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# Senate HHS Committee Testimony
# Texas Hospital Association

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My name is John Hawkins, President/CEO of the Texas Hospital Association. THA represents all hospital types, including urban, rural, public, private, children's, and behavioral health hospitals. Thank you for the opportunity to testify today.

I want to start by stating that we acknowledge the concerns over the cost of healthcare. Hospital costs and prices may not always be easy to understand, but despite the complexity, there is also transparency built into the system.

**What are the main cost drivers for hospitals?**

Workforce

Most hospital expenses – roughly 60% – are on the workforce. From nurses, janitors, billing and claims staff to care coordinators, hospitals are often one of the biggest employers in their communities. In Texas, hospitals directly employ over 472,000 people, and since COVID, the cost of doing so has increased. The average pay of Texas RNs rose from $74,540 in 2019 to $91,690 in 2024 – a 23% growth in the past five years. Data from the Department of State Health Services indicates that hospitals spent 44% more on salaries and 42% more on employee benefits in 2024 than they did in 2019.

To the point of hospital pricing data, we do want to caution against the use of any tool that doesn't capture the full costs a hospital incurs. For example, the NASHP Hospital Cost Tool does not include all hospital costs, does not match costs appropriately with associated revenues, and distorts hospital margins. Importantly, the margin data don't capture physician subsidy costs, don't fully account for non-patient-care overhead costs necessary for hospital operations (such as maintenance), or the full unreimbursed cost of resident training programs. It omits key industry segments, including children's hospitals and other hospitals that do not file Medicare cost reports, and also does not adjust for Texas-specific financing and payment features of the Medicaid 1115 waiver.

Ultimately, each hospital will have a unique story to tell on the challenges of operating a hospital in the state of Texas. Knowing what is missing from cost tools like NASHP is important for outlining the true costs of health care.

## Pharmaceuticals

Nearly 10% of hospital expenses are on pharmaceuticals. Hospitals have recently seen double-digit annual growth in drug costs (12%), with greater growth among academic medical centers (22%), safety-net hospitals (15%) and hospitals seeing higher acuity patients (17%). Together, high drug prices, frequent price changes by drug manufacturers, and supply chain inefficiencies create one of the most volatile components of hospital budgets. While it cannot be overstated how clinically transformative many of these medicines provided in hospital settings are for patients, the cost increasingly threatens patients' access to them.

## Supplies

Just like other businesses, hospitals rely on extremely complex supply chains, many of which are still recovering after the pandemic. As an example of supply chain fragility, the recent Iranian blockade of the Strait of Hormuz blocked Qatari helium from reaching the global market, spiking helium prices by a reported 50-70%. Overall, 18% of hospital spending is on supplies, and supply costs have continued to grow at a rate exceeding consumer inflation – 4% in the last year and 12% in the past three years, after controlling for utilization. Considering the cost of items hospitals use every day – for instance, a single ICU-capable bed can cost $25,000–$30,000, and a neonatal incubator costs $35,000 – any increase affects a hospital's bottom line.

For example, in 2024, hospitals nationwide spent:

- Over $10 billion on surgical and medical instruments (up 7% from 2023);
- Nearly $4.5 billion on computing infrastructure and data processing (up 15% from 2023);
- Nearly $1.4 billion on diagnostic imaging equipment (up 8% from 2023).

Hospital care in Texas is expensive because hospitals provide high-quality care to the sickest patients using the most talented workforce and cutting-edge medicine and technology. What sets hospitals apart from other industries is that they have to be open 24/7 and ready for any and all emergencies. Hospitals are not like other businesses that can simply scale down. If the physician or nurse workforce costs rise, hospitals have to meet those costs, face closure, or limit lifesaving services.

## Medicaid Supplemental Payments Still Short Hospitals

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, leaving $9 billion in total unreimbursed care – 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. 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 recently praised Texas' practice to report provider-level financing and payment data "in a standard way that could be a model for other states."

## Why Texas Hospitals Differ From Other States

### Facility Fees ARE the Hospital Payment

Facility fees are a critical part of paying for a patient's care, and they ensure outpatient clinics remain open and Texans continue to have access to lower-cost, more convenient options for health care. As medicine and health care have evolved, more and more care is provided in outpatient, less costly settings, and hospitals have responded to the needs of the community by establishing more outpatient settings for that care.

There are several common misconceptions regarding 'facility fees.'

1. In Texas, due to the corporate practice of medicine doctrine, hospitals (except for rural and public hospitals) cannot directly employ physicians. Therefore, the law in Texas requires split billing for physicians who practice in hospital-based clinics and outpatient departments.
    a. **Professional fee** payments compensate the time and talent of the physician.
    b. **Facility fee** payments cover all other aspects of a patient's care and environment. They pay nurses and other office staff, supplies, equipment (including everything from blood pressure cuffs to required back-up generators, which has been particularly important in times of grid uncertainty), housekeeping, billing, and administrative expenses including prior authorizations, and required governmental reports.
2. Researchers who have published work on facility fees often point to states where physician employment is permitted, like in Connecticut, Maine, and Indiana. Texas is not like these other states. More importantly, states all have different payor mixes and insurance coverage rates.
3. It is also important to note that hospitals are not the only entities that have outpatient facilities. In fact, from 2019-2023, health insurers, private equity, and other entities were responsible for most purchases of physician practices, with hospitals only accounting for 8% of those purchases.
4. Additionally, high-deductible health plans and high out-of-pocket expenses are driving patient confusion and complaints about facility fees. Nationally, high-deductible health plan availability increased from 33% in 2014 to 51% in 2023 for workers. More insured patients are finding their coverage does not cover facility fees, or that their deductible is so high, they're effectively paying for nearly all their health care out-of-pocket.

Texas hospitals have invested heavily in expanding services offered in the outpatient setting, expanding access to health care and jobs. Hospital Outpatient Departments are vital in moving patients away from the inpatient setting and reducing health care costs. Importantly, hospital outpatient services have allowed new access to care points for counties across the state that were unable to see specialists or receive non-emergent care in their communities. This has a favorable impact on health care costs – national health care expenditures are growing at a slower rate than in decades past thanks in part to inpatient surgeries shifting more toward outpatient settings.

Additionally, research supports that patients that seek care in HOPDs are not always the same patient population that seek care in a non-HOPD. They are often older, sicker, and need a higher level of care, which means a higher level of cost and reimbursement is necessary to treat that patient population. More importantly, the licensing and regulatory requirements of a hospital-owned outpatient facility are not the same as others. HOPD's have enhanced regulatory requirements that others do not have. If an HOPD is neither a remote nor an on-campus facility, they cannot charge a facility fee.

Consolidation

Healthcare consolidation is an oft-cited concern at state and federal levels. 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. Often, hospitals' acquisition of other smaller practices preserves access to care in communities. It can also prevent unnecessary complications and costs resulting from travel-related barriers to care. **The solution lies not in restricting a viable solution but in addressing the underlying economic stresses that threaten their viability, such as insufficient reimbursement and unsustainable administrative burden.**

Lastly, I do want to address some of the reasons why physicians are selling their practices to a hospital or other entity. According to the AMA, its survey indicates that 80% of physicians cited their inability to negotiate higher payment rates with payors as a "very important" or "important" reason their practice was sold to or acquired by a hospital or health system. The second most cited reason physicians sold their practice was the burden of managing payors regulatory and administrative requirements. I want to emphasize that we wholly support increasing physician reimbursement to also reflect the true cost of delivering care. If physician reimbursement were higher, we would have more access to care points in counties across Texas, and preventative care lowers the cost of health care.

## Charity Care

Texas established the most stringent hospital charity care law in the nation in 1993. 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 benefits received. Texas' extensive charity care requirements and state oversight hold nonprofit hospitals accountable and provides a leading example for the rest of the nation.

## Price Transparency

Texas hospitals fully support state and federal price transparency efforts that help patients access clear, accurate information about hospital prices and help employers become more informed consumers as the primary purchasers of health care services through employer-sponsored insurance. President Trump and Secretary Kennedy have made price transparency a focal point of their health care affordability policy agendas, and THA supports efforts to align Texas law with federal law. Texas HHSC data indicates that only one Texas hospital has been cited and sanctioned by HHSC for non-compliance. Texas hospitals are and will continue to remain committed to ensuring compliance with all laws and regulations on price transparency.

## Conclusion

The Texas Hospital Association appreciates being a part of the ongoing discussion on healthcare affordability in the state of Texas. It is our earnest hope that we can have a deeper conversation on the root causes that are leading to some of the challenges being discussed in the committee, and work to find solutions that don't hamper a hospital's ability to continue to provide the quality care Texans have come to expect from our world class facilities.