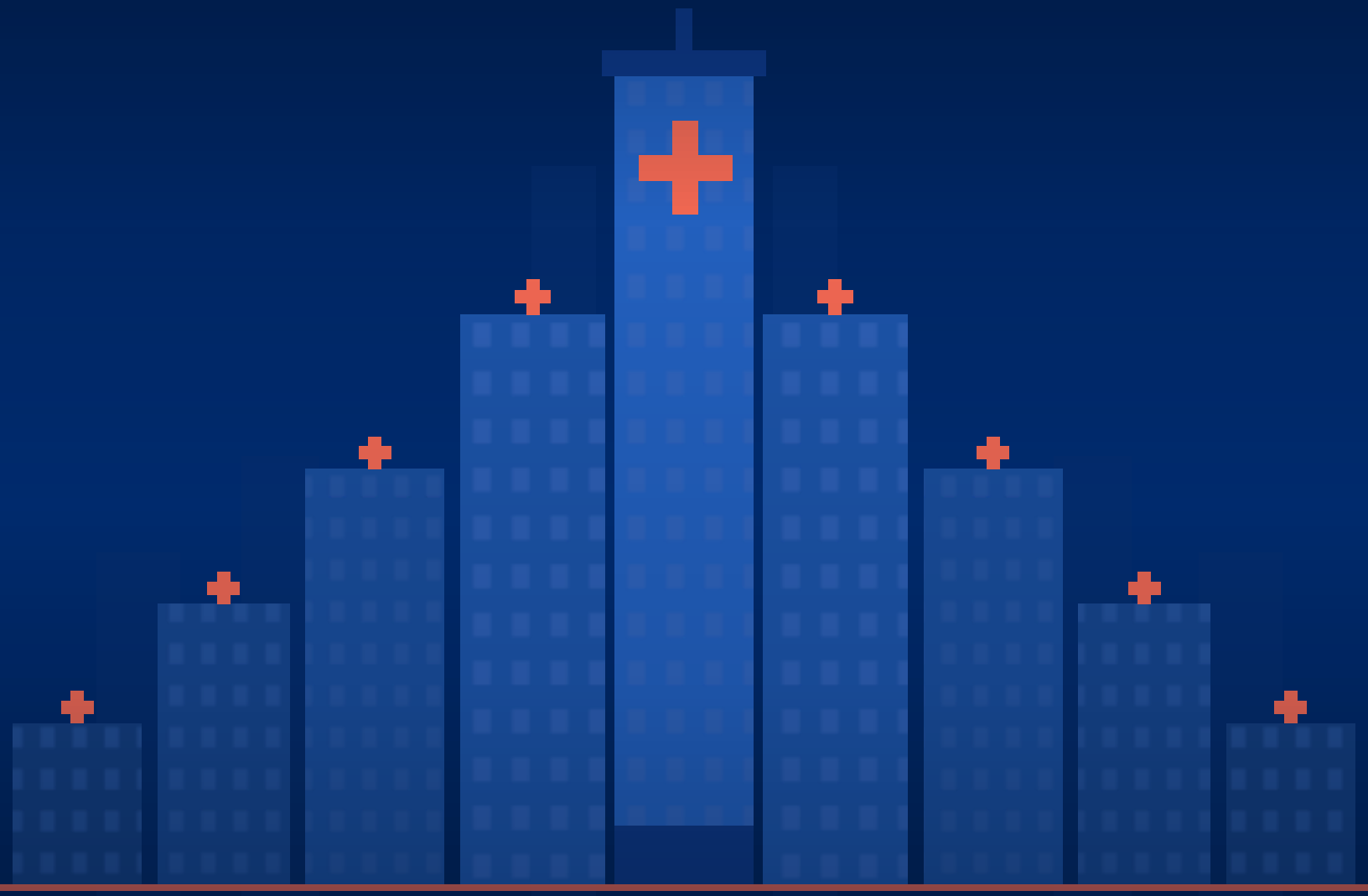
TEXAS 2036

MINI REPORT
HEALTH CARE · PROVIDER MARKETS



SYMPTOMS OF AN UNHEALTHY MARKET

Hospital Consolidation in Texas

A diagnosis of the **competitive** pillar of a healthy market — where consolidation is leaving Texans with fewer choices and higher prices.

Alec Mendoza
Policy Advisor, Health and Economic Mobility, Texas 2036

JULY 2026

The Rising Price of Healthcare in Texas

The average annual premium for employer-sponsored family health insurance coverage in Texas was around $27,000 in 2025, roughly one-third of the state's median household income.[1] 85% of Texas employers say that their healthcare prices are rising at an unsustainable rate.[2] This broader statewide trend also has impacts on state-run benefit plans and taxpayer dollars. For example, TRS-ActiveCare health insurance prices are rising so quickly that the legislature had to allocate $369 million in above baseline spending just to limit premium increases to 10%.[3]

These pressures are part of a national pattern. U.S. healthcare spending totaled $5.3 trillion in 2024, making up 18% of our GDP.[4] CMS projects spending growth will outpace GDP through 2033, reaching 20.3% of GDP.[5] These costs are borne primarily by families, employers, states, and the federal government alike.

While there are many factors that have contributed to this increase in spending, hospital care is the largest source of spending on health in the United States. Hospital care has contributed more than other categories to the growth in national health spending over time as it accounted for 40% of spending growth between 2022 to 2024.[6] Hospital consolidation is a structural driver of this increase, reshaping healthcare markets across the state and nation with measurable effects on prices and mixed evidence on quality.

What is Hospital Consolidation?

Hospital consolidation occurs when hospitals or health systems merge together to build larger health systems. Hospitals consolidate for a range of reasons, including increasing market share, improving negotiating power with insurers, operating more efficiently, and helping struggling providers keep their doors open in underserved areas. However, this growth in consolidation has led to significantly less competition in our healthcare market. Evidence consistently shows that consolidation leads to increased prices and declines in affordability and access, while the evidence that consolidation improves quality remains mixed or inconclusive.

1 KFF, "2025 Employer Health Benefits Survey," KFF, October 22, 2025. https://www.kff.org/health-costs/2025-employer-health-benefits-survey/

2 Glenn Hamer, "Texas Businesses to Lawmakers: Don't Add to Employer Healthcare Costs," Texas Association of Business, December 4, 2024. https://www.txbiz.org/2024/12/04/texas-businesses-to-lawmakers-dont-add-to-employer-healthcare-costs/

3 Teacher Retirement System of Texas, "2025 TRS-Related Legislation Summary," Teacher Retirement System of Texas, 89th Regular Legislative Session. https://www.trs.texas.gov/about/legislative/legislative-materials/2025-trs-related-legislation-summary

4 Centers for Medicare & Medicaid Services, "NHE Fact Sheet," CMS.gov, last modified January 14, 2026. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet

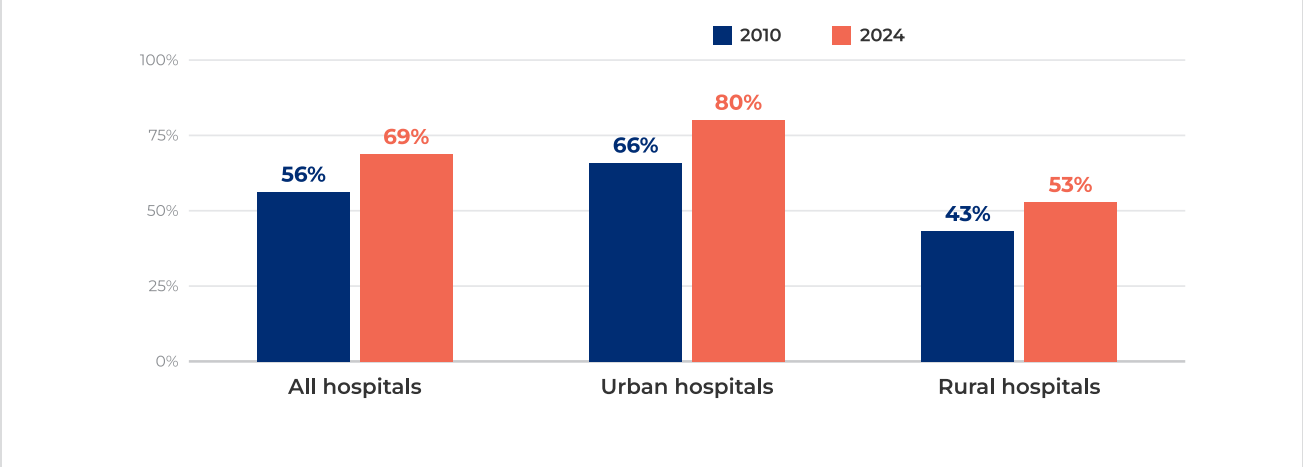
5 Ibid.

6 Jamie Godwin, Zachary Levinson, and Tricia Neuman, "Hospital Spending Accounted for 40% of the Growth in National Health Spending Between 2022 and 2024," KFF, February 11, 2026. https://www.kff.org/health-costs/hospital-spending-accounted-for-40-of-the-growth-in-national-health-spending-between-2022-and-2024/

The Growth of Hospital Consolidation

The increase in hospital consolidation is not new, as it has occurred rapidly over the past ten years. From 1998 to 2017, there were 1,573 hospital mergers, and another 428 hospital and health system mergers announced from 2018 to 2023.[7] More than two-thirds of hospitals (69%) are now part of a larger health system, an increase from 56% in 2010.[8] Mergers have occurred in both urban and rural communities, with system affiliation growing from 66% in 2010 to 80% in 2024 among urban hospitals and from 43% in 2010 to 53% in 2024 among rural hospitals.[9]

SHARE OF HOSPITALS AFFILIATED WITH A HEALTH SYSTEM



Source: KFF, "Key Facts About Hospitals" (2025) and KFF analysis of hospital market competition (2024).

Hospital Consolidation Impact on Healthcare Prices

As hospital consolidation has continued to grow, data over time has shown a consistent link between consolidation and higher prices. A 2025 U.S. Department of Health and Human Services report found that hospital-to-hospital mergers in concentrated markets can raise hospital prices between 6% to 65% reflecting variation in market concentration, with higher increases in the most concentrated markets.[10] Similarly, a 2023 Senate Finance Committee hearing on consolidation and corporate ownership in healthcare found that it is not uncommon for hospital mergers to generate price increases of 20% or more.[11] These hospital price increases contribute to increases in premiums for employer-sponsored insurance, reductions in workers' pay and employment, and pressure on government budgets.

7 Zachary Levinson, Jamie Godwin, Scott Hulver, and Tricia Neuman, "Ten Things to Know About Consolidation in HealthCare Provider Markets," KFF, April 19, 2024. https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

8 Zachary Levinson, Scott Hulver, Jamie Godwin, and Tricia Neuman, "Key Facts About Hospitals," KFF, February 19, 2025. https://www.kff.org/health-costs/key-facts-about-hospitals/

9 Jamie Godwin, Zachary Levinson, and Tricia Neuman, "One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2024," KFF, March 27, 2026. 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/

Hospital Consolidation Impact on Access and Quality

While some hospital mergers and acquisitions have helped preserve financially vulnerable hospitals, studies show that this process can also reduce local access, increase travel times, and lower the availability of key services, especially in rural communities.[12] Merging hospital systems sometimes close facilities or eliminate essential services that rarely earn a profit, such as maternity wards and primary care clinics.[13] Rural hospital closures force residents to travel roughly 20 miles further for common inpatient services, and the post-consolidation price increases in hospital markets might deter patients from seeking care altogether due to higher out-of-pocket costs.[14]

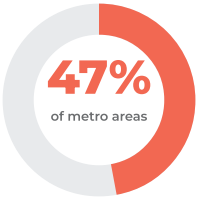
The measured impact of consolidation on healthcare quality has been mixed.[15] One study found that increased market concentration was associated with higher risk-adjusted mortality rates for heart attacks,[16] and another found that hospital mergers were associated with a small decrease in patient experience measures and no changes in 30-day readmission and mortality rates.[17]

While interpreting the evidence of quality is complicated with many factors at play in measurement, it is notable that the weight of evidence points toward consolidation increasing prices, while findings on quality remain mixed.

Hospital Consolidation in Texas

According to a recent KFF analysis of the competitive market for hospital care, one or two health systems controlled the entire market for inpatient hospital care in nearly half (47%) of metropolitan areas in 2024.[18]

METROPOLITAN MARKETS WITH ONLY ONE OR TWO HOSPITAL SYSTEMS, 2024



In nearly half of all U.S. metropolitan areas, just **one or two health systems** controlled the entire market for inpatient hospital care.

The remaining 53% of metro areas had three or more competing systems.

Source: KFF analysis of hospital market competition, 2024.

12 U.S. Government Accountability Office, "HealthCare Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation," GAO-25-107450, September 22, 2025. https://www.gao.gov/products/gao-25-107450

13 Rachel Mosher Henke, Kathryn R. Fingar, H. Joanna Jiang, Lan Liang, and Teresa B. Gibson, "Access to Obstetric, Behavioral Health, and Surgical Inpatient Services After Hospital Mergers in Rural Areas," Health Affairs 40, no. 10 (October 2021): 1627–1636. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00160

14 U.S. Government Accountability Office, "Rural Hospital Closures: Affected Residents Had Reduced Access to HealthCare Services," GAO-21-93, December 22, 2020. https://www.gao.gov/products/gao-21-93

15 Jodi L. Liu, Zachary M. Levinson, Annetta Zhou, Xiaoxi Zhao, PhuongGiang Nguyen, and Nabeel Qureshi, "Environmental Scan on Consolidation Trends and Impacts in HealthCare Markets," RAND Corporation, September 30, 2022. https://www.rand.org/pubs/research_reports/RRA1820-1.html

16 Daniel P. Kessler and Mark B. McClellan, "Is Hospital Competition Socially Wasteful?" The Quarterly Journal of Economics 115, no. 2 (May 2000): 577–615. https://www.jstor.org/stable/2587004

17 Nancy D. Beaulieu, Leemore S. Dafny, Bruce E. Landon, Jesse B. Dalton, Ifedayo Kuye, and J. Michael McWilliams, "Changes in Quality of Care After Hospital Mergers and Acquisitions," New England Journal of Medicine 382, no. 1 (January 2, 2020): 51–59. https://www.nejm.org/doi/full/10.1056/NEJMsa1901383

18 Jamie Godwin, Zachary Levinson, and Tricia Neuman, "One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2024," KFF, March 27, 2026. 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/

This national pattern is reflected in Texas, where nine metropolitan areas only have one or two hospital systems. These areas are spread out across the state and include Amarillo, Abilene, Midland, Odessa, San Angelo, Laredo, Eagle Pass, Victoria, Corpus Christi. Out of these areas, three of them (Abilene, Amarillo, Eagle Pass), only have one hospital system. In these areas, competition for inpatient care is limited by definition; patients have few or no choices among providers.

TEXAS METROPOLITAN AREAS WITH ONE OR TWO HOSPITAL SYSTEMS

One hospital system Two hospital systems

Source: KFF analysis of hospital market competition, 2024.

Another revealing story lies in the Texas metro areas that appear to have more competition on paper, with three or four hospital systems, yet where market power is just as concentrated in practice. In the Austin metro area, which has a population of 2.6 million, two systems controlled 89% of the inpatient hospital care market, even though the metro area has four health systems. The remaining two systems account for just 11 percent between them. Despite the presence of four systems, the market is functionally a duopoly.

Austin is not an anomaly in Texas. We see this same pattern in areas across the state.

- In the Bryan metro area, there are three hospital systems but the largest two control 99% of the market.
- In the Lubbock metro area, there are four hospital systems but the largest two control 96% of the market.

In each of these markets, the number of health systems can create an illusion of competition. Having four hospital systems might sound competitive in a metro area, but when two hospital systems control nearly all inpatient care, the remaining systems lack the scale to offer a meaningful alternative for patients. Since they control a smaller share of the market, these remaining systems also lack the bargaining leverage to create downward pressure on prices in insurer negotiations potentially leading to higher prices despite the appearance of competition.

Policy Options to Consider

This data raises important questions for Texas families and employers. In a state where healthcare prices are becoming the number one financial concern for families, the degree of concentration in Texas's hospital markets warrants attention. The Texas legislature has policy options to consider addressing hospital consolidation and targeting a part of rising healthcare spending and prices.

1 Transparency in Healthcare Ownership

Problem: *When ownership is opaque, consolidation is invisible to patients, employers, and regulators.*

As hospital systems grow through acquisitions, the ownership structures behind the facilities where Texans receive care can become difficult to track. Ownership transparency policies would require health systems to publicly disclose corporate affiliations, subsidiary relationships, and ownership interests. This includes enhanced disclosure requirements so that patients, employers, and insurers can identify which facilities belong to which systems and how consolidation is reshaping their local market. When ownership structures are opaque, it becomes harder for regulators and market participants to identify when a market is becoming more concentrated or when referral patterns may reflect corporate affiliations rather than patient needs. Requiring clear, accessible ownership disclosures is a foundational step that gives policymakers and the public the information needed to assess market conditions accurately. It can also help patients understand if and when their physician is operating under the control or management of a group owned or affiliated with a major health system.

States such as Indiana[19] and Colorado[20] have taken steps to address hospital market consolidation by requiring healthcare entities, insurers, and pharmacy benefit managers to report ownership information and comply with federal price transparency requirements.

19 Indiana Department of Insurance, "HEA 1666 Healthcare Ownership Information Reporting," Indiana Department of Insurance, published June 25, 2025. https://www.in.gov/idoi/insurance-laws-rules-and-bulletins/hea-1666-healthcare-ownership-information-reporting/

20 Colorado General Assembly, "SB24-080: Transparency in Health-Care Coverage," 2024 Regular Session, signed into law June 5, 2024. https://leg.colorado.gov/bills/sb24-080

2 State Antitrust Authority

Problem: *Federal merger review is too slow and too narrow to catch local market concentration before it hardens.*

Federal antitrust enforcement has historically been the primary tool for reviewing hospital mergers, but the scale and pace of consolidation suggest a role for state-level action as well. State anti-trust legislation could authorize the Texas Attorney General, or the Health and Human Services Commission, or another designated agency to review proposed hospital mergers and acquisitions for their competitive effects on local markets, with the ability to challenge transactions that would substantially increase concentration.

States such as Indiana enacted legislation requiring healthcare entities to provide 90 days' notice to the state attorney general before mergers or acquisitions involving assets totaling more than $10 million.[21]

3 Prohibiting Anti-Competitive Contracting Provisions

Problem: *All-or-nothing clauses let dominant systems force insurers to accept their full price slate or lose access entirely.*

In 2023, Texas took an important step when the legislature passed HB 711, which prohibits anti-steering, anti-tiering, gag, and most favored nation clauses in provider-insurer contracts.[22] However, this bill did not include a prohibition on all-or-nothing clauses, a consequential anti-competitive provision in highly concentrated markets. All-or-nothing clauses require an insurer to include every facility in a health system's network or none of them, even if some of those facilities have higher costs or lower quality.

In a market like Austin, where two health systems control 89% of inpatient care, an all-or-nothing clause means an insurer cannot selectively exclude a higher-cost facility within one of those systems while keeping lower-cost alternatives in its network. The insurer must accept the system's full slate of facilities and their associated prices or lose access to the system entirely. This means that both of these systems can effectively guarantee that all of their affiliated providers will be in network by utilizing all-or-nothing approaches to contracting, reducing competition in areas where it could still exist.

21 Indiana General Assembly, "Senate Bill 219: Uniform Antitrust Pre-merger Notification Act," 2026 Regular Session. https://iga.in.gov/legislative/2026/bills/senate/219/details

22 Texas Legislature, "HB 711: Relating to Certain Contract Provisions and Conduct Affecting HealthCare Provider Networks," 88th Regular Session, signed into law June 12, 2023. https://capitol.texas.gov/BillLookup/History.aspx?LegSess=88R&Bill=HB%20711

4 Price Regulation in Highly Concentrated Markets

Problem: *When competition is already gone, market pressure alone might not bring prices down.*

When market concentration has already reached levels that limit competitive pressure, price regulation is an additional tool that policymakers could consider. In theory, antitrust agencies could pursue litigation to break up large consolidated hospital systems into smaller units, but this path is uncertain, potentially disruptive, and has rarely been pursued by the FTC or DOJ.

One proposed framework would offer highly consolidated hospital systems a choice.[23] In non-rural markets where concentration exceeds an extremely high threshold, hospitals with greater than a set amount of market share would be required to accept rates at an administratively determined amount. Under this approach, systems that find that rate cap too restrictive could choose instead to voluntarily divest holdings to bring their regional market concentration below a certain threshold, restoring their ability to negotiate rates above the administratively determined rate. This framework preserves market-based pricing in competitive areas while creating a meaningful incentive for consolidated systems to either accept pricing restraints or restore competition through divestiture.

This framework closely mirrors the federal Hospital Competition Act, introduced in 2020 by Republican Congressman Jim Banks of Indiana.[24] The bill reflected a market-oriented approach to hospital consolidation, one that prioritizes restoring competition over government price-setting.[25] The choice-based design at the core of this framework, where hospitals can avoid rate caps by voluntarily divesting to restore competition, is what distinguishes it from traditional rate regulation.

In 2025, Indiana became one of the first states to enact legislation establishing price benchmarks for high-priced nonprofit hospitals, requiring them to move prices below a statewide average by 2029 or risk losing their tax-exempt status.[26] It is worth noting that price regulation is among the most interventionist options, and its design would need to balance cost containment with ensuring hospitals can maintain quality and access to care.

Closing

Taken together, these four policy options offer Texas legislators a graduated set of tools, from ownership to price benchmarks, calibrated to the degree of market concentration in each community. The common thread is restoring the competitive conditions that keep prices accountable and options open for Texas families and employers.

23 Avik Roy, "Affordable Hospital Care Through Competition and Price Transparency," Foundation for Research on Equal Opportunity (FREOPP), n.d. https://freopp.org/whitepapers/affordable-hospital-care-through-competition-and-price-transparency/

24 Rep. Jim Banks, "Hospital Competition Act of 2020," H.R. 8098, 116th Congress, introduced August 25, 2020. https://www.congress.gov/bill/116th-congress/house-bill/8098/tex

25 Texas 2036, "Will Healthcare Be More Affordable in 10 Years?" Texas 2036, May 5, 2026. https://texas2036.org/posts/will-healthcare-be-more-affordable-in-10-years/

26 David C. Lewis, Luke Roth, and Brian Allen, "State of Indiana Hospital Price Benchmarking Medicare Repricing Analysis," Milliman, prepared for the Indiana Department of Insurance, November 2025. https://iga.in.gov/publications/agency_report/2025-Annual-Report---Hospital-Price-Benchmarking-Medicare-Repricing-Analysis.pdf

Alec Mendoza
Policy Advisor · Texas 2036
alec.mendoza@texas2036.org