Policy Options for the Texas House Select Committee on Health Care Affordability

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On April 30, 2026, Christopher M. Whaley testified in front of the Texas House Select Committee on Health Care Affordability. Whaley's remarks and written testimony highlighted both the causes and the impacts of high and rising health care prices, as well as how states and policymakers have attempted to improve health care affordability through innovative solutions. As the Select Committee considers policies to improve health care affordability in Texas, this memo presents policy options for legislators to consider.

This memo was produced by economists and attorneys at the Center for Advancing Health Policy through Research (CAHPR) at the Brown University School of Public Health. CAHPR is a nonpartisan center dedicated to generating research that informs policies aimed at reducing costs, improving patient well-being, and driving meaningful transformations in U.S. health care delivery.

Policy Options

- **Reference-Based Hospital Pricing**: To address excessive hospital prices that are the result of consolidation, the state could set an upper limit on the amount a hospital can charge for services. The state could apply this limit to the entire commercial market (as Indiana and Vermont have done), or the state could apply this limit solely to the state employee health plans (as Montana, Oregon, and Washington have done). By limiting prices paid by the state employee plans (the Employees Retirement System and the Teacher Retirement System), Texas could ensure that taxpayer dollars are aligning with taxpayer value. This policy has proven to be effective, with CAHPR researchers finding that Oregon's policy saved the state $107.5 million—about 4% of total plan spending—over its first two years and three months in effect. Texas could establish a reference-based limit on hospital prices using any of a variety of different benchmarks: the limit could be a percentage of the Medicare rate (as Montana, Oregon, Vermont, and Washington did), the limit could be based on the average prices charged in the commercial market (as Indiana did), or the limit could be based on a percentile of the prices that the state employee plan currently pays for hospital services.
- **Facility Fee Ban**: To save money for Texans and to disincentivize vertical consolidation, the state could ban facility fees for routine services that would traditionally be provided in a

non-hospital setting. Facility fees are additional fees—on top of the "professional fee" that physicians are paid for providing a service—that are meant to cover the overhead costs of operating a hospital. After a hospital acquires a physician practice, the hospital can charge a facility fee at what was once an independent physician practice but is now referred to as a "hospital outpatient department." To prevent these unnecessary and excessive fees, states including Connecticut, Indiana, New York, and Ohio have banned facility fees for certain routine services that can safely be provided in a non-hospital setting. Representative Tom Oliverson's HB 3321 from last year is an example of a bill that would prohibit facility fees for certain routine services.

- **Transaction Notification/Review**: To provide the state with additional insight and/or input into the consolidation of Texas' health care system, the state could establish new requirements for health care entities to notify the state prior to major health care transactions. This could come in the form of new notice requirements, or it could come in the form of a pre-transaction review & approval process. Below are some options that Texas policymakers could consider.
    - *Prior Approval for Health Care Transactions*: Texas could require the review and approval of major health care transactions. The state could establish a process that would enable the state to understand how major transactions would affect health care prices and quality, and allow the state to prevent transactions that would lead to unaffordable health care. A transaction review process in Texas could be led by the Attorney General, the Department of State Health Services, or a new entity dedicated to reviewing these transactions. Similar statutes are already in place in states such as New Mexico and Oregon. Erin Fuse Brown, Director of the Health Law Lab at CAHPR, has co-written this policy brief that walks through considerations for different forms of state transaction reviews.
    - *Prior Notice for Health Care Transactions*: The state could require notice requirements for health care transactions. Representative James Frank's HB 2747, as reported by the House Committee on Public Health last year, is an example of this. That bill would have required pre-transaction notification to the Attorney General for health care transactions in which one of the parties had greater than $5 million in gross annual revenue. The bill covered transactions involving all health care entities, including physician organizations, hospitals, and other health care facilities. That bill also allowed the Attorney General to direct studies related to consolidation in health care markets and the impacts of completed transactions. However, this bill would not give

the state the ability to disapprove of a potentially harmful transaction. This bill is similar to laws already on the books in states such as Indiana and Illinois.

- *Hart-Scott-Rodino Act Disclosures*: Texas could require entities that are already required to file premerger disclosures under the federal Hart-Scott-Rodino (HSR) Act to also file those disclosures with the state. Similar laws exist in California, Colorado, and Washington, and a similar bill passed through Utah's House of Representatives in 2025. However, this policy would only provide the state with insight into the largest health care transactions. As of 2026, the HSR reporting threshold is $133.8 million, which is far too high to capture most physician group transactions.

- **Ownership Transparency**: To provide the public with more transparency into health care consolidation, Texas could require health care entities to provide regular reporting on their ownership structures. Indiana and Massachusetts already require this sort of ownership reporting annually, and Maine and Vermont enacted legislation this year to require one-time (and post-transaction) ownership reporting by health care entities. Representative Jay Dean's HB 4408 from last year is an example of a bill that would require health care entities to report on their organizational structure and any significant equity investors.
- **Corporate Practice of Medicine (CPOM) Doctrine**: To ensure physicians maintain autonomy after their practice is acquired by corporate investors, states are strengthening their existing restrictions on the corporate practice of medicine (CPOM). As our team has written, corporate entities commonly use management services organizations (MSOs) to obtain *de facto* control of medical practices without formally owning them. To maintain the autonomy of health care providers, states are taking action to prevent MSOs from controlling medical decision-making. Oregon's SB 951, which was enacted in 2025, is one of the most notable examples of this. The new law places restrictions on MSOs and their contracting agreements with medical practices. In addition, the bill prohibits noncompete and non-disparagement clauses for physicians and other medical licensees to improve worker mobility and competition. States such as California and Vermont have recently adopted laws strengthening their CPOM doctrines, and similar bills have also been filed in New Hampshire, North Carolina, and South Carolina.
- **Community Benefits/Charity Care Reform**: As part of their tax exemption, nonprofit hospitals are required to offer financial assistance and charity care to patients who cannot afford care. Yet, many low-income consumers report difficulty in obtaining financial assistance, and nearly half of tax-exempt hospitals send medical bills to lower-income patients who should qualify for financial assistance. Despite this, there has been little or no

enforcement of nonprofit hospitals' compliance with tax-exemption requirements. States can set their own standards for state and local property tax exemption. Texas could require hospitals to report on the amount of tax exemptions that they are currently receiving, as well to thoroughly report the charity care and community benefits that they are providing. The state could also require minimum levels of charity care based on a hospital's tax-exemption value, or standardize eligibility thresholds for required financial assistance.

- **Prohibit All-Or-Nothing Contract Terms**: Representative James Frank's HB 711 from 2023 has already made Texas a leader in banning anticompetitive contract terms. However, the state could go further by taking action to prohibit all-or-nothing contract terms, such as all-plan or all-product clauses. These clauses, which are often used by dominant health systems, require insurers to contract with all of the entities and providers within a health system in order to contract with the health system at all. Or, they may require health insurers to include the health system in all plans or products, including narrow network plans. These provisions allow dominant health systems to use their market power to charge more for services within their systems.