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Information Alert

What the Hearing Got Wrong About Hospital Finances

Last week, the Texas House Health Care Affordability Select Committee held its first interim hearing to examine rising healthcare costs, with much of the discussion focused on hospitals' role in driving this growth. In this hearing, invited testimony included national think tanks, researchers, and nonprofit organizations. These out-of-state witnesses relied on national cost tools and data sources that demonstrated immense unfamiliarity with Texas' unique statutory requirements and ultimately gave a flawed impression of the industry.

Consolidation Keeps Care Available

Healthcare consolidation is an oft-cited concern at state and federal levels. During the hearing, invited witnesses continued to advance a narrative that physician practice acquisitions drive higher costs for patients. This overly simplistic narrative omits some critical components of the issue. First, mergers can and do create efficiencies that lower costs while allowing health systems to invest more in quality improvements and retain or expand the scope of services they offer. In fact, research shows that revenues per admission at merging hospitals decrease by approximately 3.3% relative to non-merging hospitals, resulting in savings that preserve patient access to care.

Hospital and physician consolidation is often spurred by financial headwinds that make independent operation nonviable. In demonizing hospitals' acquisition of distressed practices and facilities, the panelists failed to acknowledge a lack of alternatives to consolidation, particularly in rural communities. Often, hospitals' acquisition of other smaller practices preserves access to care in communities. It also can prevent unnecessary complications and costs resulting from travel-related barriers to care.

Patients recognize that if the choice is between the loss of their provider or consolidation, they prefer consolidation as a means to keeping care local. This perspective is borne out by recent public opinion research showing about six in ten people view consolidation of clinics with hospital systems favorably. If the state wishes to ensure that smaller practices and independent hospitals remain operational, the solution lies not in restricting a viable solution but in addressing the underlying economic stresses that threaten their viability.

The NASHP Hospital Cost Tool Misleads on the Cost of Care

Hospital care is expensive because the highly skilled personnel and supplies hospitals pay for are expensive. Hospitals must be open and able to treat and stabilize any health care need 24/7, utilize extremely expensive and advanced equipment, hire and train some of the most highly skilled workers, and provide care for everyone regardless of ability to pay. In 2025, total hospital expenses grew 7.5% — more than twice the rate of growth in hospital prices — driven by increased patient complexity, growing uncompensated care, and continued underfunding. Furthermore, hospitals are often adjusting prices to keep pace with rising healthcare demands and the escalating costs of workforce, supplies, and pharmaceuticals – as outlined in *THA's Truth Behind Growing Hospital Costs alert*.

Testimony at the hearing relied heavily on the NASHP Hospital Cost Tool, which purports to represent the financial health of the hospital industry but draws on Medicare data that were never intended for that purpose. Witnesses overlooked key limitations of the financial data in the tool – namely, that these tools do not fully account for physician subsidy costs or expenses not directly tied to patient care. Data from this unreliable tool significantly undercounts the actual costs of hospital operations and suggests that hospitals could "break even" by charging commercial payers rates tied to undercounted costs. Tying future reimbursement to a historical break-even point is flawed. It improperly assumes services, prices, and costs stay the same as in a previous data year, and the tool makes no attempt to adjust outputs to present market conditions. Deploying it in the manner suggested by witnesses risks pushing the state precariously toward government rate- setting in private markets.

Texas Sets the Gold Standard for Charity Care

National witnesses made false claims about regulation of nonprofit hospitals, with no regard for the reality of Texas' three-decade-old stringent charity care statutes. Witnesses also incorrectly implied that nonprofit hospitals fail to deliver sufficient charity care and community benefits to justify their tax-exempt status. Both characterizations are patently wrong.

Texas established the most stringent hospital charity care law in the nation in 1993 and hasn't looked back. The law requires all nonprofit hospitals to deliver a minimum amount of charity care and community benefits each year or risk losing their tax exemption. Texas' nonprofit hospitals deliver billions of dollars in free and discounted care annually to patients unable to pay. Transparent and detailed reporting is mandated by state and federal law to prove charity care costs and maintain tax-exempt status.

In 2024, Texas's own regulatory data show 127 Texas nonprofit hospitals subject to state charity care minimums collectively provided $14.9 billion in charity care and community benefits. Notably, that includes $3.4 billion – or 162% – more charity care than required by the state standards.

The state of Texas also recently commissioned a comprehensive third-party report on hospital finances, charity care, medical debt, and the value of nonprofit tax-exempt benefits. Data in this report show that nonprofit hospitals in Texas deliver $11.40 in unpaid care to low-income Texans and $19.00 in total community benefits for every $1.00 in tax benefit received. Texas' extensive charity care requirements and state oversight hold nonprofit hospitals accountable and provides a leading example for the rest of the nation.

Medicaid Supplemental Payments Still Short Hospitals

Panelists ignored key characteristics of Texas' Medicaid supplemental payments and the unique transparency and accountability the legislature has installed within the program. In Texas, base Medicaid reimbursement rates fall well below the cost of care, reimbursing only 72% of inpatient costs and 75% of outpatient costs on average. Costs of care for uninsured patients are almost 100% unreimbursed. While supplemental payments help narrow these gaps, they do not eliminate them leaving hospitals on the hook for the remaining cost of treating Medicaid and uninsured patients. Texas hospitals incurred $27 billion in Medicaid and uninsured costs in 2025, while the supplemental payment system netted $18 billion – based on aggregated cost and payment data from HHSC.

According to the Medicaid and CHIP Payment and Access Commission (MACPAC), Texas hospitals earn 80-90% of Medicare rates on Medicaid directed payments after accounting for the self-financed portion of the payment. Although the Texas Medicaid supplemental payment environment is complex, it is fully transparent and publicly accountable, contrary to assertions by numerous witnesses. In fact, once again, Texas stands out as a national leader in Medicaid supplemental payment transparency. Every dollar that passes through the program is accounted for and publicly visible. MACPAC praised Texas' practice to report provider-level financing and payment data "in a standard way that could be a model for other states."

Last week's hearings relied on testimony from out-of-state scholars and think tanks unfamiliar with how Texas hospitals actually operate. It is imperative that all stakeholders be included in these conversations to provide essential context for complicated financial data and greater visibility into the full spectrum of care. Texas hospitals are always at the ready and able to provide the highest quality care to patients and the highest quality insights into the state's health care system to Texas policymakers.