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"Tax-Exempt Hospitals and the Community Benefit Standard"

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Chairman Schweikert, Ranking Member Pascrell, and members of the Subcommittee, thank you for devoting your valuable time to focus on tax-exempt hospitals and the community benefit standard. It is my honor to participate in today's hearing. Thank you for giving me the opportunity.

I am Ge Bai, a Certified Public Accountant, Professor of Accounting at The Johns Hopkins Carey Business School, and Professor of Health Policy and Management (joint) at The Johns Hopkins Bloomberg School of Public Health. My research expertise is in health care accounting, finance, and policy. I am affiliated with Johns Hopkins Center for Health Services and Outcomes Research, Hopkins Business of Health Initiative, and Johns Hopkins Drug Access and Affordability Initiative. From March 2022 to March 2023, I served as a visiting scholar at the Congressional Budget Office's Health Analysis Division. I have published numerous research articles on leading academic journals regarding tax-exempt hospitals' provision of community benefit and other activities.

My testimony has three focuses: (1) tax-exempt hospitals' obligation to provide community benefit, (2) evidence on tax-exempt hospitals' insufficient provision of community benefit, and (3) other benefits received by tax-exempt hospitals and other activities. I aim to provide an objective holistic evidence-based summary of tax-exempt hospitals and the community benefit standard. The opinions expressed herein are my own and do not necessarily reflect the views of The Johns Hopkins University or any of its subsidiaries or affiliated entities.

Section I: Tax-Exempt Hospitals' Obligation to Provide Community Benefit

Hospitals are the largest industry in the United States with annual revenues exceeding $1.4 trillion.[1] The majority of U.S. hospitals are organized as tax-exempt institutions.[2] They are exempt from paying federal and state income tax, sales tax, and property tax, and enjoy other tax-related benefits such as the ability to issue tax-free bonds and receive charitable contributions that allow donors to receive a tax deduction.[3] The value of tax-exempt hospitals' tax exemption was estimated by the Kaiser Family Foundation to be $27.6 billion in 2020.[4] Tax exemptions are worth more to hospitals located in wealthy areas with high property value (higher property tax exemption) and high profitability (higher income tax exemptions), regardless of the community benefit they provide.[3]

Historically, most hospitals in the U.S. were founded by religious organizations or philanthropists, with the mission to relieve the suffering of the disadvantaged patients.[5] These hospitals were incorporated under their applicable state statute as nonprofit organizations. Their obvious charitable pursuits—to relieve the suffering of the disadvantage patients— justified their tax-exempt status. The nonprofit ownership form dictates that tax-exempt hospitals cannot have residual claimants. Therefore, they do not have shareholders and do not distribute dividends. In the meantime, they also do not have the ability to obtain equity financing or benefit from the disciplining effects of shareholders and capital markets.

Nonprofit status does not independently confer tax exemption. The legal requirements for a hospital to be exempt from paying taxes are defined by the Internal Revenue Services (IRS): A nonprofit hospital must be organized and operated exclusively to promote one of the purposes specified in section 501(c)(3) of the Internal Revenue Code, including charitable, religious, educational, and scientific purposes.[6] This provision dates back to the first Internal Revenue Code, adopted in 1913 after the enactment of the 16th Amendment.[5] Over the years, the Internal Revenue Service has issued guidance interpreting this language. In 1956, the Internal Revenue Service (IRS) began requiring a nonprofit hospital to "be operated to the extent of its financial ability for those not able to pay for the services rendered." In 1969, the IRS adopted the "community benefit standard," which required hospitals to promote "the health of a class of persons that is broad enough to benefit the community." State usually follow federal criteria to confer tax exemption for state and local taxes.[5]

Over time, the market for hospital services has become far more competitive and commercial, in which tax-exempt hospitals received more and more money from insurers' and patients' payments than from philanthropic contributions and compete aggressively with one another and with for-profit

[1] https://www.ibisworld.com/united-states/industry-trends/biggest-industries-by-revenue/
[2] https://www.aha.org/statistics/fast-facts-us-hospitals
[3] https://www.healthaffairs.org/do/10.1377/forefront.20210903.507376
[4] https://www.kff.org/health-costs/issue-brief/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/
[5] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.25.w312
[6] https://www.irs.gov/charities-non-profits/charitable-organizations/exemption-requirements-501c3-organizations

hospitals. In 2010, the Patient Protection and Affordable Care Act (ACA) required tax-exempt hospitals to report certain information regarding the provision of community benefits in their annual tax filings (Form 990, Schedule H), including the costs of providing charity care (i.e., care for which hospitals receive no or partial payment from low-income patients), Medicaid shortfalls (i.e., care whose cost to provide exceeds Medicaid payments), education, research, and other community activities. In addition, hospitals are required to address community health needs, such as illness prevention and social determinants that influence health.[7,8] In 2020, the Government Accountability Office reported that the IRS faces substantial operational challenges in overseeing these activities and using them to determine tax-exempt eligibility.[9]

Form 990 allows tax-exempt hospitals to document different components of community benefit. Each component has different congruence, sensitivity, and precision in its ability to measure the extent to which it advances the hospital's charitable missions.[3] For example, Medicaid shortfalls are partially determined by the Medicaid rate in each state and thus is less affected by an individual hospital's charitable intentions than charity care (hospitals determine their own charity care eligibility policies). Some health improvement activities are not clearly distinguishable from marketing activities; and the spending on certain community benefit components can be prone to manipulation. The variations across community benefit components have undermined the informativeness of the aggregated value of community benefit provision and created challenges to compare across hospitals. In addition, the IRS does not provide a benchmark to evaluate the sufficiency of community benefit, thus hindering the usefulness of reported provision of community benefit.

In sum, tax-exempt hospitals have a social contract with taxpayers—taxpayers grant hospitals subsidies in the forms of tax exemptions and other tax-related benefits, and hospitals have the obligation to provide community benefits to justify this sizeable subsidy.

Section II: Evidence on Tax-Exempt Hospitals' Insufficient Provision of Community Benefit

As the GAO report concluded, currently the IRS does not specify any quantitative requirements for community benefits or charity care.[9] Therefore, an appropriate approach to examine whether tax-exempt hospitals provided sufficient community benefit is to compare between tax-exempt hospitals and for-profit hospitals, which pay federal, state, and local taxes and are not eligible for other tax-related benefits, such as issuing tax-free bonds and receiving tax-deductible charitable contributions.[3] My colleagues and I focused on two largest components of community benefit, charity care and Medicaid shortfalls.

[7] https://www.irs.gov/pub/irs-pdf/f990sh.pdf
[8] https://www.irs.gov/pub/irs-pdf/i990sh.pdf
[9] https://www.gao.gov/products/gao-20-679

Hospitals deliver charity care when they provide all or a portion of their services free of charge or at a discount to financially disadvantaged patients without expectation of payment.[10] The Affordable Care Act (ACA) also requires tax-exempt hospitals to provide charity care to eligible patients on the basis of their own self-determined criteria.[11] Charity care, by directly relieving patients' financial burdens, is the single community benefit component that precisely and congruently reflect the advancement of a hospitals' charitable missions. Provision of charity care also has the potential to prevent low-income uninsured and underinsured patients who struggle with medical bills from falling into the welfare trap and increasing taxpayer burden, which directly fulfills the social contract between tax-exempt hospitals and taxpayers—hospitals receive taxpayer subsidies and in return provide charity care to relieve burdens for patients and taxpayers.

In a study published in Health Affairs in 2021, my colleagues at Johns Hopkins and I, using 2018 Medicare Hospital Cost Reports, compared charity care provision across between tax-exempt hospitals and for-profit hospitals.[10] In aggregate, tax-exempt hospitals spent $2.3 of every $100 in total expenses incurred on charity care, which was less than for-profit hospitals ($3.8). More than one-third of tax-exempt hospitals (36%) provided less than $1 of charity care for every $100 in total expenses. In addition, among regional markets where all three hospital ownership types (tax-exempt, for-profit, and government-owned) coexisted, tax-exempt hospitals had lower aggregated charity-care-to-expense ratios than for-profit hospitals more than 30% of the time. Furthermore, the charity care provision was distributed unevenly among tax-exempt hospitals. In my coauthored study published in JAMA Internal Medicine, we found that the top 5% tax-exempt hospitals with the highest profit accounted for more than half of the total profit generated by all tax-exempt hospitals but provided only approximately 20% of total charity care.[12]

In another study my coauthors and I published in JAMA Open Network last year, we examined the largest component of community benefit, Medicaid shortfalls, defined as the costs for treating Medicaid beneficiaries minus payments received from the Medicaid program.[13] We found that in 2019 tax-exempt and for-profit hospitals in aggregate had similar Medicaid shortfalls as a share of expenses (2.51% vs 2.53%). In 23 of the 45 states in which both tax-exempt and for-profit hospitals operate, tax-exempt hospitals as a group had lower Medicaid shortfalls as a share of expenses than for-profit hospitals. We observed the same patterns in states that did and did not expand Medicaid.

Taken together, tax exempt hospitals in aggregate fell short compared to for-profit hospitals in providing the two largest components of community benefit as defined by the IRS--charity care and Medicaid shortfalls.

[10] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.01627
[11] Charity care categorically differs from bad debt, which is recorded after hospitals write off receivables for which they initially expected payment and then attempted to collect it.
[12] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2760774
[13] https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2789009

Section III: Other Benefits Received by Tax-Exempt Hospitals and Other Activities

Besides direct taxpayer subsidies, many tax-exempt hospitals with Disproportionate Share Hospital (DSH) status also generate substantial profits from the federal 340B Drug Pricing Program. The 340B program, created by Congress in 1992, allows qualifying tax-exempt and government hospitals serving a large number of low-income patients to purchase discounted drugs from pharmaceutical companies and then sell them at a profit.[14,15] However, this "buy-low-sell-low" program for safety-net hospitals has evolved into a "buy-low-sell-high" program for eligible tax-exempt hospitals, who can generate substantial profits by providing these drugs to well insured patients.[16] To take advantage of the 340B program, many tax-exempt hospitals have acquired or affiliated with clinics located in wealthy communities, and then shifted care away from outpatient physician offices to more expensive hospital outpatient centers.[15,16,17]

Many tax-exempt hospitals have adopted other revenue-enhancing activities that would normally be expected from for-profit entities, such as using anti-competitive tactics to retain market share and raise prices,[18] failing to offer charity care to eligible patients,[19] and employing aggressive debt-collection practices.[20] Furthermore, in my coauthored study recently published in Health Affairs, we found that more than one-third of tax-exempt hospitals compensated their trustees.[21] In contrast, trustees are generally not compensated in other types of 501(c)(3) tax-exempt entities.[22] Also, holding other things equal, tax-exempt hospitals that compensated their trustees provided less charity care than other tax-exempt hospitals that did not compensate their trustees. A report published in February this year by North Carolina Department of State Treasurer also shows that some tax-exempt hospitals provided substantial compensation to their executives, a practice more commonly observed in for-profit entities than in 501(c)(3) tax-exempt entities.[23]

Taken together, many tax-exempt hospitals have been deviating from their original charitable pursuits to focus on expanding their market share and enhancing profitability. Their behaviors are inconsistent with the charitable missions.

Section IV: Policy Recommendations

The evidence above suggests that tax-exempt status provides no assurance that tax-exempt hospitals will provide sufficient community benefit to justify their favored status or behave in accordance with their charitable missions. Currently, there is insufficient data at the federal level to compare the

[14] https://www.nejm.org/doi/full/10.1056/nejmsa1706475
[15] https://www.hrsa.gov/opa/eligibility-and-registration
[16] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0540
[17] https://www.nytimes.com/2022/09/24/health/bon-secours-mercy-health-profit-poor-neighborhood.html
[18] https://www.justice.gov/opa/pr/atrium-health-agrees-settle-antitrust-lawsuit-and-eliminate-anticompetitive-steering
[19] https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html
[20] https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2783297
[21] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00620
[22] For-profit entities usually compensate their board of directors.
[23] https://www.shpnc.org/what-the-health/hospital-executive-pay-nc

amount of community benefits provided by a given tax-exempt hospital with the subsidies received by that hospital. Independent estimates of the value of the tax exemption could provide an objective assessment, but such estimates rely on assumptions that may not be reliable. To close this information gap, the IRS should revise Form 990 Schedule H so that tax-exempt hospitals would be required to report: (1) foregone state sales tax, (2) foregone state and local property tax, (3) other foregone state and local taxes, (4) savings from issuing tax-exempt bonds, (5) gross profits from the 340B program, and (6) charitable contributions received. Foregone federal and state income taxes are excluded from the reporting due to the difficulties in estimating these taxes.[24]

Form 990 is reported at the entity level, identified by the employer identification number (EIN), meaning that subsidiaries belonging to the same hospital system, such as physician practices and health plans, would be included in the system's aggregated Form 990. Tax-exempt hospitals would be able to use their existing financial records to generate most of the requested information, with only a modest administrative burden. Currently, some tax-exempt hospitals in Texas are already required to self-report their tax exemption value (excluding federal income tax exemption).[3]

Greater visibility is a prerequisite for policy action. Disclosure of taxpayer subsidies would facilitate the identification of tax-exempt hospitals that have a misalignment between taxpayer subsidies and community benefits. Because both itemized taxpayer subsidies and itemized community benefits would be reported, policymakers and stakeholders could compare between certain types of community benefits that are more reflective of charitable missions (e.g., charity care) and certain tax subsidies that are more relevant to the community of interest (e.g., property tax exemption). Disclosure of taxpayer subsidies can prompt further policy interventions to address potentially unwarranted tax exemptions. States can separate their tax exemption standards from the federal tax exemption standards and use the disclosed information to challenge some hospitals' tax exemption status at the state or county level.

It is worth noting that many tax-exempt hospitals face substantial fiscal challenges. Certain federal interventions, such as setting a minimum dollar amount requirement, could threaten financial viability of some hospitals, reduce incentives for hospitals to provide more than the minimum amount, and encourage report manipulations. The proposed disclosure of taxpayer subsidies has the potential to allow stakeholders and policymakers the flexibility to understand, design, and test alternative ways of encouraging tax-exempt hospitals to provide meaningful community benefits.

Thank you again for giving me the opportunity to participate in this hearing and I would be pleased to answer any questions you may have.

[24] An organization's taxable income (calculated based on the Internal Revenue Code), is rarely the same as its accounting income (calculated based on the Generally Accepted Accounting Principles).