

1. Healthcare Consolidation

Assertion heard in testimony: Consolidation of hospitals and

physician groups is the primary driver of Texas health care cost growth, and Texas leads the nation in hospital-market consolidation.

Consolidation is a symptom, not the disease. No one forces an independent physician group to affiliate with a hospital system. Inadequate physician reimbursement, an increasingly complex private-pay reimbursement scheme, administrative burden and the simple economics of scale are what push independent practices toward affiliation. Losing an access point entirely, through closure, does far more damage to affordability and preventative care than an affiliation does.

Texas Has a Diverse Hospital Market

Texas has 586 hospitals in 71 health systems, the largest number of hospitals in any state. Texas ranks 26th out of 50 states in number of hospitals per-capita. Given Texas's diverse geographies, industries and population centers, hospitals in this state operate along a spectrum. Some serve depopulated rural areas that cannot sustain more than one hospital, while others operate in hypercompetitive urban markets. Nowhere is stiff competition more evident than the Texas Medical Center in Houston, which contains six major system flagship hospitals in the space of a few city blocks.

No witness offered data in support of assertions that Texas is a highly consolidated state for hospital care. In fact, according to the consolidation [critics' own data](#), Texas is the 3rd least consolidated state in the nation (Table 1).

Health Insurer Consolidation is Far More Pronounced in Texas

In comparison to the healthcare landscape, hospitals are not the only vertically integrated actors in this market, with health plans having the distinction of highest market concentration and acquisitions in the last few decades. Independent research published by the Brookings Institution in September 2026 mapped the corporate structure of the five dominant national health insurers; CVS-Aetna, Elevance, Humana, Kaiser and UnitedHealth Group. The Brookings Institute found these five organizations alone insure roughly 126 million Americans and now own vast networks of pharmacy benefit managers, physician practices, clinics, home health agencies and surgery centers.

UnitedHealth Group's Optum division alone generated over \$270 billion in combined revenue in 2025, much of it in "related-party" payments between the insurer's own subsidiaries, meaning they were paying themselves for healthcare services. For example, \$96.9 billion (63%) of Optum Rx's revenue came from other UnitedHealth-owned entities. The researchers noted this structure creates the same opportunities to obscure true costs and profits, also known as "tunneling" that critics allege against hospital systems, at a scale that dwarfs any Texas hospital system. If vertical integration and consolidation are the committee's concern, the payer side of the market deserves the largest scrutiny of market imbalance.

A 2025 U.S. Government Accountability Office study finding that three or fewer insurers hold at least 80% of market

share in the individual and employer-group markets in at least 35 states, and that market concentration has generally increased since 2011. In Texas specifically, an American Medical Association study found that a single carrier, Health Care Service Corporation (Blue Cross Blue Shield of Texas), holds a plurality or outright majority share in every one of the 26 Texas metro areas studied – from 37% in Austin-Round Rock-San Marcos to 74% in Abilene.

In short, consolidated insurance markets mean higher premiums, fewer choices, and lower physician earnings and employment.

2. Network Adequacy is Not Driving Healthcare Costs

Assertion heard in testimony: Provider networks are, in the words of one health plan witness, “a really huge problem” that misaligns incentives and drives premiums higher. Loosening network requirements would lower costs.

Networks help protect patients and provide access to care that before network adequacy laws passed in 2023 drove astronomical out-of-pocket expenses when a patient found themselves receiving care in a hospital system and seen by various doctors who had to independently contract with health plans.

“All-or-nothing” contracting, or more complete networks, allow hospital systems to negotiate one contract covering all its facilities, rather than negotiating each facility separately. This form of negotiation alongside network adequacy laws are some of the only tools that keeps a fragmented set of hospitals, especially smaller and rural systems, from being picked apart facility-by-facility by a small number of dominant insurers. Removing “all or nothing” would shift negotiating leverage further toward insurers already holding outsized market share as established in the earlier section and would put comprehensive network coverage at risk.

It is also worth noting that the Texas Department of Insurance found, prior to the 2023 law, that more than 90% of insurers' health plan networks in the state did not meet the statutorily required network-adequacy standards, and that TDI had been routinely granting waivers rather than enforcing them. Once TDI began denying some of those waiver requests, the insurance industry's trade association sued to stop the agency from enforcing the state's own adequacy law. That sequence of events does not support the narrative that hospital-driven network requirements are the burden; if anything, it shows insurers seeking to avoid the adequacy standards that protect patient access.

Separately, a CMS rule finalized this year will allow Texas to certify non-network health plans beginning in 2028. These plans provide a fixed benefit amount rather than a negotiated network, and enrollees who see a non-participating provider are responsible for the balance. As health plan responsibility shrinks under these designs, patients and hospitals are left holding the difference, which is the same cost-shift dynamic documented with high-deductible plans.

3. Hospitals Can't Make Money Off of Medicare

Assertion heard in testimony: Medicare reimbursement is close to or above hospitals' actual cost of care. Hospitals that claim otherwise are omitting a favorable "contribution margin," and cost-shifting from government payers to commercial insurance is a myth.

A "positive contribution margin" on Medicare patients is not the same as covering a hospital's full cost of operating. Contribution margin analysis purposely excludes hospitals' fixed cost, which is a core feature of hospital economics. Hospitals' fixed costs include capital expenses and maintenance, 24/7 standby capacity that hospitals are uniquely required by law to maintain, and overhead related to regulatory, compliance, and payer relations. Fixed emergency department, labor and delivery and operating room costs do not shrink just because volume is lower. According to data provided to the affordability hearing by TORCH, 43% of Texas's 155 rural hospitals reported negative margins in 2025 despite a payer mix that is overwhelmingly Medicare and Medicaid. Government underpayment does not disappear when it isn't discussed; it lands on homeowners, businesses and privately insured patients in the form of higher premiums.

Rising physician subsidies are a related and growing piece of this picture. The cost of subsidizing physician practices has grown significantly faster than overall hospital operating expenses. This has been driven by anesthesiologist and other specialist shortages as well as increased reliance on locum tenens coverage in rural markets. Physicians are frequently paid more than the hospitals themselves for similar services despite receiving lower Medicare payments each year for physicians. Hospitals have steadily increased these subsidies specifically to keep physician practices viable, preserve patient access, and that trend is expected to continue, because ultimately the absence of these partnerships results in less access to and delayed care for patients.

4. Supplemental Payments Aren't Enough

Assertion heard in testimony: Because hospitals receive supplemental Medicaid supplemental payments on top of base rates, the shortfall from Medicaid, Medicare and uninsured care is effectively covered, and hospitals don't have funding gaps.

Base Medicaid rates reimburse hospitals, on average, only 72% of inpatient costs and 75% of outpatient costs, and care for the uninsured is almost entirely unreimbursed. **Texas hospitals incurred \$27 billion in Medicaid and uninsured costs in 2025, with total base and supplemental payments netting hospitals \$18 billion. That leaves \$9 billion in totally unreimbursed care after removing the portion of these supplemental payments which, as a reminder, are self-financed by hospitals.** Per MACPAC, the Medicaid CHIP Payment and Access Commission, a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the U.S. Secretary for the Department of Health and Human Services and states, even after directed payments, Texas hospitals still **earn only 80–90% of what Medicare would have paid for the same services.** That is not a windfall, but a partial offset.

It is important for the committee to recall how these payments are funded. In Texas, 60 cents of every Medicaid dollar

are federal funds, while 40 cents must come from the state. Unlike base Medicaid rates financed with state general revenue, hospitals themselves supply 100% of the non-federal share required to unlock federal Medicaid matching dollars for every supplemental payment. This system was conceived as a conservative approach to identifying state match dollars to ensure Texas families and small businesses are not underwriting this system through general tax dollars. As such, hospitals are self-financing it to draw down of federal funds, which is precisely why interruptions in that federal match hits hospitals directly rather than the state budget. This also means that, dollar-for-dollar, supplemental payments are more expensive for hospitals to earn than base payments.

Funding is neither stable nor guaranteed, increasing risk

Earlier this year, CMS withheld approval for three Texas Medicaid directed-payment programs, CHIRP, TIPPS and RAPPs, for the fiscal year that began Sept. 1, 2026. That resulted in \$27 million per day in losses, drawn from a combined \$9.8 billion in annual program funding that is responsible for an estimated 90,000 Texas jobs and \$20 billion in statewide annual economic impact. Additionally, CMS was separately interrupting \$1.4 billion in 2026 CHIRP quality-incentive payments in a program it already approved last year. CMS approved these funds, both for FY27 and 2026 CHIRP quality-incentive payments, on Sept. 17, restoring critical payments for Texas hospitals.

This was not a new or isolated dispute: Texas sued CMS over these same financing methods in 2021 and 2023 and won in federal court both times, yet in 2021 alone hospitals lost \$7 million per day for seven months during the litigation. These cuts threaten to impact service-line areas such as neonatology, obstetrics, and cardiovascular/thoracic surgery. With 41% of Texas rural hospitals reporting less than 30 days of cash on hand, the hospitals least able to absorb a delay are also the most dependent on these payment programs.

Layered on top of that near-term dispute, a proposed federal rule implementing last year's reconciliation law (H.R. 1) is projected to cut roughly \$1 billion per year from Texas hospitals' Medicaid payments starting in 2028, threatening obstetrics/gynecology, neonatology, pediatrics, behavioral health, oral and maxillofacial surgery and otolaryngology specifically. Nationally, H.R. 1 is projected to cut nearly \$1 trillion from Medicaid over the next decade. Multiple Texas systems have already told THA they are regionalizing or consolidating exactly these service lines in anticipation of further cuts, and some have identified facilities that could close outright if supplemental funding shrinks further. It is important to note that a not insignificant component of these payment cuts would come from the edits in the proposed federal rule, not the statutory language passed in H.R. 1.

It is worth acknowledging directly what the supplemental payment system does not do: it does not reimburse care for lower-income patients who are commercially insured, including those in high-deductible plans. Amounts those patients cannot pay become bad debt with no Medicaid payment offset at all. That gap is separate from, and in addition to, the \$9 billion Medicaid uninsured shortfall above.

5. Hospitals Aren't Efficient Because They Don't Have to Be

Assertion heard in testimony: Because Hospitals have historically been insulated from market pressure by favorable government reimbursement, they have never had to pursue efficiency the way a normal competitive industry would.

THA's own testimony documents a specific, current list of efficiency initiatives that member systems have adopted as permanent operating functions: active labor-productivity and flexible-staffing programs that reduce reliance on costly agency labor; supply-chain vendor-rebate compliance and ongoing contract renegotiation; corporate overhead governance, including committee-level review of new hires and vendor spending; drug formulary management and utilization review; and throughput and capacity initiatives that reduce avoidable cost. Several of the state's largest systems describe this as a standing function of their organizations. At the end of the day, hospitals are businesses, and inefficiency runs counter to the goal of running successful businesses.

Another example of Texas hospitals being early adopters of efficiency in comparison to other states can be found in value-based payment arrangements, driven in part by the quality-reporting requirements attached to Medicaid supplemental and directed-payment programs. The state's own All-Payer Claims Database shows that the cost of inpatient care has decreased over time as a result. Additional regulatory requirements tied to best practices and CMS certification can also be cited as efficiencies. Examples of this can be found in basic hand washing and hygiene efforts and optimized patient flow processes. This is difficult to reconcile with a claim that hospitals have faced no pressure to improve efficiency.

Table 1. Estimated Market Share of

Largest Hospital Systems by State

Rank	State	Estimated market share of five largest hospital systems, 2023	Estimated market share of three largest hospital systems, 2023
1	Delaware	100%	85%
2	Hawaii	96%	76%
3	Utah	95%	87%
3	District of Columbia	95%	86%
3	Rhode Island	95%	82%
6	North Dakota	90%	71%
7	West Virginia	89%	84%
8	Maine	87%	72%
9	Nevada	84%	68%
10	South Dakota	82%	80%
11	Connecticut	81%	67%
12	Vermont	76%	76%
13	Iowa	74%	68%
13	Washington	74%	56%
13	Colorado	74%	54%
16	Idaho	73%	59%
17	New Hampshire	72%	52%
18	Arizona	70%	57%
19	Nebraska	69%	53%
20	North Carolina	66%	53%
20	New Mexico	66%	51%
22	South Carolina	65%	48%
22	Minnesota	65%	46%
24	Maryland	64%	51%
25	Louisiana	63%	50%
25	Michigan	63%	44%
27	Wyoming	61%	48%
27	Kentucky	61%	43%
29	Massachusetts	60%	45%
29	Virginia	60%	43%
31	Kansas	59%	46%
31	Montana	59%	39%
33	New Jersey	58%	47%
33	Missouri	58%	46%
33	Oregon	58%	43%

33	Oklahoma	58%	38%
37	Georgia	57%	41%
38	Mississippi	56%	41%
39	Wisconsin	52%	38%
39	Indiana	52%	35%
41	Florida	51%	40%
41	Ohio	51%	37%
41	Alabama	51%	36%
44	Arkansas	49%	35%
44	Tennessee	49%	33%
46	Pennsylvania	48%	35%
47	Illinois	47%	33%
48	Alaska	46%	36%
49	Texas	44%	32%
50	California	42%	31%
51	New York	39%	27%

Source: Families USA. (May 2026). "Big Systems, Bigger Profits: Consumers Are Paying the Price of Corporate Hospital Power,"

Sources: Texas House Select Committee on Health Care Affordability hearing transcript; John Hawkins/THA written testimony to the Select Committee on Health Care Affordability (Sept. 1, 2026) and to the House Committee on Insurance (June 4, 2026); THA, "In the Crosshairs: Texas Hospitals Face \$10 Billion Crisis"; THA internal House Affordability Q&A; THA, "The Reality of the Deal" (Behind the Headlines, July 13, 2026), citing U.S. GAO, Private Health Insurance: Market Concentration Generally Increased from 2011 through 2022, and Texas Medical Association / AMA, Competition in Health Insurance (2025); Richard G. Frank and Samuel Peterson, "Mapping Vertical Integration in US Health Insurance," Brookings Institution (Sept. 3, 2026); KFF State Health Facts, Total Hospitals by State (AHA Annual Survey, 2024); U.S. Census Bureau, Vintage 2024 state population estimates.