Bipartisan Policy Center

Health Care Provider Consolidation

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I. ISSUE OVERVIEW

Ongoing consolidation among hospitals, physician practices, and other providers poses a serious challenge to the U.S. health care system—offering potential benefits to some but also with significant worrying impact on rising health care prices.

Provider consolidation remains pronounced among both hospitals and physician practices. The share of hospitals operating independently declined from about 90% in 1970 to 32% in 2019—and about 90% of U.S. hospital markets are currently classified as "highly concentrated." Similarly, according to data from the American Medical Association (AMA), only 42.2% of physicians now work in independent physician-owned practices—an 18-point drop since 2012.

Providers seeking to consolidate often cite positive driving factors, such as a desire to improve patient outcomes through integrated or value-based care models, acquire bargaining leverage with market-dominant payers, achieve economies of scale, or help save economically struggling rural hospitals and physicians.

Nevertheless, a substantial body of research shows that provider consolidation leads to significantly higher prices—to the detriment of patients and the health system at large. According to January 2025 data from the Department of Health and Human Services (HHS), horizontal hospital-to-hospital mergers in concentrated markets can raise hospital prices from 6% to 65%, while hospitals' acquisition of physician practices (vertical integration) can lead to a 14% average increase in prices for physicians' services.

The challenge is finding ways to restrain consolidation-driven price increases, while still taking advantage of the benefits that consolidation can provide. Policymakers have proposed or pursued several options to address this challenge, including better antitrust enforcement; improved transparency requirements; and requiring site-neutral payments in Medicare. Additional federal and state policy levers also have the potential to impact provider consolidation, including examining Medicaid's 340B drug pricing incentives, anticompetitive contract terms, scope of practice rules, and hospital certificate of need programs.

Although consolidation has increased across the health care system, including among insurers, this issue brief focuses on the benefits of and challenges associated with growing consolidation among health care providers—chiefly hospitals and physician practices.[1,2]

Experts from the Bipartisan Policy Center, the American Enterprise Institute (AEI), and the Brookings Institution co-authored a Health Affairs Forefront article, "Restraining Health Spending While Protecting Access: Potential For Bipartisan Action" (May 2025), spotlighting several bipartisan health policy reforms that would improve upon the status quo— among them addressing health system consolidation and Medicare site neutrality.[3]

II. EXTENT OF PROVIDER CONSOLIDATION

Driven both by the expansion of hospital systems and the significant erosion of independent physician practices, consolidation in health care provider markets has become pervasive in recent decades (see Figure 1).

Consolidation can occur horizontally—such as when one hospital or health system merges with or acquires another hospital—or vertically—such as when a health system acquires other parts of the care chain, notably physician practices or outpatient centers. When providers operating in different geographic markets merge, it is often referred to as a cross-market merger.

Hospitals and Health Systems

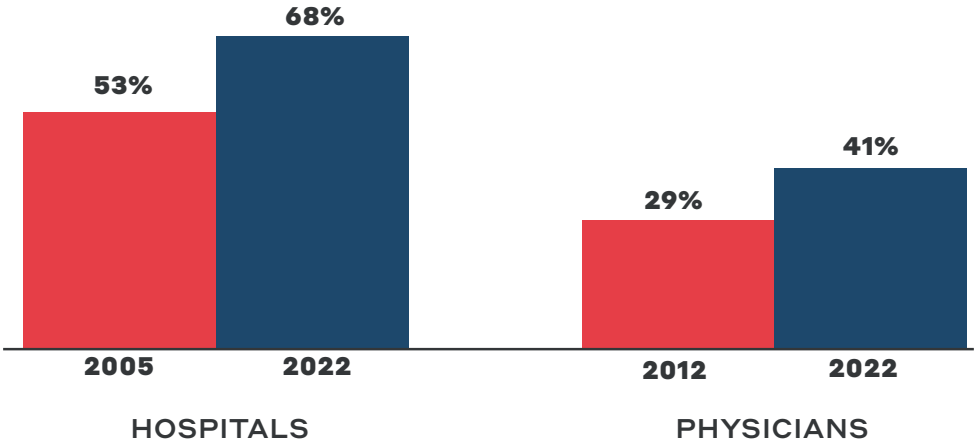
According to a 2024 analysis, one or two hospitals and health systems controlled the entire market for inpatient hospital care in nearly half (47%) of metropolitan areas in 2022—while in more than four of five metropolitan areas (82%), one or two such hospitals and health systems controlled more than 75% of the market.

Historically, the proportion of independent hospitals has fallen dramatically. Independent hospitals declined from 90% of the market in 1970 to 32% in 2019. Similarly, a separate 2024 review of recent studies found that nearly 70% of U.S. hospitals are now system-affiliated.

From 1998-2017, 1,573 hospital mergers were announced, followed by another 428 mergers between 2018 and 2023—and the share of community hospitals that are part of a larger health system increased from 53% in 2005 to 68% in 2022. The 10 largest health systems in the United States accounted for about one-fifth of nonfederal acute care hospital beds in 2022.

Notably, the picture for hospitals in rural areas is starker. These facilities often operate on much thinner margins than their urban counterparts—as do rural physician practices. For such facilities, consolidation can offer a path to survival and, in some cases, to improved clinical outcomes.

Figure 1: An Increasing Share of Hospitals Are Affiliated with Health Systems, and an Increasing Share of Physicians Are Affiliated with Hospitals or Health Systems



See endnote 2 for Figure 1 sources.[4]

Physician Practices

Physician practice trends also show dramatic change, driven largely by escalating acquisition of physician practices by health systems (See Figure 2), and to a lesser but growing extent, from acquisitions by private equity (PE) and corporate entities. Physicians today are also burdened by high administrative costs and reimbursements that have not kept up with inflation—factors that make surviving as an independent provider increasingly challenging.

According to the U.S. Government Accountability Office (GAO), at least 47% of U.S. physicians in 2024 were employed by or affiliated with hospital systems, up from 30% in 2012. Similarly, a 2025 AMA analysis found that only 42.2% of physicians in 2024 were in physician-owned independent private practice—18 percentage points lower than in 2012.

Independent physician practices are not only becoming less common but those that remain are becoming larger. Small practices are losing market share to larger practices. According to the AMA, the percentage of physicians working in practices with 10 or fewer physicians fell from 61.4% in 2012 to 51.8% in 2022, while over the same period, the share in very large practices with 50 or more physicians grew from 12.2% to 18.3%.

Also of note are acquisitions of provider entities by insurers, a growing trend that has not yet been thoroughly studied. This form of vertical integration has the potential to fully link clinical and financial incentives to provide appropriate and high-quality care. However, it also raises concerns about creating misaligned financial incentives that could impact access to care.

Figure 2: Distribution of Physicians by Practice Ownership

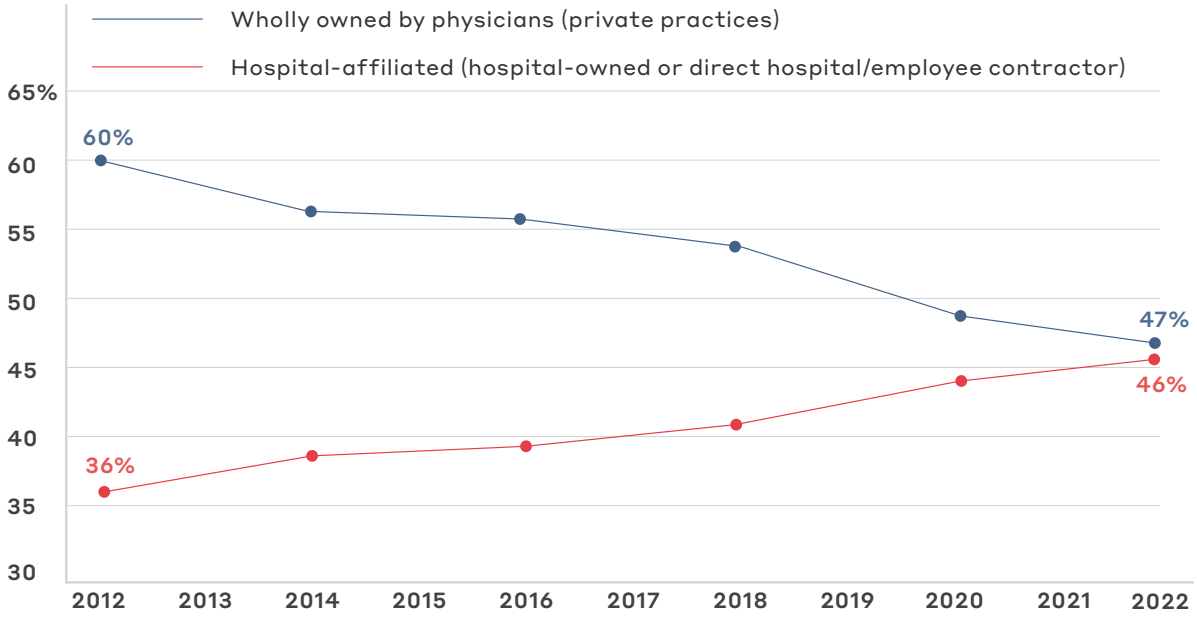


Chart: Bipartisan Policy Center • Source: Kane CK. Recent Changes in Physician Practice Arrangements, American Medical Association (AMA), Policy Research Perspectives; July 2023

See endnote 5 for additional notes on Figure 2.[5]

Private Equity Investment

Concurrently, the GAO has found that private equity (PE) investment in physician practices is growing nationally. According to the AMA, about 6.5% of physicians worked in private equity-owned practices in 2024, an increase from 4.5% in 2022.

Although PE-acquired practices account for only a small share of physician practices nationally, they disproportionately account for acquisitions in certain geographic and specialty markets. Another estimate found that physician practice acquisitions by private equity rose from about 75 deals in 2012 to 484 deals in 2021.

Private equity investment also varies greatly by practice type, with specialty practices garnering much greater PE interest than primary care practices. Only 1.5% of primary care physicians in 2022 were part of a PE-backed practice, according to the GAO, whereas 29% of retina specialists, for example, worked in PE-backed practices.

Advocates for PE investment contend that private equity firms deploy their capital where it is going to be most useful, whether it be expanding physician practices into rural communities, financing innovative medical devices, improving delivery of medical supplies, or investing in promising new drugs.

Critics, on the other hand, argue that PE firms sometimes burden acquired health care organizations with unmanageable debt, and that despite recent increased regulatory attention, PE investors can evade regulatory attention through serial acquisition or the "roll up" of small entities.[6] These critics contend that PE-driven consolidation can increase costs, compromise care, and diminish patient satisfaction.

Examining the impact of private equity investments on health care providers is beyond the scope of this issue brief, but it is important for policymakers to understand and consider the different perspectives surrounding this emerging trend.

III. MOTIVATIONS DRIVING PROVIDER CONSOLIDATION

Providers seeking to consolidate often cite several potential benefits, such as gaining greater bargaining power with powerful payers, facilitating integrated delivery systems and coordination, achieving economies of scale, and securing the survival of economically struggling rural hospitals and doctors.[7] These and other important factors include:

- **Greater Bargaining Power:** Consolidation can be attractive to providers because larger systems generally have better leverage to negotiate better rates and favorable contracts with insurers. Providers argue that their own consolidation can counter the consolidation of increasingly powerful insurers and other payers.
- **Facilitate Integrated Delivery Systems and Value-Based Care:** Advocates argue that some consolidation is necessary to ensure the success of centers of excellence, accountable care organizations (ACOs), and other models of integrated care or value-based payment, and that antipathy to consolidation should not overshadow the demonstrated track record of such integrated or value-based models in improving the quality of care, access, and patient satisfaction.
- **Improved Coordination:** Similarly, consolidation can improve clinical and administrative coordination. Some health care providers view consolidation as a way to align incentives, enable common clinical protocols, and establish shared information systems. Better coordination can also reduce fragmentation across care sites, facilitate smoother patient handoffs, and improve care management.
- **Economies of Scale:** Achieving greater economies of scale can motivate providers to consolidate. Larger organizations can spread fixed costs (such as technology, administration, and compliance) over more patients. Size also lowers per-unit costs and can improve purchasing power and access to capital investment, making care delivery more financially sustainable.
- **Boost Struggling Rural Hospitals and Physicians:** Health care consolidation can provide a lifeline for struggling rural and economically distressed hospitals and physicians by providing access to capital, shared administrative and clinical resources, and system-level support to stabilize finances and maintain essential services.
- **Respond to Medicare Site-of-Service Payment Differentials (e.g., lack of Site Neutrality):** Current law allows hospitals to bill Medicare at higher rates when services shift from physician offices to hospital outpatient departments (lack of site neutrality). This policy incentivizes more hospitals to acquire provider practices than would otherwise be the case.

- **Respond to Medicaid 340B Payment Incentives:** The Medicaid 340B drug pricing program creates an incentive for 340B hospitals to acquire physician practices so they can maximize patient volume (especially among patients with commercial insurance).
- **Respond to High Practice and Regulatory Costs:** Provider practices and facilities, particularly smaller ones, face growing infrastructure demands and regulatory compliance costs, which are burdens that can be shared through consolidations.

IV. CONSOLIDATION'S IMPACT ON PRICES, ACCESS, AND QUALITY

Despite the beneficial effects of provider consolidation in some circumstances (such as the development of ACOs and other integrated delivery systems), data consistently shows that consolidation drives price increases for consumers. Meanwhile, evidence of consolidation's effects on access and quality remains mixed.

Impact on Prices

Continuing consolidation among health systems and physician practices is not just an academic concern. Data over time has shown a consistent link between consolidation and higher prices.

Much public attention focuses on the impact of horizontal consolidations among hospitals on prices, but vertical hospital-physician consolidations also affect prices.

A 2025 comprehensive HHS synthesis of evidence on horizontal consolidations found that hospital-to-hospital mergers in concentrated markets can raise hospital prices between 6% to 65%. Similarly, a 2023 bipartisan analysis by the Senate Finance Committee concluded that it is not uncommon for hospital mergers to generate price increases of 20% or more.

The GAO in September 2025 published a review of multiple studies on vertical consolidations involving hospitals and physicians. It concluded that in most cases, "physician consolidation with hospital systems can lead to increased spending and prices"—with prices for physicians' services increasing 14% on average after acquisition.

This finding is consistent with a 2017 analysis by the Medicare Payment Advisory Council (MedPAC). It stated that physician-hospital consolidations increase prices for both commercial and Medicare physician services. Exacerbating the problem is that hospital outpatient departments charge higher fees for services than physicians in nonhospital settings. For example, MedPAC found that Medicare in 2016 spent $1.6 billion more than it would have if prices for evaluation and management office visits in vertically integrated hospital outpatient departments were the same as freestanding office prices.

Finally, a GAO 2025 analysis found that private equity investment in physician practices can lead to increases in commercial insurance spending, particularly for specialty physician practices. The GAO cites survey data showing that in six out of 10 specialties examined from 2012-2021, commercial insurers' spending increased relative to practices that did not receive private equity investment. These relative price increases ranged from 4% to 16% depending on the practice specialty.

Also worth noting are the potential downstream societal consequences of consolidation-driven price increases. A 2024 National Bureau of Economic Research paper (by Brot-Goldberg, Cooper et al.) traces a causal chain from price increases from hospital mergers to increases in premiums for employer-sponsored insurance, to reductions in workers' pay and employment—with attendant lowered tax revenue and squeezed government budgets.

Impact on Access and Quality

The impact of provider consolidation on patient access is more mixed, according to HHS data and other analyses. Some mergers and acquisitions have helped preserve financially vulnerable hospitals and provider groups, while other studies show that consolidation can reduce local access, increase travel times, and lower the availability of key services in affected communities, especially in rural areas. Yet other evidence suggests that vertical physician-hospital consolidations can produce modest increases in patient utilization and spending per patient.

Meanwhile, merging hospitals sometimes close facilities or eliminate essential services that rarely turn a profit, such as maternity wards, emergency departments, and primary care clinics, particularly in underserved and rural areas.

The GAO reported in 2021 that rural hospital closures force residents to travel roughly 20 miles farther for common inpatient services (and about 40 miles farther for less common services). Additionally, significant post-consolidation price increases in hospital markets can deter patients from seeking care because of the higher out-of-pocket costs.

Similarly, evidence on the impact of consolidation on health care quality has been limited. An examination of health systems published in JAMA concluded that "performance on measures of preventive care, clinical quality, and patient experience was modestly higher for health system physicians and hospitals than for nonsystem physicians and hospitals," while another study found no difference in patients' 30-day readmission rates when their primary care physician was part of a large system.

Interpreting evidence on the effects of consolidation on quality is complicated by the fact that measuring quality and its many dimensions is difficult, and that changes in quality from consolidation can take time to materialize.

V. POLICY EFFORTS TO BETTER REGULATE CONSOLIDATION

The significant consolidation of health care providers in recent decades—and especially its impact on health care prices—continues to draw the attention of policymakers seeking to more effectively manage the consequences of this trend in their communities.

Policymakers have pursued or proposed several policy options to address provider consolidation. These include better antitrust enforcement; improved transparency requirements; and requiring site-neutral payments in Medicare. Additional federal and state policy levers also have the potential to impact provider consolidation, including modifying Medicaid's 340B drug pricing program and revisiting certain state laws and regulations, such as noncompete contract terms, scope of practice rules, and hospital certificate of need programs.

Antitrust Enforcement

Although the United States lacks a unified set of policy levers to regulate provider consolidation, federal antitrust law offers arguably the strongest—albeit imperfect—tools currently available.

Federal antitrust standards in health care, shared by the Department of Justice (DOJ) and the Federal Trade Commission (FTC), have undergone a substantive shift in recent years. In 2023, DOJ and the FTC jointly released a modernized set of merger guidelines, which, although not targeted at health care, expanded the analytical tools and frameworks used to evaluate transactions, including those in the health care sector.

These guidelines supersede prior guidance and emphasize assessing the structure of local health care markets, with greater attention to concentrated hospital and physician-group environments and the labor-market effects of mergers. The new guidelines address serial acquisitions and private equity "roll-up" strategies that historically operated below regulatory thresholds.

This evolving federal antitrust posture has also included changes to the federal merger review process. Recent updates to premerger notification requirements (2024) have expanded the categories of information parties must disclose, particularly regarding ownership structures, debt arrangements, and patterns of serial acquisitions.

These modernized federal guidelines mean that health care entities engaged in consolidation now potentially face more extensive regulatory requirements and heightened investigatory burdens, litigation risk, and compliance costs.

Nevertheless, despite the arrival of the FTC/DOJ's strengthened guidelines in 2023, the actual number of federal health care enforcement actions remains relatively modest (as of 2025) compared with overall health care consolidation. This is consistent with antitrust enforcement trends across sectors. For example, through the third quarter of 2025, just 11 significant antitrust investigations were concluded—well below the average of 18.1 completed by the end of the third quarter going back to 2011.

In recent years, Congress has held hearings examining the fiscal impact of hospital and physician-group concentration on both commercial prices and federal health spending. However, such congressional interest has not yet advanced to legislation being considered on the House or Senate floor.

Meanwhile, even as antitrust enforcement actions at the federal level remain relatively sparse and Congress has not taken recent action, several state attorneys general (e.g., Massachusetts, Pennsylvania, and Maryland) have brought their own antitrust suits using federal and state law to block certain consolidations.

Also, a number of states (such as Oregon, Nevada, and New York) have enacted laws to limit anticompetitive health care transactions—for example, by requiring pretransaction notification, authorizing merger review, or expanding the oversight of acquisitions and affiliations.

Finally, one approach to antitrust enforcement proposes offering hospitals in highly concentrated markets a choice: either remain consolidated and accept a cap on prices (set lower than current commercial hospital payment rates), or voluntarily divest some holdings to reduce consolidation in their region below a defined concentration threshold.[8] This approach is discussed in BPC's co-authored Health Affairs Forefront article (May 2025).

Transparency Requirements

Enhanced requirements for price transparency in recent years show promise as a useful tool to assess consolidation activity.

Notably, the relatively comprehensive hospital price transparency rules promulgated by the Centers for Medicare & Medicaid Services (CMS), first implemented in 2021 and tightened through successive rulemaking, require hospitals to publicly disclose payer-specific negotiated rates, service codes, and out-of-pocket cost estimates in standardized, machine-readable formats.

CMS has also increased civil monetary penalties for noncompliance and expanded the categories of required data to improve consistency and usability. Compliance tracking data (for 2021–2023) from the GAO shows that CMS issued more than $4 million in fines to 14 hospitals that failed to take timely corrective action after receiving price transparency noncompliance citations.

Congress is increasingly interested in tackling this issue, evidenced by a bipartisan proposal, the Patients Deserve Price Tags Act (S. 2355), from Sens. Roger Marshall (R-KS) and John Hickenlooper (D-CO), as well as the bipartisan Fair Billing Act (S. 2497), from Sens. Maggie Hassan (D-NH) and Marshall. Additional congressional transparency proposals have been introduced, although none has yet advanced to full floor consideration.[9]

Several states have adopted their own health care price transparency measures. Notably, Colorado, Maine, and New Hampshire have established robust provider- or service-level transparency requirements, including mandatory reporting of negotiated rates or charges through all-payer claims databases or other publicly accessible platforms.

Analysis indicates that in addition to price transparency rules, requirements for greater ownership and financial transparency contribute to a better line of sight into provider transactions—particularly those involving private equity investment. A number of bills in Congress have been introduced to address this concern.[10]

Together, efforts to expand transparency—at both the federal and state levels—aspire to reduce the opacity that often accompanies health care transactions, enabling providers, purchasers, and regulators to better evaluate the effects of consolidation. Nevertheless, as valuable as enhanced transparency requirements can be, evidence suggests that their effectiveness is limited unless they are paired with more-robust tools, such as antitrust enforcement.

Medicare Site Neutrality

Although CMS does not regulate provider mergers directly, its Medicare payment policies play a central role in shaping consolidation incentives—not only in Medicare but also in commercial markets, which often follow Medicare's lead.

Differences between Medicare's hospital outpatient department payment rates and the Medicare physician fee schedule have encouraged hospitals to acquire independent physician practices and reclassify them as outpatient departments, thereby enabling higher reimbursement for identical services and encouraging consolidation.

Although Congress and successive administrations have taken limited action to move toward greater site neutrality (e.g., site-neutrality provisions in the 2015 Bipartisan Budget Act, and more recently in CMS's 2026 Hospital Outpatient Prospective Payment final rule), Medicare still pays, on average, two to four times more for many identical outpatient procedures when they are performed in a hospital outpatient department instead of a physician's office.

This persistent payment differential is a significant motivator for hospitals and physician practices to consolidate. Were it to be fully eliminated, the impact on hospital and physician behavior could be significant.

As BPC highlighted in its "Site Neutrality in Medicare Payment" (2025) issue brief, the status of congressional action on site neutrality is uncertain. On the one hand, site neutrality would yield significant federal budget savings (approximately $157 billion over 10 years), and it enjoys strong bipartisan support from physicians and insurers. However, hospital-sector resistance remains strong.

Other Potential Policy Levers

In addition to the policy levers reviewed above—better antitrust enforcement, improved transparency requirements, and requiring site-neutral payments in Medicare—other federal and state rules can also impact health care consolidation and may merit attention. These include rules regarding anticompetitive contract terms, scope of practice rules, hospital certificate of need programs, and Medicaid 340B drug price incentives.[11]

- **Noncompete Contract Terms and Other Anticompetitive Contracting Practices:** Noncompete contract clauses prevent clinicians from accepting employment with other providers within a certain geographic distance or within a certain period of time. These clauses can limit providers' mobility and accelerate consolidation among providers. Some researchers also raise concerns about the potential anticompetitive effects of restrictions in provider-insurer contracts, such as anti-steering, anti-tiering, and all-or-nothing clauses.
- **State Scope-of-Practice Rules:** State scope-of-practice (SOP) rules are common in many states and restrict the range of services that nonphysician providers can deliver independently. Intended to protect patients, SOP rules can also reduce competition by pushing independent nonphysician practitioners (e.g., nurse practitioners) toward employment or affiliation with larger integrated systems.
- **Certificate of Need (CON) Laws:** In place in some form in about 35 states, CON laws generally require that providers (usually hospitals) obtain state approval to make major capital expenditures. Although intended to reduce costs and inefficiencies, this dynamic creates an incentive for smaller hospitals to merge with larger ones rather than undertake the often costly burden of securing their own CON approvals.
- **Medicaid 340B Drug Pricing Program:** The 340B program requires drug manufacturers to offer significant discounts to qualifying eligible providers. While well intentioned and important, the program also creates incentives for 340B hospitals to consolidate with physician practices so they can maximize patient volume (especially among patients with commercial insurance).

VI. CONCLUSION

For the U.S. health care system, consolidation among hospitals, physician practices, and other providers can create uncompetitive markets and can fail to improve care or to preserve access to treatment.

Provider consolidation, however, can also support positive goals, including the growth of integrated or value-based care and avoiding closures of financially strained hospitals in rural or underserved areas. In some markets with provider shortages, consolidation may be the only way a provider can remain standing. However, these benefits must be balanced with the challenges associated with consolidation, particularly the significant price increases and loss of competition that often follow it.

Any policy reforms to address provider consolidation should recognize the unique needs of providers and patients across different geographies or markets to support access to high-value, integrated care while encouraging appropriate competition. Potential solutions include better antitrust enforcement, improved transparency rules, requiring site-neutral payments in Medicare, and assessing other federal and state rules that affect competition.

Health Program

BPC's Health Program advances bipartisan policy solutions to build a more cost-effective, evidence-based health care system to improve population health. We work to strengthen and sustain Medicare and Medicaid, accelerate the shift toward value, address inefficiencies and misaligned incentives, and responsibly leverage technology and innovation.

Disclaimer

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders, board of directors, funders, or advisers.

ENDNOTES

1 See Leemore S. Dafny, Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience, The Commonwealth Fund, November 2015.

2 See United States House Committee on Ways and Means, 5 Key Moments from Ways and Means Committee Hearing with Health Insurance CEOs, January, 2026.

3 See BPC's issue brief "Site Neutrality in Medicare Payment" (November 2025) and report Sustaining and Improving Medicare (December 2023).

4 Sources for Figure 1: KFF analysis of American Hospital Association (AHA) hospital data from the AHA Annual Survey Database and the AHA Trendwatch Chartbook (2021), and of AMA physician data from the AMA report.

5 The numbers in Figure 2 do not sum to 100% because "private equity" ownership (for which comparable data was only available for 2020 and 2022) and "other" ownership (wholly owned by a health maintenance organization/managed care organization and fill-in responses) were not included in this graph.

6 "Roll up" in the consolidation context usually means the acquisition of several smaller firms and merging them under common ownership, brand, and operations.

7 See for example analyses from the Medicare Payment Advisory Council (MedPAC, 2017 and 2020), HHS, GAO, and RAND Corp.

8 See BPC's 2020 report Bipartisan Rx for America's Health Care for additional details.

9 Other health care transparency proposals pending in Congress include the No Surprises Act Enforcement Act, sponsored by Sens. Roger Marshall (R-KS) and Michael Bennet (D-CO), and the Health Care PRICE Transparency Act, sponsored by Rep. Warren Davidson (R-OH).

10 See, e.g., H.R.5378 (118th Congress); H.R.1754 (118th Congress).

11 See, e.g., Robert A. Berenson, Jaime S. King, et al., Addressing Health Care Market Consolidation and High Prices, January 2020, and HMS-HCC-AV-Report-Final.pdf, February 2025.