinforce a basic point: When patients cannot access continuous, physician-led care early and reliably, the system ultimately pays more for avoidable complications, higher-cost interventions, and worsening outcomes.

That is why any serious discussion of affordability must address the underlying conditions that drive utilization, intensity, and total cost.

2. The effects of insurance design, cost sharing, market structure, and payment policies on patients and employers

Coverage is not truly affordable if patients cannot realistically use it. A plan may have a lower premium, but still impose high deductibles, burdensome copays, narrow networks, aggressive prior authorization, unstable formularies, or weak out-of-network protections that delay care and shift costs to patients and physician practices. Additionally, health plans that offer less comprehensive coverage can lead to higher out-of-pocket costs, delayed care, worse patient outcomes, destabilized risk pools, and more uncompensated care. Affordability must mean meaningful coverage in practice, not simply cheaper coverage on paper. If a service is not covered for a patient, then the cost to the patient increases.

Payment policy matters just as much. Physician payment has not kept pace with inflation in practice costs. The AMA reports that, after adjusting for inflation in practice costs, Medicare payment to physician practices declined **33% from 2001 to 2025**.^{ix} That erosion affects more than Medicare alone, because many commercial contracts are built on Medicare's payment structure. When payment falls behind while administrative demands increase, physician practices become less viable, especially in rural and underserved communities. In practical terms, physicians are being asked to do more nonclinical work for less real payment. That is not a stable foundation for patient access to care.

Market structure amplifies these problems. The AMA's 2025 insurance competition study found **97% of commercial insurance markets** and **97% of Medicare Advantage markets** in metropolitan statistical areas were highly concentrated, meaning a small number of insurers control most of the market.^x In concentrated insurance markets, premiums can be higher while physician and provider payment is pushed downward. That is harmful to patients, employers, and physician practices alike.

The impact on employers is especially important. Rising health care costs function like an economic drag on wages and business growth. However, most employers have limited options of health benefit plans to offer their employees. A lack of competition in the market leaves small employers with a false choice of paying higher costs for insurance or leaving employees uncovered.

3. The impact of consolidation on patient choice, market competition, and price and value in health care services

Nationally, the health care sector has seen a significant rise in consolidation and vertical integration in recent years. Specific to physicians, many practices have merged or have been targeted for acquisition by insurers, hospital systems, and corporate entities. When policy discussions focus on consolidation as a cause of higher costs, many fail to consider that it is also a consequence of underlying financial pressures and administrative burdens. Any analysis that condemns the end result while ignoring the pressures that produced it is incomplete. Physician practices face rising payroll, rising overhead costs, rising technology costs, rising compliance costs, insurer friction, and reimbursement that does not keep pace. Remember physician practices are employers too. They face the same pressures as other employers, with the added administrative burdens imposed by public and private insurers. Moreover, physician practices that lack the relative bargaining power of an insurer in a concentrated insurance market are unable to fairly negotiate contracts, forcing them to accept below-market rates. Those combined pressures push some physicians toward consolidation or alternative practice arrangements out of sheer necessity to address practice viability challenges.

The trend is significant nationally. The U.S. Department of Health and Human Services, U.S. Department of Justice, and Federal Trade Commission recently summarized evidence showing physician practice and provider consolidation tends to increase prices, reduce patients' access to care, and often fail to improve quality. They also noted insurer concentration can depress physicians' payments without passing savings through to consumers^{xi}

This aligns with the AMA's 2025 insurance competition study that found health insurer consolidation can cause competitive harm even when the acquiring insurer concedes to pro-competitive clauses. For example, the AMA study notes a 2008 merger between UnitedHealth Group and Sierra Health Services that was only allowed under the condition that UnitedHealth Group divest most of its Medicare Advantage business in the Las Vegas area. Nonetheless, premiums in the commercial market increased by almost 15%.^{xii} This matters directly to affordability and patient choice.

In TMA's view, efficient and accessible physician practices contribute to patient choice (enhancing market competition) and quality care. The goal should be to support timely, coordinated care in the most appropriate and efficient setting, which is often the physician office rather than a higher-cost setting. That is especially important as the population ages and the complexity of chronic disease management increases. When physicians make health care decisions in conjunction with their patients, outcomes are improved and costs are lowered.^{xiii}

4. Consumer transparency in prices, benefits, and out-of-pocket costs

Transparency is important, but it must be clear, accurate, and actionable. A posted price provides little value if a patient still cannot tell whether the physician is in network, whether the service is covered, what prior authorization is required, or what the patient's actual out-of-pocket obligation will be. Similarly, transparency tools are not helpful if health plans' provider directories are inaccurate, plan benefits are difficult to interpret, or a patient learns too late that an attractive, lower-premium product carries significantly higher financial risk. Additionally, the remedy should not be worse than the disease; requirements to achieve price transparency should not be duplicative or add undue administrative burden^{xiv} so as to further increase costs.

TMA supports better consumer information, but transparency should not become a substitute for meaningful coverage or fair payment. A plan that relies on narrow access, delayed approvals, weak networks, or inadequate benefits is not truly affordable if it causes patients to postpone care, abandon treatment, face unplanned financial hardship, or lose access to their physicians when they need care most. For instance, lower-premium, less comprehensive products can mislead patients unless the tradeoffs are plainly disclosed up front. Texas patients and employers need transparency not only about sticker prices ("your premium"), but also about benefits ("what your plan covers"), network adequacy ("where and when you can get care"), and likely out-of-pocket costs.

Conclusion

TMA agrees that Texas must address affordability. The committee's four topics point to the right broader questions: administrative burden, insurance design/payment policy, consolidation, and transparency. On each of those issues, the evidence shows that barriers to physician practices add cost, reduce competition, and ultimately harm patients. It is important to note that cutting costs in one area can raise them in another. Real affordability means a fundamental change that is not on the backs of the patients, or those truly providing care.

If Texas wants to lower costs without worsening access, it should reduce administrative waste, preserve meaningful coverage, support physician practices, and scrutinize market structures that reward consolidation and higher-cost settings. That is the path to affordability that protects both patients and the physicians who care for them.

Thank you for the opportunity to provide this testimony. TMA looks forward to working with the committee to advance policies that reduce waste, strengthen access to care, and improve the health of all Texans.

Should you have any questions, please contact Ben Wright, TMA director of public affairs, at Ben.Wright@texmed.org.

Respectfully,

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ⁱ Centers for Medicare & Medicaid Services, NHE Fact Sheet, updated Jan. 14, 2026.

ⁱⁱ Hartman M, Martin AB, Lassman D, Catlin A, et al. National Health Care Spending Increased 7.2 Percent in 2024 as Utilization Remained Elevated. *Health Affairs*. 2026;45(2):110-120.

ⁱⁱⁱ American Medical Association, 2024 Prior Authorization Physician Survey.

^{iv} Medical Group Management Association, 2026 Regulatory Burden Report.

^v America’s Health Rankings, Texas state profile, accessed Apr. 2026.

^{vi} CDC’s Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC). See also, Shrestha, SS, et al., “Cost of Cigarette Smoking–Attributable Productivity Losses, U.S., 2018,” *AJPM*, July 27, 2022.

^{vii} Berkowitz SA, Basu S, Gundersen C, Seligman HK. State-Level and County-Level Estimates of Health Care Costs Associated with Food Insecurity. *Prev Chronic Dis* 2019;16:180549.

^{viii} Sinsky CA, Shanafelt TD, Dyrbye LN, Sabety AH, Carlasare LE, West CP. Health Care Expenditures Attributable to Primary Care Physician Overall and Burnout-Related Turnover: A Cross-sectional Analysis. *Mayo Clin Proc*. 2022;97(4):693-702. doi:10.1016/j.mayocp.2021.09.013

^{ix} American Medical Association, Medicare physician payment issue materials and inflation chart.

^x American Medical Association. Competition in Health Insurance: A Comprehensive Study of U.S. Markets. Chicago, IL: American Medical Association; 2025.

^{xi} U.S. Department of Health and Human Services; U.S. Department of Justice; Federal Trade Commission. Consolidation in Health Care Markets: Request for Information Response Report. Washington, DC: U.S. Department of Health and Human Services; 2024.

^{xii} American Medical Association. Competition in Health Insurance: A Comprehensive Study of U.S. Markets. Chicago, IL: American Medical Association; 2025.

^{xiii} For example, see the following Physician-Owned Hospital Report: [Physician-Owned Hospitals Report - 3-11-24 - for PAL.pdf](#).

^{xiv} For example, anesthesiologists have certain time components that affect their billing. Transparency requirements that fail to recognize the practical realities of billing and/or the difficulty predicting the ultimate "price" can increase administrative burdens on practices without adding corresponding value to the consumer.