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Consolidation is changing health care in Texas. Patients are looking to alternatives

Mergers and acquisitions are contracting the health care space and driving up patient bills, data shows.



By **Amber Gaudet**
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Dr. Elizabeth Kassonoff-Piper, who works in a direct primary care/concierge medicine clinic, poses for a photo in a patient room at North Texas Preferred Health Partners on Tuesday, Aug. 12, 2025.

JUAN FIGUEROA / STAFF PHOTOGRAPHER



U.S. health care costs have grown exponentially over the past several decades, outpacing economic growth in 2023.

During that time, the nation has seen an increasing number of health care mergers and acquisitions, and Texas is no exception: In particular, the Dallas hospital market has become more concentrated as costs have risen.



Partly driving the dynamics are hospitals and private equity firms gobbling up specialty practices, which is [leaving fewer independent providers](#).

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One Texas acquisition spree has even drawn the attention of the Federal Trade Commission, which has an [open lawsuit](#) against U.S. Anesthesia Partners and private equity firm Welsh, Carson, Anderson & Stowe.

In a complaint, the FTC accused the parties of “a multi-year anticompetitive scheme to consolidate anesthesiology practices in Texas, drive up the price of anesthesia services provided to Texas patients, and boost their own profits.”

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To some watchdogs, the suit is a telling example of an alarming trend in health care: a rapid acceleration in buyouts and consolidation that ultimately decrease competitiveness and [lead to higher costs for patients](#).

As patients face fewer lower-cost, traditional medical choices, they're looking to alternatives — and so are physicians.

The cost-consolidation loop

Cardiologist Dr. Richard Snyder has been in private practice since 1993, and his practice, Heartplace, was acquired by national private equity group U.S. Heart & Vascular in May 2023.

Since then, Heartplace has expanded its footprint significantly, bringing on more than a dozen new doctors and building imaging centers throughout Dallas-Fort Worth.

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Those ownership shifts have become more necessary as physicians contend with the growing costs of operating a practice and declining reimbursements. COVID-19 [accelerated cost pressures and revenue losses](#) among health care providers, as patients spent less on routine and elective care.

Those financial realities, along with increasing administrative burdens, have made acquisitions — either by major hospital systems, private equity or larger physician groups — more attractive for once-independent practices.

“You’ve got sort of these upward pressures on the operational expense side, and you’ve got downward pressures on the reimbursement, and so sustaining a solo, independent or a small practice of physicians just becomes operationally very difficult,” said Jon Roth, who serves as executive vice president of Dallas County Medical Society.

Major insurers have also pointed to increasing consolidation as a driver of higher health care costs, but hospitals and physician groups say it's necessary to join forces.

Acquisitions can be a lifeline for struggling rural hospitals, giving them operating capital, an ability to share cost burdens, improved workflow and better bargaining power with insurers.

In a reflection of how deals can help make institutions more flush, nearly 40% of hospitals in an analysis by Kaufman Hall [added new services post-acquisition](#), according to the American Hospital Association, a hospital lobbying group.

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“I think there are some real benefits associated when you do the appropriate merger and the appropriate acquisition,” said Steve Love, president of the DFW Hospital Council.

That ability to drive a harder bargain with third parties like insurers can be essential to keeping the doors open — and ultimately translate to bigger bills for patients.

A [slew of studies](#) examining the impact of acquisitions on costs have found consolidation to be a driver of higher prices. Prices at “monopoly hospitals” were 12% higher than those at hospitals in markets with at least four rivals, a [2018 study found](#).

Some argue that not all mergers are created equal. Snyder said his practice’s relationship with U.S. Heart & Vascular has allowed them to save patients money, by providing the capital to open ambulatory surgery centers where patients can have simple procedures done for a fraction of the cost as on a hospital campus.

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“An echocardiogram, which is an ultrasound test we do in the office, is about \$134 in my office. But if I go one floor below, it’s \$500 in the hospital outpatient lab,” Snyder said.

A [2025 study](#) found that hospital-affiliated physicians were the highest-cost providers of outpatient services across cardiology, gastroenterology, orthopedics and urology.

Those physicians were far more likely to perform procedures in high-cost outpatient departments of hospitals than in ambulatory surgery centers or medical offices.

The Las Vegas Trail Health Center pictured, Tuesday, July 29, 2025, in Fort Worth.

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‘Out to make money’

Data shows that even when acquisitions help practices spend less, patients’ bills often don’t reflect those efficiencies.

“Private equity is out to make money... this is the problem with all of these organizations,” said Vivian Ho, a health economist at Rice University.

“Even though a hospital will say that we can lower costs per patient... they have not been shown to pass the savings on to patients. They use their consolidated market power to charge higher prices.”

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Insurers share some of the blame for higher costs, too — data shows [insurance mergers also lead to higher premiums](#). But “the biggest factor for explaining increases in prices over time is hospital care,” said Ho, who also serves on Blue Cross Blue Shield’s community advisory board.

The hospital price index has risen faster than both insurance premiums and professional services, and hospitals have maintained higher profit margins than insurers, [Ho’s research found](#).

Those sounding the alarm about increasing consolidation say it’s less about the impact of different types of acquisitions than how frequent tie-ups and buyouts weaken competition.

“If there’s four players in a market, if I’m any of the four, I can buy one of the other ones [and] we all make more money,” said state Rep. James Frank.

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“I don’t think there is one ownership style that is evil and one is good. Market consolidation is the problem,” the Wichita Falls Republican said.

Alternatives draw physicians, patients

Despite impacts to patient costs, acquisitions can bring benefits for physicians including stable pay and hours. But some say they also bring downsides, like less autonomy over practice standards.

That’s leading a subset of physicians to opt out of the traditional health care model altogether — and lean into alternatives they say will bring more value for both patients and doctors alike.

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Dr. Elizabeth Kassanoff-Piper started her career as an internist in 1999 before transitioning to concierge care as part of a Baylor Hospital team in 2013.

Concierge, or direct primary care, asks patients to pay annual membership fees that allow doctors to carry lighter patient loads.

That means longer appointments — usually 30 minutes instead of 10 or 15 for a regular visit and longer for physicals — and less pressure to fit everything into a billable event. A 2021 study by the National Institutes of Health found direct primary care had [grown more than 1,000%](#) in the previous six years.

Kassanoff-Piper and her fellow doctors formed their own concierge care practice, Preferred Health Partners, in 2015. Since then, Preferred Health has expanded to nine locations throughout Dallas-Fort Worth and in Austin.

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Many direct primary care practices don't accept insurance — instead, patients pay a monthly or annual fee that covers typical primary care services. Other clinics like Preferred do bill insurance for services not covered by the annual fee, which varies by provider but can range [from \\$1,200](#) to \$3,000 or more.

It's not an alternative to health insurance, since hospital stays and any other medical services outside what the primary care practice offers wouldn't be covered. But the model is one that's been growing at a time when options in the classic health care space have contracted.

For Kassanoff-Piper, it meant turning away from the pressures of large hospital systems to spend less time with patients and fit more appointments in.

"I really wanted to do the opposite, which was spend more time with my patients, and really get to know them better," the physician said.

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She has about 500 patients as opposed to the more than 2,000 that a primary care physician at a traditional practice might have, and they have direct access to her outside of appointments.

Older patients and those with chronic illnesses or more complex medical histories tend to see the most benefit, according to Kassanoff-Piper.

Providers can spend more time examining prescription lists for contraindications, helping coordinate care and talking to patients about supplements and lifestyle than is common in more corporatized practices, she said.

Kassanoff-Piper and her fellow physicians also opted to bring on services they don't see a profit from, like a staff nutritionist and in-house X-rays.

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“Those are decisions we probably wouldn't have been able to make if we were owned by a group of investors or owned by a hospital system who was really more... concerned about profitability,” she added.

More satisfaction, but more needed

Other alternatives have popped up, too. Virtual-only specialty clinics for everything from mental health to gastroenterology and menopause care have become increasingly common.

The percentage of hospitals offering telehealth services grew from 72% to nearly 87% between 2018 and 2022, according to the American Hospital Association.

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Though direct primary care isn't a fix for the larger cost burdens of the medical system, it's one way that patients are pivoting amid an increasingly expensive environment that leaves less time for personalized care.

"I think that both doctors and patients have been seeing and feeling a little bit more satisfied with some of those delivery mechanisms than the ones that you see in the more administrative and bureaucratic larger systems," said Charles Miller, director of health and economic mobility policy at Texas 2036, a nonpartisan think tank.

"For common, low-cost events, this is the sort of model that may make sense, and primary care seems like a very ripe environment for that to happen. But for higher-cost, lower-frequency [care]... it's probably not a model that's going to be as productive or attractive."

Patients have signaled they want more transparency around health care ownership structures and share widespread concerns about high health care costs.

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More than 70% of Texans said they're paying more for health care than five years ago and 87% are concerned about increasing consolidation, according to a [November 2024 poll by Texas 2036](#).

Many types of mergers don't make news, though. Often people aren't seeing a bigger hospital bill and connecting it with recent acquisitions — so while patients want lower costs, there is little public pressure around reigning in consolidation.

"I don't think people get it. I don't think people think when they hear something else is being bought up, I don't think people go, 'Oh, I'm about to get charged facility fees that I wasn't charged before,'" said Frank, the GOP legislator.

Rice University's Ho is working on raising awareness among human resources executives who are responsible for negotiating employer-sponsored health insurance, often through brokers. That process can be overwhelming and lead to less competitive deals for employees, Ho said.

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Complicated contracts for benefit plans often include commissions for brokers that can drive costs up, for example, and many HR departments lack the resources to vet claims data, she said.

But a big piece of the puzzle in driving down costs will be making patients sensitive to direct price increases, experts say.

"Even if you have transparency and competition, the consumer actually has to care what it costs," Frank said. "If you look at any surgery, you can go to one place and it's \$50,000 and another place is \$25,000. To a consumer, the way the insurance is set up, all you know is what your deductible is, so you don't care."

That's where things like tiered plans — which tailor the amount of a co-pay to how expensive a care provider is — can come in, Ho said. That can encourage patients to seek out less expensive care and stimulate price competition among hospital systems and private practices.

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“We just can’t keep on as consumers going to the most expensive place with no cost,” Ho said. “If we get a little bit of skin in the game but we still have access to really high-quality care, then you have price sensitivity, and then it’s going to look more like a downward sloping demand curve.”

Meanwhile, regulation at the state level could also help increase transparency about health care deals, and target practices like charging hospital facility fees for off-campus office or telehealth visits.

Frank introduced House Bills 2747 and 2556 to strengthen reporting requirements around mergers and facility fee charges, respectively, this legislative session, though the bills did not make it to the governor’s desk.

“When the government’s making the rules, you really don’t have a free market, which we don’t, but the government is not stepping into things like antitrust issues, which is exactly where we should be,” Frank said. “Because anytime you have a monopoly, you all of a sudden distort the market.”

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Broad bipartisan consensus could help move legislation forward in future sessions, according to Texas 2036’s Miller. While insurers and big care providers both vie for financial gains, advocates say that may be the best strategy to combat runaway costs for patients.

“What’s happening... is rational actors are doing on both sides what they need to to survive in the current marketplace environment, and if we as the public, as policymakers, don’t like that, we need to change the rules of the game,” Miller said.

“And I think if we do change the rules of the game, people will respond to that,” he added.

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By **[Amber Gaudet](#)**

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