HEARING ON TAX-EXEMPT HOSPITALS AND THE COMMUNITY BENEFIT STANDARD

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

APRIL 26, 2023

Serial No. 118–12

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PUBLISHING OFFICE
53–243 WASHINGTON : 2024

COMMITTEE ON WAYS AND MEANS

JASON SMITH, Missouri, *Chairman*

VERN BUCHANAN, Florida
ADRIAN SMITH, Nebraska
MIKE KELLY, Pennsylvania
DAVID SCHWEIKERT, Arizona
DARIN LAHOOD, Illinois
BRAD WENSTRUP, Ohio
JODEY ARRINGTON, Texas
DREW FERGUSON, Georgia
RON ESTES, Kansas
LLOYD SMUCKER, Pennsylvania
KEVIN HERN, Oklahoma
CAROL MILLER, West Virginia
GREG MURPHY, North Carolina
DAVID KUSTOFF, Tennessee
BRIAN FITZPATRICK, Pennsylvania
GREG STEUBE, Florida
CLAUDIA TENNEY, New York
MICHELLE FISCHBACH, Minnesota
BLAKE MOORE, Utah
MICHELLE STEEL, California
BETH VAN DUYNE, Texas
RANDY FEENSTRA, Iowa
NICOLE MALLIOTAKIS, New York
MIKE CAREY, Ohio

RICHARD E. NEAL, Massachusetts
LLOYD DOGGETT, Texas
MIKE THOMPSON, California
JOHN B. LARSON, Connecticut
EARL BLUMENAUER, Oregon
BILL PASCRELL, JR., New Jersey
DANNY DAVIS, Illinois
LINDA SANCHEZ, California
BRIAN HIGGINS, New York
TERRI SEWELL, Alabama
SUZAN DELBENE, Washington
JUDY CHU, California
GWEN MOORE, Wisconsin
DAN KILDEE, Michigan
DON BEYER, Virginia
DWIGHT EVANS, Pennsylvania
BRAD SCHNEIDER, Illinois
JIMMY PANETTA, California

MARK ROMAN, *Staff Director*
BRANDON CASEY, *Minority Chief Counsel*

SUBCOMMITTEE ON OVERSIGHT

DAVID SCHWEIKERT, Arizona, Chairman

BRIAN FITZPATRICK, Pennsylvania
GREG STEUBE, Florida
CLAUDIA TENNEY, New York
MICHELLE FISCHBACH, Minnesota
BETH VAN DUYNE, Texas
RANDY FEENSTRA, Iowa
NICOLE MALLIOTAKIS, New York

BILL PASCRELL, New Jersey
JUDY CHU, California
BRAD SCHNEIDER, Illinois
SUZAN DELBENE, Washington
GWEN MOORE, Wisconsin

C O N T E N T S

OPENING STATEMENTS

WITNESSES

MEMBER QUESTIONS FOR THE RECORD

PUBLIC SUBMISSIONS FOR THE RECORD

United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

FOR IMMEDIATE RELEASE
April 19, 2023
No. OS-01

CONTACT: 202-225-3625

Chairman Smith and Oversight Subcommittee Chairman Schweikert Announce Subcommittee Hearing on Tax-Exempt Hospitals and the Community Benefit Standard

House Committee on Ways and Means Chairman Jason Smith (MO-08) and Oversight Subcommittee Chairman David Schweikert (AZ-01) announced today that the Subcommittee on Oversight will hold a hearing on tax-exempt hospitals and the community benefit standard. The hearing will take place on **Wednesday, April 26, 2023, at 2:00pm in the 1100 Longworth House Office Building**.

Members of the public may view the hearing via live webcast available at https://waysandmeans.house.gov. The webcast will not be available until the hearing starts.

In view of the limited time available to hear the witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMSubmission@mail.house.gov.

Please ATTACH your submission as a Microsoft Word document in compliance with the formatting requirements listed below, **by the close of business on Wednesday, May 10, 2023**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Please indicate the title of the hearing as the subject line in your submission. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.
All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

The Committee seeks to make its facilities accessible to persons with disabilities. If you require accommodations, please call 202-225-3625 or request via email to WMSubmission@mail.house.gov in advance of the event (four business days' notice is requested). Questions regarding accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the Committee website at http://www.waysandmeans.house.gov/.

###

TAX-EXEMPT HOSPITALS AND THE COMMUNITY BENEFIT STANDARD

WEDNESDAY, APRIL 26, 2023

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The subcommittee met, pursuant to call, at 2:24 p.m., in Room 1100 Longworth House Office Building, Hon. David Schweikert [chairman of the subcommittee] presiding.

Chairman SCHWEIKERT. The subcommittee will come to order, and I hit the gavel. It's too pretty to actually use, Mr. Chairman. The Chairman was kind enough to provide us, all the new chairman of the subcommittees a fancy gavel, which we appreciate.

I do want to take one little point of personal privilege here. We actually have our senior staffer Shawn—where are you Shawn? Is—your spouse is going to have a baby in just a few hours.

SHAWN. That's the [indiscernible.] [Laughter.]

Chairman SCHWEIKERT. We are going to—yeah, we hope so. Yeah. And we won't explain how that happened. We're going to pass this little bib down, and I'm going to beg of all the members to write a little note. But they're going to induce labor in a couple hours, and I thought this would be a really neat gift from all of us, both Republican and Democrat, it's a little baby bib for the new little tyke's future.

Shawn, stand up. Wave.

SHAWN. Hello. [Applause.]

Chairman SCHWEIKERT. Yay. All right, now back to work, without knocking over my coffee.

I'd like to welcome everyone to today's oversight subcommittee hearing. This is our first oversight committee hearing of this Congress, and I'm happy that our first hearing we will be able to work with who has become my friend, Mr. Pascrell, and his team in putting this hearing together.

Our approach today is not intended to be partisan or to beat up on anyone. We just want information and to understand. As I spoke with some of the witnesses, we see things coming at us from both directions. Help us understand what's actually happening in that tax-exempt world.

Today's focus is tax-exempt hospitals and the community benefit standards. Hospitals must maintain certain requirements to obtain and maintain their tax-exempt status, including organizational and operational requirements, community benefits, and also those things spelled out in the ACA. When it comes to community bene-

fits, various academics, think tanks have sought to put a value on both the tax exemption of hospitals which they receive and then the community benefits they provide.

We know that the tax exemptions are very valuable. One of our witnesses today from the newly named KFF, we all know as Kaiser, will talk about their work showing that tax exemptions were valued around 28 billion dollars, and we are going to ask you how you calculated that math, in 2020. With half of that coming from the federal tax exemption, KFF has also found that the value of charitable care provided by hospitals vary substantially across facilities ranging from .1 percent in operating expenses of hospitals to some well over seven percent, and some with other variances.

Additionally, the Lown—pronounced properly? The Lown Institute have made efforts to calculate fair share spending for nonprofit hospitals by comparing each system's spending on financial assistance, community investment to establish a value of its tax exemption. The institute's results show significant deficits in community benefits provided as compared with the value of some of these hospital's tax exemption.

Moreover, some articles and studies, including one by one of our witnesses today, argued that for-profit hospitals on average provide more charity care than tax-exempt hospitals. Conversely, groups like our friends at the American Hospital Association have published an analysis arguing that the value of community benefits provided by hospitals substantially exceed the value of the tax exemption. The wide variance here seems to come from the lack of guidelines and also what we've done in Congress, and the IRS now in its definitions of community benefits.

We are also pleased to have witnesses here today from the GAO who will talk about the GAO Study, the report they did in 2020, and the nature of the standards that the IRS's inability to conduct effective oversight on the tax exemption value of hospitals. All of this makes exploring the tax-exempt hospitals, and the level of community benefits they provide, a worthwhile conversation.

And with that, I thank all of our witnesses for being here, and I'd like to turn it over for his opening statement, my friend, Ranking Member Mr. Pascrell.

Mr. PASCRELL. Thank you, Mr. Chairman. I'm here to kick off our first oversight subcommittee hearing. And congratulations on your gavel.

Our committee holds a sacred duty to ensure hospitals respond with the highest quality of care. We know one size does not fill all to provide the care our communities need. Tax-exempt hospitals deliver unmatched benefits and are the very cornerstone of our hospital system. Nonprofit network cares for our most vulnerable. You got to remember that.

These hospitals collectively deliver more in benefits and charity care than other hospitals. There are nearly 3,000 not-for-profit hospitals across America. In my state, New Jersey, 65 of these institutions keep our communities healthy. I'm committed to robust oversight of our tax-exempt hospitals. Many nonprofit hospital systems can and must do better.

But we cannot lose sight of the harm Wall Street has done already to our entire health system. This subcommittee must con-

tinue taking a closer look at the opaque ownership of hospitals. Private equity control is often shielded like a Russian nesting doll, designed to block oversight by the government and from patients. By tightening their grip over healthcare, corporate tycoons place profits over patients. Big bucks over the Hippocratic oath. Our committee has the receipts.

As chairman, I led a hearing last Congress on the impacts of private equity on healthcare. What we exposed still needs fixing. Wall Street loads debt onto companies, sometimes leading to bankruptcy. Facility closures, fired workers, neglected patients, and damaged communities.

In 2022, private equity investment in healthcare grew to 90 billion dollars. PE stretches like an octopus with tentacles in large and small hospitals, physician practices, dental practices, nursing homes. These trends demand further investigation. Our committee cannot ignore threats to hospitals harm our communities and access to care.

And I thank you, Mr. Chairman, and I wish you the best of luck.

Chairman SCHWEIKERT. You're very kind. Thank you, Mr. Pascrell.

And to the big chairman, Mr. Smith, share with us.

Chairman SMITH. Thank you, Chairman Schweikert and Ranking Member Pascrell. It's a pleasure to be before your first oversight subcommittee.

Today the oversight subcommittee is meeting to examine the tax-exempt status of nonprofit hospitals to ensure they are operating in the best interest of patients, communities, and taxpayers. As the committee with oversight jurisdiction over the IRS, the tax code, the administration, and healthcare, we know this is an issue that is of great importance to American's health. That's not only because of the obvious essential role that hospitals play in our healthcare system, but also because of their particular importance to many communities across the country where they are often the only option for medical treatment. That's particularly true in rural areas that many of us here represent.

Nonprofit hospitals account for almost 60 percent of hospitals in the United States. The federal tax-exempt status granted to most of these hospitals is significant. It is estimated to be worth 14 billion with nearly another 14 billion coming from state and local exemptions. Recent studies and articles have raised concerns, however, that the level of community benefit, which includes charity care, provided by tax-exempt hospitals has been inadequate compared to the value of their tax exemption.

Additionally, numerous news reports highlight aggressive billing practices, executive compensation in the millions of dollars, and abuses in the 340B Program. The level of executive compensation is particularly alarming. The top 10 nonprofit hospital CEOs average more than seven million annually. Some as high as 14 million.

This further questions whether these facilities are living up to their mission statements. In the best case scenario, tax-exempt hospitals provide meaningful community benefits that exceed the value of their tax exemptions, and some do; but given the concerns that exist, an examination is needed to determine if sufficient com-

munity benefits, including charity care, are being provided to ensure vulnerable patients and communities are being protected.

This hearing is an opportunity for us to learn from expert witnesses and identify any issues that may need to be addressed through legislation so that we can be confident that nonprofit hospitals are meeting the responsibilities and have the resources they need. Additionally, we must be sure that the laws, rules, and regulations under which they operate are clear and effective.

I'm confident that together we will identify the problems and the potential improvements that will benefit patients and communities with the flexibility that they need.

Yield back, Mr. Chairman.

Chairman SCHWEIKERT. Thank you, Mr. Chairman.

Now for our witnesses. Our first witness is Jessica Lucas-Judy, Director of Strategic Issues at the U.S. Government Accountability Office. We all kindly referred to it as GAO.

Second, Ge Bai, Professor of Accounting at the John Hopkins Carey Business School and Professor of Health Policy and Management at the John Hopkins Bloomberg School of Public Health.

Third, Zachary—is it Levinson—Director of a new project at the KFF, we all know as Kaiser, that examines business practices of hospitals and their providers and their impact on costs and affordability.

And fourth, Melinda Hatton, General Counsel and Secretary for the American Hospital Association.

Ms. Jessica Judy, your written statement will be made part of the record. You have five minutes. Please share with us.

STATEMENT OF JESSICA LUCAS-JUDY, DIRECTOR OF STRATEGIC ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. LUCAS-JUDY. Chairman Schweikert, Ranking Member Pascrell, members of the subcommittee, I'm pleased to discuss GAO's 2020 report on requirements that hospitals must meet for tax-exempt status and challenges that IRS faces with those requirements.

To maintain federal tax-exempt status, a hospital must operate for a charitable purpose to promote health for the benefit of the community. In 1956, IRS required tax-exempt hospitals to provide charity care, operating to benefit those not able to pay. In 1969, IRS removed the charity care requirement. In its ruling, IRS identified six factors that distinguish how one hypothetical hospital satisfies requirements and the second does not.

These factors, referred to as the community benefit standard, include providing emergency treatment to all and using surplus funds to advance medical research. A hospital need not meet all of the factors to qualify. IRS does not have authority to define specific types of hospital activities. The factors that IRS identified are examples not requirements.

Some of the factors may have lost relevance. For example, some are now common features of all hospitals. Hospitals are required by law to provide emergency treatment to all, regardless of ability to pay. These factors may be a less useful gauge than they once were.

Representatives of tax-exempt hospitals told us the community benefit standard offers needed flexibility, but the lack of clarity cre-

ates challenges. A hospital could maintain a tax exemption by operating an emergency room that's open to all while spending little to no money on community benefit activities. We found 30 hospitals that reported no spending on community benefits in 2016 and other hospitals that could have been at risk for noncompliance.

IRS officials told us the agency had not revoked a hospital's tax-exempt status for failing to provide sufficient community benefits in the previous 10 years. We recommended that Congress consider specifying services and activities it believes would provide sufficient community benefits. To date, Congress has not enacted such legislation.

IRS requires a tax exempt hospital to file Schedule H with its Form 990 annually. However, Schedule H solicits information inconsistently. For example, IRS directs hospitals to specify the costs for providing health education, but hospitals may describe the use of surplus funds to improve facilities and patient care in a narrative without specifying an amount. Our analysis found inconsistencies in what hospitals reported in those narratives. Some provided numerous examples, others did not address any of the factors.

We recommended IRS update its forms and instructions to ensure that the community benefit information is clear and can be easily identified. IRS agreed. In response, it adjusted the instructions to indicate responses should include all the community benefit factors. However, IRS still asks hospitals to describe that information narratively. IRS could fully implement our recommendation through further updates to its forms to help ensure community benefit information is clear and can be easily identified.

Turning now to the Patient Protection and Affordable Care Act, or PPACA, it established four additional requirements for hospitals. These include conducting a community health needs assessment and setting limits on charges and collection. IRS requires hospitals to self-report compliance with all four of the requirements on Schedule H, answering a series of yes or no questions for each. IRS referred almost 1,000 hospitals to its audit division for potential violations in five years but could not identify whether any of these referrals related to community benefits.

IRS said it sends back incomplete forms, but we found some hospitals left the community benefit section blank. IRS's guidance for its revenue agents contain specific questions that address the community benefit factors, but there was no direction on when a hospital should be referred to audit. Further, IRS could not determine if hospitals were being selected for audit for potential noncompliance related to community benefits.

We recommended IRS establish a process to identify hospitals at risk for noncompliance as well as specific audit codes. IRS updated its guidance for employees and established an audit code for the community benefit standard, which we think will help ensure it's effectively reviewing hospital's community benefit activities.

In conclusion, IRS can easily verify whether the legal requirements of PPACA are met, but it's harder to verify the community benefits because IRS does not have authority to define specific services and activities that hospitals must undertake to qualify for a tax exemption. Additional clarity about specific services and ac-

tivities Congress believes would provide sufficient community benefits could help.

Chairman Schweikert, Ranking Member Pascrell, members of the subcommittee, this concludes my remarks, and I'm happy to answer any questions you have.

[The statement of Ms. Lucas-Judy follows:]

United States Government Accountability Office

Testimony

Before the Subcommittee on Oversight, Committee on Ways and Means, House of Representatives

For Release on Delivery
Expected at 2 p.m. ET
Wednesday, April 26, 2023

TAX ADMINISTRATION

IRS Oversight of Hospitals' Tax-Exempt Status

Statement of Jessica Lucas-Judy, Director, Strategic Issues

GAO-23-106777

GAO Highlights

Highlights of GAO-23-106777, a testimony before the Subcommittee on Oversight, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

Slightly more than half of the approximately 5,000 community hospitals in the United States are private, nonprofit organizations. IRS and the Department of the Treasury have recognized the promotion of health as a charitable purpose and have specified that nonprofit hospitals are eligible for a tax exemption. IRS has further stated that these hospitals can demonstrate their charitable purpose by providing services that benefit their communities as a whole.

In 2010, Congress and the President enacted PPACA, which established additional requirements for tax-exempt hospitals to maintain a tax exemption.

This testimony discusses the requirements for a nonprofit hospital to qualify for tax-exempt status and challenges with verifying compliance with some of those requirements, and is based on a report that GAO issued in September 2020. This testimony reflects updated information GAO obtained from IRS regarding its implementation of the recommendations made in that report.

What GAO Recommends

In September 2020, GAO recommended Congress consider specifying what services and activities demonstrate sufficient community benefit. As of April 2023, Congress had not enacted such legislation. GAO also recommended IRS update tax forms to increase transparency about hospitals' community benefits. IRS agreed and made minor adjustments to the form's instructions, but the form still relies on a narrative description of community benefits that hospitals provide.

View GAO-23-106777. For more information, contact Jessica Lucas-Judy at (202) 512-6806 or lucasjudyj@gao.gov.

April 26, 2023

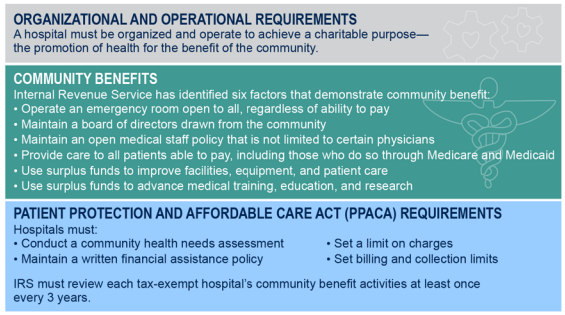
TAX ADMINISTRATION

IRS Oversight of Hospitals' Tax-Exempt Status

What GAO Found:

Hospitals must satisfy three sets of requirements for a nonprofit tax exemption (see figure) but hospital community benefits are not defined in law.

Requirements for Nonprofit Hospitals to Obtain and Maintain a Tax Exemption



Source: GAO review of relevant laws and regulations. | GAO-23-106777

In 1969, the Internal Revenue Service (IRS) identified factors that can demonstrate community benefits, but they are not requirements. IRS does not have authority to specify activities hospitals must undertake and makes determinations based on facts and circumstances. As a result, tax-exempt hospitals have broad latitude to determine the community benefits they provide, but the lack of clarity creates challenges for IRS in administering tax law.

Additionally, the form on which hospitals report community benefits solicits that information inconsistently, resulting in a lack of transparency. For example, hospitals may describe the use of surplus funds to improve facilities, equipment, and patient care narratively. This qualitative reporting format does not require tax-exempt hospitals to specify the amount of surplus funds used to improve facilities, equipment, and patient care. It could also result in incomplete information on how hospitals are providing community benefits.

GAO's 2020 analysis of IRS data identified 30 hospitals that reported no spending on community benefits in 2016. According to IRS officials, hospitals with little to no community benefit expenses would indicate potential noncompliance. IRS is required to review hospitals' community benefit activities at least once every 3 years, but was unable to provide evidence that it did so because it did not have a well-documented process to ensure those activities were being reviewed. Consistent with GAO's September 2020 recommendations, in 2021 IRS updated its overall guidance instructing its employees to document whether a hospital organization satisfies the community benefit standard and established an audit code to track that review.

Chairman Schweikert, Ranking Member Pascrell, and Members of the Subcommittee:

I am pleased to be here today to discuss our work on the Internal Revenue Service's (IRS) oversight of hospitals' tax-exempt status. Slightly more than half of the approximately 5,000 community hospitals in the United States are private, nonprofit organizations.[1] Nonprofit organizations can obtain and maintain a federal tax exemption if they are organized for one or more purposes specified in the Internal Revenue Code section 501(c)(3). The Joint Committee on Taxation estimated the total revenue loss from the tax exemption of hospitals at $12.6 billion in 2002.[2] Hospitals reported that they provided $76 billion in community benefits in 2016—the most recent data available when we reviewed this issue in 2020.[3]

Nonprofit hospitals can be tax-exempt if they provide certain community benefits, such as an emergency room open to all.[4] They must also meet legal requirements in the Patient Protection and Affordable Care Act (PPACA), such as maintaining a written financial assistance policy.

My remarks today are based on our September 2020 report on IRS oversight of tax-exempt hospitals.[5] I will focus on three aspects of this report—(1) the requirements that must be met for a nonprofit hospital to qualify for tax-exempt status, (2) challenges with verifying compliance with some of those requirements, and (3) IRS's oversight of the community benefit standard and PPACA requirements.

[1]American Hospital Association, Fast Facts, accessed April 17, 2023, https://www.aha.org/statistics/fast-facts-us-hospitals. Community hospitals exclude nonfederal psychiatric hospitals and other hospitals, including long-term care hospitals and those within an institution.

[2]Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits* (Washington, D.C: December 2006) reports the Joint Committee on Taxation estimate.

[3]GAO, *Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status,* GAO-20-679 (Washington, D.C.: Sept. 17, 2020). For the purposes of this statement, we use the term "tax-exempt hospitals" to refer to nongovernmental, nonprofit, and tax-exempt hospitals. Government hospitals—including those at the federal, state, tribal, and local levels—are also exempt from federal taxation.

[4]IRS defines a hospital organization as an entity that operated at least one hospital facility during a tax year. A hospital facility is an entity that is required to be licensed, registered, or similarly recognized by a state as a hospital. Nonhospital health care facilities may include, but are not limited to, rehabilitation and other outpatient clinics, mobile clinics, and skilled nursing facilities.

[5]GAO-20-679.

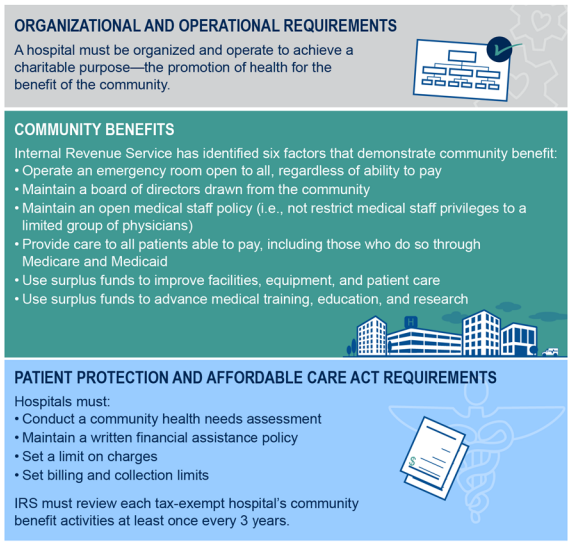
To conduct our prior work, we reviewed relevant provisions of the Internal Revenue Code, Department of the Treasury regulations, revenue rulings, and guidance. We also reviewed IRS policies, procedures, audit plans, and determining factors for reviewing tax-exempt hospitals, and we interviewed IRS officials. We examined the most recent data available at the time of that report (tax year 2016) from forms hospitals are required to file with IRS documenting the community benefits they provide and their compliance with PPACA. More detailed information on our objectives, scope, and methodology can be found in the 2020 report. Since the issuance of that report, we received and reviewed information from IRS on actions taken in response to our recommendations.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Requirements for Hospitals' Tax-Exempt Status

Nonprofit hospitals must satisfy three sets of requirements to obtain and maintain federal tax-exempt status (see fig. 1).

Figure 1: Requirements for Nonprofit Hospitals to Obtain Federal Tax-Exempt Status



Source: GAO review of relevant laws and regulations. | GAO-23-106777

The Internal Revenue Code requires that all organizations seeking a tax exemption under section 501(c)(3) be organized and operated for one or more purposes, which can be charitable, religious, or educational, among others.[6] The code does not specifically identify hospitals as being eligible for a tax exemption. However, IRS and federal courts have recognized

[6]Section 501 of the Internal Revenue Code covers the majority of these organizations, which include public charities, social welfare organizations, business leagues, and private foundations. Other types of organizations, such as education-oriented programs, farmers' cooperatives, and political organizations, are also wholly or partially tax exempt. 26 U.S.C. §§ 501(c)(3), 521, 527, 529-530.

that the promotion of health for a community's benefit is a charitable purpose.[7]

IRS has also identified factors—referred to as the community benefit standard—for how hospitals could demonstrate that they provide benefits to the community. As described below, the types of benefits they could provide are not detailed in the Internal Revenue Code and are not mandatory by law.

Lastly, as shown in figure 1, PPACA established four additional requirements that tax-exempt hospitals must meet to maintain a tax exemption.[8]

Development of the Community Benefit Standard

In a 1956 revenue ruling, IRS required tax-exempt hospitals to provide charity care to the extent of their financial abilities.[9] IRS determined in the ruling that only hospitals that operated for the benefit of those not able to pay, and not exclusively for the benefit of those who were able and expected to pay, could qualify for a tax exemption.

In 1959, Treasury updated its regulations to establish that organizations can receive tax-exempt status by demonstrating a charitable purpose, such as the promotion of health.

In 1969, 4 years after Congress and the President created Medicare and Medicaid, IRS removed the requirement for tax-exempt hospitals to provide charity care—patient care without charge or at rates below cost—when it issued Revenue Ruling 69-545.[10] The ruling compares the extent to which two hypothetical hospitals satisfy the Internal Revenue Code's requirements for a tax exemption. In making that comparison, the ruling identifies six factors that distinguish how one hospital satisfies the requirements and how the second does not. IRS says that although a hospital is no longer required to provide charity care, it considers doing so to be a significant factor indicating community benefit.

There is no specific definition of community benefit. These six factors currently serve as the primary examples of community benefits that

[7]See Geisinger Health Plan v. Comm'r, 985 F.2d 1210, 1216 (3d Cir. 1993) (discussing IRS policy and cases construing exemption provisions for hospitals).

[8]Pub. L. No. 111-148, tit. IX, § 9007, 129 Stat. 119, 855 (2010), *codified at* 26 U.S.C. § 501(r).

[9]Rev. Rul. 56-185, 1956-1 C.B. 202. Charity care is generally defined as care provided to patients whom the hospital deems unable to pay all or a portion of their bills.

[10]Rev. Rul. 69-545, 1969-2 C.B. 117.

hospitals can provide to obtain and maintain a tax exemption. The factors are commonly referred to as the community benefit standard. IRS describes the six factors on its website:

- **Operate an emergency room open to all, regardless of ability to pay.** A hospital that does not operate a full-time emergency room may not be fulfilling the community's need for emergency health care. If that emergency room is not open to everyone regardless of ability to pay, the hospital may not be serving a significant segment of the community.[11]
- **Maintain a board of directors drawn from the community.** A hospital board of directors comprised of independent civic leaders helps to ensure that the hospital serves public, rather than private, interests, and therefore operates for the benefit of the community.
- **Maintain an open medical staff policy (i.e., not restrict medical staff privileges to a limited group of physicians).** A hospital that restricts its medical staff privileges to a limited group of physicians is likely to be operating for the private benefit of the staff physicians rather than for the public interest.
- **Provide care to all patients able to pay, including those who do so through Medicare and Medicaid.** A hospital that restricts admissions to patients of staff members, or otherwise discriminates against patients with the ability to pay for nonemergency services, is not operating for the benefit of the community.
- **Use surplus funds to (1) improve facilities, equipment, and patient care; and (2) advance medical training, education, and research.** The use of surplus funds for these purposes demonstrates that a hospital is promoting the health of the community.[12]

The standard states that a hospital need not meet all of the factors to qualify for a tax exemption. The absence of any one factor, or the presence of others, may not necessarily be conclusive of the hospital's

[11]IRS Revenue Ruling 83-157 established that if a state health planning agency determined that additional emergency facilities would be unnecessary and duplicative, or if the hospital offers medical care limited to special conditions unlikely to necessitate emergency care, such as eye or cancer hospitals, then the fact that a hospital organization does not operate an emergency room will not, by itself, disqualify it from a tax exemption. Rev. Rul. 83-157, 1983-2 C.B. 94.

[12]IRS, *Charitable Hospitals — General Requirements for Tax-Exemption Under Section 501(c)(3)*, accessed April 30, 2020. https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3.

community benefits. Furthermore, IRS considers all of a hospital's facts and circumstances relevant when determining whether a hospital's community benefits are sufficient to warrant a tax exemption.

Patient Protection and Affordable Care Act Requirements

PPACA established four additional requirements that tax-exempt hospitals must meet to maintain a tax exemption.[13]

- **Conduct a community health needs assessment.** Every 3 years, each tax-exempt hospital must identify the community's health needs and develop an implementation plan for how it will address those needs.[14]
- **Maintain a written financial assistance policy.** Each tax-exempt hospital must publish a written policy that identifies who can qualify for financial assistance for medical services, how the hospital calculates costs for those services, and the actions the hospital will take in the event of nonpayment.
- **Set a limit on charges.** A tax-exempt hospital cannot charge individuals eligible for financial assistance more for medical services than they do patients with insurance.
- **Set billing and collection limits.** A tax-exempt hospital may not take extraordinary collection actions against an individual, such as filing a lawsuit, before the hospital determines whether that individual is eligible for financial assistance.

In addition, the law established a new requirement for IRS to review the community benefit activities of each tax-exempt hospital at least once every 3 years.[15]

Congress Could Clarify the Law to Improve Oversight of Tax-Exempt Hospitals

Congress has taken actions that convey an expectation that hospitals, in exchange for a tax exemption, should provide services and activities that benefit the immediate communities in which they operate. Specifically, in PPACA, Congress required tax-exempt hospitals to identify each hospital's community's health needs, indicating an expectation that hospitals provide benefits to the immediate community.

However, a broad range of activities fall within the Internal Revenue Code's requirement for a tax exemption for charitable organizations,

[13]Pub. L. No. 111-148, tit. IX, § 9007, 129 Stat. 119, 855 (2010), *codified at* 26 U.S.C. § 501(r).

[14]PPACA establishes that a tax-exempt hospital that does not meet the community health needs assessment requirement must pay an excise tax. See 26 U.S.C. § 4959.

[15]PPACA, Pub. L. No. 111-148, tit. IX, § 9007(c), 129 Stat. 119, 857 (2010).

making it challenging to ensure that the community benefits that hospitals provide justify their tax exemption.

IRS does not have authority to define specific types of services and activities that a hospital must undertake to qualify for a tax exemption. Instead, it provides guidance on the types of activities that can demonstrate community benefits. In this regard, the Internal Revenue Code does not identify explicit community benefit activities required for tax-exempt status, and the factors IRS identified in its 1969 ruling are examples and not requirements.

Furthermore, some of the factors may have lost relevance. For example, in 2005, the Commissioner of Internal Revenue told Congress that some community benefit factors, such as maintaining an open medical staff policy and accepting patients on Medicare and Medicaid, are now common features of all hospitals.[16] Additionally, the Emergency Medical Treatment and Active Labor Act, signed into law in 1986, requires that all hospitals that operate emergency rooms provide emergency treatment to all, regardless of ability to pay.[17] As a result, these standards may be a less useful gauge for measuring community benefit than they once were.

The Internal Revenue Code and IRS's implementation of it gives tax-exempt hospitals broad latitude to determine the nature and amount of community benefits they provide. Representatives of tax-exempt hospitals told us that current law and the community benefit standard offer hospitals needed flexibility in demonstrating community benefits. For example, a hospital located in a remote rural community may be the only hospital within hundreds of miles, making its existence the primary benefit to the community.

However, that lack of clarity also creates challenges for IRS in administering tax law. For example, given this ambiguity, a hospital could, in theory, maintain a tax exemption by operating an emergency room open to all and accepting patients on Medicare or Medicaid, which are common among hospitals, while spending little to no money on charity care or other community benefit activities. In our September 2020 report, we identified 30 hospitals that reported no spending on community benefits in 2016, and other hospitals that could have been at risk for

[16]*The Tax-exempt Hospitals Sector before the Committee on Ways and Means U.S. House of Representatives*, 109th Cong. 8-18, (2005) (statement of Mark W. Everson, Commissioner of Internal Revenue).

[17]Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99-272, tit. IX, § 9121(b), 100 Stat 164 (1986).

noncompliance with the community benefit standard during a similar period (see table 1).[18]

Table 1: Number of Hospital Organizations with Little to No Community Benefit Spending, Tax Years 2014-2016

	2014	2015	2016
No financial assistance	64	68	48
No community benefit spending	48	45	30
Less than 1 percent community benefit spending	142	137	108

Source: GAO analysis of Internal Revenue Service data. | GAO-23-106777

Note: Financial assistance includes financial aid (i.e., charity care), Medicaid, and other means-tested government programs. The calculation of community benefit corrects for hospitals that reported negative spending values due to excess off-setting revenues, such as grants or Medicaid reimbursements.

IRS officials told us that the agency had not revoked a hospital's tax-exempt status for failing to provide sufficient community benefits in the previous 10 years.

We recommended that Congress consider amending the Internal Revenue Code to specify services and activities Congress believes would provide sufficient community benefits, which could improve IRS's ability to oversee tax-exempt hospitals. As of April 2023, Congress has not enacted such legislation.

IRS Could Improve Transparency of Community Benefit Information but Has Taken Action to Improve Its Oversight Ability

[18]We examined data on community benefit information that hospitals report from Forms 990, Schedule H, which hospitals are required to file with IRS. Those data were obtained from IRS Statistics of Income (SOI) public microdata files that covered the entire population of tax-exempt hospitals for tax year up to 2016, the most recent year available at the time of our review.

Reporting on Community Benefits

IRS requires a tax-exempt hospital to file Schedule H with its Form 990 annually to provide the public with information on its policies and activities and the community benefits that its facilities provide. IRS has stated a tax-exempt organization's Form 990, along with its schedules, can be the primary or sole source of information the public uses to understand a tax-exempt organization's operations, such as the community benefits a hospital provides.

However, Form 990, Schedule H solicits information inconsistently, resulting in a lack of clarity about the community benefits hospitals provide. The schedule includes questions intended to capture information on each of the six factors of the community benefit standard. However, these questions are located on different parts of the schedule and hospitals are instructed to address them in different ways.

For three of the six factors, IRS explicitly directs tax-exempt hospitals to report the extent to which they have addressed them. For the other three factors, IRS provides a space for hospitals to describe in a narrative the community benefits they provide, noting those factors as examples of community benefits.

For example, IRS directs hospitals to identify the specific costs they incur by providing health education and medical research. However, hospitals may describe the use of surplus funds to improve facilities, equipment, and patient care in a narrative format.

This qualitative reporting format does not require tax-exempt hospitals to specify the amount of surplus funds used to improve facilities, equipment, and patient care. It could also result in potentially incomplete information on how hospitals are providing community benefits.

In our analysis of hospitals' Form 990, Schedule H filings for tax years 2015 through 2018, we found inconsistencies in what hospitals reported in the narrative description. Some provided numerous examples of how they used surplus funds to improve their facilities and patient care, while others did not address any of the suggested factors.

Furthermore, the quantitative, machine-readable publicly available data IRS releases on the community benefits reported by tax-exempt hospitals on Form 990, Schedule H do not contain information that hospitals describe narratively.[19] Therefore, this reporting results in information on half of the factors that is inconsistent and difficult to obtain.

[19]Forms 990 are disclosable to the public and can be requested by submitting Form 4506-A.

We recommended IRS update Form 990, including Schedule H and instructions where appropriate, to ensure that the information demonstrating the community benefits a hospital is providing is clear and can be easily identified by Congress and the public, including the community benefit factors. IRS agreed with this recommendation.

In response to our recommendation, IRS made minor adjustments to Form 990, Schedule H instructions to indicate that responses should include all of the community benefit factors. However, IRS still asks hospitals to describe narratively additional information important to understanding the full scope of the community benefits they provide. IRS could fully implement our recommendation through further updates to its forms. This would help ensure that community benefit information is clear and can be easily identified by Congress and the public.

Reporting by Facility

Form 990, Schedule H directs tax-exempt hospitals to report their community benefit expenses at the hospital organization level rather than at the facility level. Therefore, hospital organizations that operate multiple facilities report community benefits in the aggregate for all of their facilities.

For example, a hospital organization reports the amount of charity care it provides and its costs for medical training, education, and research for all of its facilities as a whole, not for each facility. In doing so, it is not transparent how much each facility contributes to the total. A few facilities could contribute the majority of community benefit expenses, while others contribute little to none. In tax year 2016, 46 percent of hospital facilities were part of a hospital organization, and therefore those facilities' community benefit expenses were reported as part of the organization as a whole.

We recommended IRS assess the benefits and costs, including the tax law implications, of requiring tax-exempt hospital organizations to report community benefit expenses on Schedule H by individual facility rather than by collective organization and take action, as appropriate.

In response to our 2020 recommendation, IRS qualitatively assessed the benefits and costs of requiring community benefit reporting on a facility-by-facility basis. According to IRS's assessment, such reporting would impose greater burdens on tax-exempt hospitals and IRS with no tax administration benefit. Specifically, IRS determined that because the tax exemption is granted at the organization level, reporting community benefits at the facility level would provide no additional tax administration benefit. While reporting at the facility level would increase transparency,

	we closed our recommendation as implemented, recognizing the tradeoffs between the burdens and benefits of more detailed reporting.
Improvements in IRS Review of Hospitals' Community Benefits	IRS verifies many aspects of hospitals' reports during its triennial Community Benefit Activity Reviews (CBAR), but it did not have a well-documented process to identify hospitals at risk for noncompliance with the community benefit standard. IRS requires hospitals to self-report compliance with all four PPACA requirements on Form 990, Schedule H, Part V. Hospitals must answer a series of yes or no questions for each of the four PPACA requirements. In addition PPACA required IRS to review information about hospitals' community benefit activities at least every 3 years. IRS referred almost 1,000 hospitals to its audit division for potential PPACA violations from fiscal years 2015 through 2019. However, IRS could not identify whether any of these referrals related to community benefits. IRS stated that it sends back forms that are materially incomplete and requests that hospitals complete the missing information; however, we found that some of the hospitals left the required community benefit section of Form 990, Schedule H blank. These hospitals may have actually spent funds on community benefit activities, but did not complete the form. Other hospitals reported spending amounts that were approximately 0 percent of expenses.[20] IRS's guidance contained specific questions that address the community benefit factors, but there was no direction on when a hospital should be referred for audit if the revenue agent is unable to verify the factor. According to IRS officials, hospitals with little to no community benefit expenses may warrant an audit. However, IRS was unable to provide evidence that it conducted reviews specifically related to hospitals' community benefits.

[20]IRS agents in the Statistics of Income group in the Research Applied Analytics and Statistics Division correct some of the Form 990, Schedule H data for obvious errors before posting the public files onto IRS's website. However, those changes do not extend to the forms themselves that IRS officials would review in a CBAR.

For example, according to IRS officials, of the 37 hospitals that reported zero or negative community benefit spending in tax year 2016:

- 21 were referred for examination or compliance check as a result of their CBAR reviews.[21]
- Six of these hospitals were referred for audit based on CBAR review of the 2016 Form 990.
- The other 15 referrals were made based on other tax years.

However, in all these cases, the referrals were made as a result of possible issues with the financial assistance policy or community health needs assessment but not issues with the community benefit standard. IRS officials said the other 16 hospitals that reported no spending on community benefits were not referred for audit because they met the PPACA requirements.

Furthermore, IRS did not have a way to determine if hospitals were being selected for audit for potential noncompliance related to community benefits during a CBAR. While it used audit issue codes that differentiate between PPACA-related noncompliance and other noncompliance, there were no codes related to potential noncompliance with the community benefit standard. According to IRS, from 2016 through 2019, fewer than 10 cases each year were referred to its audit division during the CBAR for an issue not related to PPACA.

We recommended IRS establish a well-documented process to identify hospitals at risk for noncompliance with the community benefit standard that would ensure hospitals' community benefit activities are being consistently reviewed. We also recommended IRS establish specific audit codes for identifying potential noncompliance with the community benefit standard.

In response, in 2021 IRS updated the guidance for CBAR reviews to include instructions for employees to document case files with relevant facts and circumstances considered during their review that determine whether the hospital organization satisfies the community benefit standard for exemption. IRS also established an audit code in its Case Management System under Healthcare Issues 18010.000 for "Healthcare - Community Benefit Standard for Exemption." These actions will help

[21]We provided IRS with a list of 37 hospitals that, based on our review of Form 990, Schedule H data, reported zero or negative net community benefit spending for tax year 2016. This number is larger than the amount reported in table 1, because the values in table 1 correct for the cases for which hospitals reported negative spending in Medicaid.

IRS ensure it is effectively reviewing hospitals' community benefit activities.

In summary, IRS can easily verify whether the legal requirements in PPACA are met. However, it is harder for IRS to verify community benefits because IRS does not have the authority to define specific services and activities hospitals must undertake to qualify for a tax exemption. Additional clarity about specific services and activities Congress believes would provide sufficient community benefits could improve IRS's ability to oversee tax-exempt hospitals.

In addition, IRS action to update and revise Form 990, Schedule H that enables tax-exempt hospitals to present community benefit information clearly, consistently, and comprehensively could help IRS, Congress, and the broader public better understand the full scope of the community benefits a hospital provides and whether they justify a tax exemption.

Chairman Schweikert, Ranking Member Pascrell, and Members of the Subcommittee, this concludes my prepared remarks. I look forward to answering any questions that you may have.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact me at (202) 512-6806 or lucasjudyj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Sonya Phillips (Assistant Director), Jennifer G. Stratton (Analyst-in-Charge), Caitlin Cusati, Steven Flint, Robert Gebhart, James A. Howard, Matthew Levie, Ed Nannenhorn, Sonya Vartivarian, Peter Verchinski, Daniel Webb, and Alicia White.

Chairman SCHWEIKERT. Thank you, Ms. Lucas-Judy.
Dr. Bai.

STATEMENT OF GE BAI, PROFESSOR OF ACCOUNTING, JOHNS HOPKINS CAREY BUSINESS SCHOOL AND PROFESSOR OF HEALTH POLICY AND MANAGEMENT, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

Ms. BAI. Chairman Schweikert, Ranking Member Pascrell, and members of the committee, it's my great pleasure to be here today. Thank you very much for having me.

I'm a professor of accounting at Johns Hopkins Carey Business School and a professor of health policy and management at Johns Hopkins Bloomberg School of Public Health. As a accountant, my research interest is monetary issues in healthcare. In today's testimony, I will focus on two things. Number one, the social contract between taxpayers and the tax-exempt hospitals. Number two, evidence on whether tax-exempt hospitals fulfilled their obligations to taxpayers.

My views today represent my own and do not represent that of Johns Hopkins University or its affiliations.

Let's move to number one. So hospitals is the largest industry in the United States with 1.4 trillion dollar annual revenue. Most of the hospitals, however, are tax-exempt hospitals, meaning that they are exempted from income tax at the federal, state level, property tax, sales tax. They also have lower costs of borrowing because they can issue tax-exempt bonds because bond holders do not pay income tax on the interest earned on the bonds. They can also receive tax exempt—tax deductible charitable contributions.

So beyond that, these hospitals can also benefit from the 340B Program. So this 340B Program was established by Congress in 1992 to help hospitals that benefit low income patients by giving them the ability to buy drugs at discounted price from pharmaceutical companies. This was a buy low/sell low program at that time. Now it has evolved into a buy low/sell high program because hospitals can sell those discounted drugs to well-insured patients. And it also encourage hospital's mergers and acquisitions because they can buy physician's practices and small hospitals in order to take advantage of the 340B Program.

More importantly, the tax exemptions or taxpayer subsidies worth more to hospitals with higher profitability and hospitals located in wealthy areas because of the value of property tax exemption and the value of income tax exemption. So these are the indirect and direct tax benefit or taxpayer subsidies enjoyed by nonprofit hospitals.

How about obligations? So our current tax exempt obligat—tax exempt benefit comes from 1913, the first Internal Revenue Code. At that time, nonprofit hospitals were pure charities. They focused on charitable activities with very little commercial activities.

But time has changed. Our current community benefit standards was adopted by IRS in 1969 because we have a social contract. As tax-exempt hospitals, we are going to provide all kinds of community benefit to the taxpayers. In return, we receive taxpayer subsidies.

Then the ACA defined very specifically eight different types of community benefits, including charity care, that is the discounted or free care provided by tax-exempt hospitals to low-income patients. These are uninsured or insured. And also, the Medicaid shortfall, which is the Medicaid payment versus the cost of providing care to Medicaid patients. And there are other types of community benefit. So basically, nonprofit hospitals must report to IRS how much they did for one of the eight or more than of the eight different categories and at an annual basis.

Now let's move on to my number two point. The hospitals have not yet provided more than the for-profit hospitals in overall. So our study in house affairs found that in 2018, for every one hundred dollars expense incurred by nonprofit hospitals, they only provided $2.30 for charity care, but the for-profit hospitals provided $3.80. And the similar result we found for the Medicaid shortfall.

So overall, nonprofit hospitals have not yet demonstrated that their activities are consistent with a charitable mission. So evidence suggests that tax-exempt status does not provide assurance that nonprofit hospitals will provide sufficient community benefit or behave in a way consistent with their charitable mission. Thank you very much.

[The statement of Ms. Bai follows:]

JOHNS HOPKINS
CAREY BUSINESS SCHOOL

Testimony for the Record
Submitted to the
House Committee on Ways and Means
Subcommittee on Oversight
for the Hearing
"Tax-Exempt Hospitals and the Community Benefit Standard"

April 24, 2023

Ge Bai, PhD, CPA
Professor of Accounting, Carey Business School
Professor of Health Policy & Management (Joint), Bloomberg School of Public Health
Johns Hopkins University

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).

Chairman SCHWEIKERT. Thank you. Thank you, Dr. Bai.
Dr. Levinson.

STATEMENT OF ZACHARY LEVINSON, DIRECTOR, NEW PROJECT AT THE KFF THAT EXAMINES BUSINESS PRACTICES OF HOSPITALS AND THEIR PROVIDERS AND THEIR IMPACT ON COSTS AND AFFORDABILITY

Mr. LEVINSON. Thank you, Chairman Schweikert, Ranking Member Pascrell, and distinguished members of the subcommittee. I appreciate the opportunity to be here with you this afternoon to discuss tax-exempt hospitals and the community benefit standard.

This issue has been the subject of renewed interest in light of reports on the business practices of some nonprofit hospitals, such as instances where hospitals have taken aggressive steps to collect unpaid medical bills, including from patients who may be eligible for financial assistance.

To provide context for ongoing discussion on this topic, KFF estimated the value of exemption from federal, state, and local taxes for nonprofit hospitals. We estimated that the total value was about 28 billion dollars in 2020. This represents over 40 percent of net income earned by nonprofit hospitals in that year, highlighting the large role the tax exemption may play in the financial health of these facilities.

About half of our estimate reflects the benefit of federal tax-exempt status. The federal component includes the value of not having to pay federal corporate income taxes. It also reflects estimated increases in charitable contributions and decreases in bond interest rate payments that might arise due to receiving tax-exempt status. In exchange for receiving federal tax exemption, nonprofit hospitals are expected to provide community benefits. One core example of a community benefit is charity care, which reflects free or discounted services for eligible patients who are unable to afford their care.

Hospital charity care programs help fill in gaps in coverage for uninsured patients as well as insured patients whose plans may have large cost-sharing requirements. We estimated that nonprofit hospitals spent about 16 billion dollars on charity care in 2020, which is less than our 28 billion dollar estimate of the value of tax exemption. We focused on charity care to provide context for one of the clearest examples of a public good provided by nonprofit hospitals.

However, nonprofit hospitals engage in many other activities that may benefit their communities. These include covering unreimbursed costs related to treating Medicaid patients—excuse me, offering unprofitable services that are important for local access, supporting medical training, and funding research, among other activities. Nonetheless, research suggests that community benefit spending may vary substantially across hospitals, and some have suggested the need for additional measures to be sure that all nonprofit hospitals are carrying their weight.

Several proposals have been floated to increase the provision of community benefits and better align these activities with local need. Approaches include expanding requirements for hospital charity care programs, requiring hospitals to spend a minimum

amount on community benefits, requiring greater community involvement in hospital decision making, and increasing transparency in oversight of community benefits.

Policies that seek to strengthen the regulation of federal nonprofit status would inevitably involve tradeoffs. For example, some policies may require new spending on certain community benefits. While hospitals may try to offset this new spending by operating more efficiently, it's also possible that some would cut costs in ways that could be harmful to patients or the broader community, such as by discontinuing certain services or laying off staff.

It may be especially challenging for some to implement new activities given recent financial challenges facing hospitals and other financial challenges that are on the horizon. This includes the end of the public health emergency and the unwinding of Medicaid continuous enrollment which could lead to many individuals losing coverage and subsequently requiring charity care.

At the same time, policies to strengthen standards for community benefit could increase the provision of benefits that are important to patients and communities, such as extending free or discounted services to more patients who would otherwise have difficulty affording their care. In the context of recent financial challenges facing hospitals, strengthening community benefit requirements could also protect prioritized services and activities from hospital's attempts to cut costs. Given the large role that nonprofit hospitals play in the nation's healthcare system, the community benefits that they provide may have a large bearing on patient's access to affordable care and the health of communities.

Thank you, and I look forward to answering your questions.

[The statement of Mr. Levinson follows:]

Oversight of Nonprofit Hospital Tax-Exempt Status: Background and Key Considerations

Zachary Levinson, Ph.D.

KFF

Prepared for the Subcommittee on Oversight of the Committee on Ways and Means

U.S. House of Representatives

Hearing on

Tax-Exempt Hospitals and the Community Benefit Standard

April 26, 2023

KFF

Introduction

Good afternoon, Chairman Schweikert, Ranking Member Pascrell, and distinguished Members of the Subcommittee. Thank you for inviting me to testify about tax-exempt hospitals and the community benefit standard.

I am Zachary Levinson, the director of a new project at KFF examining the business practices of hospitals and other providers and their impact on costs and affordability. KFF is a non-profit organization providing non-partisan health policy analysis, polling, and journalism (KFF Health News) for policymakers, the media, the health policy community, and the public. We are not associated with Kaiser Permanente.

Over the years, some policymakers have questioned whether nonprofit hospitals provide sufficient benefit to their communities to justify their exemption from federal, state, and local taxes. This issue has been the subject of renewed interest in light of reports of nonprofit hospitals taking aggressive steps to collect unpaid medical bills—such as by suing patients over unpaid medical debt—including from patients who are likely eligible for financial assistance.[1] Given these concerns, several policy ideas have been floated to better align the activities of nonprofit hospitals with the needs of their communities and the value of their tax exemption.

During my testimony, I will describe the value of tax exemption, federal oversight of community benefits, concerns about the adequacy of government requirements, proposed policy solutions, and general tradeoffs of policies that seek to strengthen requirements for tax-exempt status.

The Value of Tax Exemption

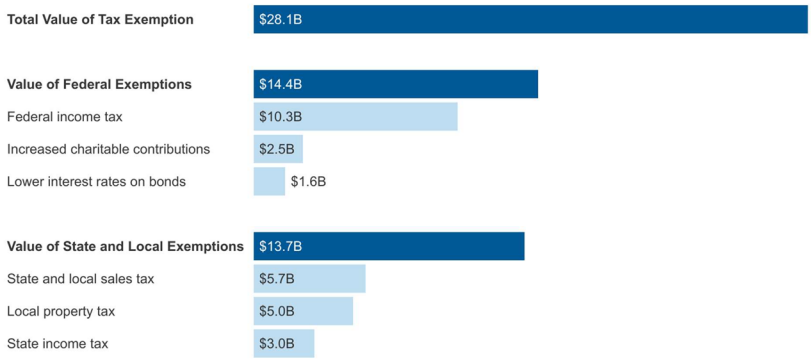
We recently estimated the value of tax exemption for nonprofit hospitals to provide context for debates about the adequacy of community benefits provided by these facilities. One motivation for our work was to update a previous estimate from 2011, which predated large changes to the federal tax code and health insurance coverage expansions under the Affordable Care Act (ACA) of 2010. We relied on a modeling approach based on prior research, using data from hospital cost reports, filings with the Internal Revenue Service (IRS), and the American Hospital Association survey.

We estimated that the total value of tax exemption for nonprofit hospitals was about $28 billion in 2020 (Figure 1).[2] This represented over two-fifths (44%) of net income (i.e., revenues minus expenses) earned by nonprofit facilities in that year.

About half of our estimate of the total value of tax exemption reflects the benefit of receiving federal tax-exempt status. The federal component of our estimate includes the value of not having to pay federal corporate income taxes. It also reflects estimated increases in charitable contributions and decreases in bond interest rate payments that might stem from tax-exempt status.

Figure 1

The Total Estimated Value of Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020



NOTE: Value of tax exemption reflects the estimated benefit of not having to pay federal, state, and local taxes as well as estimated increases in charitable contributions and decreases in bond interest rate payments due to tax-exempt status.
SOURCE: KFF analysis of RAND Hospital Data, 1996-2020; the American Hospital Association (AHA) Annual Survey Database, 2011-2020; and Internal Revenue Service (IRS) Form 990 data, 2011-2020.

KFF

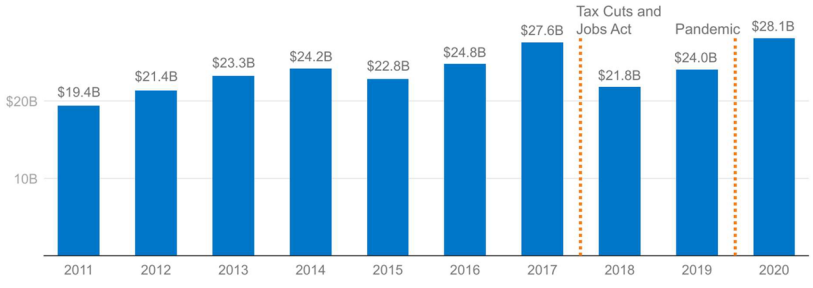
We also found that the value of tax exemption grew over time from about $19 billion in 2011 to about $28 billion in 2020 (Figure 2). One notable exception to this trend was a large decrease in the value of tax exemption in 2018 following the implementation of the Tax Cuts and Jobs Act of 2017, which reduced corporate income tax rates and therefore decreased the value of being exempt from federal income taxes for nonprofit hospitals.[3] Conversely, there was a large increase in the value of tax exemption in 2020, which overlapped with the start of the COVID-19 pandemic. This primarily reflects a large increase in aggregate net income for nonprofit hospitals in 2020. Although there were disruptions in hospital operations in 2020, hospitals received substantial amounts of government relief,[4] and it is possible that other sources of revenue, such as from investment income, may have also led to increases in taxable income. Increases in the estimated value of tax exemption over time also reflect trends that preceded the pandemic, such as the growth of supply expenses and net income, both of which would carry tax implications if hospitals lost their tax-exempt status.

The value of the tax exemption may have decreased since 2020 given the more recent financial challenges facing the hospital sector. These challenges include the erosion of government pandemic relief funds, costs associated with labor shortages, and broader economic trends that have led to rising prices and investment losses.[5] The recent unwinding of the Medicaid continuous enrollment provision—which was introduced at the start of pandemic—may also have implications for hospital finances. A KFF analysis estimated that millions of people could lose Medicaid enrollment as a result, which may increase

hospitals' charity care and other uncompensated care costs.[6] We were unable to evaluate the value of tax exemption in the context of recent trends given lags in the availability of our data.

Figure 2

The Value of Tax Exemption Grew From About $19 Billion in 2011 to About $28 Billion in 2020, Representing a 45 Percent Increase



NOTE: A given hospital may appear in one year but not another due to missing data or hospital openings and closures. Value of tax exemption reflects the estimated benefit of not having to pay federal, state, and local taxes as well as estimated increases in charitable contributions and decreases in bond interest rate payments due to tax-exempt status. The Tax Cuts and Jobs Act of 2017 permanently reduced the corporate income tax rate from 35 to 21 percent effective 2018.
SOURCE: KFF analysis of RAND Hospital Data, 1996-2020; the American Hospital Association (AHA) Annual Survey Database, 2011-2020; and Internal Revenue Service (IRS) Form 990 data, 2011-2020.

KFF

While our analysis focused on the total value of tax exemption, the benefit to a specific hospital or health system will vary based on its finances and the state and local policy where it operates. It is possible that tax exemption may tend to provide greater value to nonprofit hospitals or health systems with greater resources that are serving wealthier patients. For example, hospitals operating in wealthier areas of a given region may receive greater value from local property tax exemption than hospitals in areas where property values are lower. Similarly, hospitals with low versus high safety-net indices tend to earn higher margins[7] and may therefore receive greater value from income tax exemption, all else equal. In sum, there may be a mismatch between the benefit of tax exemption and the needs of the patients and community that a given hospital serves.

As is the case with previous work, we were unable to capture the effects of all nuances of the tax code, nor the various actions that nonprofit hospitals might take to reduce their tax burden if they lost tax-exempt status, such as by changing how they operate or how they account for revenues and expenses. In general, evaluating the value of tax exemption is challenging given the limitations of available data and uncertainty about how hospitals would respond to losing their tax-exempt status.

Federal Oversight of Community Benefits

The IRS evaluates community benefits in determining whether a hospital is considered "charitable" and thus tax-exempt. The IRS identifies six factors that demonstrate community benefits:

1. "Operating an emergency room open to all, regardless of ability to pay
2. Maintaining a board of directors drawn from the community
3. Maintaining an open medical staff policy
4. Providing hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare
5. Using surplus funds to improve facilities, equipment, and patient care; and
6. Using surplus funds to advance medical training, education, and research."[8]

The IRS requires hospitals to document community benefit activities through Schedule H of Form 990 on an annual basis.[9] Part I of Schedule H asks hospitals to report net expenses for each of a set of specified community benefits. This list includes expenses that are directly related to patient care, such as unreimbursed Medicaid costs, charity care costs, and losses on certain unprofitable services (e.g., that are necessary to meet community need). The list also includes other net expenses, such as for unreimbursed medical education, unfunded research, and community health improvement activities. Hospitals may report additional community benefits in other parts of Schedule H. For instance, while the IRS does not allow hospitals to report unreimbursed Medicare costs or bad debt as a community benefit under Part I, it does allow them to report these expenses elsewhere and explain why some, if any, of these costs should be considered a community benefit.

The federal government has revised its standards for tax-exempt hospitals over time, including by introducing new requirements under the ACA. The ACA requires nonprofit hospitals to meet the following four criteria:[10]

- **Establish a financial assistance policy (FAP).** The FAP must describe who is eligible for We relied on charity care, the level of assistance provided, and how patients can apply. A hospital must make its FAP easily accessible to patients and ensure that the FAP is translated into the languages commonly spoken in the community served by the hospital.
- **Cap charges to patients eligible for charity care based on amounts generally billed to other payers.** Federal regulation defines approaches for calculating the amount generally billed based on fee-for-service Medicare rates, Medicaid rates, and/or commercial plan payment rates.
- **Conduct a community health needs assessment (CHNA) every three years and adopt an implementation strategy to address those needs.** The CHNA must define the community that the hospital serves and evaluate the health needs of that community, taking into account input from local stakeholders. Community health needs could include, for example, lowering financial barriers to health care or addressing social determinants of health.

- **Make reasonable efforts to determine if a patient is eligible for charity care before engaging in certain debt collection practices,** including selling the patient's debt to third parties, reporting the debt to credit agencies, and taking legal action to control a patient's financial assets. A "reasonable effort" could entail, for example, notifying the patient of the FAP and giving them at least four months to apply following their first bill after being discharged from the hospital.

Adequacy of Federal Oversight

The Government Accountability Office (GAO) and others have questioned whether current federal standards provide adequate oversight of community benefits. Concerns include the following:

- **There are no statutory or regulatory requirements for specific community benefits.** The IRS uses the six broad factors described above when evaluating a hospital's community benefits. However, the GAO has noted that there is no guidance on what constitutes a sufficient level of these benefits or how the IRS weighs different factors when evaluating hospitals' community benefits.[11]
- **There are limited standards for financial assistance programs.** Although the ACA requires that hospitals establish a financial assistance program, there are no requirements about who must be eligible or how much assistance must be provided.[12]
- **The IRS does not require standardized reporting for all community benefits.** The GAO has noted that, while Schedule H of IRS Form 990 includes specific, detailed, and standardized questions about some community benefits, it does not require other community benefits to be reported in a standardized way.[13] For example, hospitals are instructed to report details about the "use of surplus funds to improve facilities, equipment, and patient care" in an open-ended, narrative section.
- **Some community benefits acknowledged by the IRS may not be aligned with local needs.** For example, "using surplus funds to improve facilities, equipment, and patient care" may include some activities that are not targeted towards the greatest needs in the community, such as instances where a hospital opens a new facility in a wealthy neighborhood.[14]

The GAO reported in 2020 that the IRS had not revoked a hospital's nonprofit status on the basis of community benefits over the prior ten years.[15]

States fill in some of the gaps in federal standards for tax-exempt status and community benefits but have varying approaches. For example, about half of states require all or a subset of hospitals to offer charity care to certain eligibility groups.[16] These state regulations vary in terms of which hospitals they cover, the eligibility criteria, and the level of assistance that must be provided. For example, Nevada requires a subset of hospitals to provide free care to uninsured patients with very low incomes (about 40% of the federal poverty level [FPL] in 2022 depending on household size), while Maryland requires every acute and chronic care hospital to provide free care to both insured and uninsured patients at or below 200% of the FPL and to provide discounted care to patients with higher incomes. There is little information about the effectiveness of state regulations or the extent to which they are enforced.

Value of Community Benefits Relative to Tax Exemption

The extent to which nonprofit hospitals provide sufficient benefit to their communities to justify tax exemption is a matter of ongoing debate. Answering this question may be challenging and likely depends on at least a few considerations, such as: (1) what counts as a community benefit, (2) whether comparisons consider the total value of community benefits provided by nonprofit hospitals or only the *additional* value they provide relative to for-profit hospitals, and (3) whether certain business practices—such as instances where nonprofit hospitals have engaged in anticompetitive behavior, charged high commercial prices, and engaged in aggressive debt collection practices[17]— affect assessments of the value that nonprofit hospitals provide to their communities.

Whether the value of community benefits exceeds the value of tax exemption, or vice versa, may vary across hospitals and health systems. For instance, one study estimated that the value of community benefits exceeded the value of tax exemption for about three-fifths (62%) of nonprofit hospitals during 2011-2018 (when focusing on the additional benefits provided relative to for-profit hospitals), while the reverse was true for the remaining hospitals (38%).[18] That study also estimated that the value of community benefits was more likely to exceed the value of tax exemption in counties with higher poverty rates, among other findings.

Hospital Charity Care

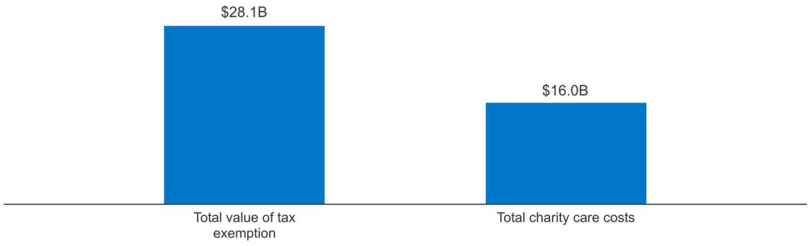
Hospital charity care—which is one type of community benefit—has received renewed scrutiny amid national discussions about medical debt. About four in ten adults (41%)—and about six in ten (57%) of those with household incomes below $40,000—reported some level of medical debt in a 2022 survey.[19] A large share of adults who reported medical debt cited costs associated with hospitalizations (35%) and emergency care (50%) as sources of unpaid bills. Estimates based on survey data also suggest that medical debt totaled at least $195 billion in 2019.[20]

Hospital charity care programs provide free or discounted services for eligible patients who are unable to afford their care. These programs could help fill in gaps in coverage for uninsured patients, as well as insured patients, whose plans may have large cost-sharing requirements. However, eligibility criteria vary across hospitals, and news reports have documented instances where eligible patients have fallen through the cracks. Policymakers have explored options to strengthen the oversight of hospital charity care programs in response to concerns about medical debt and the affordability of care more generally.

Our estimate of the value of tax exemption exceeded estimated charity care costs among nonprofit hospitals in 2020, a difference of $28 billion versus $16 billion (Figure 3). This result highlights that the charity care provided by nonprofit hospitals—one core component of community benefit—may not on its own justify tax exemption, though nonprofit hospitals also provide many other benefits to the communities they serve and the public at large.

Figure 3

The Total Estimated Value of Tax Exemption (About $28 Billion) Exceeded Total Estimated Charity Care Costs ($16 Billion) Among Nonprofit Hospitals in 2020, Though Charity Care Represents Only a Portion of the Community Benefits Reported by These Facilities



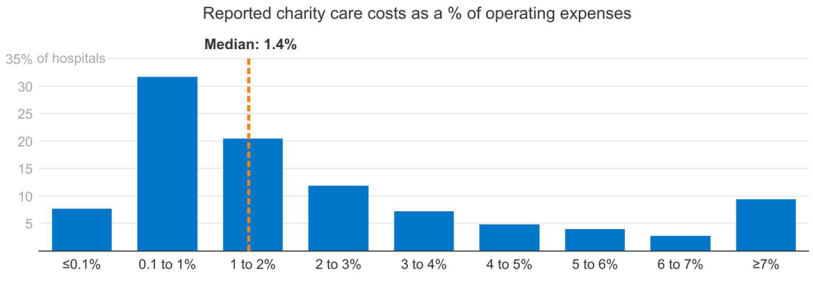
NOTE: Value of tax exemption reflects the estimated benefit of not having to pay federal, state, and local taxes as well as estimated increases in charitable contributions and decreases in bond interest rate payments due to tax-exempt status.
SOURCE: KFF analysis of RAND Hospital Data, 1996-2020; the American Hospital Association (AHA) Annual Survey Database, 2011-2020; and Internal Revenue Service (IRS) Form 990 data, 2011-2020.

KFF

Hospitals vary substantially in the amount of charity care that they provide (Figure 4). For example, while charity care costs represented 0.1 percent of operating expenses or less on the lower end of the spectrum, it represented 7 percent of operating expenses or more among a similar share of hospitals.[21]

Figure 4

Half of All Hospitals Reported That Charity Care Costs Represented 1.4% Or Less of Their Operating Expenses in 2020, Though the Level of Charity Care Varied Substantially Across Facilities



NOTE: Includes 4,279 hospitals in 50 states plus DC. Missing charity care costs recoded as $0 if hospital reported total unreimbursed and uncompensated care costs but left as missing otherwise. Excludes hospitals with incomplete data for the calendar year, missing or negative operating expenses or charity care costs, or outlier amounts of charity care as a percent of operating expenses (≥38.0%).
SOURCE: KFF analysis of RAND Hospital Data, 2020

KFF

Differences across hospitals in part reflect the extent to which their patients need financial assistance. Indeed, research indicates that hospitals provide much more charity care in counties with high versus low uninsurance rates.[22] Additionally, hospitals provide much more uncompensated care (charity care plus bad debt) in states that have not expanded Medicaid, where uninsurance rates tend to be high.[23]

Differences in charity care could also reflect eligibility criteria, the level of assistance provided, and application procedures, which vary across hospitals.

To our knowledge, it is unknown what share of low-income patients are eligible for hospital charity care, let alone what share of eligible patients end up benefiting from these programs, or what share of their costs are covered.

Federal and State Policy Proposals Intended to Improve Community Benefits

Several federal and state policy proposals have been floated to increase the provision of community benefits and better align these activities with local needs, some of which have already been implemented among a subset of states:

- **Expand charity care eligibility,** by creating or expanding requirements that hospitals extend charity care to certain groups of patients. For example, the state of Washington requires a group

of large hospitals and health systems to provide free hospital care to patients with incomes below 300% of FPL and discounted care to patients with incomes from 300% to 400% of FPL (while allowing hospitals to impose asset tests for the latter group), and it has similar but less extensive requirements for all remaining hospitals.[24]

- **Improve uptake of charity care among eligible patients**, such as by requiring that hospitals screen patients for eligibility and notify patients of potential eligibility throughout billing and collections processes.[25]
- **Establish quantitative standards** by requiring that a given hospital spend a minimum amount on certain community benefits (e.g., charity care).[26] A market-based alternative would be to create a floor-and-trade system for charity care where hospitals would be required to either provide a minimum amount of charity care for certain eligibility groups or buy credits from other hospitals that do so.[27] This is intended to account for the fact that the need for charity care varies across communities. Quantitative standards could take hospitals' financial health into account. For example, Oregon has established a minimum community benefit spending floor that increases with hospitals' operating margins.[28]
- **Require greater community involvement in hospital decision-making**, such as by requiring more extensive involvement from certain community members in the development of community health needs assessments or by specifying that boards of directors are more representative of the community that a given hospital serves.[29]
- **Revise IRS community benefit standards to better align with community need,** for example, by more clearly recognizing investments in the social determinants of health (e.g., housing) as a community benefit given the growing attention that these initiatives have received as a means for addressing local health needs.[30] Some have also recommended that the IRS narrow its standards to exclude activities that may do little to address community needs (e.g., opening new facilities in wealthy areas).[31]
- **Increase oversight,** such as by requiring that hospitals provide more detailed information about their community benefits and report the estimated value of certain tax exemptions (e.g., sales and property tax exemptions).[32] The GAO has also recommended that Congress consider specifying what it considers adequate community benefits, leading to clearer standards for tax-exempt status.[33]

Policies that seek to strengthen the regulation of nonprofit status would inevitably involve tradeoffs. For example, some of the policies discussed above would require new spending from some nonprofit hospitals on specific types of community benefits. While hospitals may be able to respond by operating more efficiently in order to devote more resources to community benefit, it is possible that some would cut costs in ways that are harmful to patients or the broader community, such as by discontinuing certain services or laying off staff. It may be especially challenging for some nonprofit hospitals to implement new community benefit activities given recent financial challenges, such as the erosion of government pandemic relief, labor shortages, and broader economic trends that have led to rising prices and investment losses.

At the same time, these policies could increase the provision of benefits that are important to patients and communities and better align these activities with local needs and priorities, as intended. For example, this could include extending free or discounted services to more patients who would otherwise have difficulty affording needed care. In the context of recent financial challenges facing hospitals, strengthening community benefit regulations could protect prioritized services and activities from hospitals' attempts to cut costs.

One consideration for these policies is how they might affect hospitals differently depending on the communities they serve, the amount and type of benefits that they already provide, and their ability to absorb new costs, as well as the increase in the demand for charity care that could result from the unwinding of Medicaid continuous enrollment.

Conclusion

Tax exemption plays a significant role in the financial health of nonprofit hospitals, with an estimated value of $28 billion in 2020 or over 40 percent of net income earned in that year. In exchange for receiving tax exemption, nonprofit hospitals are expected to provide benefits to the communities that they serve, though there is ongoing debate about how the value of these activities stack up against the tax benefits that nonprofit hospitals receive. Some scrutiny has focused on the provision of charity care, which helps patients afford needed care and varies substantially across facilities.

Several federal and state policy proposals have been floated to increase the provision of community benefits and better align these activities with local needs. These policies would inevitably involve tradeoffs, such as possibly leading to new costs during a period when some hospitals are facing financial challenges while potentially expanding the provision of valuable services to patients and communities.

Endnotes

[1] Noam M. Levey, "Hundreds of Hospitals Sue Patients or Threaten Their Credit, a KHN Investigation Finds. Does Yours?," KFF Health News, (Dec. 2022), https://kffhealthnews.org/news/article/medical-debt-hospitals-sue-patients-threaten-credit-khn-investigation/; Jay Hancock and Elizabeth Lucas, "'UVA Has Ruined Us': Health System Sues Thousands Of Patients, Seizing Paychecks And Claiming Homes," KFF Health News, (Sept. 2020), https://kffhealthnews.org/news/uva-health-system-sues-patients-virginia-courts-garnishment-liens-bankruptcy/; Jessica Silver-Greenberg and Katie Thomas; "They Were Entitled to Free Care. Hospitals Hounded Them to Pay," New York Times, (Dec. 2022), https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html.

[2] Jamie Godwin, Zach Levinson, and Scott Hulver, "The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020," KFF, (Mar. 2023), https://www.kff.org/health-costs/issue-brief/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/.

[3] Tax Policy Center, "How did the Tax Cuts and Jobs Act change business taxes?," (2022), https://www.taxpolicycenter.org/briefing-book/how-did-tax-cuts-and-jobs-act-change-business-taxes.

[4] Nancy Ochieng et al., "Funding for Health Care Providers During the Pandemic: An Update," KFF, (Jan. 2022), https://www.kff.org/coronavirus-covid-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update/; MACPAC, "COVID Relief Funding for Medicaid Providers", (Feb. 2021), https://www.macpac.gov/wp-content/uploads/2021/02/COVID-Relief-Funding-for-Medicaid-Providers.pdf.

[5] Erik Swanson, "National Hospital Flash Report: March 2023," KaufmanHall, (Mar. 2023), https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-march-2023; Christopher M. Whaley, Sebahattin Demirkan, and Ge Bai, "What's Behind Losses At Large Nonprofit Health Systems?," Health Affairs Forefront, (Mar. 2023), https://www.healthaffairs.org/content/forefront/s-behind-losses-large-nonprofit-health-systems; Suzie Dezai et al., "Outlook For U.S. Not-For- Profit Acute Health Care: A Long Road Ahead," S&P Global Ratings, (Dec. 2022); https://www.spglobal.com/ratings/en/research/articles/221201-outlook-for-u-s-not-for-profit-acute-health-care-a-long-road-ahead-12573554.

[6] Jennifer Tolbert and Meghana Ammula, "10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision" KFF, (Apr. 2023); https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/.

[7] MedPAC, "March 2023 Report to the Congress: Medicare Payment Policy, Chapter 3: Hospital Inpatient and Outpatient Services," (Mar. 2023), https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/.

[8] Internal Revenue Service, "Charitable Hospitals – General Requirements for Tax-Exemption Under Section 501(c)(3)," (last updated Jul. 15, 2022), https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3.

[9] Internal Revenue Service, "2022 Instructions for Schedule H (Form 990)," (Sep. 2022), https://www.irs.gov/pub/irs-pdf/i990sh.pdf; Congressional Research Service, "501(c)(3) Hospitals and the Community Benefit Standard," (May 2010), https://crsreports.congress.gov/product/pdf/RL/RL34605.

[10] Internal Revenue Service, "Requires for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r)," (last updated Jul. 15, 2022), https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r.

[11] Jessica Lucas-Judy et al., "Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status," Government Accountability Office, (Sept. 2020), https://www.gao.gov/assets/gao-20-679.pdf.

[12] Andrea Bopp Stark and Jenifer Bosco, "An Ounce of Prevention: A Review of Hospital Financial Assistance Policies in the States," National Consumer Law Center, (Nov. 2021), https://www.nclc.org/wp-content/uploads/2022/09/Rpt_Ounce_of_Prevention.pdf.

[13] Jessica Lucas-Judy et al., "Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status," Government Accountability Office, (Sept. 2020), https://www.gao.gov/assets/gao-20-679.pdf.

[14] Sunjay Letchuman et al., "Revise the IRS's Nonprofit Hospital Community Benefit Reporting Standard," Health Affairs Forefront, (Apr. 2022), https://www.healthaffairs.org/do/10.1377/forefront.20220413.829370/

[15] Jessica Lucas-Judy et al., "Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status," U.S. Government Accountability Office, (Sept. 2020), https://www.gao.gov/assets/gao-20-679.pdf.

[16] Andrea Bopp Stark and Jenifer Bosco, "An Ounce of Prevention: A Review of Hospital Financial Assistance Policies in the States," National Consumer Law Center, (Nov. 2021), https://www.nclc.org/wp-content/uploads/2022/09/Rpt_Ounce_of_Prevention.pdf.

[17] Jessica Silver-Greenberg and Katie Thomas, "They Were Entitled to Free Care. Hospitals Hounded Them to Pay," New York Times, (Sept. 24, 2022), https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html.

[18] Hossein Zare, Matthew D. Eisenberg, and Gerard Anderson, "Comparing The Value Of Community Benefit And Tax-exemption In Non-profit Hospitals," 57(2) *Health Services Research* 270-284 (May 2021), https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13668.

[19] Lunna Lopes et al., "Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills," KFF, (Jun. 2022), https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/.

[20] Matthew Rae et al., "The Burden of Medical Debt in the United States," KFF, (Mar. 2022), https://www.kff.org/health-costs/issue-brief/the-burden-of-medical-debt-in-the-united-states/.

[21] Zachary Levinson, Scott Hulver, and Tricia Neuman, "Hospital Charity Care: How It Works and Why It Matters," KFF, (Nov. 2022), https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/.

[22] Ge Bai et al., "Analysis Suggests Government and Nonprofit Hospitals' Charity Care Is Not Aligned With Their Favorable Tax Treatment," 40(4) *Health Affairs* 629-636 (Apr. 2021), https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01627.

[23] MACPAC, "Report to Congress on Medicaid and CHIP, Chapter 4: Annual Analysis of Disproportionate Share Hospital Allotments to States," (Mar. 2023), https://www.macpac.gov/publication/march-2023-report-to-congress-on-medicaid-and-chip/.

[24] Washington State Office of the Attorney General, "Washington State Charity Care Law," (accessed Apr. 23, 2023); https://www.atg.wa.gov/charitycare.

[25] Innovation for Justice, "Medical Debt Policy Scorecard: Data" (accessed Apr. 23, 2023), https://www.medicaldebtpolicyscorecard.org/.

[26] Emily Gee and Thomas Waldrop, "Policies to Hold Nonprofit Hospitals Accountable," Center for American Progress (Oct. 2022), https://www.americanprogress.org/article/policies-to-hold-nonprofit-hospitals-accountable/.

[27] David Dranove, Craig Garthwaite, and Christopher Ody, "A Floor-and-Trade Proposal to Improve the Delivery of Charity-Care Services by U.S. Nonprofit Hospitals," Brookings Institution, (October 2015),

https://www.brookings.edu/research/a-floor-and-trade-proposal-to-improve-the-delivery-of-charity-care-services-by-u-s-nonprofit-hospitals/.

[28] Office of Health Analytics, "Community Benefit Minimum Spending Floor Methodology Announcement for Hospital Fiscal Years 2022 and 2023," Oregon Health Authority, (accessed April 23, 2023), https://www.oregon.gov/oha/HPA/ANALYTICS/HospitalReporting/FY22-23-Spending-Floor-Announcement.pdf.

[29] Sunjay Letchuman et al., "Revise the IRS's Nonprofit Hospital Community Benefit Reporting Standard," Health Affairs Forefront, (Apr. 2022), https://www.healthaffairs.org/do/10.1377/forefront.20220413.829370/; Amy Clary, "How States Keep Community at the Center of Hospitals' Community Health Needs Assessments," National Academy for State Health Policy, (Apr. 2019), https://nashp.org/how-states-keep-community-at-the-center-of-hospitals-community-health-needs-assessments/.

[30] Jessica Lucas-Judy et al., "Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status," Government Accountability Office, (Sept. 2020), https://www.gao.gov/assets/gao-20-679.pdf; Michael Rozier, Susan Goold, and Simone Singh, "How Should Nonprofit Hospitals' Community Benefit Be More Responsive to Health Disparities?" 21(3) *AMA Journal of Ethics* E273-280 (March 2019), https://journalofethics.ama-assn.org/article/how-should-nonprofit-hospitals-community-benefit-be-more-responsive-health-disparities/2019-03.

[31] Sunjay Letchuman et al., "Revise the IRS's Nonprofit Hospital Community Benefit Reporting Standard," Health Affairs Forefront, (Apr. 2022), https://www.healthaffairs.org/do/10.1377/forefront.20220413.829370/.

[32] Jessica Lucas-Judy et al., "Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status," Government Accountability Office, (Sept. 2020), https://www.gao.gov/assets/gao-20-679.pdf; Ge Bai, Elizabeth Plummer, Gerard F. Anderson, "Use The Hospital Compare Website To Make Hospital Community Benefit More Transparent," Health Affairs Forefront, (Sep. 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210903.507376/full/.

[33] Jessica Lucas-Judy et al., "Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status," Government Accountability Office, (Sept. 2020), https://www.gao.gov/assets/gao-20-679.pdf.

Chairman SCHWEIKERT. Thank you, Doctor.

Ms. HATTON. Could you hit your button?

STATEMENT OF MELINDA HATTON, GENERAL COUNSEL AND SECRETARY, AMERICAN HOSPITAL ASSOCIATION

Ms. HATTON. Chairman Schweikert, Ranking Member Pascrell, and distinguished members of the subcommittee, thank you for the opportunity to testify at this hearing. On behalf of the American Hospital Association's 5,000 member hospitals and health systems, I look forward to sharing the many ways hospitals provide benefits to their communities as we strive to ensure all individuals reach their highest potential for health.

Every hospital——

Chairman SCHWEIKERT. Ms. Hatton, forgive me. I know—will you pull the mic closer to you?

Ms. HATTON. Sure.

Chairman SCHWEIKERT. It's—the acoustics in this room are really bad.

Ms. HATTON. Thank you.

Every hospital provides valuable and vital services to their patients and communities. These include 24/7 emergency care, specialized surgeries, and treatment for complex diseases that only hospitals can provide. Tax-exempt hospitals have special obligations to their communities in exchange for that privilege. Tax-exempt hospitals report the amounts they spend on community benefits yearly and conduct a community health needs assessment at least every three years. Hospitals work with their communities to develop these assessments to decide which priority health issues they should tackle. There's no doubt that these hospitals both meet and exceed any requirements and expectations that attach to the privilege of tax exemption.

A few key facts. In 2019, which is the most recent tax year that comprehensive information is available, tax-exempt hospitals devoted nearly 14 percent of their total expenses to community benefit programs, and about half of that was for financial assistance and other means tested benefits. In addition, the most recent report by the international accounting firm of EY demonstrated that the return to taxpayers for hospital's federal tax exemption is nine to one. That means for every one dollar of tax exemption, taxpayers receive nine dollars of community benefit. I think that's a remarkable return by any standard.

For nearly 100 years, it's been widely recognized that fulfilling a hospital's charitable mission is multifaceted and does not rest on the provision of financial assistance alone. The community benefit standard established by the IRS from its hospitals to satisfy their community benefit obligations by providing a mix of financial assistance, services, and programs tailored to meet the needs of their communities. In 2008, as part of a major overhaul of Form 990, the IRS developed Schedule H. This is the form tax-exempt hospitals use to report the range of community benefits they provide.

The AHA has been collecting comprehensive information on the benefits reported in Schedule H since 2009. The amount of community benefit has remained steady between 11 and 14 percent of total hospital expenses with financial assistance and Medicaid un-

derpayments counting for about half that total. Since reporting began, hospitals have provided between 894 billion and 1.3 trillion dollars' worth of community benefits.

One of the greatest accomplishments of the community benefit standard is the flexibility it gives to hospitals to meet the needs of the unique communities they serve. Let me give you two brief examples.

HonorHealth in Scottsdale, Arizona supports its communities through a variety of programs that increase access to healthcare, provide early childhood education, food bank access, senior daycare, and trauma and deployment training for military professionals. St. Joseph's Health in Patterson, New Jersey works with community partners, including faith-based, civil, and social organizations, schools, and others to offer a wide-range of services. Some examples include educational programs on autism, diabetes, obesity, asthma, and other support services for parents of infants and toddlers with a special focus on children with developmental disabilities and delays. Every single hospital has examples of programs that are designed to address the unique needs of their communities.

Before closing, just let me note that we do have some areas agreement with the other three witnesses that you've heard from. There should be more emphasis on the value of social determinants of health. The Schedule H form could and should be more user-friendly for communities. The value of grants that support programs, services, research, and training should be counted, and setting minimum dollar thresholds would not be helpful or prudent.

In conclusion, hospitals do more than any other sector of healthcare to support the communities they serve and more than enough to support their tax exemption.

Thank you again for the opportunity to testify, and I look forward to your questions.

[The statement of Ms. Hatton follows:]

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Testimony

Of the

American Hospital Association

For the

Committee on Ways and Means

Subcommittee on Oversight

Of the

U.S. House of Representatives

"Tax-Exempt Hospitals and the Community Benefit Standard"

April 26, 2023

Chairman Schweikert, Ranking Member Pascrell and members of the Subcommittee, I am Melinda Hatton, general counsel and secretary for the American Hospital Association (AHA). On behalf of the AHA's nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, thank you for the opportunity to testify at today's hearing on tax-exempt hospitals and the community benefit standard.

Every hospital and health system across the nation provides valuable and vital services to the patients and communities they serve. Those include a range of services from urgent to highly specialized care delivered in inpatient settings to many programs and services delivered in the community that advance health and wellness. For example, hospitals and health systems provide financial assistance to help those in need, subsidies for services that would otherwise be unavailable, such as burn or neonatal units, transportation, food pantries, training for the next generation of caregivers and vital research to aid in the treatment of longstanding diseases, such as cancer, and new

challenges such as COVID-19. In sum, hospitals do more than any other sector of health care to promote and protect the health of their communities.

Tax-exempt hospitals have special obligations to their communities in exchange for that privilege. They report the amounts they spend on community benefits yearly and conduct a community needs assessment at least every three years. There is no doubt that these hospitals both meet and exceed any requirements and expectations that attach to the privilege of tax exemption. The essential facts are:

- For the most recent tax year for which comprehensive information is available (2019), tax-exempt hospitals devoted nearly 14% of their total expenses to community benefit programs, about half of which was for financial assistance and certain other means tested community benefits.
- The most recent report by the international accounting firm EY demonstrated that the return to taxpayers for hospitals' federal tax exemption is $9-to-$1; that is for every one dollar of tax exemption taxpayers receive $9 of community benefits. That is a remarkable return by any standard.

A LONG HISTORY OF COMMUNITY BENEFIT BEYOND FINANCIAL ASSISTANCE

For the past nearly 100 years, it has been widely recognized that fulfilling a hospital's charitable mission is multifaceted and does not rest on the provision of financial assistance alone. A sampling of decades of court rulings provides clear evidence for that proposition.

In 1925, the Kansas Supreme Court, in *Third Order of St. Dominic v. Younkin*, stated unequivocally that hospitals' charitable obligations went beyond financial assistance:

> "When an institution is incorporated for benevolent purposes without capital stock, and no dividends are declared or paid, and conducts a hospital, and all the earnings of the hospital from pay patients, gifts, bequests or whatever sources are used in the maintenance, extension and improvement of the hospital, and which admits patients without regard to race, creed or wealth, it is uniformly held that such hospital is conducted exclusively for charitable purposes."

Fifteen years later, the Texas Supreme Court built on the Kansas court's decision in *Santa Rosa Infirmary v. City of San Antonio* stating:

> "[T]he mere fact that pay patients largely predominate over the charity patients, or that the institution did not go into the highways and byways seeking out those to whom its charitable office might be extended, could not, under the great weight of authority, be said to so detract from its charities as to disqualify it as an institution of purely public charity."

Twenty five years later, in *City of Richmond v. Richmond Memorial Hospital,* the Virginia Supreme Court went further identifying a greater range of activities that contribute to a

hospital's charitable mission and underscoring that financial assistance was not the touchstone for determining whether a hospital met its charitable obligations: [1]

> "[n]on-profit hospitals which are devoted to the care of the sick, which aid in *maintaining public health*, and contribute to the *advancement of medical science*, are and should be regarded as charities....
>
> A tax exemption cannot depend on any such vague and illusory concept as the percentage of free service actually rendered. This would produce chaotic uncertainty and infinite confusion, permitting a hodgepodge of views on the subject." (emphasis supplied)

Researchers too have recognized that the benefits tax-exempt hospitals provide go beyond financial assistance, including that tax-exempt hospitals are "considerably more likely" to provide unprofitable services, including psychiatric and hospice services.[2] The authors of that study warn that overlooking the significance of ownership for service provision "has critical health and spending consequences."

Through a series of decisions spanning almost a century, the courts and many commentators recognized that hospitals' charitable mission goes beyond financial assistance.[3] In 1969, IRS Revenue Ruling 69-545 memorialized that position and established the "community benefit" standard, which remains in effect today. That ruling and its progeny establish that "promotion of health in a manner beneficial to the community and free of any private benefits or profits is a charitable purpose." The standard permits hospitals to satisfy their community benefit obligations by providing a mix of financial assistance, services and programs tailored to meet the needs of *their* communities.

One of greatest accomplishments of the community benefit standard is the flexibility it gives to hospitals and health systems to meet the needs of *their* communities. A small rural community in Montana will not have the same needs for support and services as a hospital in downtown Atlanta. And it always should be up to those communities to decide if the amount, range and focus of their hospital's community benefit activities meets *their* needs. Any suggestion that the IRS should both define and evaluate community benefit clearly misses the point. Community benefit can only be fairly judged by those in the community in which the benefits accrue.

The examples of community benefit activities described in the appendix to this testimony demonstrate that hospitals' community benefit activities are responsive to

---

[1] Southern Methodist Hosp. & Sanatorium v Wilson, 51 Ariz. 424 at 462 (1938) We think the position that the test of a charitable institution is the extent of the free services rendered, is difficult of application and unsound in theory.

[2] Jill R. Horwitz and Austin Nichols, Hospital Service Offerings Still Differ Substantially by Ownership Type, Health Affairs, March 2022 (Horwitz)

[3] Robert Bromberg, Tax Planning for Hospitals, 1977.

their distinctive communities. The following two examples vividly illustrate the benefits of that flexibility:

HonorHealth in Scottsdale, Ariz., supports the communities it serves through a variety of programs that increase access to health care, provide early childhood education, food bank access, senior day care, and trauma and deployment training for the military professionals. A few examples of the programs and services it provides include distributing 15,000 food boxes to families in need in 2021 through Desert Health. It has an affiliation with a local federally qualified health center to provide more comprehensive care to those in need, including dental and behavioral care, health and nutrition education, and other community resources. It also has a special Military Partnership Program to provide professional educational training to members of the military in areas such as readiness skill sustaining training, medical simulation and nurse transition.

St. Joseph's Health in Paterson, N.J., works with a wide range of community partners, including faith-based groups, civic and social organizations, schools and universities, as well as professional groups to offer a wide range of health information and services. Some examples of its commitment to the community it serves include educational programs on autism, diabetes, obesity, asthma and the dangers of substance abuse provided through St. Joseph's Children's Hospital. It also provides educational programs and support services for parents of infants and toddlers from birth through age three, with a special focus on children with developmental delays and disabilities. Through its Diabetes Education Center at St. Joseph's Wayne Medical Center nurse educators provide monthly education and support groups for people with diabetes.

COMMUNITY BENEFIT REPORTING

In 2008, as part of a major overhaul of Form 990, the IRS developed Schedule H, which is a form for reporting the range of community benefits tax-exempt hospitals provide. The form inquires about a number of areas that pertain to tax-exempt obligations in addition to charts for reporting community benefits at cost. Those include financial assistance, Medicaid underpayments and those from other means-tested programs along with community health improvement services, health professions education, subsidized health services, research, community building, bad debt (attributable to those who would have qualified for financial assistance) and Medicare underpayments. All of those areas pertain directly to a hospital's community benefit activities and obligations. While the form does not encompass the entire range of care, services, goods and beneficial activities hospitals provide to their communities in service of their health and wellness, it is a good start and hospitals can provide more detail in Schedule O. Schedule O implicitly recognizes that "ease of measurement does not make uncompensated care costs more valuable, financially or otherwise, than providing a mix of services that is less driven by relative profitability."[4]

---

[4] Horwitz at 340.

The AHA has been collecting comprehensive information on the benefits reported in Schedule H since 2009.[5] Since then, the amount of community benefit has remained steady at roughly 11%-14% of total hospital expenses with financial assistance and Medicaid underpayments counting for about half or more of the total.

	Financial Assistance & Certain Other Community Benefits	Total Benefits to the Community
	All Hospitals	All Hospitals
2009	8.4%	11.3%
2010	8.2%	11.6%
2011	8.9%	12.3%
2012	8.8%	12.3%
2013	8.6%	11.7%
2014	N/A**	N/A**
2015	10.0%	13.3%
2016	10.0%	13.7%
2017	10.3%	13.8%
2018	10.3%	13.9%
2019	10.5%	13.9%

***All data are presented as a percent of total expenses**
**** 2014 results year was skipped for 2015**

In total, since reporting began hospitals and health systems have provided between $894 billion and $1.3 trillion worth of community benefit, demonstrating an outstanding commitment to their communities. AHA's annual Schedule H report contains a more detailed breakdown for the total by size, location, type and system-affiliation along with an explanation for the bad debt and Medicare underpayment categories. Both the latter categories represent benefits to patients who needed assistance and gaps filled due to pervasive underpayments.

COMMUNITY BENEFIT – WILL IT BE AFFECTED BY THE PANDEMIC?

The suggestion that community benefit declined during the pandemic is premature speculation because no comprehensive data is yet available for tax year 2020. Either the forms have not yet been filed because the IRS allowed more time for filing or they have not been processed by the IRS.

---

[5] 2014 was an exception.

First, it's important to recognize that there may be no better example of the benefits hospitals provide to their communities than the role they played during the COVID-19 pandemic. Many hospitals collaborated extensively with local public health authorities to implement COVID-19 mitigation strategies, and those effects were felt far beyond the four walls of any hospital. In addition, hospitals and health systems developed public awareness campaigns, and later in the pandemic, served as vaccination sites, working with their staffs and other resources to stand up a rapid vaccination effort to curb the spread of new cases. This activity is a reflection of the energy, commitment and dedication of hospitals' teams, which may never be fully accounted for on a balance sheet or cost report but should be acknowledged nonetheless.

However, there are a number of factors that could impact the amount and distribution of community benefit during this unprecedented period. First, many hospitals implemented changes to the financial assistance policies to make them more generous.[6] However, the impact of those changes could be offset by the dramatic drop in hospital inpatient and outpatient volume in 2020 and continued instability in 2021. Many states restricted hospital volume or capacity in 2020 and 2021. For example, hospitals and health systems in Arizona were limited to 80% occupancy and at least 10 other states imposed a similar policy, reserving between 20%-30% of licensed or intensive care unit ICU beds in case of another COVID-19 surge.

Another factor that could affect the amount and distribution of financial assistance is health insurance coverage gains during the pandemic. The national uninsurance rate reached an "all-time low" of 8% in the first quarter of 2022 due in significant part to increased marketplace premium subsidies and maintenance of effort requirements on state Medicaid programs boosted.

Meanwhile, another factor is that during the pandemic Medicaid and the Children's Health Insurance Program (CHIP) enrollment grew significantly at the same time more than 39 states made temporary changes to boost Medicaid payment rates. Medicaid and CHIP enrollment grew by 23.3 million enrollees; nearly two-thirds of that increase is among low-income adults (63%) and nearly one-third is among children.[7] Combined with volume declines, those temporary expedients presage a dip in Medicaid underpayments. However, as the public health emergency ends, some estimates say 15-18 million people could lose Medicaid coverage, likely boosting the demand for financial assistance and Medicaid underpayments in subsequent years.

CONCLUSION

The benefits hospitals and health systems provide to their communities far surpass any other sector of health care. Tax-exempt hospitals provide a wide range of benefits most

---

[6] 2022 JAMA study
[7] Kaiser Family Foundation

of which are publicly reported each year. Much of the benefits can be tallied from those filings and every year since reporting began they have exceeded the benefit conferred by their federal tax exemption. More importantly, both the numbers and the range of benefits — from financial assistance for care, to backstopping federal programs that consistently underpay, to training and research, community support and the thousands of other efforts hospitals make to promote and protect the health and wellbeing of the communities — demonstrate hospitals' commitment to their communities and their enduring value.

Appendix 1.
Sampling of Community Benefit Examples – April 2023

UCHealth (Denver, Colo.)
The At-Risk Intervention and Mentoring Program (AIM) at UCHealth University of Colorado Hospital, is a hospital-based violence intervention program that addresses violence as a health issue, aiming to reduce upstream risk factors while enhancing protective factors. AIM specifically identifies youth and adults in the Denver metro area who are at risk of repeat violent injury and links them with hospital and community-based resources that tackle underlying risk factors for violence. The AIM program — an expansion of the program at Denver Health — utilizes best practices, trauma-informed care and a public health approach to provide care. It relies on culturally competent and highly trained outreach workers, paired with public data and research, to interrupt the cycle of violence within these communities. These outreach workers offer support in myriad ways. They meet with patients and their families when they are admitted to the hospital after sustaining an intentional violent injury. They build trusting relationships through culturally sensitive, trauma-informed care. And workers continue to follow patients and families long term to ensure they are connected with support to aid in their healing and recovery process. The list of services they provide ranges from mental health and substance use to legal support, job training and much more. Part of a national effort called The Alliance for Violence Intervention, which builds and connects violence intervention programs and promotes equity for victims of violence globally, AIM is run in partnership with the Gang Rescue and Support Project (GRSP). GRSP is a peer-run, intervention program that works with youth who are at-risk of gang involvement or are presently active in gangs, helps families of gang victims and serves as a youth advocate.

Samaritan Health Services (Corvallis, Ore.)
Responding to community needs is essential to Samaritan Health Services' mission of "Building Healthier Communities Together." To that end, the health system collaborates with other local nonprofit organizations to serve people who need health care, regardless of their circumstances and ability to pay, and to help meet other social determinants of health. These efforts are backed up by Samaritan's vast investment in community health. In 2022, the health system invested more than $174 million in a wide range of community health improvement activities, including programs and workshops attended by more than 28,000 people, health-related research with 915 participants, training for 1,448 health professionals, and grants to local nonprofits in support of health initiatives. Community benefit services include veterans support, chaplain services and maternity care coordination, to name a few. One example of Samaritan Health Services' investment in its community is its partnership with Pathfinder Clubhouse in Corvallis. This organization provides low-barrier, nonclinical support and other resources to improve the lives of adults living with mental illness. Visit www.samhealth.org/CommunityBenefit for more information.

UMass Memorial Health (Worcester, Mass.)
In 2021, UMass contributed $268.1 million to positively impact the health and well-being of the communities it serves. These community benefit contributions include charity care, subsidized health services, education of health care professionals, research, community-based programming and partnerships. In addition, $85.8 million was absorbed through bad-debt write-offs and Medicare shortfalls. The health system adopted a systemwide anchor mission to address social determinants of health in economically challenged neighborhoods. This initiative is engaged in housing and neighborhood revitalization projects. For example, in 2021 Worcester Common Ground completed a 31-unit housing project to low-income residents. The building features a large community room and a rooftop greenhouse where tenants can grow vegetables in partnership with a youth agriculture program – UMass Memorial invested in this community health improvement effort to address housing and food insecurity. UMass Memorial Health has a strong partnership with UMass Chan Medical School the state's first and only public academic health sciences center along with the Center for Clinical and Translational Science. It works to educate physicians, scientists and advanced practice nurses to advance health and well-being through pioneering advances in education, research and health care delivery. In addition to participating in cutting-edge research, the health system's physicians, staff and students commit countless hours to public service efforts to make the region a healthier place to live by harnessing the skills and expertise of the organization to address pressing local needs, such as yearly free flu vaccinations clinics for elderly and other vulnerable populations.

Wellstar Kennestone Hospital (Marietta, Ga.)
Just as health care can extend beyond the doctor's office, learning can extend beyond the schoolroom. Wellstar Kennestone Hospital and its affiliated OB/GYN and pediatrics offices, recently implemented the Talk With My Baby program in an effort ensure that all babies and toddlers gain the foundational skills necessary to build literacy. Supported by a grant from the Joseph B. Whitehead Foundation, the goal of the program is to ensure that every child can read by third grade. Eighty-five percent of brain growth occurs during the first three years of life, and much of that can be encouraged with regular verbal interaction. The program will educate and support new parents in their important role as their child's first teachers. Books, of course, are an important resource, but songs, eye contact and just chatting with a young child are all vital parts of building strong language centers in the brain early on. This effort is focused on creating a connected ecosystem with schools and early childhood educators to enhance literacy and create a national model that can be expanded to serve and support our country's youth. Georgia ranks 41st out of 50 states for literacy, and literacy rates are closely tied to race, ethnicity and ZIP code. This program aims to remove those barriers to equity and equip parents with the tools and knowledge they need so that they, in turn, can support their children. Working with patients and the community, the Talk With My Baby program will help build strong scholars before the school years have even begun.

Meritus Health (Hagerstown, Md.)
Meritus contributed more than $57 million in benefits to the community in fiscal year 2022. The majority of that community benefit was provided through mission-driven health care services, the crucial and foundational support the health system provides to advance health and well-being in the community. Access to health services for all remains a priority with more than $10 million reported for charity care, the free or discounted health and health-related services provided for patients who cannot afford to pay their medical bills. Meritus Health believes that health care is not just for people when they are sick or injured. When obesity was determined to be a top ranked health priority in Washington County, Meritus Health collaborated with the local public health department to create "Healthy Washington County" a coalition of public and private organizations whose mission is to strengthen the health and wellness of our community and residents. Meritus is working to "Go For Bold" and support the community to lose 1 million pounds by 2030. The health system also is investing in the health of the community through the proposed Meritus School of Osteopathic Medicine to ensure that access to care in the

community continues for generations to come, providing community-based medical education and by supporting the education of well-trained and socially responsible physicians.

Baystate Health (Springfield, Mass.)
In 2021, Baystate Health hospitals provided over $153 million community benefit including research and educational programs. Research discoveries can translate into better patient care — now and in the future. Baystate researchers conduct clinical, translational and health services research in many medical and surgical specialties and also participate in national clinical trials that study potential new treatment methods and contribute to the advancement of science. Baystate has a technology innovation center that works with technology companies — from one-person startups to tech giants — on innovations like remote monitoring technology and e-visits with health care professionals. The Department of Healthcare Delivery & Population Sciences leverages expertise in population health, clinical effectiveness and outcomes research to focus on making health care more effective and efficient. For example, medical students in Baystate's Population-based Urban and Rural Community Health track were embedded in local community service organizations as part of their Population and Community Health Clerkship to focus on priorities identified by the community including, substance use in rural areas, gun violence, the digital divide for Spanish speakers, and food deserts. Students discussed their projects in a virtual presentation to legislators, community members and faculty.

Mon Health Medical Center (Morgantown, W.Va.)
Mon Health has partnered with local community organizations and health care providers to break down barriers and get people back in the workforce, in particular those who are living in shelters or have lost their job due to COVID-19. Called Pathways to Success (P2S), the initiative is designed to empower positive systemic change that improves the health and lives of individuals in the community. The first P2S cohort included individuals who filled roles at the medical center in housekeeping and environmental services, guest and customer services, registration and nutrition and food service. The program — described as a "hand up" not a "handout" — provides education and training, reliable transportation, health care benefits, daily meals, mentorship and more. As a result of the pilot program, individuals have moved out of a shelter and into their own homes, and others are in the process of securing housing because they now have a steady income. Some individuals have been reconnected with family. To sustain the program and work toward long-term success, the program will continue to partner with community referral organizations.

AtlantiCare (Egg Harbor Township, N.J.)
AtlantiCare is starting early in developing the next generation of health care workers. The hospital hosted its inaugural High School Hiring Blitz, interviewing high school seniors who want to start building their careers in health care and enhance their college applications. The goal is to support students who are looking for learning opportunities and financial resources; build relationships with the next generation of health care workers early on. The high school seniors will work at AtlantiCare Regional Medical Center's hospital campuses and other areas of the health care system. Jobs include full-time and part-time positions with benefits, as well as pool positions.

UK HealthCare (Lexington, Ky.)
UK HealthCare views community partners as "a large part of who we are." The Healthcare Jumpstart Program is a partnership between the health system, Bluegrass Community & Technical College (BCTC) and school districts in the state to support students interested in a health care career and also to increase interest in the health care field. In addition, the program will establish a workforce pipeline "to fill critical roles" at hospitals and other health care settings. The Healthcare Jumpstart Program offers students an accelerated path to a nursing career by "providing resources and learning opportunities to earn dual credit while in high school so that they can get a head start on their college education," according to the UK HealthCare announcement. The dual-credit courses are prerequisites for an associate degree in nursing, or ADN. Students who successfully complete

the program at BCTC will be eligible for tuition scholarships and guaranteed employment. Program leaders say that Jumpstart students would be able to earn their ADN in less than two years after high school, preparing them to work as a registered nurse. Advanced practice providers from UK HealthCare will teach some of the BCTC courses. By providing young students with the educational and financial resources to pursue a health care career at an accelerated pace, UK HealthCare is reinforcing their commitment to creating a healthier Kentucky on every level.

Banner Health (Phoenix, Az.)

As a retirement destination, Arizona has the fastest growing rate of Alzheimer's disease in the nation. The state is expected to see an increase of 33% or more in older adults living with Alzheimer's between 2020 and 2025. Banner Health and the Banner Alzheimer's Institute are introducing a new standard of care that provides ongoing hope and help for people with Alzheimer's and their families. One of the health system's key focus areas is promoting brain health in underserved communities. Some of the latest efforts include:

- In partnership with Dignity Health, Mayo Clinic and advocate organizations such as the Alzheimer's Association, Banner Health hosted a day of health and wellness activities aimed at addressing critical health conditions in communities of color and other underserved individuals and families. The focus was on promoting brain health, heart health and stopping the spread of COVID-19. African Americans and Hispanics are disproportionately affected by heart disease, various types of dementia, such as Alzheimer's disease and COVID-19. Education shared at the event underscored how a health, active lifestyle can decrease the risk of dementia by 40%.
- Banner Health collaborated with Arizona State University on new research that more accurately detects early indicators of the Alzheimer's disease through neuroimaging — generating images of the brain — and ways to more clearly visualize its physiological signs. Advances in neuroimaging and related medical technologies help physicians better understand how Alzheimer's disease is developed, how it progresses over time and enable data-driven approaches that will lead to effective treatments that will slow down disease progression and prevent or even cure the disease.
- Banner Health supports The City of Phoenix Memory Café Program, which provides persons living with early to moderate dementia a safe place to socialize and participate in activities facilitated by professionals that stimulate and support brain health. Memory Cafes offer opportunities for care partners to engage in supportive conversations with others and learn how best to support their loved ones.

Chairman SCHWEIKERT. Thank you, Ms. Hatton.

Now we're going to have some questions, and the benefits of being chairman, I get to go first.

Ms. Lucas-Judy, a very simplistic question. If the IRS documentation were updated, Ms. Hatton just said the last time the form was updated was 2008, what would we change to make it so we would have a commonality of understanding of the community benefit being offered with this exemption.

Ms. LUCAS-JUDY. Well, as you probably know, IRS recently came out with its strategic operating plan for using the funds from the Inflation Reduction Act, and part of the vision that was laid out there was one of the initiatives was to revise forms in general to try to make them more user friendly, more transparent, make them easier——

Chairman SCHWEIKERT. You beat me to my punchline. So what would you do to change the design of the form? What are the couple things we need to know?

Ms. LUCAS-JUDY. So some of the things you need to know would be what is it that hospitals are doing to address the community benefit. I mean, right now, it's scattered on several different parts of the form and some of the information is collected through a quantitative or a, you know, sort of contained kind of answer. Some of it, as we mentioned, three of the factors are addressed generally in a narrative that's then not captured in the electronic version.

So it's difficult—from what we heard from hospital associations, it's difficult for them sometimes to even know what to include where on the form, what kind of information would be useful. And then it's difficult for users, for members of the public, for Congress, for researchers to be able to know where to look on the form to find the answers as to what is it that a hospital is providing.

Chairman SCHWEIKERT. So an update in the design of the form.

Ms. LUCAS-JUDY. Right.

Chairman SCHWEIKERT. Ms. Hatton, do you agree that at least we could ever throw together a working group to just update the way we accept that information?

Ms. HATTON. So, Mr. Chairman, we—a working group would be good. And that's actually originally how the Schedule H form was designed, by a working group. I think one of the things this committee could consider, the IRS is not one of the agencies that's subject to notice and comment, so when they update a form, when they update instructions, they don't go out to the public and those most affected——

Chairman SCHWEIKERT. And to your——

Ms. HATTON [continuing]. To get——

Chairman SCHWEIKERT. To your point, you're actually making one of the reasons for this discussion.

Ms. HATTON. To widespread—you know, to determine from the communities the ways in which the form could be, you know, made easier so that it would be easier for community members to use them. I mean, I think it's important that we don't ever define community out of community benefit because those are the individuals that really best understand the impact of the programs and the

services that the hospitals are providing. And the ability for them to use the form and understand the form more easily is paramount.

Chairman SCHWEIKERT. Understood. But much of my concern there is actually much more mechanical. You know, when we all look at the form to be able to make policy decisions off the data.

Ms. Bai, you said a couple things that I need to understand as an accountant or as an expert in public accounting. How did you get to the conclusion of here's your value of the tax exemption and here's what you see being put out in charitable care, community benefit? Could you first walk us through the numbers as your research demonstrated, and how did you partially get to that math?

Ms. BAI. I love that equation analogy. Yes. On one side, let's first look at taxpayer subsidiaries, right. Right now, let's assume the—let's put aside whether eight categories of charity—of community benefit is justifiable or not. Let's assume they are. Then IRS Form 990, Schedule H already has very explicitly, right, charity care, Medicaid, shortfall, everything listed by the line. But what is missing is how much taxpayer subsidies received by these hospitals at the hospital level.

Let's say we add three lines on the Schedule H. Number one, forgone property tax. Number two, foregone sales tax. Number three, 340B profit or gross profit. So that will help tremendously for the public and the stakeholders at every level to compare that on one hand you have the taxpayers subsidies; on the other hand, what is the tax benefits, right, and how much you give back to community.

And also, by the way, this is a very conservative measure. Why? Because a lot of the community benefit categorized, you know, charity care, Medicaid shortfall, and education, you know, all these things also provided by for-profit hospitals as well. So this is a very conservative measure.

Chairman SCHWEIKERT. Well, first—and back to one of the cores of the question. Here's the value—as you were looking at nonprofits, here's the value of those levels of tax benefit. Over here is what you saw going out in charity care, community benefits. And I will tell you, I had a hook at the end. I wanted to see across the country how many received dis pro share, disproportion share benefits also as a backfill. What is that differential in your research? What's the gap?

Ms. BAI. So that is the reason we are here, right, to discuss this—because there's no way to know at the hospital level how much is the taxpayer subsidy. Now our friends have already estimated, but that is at the national level, and that's based on a lot of assumptions.

At the individual hospital, you know, how much is the income tax that they would have paid if they had been for profit? There's no way to know because a taxable income is very different from this closed accounting income. And also property tax, right, we do not know. And, you know, think about the hospitals, you know, in a very wealthy area. They're property tax is going to be very high, right, compared to a hospital in a rural area. So that's why we need the disclosure. We need IRS to have the disclosure on the Schedule H.

Chairman SCHWEIKERT. Well, Dr. Bai, but in some of your testimony you actually have some estimates of what that gap is.

Ms. BAI. So that I think is from Kaiser Family Foundation. They have about 28 billion dollars.

Chairman SCHWEIKERT. Oh, that's the—that's Kaiser's estimate——

Ms. BAI. Yeah.

Chairman SCHWEIKERT [continuing]. Of the value of the tax exemption.

Ms. BAI. Mm-hmm.

Chairman SCHWEIKERT. And do we have actually—in any of your research, have you ever attempted to do the value of the, let's just call it charity care?

Ms. BAI. Charity care is lower than that, yes.

Chairman SCHWEIKERT. Okay.

Ms. BAI. So we have the same conclusion. So the tax exemption value as estimated is actually lower than—sorry, it's higher than the charity care provided. Thank you.

Chairman SCHWEIKERT. Okay. Dr. Bai, my last question is, how did you come up with the calculation that you believe many for-profit hospitals are actually taking and providing more as a percentage of their book of value in charitable care?

Ms. BAI. Thank you so much. The for-profit hospitals are minority, right, in the hospital industry. So we found in 2018 for every 100 dollars expense incurred by hospitals, the for profit provided, this in aggregate, a $3.80. Okay. That's in aggregate. But for nonprofit, it's about $2.30. So that means the nonprofit, the aggregate provide the less charity care than for profit counterpart, which actually pay tax. And I have no reason to believe that things have changed in 2019 or 2020. But that's the overall picture.

And we found similar results for Medicaid shortfall, which is also one of the most important community benefit components. The nonprofit do not have evidence—you know, there's no evidence that the nonprofit hospitals provided more Medicaid shortfall then for-profit hospitals, which again, pay all the taxes.

Chairman SCHWEIKERT. Okay. The last thing and then we'll go to our ranking member. When you've been doing your calculations, were you also able to see if there were certain state backfills, like in our Arizona system or in disproportionate share that also backfills some of these—the charity care?

Ms. BAI. That we did not examine. You know, Chairman, so we—our—right now there's no benchmark, right. We do not know if the charity care or community benefit is sufficient or not. That's why we chose to look at a benchmark using for profit ones.

Chairman SCHWEIKERT. Okay.

Ms. BAI. Yeah.

Chairman SCHWEIKERT. All right.

Ms. BAI. But that's a great question.

Chairman SCHWEIKERT. Thank you, Doctor.

And to our ranking member, Mr. Pascrell.

Mr. PASCRELL. Ms. Hatton, all the folks that gave testimony today know what they're talking about. I want to ask questions in a particular area. You touched on it, so you're going to get most of the questions.

So please share some of the upstream projects our nation's nonprofit hospitals have undertaken to address social factors of health

in the wake of COVID–19. Could you tell us some of those projects so we can put it in context what we're all talking about?

Ms. HATTON. Thank you. During COVID–19, hospitals stepped up into many shoes. They worked with a public health agency. In fact, many of them became the public health agencies to both develop effective testing kits, to reach out to their communities to provide effective information and accurate information on both the virus and the vaccines. And many of them stood up vaccine sites in very innovative ways to assure their communities got vaccines.

One of our favorite examples is in Charlotte, North Carolina. One of our hospital systems partnered with the Charlotte Motor Speedway to be able to give vaccinations to those in attendance at the race. So hospitals really stepped in an enormous way to fill those kinds of gaps, all of which I think—all of which, you know, shows—demonstrates commitments to their community.

There are many other upstream activities that hospitals also undertake around social determinants of health. Whether it's food pantries, whether it's education, whether it's training, whether it's work training, whether it's education for professionals. One of the gaps—one of the workforce gaps that I think this committee is very aware of, in particular, is the shortage of nurses. And we find that many of our hospitals are spending considerable resources to open training opportunities—to give training opportunities to nurses because every year there are many more applicants for nursing slots than there are training opportunities.

Mr. PASCRELL. Let me ask you this. The Ernst and Young report, a very specific report, very specific about what we're talking about today, that report was from 2019, I believe. Nonprofit hospitals provided over 51 billion dollars in unreimbursed expenses in means tested government programs. Do you have a sense of what that amount was in 2020 to 2021 during the height of the pandemic? Does anybody?

Ms. HATTON. We don't yet have that information, both because the IRS gave tax-exempt hospitals some additional time to file their Form 990s and Schedule Hs, but also because the IRS is behind on processing them.

Mr. PASCRELL. Has everybody filed?

Ms. HATTON. So we won't have—we don't expect to have that information til closer to the end of the year.

Mr. PASCRELL. Has everyone filed, now that we're in 2023?

Ms. HATTON. We don't know if everyone's filed. Again, hospitals—the IRS gave hospitals an extension on filing for this year because of the pandemic, so the number of actual Schedule Hs that are available are just a fraction of what you usually see this time of year. And again, there's some processing issues on the part of the IRS. So again, we don't expect to have that data until later this year, but when we do, we'll be happy to share it with the subcommittee and do our annual Schedule H report on that data.

Mr. PASCRELL. Can anyone add anything to—Dr. Bai.

Ms. BAI. Thank you. Thank you, Ranking Member. In our study, we did not have direct number on the—you know, what you just mentioned. But we found that overall profitability of hospitals actually increased during pandemic. Why? Because of relief money.

So looking at—operating income went down because, you know, no patients came and a lot cancelled, delayed procedures. But because of the relief money received, they actually enjoyed a higher financial viability, higher profitability than before the pandemic. In other words, Congress have provided them more than their fair share to endure the pandemic. That's what our study found.

Mr. PASCRELL. My time's out, but God bless you. Providers and patients, I hear this all the time and so do you, the healthcare workforce is in crisis. Tell me how this has impacted our nation's nonprofit hospitals. Just be brief, but to the point. Speak up, please. You shut your mic off?

Ms. HATTON. No, it should be on.

Mr. PASCRELL. Now you put it on.

Ms. HATTON. Okay, sorry. The chronic shortages in workforce started before the pandemic but they were greatly exacerbated by the pandemic and persists today. Nonprofit hospitals were impacted—have been impacted a number of different ways, including by the costs, particularly of contract labor going up twice or three times what they were before the pandemic. In fact, a number of the members of this subcommittee signed a letter to the Federal Trade Commission asking it to investigate staffing—price—alleged price gouging by staffing agencies because of those price increases.

The price of materials skyrocketed and continue to sky—has continued to skyrocket. And just the general inflation that we see in the economy has also impacted hospitals. So all of that has made the workforce shortage a top priority, you know, for America's hospitals. And many—as I indicated earlier, many community benefit efforts on the part of nonprofit hospitals are now being directed to train individuals to try to alleviate that shortage.

Mr. PASCRELL. Thank you very much for your testimony, all of you. And thank you, Mr. Chairman.

Chairman SCHWEIKERT. Thank you, Mr. Pascrell.

Mr. Fitzpatrick.

Mr. FITZPATRICK. Thank you, Chairman Schweikert, for holding this important hearing.

In my home state of Pennsylvania, we do not have a public hospital system. In 2021, uncompensated care in Pennsylvania approached 900 million dollars, an increase of just under five percent from 2020.

My first question, Ms. Hatton, how—in your estimation, how, if at all, has the amount of community benefit provided by tax-exempt hospitals changed over the years?

Ms. HATTON. The amount of community benefit actually since we've been measuring it for Schedule H has remained quite steady, between 11 and 14 percent of hospital expenses. And again, about half of that has been for financial assistance, Medicaid underpayments, and other means tested programs.

Mr. FITZPATRICK. And your testimony mentions that the national uninsurance rate reached an all-time low of eight percent in the first quarter of 2022. How do you believe that has impacted the amount of community benefits, including charity care, that the hospitals are not providing?

Ms. HATTON. We don't yet know that for certain, but we expect that that will mean that there is likely more impact on Medicaid

underpayments in the future because with more individuals qualifying for Medicaid during the pandemic.

Mr. FITZPATRICK. Okay. I yield back, Mr. Chairman.

Ms. HATTON. Did I misunderstand your question?

Mr. FITZPATRICK. No, you got it.

Ms. HATTON. Okay.

Mr. FITZPATRICK. I yield back.

Chairman SCHWEIKERT. Thank you, Mr. Fitzpatrick.

Ms. Chu.

Ms. CHU. Ms. Hatton, in your testimony, you highlighted the importance of having flexibility in the community benefit standard to allow hospitals and health systems to support the social determinants of health that most impact their specific communities, including safe housing, nutritious food, and transportation. For example, in my district in California, Monterey Park Hospital uses their tax-exempt status to provide free transportation to and from the hospital for patients within a ten-mile radius for outpatient services, emergency room service, surgery, and admissions.

Can you expand on the importance of sustaining this flexibility in the community benefit standard so that hospitals can tailor their services to the unique needs of their communities?

Ms. HATTON. One of the geniuses behind the community benefit standard has been exactly that kind of flexibility so that hospitals can look at their communities to determine what it is they need. Is it food insecurity, is it transportation needs, is it employment, is it—you know, is it education? What exactly are the deficits?

And I should also mention that hospitals do this in a couple of different ways, including through the community health needs assessment, where they work with the community and public health authorities to determine exactly what the highest priority needs are in that community, and they work together, again, with these same groups to develop a plan and actually evaluate the impact of the plan.

So the community benefit standard and its flexibility has been essential to allowing communities of all sizes with all different needs really to be able to prioritize those health issues that they can tackle along with their communities.

Ms. CHU. And do you think Form 990, Schedule H captures the amount that hospitals are putting in, such as this?

Ms. HATTON. I think it's probably an undercount, particularly on social determinants of health. One of the recommendations that we had and others have had is to elevate the importance of social determinants of health and make it more clear and I think more evident to those who are filling out the form of the importance of capturing that information and putting it on the form.

Ms. CHU. Director Lucas-Judy, it's clear that there are many nonprofit hospitals that deliver community benefits to our communities, but in recent years, certain tax-exempt hospitals have pursued aggressive debt collection, denied charity care to those who qualify, and have engaged in anticompetitive practices at the expense of patients and taxpayers. In your testimony, you mentioned that hospitals Form 990 and Schedule H can be the primary or sole source of information available to the public to understand the

community benefits provided by a tax-exempt hospital. You pointed out certain deficiencies in the reporting.

And I'd like to know specifically what sort of things would you change to update Form 990, Schedule H to include clearer information to the general public and to Congress. For instance, what would you do about the narrative issue, because you outlined that the narrative doesn't get transmitted to the public at all in the electronic reporting? And then also, would you require an answer, because you pointed out that some hospitals had extensive answers there and some had nothing at all. And would you eliminate some questions, like the provision of emergency care at the emergency room?

Ms. LUCAS-JUDY. Well, what we looked at is what is IRS doing to determine the extent to which hospitals are providing community benefits and what is it that they're reporting as part of that oversight. And what we found was that the form really doesn't allow anyone to do that because the—for one thing, the community benefit standard itself really is not a standard, it's a series of examples of things that could be provided.

But even if you were looking at those factors that currently make up the community benefit standard, they're on different parts on the form, and as I mentioned, they're—some of them are closed-ended questions, some of them are open-ended narrative and sort of more optional. That narrative question tries to address several of the factors, and even go beyond, and so IRS really is left with a facts and circumstances determination in each case.

And so, you know, one of the things for a good tax system is to make sure that you're treating similar taxpayers similarly, and right now you really can't do that, either with the standard as it currently is determined and also in the reporting itself.

Ms. CHU. So what would you do about the narrative problem?

Ms. LUCAS-JUDY. Well, that would be something that it would be up to IRS to determine how to do, but if those factors are important, then we think that IRS could design the form in such a way so that the factors are more clearly addressed.

Ms. CHU. Thank you. I yield back.

Chairman SCHWEIKERT. Thank you, Ms. CHU.

Mr. Steube.

Mr. STEUBE. Thank you, Mr. Chairman.

Nonprofit hospitals derive substantial benefits from their tax-exempt status, but in some cases aren't providing the charity care that their nonprofit status requires. Nonprofit hospitals have an obligation to serve indigent patients and not try to push them off on other hospitals, but the numbers show they aren't doing this.

For instance, in 2020, nonprofit hospitals received almost 40 percent more in tax benefits than they provided in charity care. A New York Times report found that a nonprofit hospital in New York City received nearly 250 million in tax benefits a year for which they are supposed to provide charity care. But according to the report, that hospital routinely told ambulance workers to take homeless patients to other hospitals.

My question is for Dr. Bai and Dr. Levinson. There are several requirements that tax-exempt hospitals must meet to maintain tax exemption, two of which include maintaining a written financial as-

sistance policy for needy patients and the requirement that hospitals set billing and collection limits. But we are increasingly hearing about how some nonprofit hospitals are making it difficult for eligible patients to get financial assistance, are delaying checking patient's eligibility for financial assistance, and are sometimes engaging in aggressive billing and debt collection practices.

Are you familiar with these practices, and if so, can you elaborate on the practices you have seen from some hospitals? I'll start with Dr. Bai.

Ms. BAI. Thank you, Representative Steube. Thank you very much for the question.

What we have seen is that hospitals have 100 percent discretion in designing those eligibility criteria, right. To start, if you have your resource available, you can make the policy very generous, so many people would have been qualified to receive charity care. That's number one.

But the way we are seeing it is, no, many hospitals did not do that. And beyond that, as you already mentioned, they are trying to make the charitable—charity care policy very obscure. So patients under stress would not be able to find the policy, so they would lose the opportunity to apply for it. And then after that, once they incur that, some hospitals go into very aggressive techniques to go after them, garnish wages, et cetera.

So these, as you mentioned, this is really against their charitable mission, not consistent with what's the purported mission statement.

Mr. STEUBE. Dr. Levinson, do you have anything to add to that?

Mr. LEVINSON. I agree with everything Dr. Bai said. I should also mention, there—again, it is a requirement that hospitals have a financial assistance policy in place. As Dr. Bai was mentioning, there are fairly limited requirements of what that financial assistance policy has to entail, and that both includes who is eligible for charity care but also it grants hospitals substantial flexibility in their application procedures and how often they have to notify patients of their eligibility.

So, for example, hospitals are currently required to make a reasonable effort to determine eligibility before taking extraordinary collections actions. However, that could, for example, include notifying a patient of their eligibility and giving them four months to apply for financial assistance.

There's some areas of the country where states have required more transparency around financial assistance policies, such as sending patients information about financial assistance with every bill that they receive and once their bill goes to collections.

Mr. STEUBE. And when—and I'll just stick with you, Dr. Levinson, if that's okay. When nonprofit hospitals aren't providing the charity care that they are obligated to provide, how does that impact other hospitals that are in the area? Dr. Levinson first, and then you can add, if you want.

Mr. LEVINSON. Thank you for that question. So, you know, in theory, it most directly impacts the patients at those hospitals who ultimately might be saddled with medical debt. It could also I think conceivably lead to some patients choosing to receive their care at

other hospitals where those hospitals will in turn be obligated to cover their charity care costs.

Mr. STEUBE. Dr. Bai, do you want to add something to that?

Ms. BAI. Yeah, thank you. And more importantly, you know, these patients are not high-income patients, right. Many of them are struggling, working class Americans, very marginalized. And if they are being collected—you know, very aggressively pursued for medical debt, they might just give up and fall into the welfare trap. That will increase taxpayer burden.

See, there is a social contract. So the taxpayers lacks the subsidy, go to nonprofit hospitals, but in return they must help taxpayers by helping those marginalized and very struggling low-income Americans so they can stay in the workforce and stop being a taxpayer's burden. So I think that is a breach of the social contract.

Mr. STEUBE. Well, and real quick, I only have a couple seconds left. And for both of you, of the various types of community benefits that hospitals provide, how many of those do hospitals receive reimbursement for through other means such as Medicare, Medicaid, DSH, 340B, et cetera? So they're taking that as well, correct? Go—Dr. Bai.

Ms. BAI. Thank you. So right now there is no transparency regarding this 340B Program, so it has become a, you know, buy low/sell high program. So that is the transparency we probably need. But in other—the DSH also is a black box. The tax exemption value also, as we have mentioned. You know, you don't have the information at the hospital level. Thank you.

Mr. STEUBE. I'd ask unanimous consent, Mr. Chairman, to add, "Hospitals Often Don't Help Needy Patients, Even Those Who Qualify." I ask unanimous consent to add that to the record. And also the New York Times article, "They Were Entitled to Free Care. Hospitals Hounded Them to Pay."

Chairman SCHWEIKERT. So ordered.

[The information follows:]

https://www.wsj.com/articles/nonprofit-hospitals-financial-aid-charity-care-11668696836

Hospitals Often Don't Help Needy Patients, Even Those Who Qualify

Some make getting aid hard, delay checking eligibility and press for payments that aren't refunded

By Anna Wilde Mathews Follow , *Andrea Fuller* Follow *and Melanie Evans* Follow

Nov. 17, 2022 10:12 am ET

Nonprofit hospitals must have financial-assistance policies for needy patients, under federal requirements tied to an estimated $60 billion in annual tax breaks.

They often make that aid hard to get. Hospitals put up obstacles, delay checking eligibility and sometimes press for payments that aren't refunded even if a patient eventually gets qualified for assistance.

That is according to a Wall Street Journal analysis of thousands of nonprofit hospital policies in filings to the Internal Revenue Service and posted by hospitals, as well as thousands of pages of internal documents from government hospitals obtained through public-record requests and the experiences of dozens of advocates and patients who have applied for aid.

Ashley Harrison seemed like a perfect candidate for financial assistance under the policy of Advocate Aurora Health, a major nonprofit hospital system.

For a visit to the emergency room of Advocate South Suburban Hospital near Chicago, where she went with symptoms that turned out to be the first signs of leukemia, she was billed more than $36,000. Ms. Harrison's annual income was about $24,000, about half the financial cutoff that typically qualifies for full bill forgiveness, according to Advocate Aurora's guidelines.

When she asked the hospital system for help in March, she didn't get it. Ms. Harrison said the hospital had told her to wait to apply for aid while insurance was pending, and then when she did apply, she was told she had waited too long. She appealed and for months Advocate Aurora representatives gave conflicting feedback about her application, she said.

"It was confusing, and long, and drawn-out," she said. One thing was always clear, she said: The bill was unaffordable. "There's no way."

Such experiences are common among patients seeking aid from nonprofit hospitals. Among the Journal's findings:

•Though hospitals have the power to prequalify low-income patients for charity care and never send a bill, about 450 nonprofit facilities—roughly 15% of the 3,100 nonprofit facilities in the Journal's analysis of tax documents—didn't report using the option.

•Even among the hospitals that told the IRS they do prequalify people, many spent months chasing patients for payment before checking eligibility. The parent organizations for roughly 1,000 of those facilities reported pursuing at least $2 billion in billings to patients who likely qualified for aid.

•In scripts and other training material for staff who talk to patients about bills, obtained through public-record requests to more than 100 government hospitals, the possibility of financial assistance is sometimes raised only as a last resort, or not at all.

An earlier Journal analysis of Medicare filings highlighted how little of nonprofit hospitals' billions in revenue goes toward financial help for low-income patients. The new analysis uncovered the barriers many hospitals place in the way of patients who should qualify for assistance—even under the hospitals' own criteria.

Under tax laws, nonprofit hospitals are set up to function as charities benefiting their communities. Government facilities, whose policies the Journal also looked at, are also intended to serve the public, though they aren't subject to all the same IRS requirements as private nonprofits. The Journal found that many of these hospitals act like for-profit businesses in their efforts to get paid, even by those who can't afford it.

Ms. Harrison's experience started when she went to the Advocate South Suburban emergency room late on Dec. 20, 2019. Then 30 years old, she was weak, unable to eat and had difficulty breathing. She was diagnosed with a possible case of acute promyelocytic leukemia, according to physician notes, and later transferred to another hospital.

Her brief stay at Advocate South Suburban generated a big bill: $36,733.13. She had two forms of insurance—Medicaid and a private plan—but neither covered the cost. Ms. Harrison said the private plan told her the hospital was out of its network. A spokeswoman for the Illinois Medicaid agency said it retracted its payment at the request of the hospital. In a written statement, she said, "there can be lots of honest, good-faith complications with claims," but that the patient shouldn't have been billed.

Ms. Harrison with her son, Amir. She said her hospital billing experience was 'confusing, and long, and drawn-out.' Photo: Jamie Kelter Davis For The Wall Street Journal

Ms. Harrison, who has a son now 3 years old, said the hospital told her she wasn't eligible for financial assistance while insurance was pending. Eventually, she started getting calls from a collection agency. A letter in March 2022 said she was past due and warned her debts can get reported to credit bureaus.

By then, Ms. Harrison had filed an aid application with Advocate Aurora, with help from Dollar For, a nonprofit that helps patients navigate hospital bills. Tax documents included with the application, filed March 9 and viewed by the Journal, showed 2019 income of about $24,000; in 2020, when she was on disability due to her cancer, she took in less than $20,000. She is still on disability.

Advocate Aurora says it typically forgives bills for patients with incomes of 250% of the federal poverty level, or around $46,000 for a family of two.

The hospital system granted no assistance, though, and she filed an appeal in June. At various times, according to Ms. Harrison and Dollar For, hospital representatives said her application came too late, or that the hospital was still seeking payment from her insurance. Meanwhile, the collection agency kept calling, Ms. Harrison said.

After The Wall Street Journal requested comment on Ms. Harrison's case in September, she said Advocate Aurora reached out to request an additional document, then informed her that financial assistance would cover her entire bill.

In a written statement, a spokesman for Advocate South Suburban called the denial a mistake, citing a change in its record system, human error and her insurer's decision not to cover the

care. "While we continue to express our apologies to our patient for her initial experience, we are thankful to have resolved this situation and provided financial assistance," the hospital spokesman said. He said the hospital has "invested in technology and made policy changes to make it easier to access financial assistance."

Hospitals often have complex financial-aid applications that require patients to reveal sensitive personal information.

Aspirus Health, a 17-hospital nonprofit system based in Wisconsin, has a 19-item checklist, including tax returns, pay stubs, retirement-account documentation, mortgage information and three months of bank statements showing all deposits and withdrawals. The form demands the make, model and loan balance on all vehicles, along with the applicant's monthly costs for 17 categories, from water and sewer charges to cable-TV bills and alimony. It also asks if any member of the household is pregnant. Patients have 10 days to complete the application, the document says.

Aspirus didn't respond to requests for comment.

Presumptive eligibility

Hospitals can choose to grant aid by prequalifying low-income patients for charity care. The process, known as presumptive eligibility, can identify eligible patients without an application, using third-party data vendors that do reviews similar to those performed to approve consumers for credit cards. Industry financial standards require only one piece of reliable information to show a patient qualifies for aid, such as an income estimate from consumer credit companies.

Major companies, including Experian PLC and TransUnion, have in recent years sold hospital services that verify which patients qualify for financial aid. TransUnion recently sold its unit to a company now called FinThrive Revenue Systems LLC, which uses information on mortgages, student loans and credit cards to calculate whether patients lack the money to pay medical bills, said Jonathan Wiik, a vice president for FinThrive's healthcare business.

FinThrive said its estimates were at least 94% accurate based on an analysis that compared an anonymous sample of results matched with income tax records. Experian said information about its algorithms is proprietary.

Advocate South Suburban Hospital, in Hazel Crest, Ill. Photo: Jamie Kelter Davis For The Wall Street Journal

Hospitals that auto-enroll patients also typically use other information from public social services, such as food or housing subsidies, or sometimes grant aid based solely on circumstances such as homelessness.

Many hospitals don't use this approach, or turn to it only after first dunning patients for months, according to the Journal's analysis.

The Journal reviewed the latest available federal tax forms for the country's nonprofit hospital organizations, which typically covered the 2020 fiscal year. The forms cover general hospitals but in some cases include a few surgery centers and other medical settings. The analysis excluded hospital organizations that left completely blank the portion of the form examined by the Journal.

Among the approximately 450 facilities that didn't indicate they used presumptive eligibility were some owned by prominent nonprofits including the Mayo Clinic and Delaware's ChristianaCare.

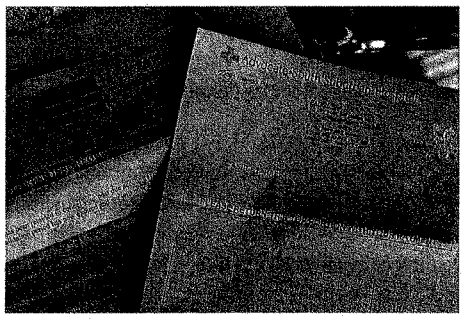
In a statement, a Mayo Clinic spokesman said it asks patients to complete a questionnaire "so we can better understand their unique situation and assist with coverage," though it automatically grants help to patients eligible for Medicaid. Mayo is now considering using data vendors to identify patients in need, but feels "socioeconomic data alone are not necessarily an accurate predictive indicator," he said.

ChristianaCare is working on a plan to offer presumptive eligibility at its two main hospitals in Delaware and expects to finish next year, said a spokesman. A smaller Maryland hospital the system owns already offers it, he said.

Nearly 2,700 nonprofit facilities reported in tax forms that they do use presumptive eligibility. But roughly 40% of that group belonged to parent organizations that reported pursuing payments from patients who were likely eligible for financial assistance—for a total of around $2 billion worth of "bad debt," or billings that they ultimately failed to collect.

That could reflect that hospitals performed the presumptive eligibility checks only after they had billed patients for months, or that they didn't run the checks on all patients, according to Keith Hearle, president of Verité Healthcare Consulting LLC, which advises nonprofit hospitals.

Hospitals are allowed by the IRS to grant patients financial assistance at the outset of billing, Mr. Hearle said. Hospital regulators, including the IRS and the Centers for Medicare and Medicaid Services, allow hospitals to use tools that prequalify patients for financial aid.



Bills related to Ms. Harrison's hospital stay. Photo: Jamie Kelter Davis For The Wall Street Journal

The delays and gaps in assessment can create medical debt for low-income patients who could qualify for financial assistance. Advocates say some patients who can't afford hospital charges pay them using credit cards, creating new financial problems.

Presbyterian Healthcare Services, which owns the largest hospital in Albuquerque and eight others across New Mexico, seeks to collect bills for 120 days before it performs presumptive-eligibility checks. About 70% of the $17.8 million in unpaid bills the system pursued in 2020 was tied to patients who were likely eligible for charity, according to what it reported to the IRS. The system at the time screened bills for financial aid after seeking to collect bills for 150 days, but has since shortened the window it seeks to collect by a month.

The hospital system considers financial-aid applications to be more reliable than tools to estimate eligibility, said Jim Noble, Presbyterian's chief financial officer. Using algorithms to identify eligible patients is "a final safeguard," he said.

Payments made by patients who are later auto-enrolled in financial aid aren't refunded by Presbyterian, he said.

Banner Health, a 30-hospital nonprofit based in Arizona, waits four months and sends at least three bills before it screens patients with unpaid charges for financial aid. Banner makes efforts to reach patients about its financial-aid policy, using mail, email and other avenues, said Becky Armendariz, a spokeswoman for Banner.

If patients pay part of their bills, then later qualify for presumptive aid, Banner doesn't refund their payments, the spokeswoman said.

Pushing for payment

Separate from the analysis of nonprofit hospitals' IRS documents, the Journal also obtained internal documents on patient-billing procedures from large state and local government hospitals, including academic medical centers, through public-records requests. These hospitals share a similar mission with private nonprofits to serve communities.

The thousands of pages of procedures, scripts and other training material for hospital staff give an inside look at how some hospitals routinely push patients toward payment, including through installment plans that may come with interest. The guidelines often play down or don't raise the option of financial assistance. Adding to the pressure, these tactics are often deployed before the patient gets care.

In a document titled "Collections Scripting for Non-Emergent Visits," used by Georgia-based Augusta University Health System, staffers are supposed to start by requesting the entire amount due from the patient, saying, "How would you like to take care of that today?"

If the patient can't afford to pay, the hospital system representative requests 75% of the sum. Then half. Then a quarter, along with a payment plan for the rest, and a warning that the "minimum deposit is required to proceed with your scheduled service." If the installments for a six-month plan are too large, the staffer can offer longer plans with interest. Only if the patient refuses all of these does the script suggest mentioning financial assistance.

If the person wants to apply for assistance, and the medical appointment is within one or two days, the staffer is told to reschedule it. This would delay the appointment rather than let it proceed without payment.

An Augusta University Health System spokesman said it reserves financial assistance for those unable to pay. "We work with our patients to help them understand their cost-sharing responsibilities and arrange for payment before incurring a bill," he said in a written statement. "However, we do not delay care if it is determined to be clinically detrimental, regardless of the ability to pay."

In a scenario used in training staff at the University of Texas Medical Branch, based in Galveston, a representative calls a patient who is likely to owe more than $5,000 for a coming procedure. If the patient can't pay in full, the hospital employee asks what the person can pay, offering smaller amounts. If that doesn't work, the representative is supposed to reach out to clinical staff—and if they say the procedure can be safely delayed, it is rescheduled.

If the procedure proceeds as scheduled, the staffer warns the patient that a bill will come later. The script doesn't mention financial assistance.

In written answers to questions, a UTMB spokeswoman said care is typically not delayed, but if it is rescheduled, it "would be a clinical decision and not a financial one." She said that after a patient is notified whether care will be delayed, "if the patient states that they cannot pay, we will talk to the patient about possible assistance." The spokeswoman said the training material "did not go into specific detail about the financial counseling process in this particular deck."

Here are some of the documents received in the Journal's records requests. Not all the hospitals made financial assistance difficult. But some hospitals' policies and scripts appeared to play down information about aid or push for payment.

Nonprofit hospitals are largely allowed to decide for themselves how much medical care to write off for patients who can't afford to pay. Nonprofit hospitals wrote off 2.3% of their patient revenue in the most-recent year available, the prior Journal analysis of Medicare filings found. That's less than the 3.4% of revenue for-profit hospitals wrote off for free and discounted care. The Journal found government hospitals wrote off the largest amount, at 4.7% of patient revenue. Amounts varied widely across hospitals nationally.

Federal rules require nonprofit hospitals to disclose the aid programs and make information about the policies available on their websites. They are also supposed to include a conspicuous written notice on billing statements and offer written summaries of the policy as part of the intake or discharge process.

Advocates say patients are often unaware of the option. One 2020 poll of 820 registered voters in Maryland, commissioned by a consumer group, found that 29% of all respondents, and 50% of Black respondents, weren't aware of bill forgiveness for low-income patients.

Ondrea Connolly said she didn't learn about the possibility of assistance until she saw a video on social media mentioning it. By the time she applied, it was too late.

Ms. Connolly had an emergency caesarean section in November 2020 at Texas Health Presbyterian Hospital Dallas. The hospital's parent system, Texas Health Resources, sent her an invitation to an online portal, where she said she saw a choice: to pay the nearly $7,000 she owed, or a payment plan.

Texas Health Resources said it does highlight financial-assistance options on the portal screen.

Ms. Connolly also didn't notice the financial-assistance disclosure in the actual billing documents. One itemized statement viewed by the Journal had detailed charges on the first four pages and a description of the financial-assistance policy on a fifth page.

Facing mounting bills, Ms. Connolly signed up for the plan with the lowest payments, which included interest. In 2021, she lost her job.

After she learned about financial assistance, Ms. Connolly applied in late January 2022 with help from Dollar For. Since she was unemployed, she seemed likely to qualify for Texas Health Resources' aid program, which typically offers help to people making less than 200% of the federal poverty level—about $46,000 in income for a household of three like hers.

Ms. Connolly was rejected because she missed the deadline for applying. She appealed, writing that she applied soon after she learned of the program. "I have no idea how I am going to continue paying my bills...please help me!" she wrote.

The reply reiterated that she applied too late. It concluded: "We appreciate the opportunity to partner with you for your health and well-being."

When she saw it, Ms. Connolly said, she cried.

A Texas Health Resources spokeswoman said it highlights financial-assistance options prominently on the billing portal screen, in monthly patient billing statements and elsewhere. She said the system encourages patients who can't afford bills to apply for financial assistance, and it gives a year from the date of care to apply, "as we feel that is an adequate amount of time for a patient to either resolve a bill through payment or to apply for financial assistance."

After the Journal requested comment on her case, Ms. Connolly said, a Texas Health Resources representative called and offered her a new plan with a lower monthly payment. She accepted.

—Tom McGinty contributed to this article.

Write to Anna Wilde Mathews at anna.mathews@wsj.com, Andrea Fuller at andrea.fuller@wsj.com and Melanie Evans at Melanie.Evans@wsj.com

Appeared in the November 18, 2022, print edition as 'Some Hospitals Skimp on Aid'.

PROFITS OVER PATIENTS

They Were Entitled to Free Care. Hospitals Hounded Them to Pay.

With the help of a consulting firm, the Providence hospital system trained staff to wring money out of patients, even those eligible for free care.

Illustration by Mel Haasch; Photographs by Jovelle Tamayo for The New York Times


By Jessica Silver-Greenberg and Katie Thomas

Published Sept. 24, 2022 Updated Dec. 15, 2022

In 2018, senior executives at one of the country's largest nonprofit hospital chains, Providence, were frustrated. They were spending hundreds of millions of dollars providing free health care to patients. It was eating into their bottom line.

The executives, led by Providence's chief financial officer at the time, devised a solution: a program called Rev-Up.

Rev-Up provided Providence's employees with a detailed playbook for wringing money out of patients — even those who were supposed to receive free care because of their low incomes, a New York Times investigation found.

In training materials obtained by The Times, members of the hospital staff were instructed how to approach patients and pressure them to pay.

"Ask every patient, every time," the materials said. Instead of using "weak" phrases — like "Would you mind paying?" — employees were told to ask how patients wanted to pay. Soliciting money "is part of your role. It's not an option."

If patients did not pay, Providence sent debt collectors to pursue them.

More than half the nation's roughly 5,000 hospitals are nonprofits like Providence. They enjoy lucrative tax exemptions; Providence avoids more than $1 billion a year in taxes. In exchange, the Internal Revenue Service requires them to provide services, such as free care for the poor, that benefit the communities in which they operate.

But in recent decades, many of the hospitals have become virtually indistinguishable from for-profit companies, adopting an unrelenting focus on the bottom line and straying from their traditional charitable missions.

To understand the shift, The Times reviewed thousands of pages of court records, internal hospital financial records and memos, tax filings, and complaints filed with regulators, and interviewed dozens of patients, lawyers, current and former hospital executives, doctors, nurses and consultants.

The Times found that the consequences have been stark. Many nonprofit hospitals were ill equipped for a flood of critically sick Covid-19 patients because they had been operating with skeleton staffs in an effort to cut costs and boost profits. Others lacked intensive care units and other resources to weather a pandemic because the nonprofit chains that owned them had focused on investments in rich communities at the expense of poorer ones.

And, as Providence illustrates, some hospital systems have not only reduced their emphasis on providing free care to the poor but also developed elaborate systems to convert needy patients into sources of revenue. The result, in the case of Providence, is that thousands of poor patients were saddled with debts that they never should have owed, The Times found.

Founded by nuns in the 1850s, Providence says its mission is to be "steadfast in serving all, especially those who are poor and vulnerable." Today, based in Renton, Wash., Providence is one of the largest nonprofit health systems in the country, with 51 hospitals and more than 900 clinics. Its revenue last year exceeded $27 billion.

Providence is sitting on $10 billion that it invests, Wall Street-style, alongside top private equity firms. It even runs its own venture capital fund.

In 2018, before the Rev-Up program kicked in, Providence spent 1.24 percent of its expenses on charity care, a standard way of measuring how much free care hospitals provide. That was below the average of 2 percent for nonprofit hospitals nationwide, according to an analysis of hospital financial records by Ge Bai, a professor at the Johns Hopkins Bloomberg School of Public Health.

By last year, Providence's spending on charity care had fallen below 1 percent of its expenses.

The Affordable Care Act requires nonprofit hospitals to make their financial assistance policies public, such as by posting them in hospital waiting rooms. But the federal law does not dictate who is eligible for free care.

Bev Kolpin, a former Providence employee in Oregon, was billed $8,000 despite being eligible for discounted care. Jovelle Tamayo for The New York Times

Ten states, however, have adopted their own laws that specify which patients, based on their income and family size, qualify for free or discounted care. Among them is Washington, where Providence is based. All hospitals in the state must provide free care for anyone who makes under 300 percent of the federal poverty level. For a family of four, that threshold is $83,250 a year.

In February, Bob Ferguson, the state's attorney general, accused Providence of violating state law, in part by using debt collectors to pursue more than 55,000 patient accounts. The suit alleged that Providence wrongly claimed those patients owed a total of more than $73 million.

Providence, which is fighting the lawsuit, has said it will stop using debt collectors to pursue money from low-income patients who should qualify for free care in Washington.

But The Times found that the problems extend beyond Washington. In interviews, patients in California and Oregon who qualified for free care said they had been charged thousands of dollars and then harassed by collection agents. Many saw their credit scores ruined. Others had to cut back on groceries to pay what Providence claimed they owed. In both states, nonprofit hospitals are required by law to provide low-income patients with free or discounted care.

"I felt a little betrayed," said Bev Kolpin, 57, who had worked as a sonogram technician at a Providence hospital in Oregon. Then she went on unpaid leave to have surgery to remove a cyst. The hospital billed her $8,000 even though she was eligible for

discounted care, she said. “I had worked for them and given them so much, and they didn’t give me anything.” (The hospital forgave her debt only after a lawyer contacted Providence on Ms. Kolpin’s behalf.)

Gregory Hoffman, Providence’s chief financial officer, said in an interview that The Times’s findings about the hospital system’s treatment of poor patients “are very concerning and have our attention.” He said Providence wanted “to get things right, on behalf of our communities and on behalf of our patients,” though he acknowledged that the Rev-Up program initially had “some hiccups,” including sending Medicaid patients to debt collectors.

Melissa Tizon, a spokeswoman for Providence, said the health system stopped doing that in December, although that was two years after an executive raised internal alarms about the practice. Providence has also instructed the debt collection firms it works with to not use “any aggressive tactics such as garnishing wages or reporting delinquent accounts to credit agencies,” she said.

Ms. Tizon said Providence was the largest provider of charity care in Washington. While the hospital system has been providing less of that care in recent years, she said, Providence has been treating more patients on Medicaid, the federal-state insurance program for poor people.

“Our practices comply with and in many instances exceed state requirements,” she said.

Paying With Poultry

The Providence hospital in Olympia, Wash., billed Harriet Haffner-Ratliffe, who was eligible for charity care, almost $2,300 after she gave birth to twins. Jovelle Tamayo for The New York Times

Providence’s transformation from a small charitable organization to a huge hospital system mirrors the story of the country’s nonprofit hospitals.

Providence was founded in 1856 when, at the request of a local bishop, Mother Joseph and four other nuns from the Sisters of Providence trekked from Montreal to Vancouver, Wash., to provide services to the poor. Their first hospital, St. Joseph, was a single room with four beds. The hospital charged patients $1 a day, not including extras like whiskey.

Patients rarely paid in cash, sometimes offering chickens, ducks and blankets in exchange for care.

At the time, hospitals in the United States were set up to do what Providence did — provide inexpensive care to the poor. Wealthier people usually hired doctors to treat them at home.

Given their work serving the indigent, hospitals were exempted from state and federal taxes.

That system remained relatively unchanged until the federal government created Medicare and Medicaid in the 1960s. Millions more people suddenly had insurance that covered medical expenses.

The I.R.S. began allowing hospitals to justify their tax exemptions by providing a broader range of loosely defined benefits to their communities beyond treating patients for free. Some hospitals took advantage of the new leeway, arguing that things like employees' salaries counted toward the I.R.S. requirement.

Top government officials warned that hospitals were abusing their privileged status as nonprofits.

"Some tax-exempt health care providers may not differ markedly from for-profit providers in their operations, their attention to the benefit of the community or their levels of charity care," the I.R.S. commissioner Mark W. Everson wrote to the Senate in 2005.

Some hospital executives have embraced the comparison to for-profit companies. Dr. Rod Hochman, Providence's chief executive, told an industry publication in 2021 that "'nonprofit health care' is a misnomer."

"It is tax-exempt health care," he said. "It still makes profits."

Those profits, he added, support the hospital's mission. "Every dollar we make is going to go right back into Seattle, Portland, Los Angeles, Alaska and Montana."

Since Dr. Hochman took over in 2013, Providence has become a financial powerhouse. Last year, it earned $1.2 billion in profits through investments. (So far this year, Providence has lost money.)

Providence also owes some of its wealth to its nonprofit status. In 2019, the latest year available, Providence received roughly $1.2 billion in federal, state and local tax breaks, according to the Lown Institute, a think tank that studies health care.

The greater the hospital system's profits, the more money it could pump into expanding. In addition, the greater its cash reserves, the stronger its credit rating. A pristine rating allowed Providence to inexpensively borrow money, which it could then funnel into further growth.

Over the past decade, Providence has opened or acquired 18 hospitals. Dr. Hochman earned $10 million in 2020.

'Don't Accept the First No'

Ms. Haffner-Ratliffe's debt from the birth of her sons continues to have financial repercussions five years later. Jovelle Tamayo for The New York Times

Even before the Rev-Up program, Providence was collecting money from poor patients, sometimes in violation of state laws, according to five current and former executives and a review of patient complaints filed with regulators.

Harriet Haffner-Ratliffe, 20, gave birth to twins at a Providence hospital in Olympia, Wash., in 2017. She was eligible under state law for charity care.

Providence did not inform her. Instead it billed her almost $2,300. The hospital put her on a roughly $100-a-month payment plan.

It was more than Ms. Haffner-Ratliffe, who was unemployed, could afford. She had to ration gas for her car. One day, her boyfriend walked into their apartment and found her surrounded by bills, crying. When she fell behind on the payments, Providence dispatched a debt collector to pursue her.

For people already on the financial brink, debt collection companies can push them over the edge. The companies often inform credit-rating firms about patients' debts, which can torpedo their credit scores. That, in turn, can make it much harder and more expensive to buy or rent a car or home or to borrow money.

Ms. Haffner-Ratliffe's ordeal chopped her credit score by about 200 points. For years, she couldn't get a credit card. (Ms. Tizon, the Providence spokeswoman, said that the hospital had told Ms. Haffner-Ratliffe about how to seek financial aid but that she had not completed her application. Ms. Haffner-Ratliffe and her parents dispute that.)

Around that time, in 2018, Providence was looking for ways to save money. It had recently merged with another nonprofit hospital system, and integrating the two was expensive.

Providence turned to the consulting firm McKinsey & Company. The firm's assignment was to maximize the money that Providence collected from its patients, the five current and former executives said. In essence, the hospital system wanted to apply the tactics it had used with Ms. Haffner-Ratliffe to even more patients.

McKinsey's solution was Rev-Up, whose name was an apparent reference to the goal of accelerating revenue growth.

Training materials instructed administrative staff to tell patients — no matter how poor — that "payment is expected," according to documents included in Washington's lawsuit and training materials obtained by The Times. Six current and former hospital employees said in interviews that they had been told not to mention the financial aid that states like Washington required Providence to provide.

One training document, titled "Don't accept the first No," led staff through a series of questions to ask patients. The first was "How would you like to pay that today?" If that did not work, employees were told to ask for half the balance. Failing that, staff could offer to set up a payment plan. Only as a last resort, the documents explained, should workers tell patients that they may be eligible for financial assistance.

Another training document explained what to do if patients expressed surprise that a charitable hospital was pressuring them to pay. The suggested response: "We are a nonprofit. However, we want to inform our patients of their balances as soon as possible and help the hospital invest in patient care by reducing billing costs."

Staff members were then instructed to shift the conversation to "how would you like to take care of this today?"

Exhorting employees to do their jobs well, some versions of the training materials invoked a famous line from a speech by the Rev. Dr. Martin Luther King Jr.: "If it falls your lot to be a street sweeper, sweep streets like Michelangelo painted pictures."

Ms. Tizon, the spokeswoman for Providence, said the intent of Rev-Up was "not to target or pressure those in financial distress." Instead, she said, "it aimed to provide patients with greater pricing transparency."

"We recognize the tone of the training materials developed by McKinsey was not consistent with our values," she said, adding that Providence modified the materials "to ensure we are communicating with each patient with compassion and respect."

But employees who were responsible for collecting money from patients said the aggressive tactics went beyond the scripts provided by McKinsey. In some Providence collection departments, wall-mounted charts shaped like oversize thermometers tracked employees' progress toward hitting their monthly collection goals, the current and former Providence employees said.

On Halloween at one of Providence's hospitals, an employee dressed up as a wrestler named Rev-Up Ricky, according to the Washington lawsuit. Another costume featured a giant cardboard dollar sign with "How" printed on top of it, referring to the way the staff was supposed to ask patients how, not whether, they would pay. Ms. Tizon said such costumes were "not the culture we strive for."

The Rev-Up program alarmed some Providence employees.

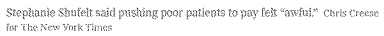
"It was awful working for this rich system and not being able to help people who were just crying in front of me," said Stephanie Shufelt, who worked in patient registration at a Providence hospital in Portland, Ore., until February 2021.

Taylor Davison, who worked in the emergency department of a Providence hospital in Santa Rosa, Calif., until last year, said Providence's tactics had struck her as predatory. She was told to approach patients as soon as doctors had finished examining them. She would crouch at their bedside and ask for money. She was required to document in the patients' charts that she had repeatedly pushed for payments.

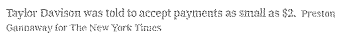
Employees were urged to collect any amount, no matter how small, she said. Some patients offered as little as $2, which she accepted.

"Here are people coming in at the worst moment of their lives, and I'm asking them to empty their wallets," Ms. Davison said.

Providence paid McKinsey at least $45 million in 2019 for its assistance, tax filings show.



Stephanie Shufelt said pushing poor patients to pay felt "awful." Chris Creese for The New York Times



Taylor Davison was told to accept payments as small as $2. Preston Gannaway for The New York Times

Warning About Harm to Patients

When patients left a hospital without paying, Providence sent them at least three bills. If they still did not pay, they would receive one last warning.

"This is your final opportunity to pay your account," one such letter said. Otherwise, it went on, Providence would enlist "a third-party agency that may adversely affect your credit rating."

Under Washington's law, Providence was supposed to screen patients at the hospital to assess whether they qualified for free or discounted care. But Providence often checked patients' income only after months of hounding them had failed, according to depositions included in the Washington lawsuit and internal memos that a former Providence executive shared with The Times.

At that point, Providence ran accounts through a screening tool provided by Experian, a credit reporting company, to determine whether accounts were eligible for free care.

But despite Rev-Up, the amount of free care that Providence was providing was "spiking," an executive later explained in an email to colleagues. So in 2019, Providence's chief financial officer at the time, Venkat Bhamidipati, and other executives made a change, according to the five current and former Providence executives and depositions included in Washington's lawsuit.

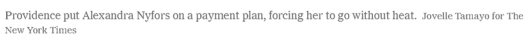
Previously, when treating patients who were on Medicaid, Providence eventually waived any outstanding portion of their bill. In 2019, Providence stopped doing that. Medicaid patients were sent to debt collectors instead. That appeared to violate laws in Washington, Oregon and California that required nonprofit hospitals to provide free care to patients earning below certain thresholds, according to regulators.

Some Providence executives warned that the changes were harming patients.

"I just want it made clear to our leadership that patients that would normally have been eligible for charity care are going to bad debt," Lesa Wood, a director of financial counseling and assistance, emailed colleagues in late 2019.

In 2020, a Providence executive wrote to co-workers to report that the system's charity care spending was down "across all markets."

Skimping on Groceries



Providence put Alexandra Nyfors on a payment plan, forcing her to go without heat. Jovelle Tamayo for The New York Times

In November 2020, Paulo Aguirre went to a Providence hospital in Orange County, Calif., with a splitting headache, blurred vision and nausea. Doctors gave him a shot that made the pain "go right away," he said.

Mr. Aguirre earned minimum wage working at a dental office and was on California's version of Medicaid, known as Medi-Cal. Under California law and Providence's financial assistance policy, his low income qualified him for free care.

In early 2021, Mr. Aguirre said, he received a bill from Providence for $4,394.45. He told Providence that he could not afford to pay.

Providence sent his account to Harris & Harris, a debt collection company. Mr. Aguirre said that Harris & Harris employees had called him repeatedly for weeks and that the ordeal made him wary of going to Providence again.

"I try my best not to go to their emergency room even though my daughters have gotten sick, and I got sick," Mr. Aguirre said, noting that one of his daughters needed a biopsy and that he had trouble breathing when he had Covid. "I have this big fear in me."

That is the outcome that hospitals like Providence may be hoping for, said Dean A. Zerbe, who investigated nonprofit hospitals when he worked for the Senate Finance Committee under Senator Charles E. Grassley, Republican of Iowa.

"They just want to make sure that they never come back to that hospital and they tell all their friends never to go back to that hospital," Mr. Zerbe said.

Last October, an ambulance rushed Alexandra Nyfors to the Providence hospital in Everett, Wash. A diabetic, she was severely dehydrated, and her kidneys were failing. Providence put her on intravenous medications to treat an underlying infection. She spent about two weeks in the hospital.

Ms. Nyfors, 66, is covered by Medicare, and her only income is about $1,700 a month in federal disability payments. Under Providence's policies and state law, she was eligible for free care because of her low income.

But Providence billed her $1,950 — the amount left over after Medicare covered its share. The remaining sum was daunting. It was getting colder, and Ms. Nyfors knew her heating bill would gobble up much of her monthly check. But when she went on the hospital's website, she said, there were only two choices: Pay in full or set up a payment plan.

Ms. Nyfors agreed to have $162.50 automatically withdrawn from her bank account each month until the bill was settled. She

started buying fewer groceries, she said. She went without heat. She split her medication in two to make it last longer.

She had no idea she qualified for free care until she read about Washington's lawsuit. After Ms. Nyfors was interviewed by The Everett Daily Herald, Providence forgave her bill and refunded the payments she had made.

In June, she got another letter from Providence. This one asked her to donate money to the hospital: "No gift is too small to make a meaningful impact."

Employees at the Providence hospital in Santa Rosa, Calif., were told to seek money from patients as soon as doctors finished examining them. Preston Gannaway for The New York Times

Following a Script 'Like Robots'

In 2019, Vanessa Weller, a single mother who is a manager at a Wendy's restaurant in Anchorage, went to Providence Alaska Medical Center, the state's largest hospital.

She was 24 weeks pregnant and experiencing severe abdominal pains. "Let this just be cramps," she recalled telling herself.

Ms. Weller was in labor. She gave birth via cesarean section to a boy who weighed barely a pound. She named him Isaiah. As she was lying in bed, pain radiating across her abdomen, she said, a hospital employee asked how she would like to pay. She replied that she had applied for Medicaid, which she hoped would cover the bill.

After five days in the hospital, Isaiah died.

Then Ms. Weller got caught up in Providence's new, revenue-boosting policies.

The phone calls began about a month after she left the hospital. Ms. Weller remembers panicking when Providence employees told her what she owed: $125,000, or about four times her annual salary.

She said she had repeatedly told Providence that she was already stretched thin as a single mother with a toddler. Providence's representatives asked if she could pay half the amount. On later calls, she said, she was offered a payment plan.

"It was like they were following some script," she said. "Like robots."

Later that year, a Providence executive questioned why Ms. Weller had a balance, given her low income, according to emails disclosed in Washington's litigation with Providence. A colleague replied that her debts previously would have been forgiven but that Providence's new policy meant that "balances after Medicaid are being excluded from presumptive charity process."

Ms. Weller said she had to change her phone number to make the calls stop. Her credit score plummeted from a decent 650 to a lousy 400. She has not paid any of her bill.

Susan C. Beachy and Beena Raghavendran contributed research.

Share your experience with New York hospitals.

If you work in a New York City hospital or if you're an emergency service worker, we want to hear from you. We will not publish any part of your submission without contacting you first.

Which hospital do you work for? If you work for multiple hospitals, please let us know which ones.

What is your job there?

Tell us a little bit about why you're writing. Use as many or as few words as you need.

0 words

What is your name? *

What is your email address? *

What is your phone number?

Where do you live?

Search places

How do you prefer to be contacted (email, text, Signal, WhatsApp, etc.)?

If you'd like to get in touch about this story using a platform like Signal, Secure Drop or other channels, please read more on how to do that at: nytimes.com/tips

By clicking the submit button, you agree that you have read, understand and accept the Reader Submission Terms in relation to all of the content and other information you send to us ("Your Content"). If you do not accept these terms, do not submit any content. Of note:

- Your Content must not be false, defamatory, misleading or hateful, or infringe any copyright or any other third-party rights or otherwise be unlawful.
- We will use the contact details that you provide to verify your identity and answers to the questionnaire, as well as to contact you for further information on this story.

Submit

Chairman SCHWEIKERT. Thank you, Mr. Steube.

Mr. Schneider.

Mr. SCHNEIDER. Thank you, Mr. Chairman. Chairman Schweikert, Ranking Member Pascrell, thank you for having this conversation. The witnesses, thank you for sharing your perspectives and insights as we try to understand this issue better.

I think back through the pandemic and even the years before that, I visited hospitals throughout my district, and I hear the same concerns repeating themselves over and over. Among the most, Ms. Hatton, you touched on it, is just getting good providers, whether it's nurses or doctors. We are struggling. And I live in the suburbs of Chicago, a place where there is a lot of access. Rural communities I know are having an even harder time.

We know that the first responders, the frontline workers, the doctors, the nurses were the heroes of the pandemic, but they've been squeezed as well throughout this period. And so as we come out of the pandemic, and we're looking forward to making sure people have access to care, access to quality hospitals is critical.

Ms. Hatton, you touched on the fact that these nonprofit hospitals providing community benefit, it's nine dollars for every dollar they're benefitting. Would love to get further expansion of how that's working, how you see that nine dollars playing, and the impact it's having. But, in particular, with respect to training doctors and nurses, the hospitals are often the places where our professionals go for that medical training.

Ms. HATTON. That's a major focus for many hospitals, to provide training opportunities for, you know, workforce. And again, it's become—the workforce shortages in focus before the pandemic, they were exacerbated by the pandemic, made those programs even more important, again, particularly with nurses. And I know in the Chicago area that you're suffering from a shortage of nurses.

And again, one of the issues there is there are so many applicants than there are training opportunities, which means that hospitals—part of what hospitals can do on community benefit is to open up more training slots so that more applicants have an opportunity to actually train. And they're doing this one in a number of different ways in a number of different staff shortages, but it's a major focus. And I expect when we see the next iteration of health—community health needs assessments, we'll find training for the workforce becomes one of the priority programs that hospitals want to tackle together with their communities.

Mr. SCHNEIDER. Great, thank you.

Let me turn to Ms. Lucas-Judy. We were talking about the form, and I know others have asked how do we make the form better. If I understand this correctly, the form basically asks the hospital to quantify their contribution but without full meaning, without full capture of data. Is that a fair statement?

Ms. LUCAS-JUDY. For some of the factors, it's asking for a quantitative answer, and for others it's just what is it important to know about the community benefit that your hospital provides. That's very amorphous.

Mr. SCHNEIDER. Okay. So at best, it's a partial quantification, at worst it's an amorphic description. It doesn't get into the quality

of the community service provided, it is a partial snapshot. Is that fair?

Ms. LUCAS-JUDY. Right. And it's a form that's attempting to get something very complicated, and that's part of why, you know, we think it's important for Congress to maybe clarify what the community benefit standard ought to be or, you know, what—some of these things that have been discussed, you know, whether it be the social determinants of health or other things.

You know, if a hospital is providing these services, and we're going to be subsidizing it through the tax code, it's important to be clear about what those types of things are, and still preserve some flexibility to be able to meet local needs.

Mr. SCHNEIDER. And going back to my previous question, training the next generation of doctors or training nurses and other medical professionals, that's something that has value not just to the specific community but to the nation as a whole. Is that fair?

Ms. LUCAS-JUDY. Certainly that is one of the things that could be considered.

Mr. SCHNEIDER. And my last question along these lines, so we have partial quantitative, we have a very superficial qualitative description, not a quality assessment, but the other thing I'm hearing is we don't have the transparency necessary to fully understand what community benefits are being provided. And I'm running out of time. Is that a fair statement as well?

Ms. LUCAS-JUDY. Yes, that's correct.

Mr. SCHNEIDER. So for us it's better numbers, more transparency [indiscernible].

Ms. LUCAS-JUDY. Correct.

Mr. SCHNEIDER. All right. I yield back. Thank you very much.

Chairman SCHWEIKERT. Thank you, Mr. Schneider.

Ms. Tenney.

Ms. TENNEY. Thank you, Mr. Chairman, and thank you Ranking Member, and thank you to our witnesses.

I have a pretty extensive background serving on different levels of hospital boards, and especially in the rural upstate communities where I'm from. My grandfather founded a hospital in a rural community in upstate New York, and I—it's always been a struggle to get quality care and to—I think it has to be emphasized that New York City, even Westchester and Long Island, is very different from upstate New York in terms of evaluating the hospitals. And I understand the ability to take advantage of this tax-exempt status. All of the hospitals in New York are nonprofit and two are actually community—or county owned, including one in Wyoming County which is in my district, and another one outside my district.

But I want to just jump right into some of the questions I have. I want to get into just asking—and first I want—Ms. Lucas-Judy, you've done a good job of explaining how vague and amorphous this standard is on defining what community benefits are. Could you tell me on the 990, the Schedule H, what would you do to improve this and what could the hospitals provide? And I know this is a multiple part questions. Could you tell me in your research, have you seen a distinction between upstate rural New York and

downstate, if it's in any of your studies, or even in any other state that has a nonprofit hospital system?

Ms. LUCAS-JUDY. So that last question, that wasn't part of the scope of this particular review, but I can tell you that in earlier work that GAO has done, we did find quite a bit of variability in terms of even the types of information that hospitals were providing, the definitions that they were using and the ways that they were measuring their charity care and uncompensated care, and some of that had to do with different standards at the state level as well.

In terms of things to do to make the form itself, I mean, ideally, as IRS is looking to make all of its forms more user friendly, both for the taxpayer who is having to report the information as well as people who are trying to, you know, get information from it, this I think would be a good form for them to look at to figure out is there an easier way, a more transparent way to get this information reported.

But, you know, sort of in the short term, we think it's important to be able to cover all the different factors that IRS considers to make sure that its reviewers have that information to be able to determine whether a hospital is meeting the community benefit standard.

Ms. TENNEY. Well let me ask, I mean, do you suggest that we in Congress come up with a different standard for not-for-profit hospitals, or do you think we need to do better oversight?

Ms. LUCAS-JUDY. I think not necessarily an either/or question. I think certainly having some more definition around what the community benefits are that a hospital could be providing would certainly be helpful to make sure that taxpayers—different types of hospitals are being treated the same and have that same opportunity.

Ms. TENNEY. So in your September 2020 GAO report, you identified 30 hospitals that reported spending nothing on community benefits in 2016. In addition, 48 hospitals reported spending nothing on financial assistance, and 108 hospitals reported spending less than one percent of expenses on community benefit spending, placing them at a high risk of noncompliance in community benefit standard, as you've pointed out.

What do these hospitals generally state in their community benefit standard to meet this? I know you sort of answered that, but what did they say, like what was listed? Because we do have, obviously, you know, a concern about that, and I don't know if that's—these are upstate hospitals, or profit, nonprofit, you know what I mean? I don't know which state they're from but——

Ms. LUCAS-JUDY. Right. So we weren't identifying specific hospitals.

Ms. TENNEY. Right.

Ms. LUCAS-JUDY. But we were flagging this as an area of concern and something that seems like it should have, you know, triggered some additional review on the part of IRS.

Ms. TENNEY. I guess what I want to say—allow me to reclaim my time for—are these hospitals, were they more rural, were they more urban, what would you say? Was there some commonality that you could say that you saw——

Ms. LUCAS-JUDY. So that——

Ms. TENNEY [continuing]. In the trending on the——

Ms. LUCAS-JUDY. That was not information that we had. We did refer them—all of them to IRS and some of them did go back and get additional information on. And it's not necessarily that those hospitals were not even spending money, they just weren't reporting it. And so that part of our point was that the form itself isn't being used effectively for oversight.

Ms. TENNEY. Okay.

Ms. LUCAS-JUDY. Because if you had, you know——

Ms. TENNEY. So we got—I understand about the form because we've talked about whether we should change it, but let me ask you this. There is a big difference state to state. And did you and your study come up with the difference between say states like New York, which have a very different type of healthcare system, and it's really burdensome for rural hospitals to survive. Most of them my area are really in freefall, I mean, because of the mandates coming from the government in Albany.

I mean, would you say there's a distinction say based on state to state and the way we do healthcare?

Ms. LUCAS-JUDY. That definitely was not in the scope of this work, but I do know that, you know, again, in earlier studies, trying to find a difference, looking at different kinds of states and different uncompensated care that they were providing, the differences between the nonprofit and the for-profit hospitals was actually very small.

Ms. TENNEY. Wow, that's interesting. Thank you so much. I think my time's out. I yield back.

Chairman SCHWEIKERT. Thank you. Thank you, Ms. Tenney.

And Ms. DelBene.

Ms. DELBENE. Thank you, Mr. Chairman, and thanks to everyone for taking the time to join us today. We really appreciate it.

Ms. Lucas-Judy, we've been talking a lot about how challenging it can be for the IRS to determine whether a hospital is providing sufficient community benefits because the requirements are so ambiguous. You also recommend that the IRS assess community benefits at the facility level rather than the collective organization. And I wondered if you could talk a little bit about why you think that's important to increase transparency and enforcement.

Ms. LUCAS-JUDY. Right. So one of the things that we found, as you mentioned, was that there—the community benefits were reported at the aggregate level, at the organizational level and not at the facility level. And when you have very, very large organizations full of multiple hospitals all reporting one level of community benefit, it's very difficult to know, you know, maybe one hospital in that system is contributing and not the rest of them at all. And so for a transparency and accountability perspective, that's difficult.

We recommended that IRS assess the costs and benefits of changing that reporting because for the ACA requirements, those are at the facility level rather than at the organization level. IRS looked at that qualitatively and determined that the administrative burden that it would put on the hospital and on IRS was not worth

the tax administration benefit that they would get. We still think it's important for transparency, but we understand their point.

Ms. DELBENE. Okay. Thank you very much. Also, we were talking about the importance of healthcare services to our most indigent communities and that despite the benefits, we know that there needs to be increased oversight. And there is reference to a New York Times article last year where Providence, a nonprofit hospital system that actually has a large presence in my state of Washington, engaged in aggressive practices intended to increase payments from patients who should have received free or discounted medical care.

Ms. Hatton, I was wondering, how can the federal government increase oversight of tax-exempt hospitals to ensure that their practices are consistent with the law? You're—yeah, there you go.

Ms. HATTON. There really is, I think, a great deal of oversight for hospitals now. And there's a great deal of transparency when you look at all of the different parts of the requirements for tax-exempt hospitals. One, there's the reporting on Schedule H, which is really quite comprehensive.

But there's also the community health needs assessment, and again, that's a report that's done by the hospitals in conjunction with the community, with the public health authorities and civic groups, including civic groups that represent disadvantaged communities to determine—not only just to determine the priorities but determine how the priorities will be addressed and whether or not they've successfully addressed them. That's really a lot of oversight I think for what tax-exempt hospitals are doing in their communities on the community level.

Ms. DELBENE. Ms. Lucas-Judy, is there anything you'd add there? Because clearly we need to have oversight so we can see if folks aren't receiving the benefits that they deserve. What else can we do to make sure they are operating?

Ms. LUCAS-JUDY. The ACA required IRS to do triannual reviews of the hospital's compliance with the other requirements, and that included things like the community health needs assessment. And we found that IRS had—in doing those reviews, had referred about a thousand hospitals during the five-year period that we examined for their audit and examination.

They were working—treating some of the initial reviews as sort of educational opportunities to make sure that hospitals were aware of the requirements, and we saw that the self-reported compliance with all of the ACA requirements did go up over the course of time that we were—of our review.

But the one thing that we found was that, again, IRS couldn't—didn't have the mechanism in place to be able to say whether or not any of these reviews looked at community benefits, and so they made a number of changes to their guidance for doing the reviews and to the way that it codes the results, so we'll be curious to see the results of that in a few years.

Ms. DELBENE. Thank you. Thank you, Mr. Chairman, I yield back.

Chairman SCHWEIKERT. Thank you, Ms. DelBene.

Ms. Fischbach.

Mrs. FISCHBACH. Thank you, Mr. Chair, and thank you so much for all of our testifiers—all of our witnesses here today. I appreciate it.

I'm from Minnesota. Minnesota's hospitals and health systems contributed 3.3 billion to their communities and 649 million in uncompensated care in 2020. In my district, smalltown hospitals are more than just a place where people receive healthcare. They act as a staple in the community helping bridge the gap between workforce, education, and law enforcement.

Our nation's opioid and chemical dependency crisis is out of control. I think everybody can agree with that. Facilities such as the ones in my district have partnered with community members and outside organizations in their area to come up with collaborative prevention efforts that include unused medication disposal systems, and strengthening relationships, and creating referral pathways between mental health and chemical dependency providers, clinics, law enforcement, emergency medical, schools, and social services. So there's a whole array of things that those hospitals are helping with and doing.

One hospital, I'll just use the example, is actively participating in the program is in Alexandria, Minnesota. It's a small town of less than 15,000 people. And it was the first Minnesota hospital to be named one of the top rural and community hospitals in the nation. So this is what's happening in rural areas all across our country.

It's obvious that the incredible relationship that they share with their community, law enforcement, schools, and other community leaders has helped this hospital to thrive and address the needs of the community. Minnesota is my home, and it is home to many, many nonprofit small community hospitals that utilize these tax exemptions to support the healthcare communities to meet the needs of their communities.

Dr. Bai, how has the healthcare landscape changed since this tax exemption was first made available to those hospitals?

Ms. BAI. So if we think about the origin of the tax exemption, 1923—sorry, 1913, at that time, hospitals scoffed the tax exemption because they were charities, right. They have the doctors and nurses as volunteers. But then things have changed, because think of the proportion of their revenue coming from commercial activities versus coming from charity activities. Totally different today. That's why our, you know, community benefit standard has to also change to come—yeah, to be consistent with this.

But I want to emphasize that any heavy-handed policy efforts will have a lot of unintended consequences on hospitals. And so just to mention, right, there are some hospitals with a lot of financial vulnerability, and if we, you know, have bright-line initiatives, and they might be under huge pressure, it might close, and that will affect the access of care to the local community.

So therefore, I believe still we should do disclosure. Then let the local community decide, the state or local level decide what to do, because they really pay the lion share in terms of taxpayer subsidies, because property tax is almost always the largest component. Thank you.

Mrs. FISCHBACH. And maybe you can just go a little bit more into, you know, if the requirements that the hospitals abide—must abide by to obtain and maintain their tax-exempt status—I'm sorry, I'm fighting a cold, so I'm a little—it's a little—sometimes I'm stuffed up. But how have those changed to reflect some of these changes in the landscape? Maybe you could go into a little more—you kind of mentioned it, but if you can go in a little more detail.

Ms. BAI. Yeah. There's very little evidence that IRS or the state attorney general have used the tax exemption as—taken away tax exemption using any evidence. There's no such enforcement. And recently in Pennsylvania, four nonprofit hospitals lost their property tax exemption because of a special statute in Pennsylvania. So I would say so far there—this threat has not been credible from—you know, from the enforcement at the federal or state level.

Mrs. FISCHBACH. Okay.

Ms. BAI. They have been enjoying the tax exemptions.

Mrs. FISCHBACH. Well, thank you very much, and I appreciate it. And I was going to ask about the same thing that Ms. Tenney was asking, so I appreciate that she asked that and there was that discussion included because that's a concern, too. But thank you very much, and I yield back.

Chairman SCHWEIKERT. Thank you, Mr. Fischbach.

Ms. Moore.

Ms. MOORE of Wisconsin. Thank you so much, Mr. Chairman, Mr. Ranking Member, and our witnesses for being here today. This is a very important topic, and I really have been listening very carefully to the questions that my colleagues have been asking and your responses, and it's really given me a lot of thought about whether or not we ought to constrict the definition of what community benefits are or whether we ought to leave the flexibility there, because communities are so very, very different.

And I also, I'm going to ask a question, I have no idea what the answer is to this question, but I know it's a source of frustration for me. Ms. Hatton, you talked about social determinants of health, and one of the frustrations we have around here is that there's not a lot of dynamic scoring on healthcare issues so that the predictability—so that they won't necessarily score as a benefit or preventive medicine.

So if I, for example, as a hospital decide I'm in a community where there's a lot of diabetes, and say I give six workshops a year on cooking and alternative eating styles, and so on and so forth, can I only claim as a community benefit the amount of money I spent on the lecturer, and the venue, and the food, or can I come back and say, we've reduced diabetes by 20 percent based on our outreach to the community?

And if you can't do that, then what, Ms. Bai, you might want to jump in, how are we accounting for community benefits if we aren't allowing the institutions to demonstrate through what they're doing that there is some impact? You know, it could be any numbers of things. We see that, you know, kids are poor, so we're giving out fruits and vegetables to increase the fruits and vegetable intake, and, you know, a year later, obesity has decreased.

So I guess who should I ask? Can I ask you, Ms. Hatton, Ms. Bai?

Ms. HATTON. You can do both.

Ms. MOORE of Wisconsin. Okay.

Ms. HATTON. You can take an exemption on your—you can take the credit for it on your Schedule H for the amount that you spend on those workshops. But that's where the second part of your question is where the community health needs assessment comes in. And that is, if this is a need of the community, and again, hospital working with community groups, determine that this is need, one of the things that they—among the things that they're going to document is what is the need, what's the plan to tackle it, and what's the results of tackling it.

So you get really transparency in two different ways. One, you get a number, which will really—which, you know, when you come to social determinants of health, the amount that you spend on it may not really be commensurate with the impact. It may have a huge impact on people's lives.

Ms. MOORE of Wisconsin. And that's my conundrum because——

Ms. HATTON. Yeah.

Ms. MOORE of Wisconsin [continuing]. Ms. Bai said more than once that some of the nonprofit hospitals don't necessarily provide as much community impact. But, I mean, if we were to have this sort of dynamic scoring to be able to say, yeah, you know, we reduced diabetes in this community, and to be able to add up and count up how much diabetes costs every year and so on. Ms. Bai.

Ms. BAI. Thank you so much, Ms. Moore. One challenge is [indiscernible], the impact of the hospital on the health and wellbeing of the community residents. And the second, if we are—as the GAO report has already mentioned, that right now the reporting is already quite complex and their lack of standardization. What we have to remember is when we make the standards very complex it becomes a very regressive system. The rich and the powerful hospitals will be able to hire consultants, right, to window dressing—to window dress to make themselves look good.

Ms. MOORE of Wisconsin. What do you think, ma'am? Yeah. We've got 27 seconds.

Ms. LUCAS-JUDY. Well, certainly, I mean, accountable is our middle name, and so we do think it's important for there to be some accountability, some transparency, some measures in place for the community needs assessment. You know, part of it was to——

Ms. MOORE of Wisconsin. But what about the conundrum with how they're scored? I mean, prevention—this is why people say we have a sick care system instead of a healthcare system, you know, because prevention, if it were scorable, maybe people would do more of it, and providing it as a general healthcare practice, you know.

Ms. LUCAS-JUDY. And those are definitely things that Congress could consider if it wanted to, you know, put in place, like what is it that we want from our hospitals? What is it that we think some of these community benefits could be, and what kind of reporting, what kind of outcomes is it important for them to be able to provide to demonstrate that they are making a difference in the community?

Ms. MOORE of Wisconsin. Okay, thank you. My time is up. Thank you, and I yield back.

Chairman SCHWEIKERT. Thank you, Ms. Moore.

Ms. Van Duyne.

Ms. VAN DUYNE. Thank you, Mr. Chairman, and thank you to all of our witnesses.

This hearing is about access to quality care for all Americans and having good options for getting that care. And while nonprofit hospitals can serve a critical role in providing a benefit to our local communities, I have serious concerns about the IRS guidelines that are in place that are used to identify whether a hospital meets those requirements. We've talked about that, you know, pretty much all day.

But in some cases, it looks like a patient with financial insecurity needs to fill out more paperwork to receive financial aid than it does for a hospital to obtain nonprofit status. In a Wall Street Journal article published in November of last year, they detail how a patient must use a 19-item checklist that includes three months' worth of bank statements that must be shown, and show all deposits and withdrawals, loan information on all cars that they may own and, among other things, a list of the applicant's monthly expenditures for 17 different categories.

They must do all of this while meeting a 10–day deadline set by the hospital to file their paperwork to see if they even qualify for financial aid.

Meanwhile, a nonprofit hospital only needs to satisfy limited and very vague requirements set by the IRS to maintain their status. This is clearly one example of how things can go wrong, so I'm glad that we're having this hearing today. That—it shows that when Congress delegates authority to an executive agency without sufficient oversight, agencies like the IRS can confuse—can create more confusion and bureaucracy in our healthcare system.

Dr. Bai, is the excessive amount of paperwork required to be completed by a patient in financial distress to receive access to care, is that a requirement by the IRS?

Ms. BAI. It is actually indirect requirement from the IRS. So the IRS says hospitals must have eligibility policy there. What exactly in the policy is up to the hospital to decide.

Ms. VAN DUYNE. So it's not the IRS then that's requiring it, the hospital gets to decide.

Ms. BAI. [Indiscernible], exactly. But you have to——

Ms. VAN DUYNE. So the IRS is not requiring that they fill out a list of every single expenditure for 17 different categories.

Ms. BAI. Yes, that's correct. So if a hospital wants to do good things, they can. They can make it very accessible and tell the patients face to face and make it like a one-step process; or if they want to do, you know, like try to increase their revenue and reduce their charity care, they can make the process very, very complicated.

Ms. VAN DUYNE. Okay. so this sounds like it might possible be a hospital that's trying to avoid financial aid——

Ms. BAI. Exactly

Ms. VAN DUYNE [continuing]. Through creating a very overburdensome paperwork trail for their patients.

Ms. BAI. Mm-hmm. And also increase eligibility. The, you know, floor level. Let's say it's 300 percent, the federal poverty line——

Ms. VAN DUYNE. Is there something that Congress can do to address this?

Ms. BAI. So I think if we have a broad bright-line requirement of eligibility, then there will be no variation, right. Some hospitals, you know, wealthy neighborhood, they wanted them to be more general, right. But some hospitals in a poor neighborhood, you want them to be—especially facing financial threats, you want them to be more flexible.

So I think this should be decided at the local level, at state or county level. Once they have the information from the federal government, they can decide based on their situation.

Ms. VAN DUYNE. Okay. So, Dr. Levinson, can you give some examples of the different kinds of activities that hospital report as a community benefit, considering that no one specific type of community benefit is used to determine the hospital's nonprofit status?

Mr. LEVINSON. Yes. So as Director Lucas-Judy described, there are six broad categories, examples of community benefits that hospitals can provide, and hospitals are also required to report specific expenses on specific types of community benefits to their Schedule H, so that includes, as we were discussing before, charity care, unreimbursed costs for Medicaid, unfunded medical research, unfunded medical training, and so forth. And then there are also opportunities in Schedule H to narratively describe other community benefits that hospitals might be providing.

Ms. VAN DUYNE. All right, I appreciate that. I mean, recognizing that the IRS is responsible for enforcing the hospital's nonexempt status, I don't think anyone would be comfortable knowing that a random IRS agent is charged with determining if a hospital in my district is meeting the needs of a community. As I can you, the needs of north Texas did not reflect necessarily the needs of Congressman Fischbach or Congresswoman Malliotakis' district or anyone on this committee.

So I look forward to continuing to further look into this issue to see how Congress can do a little bit more. And thank you very much for your testimonies today. I yield back.

Chairman SCHWEIKERT. Ms. Malliotakis.

Ms. MALLIOTAKIS. Thank you, Mr. Chairman. My home state of New York is in a unique situation compared to many other districts and the rest of the country because practically all our hospitals are nonprofits due to regulations at the state level. In my district, in Staten Island in particular, I have two nonprofit hospital systems and, you know, they do an amazing job. They work tirelessly to serve our community, and I'm very proud to represent them.

And when we're talking about fair share value, meaning how hospitals contribute to their communities compared to the tax breaks they receive, I think there are some important aspects that may get overlooked. For example, more than seven out of 10 of the patients my hospitals on Staten Island care for are either on Medicare, or Medicaid, or both. Public programs that have a much lower rate of reimbursement than commercial insurers, as you know. Medicaid reimbursement pays 60 cents on the dollar compared to

private and commercial insurance, meaning that the hospital is eating 40 cents for every dollar.

Ms. Lucas-Judy, my first question is for you. When the IRS is evaluating the community benefits of nonprofit hospitals in order to maintain their tax-exempt status, does the rate at which they treat patients on public health programs such as Medicaid factor into the equation?

Ms. LUCAS-JUDY. So for the community health benefit section, you know, what they're looking at is just some of the extent to which hospitals report that they are addressing those factors. But as I mentioned in the testimony, it's very open ended, and so there really isn't necessarily an assessment of, you know, what—it's not clear what it is that the IRS would be assessing against, I guess is what I was trying to say.

Ms. MALLIOTAKIS. So there should be better metrics. There should certainly be better criteria to make this evaluation, and they should specifically take into account Medicaid, Medicare at the hospital.

Ms. LUCAS-JUDY. Well, there—so there are different parts. So under the ACA, there are certain requirements that hospitals have to meet, and there are other reporting requirements, separate from these as well in terms of things getting at some of the uncompensated care. But some of the variability in what hospitals report and one of the reasons why it's difficult to know the extent to which community benefit—or what the full extent of community benefits is that hospitals are providing is things like to the extent to which the unreimbursed—uncompensated care for Medicare and Medicaid are included.

Ms. MALLIOTAKIS. Okay. In addition to filling out the IRS tax forms to qualify for nonprofit status, my home state of New York goes a step further in requiring nonprofit hospitals to include budgets in their community service plans, to demonstrate investments in evidence-based community health interventions.

Dr. Bai, what are the advantages of Congress enacting changes to the IRS code that would require well-defined charity care minimum rates and/or detailed plans as to how nonprofit hospitals are providing community benefit?

Ms. BAI. Thank you. I think there will be several unintended consequences if we set a bright-line rule. Let's say, you know, two percent of revenue. I'm just making it up. That will discourage current good performers if there are, right, to reduce their charity care.

Number two, there are some financially vulnerable hospitals already struggling, especially in rural areas. If we set a standard apply to every hospital, then these, you know, financially vulnerable hospitals would be more vulnerable.

And number three, no, we—these hospitals will lose a signaling channel, right. If they want to show the community, you know, we are doing something that—right now they can show in there a higher provision of charity care or community benefit. But if—I know we have seen evidence from academic studies. Once you start this bright-line, and then the hospitals might converge to that level, then we lose the signaling factor.

Ms. MALLIOTAKIS. Okay. And one other issue that I heard a lot from my hospitals—not just mine but across New York City, is the influx of the undocumented immigrants receiving care. It's placing a tremendous strain on the hospitals, it's overcrowding our emergency rooms, and it's obviously coming at a burdensome cost to taxpayers. Hospitals, you know, now have to shift critical resources, and I'm concerned about how that may diminish care for my constituents.

And, Ms. Hatton, is there something that you—is this something that you've been hearing from hospitals, and how would that factor in to nonprofit charity care requirements?

Ms. HATTON. If I could go back to your very first question about Medicare and Medicaid underpayments, which are pervasive in New York and other places, those are counted on Schedule H, and there's a specific way that they're counted on Schedule H. So they do—the hospitals do get credit for those underpayments, which again, in New York are quite significant. And those show up right in the numbers and are very explicit on the form, so they're definitely getting credit for that.

With respect to patients who are—patients without insurance, hospitals—and who have no—you know, have no access to insurance, hospitals can do a couple of things. They can write it off as uncompensated care and then estimate the amount of uncompensated care that—that's attributable to patients who don't have insurance, which all these patients wouldn't have insurance.

So there's a way to sort of account for the care and for the amount of care they're providing without any pay for that care right on Schedule H. And we encourage hospitals to do that so that you get a more accurate picture of how much care that they're—how much community benefit they're providing in free and unreimbursed care.

Ms. MALLIOTAKIS. The Chairman is giving me the eye. My time is up. Thank you.

Chairman SCHWEIKERT. Thank you, Ms. Malliotakis.

Dr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman.

Let me just start out first, Dr. Wenstrup was not able to come, so I would like to ask unanimous consent to enter Dr. Wenstrup's statement into the record, as he was unable to be here today, but as a physician colleague, has valuable insights into this topic.

Chairman SCHWEIKERT. So ordered.

[The statement of Mr. Wenstrup follows:]

House Ways and Means Subcommittee on Oversight

Hearing on Tax Exempt Hospitals and the Community Benefit Standard

April 26, 2023

Congressman Brad R. Wenstrup

Thank you, Chairman Smith, Ranking Member Neal, and Subcommittee Chairman Schweikert, for holding this hearing today. I would also like to thank all our witnesses for being here to examine hospitals' tax-exempt status and the Community Benefit Standard.

The purpose of today's hearing is to better understand the community benefit being provided by tax-exempt hospitals, including the charity care they provide. Allowing hospitals who meet the eligibility requirements to obtain nonprofit, tax-exempt status was designed to support hospitals that are treating high numbers of uninsured, poor, or vulnerable patients.

This important benefit has allowed patients to receive care in nonprofit hospitals regardless of their ability to pay and can provide great benefit in communities that are rural or underserved.

However, as the cost of nonprofit hospital tax exemptions continues to grow, recent reports and studies have started to examine the level of community benefit provided by these tax-exempt hospitals. And while there are many good actors, it is our job as Members of Congress to provide the oversight necessary to ensure that bad actors are not abusing the incentives – which are ultimately taxpayer dollars – that have been put in place to meet the needs of vulnerable patient populations. As the cost grows, it is our responsibility to ensure that additional costs are due to increasing levels of care and services provided to the community, and not due to business decisions of health care systems.

Nonprofit hospitals should be providing a level of community benefit that aligns with the value they are receiving from their tax-exempt status. Taxpayers who are on the hook for providing this benefit deserve to know what they are getting in return.

I look forward to hearing from the witnesses today on the community benefit and charity care they provide and ways that we can work together to improve the requirements to maintain tax-exempt status. In doing so, we can work together to ensure hospitals are providing the required community benefits that justify these exemptions.

Chairman SCHWEIKERT. And thank you for joining us on the subcommittee.

Mr. MURPHY. Yeah, thank you.

Thank you guys for coming, I appreciate you all bringing your expertise. Just as a point of reference, I've been a physician for over 30 years, was chief of staff of a Level 1 trauma center, close to a thousand beds. We had a 12 hospital system, close to a two billion dollar budget, so I know some of the language. We are a non-for-profit entity.

I know some of the challenges over the last two years have been extraordinary, things we've actually—hospitals have never faced before, travel nurses especially. Who would have foretold this and the exponential rise in the cost for travel nurses.

I—you know, I want people to earn the highest wage as possible, but it got to be the point where hospitals were actually closing beds because they could not afford the care of nurses. And I'm sorry, I took an oath as a physician, and I know nurses took an oath to care for patients, and I think fortunately the pendulum has swung back and hopefully will stay there. You know, you want people to earn, but our first and primary goal—or first and primary oath is to take care of patients, as are all people on the medical staff, including executives, C-suite people, and everything. I know medical supplies have grown. The inflation rate to Medicare is essentially nonexistent comparatively. Absolutely abusive practices by insurance companies.

This—I mean, this is going to be a little political here. There was a bipartisan law, bicameral law sent over to the President that was signed during the last Trump Administration, and this Administration has absolutely disregarded the intent of the law, giving everything to insurance companies, and such to the effect that they send out letters to attack physician repayments and some of the other things. Absolutely wrong.

So let's get back to the order of the day, and that's the tax-exempt status of a non-for-profit, which I think is a good thing. It allows institutions to actually be able to serve at risk communities. I live in one, a very, very poor rural area in eastern North Carolina.

But a couple things I'm going to ask different folks to give me some help with. Dr. Bai, I'm in receipt of some things I just don't quite understand, some 990 forms, from one of the institutions in North Carolina I won't name, that shows some significant, and I mean billions of dollars of offshore accounts from a non-for-profit institution. Can you tell me why would any non-for-profit do that? Why are they hiding money offshore? What's the purpose of that?

Ms. BAI. Well, we have seen evidence that nonprofit hospitals have been engaged in all sorts of activities that you would only expect in for profit entities. For example, this offshore hiding, and then investment in private equity and venture capital, and then investing the income, doing some quite risky investment and going after return. So this is only one of the examples of this underlying trend that nonprofit hospitals have been behaving more and more profit oriented like their for profit counterpart.

Mr. MURPHY. I mean, what's the motive for that? Is it to avoid taxes or some—what—why were—why are they doing this? Because it—honestly, it just doesn't pass the smell test.

Ms. BAI. I think these activities, none of them is random, none of them is accidental, everything is strategic. For, you know, expanding market share, making more money, you know, profit driven, yeah.

Mr. MURPHY. Okay. I just—you know, it just looks kind of funny when you've got all of the sudden non-for-profits that are supposed to be charity institutions shifting money offshore.

I will tell you, Ms. Matton—or Hatton, I got a pet peeve, and that's CEO administrative compensation in this country. And especially, you know, in the chairman's remarks that the top 10 nonprofits average seven million. I'm a physician, and I take care of patients, nurses take care of patients, and I love my CEOs, one of my best friends is a CEO, but this is absurd. Absolutely absurd, when we have charity care going in this country where the CEOs, Executives are paid millions of dollars, getting taxpayer money to get these—to run their hospitals. I'd love for you to comment on that.

Can I have an extra two minutes?

Ms. HATTON. First of all, let me thank you for your support for trying to get at the price gouging by staffing agencies, and I think you were talking about surprise billing——

Mr. MURPHY. Yep.

Ms. HATTON [continuing]. And thank you for your support there, we very much appreciate it. As you know, we were one of the original groups that went to court over surprise billing——

Mr. MURPHY. Right.

Ms. HATTON [continuing]. To vindicate that.

In terms of CEO compensation, for tax exempt executives, they typically go through a process to have the amount of their compensation reviewed by an independent committee that has comparability data. And again, everyone on the committee is independent to try to determine whether or not that compensation is reasonable and fair for that job. It's called the rebuttable——

Mr. MURPHY. Yeah. And I'll just tell you, I'm familiar with that.

Ms. HATTON. Yeah.

Mr. MURPHY. But let me tell you, being on the other side of the coin, being up at 2:00 in the morning and repair—saving the life of a gunshot victim and everything, I kind of get honestly ticked off about that because I know boards do that in compensated care, but here we are, we're taking care of the patients. They're running hospitals. Why are they being paid more than the people who take care of the patients?

I get it. It's important to run hospitals, big systems and everything. But it doesn't pass the smell test for patients when they hear about that. I've had patients come and bring their Medicare bill to me and apologize to me for the amount of money I get. And so when the cuts go through and we're trying to trim healthcare costs, guess who gets cut? The people who deliver the care.

And so I think this needs to be a reckoning with boardrooms across the country, especially in nonprofits. Nonprofits. Charity care. That we need to reexamine CEO pay because it's just not

right. I believe in people earning as much as they can, but when physicians, the people who are delivering the care, when they've had a 20 percent cut in their average care in the last 20 years, but CEO pay keeps rising. It's absolutely absurd.

So I—you know, I know you're not controlling it, but it's something that's really important to patients. And at the end of the day, that's what we're talking about.

Ms. HATTON. Yeah, we understand. And just want you to understand that the process of setting that is a fair and independent process and——

Mr. MURPHY. I get it.

Ms. HATTON. And, you know, you can certainly argue with the results, but all the nonprofit CEOs use that to try to come up with a compensation that's fair and reasonable.

Mr. MURPHY. I get it. I get it. But I'm sorry, I just don't get that they should be earning more than the people who deliver the care.

Ms. HATTON. I understand.

Mr. MURPHY. So, all right, thank you, Mr. Chairman. I'll yield back.

Chairman SCHWEIKERT. Thank you, Dr. Murphy.

Mr. Hern.

Mr. HERN. Thank you, Mr. Chairman, thank the witnesses for being here for a couple of hours now talking about this issue.

I'm not a doctor, certainly don't play one on TV, but I'm a business person, and somebody that's concerned about where the cost for healthcare industry is going. And, you know, as we know, and I'm going to state some obvious here, hospitals play a very important role in delivering cares to—care to Americans in our rural areas, which I grew up in. They are usually the largest employer and the first line of defense for miles when an accident happens. But the role hospitals play in urban areas is evolving. And I live in Tulsa, and we have really great hospitals there doing a lot of great work.

In the 1960s, hospitals popped up all over the country as the only site of care, and more than 60 years later, there's several different types of hospitals that are not only the—not the only option for care. There are family physician offices, ambulatory surgical centers, urgent care centers, rehab centers, nursing homes, and the list goes on and on and on. The diverse options patients have speaks to the American entrepreneurial spirit and the freedom to choose.

And as our healthcare system evolves, Congress must examine each sector of the industry to root out bad actors. And what we're seeing in these—and, Dr. Bai, you did a great job. I read your article, your research on that. We see the benefit from nonprofit tax status while delivering less charity care than their profit competitors. Abused federal programs like the 340B to prop up their bottom lines instead of helping the members that they are supposed to be serving. Buy off-campus physician offices and immediately increase the prices by 200 percent.

This is totally unacceptable. As a member of Congress who must ensure the people represent—that we represent are not taken advantage of and that the taxpayer money is well spent. Again, I

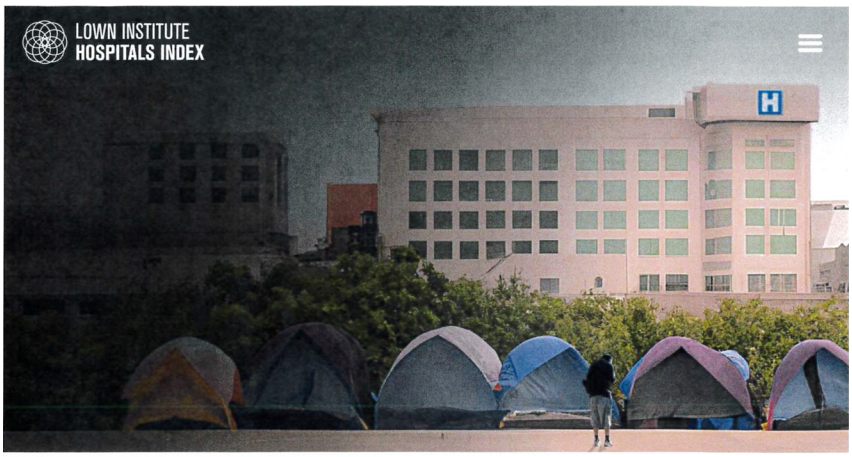
want to reiterate my interest in rooting out the bad actors doing this. And there are many hospitals throughout the country earning their community benefit.

I am fortunate, as I mentioned, to be in Tulsa, and we have several world-class hospitals that innovate and cut costs to compete with their competitors down the street. They invest in the community and make tough decisions while closing down units to keep their businesses running.

Many hospitals across the country similarly contribute to their communities. For example, there are over 250 physician-owned hospitals which collectively paid more than 1.2 billion dollars in taxes in 2021, and over 1,000 investor-owned hospitals similarly paid billions in taxes and provided 65 percent more charity care than their exempt counterparts. However, I can't say the same for many bad actors nationwide.

So I want to insert for the record, Mr. Chairman, a report from the Progressive Institute—Lown Institute. Mr. Chairman, if I could enter this for the record. Thank you.

[The information follows:]



2023 RESULTS

FAIR SHARE SPENDING

How much are hospitals giving back to their communities?

Fair Share Spending, 2023

Lown Institute

59:55

the Lown Institute.

The Lown Institute Hospitals Index is the first ranking to measure meaningful community investment for nonprofit hospitals nationwide. (press release | methodology)

The Institute calculated "fair share" spending for more than 1700 nonprofit hospitals, by comparing each system's spending on financial assistance and community investment to the estimated value of its tax exemption. The data source for "fair share" spending is IRS Form 990 for fiscal year ending 2020.

KEY TAKEAWAYS

Out of 1,773 nonprofit hospitals evaluated, 77% spent less on charity care and community investment than the estimated value of their tax breaks – what we call a "fair share" deficit.

The total "fair share" deficit for these hospitals amounted to $14.2 billion in 2020. That's enough to erase the medical debts of 18 million Americans or rescue the finances of more than 600 rural hospitals at risk of closure.

Many of the hospitals with the largest "fair share" deficits also received millions in COVID-19 relief funding and ended the year with high net incomes.

In four states (MA, MN, RI, and Washington, DC), the total "fair share" deficit for all

hospitals is enough to wipe out all medical debt on credit reports in the state.

In 41 states, the total "fair share" deficit for all hospitals is enough to cover the net losses of all rural hospitals in the state in 2020.

25 HOSPITALS WITH LARGEST FAIR SHARE DEFICITS

25 HOSPITALS WITH LARGEST FAIR SHARE SURPLUSES

FAIR SHARE DEFICIT BY STATE

METHODOLOGY

Media inquiries should be directed to Aaron Toleos, vice president of communications for the Lown Institute, at atoleos@lowninstitute.org.

An initiative of the Lown Institute

Mr. HERN. That outlines how out of this 1,773 tax-exempt hospitals evaluated, 77 percent spent less on charity care and community investment than the estimated value of their tax breaks.

As a business owner, I'm a firm believer in getting the government out of the way, but if the federal government is providing hospitals 27.6 billion dollars in tax relief, we must make sure they are accurately reporting their value and earning it. And the nonpartisan GAO concluded that under the current law, there are no qualitative requirements for community benefits or charity care.

Dr. Bai, thank you for your testimony today. I appreciate how you described your community benefit as a social contract between hospitals and their communities. As you know, the federal program provides many incentives to hospitals such as the 340B Program, paying more for services in physician offices and nonprofit hospital tax exemptions. I especially like, as my colleague to my immediate left stated, in the 990, I like your additional requirements suggested for reporting these so we don't have to go dig through a lot of things.

But what—to what extent are these incentives making it hard for small business healthcare facilities to survive or enter their marketplace?

Ms. BAI. Yes. Actually, these current regulations are the major reason we are seeing more and more mergers and acquisitions and the small players leaving the market. And then the result is higher price for private pay patients. Like the 340B Program you mentioned and the tax exemption status. And then we have the banning from the ACA banning physician-owned hospitals. And at the state level, we have a lot of certificate of needs law. And then we have the set of non-mutual payments, we pay hospitals more than physicians.

These are, in my opinion, policy failures. Many people would say, oh, the high prices is because market failure. No. The Congress and administration has made it very hard for small ones to compete, and it makes the life of big ones easy. So these are fundamental policy failures, that's why we're seeing higher and higher price and less and less competition.

Mr. HERN. So if I may ask you in the last 12 seconds here, because I always like to ask our witnesses this because you come here and you testify, and you really walk out of here and you're saying nobody asked me what we think we should do differently. So I'm going to ask you that. How do you think Congress can improve reporting to get a better picture of the community benefit?

Ms. BAI. First——

Mr. HERN. So I'm going to give you a chance to talk about your changes to the 990, as an example.

Ms. BAI. Yes. Very simple. Add several lines. Let hospitals self-report their estimated property tax exemption, sales tax exemption, and then charity contributions they received, and then the cost of savings—lower cost of borrowing because they can issue tax-free bonds, and also 340B profit. All these things can be easily estimated and no other administrative burden whatsoever. But that will give taxpayers, stakeholders, policymakers huge transparency for them to make decisions.

Mr. HERN. And if I may, in your research, today's technology, that should make that relatively easy. I mean, I could see 20 years ago that might be a little bit difficult, but today that should be just adding and programming a line on the 990 software, right?

Ms. BAI. Yes, thank you, Mr. Hern. And also, we do not want them to report estimated federal income tax or state income tax because, you know, accounting income is different from tax income. But all the other things can be easily reported, and they are really the meat.

Mr. HERN. Thank you so much, Mr. Chairman, I yield back.

Chairman SCHWEIKERT. Thank you, Mr. Hern.

I can't thank all of you enough for spending time with us. There's still dozens of questions. I was showing an article from an Arizona CEO of a nonprofit system that was paid 25 and a half million in one year. You get questions when things like that happen. There is a number of hospital systems, now it may be because they're producing insurance products or other things, that I have one that has a billion dollars in the Caribbean. Would help us to be able to have enough sunlight so we understand when we get questions on how we explain these things.

So, first, thank you for being here. I must tell you, the actually intellectual level of the conversation was one of the best hearings we've had, particularly so far this year.

And I now need to—please be advised that members have two weeks to submit written questions, and do expect some questions from us, and answered later in writing. Those questions and your answers will be made part of the record of this hearing.

And with that, the subcommittee is adjourned.

[Whereupon, at 4:17 p.m., the subcommittee was adjourned.]

MEMBER QUESTIONS FOR THE RECORD

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Q&A

of the

American Hospital Association

for the

Committee on Ways and Means

Subcommittee on Oversight

of the

U.S. House of Representatives

"Tax-Exempt Hospitals and the Community Benefit Standard"

May 22, 2023

1. **In your testimony, you say "[a]ny suggestion that the IRS should both define and evaluate community benefit misses the point. Community benefit can only be fairly judged by those in the community in which the benefits accrue."**

a. **Are you suggesting that communities develop their own methods for holding hospitals in their area accountable to meeting the needs of their communities?**

Communities have several powerful tools that enable them to fully and fairly evaluate and directly influence the community benefits provided by the tax-exempt hospitals in their communities.

First, the form 990 — which tax-exempt hospitals must file yearly — contains a schedule that is focused solely on community benefit, Schedule H.[1] The instructions for the form describe the purpose: "Hospital organizations use Schedule H (Form 990) to

[1] https://www.irs.gov/pub/irs-pdf/i990sh.pdf

provide information on the activities and policies of, and community benefit provided by, its hospital facilities and other non-hospital health care facilities that it operated during the tax year."

The form provides extensive information on the hospital's financial assistance policy, such as the thresholds for assistance; the method for applying for assistance and how the assistance policy is widely publicized; the actual amounts of financial assistance provided, including free or discounted care and Medicaid and Medicare underpayments; and other important benefits. These benefits include community health improvement activities; health professions education; research; community building activities such as economic development, workforce development and environmental improvements; and bad debt attributable to patients who would have qualified for financial assistance but declined to apply. There is also space on the form to describe the many other programs, activities and undertakings by the hospital in service of the health and well-being of their patients and communities.

This information, some of which is financial, gives community members enormous insight into the amounts and means by which the hospital serves its community, which is unparalleled in the health care field. Neither drug nor commercial health insurance companies regularly make these disclosures, nor are they required to.

Second, while numbers and other information found on Schedule H provide extremely useful insights, these are further and amply supplemented by the hospital's Community Health Needs Assessment (CHNA). Section 501(r)(3)(A) of the tax code requires a hospital organization to conduct a CHNA every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA. The CHNA requires extensive community input.

The first requirement is that the hospital define the community served, considering not only geography, but the target populations such as women and children, and "principal functions" such as focus on specialty areas or targeted diseases. The community served must encompass those who may be medically underserved. Then the hospital must identify the significant needs of the community and the resources it will bring to bear to meet them. The needs must be prioritized based on extensive input from the community, including from at least one public health department; members of the community who are medically underserved, low income or historically marginalized or those who represent them; and any written comments provided. The established priorities must be fully documented, including the underlying data, rationale and participants, along with a fully documented implementation strategy. Finally, it must be approved by the hospital's board of trustees or one of its committees.

There is no other sector in health care that provides as much information, insight, service or benefit as those provided by hospitals. Communities have more than sufficient information readily at hand to make a full and fair determination about whether the enormous array of benefits provided meets their community's needs in whatever manner best suits that community.

Just a small sample of CHNA assessments illustrates the diversity that characterizes the communities served by hospitals and the compelling rationale for preserving flexibility required to meet the needs of those communities:

- **NYU Langone Health; New York City, N.Y.** NYU Langone has taken a data-driven approach to identify communities of need in the service area and then implement programs in close partnership with communities.[2] Partnerships with local communities highlighted needs in particular communities, including the Arab American community in southwest Brooklyn on the lower east side of Manhattan and Chinatown. Having identified these communities, additional data are being collected through partnerships such as the NYULH Brooklyn Arab Community Advisory Council, which includes 19 community-based organizations, with the goal of learning more about the health needs and priorities of that community. To address the needs and strengths of the Chinatown community, NYULH has developed partnerships with community groups such as Asian Americans for Equality, the Charles B. Wang Community Health Center, and the Chinese American Planning Council.

- **Our Lady of the Lakes Regional Medical Center; Baton Rouge, La.** Our Lady of the Lakes Regional Medical Center (OLLRMC) is a founding organization of a region-wide collaborative to improve the health of the Baton Rouge community, Healthy BR.[3] Healthy BR is led by a multisector group and identifies its community service areas and health priorities through a collaborative process. This regional approach enables OLLRMC to address community societal factors across a wide range of areas and industries.[4]

- **Titus Regional Medical Center; Mt. Pleasant, Texas.** Titus Regional Medical Center (TRMC) is in East Texas and serves a largely rural area. TRMC leadership is strategically integrated across the community, and the CEO provides his personal contact information to community members to share their needs. TRMC also takes a systematic approach to identifying needs and plans collaboratively with community groups and members to develop tailored approaches to addressing needs.[5]

b. Do you think we should have communities more directly engaged in the community benefit needs assessment process?

---

[2] Link to 2022 CHNA report: https://nyulangone.org/our-story/community-health-needs-assessment-service-plan
[3] https://healthybr.com/
[4] Link to 2021 CHNA report: https://ololrmc.com/assets/documents/chna/chna-2022-3-21-22-.pdf
[5] Link to 2022 CHNA report: https://www.titusregional.com/about/community-health-needs-assessment/

The CHNA process is very inclusive and ensures extensive community involvement in the process of evaluating local priorities. As described above, virtually every member of the community, including those most in need, can be either directly involved or ably represented in the development and execution of the CHNA. And the hospital's board or a committee authorized by the board gives its approval to the CHNA after a thorough review, providing yet another layer of community involvement and oversight. Because the CHNA process effectively and extensively promotes community engagement, AHA has no recommendations for changes currently.

c. Do you support strengthening community involvement in the community benefit needs assessment process through stronger participation or engagement on Boards of Directors? Would you support community members sitting on the Boards of Directors?

The Board of Directors or Trustees (board) for tax-exempt hospitals are directly involved. It is well established that a board may create one or more committees and appoint members of the board to serve on them. These committees may exercise the powers of the board. In this case, that is to oversee and approve the CHNA. It is also relevant that the entire board reviews the Form 990 each year, which includes the extensive information on community benefits provided by Schedule H. That provides an additional layer of oversight of the hospital's community benefit obligation.

As to the composition of the board, that should be a determination made by each organization based on their needs, the community and those served. There are numerous ways that a hospital board can and does receive and incorporate public input, including having members of the community serve on the board and/or board committees, both fiduciary and advisory, to ensure that the voices of those served are included in their deliberations.

d. What practical ways do you believe the community benefit needs assessment process can be better operationalized?

Our suggestions to the committee focused on making the Form 990's Schedule H more user-friendly for community members. For example, designing a simple cover page with the information already collected that would be most useful to the community would be a major improvement. Currently, the form is designed for the benefit of IRS personnel, who, with all due respect, are unlikely to be in the position to determine whether the amount and distribution of community benefits are best suited to the community served by that hospital. AHA would be eager to engage in a public forum to help bring such a design to fruition.

It would also be useful to have the redesigned Schedule H emphasize the importance of community building activities. Early on the IRS failed to appreciate the value of improved food access and security, housing, education and training to sustain or bolster the community's health and well-being. It is now well established that initiatives such as those are essential to get and/or keep communities healthy. That omission is reflected

in the current configuration of the form that can and should be remedied at the IRS' earliest opportunity.

While not strictly operational, the Committee may wish to consider at some point whether other sectors of health care that benefit from government programs, such as the commercial health insurance or prescription drug industries, should be required to report public benefits in a manner like the extensive reporting already provided by hospitals.

e. Additionally, what information would a community need from the hospital to be able to make such determinations, and are hospitals prepared to share that information?

Considering the extraordinary range of information on community benefits available through the Form 990 Schedule H, as well as the focused participation and required reporting — including on planning and execution — involved in the CHNA, communities have more than enough information to determine themselves if additional information could be useful. That should be a determination that each community can and should undertake on its own considering its particular needs, geography, traditions, expectations and the many other considerations that go into determining what works best for those served by the hospital. That is not a determination that can or should be made centrally by a federal agency, which is, at best, remote from those considerations and not answerable to those communities.

2. Per IRS rules, tax-exempt hospitals are required to provide community benefits that promote health. The IRS has identified six factors that could demonstrate community benefits, including the use of funds to improve facilities, equipment and patient care. To what extent does the reduction of services (including cutting essential lines of services, shuttering hospitals or reducing staff to unsafe levels) factor into a determination of whether community benefits are provided — and, if it's not, do you think it should be? Should we be taking a more holistic approach, whereby we balance those positive actions with other actions that may have a negative impact?

The basis for tax exemption and the contours of the community benefit standard as articulated by the IRS is as follows:

To qualify as an organization described in Section 501(c)(3), a hospital must:

- Demonstrate that it provides benefits to a class of persons that is broad enough to benefit the community, and
- Operate to serve a public rather than a private interest.

Rev. Rul. 69-545 provides the following factors that demonstrate community benefit:

- Operating an emergency room open to all, regardless of ability to pay,

- Maintaining a board of directors drawn from the community,
- Maintaining an open medical staff policy,
- Providing hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare,
- Using surplus funds to improve facilities, equipment and patient care, and
- Using surplus funds to advance medical training, education and research.

Although no one factor is determinative in considering whether a nonprofit hospital meets the community benefit standard, the IRS weighs all the relevant facts and circumstances in evaluating these factors. Additional factors, such as whether a hospital provides financial assistance to those not able to pay, are relevant in determining whether the hospital is providing a benefit to the community.

The financial plight of hospitals has never been more concerning. The primary culprit is sustained and significant increases in the costs required to care for patients. These costs are putting hospitals' financial stability, and hence their ability to provide services, at risk — or worse. They are the result of a confluence of historic inflation boosting the cost of medical supplies and equipment; workforce shortages exacerbated by price gouging contract labor firms; and the cost of caring for sicker patients with longer hospital stays. Coming directly on the heels of two years of battling the COVID-19 pandemic, these costs are forcing many hospitals to make difficult decisions about how to sustain locations and service lines that are not financially self-sufficient.

To be specific, hospital expenses increased more than double the increase in Medicare reimbursement for inpatient care between 2019-2022. Over half of America's hospitals ended 2022 with an operating loss. This is one of the primary reasons hospitals have been forced to discontinue service lines or sites of services or close their doors altogether. In April 2023, the AHA released a comprehensive report on these and other forces driving up the cost of hospital care, titled, "The Financial Stability of America's Hospitals and Health Systems is at Risk as the Costs of Caring Continue to Rise."[6]

Among other financial challenges, the report documents the fact that the median price of a new prescription drug now exceeds $200,000, raising hospital drug expenses per patient by almost 20% between 2019 and 2022. Further, tactics by commercial health insurers to delay, deny and derail treatment for patients and reimbursement for hospitals have resulted in hospitals carrying large balances in accounts receivable. An AHA study found that 50% of hospitals and health systems have more than $100 million in accounts receivables for claims that are older than six months. It is hardly surprising that in the face of these and other challenges, hospitals, including tax-exempt hospitals, must make difficult decisions about how best to serve their communities, none of which should affect their tax-exempt status or diminish the service they provide to the communities to the best of their financial ability.

---

[6] https://www.aha.org/costsofcaring

PUBLIC SUBMISSIONS FOR THE RECORD

better solutions
for healthcare™

Chairman David Schweikert (R-AZ)
Ranking Member Bill Pascrell (D-NJ)
House Committee on Ways and Means
Subcommittee on Oversight

Dear Chairman Schweikert and Ranking Member Pascrell:

As healthcare prices continue their unsustainable rise year over year, we are calling upon policymakers to prioritize market-based solutions to address the affordability crisis impacting American workers and their employers. We appreciate the upcoming bipartisan hearings and roundtables to examine these important issues, and we call on Congress to take immediate action on these burdens facing employers and employees.

The escalating cost of healthcare services is a primary concern of businesses.[1] Both employees and their employers have been hurt by a 600% increase in hospital prices since 1990. Hospital services now represent the largest share of total healthcare spending, accounting for 44% of total spending for privately-insured Americans. Higher cost care settings can impose considerable financial burden on patients through higher out-of-pocket payments at the point of care and potentially higher health insurance premiums. It should be no surprise that the cost of employer-provided health coverage has increased by 43% in the last 10 years, with hospitals serving as the leading driver behind rising costs.

As Congress works to solve America's healthcare affordability crisis, we applaud your focus on the role that hospitals and large health systems play in driving up healthcare costs for consumers, employers, public sector purchasers, and the government. A lack of market competition, pricing transparency, and price mark-ups have exacerbated significant market distortions and undercut the stability and sustainability of the system.

We ask the committee to advance legislation that promotes and encourages market-based solutions and fair dealing among all stakeholders to address the uncontrollable rise of healthcare costs and reduce costs for all Americans. We look forward to working with you to drive the legislative proposals required to support our system's foundations, help fix areas that have become broken, and promote beneficial growth, innovation, and investment to protect the health of consumers, employers, and their families across the country.

Sincerely,

Better Solutions for Healthcare

---

[1] "Health Insurance, Labor, and Taxes Remain Top Issues for Small Business Owners in NFIB's Every-Four-Year Study." *NFIB*, 13 August 2020, https://www.nfib.com/content/press-release/homepage/health-insurance-labor-and-taxes-remain-top-issues-for-small-business-owners-in-nfibs-every-four-year-study/.

Comments for the Record
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Oversight
Hearing on Tax-Exempt Hospitals and the
Community Benefit Standard
Wednesday, April 26, 2023 at 2:00 PM

Michael G. Bindner
The Center for Fiscal Equity

Chairman Schweikert and Ranking Member Pascrell, thank you for the opportunity to submit our comments. We have a few brief comments.

While there is no reporting data to show whether non-profit hospitals measure up in providing charity care during the pandemic, had they not been doing so, it would have been noticed as the entire sector was under a microscope.

Regardless of whether the IRS has audited these hospitals, they are still required to have internal compliance audits as to their financial stability and integrity, which would include meeting legal requirements.

In prior years, when religious organizations ran hospitals, the need to monitor charity care performance was not required. They were trusted to provide for the poor. In some cases, it was in the name of the religious order, such as The Sisters of Charity or The Sisters of Mercy.

With the decline in vocations, many of these hospitals are under professional management. Certain hospital CEOs at Catholic hospitals have been reported as having CEO level salaries, which many have considered scandalous, especially given how they have been run. Although independent auditing will review legal requirements, the CEO culture is known for hiding inconvenient information.

It is important to add a further check on charitable compliance, as professionalism in business is often synonymous with amoral behavior. This is why our recent CEO president failed so miserably in an office that requires moral authority rather than the seeking of personal gain by the executive class.

This need is all the more reason why the IRS needed, and still needs, a larger enforcement budget. Even with additional budget authority, the agency is short staffed.

As far as community service, the recent Dobbs Case reminds us of the exemption granted under law to Catholic Hospitals regarding certain kinds of women's health care. When only Catholic hospitals are left in some states, due to consolidation, it makes this policy that more acute. In order for such hospitals to fully serve women, the drama of abortion politics must settle into compromise. There are proposals on both sides for a federal solution - either a federal law banning most abortions or permitting it in all cases. At some points, electoral stunts need to recede and real compromise must be sought.

In both scenarios, the need to take the issue away from the states is obvious. Justice Alito ignored the problems of both slavery and Jim Crow as reasons why there should not be abortion states and anti-abortion states. The respondents relied on the question of rights rather than on the

question of powers. Had they examined the competencies of federal and state government on the question of who makes the rules on personhood, the answer is obviously that this responsibility must be federal.

A ruling along those lines would have ended the issue at the status quo - with no regulation of abortion unless Congress recognized the rights of the unborn as reservoirs of positive rights. They are already recognized as having the right to life against government action. It is the same as the right to life for adults - the right to not be executed without due process. It is why we do not execute pregnant women, as well as the right to seek redress for outside injury.

What they cannot claim is a right against the welfare of its mother - especially if the child is doomed due to a fatal defect. In such cases, termination is the only ethical solution - even in Catholic hospitals. Especially if the Catholic hospital is the only hospital for miles around.

For the larger issue, the right to an abortion in the very early stages should be federally guaranteed. After the embryo becomes a fetus - a little person in Latin - then pregnancies should be ended in a live birth, but with no medical intervention required to save the child (other than baptism or other religious blessing). This form of termination should have no upper limit. No one has a right to NOT be born.

Regardless, the Catholic Health Association should have been asked to present testimony on this issue. Since they were not included, their comments should be specifically invited on the issue of charitable care. Ambushing them with an abortion discussion would be rude.

Finally, in a cooperative economy, where companies are owned by their employees and also provide cooperative (democratically chosen) consumption options - especially healthcare - the need for both outside insurance and charitable care will be eliminated. That day may be sooner than you realize, as capitalism's flaws are showing.

A few simple steps will quicken the process, such as allowing insured personal accounts for Social Security holding corporate preferred and voting stock (not shares in the Wall Street Casino) and giving holders of public stock the same capital gains exemption given to private company owners when selling to a qualified broad-based Employee Stock Ownership Plan. While the first option is unlikely to ever pass, the second should attract bipartisan support.

Please see our attachment on Asset Value Added Taxes for more information.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Attachment - Asset Value Added Taxes - The President's Fiscal Year 2023 Budget, June 7, 2022

There are two debates in tax policy: how we tax salaries and how we tax assets (returns, gains and inheritances). Shoving too much into the Personal Income Tax mainly benefits the wealthy because it subsidizes losses by allowing investors to not pay tax on higher salaries with malice aforethought.

Asset Value-Added Tax (A-VAT) is a replacement for capital gains taxes and the estate tax. It will apply to asset sales, exercised options, inherited and gifted assets and the profits from short sales. Tax payments for option exercises, IPOs, inherited, gifted and donated assets will be marked to market, with prior tax payments for that asset eliminated so that the seller gets no benefit from them. In this perspective, it is the owner's increase in value that is taxed.

As with any sale of liquid or real assets, sales to a qualified broad-based Employee Stock Ownership Plan will be tax free. This change would be counted as a tax cut, giving investors in public stock who make such sales the same tax benefit as those who sell private stock.

This tax will end Tax Gap issues owed by high income individuals. The base 20% capital gains tax has been in place for decades. The current 23.8% rate includes the ACA-SM surtax), while the Biden proposal accepted by Senator Sinema is 28.8%. Our proposed Subtraction VAT would eliminate the 3.8% surtax. This would leave a 25% rate in place.

Settling on a bipartisan 22.5% rate (give or take 0.5%) should be bipartisan and carried over from the capital gains tax to the asset VAT.A single rate also stops gaming forms of ownership. Lower rates are not as regressive as they seem. Only the wealthy have capital gains in any significant amount. The de facto rate for everyone else is zero.

With tax subsidies for families shifted to an employer-based subtraction VAT, and creation of an asset VAT, taxes on salaries could be filed by employers without most employees having to file an individual return. It is time to TAX TRANSACTIONS, NOT PEOPLE!

The tax rate on capital gains is seen as unfair because it is lower than the rate for labor. This is technically true, however it is only the richest taxpayers who face a marginal rate problem. For most households, the marginal rate for wages is less than that for capital gains. Higher income workers are, as the saying goes, crying all the way to the bank.

In late 2017, tax rates for corporations and pass-through income wee reduced, generally, to capital gains and capital income levels. This is only fair and may or may not be just. The field of battle has narrowed between the parties. The current marginal and capital rates are seeking a center point. It is almost as if the recent tax law was based on negotiations, even as arguments flared publicly. Of course, that would never happen in Washington. Never, ever.

Compromise on rates makes compromise on form possible. If the Affordable Care Act non-wage tax provisions are repealed, a rate of 26% is a good stopping point for pass-through, corporate, capital gains and capital income.

A single rate also makes conversion from self-reporting to automatic collection through an asset value added tax levied at point of sale or distribution possible. This would be both just and fair, although absolute fairness is absolute unfairness to tax lawyers because there would be little room to argue about what is due and when.

Ending the machinery of self-reporting also puts an end to the Quixotic campaign to enact a wealth tax. To replace revenue loss due to the ending of the personal income tax (for all but the wealthiest workers and celebrities), enact a Goods and Services Tax. A GST is inescapable. Those escapees who are of most concern are not waiters or those who receive refundable tax subsidies. It is those who use tax loopholes and borrowing against their paper wealth to avoid paying taxes.

For example, if an unnamed billionaire or billionaires borrow against their wealth to go into space, creating such assets would be taxable under a GST or an asset VAT. When the Masters of the Universe on Wall Street borrow against their assets to avoid taxation, having to pay a consumption tax on their spending ends the tax advantage of gaming the system.

This also applies to inheritors. No "Death Tax" is necessary beyond marking the sale of inherited assets to market value (with sales to qualified ESOPs tax free). Those who inherit large cash fortunes will pay the GST when they spend the money or Asset VAT when they invest it. No special estate tax is required and no life insurance policy or retirement account inheritance rules will be of any use in tax avoidance.

Tax avoidance is a myth sold by insurance and investment brokers. In reality, explicit and implicit value added taxes are already in force. Individuals and firms that collect retail sales taxes receive a rebate for taxes paid in their federal income taxes. This is an intergovernmental VAT. Tax withheld by employers for the income and payroll taxes of their labor force is an implicit VAT. A goods and services tax simply makes these taxes visible.

Should the tax reform proposed here pass, there is no need for an IRS to exist, save to do data matching integrity. States and the Customs Service would collect credit invoice taxes, states would collect subtraction VAT, the SEC would collect the asset VAT and the Bureau of the Public Debt would collect income taxes or sell tax-prepayment bonds.

Contact Sheet

Michael G. Bindner
Principal Consultant
The Center for Fiscal Equity
14448 Parkvale Road, Suite 6
Rockville, Maryland 20853
301-871-1395
Fiscalequitycenter@yahoo.com

Committee on Ways and Means
Subcommittee on Oversight
Hearing on Tax-Exempt Hospitals and the Community Benefit Standard
Wednesday, April 26, 2023 at 2:00 PM

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.