REPORT

HEALTH CARE PRICES

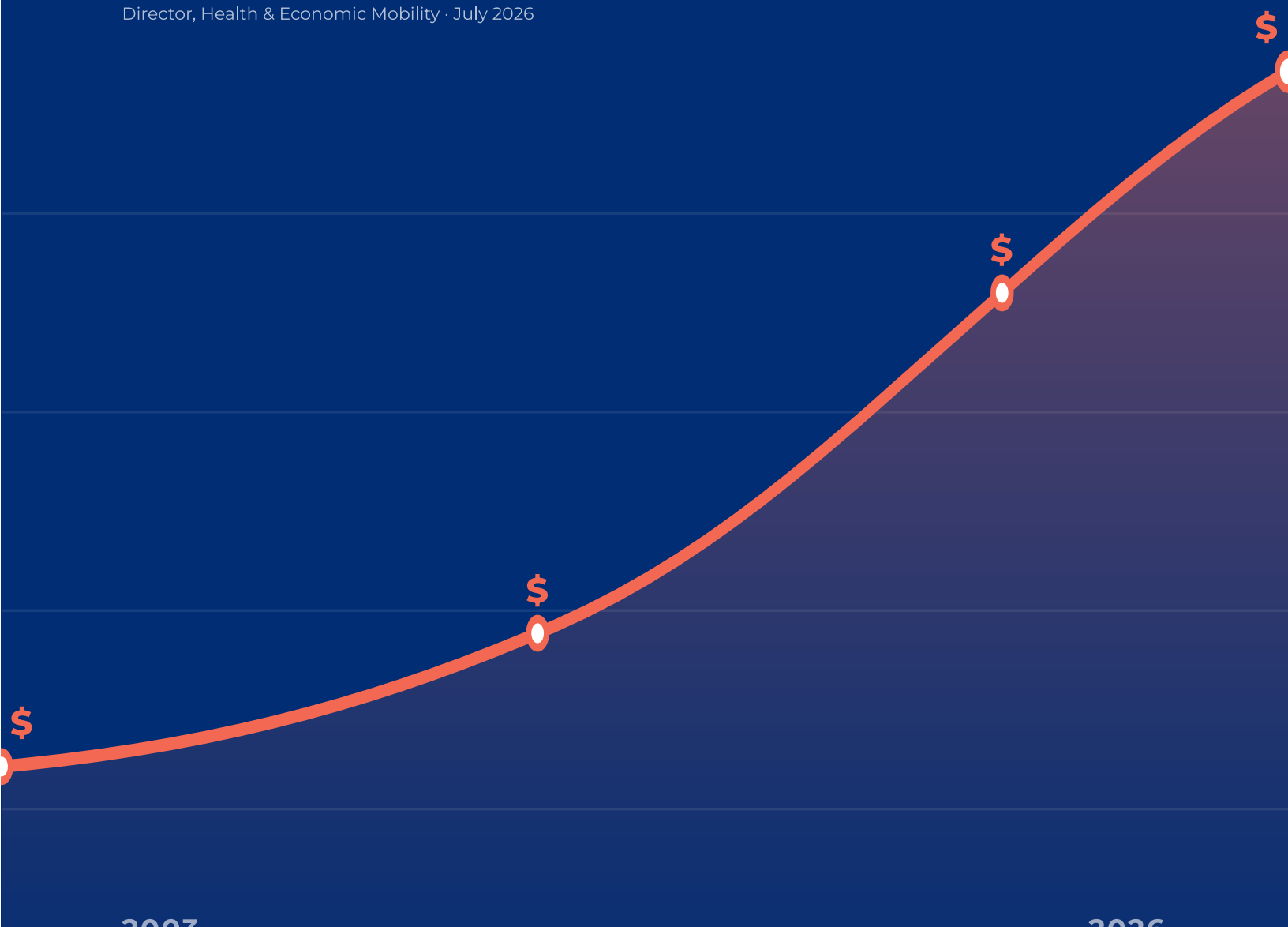
TEXAS 2036

It's Still the Prices.

New federal data sparked a fresh debate over what drives U.S. health spending. The answer hasn't changed — the industry has just gotten very good at raising the amount patients pay without calling them price increases.

By Charles Miller

Director, Health & Economic Mobility · July 2026



Key Takeaways

01 **Recent CMS data measures one thing; what patients pay is another.** The 2024 figures appeared to show medical inflation slowed — but CMS only tracks rate changes at the same provider for the same billing code. The prices patients pay for the same care keep climbing through pathways CMS's measure does not catch.

02 **Three ways patients pay more for the same care — and CMS doesn't count any of it as a price increase.** When AI billing tools record a visit as a higher-complexity service, when the doctor's office is acquired by a hospital and the bill suddenly includes a "facility fee," or when an insurer or hospital system steers patients to a higher-priced provider it owns. No individual provider's rates changed, so CMS's measure misses it — but patients see the result on every bill.

03 **Texas can address both sides of the referral problem.** Self-interested steering — by insurers toward affiliated networks, by hospital systems toward higher-priced owned facilities — raises what patients pay without changing any individual provider's rates. HB 711 and SB 926 already imposed a fiduciary duty on insurers when they steer patients. The symmetric step: protect physicians who refer in their patients' best interest, even when that cuts against employer or system pressure.

The Setup: A Costly System, a New Debate

Americans spend too much on health care. That is not a controversial statement. The country spent roughly $5.3 trillion on health care in 2024 — about 18 cents of every dollar the U.S. economy produces, the highest share ever recorded.[2] Families with employer-sponsored coverage now pay an average of $26,993 a year in premiums for family coverage — a 6 percent jump in 2025 alone, and about one-third of the typical American household's income.[3] In Texas, 63 percent of Texas households say they have skipped or postponed care in the past year because of cost.[4]

But here's where it gets complicated: a debate is underway among health economists about exactly *why* spending keeps climbing. Getting the answer right matters enormously for what policymakers and employers do next, and whether the focus is on managing the amount of care consumed (either by managing health to reduce the need for care, or by reducing the amount of unneeded care) or on addressing the market conditions that are enabling high prices.

Nearly $27,000

AVERAGE ANNUAL PREMIUM TO INSURE A FAMILY

Roughly **one-third of the median U.S. household's pre-tax income** — and rose 6% in 2025, the third straight year of 6%+ increases.

$5.3 trillion

TOTAL U.S. HEALTH SPENDING IN 2024

18 percent of the entire U.S. economy — the highest non-pandemic year ever recorded, and where the prices-vs-utilization debate matters most.

The Traditional View: It's the Prices

For twenty years, the dominant explanation in health policy research has been straightforward: Americans pay more for health care not because they use more of it, but because units of care are priced higher here than anywhere else in the developed world.

In 2003, a team of researchers from Johns Hopkins and Princeton put the data behind that intuition. Looking at OECD statistics, they published "It's the Prices, Stupid" — finding that the U.S. had fewer hospital admissions per capita, fewer physician visits per capita, and fewer practicing physicians per capita than most comparable countries, but spent far more.[5] The conclusion: the U.S. pays two to five times what other countries pay for the same drugs, procedures, and physician services.

2 Hartman M, et al. "National Health Care Spending Increased 7.2 Percent In 2024 As Utilization Remained Elevated." CMS Office of the Actuary, *Health Affairs* (2025). DOI: 10.1377/hlthaff.2025.01683.

3 Kaiser Family Foundation, *2025 Employer Health Benefits Survey* (Sept. 2025). National family-coverage premium average $26,993; up 6 percent year-over-year.

4 Episcopal Health Foundation, *2024 Texas Health Care Affordability Poll* (released Feb. 2025; survey conducted Nov. 11–Dec. 20, 2024 by SSRS, n=2,008 Texas adults). 56 percent of Texans reported skipping or postponing care due to cost.

5 Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V. "It's the Prices, Stupid: Why the United States Is So Different from Other Countries." *Health Affairs* 22(3) (2003): 89–105.

They updated that analysis in 2019 and found nothing had changed.[6] Despite a decade of health reform, the Affordable Care Act, and every variety of managed care, the U.S. was still paying vastly more for the same goods and services than Canada, Germany, France, or Australia.

> *The conclusion that prices are the primary reason why the US spends more on health care than any other country remains valid, despite health policy reforms and health systems restructuring that have occurred since.*
>
> **Anderson, Hussey, and Petrosyan, *Health Affairs* 2019**

The policy logic that follows is direct: if prices are the problem, focus on ways to lower those prices, not ways to reduce utilization. That framework helped drive Medicare drug price negotiation (enacted in the Inflation Reduction Act in 2022), proposals for hospital rate regulation, arguments for requiring price transparency, and a growing bipartisan consensus that consolidation is producing monopoly-like pricing power.

Does the New Evidence Challenge the Consensus on Prices?

In December 2025, the Centers for Medicare and Medicaid Services (CMS) released its annual National Health Expenditure Accounts data covering calendar year 2024 — the most comprehensive accounting of where health dollars go.[7] By early 2026, an active debate had broken out among health economists about what the numbers meant.

Health spending grew about 7.2 percent in 2024. But when CMS actuaries broke down what drove that increase, prices were not the leading culprit. Their breakdown of the roughly 7.2 percent spending growth:[2]

DRIVER OF 2024 AGGREGATE SPENDING GROWTH	SHARE OF GROWTH
Utilization & intensity (more care, more complex care)	**~3.6 percent**
Price increases (medical inflation)	**~2.5 percent**
Population growth	**~1 percent**

Source: Hartman et al., "National Health Care Spending Increased 7.2 Percent In 2024 As Utilization Remained Elevated," CMS Office of the Actuary, Health Affairs *(2025), excerpted from Exhibit 2. Note: subtracting out population growth as a driver gives a per capita spending growth rate of 6.1 percent.*

6 Anderson GF, Hussey P, Petrosyan V. "It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt." *Health Affairs* 38(1) (2019): 87–95.

7 Centers for Medicare and Medicaid Services, *National Health Expenditure Accounts — Fact Sheet* and *NHE 2024 Highlights*. The 2024 estimates were released in mid-December 2025 alongside the *Health Affairs* article cited in note 1.

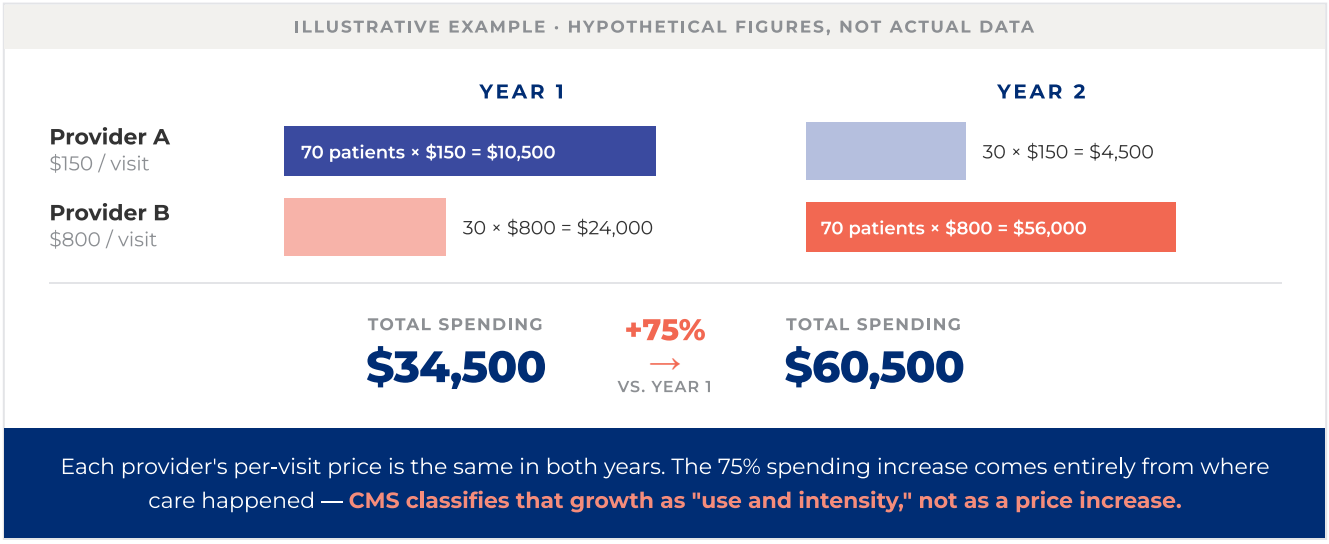
What CMS calls "medical price inflation" was roughly in line with general consumer price inflation in 2023 and 2024 — leaving, by that measure, little "excess" medical inflation.

The American Hospital Association has argued that the new data challenges the consensus on prices, citing CMS actuaries as saying *"Prices are a factor. They're part of the equation. But non-price factors are the driver."*[8] The same case was made by Harvard's Michael Chernew in a 2026 *Health Affairs* Forefront commentary titled, in a direct riff on the 2003 Anderson paper, "Growth In National Health Expenditures: It's not the prices, stupid," concluding that "the main driver of spending growth is greater volume and intensity of care."[9]

How CMS measures this matters

CMS's definition of "price" is narrower than it sounds. Its breakdown relies on producer and consumer price indexes (PPI and CPI) that track transaction prices at a fixed sample of establishments — what a given hospital or physician practice is paid for a given service. CMS does not directly measure utilization at all; "use and intensity" is simply the residual — everything in spending growth that those rates and population factors do not account for. **That definition is going to miss a lot.**

That can have a counterintuitive consequence. **Patients can pay more for the same service if providers submit higher or more billing codes for it, if it is delivered in a higher-priced setting, or if patients are steered to a higher-priced provider — even though, in each case, no individual provider has raised the prices CMS measures.**



Illustrative example — *figures are hypothetical, not actual market data. Across the two years shown, 100 patients receive the same care from the same two providers; neither provider's per-visit price changes. As more of the volume migrates from the lower-priced provider to the higher-priced one, total spending climbs 75 percent — and CMS's price-index methodology records that growth as utilization & intensity rather than as a price increase.*

8 The quote is reproduced from the American Hospital Association's May 6, 2026 blog post "Setting the Record Straight: Three Ways the Hospital Blame Narrative Gets It Wrong." We were unable to independently locate a primary CMS source for the quote, but it is consistent with the argument in Hartman et al.'s *Health Affairs* commentary accompanying the December 2025 NHE release.

9 Chernew M. "National Health Expenditure Projections, 2024–33." *Health Affairs* (2025).

It's Still the Prices — They're Just Hiding Better

Chernew is right that the prices CMS tracks were largely flat in 2024. But that is not the same as saying *the prices patients pay* were flat. The American health care industry has spent more than a decade getting better at raising what patients actually pay without raising the prices that PPI and CPI track. Much of what the CMS data calls "utilization growth" is, in significant part, structural price extraction that the federal price-index methodology cannot see.

In other words: the per-unit prices charged by particular providers may not be moving much, but the prices patients pay for nearly identical instances of care still keep climbing. The next section walks through three of the mechanisms that explain how — and why each one shows up in CMS's books as utilization rather than price.

HOW THE SAME DOLLAR GETS LABELED	
WHAT CMS COUNTS AS "PRICE"	**WHAT CMS BURIES IN "UTILIZATION"**
A provider raises its posted rate for the same service at the same location.	Upcoding · billing in a higher-priced setting · steering to a higher-priced or affiliated provider — **the patient pays more for identical care.**

EXAMPLE

Texas is ahead of the curve: HB 711 + SB 926. Before walking through the mechanisms, it is worth noting that Texas has already legislated against the worst of one of them. **HB 711** (88R, 2023) closed the loophole the DOJ has been litigating elsewhere: it renders anti-steering, anti-tiering, gag, and most-favored-nation clauses void and unenforceable when imposed by providers on insurers. **SB 926** (89R, 2025; effective September 1, 2025) handled the other direction: it expressly permits insurers, HMOs, PPOs, and EPOs to steer enrollees toward specific providers using cost-sharing differentials and tiered networks — but only subject to a **fiduciary duty** to design steering for the primary benefit of the enrollee, using objective and verifiable criteria like price and quality. Together, the two bills set a Texas norm worth holding in mind as the rest of this piece unfolds: providers cannot block beneficial steering, and insurers cannot use steering as a self-dealing mechanism. The fiduciary duty is the discipline.[1]

Three Ways What CMS Calls "Utilization" Is Really a Price Problem in Disguise

The common thread across all three mechanisms below: per-unit prices at any individual provider may not move at all, but the system steers more services to higher-priced billing codes, higher-priced settings, or higher-priced subsidiaries. Under CMS's methodology, that mix shift registers as utilization growth — which is why the "utilization" label is doing more work than it should.

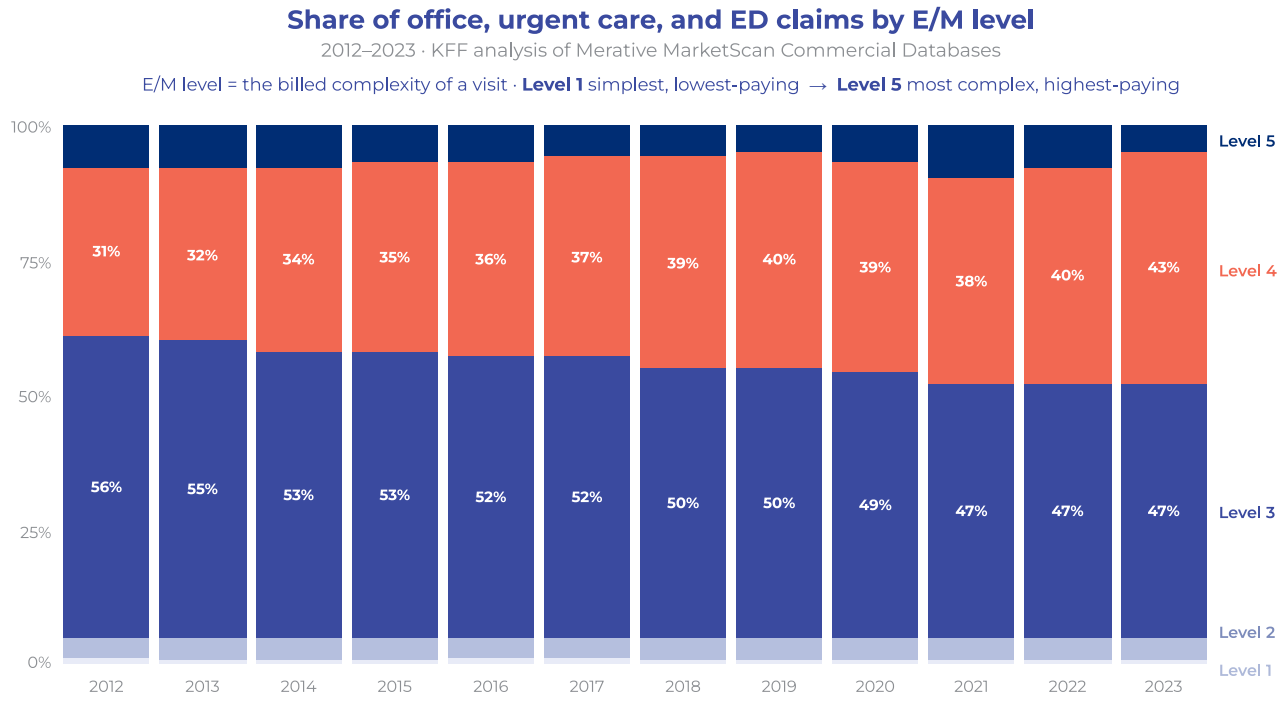
1 Texas HB 711, 88th Legislature Regular Session (2023): renders anti-steering, anti-tiering, gag, and most-favored-nation clauses void and unenforceable when imposed by providers on insurers in provider network contracts. Texas SB 926, 89th Legislature Regular Session (2025; effective September 1, 2025; Sen. Hancock): permits state-regulated health plans (HMOs, PPOs, EPOs) to steer enrollees via cost-sharing differentials or assign providers into tiered networks, but only subject to a fiduciary duty to act for the primary benefit of the enrollee or group contract holder, using objective, verifiable, accurate criteria such as quality and cost.

AI scribes, billing optimization, and the automation of upcoding

The newest and most rapidly accelerating cost driver is the adoption of AI-powered billing tools — both the "ambient scribes" that listen to doctor-patient conversations and generate clinical notes, and the retrospective record-review systems that comb through existing documentation to find every billable code a hospital might have missed. **The underlying dynamic is a billing system that rewards documentation intensity rather than care quality, transfers revenue from patients and employers to providers and intermediaries, and adds nothing to health outcomes.** AI scribes do not start this trend — they accelerate one that has been compounding for over a decade. MedPAC chair Michael Chernew flagged it in a 2025 *Health Affairs* commentary, noting evidence of increased billing for sepsis and higher-acuity evaluation and management codes.[9]

The pattern is unmistakable in commercial-claims data nationwide. KFF's analysis of office, urgent-care, and emergency-department visits shows the share of Level-4 codes climbing every single year from 2012 to 2023 — a 12-percentage-point shift toward higher-paying complexity codes that began long before AI documentation tools were widely deployed.[10]

CODING INTENSITY, BY THE DATA



The long view, 2012–2023. *KFF analysis of office, urgent-care, and emergency-department evaluation-and-management claims. Level 4 share climbed from 31 percent in 2012 to 43 percent in 2023. Recreated using TX2036 brand colors from Peterson-KFF, "Eight Trends Shaping 2026 Healthcare Costs," March 2026.*

10 Cotter L, Wager E, Xu H, Lebert T, Harris J, Brockbank B, Rae M. "Eight Trends Shaping 2026 Healthcare Costs," Peterson-KFF Health System Tracker (March 17, 2026), chart #6, "The use of artificial intelligence in healthcare is likely to accelerate coding intensity." KFF/Peterson Center on Healthcare analysis of Merative MarketScan Commercial Databases. CPT 99211–99215 (office, established patients), 99281–99285 (emergency department), and combined CPT 99201–99205/99211–99215 (urgent care). The 2012–2023 data presented here updates the earlier 2004–2021 Peterson-KFF analysis of the same trend (Schwartz et al., February 2023).

For hospital-inpatient data, Massachusetts has the deepest publicly available view of the same dynamic. The same dynamics are present in Texas commercial markets, but the kind of granular hospital coding data that would reveal them is far harder to access here — a gap the Texas All-Payor Claims Database (HB 2090, 87R) is well-positioned to close as it matures. A *Boston Globe* investigation by Jessica Bartlett published in March 2026 documented just how far this has gone in Massachusetts.[11]

> *The way we pay for health care in the country creates a game, and people learn to play the game. The game has all to do with increasing revenue. But it's gotten way out of control.*
>
> **Don Berwick, former CMS Administrator**

The *Globe* investigation focused on septicemia — sepsis — as the starkest example. Hospitalizations for septicemia in Massachusetts more than tripled since 2010, reaching more than 42,000 in the year ending September 2025. But researchers and insurers say the underlying population is not nearly three times sicker. What changed is that hospitals now have AI tools that review patient encounters, flag lab values, and optimize the order of diagnosis codes — systematically identifying and applying the most reimbursement-maximizing code for every encounter. A septicemia diagnosis generates roughly $10,000 more per claim than a diagnosis of infection alone, even when the treatment is identical.

> *Providers coding differently to generate, ultimately, higher payments without any change in the quality of care being delivered. It's just documentation.*
>
> **Michael Guerriere, Chief Actuary, Blue Cross Blue Shield of Massachusetts**

The pattern repeats across diagnoses. Patients with bronchitis or asthma are increasingly billed as having pulmonary edema or chronic obstructive pulmonary disease. C-section deliveries are now more frequently billed in conjunction with posthemorrhagic anemia — a serious complication diagnosis that triggers higher reimbursement. BCBS plan data found the share of maternity admissions coded for acute posthemorrhagic anemia increased by more than one-third over a nearly three-year period ending in early 2025, despite no corresponding increase in blood transfusion rates — the treatment you would expect if patients were actually experiencing severe blood loss. That coding shift alone added an estimated $22 million to what insurers paid for maternity admissions.

11 Bartlett J. "Hospital billing technology a factor driving surge in sepsis cases." *The Boston Globe*, March 20, 2026.

The Massachusetts Health Policy Commission documented the same dynamic with COPD: the share of inpatient COPD cases coded at the highest severity level climbed from 3 percent in 2013 to 12 percent in 2017 — a fourfold increase — even as hospital stays grew shorter and ICU use declined.[12] The patients were documented as sicker. They were not getting more care. They were generating substantially higher reimbursement.

This is not uniformly distributed. The higher-acuity coding is concentrated at hospital systems with the resources to invest in the new technology. For-profit hospitals have been quicker than nonprofits to adopt the most aggressive billing practices. If patients were genuinely sicker, all hospitals would be coding sicker patients in roughly equal measure. The concentration of upcoding at technology-equipped systems points strongly toward a billing strategy, not an epidemiological trend.

The hospital industry frames this as a defensive response to insurers' own use of AI — and that argument is not entirely wrong. One in five claims submitted by providers to commercial insurers in Massachusetts were denied, according to state data. PwC's 2026 *Behind the Numbers* report finds three out of four health plan actuaries naming AI-enhanced "cost of care" programs — claims-integrity reviews, pre-payment audits, utilization management — as the top deflator they are using to manage 2026 medical cost trend, which PwC projects will hold at 8.5 percent in the group market and 7.5 percent in the individual market, unchanged from 2025.[13] Hospitals respond with their own AI to optimize billing and recover revenue. The result is an arms race that adds administrative cost on both sides while delivering nothing additional to patients — and that, in CMS's books, shows up as "utilization growth."

Facility fees and the site-of-service shell game

When a hospital system buys an independent doctor's practice, it typically converts those physician offices into "hospital outpatient departments" (HOPDs). The doctor's visit is the same. The exam room may be the same. The physician may be the same. But the patient now gets two bills instead of one — a physician fee and a "facility fee" that can add hundreds of dollars to routine office visits, lab work, or infusions that previously cost a fraction of that.

The research on this is not ambiguous. Capps, Dranove, and Ody (*Journal of Health Economics*, 2018) found that physician charges increased by 14 percent after hospital acquisition of their practice — with roughly half of that increase directly attributable to facility fee rules and payment differentials, not any change in care quality.[14]

12 Massachusetts Health Policy Commission, *Hospital Inpatient Price Trends and Coding Intensity* (analysis released Sept. 2019, full report 2020). COPD highest-severity coding share rose from 3 percent (2013) to 12 percent (2017); statewide additional inpatient spending estimated at ~$280M Medicare and ~$300M commercial in 2017.

13 PwC Health Research Institute, *Behind the Numbers 2026*. Medical cost trend projections of 8.5% for the Group market and 7.5% for the Individual market based on a survey of actuaries at 24 U.S. health plans covering 125 million Group plan members and 12 million Individual plan members. Three of four surveyed plans cite AI-enhanced "cost of care" programs — claims-integrity reviews, pre-payment audits, utilization management — as a top cost deflator.

14 Capps C, Dranove D, Ody C. "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending." *Journal of Health Economics* 59 (May 2018): 139–152. DOI: 10.1016/j.jhealeco.2018.04.001.

This is site-of-service arbitrage — and the CMS data counts it as increased "utilization" because no individual provider's per-unit price changed, even though patients are paying higher prices as more services are being delivered in the higher-priced HOPD setting. Nothing about the underlying care changed either. The only thing that changed is who owns the building and how the bill is structured. At its core, this is a price increase that routes around the definition.

Congress has debated "site-neutral" payment policies that would pay the same rate for the same service regardless of where it is delivered. Medicare has moved in this direction for certain services. The Texas Legislature has an opportunity to act similarly for state employee and Medicaid populations.

EXAMPLE — SAME CARE, TWO BILLS

DOCTOR'S OFFICE **$150** → ACQUIRED

HOSPITAL-OWNED · SAME ROOM
$150 physician fee + **$200 facility fee** **$350**

A patient gets an infusion at their doctor's office: $150. That same doctor's office is acquired by a hospital system. Same patient, same doctor, same drug, same room — new bill: $150 physician fee + $200 facility fee. **That is not more utilization. That is a price increase with extra paperwork.**

Vertical integration and the referral conflict — hospitals and insurers alike

Hospital consolidation does not just change how visits are billed. It also changes where patients are sent. When a health system owns or is otherwise affiliated with the primary care practice, the specialist, the imaging center, the surgery center, and the post-acute rehab facility,[15] physicians face a powerful institutional incentive to keep patients "in-network" — meaning within the system's own, higher-priced facilities — rather than directing them to the best or most cost-effective option.

Patients can be steered to higher-priced settings in two distinct ways, and both are relevant.

The first is **active referral inside the system**: an employed or affiliated physician sends the patient to the system's own specialist, imaging center, or surgery center rather than a comparably-qualified outside option. Whaley and Zhao (*Journal of Public Economics*, 2024) found that physician-hospital integration drives approximately a 10 percent increase in referrals to higher-priced facilities, projecting that *if all primary-care physicians became integrated*, total Medicare spending would rise by an estimated $315 million.[16] A 2018 *Wall Street Journal* investigation by Anna Wilde Mathews and Melanie Evans documented how that pressure works in practice: at one Georgia health system, employed physicians received regular reports breaking down their referrals to specialists and ancillary services, and administrators pressed them to improve when the share of in-system referrals — what the industry calls "keepage" — was deemed inadequate.[17]

15 Vertical integration takes multiple legal forms — outright employment, exclusive contracts, professional services agreements, joint ventures, clinically-integrated networks, and management services organization (MSO) arrangements. The financial incentives to keep referrals inside the system arise across all of them, even where formal ownership of the practice is held separately for legal or regulatory reasons.

16 Whaley CM, Zhao X. "The Effects of Physician Vertical Integration on Referral Patterns, Patient Welfare, and Market Dynamics." *Journal of Public Economics* 238 (Oct. 2024): 105175.

17 Mathews AW, Evans M. "The Hidden System That Explains How Your Doctor Makes Referrals." *Wall Street Journal*, December 27, 2018. The piece documented the use of internal referral scorecards at Phoebe Putney Health System (Georgia), where employed physicians' referrals were tracked and used to press for higher in-system "keepage."

The second mechanism is **blocking the alternative**: contractual restrictions that prevent insurers and employers from steering patients away from a system's higher-priced facilities. The DOJ sued Atrium Health (then Carolinas Healthcare System) in 2016 over contract terms that prohibited insurers from directing patients to lower-cost competitors. In March 2026, the DOJ filed a new lawsuit against NewYork-Presbyterian, alleging the system used its market power to force payors to include all of its facilities in nearly every network at top-tier benefit positioning — making it impossible for an insurer to design a plan that steered enrollees to lower-cost alternatives.[18]

Insurers run the same playbook through benefit design. What hospitals do through ownership of physician practices, insurers do through ownership of the benefit design itself. Without a fiduciary duty like Texas SB 926's, the discretion that lets insurers steer enrollees toward higher-quality, lower-priced care can just as easily be used to steer them into wholly-owned subsidiaries.

Consider UnitedHealth Group, the country's largest health insurer. Through its Optum subsidiary, UHG now employs or affiliates with roughly 90,000 physicians — about 9.6 percent of the entire U.S. physician workforce. A 2025 study by researchers at Brown University and UC Berkeley found that UnitedHealthcare pays Optum physicians 17 percent more than comparable non-Optum physicians — a gap that spikes to 61 percent in markets where UnitedHealthcare controls at least 25 percent market share.[19]

Two mechanisms compound here, but CMS's accounting catches them very differently:

> **If UHG acquires a practice and rates rise at that practice after acquisition, the Producer Price Index (PPI) registers a price increase** — the same establishment in the BLS sample is now charging more for the same service, so the time-series math picks it up.
>
> **If a practice was already part of Optum at elevated rates, and UHG simply steers more enrollees to it, CMS records the resulting spending growth as utilization — because the practice's per-service rates are not changing, even though patients are now paying those elevated rates for more of their care.**
>
> The mix shift parallels the HOPD example.

This distinction matters for reading the Arnold/Fulton finding. The 17 percent gap is a *level* comparison between Optum and non-Optum physicians at a snapshot in time. It tells us UHG pays Optum above-market rates; it does not by itself tell us those rates are rising. To the extent the elevated rates are steady-state and the action is on the steering side, CMS's growth-rate methodology will not surface it. The combined effect — paying a wholly-owned subsidiary above-market rates while pushing more enrollees toward it — looks like a workaround of the ACA's medical loss ratio (MLR) requirement: payments to Optum count as "medical expenses" that satisfy the MLR rule on paper, while the money never leaves the corporate family.[20]

18 U.S. Department of Justice, *United States v. NewYork-Presbyterian Healthcare System*, complaint filed March 2026. DOJ Office of Public Affairs press release, "Justice Department Sues New York-Presbyterian Hospital for Anticompetitive Contracts That Increase Healthcare Costs for New Yorkers."

19 Arnold DR, Fulton BD. "UnitedHealthcare Pays Optum Providers Significantly More Than Non-Optum Providers." *Health Affairs* (Nov. 2025).

20 MLR compliance is calculated from the insurer's own claims, not from CMS's NHE accounting. How the federal aggregates categorize the spending does not change whether the rule has been gamed.

In 2024, Optum generated $253 billion of UnitedHealth's $400.3 billion in total revenue.[21] The pharmacy benefit manager (PBM) market offers an even starker example of the same playbook. A 2024 FTC interim report found that the Big 3 PBMs — all owned by major insurers (CVS/Aetna, Cigna/Express Scripts, UnitedHealth/OptumRx) — paid their affiliated specialty pharmacies 20 to 40 times the standard acquisition cost for certain cancer drugs.[22] A second FTC report in January 2025 calculated that this generated $7.3 billion in excess revenue for affiliated pharmacies between 2017 and 2022.[23] The mechanism is the same: design the benefit plan to steer patients to a wholly-owned subsidiary, pay that subsidiary above-market rates, and count it all as health care spending.

$7.3B

Excess revenue to insurer-affiliated pharmacies, 2017–2022 (FTC)

20–40×

Markup paid to affiliated specialty pharmacies for certain cancer drugs

The pattern — hospital systems and insurers alike — produces revenue extraction routed through ownership structure. Rate increases that occur after acquisition show up as price growth in CMS data; volume shifts toward already-affiliated subsidiaries show up as utilization. A meaningful share of the latter is structurally invisible to the federal price/utilization split.

Texas, and the symmetric step. Indiana, Connecticut, and Nevada have enacted comparable anti-steering statutes on the provider side, though without Texas's parallel fiduciary-duty rule on the insurer side.[24] HB 711 and SB 926 address one side of the referral problem: when an insurer steers an enrollee toward an affiliated provider, the steering has to satisfy a fiduciary duty to the enrollee. The symmetric pressure — on employed and system-affiliated physicians whose referrals are graded against in-system "keepage" targets[17] — remains largely unaddressed. The Texas Medical Practice Act today reaches kickback-style fee-splitting in referral conduct, but does not impose an affirmative duty on physicians to refer in the patient's best interest.[25] One direction worth considering: incorporating the affirmative referral-loyalty duty from the AMA Code of Medical Ethics into the MPA, which would give physicians a backstop when they refer in their patients' interest against employer or system pressure to do otherwise — and give the Texas Medical Board a discipline tool when that pressure crosses the line. Over 60 percent of Texans live in highly concentrated hospital markets — when those systems own the physicians, the surgery centers, and the post-acute services, patients lose the independent advocate who might have sent them somewhere cheaper and better.

21 UnitedHealth Group, *2024 Form 10-K* (filed Jan. 2025). Total 2024 revenue $400.3 billion; Optum segment revenue $253.0 billion.

22 U.S. Federal Trade Commission, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies* — Interim Staff Report (July 2024).

23 U.S. Federal Trade Commission, *Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers* — Second Interim Staff Report (Jan. 2025).

24 Anti-steering / anti-tiering / gag-clause prohibitions on the provider-insurer contracting side: Texas (HB 711, 88R, 2023), Connecticut (HB 6669, 2023), Indiana, and Nevada. NASHP, "State Strategies to Address Anticompetitive Health Care Contract Terms."

25 AMA Code of Medical Ethics Opinions 1.1.1 and 11.2.1, along with referral-specific opinions in the 6.4.x and 11.2.x series, articulate an affirmative duty of physician loyalty in the referral act. Texas has not adopted the AMA Code into the Medical Practice Act. Existing MPA and adjacent provisions reaching referral conduct (Tex. Occ. Code § 164.052(a)(18) on fee-splitting; § 102.001 on solicitation of patients; Tex. Health & Safety Code §§ 161.091–.092 on illegal remuneration) are framed as transactional prohibitions, not affirmative loyalty duties — leaving employer-grading on in-system referral patterns largely outside the Texas Medical Board's reach.

What This Means for Texas

Texas is not a passive observer in this debate. Health care prices are now the top economic concern of Texas voters: 67 percent told the Texas Politics Project in December 2025 they were "very concerned" about the cost of health care, the highest level of concern across every economic issue tested.[27] In a Texas 2036 voter poll the same fall, 82 percent said they were more likely to support a candidate who made reducing health care prices a top policy priority — ahead of homeowner's insurance (79%), property taxes (78%), and disaster response (78%).[26] The billing games described above are not abstract. They show up in the premiums Texas employers pay, in the bills Texas families receive, and in the budgets of TRS-ActiveCare and the Employees Retirement System.

Texas 2036's *Healthy Markets* framework organizes the response around three pillars — **Informed**, **Competitive**, and **Engaged** Markets — each of which addresses a piece of what the prices-vs-utilization debate is exposing:

INFORMED MARKETS

Markets cannot discipline prices that buyers cannot see. The All-Payor Claims Database (HB 2090, 87R) and price transparency requirements give purchasers, patients, and policymakers the data infrastructure to identify the price differentials between settings, providers, and contracts described above.

COMPETITIVE MARKETS

Transparency alone is not enough if markets are too consolidated for alternatives to emerge. Anti-steering protections (HB 711, 88R), out-of-pocket expense credits enabling cash-pay competition (HB 2002, 88R), site-neutral payment for state employee and Medicaid populations, and scrutiny of vertical integration deals introduce real options into highly concentrated markets.

ENGAGED MARKETS

Even transparent, competitive markets fail if the people making purchasing decisions face misaligned incentives. Fiduciary-duty requirements for referrals and benefit design, audit standards for AI-assisted billing, PBM transparency, and reference pricing for state employee plans realign incentives so that purchasers, patients, and intermediaries all benefit from lower prices and higher quality.

26 Texas 2036, *Texas Voter Poll*, September 2025. 82 percent of Texas voters more likely to support candidates who prioritize reducing health care prices; 37 percent of Texans report having delayed or skipped medical care because they did not know the final cost.

27 Texas Politics Project / University of Texas at Austin, *Texas Statewide Survey*, December 2025. 67 percent of Texas voters "very concerned" about health care costs — highest level of concern recorded across every economic issue tested.

Among these levers, the state's own purchasing power deserves particular attention — both because Texas controls it directly and because it can be aimed at each of the mechanisms described in this piece. TRS-ActiveCare covers more than 500,000 public-education employees and dependents; combined with the Employees Retirement System Group Benefits Program, the state is one of the largest single health care purchasers in Texas. Inside those plans, Texas could pay site-neutral rates that neutralize the facility-fee gap; write audit and claims-integrity standards into procurement that scrutinize AI-driven upcoding rather than absorb it; and require fiduciary-grade benefit design — including how networks are tiered and how referrals are steered — so that intermediary incentives align with enrollee interest. The broader pattern from large public-purchaser reforms is that changes made inside a sufficiently large plan tend not to stay there — CalPERS' reference-pricing experiment in California is the most-studied example, but the underlying mechanism is general: a major purchaser's contracting decisions reset benchmarks that ripple into the wider commercial market, even when the specific reform tool differs. That spillover is what turns state-as-employer reform from an internal cost-control exercise into a market-shaping lever — and it does so by having the state act as a purchaser rather than a regulator, which is a route to reform that tends to travel further in Texas.

The risk in the current academic debate is that it gets used to justify inaction on prices while the industry quietly raises them through the back door. The answer is not to choose between the two camps. It is to recognize that billing games are a price problem, and to build policy that addresses both the direct and indirect versions.

The Bottom Line

Health care prices in the U.S. are still the core structural problem. But the industry has gotten better at raising the prices patients pay without calling them price increases — through facility fees, referral steering, insurer self-dealing, and AI-automated billing optimization. The policy response needs to match that sophistication: address contracted prices directly, and close the indirect channels the industry uses to extract revenue while the debate about "prices vs. utilization" keeps policymakers looking the other way.

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Additional reading: "Not the Prices" and "Still the Prices," *Health Affairs* Forefront commentary series, 2025 · KFF FTC, DOJ & Anticompetitive Health Care Practices · NBER working papers on hospital acquisitions and price increases · Texas 2036, *The State of Health Care for Texas Families.*