

Dear Chairman Frank:

Thank you for including the Texas Hospital Association in the House Select Committee on Healthcare Affordability hearing on September 1. I appreciate the opportunity to discuss what is driving healthcare costs in Texas and the steps hospitals are taking to make care more accessible, efficient and affordable. Hospitals remain committed to delivering affordable healthcare to the patients we serve.

I am writing to follow up because one fundamental distinction is important to the affordability discussion: hospitals are the only participants in the healthcare system subject to the federal Emergency Medical Treatment and Labor Act (EMTALA), which requires them to evaluate and stabilize patients who come to their emergency departments regardless of their ability to pay. Hospitals therefore carry a safety net obligation that does not fall on insurers, physicians, pharmacies or other healthcare entities.

That obligation has real costs. Hospitals maintain emergency departments, operating rooms, labor and delivery services, specialized personnel, and other capacity around the clock – even when that capacity is not fully utilized or when the patients who need it cannot pay. Those fixed costs do not disappear when payment falls short. They also don't disappear when caring for an uninsured patient or a patient whose insurance does not cover the full cost of the medical care received.

This is essential context for the Committee's discussion of affordability. Hospitals do not operate in isolation from the rest of the healthcare system, and hospital prices cannot be examined without considering the costs hospitals are required to absorb on behalf of that system.

Texas hospitals provided approximately \$27 billion in Medicaid and uninsured care in 2025, while net base and supplemental payments covered approximately \$18 billion – leaving roughly \$9 billion in unreimbursed care. These statements aren't exaggerated. They represent actual dollars and can be verified through data maintained by the state of Texas.

Financial pressures are particularly acute in rural communities. According to data presented to the Committee, 43% of Texas's rural hospitals reported negative margins in 2025, driven by a payer mix heavily weighted toward Medicare, Medicaid, and the uninsured. Hospitals cannot simply eliminate the services that lose money, because doing so eliminates access to essential care for entire communities.

The same context is important when considering the assertion that hospital consolidation is the primary driver of healthcare costs. Data do not support the characterization made in the hearing that Texas is a hotbed of hospital consolidation. Texas has 586 hospitals belonging to 71 health systems, the highest amount of any state in the country. Yet Texas ranks as the third

least consolidated state in the nation, based on the market share of its five largest hospital systems.

Concentration elsewhere in the healthcare system also deserves consideration. The insurance market is substantially concentrated, with federal and Texas-specific data showing significant market share held by a small number of carriers. These market dynamics affect the negotiating leverage available to hospitals and physicians and should be considered alongside hospital consolidation when evaluating healthcare costs.

Similarly, network requirements should not be viewed simply as a hospital-driven source of higher costs. Network adequacy protections help ensure that patients have meaningful access to comprehensive care, while "all-or-nothing" contracting can help smaller and rural hospitals negotiate with insurers that already possess significant market leverage. Weakening these protections could shift additional negotiating power toward insurers while placing comprehensive access at risk.

Finally, the suggestion that hospitals have little incentive to become more efficient does not reflect reality on the ground. Texas hospitals have implemented labor-productivity and staffing initiatives, supply-chain and vendor management, corporate overhead controls, pharmaceutical utilization management, patient-throughput initiatives, denial mitigation departments, and value-based payment arrangements. These are not temporary efforts; they are increasingly permanent components of hospital operations.

The fundamental point is that hospitals are price takers in many of the markets that determine their costs, while simultaneously being the providers legally required to stand ready to care for everyone who arrives at their doors. Hospitals do not set the price of labor, pharmaceuticals, medical equipment, or supplies, and they do not determine Medicare and Medicaid payment rates. Yet they must maintain the capacity, personnel, facilities and services necessary to meet the needs of their communities.

Texas hospitals want to be part of the solution to healthcare affordability. But meaningful reform must address the entire healthcare system rather than assigning responsibility to one sector that carries unique legal, financial, and community obligations.

We appreciate the Committee's attention to this important issue and welcome the opportunity to continue working with you and the Committee on solutions that improve affordability while protecting access, quality, and the financial stability of hospitals serving Texas communities.

Sincerely,

A handwritten signature in black ink, appearing to read "John Hawkins". The signature is fluid and cursive, with the first name "John" and last name "Hawkins" clearly distinguishable.

John Hawkins
President and Chief Executive Officer
Texas Hospital Association