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Subcommittee on Oversight
for the Hearing
"Virtue Signaling vs. Vital Services: Where Tax-Exempt Hospitals are Spending Your Tax Dollars"

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Chairman Schweikert, Ranking Member Sewell, 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. I am grateful for the opportunity to share my testimony.

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 focuses on health care accounting, finance, and policy. I am affiliated with the Johns Hopkins Center for Health Services and Outcomes Research, the Hopkins Business of Health Initiative, and the Johns Hopkins Drug Access and Affordability Initiative. From 2022 to 2023, I served as a visiting scholar at the Health Analysis Division of the Congressional Budget Office (CBO). I have published numerous research articles in leading academic journals examining nonprofit hospitals' tax-exempt status, charity care, and related financial and operational activities.

My testimony has two objectives: (1) to assess the value of tax-exempt status of nonprofit hospitals and (2) to examine how these hospitals spend their financial resources. I aim to provide

an objective, evidence-based summary of these issues. The opinions expressed here are my own and do not represent the views of Johns Hopkins University or any affiliated entities.

Section I: The Value of Tax-Exempt Status of Nonprofit Hospitals

Hospitals represent a major sector in the U.S economy, generating over $1.5 trillion in annual revenue.[1] Most U.S. hospitals are tax-exempt institutions,[2] exempt from paying federal and state income taxes, sales taxes, and property taxes. They also enjoy other tax-related benefits, such as the ability to issue tax-free bonds and receive tax-deductible charitable contributions.[3]

Historically, most U.S. hospitals were founded by religious groups or philanthropists to care for disadvantaged populations.[4] These institutions were incorporated under state nonprofit statutes, and their clear charitable mission—to alleviate the suffering of vulnerable populations—formed the basis for their tax-exempt status. Being nonprofit means that they cannot issue dividends or have shareholders. At the same time, they cannot raise capital through equity markets and are not subject to shareholder-imposed disciplines and oversight.

Nonprofit status alone does not automatically grant a hospital tax exemption. The IRS sets the legal standards for exemption. A nonprofit hospital must be organized and operated exclusively to further purposes listed in section 501(c)(3) of the Internal Revenue Code, such as charitable, religious, educational, or scientific purposes.[5] This requirement dates back to the original Internal Revenue Code of 1913, enacted after the 16th Amendment.[4] In 1956, the IRS required nonprofit hospitals 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," mandating that hospitals promote "the health of a class of persons that is broad enough to benefit the community." State governments typically follow federal criteria when granting exemption for state and local taxes.[4]

In a study published in *JAMA* last year, TCU accounting professor Elizabeth Plummer, Johns Hopkins health policy professor Mariana Socal, and I estimated the financial value that nonprofit hospitals derive from their tax-exempt status and assessed how the benefits are distributed.[6] Using methodologies consistent with current tax law and practice, we found that nonprofit hospitals collectively received $37.4 billion tax benefits in 2021, with more than half subsidized by state and local taxpayers. The breakdown was as follows: $11.5 billion in federal income tax (31%), $9.1 billion in sales tax (24%), $7.8 billion in property tax (21%), $3.7 billion in state

[1] https://www.kff.org/health-costs/key-facts-about-hospitals/?entry=national-hospital-spending-national-spending-on-hospital-care
[2] https://www.aha.org/statistics/fast-facts-us-hospitals
[3] https://www.healthaffairs.org/do/10.1377/forefront.20210903.507376
[4] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.25.w312
[5] https://www.irs.gov/charities-non-profits/charitable-organizations/exemption-requirements-501c3-organizations
[6] https://jamanetwork.com/journals/jama/fullarticle/2824116

income tax (10%), $3.2 billion in charitable contributions (8%), and $2.1 billion in interest savings from tax-exempt bonds (5%).

We also found that these benefits were highly concentrated. Hospitals with the highest profits and most valuable properties receive the greatest tax benefits. The top 7% of nonprofit hospitals received as much tax benefits as the remaining 93% combined. The largest 25% of hospitals accounted for 71% of total net income and tax benefits.

In addition to tax benefits, many nonprofit hospitals generate substantial profits through the federal 340B Drug Pricing Program. This program, established by Congress in 1992, allows eligible tax-exempt and government hospitals to purchase outpatient drugs from pharmaceutical companies at steep discounts and sell them at full prices, retaining the difference.[7,8] Not surprisingly, this "buy-low-sell-high" program has grown rapidly, from $6.6 billion in 2020 to $43.9 billion in 2021, according to a recent CBO report.[9]

Since 2016, following a rule change in the Centers for Medicare & Medicaid Services (CMS), triggered by two federal court decisions,[10,11] many urban nonprofit hospitals have dual-classified themselves as "administratively rural." This allows them to simultaneously use the high urban wage index for Medicare payments while qualifying for rural-only perks, including 340B eligibility at a lower disadvantaged patient-mix threshold (dropping from 11% to 8%). Dual-classification status also facilitates urban hospitals' access to expanded graduate medical education slots and other benefits intended to support rural health.

In a recent study published in *Health Affairs*, Johns Hopkins health policy professor Yang Wang, Brown University economics professor Chrisotpher M. Whaley and health policy strategy director Jared Perkins, and I found that the number of urban hospitals that obtained dual classification exploded from just three in 2017 to 425 in 2023, representing around one-third of all community hospital beds.[12] In 2023, three-quarters of the 425 dual-classified hospitals were nonprofits, and the largest 20, mostly major teaching hospitals, had net patient revenues ranging from $2.9 billion to over $9 billion. If left unchecked by Congress, most large hospitals could soon obtain this status.

Section II: How Nonprofit Hospitals Spend Their Financial Resources

<u>Charity Care</u>

[7] https://www.nejm.org/doi/full/10.1056/nejmsa1706475
[8] https://www.hrsa.gov/opa/eligibility-and-registration
[9] https://www.cbo.gov/publication/60661
[10] https://www2.ca3.uscourts.gov/opinarch/151202p.pdf
[11] https://caselaw.findlaw.com/court/us-2nd-circuit/1724952.html
[12] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00019

Nonprofit 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. The Affordable Care Act required nonprofit hospitals to report certain community benefit information 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 activities.[13]

Charity care, care provided free or at a discount to financially disadvantaged patients, is the most objective and comparable measure of hospitals' charitable efforts.[14] Yet, in 2021, nonprofit hospitals provided only $15.2 billion in charity care, far below their $37.4 billion in tax benefits.

In a study published in *Health Affairs* in 2021, my colleagues, Professors Hossein Zare, Matthew Eisenberg, Dan Polsky, Gerard Anderson at Johns Hopkins, and I found that, in 2018 in aggregate, nonprofit hospitals spent $2.3 of every $100 in total expenses incurred on charity care, which was less than for-profit hospitals ($3.8).[15] In addition, among regional markets where all three hospital ownership types coexisted, nonprofit hospitals in aggregate provided less charity care relative to expenses than for-profit hospitals more than 30% of the time.

Furthermore, the charity care provision was distributed unevenly among nonprofit hospitals. In another study published in *JAMA Internal Medicine*, Johns Hopkins researcher Farah Yehia, health policy professor Gerard Anderson and I found that in 2017, the top 5% most profitable nonprofit hospitals generated more than half of the total profit by all nonprofit hospitals but provided only about 20% of total charity care.[16]

In another study published in *JAMA Open Network*, Georgetown law professor David A. Hyman and Johns Hopkins health policy professor Hossein Zare, and I examined the largest component of community benefit, Medicaid shortfalls.[17] We found that in 2019 tax-exempt and for-profit hospitals in aggregate had nearly identical Medicaid shortfalls as a share of expenses. In more than half of the states, nonprofit hospitals in aggregate had lower Medicaid shortfalls as a share of expenses than for-profit hospitals.

Taken together, nonprofit hospitals, as a group, fall short of for-profit hospitals in providing the two largest components of community benefit—charity care and Medicaid shortfalls—despite the tax benefits they receive.[18]

[13] https://www.irs.gov/pub/irs-pdf/f990sh.pdf
[14] https://docs.house.gov/meetings/WM/WM06/20230426/115817/HHRG-118-WM06-Wstate-BaiG-20230426.pdf
[15] https://www.healthaffairs.org/doi/10.1377/
[16] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2760774
[17] https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2789009
[18] https://www.nejm.org/doi/full/10.1056/NEJMp2303245

Financial Investment

Many nonprofit hospitals have accumulated substantial financial investment. In a study published in *Health Affairs Forefront*, Brown University economics professor Christopher W. Whaley, Georgetown Mason accounting professor, and I found that investment losses are the major reason contributing to overall losses of nonprofit hospital systems in spring 2023.

In a forthcoming *Tax Notes* study, TCU accounting professor Elizabeth Plummer, University of Kentucky professor Stephen Lusch, and I found that in 2022, U.S. nonprofit hospitals collectively held $447 billion in investment assets, with 42% in the top 1% of hospitals, 41% in the next 9%, and the remaining 17% in the bottom 90% of hospitals. The average investment assets was $8.2 billion for the top 1%, $0.9 billion for the next 9%, and $0.04 billion for the bottom 90%.

Because creditors of nonprofit hospitals are not taxed on interest income from tax-exempt debt, nonprofit hospitals can issue debt at lower interest rates than for-profit hospitals. As in our *JAMA* study, the resultant tax benefit in 2021 was estimated to be $2.1 billion.[6] With low cost of borrowing, nonprofit hospitals can also indirectly engage in "tax arbitrage" issuing tax-exempt debt to indirectly pursue investment returns. In the *Tax Notes* study, we estimated that in 2022, with nonprofit hospitals' $178.7 billion tax-exempt debt outstanding, they obtained an annual estimated arbitrage profit of $9.4 billion.

Consolidation and Administrative Expenses

Tax-exempt status also gives nonprofit hospitals a competitive edge against independent practices, for-profit hospitals, and other facilities, and create incentives for them to engage in vertical and horizontal consolidation.[14] As a result, market concentration increased and commercial prices rose. A working paper from the National Bureau of Economic Research working paper shows that hospital consolidation raises prices, which in turn harm local economies and employment, especially among lower- and middle-income workers.[19]

Nonprofit hospitals also spend heavily on administration. A recent study published in the *Journal of Financial Economics* found that after nonprofit hospitals were acquired by private equity firms, administrative expenses on average fell by one-third without compromising quality, suggesting that nonprofit hospitals typically carry significant administrative redundancies.[20] The Lown Institute also reported that nonprofit hospitals spend substantial amounts on executive compensation.[21]

[19] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4874257
[20] https://linkinghub.elsevier.com/retrieve/pii/S0304405X25001151
[21] https://lowninstitute.org/what-do-the-highest-paid-nonprofit-hospital-ceos-have-in-common/

Section III: Policy Recommendations

As Congress considers nonprofit hospitals' accountability to taxpayers, it is important to recognize that hospitals respond to the incentives they face. Anyone in a similar situation would likely behave the same way. Addressing these underlying incentives is essential.

Close the Dual-Classification Loophole

To ensure care access for rural Americans, the federal government has designed various regulations and programs to support rural health. Congress should consider ensuring that all federal programs intended to improve rural health are directed to geographically rural hospitals, not to dually classified hospitals located in urban areas. Prohibiting dual classification for Medicare purposes would enhance the efficiency of federal rural health efforts and improve hospitals' accountability to taxpayers.

Improve Transparency

Tax-exempt status provides no guarantee that nonprofit hospitals act in accordance with their charitable missions or justify their tax benefits. Currently, insufficient federal data exist to assess the tax benefits received by individual nonprofit hospitals. To close this gap, Congress should consider requiring the IRS to revise Form 990 Schedule H so that nonprofit hospitals 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 estimation challenges.[22]

Greater visibility is a prerequisite for policy action. Disclosure of tax benefits would help identify nonprofit hospitals with misalignments between tax benefits and service provision and allow local governments and stakeholders to take targeted approaches, such as challenging certain hospitals' tax exemption status at the state or county level.

It is worth noting that many nonprofit hospitals face fiscal challenges. Disclosure of taxpayer subsidies would give stakeholders and policymakers the flexibility to design and test alternative approaches to encourage meaningful changes in hospital behaviors.

Impose Excise Tax on Investments

Just as Congress now subjects wealthy universities to a tiered excise tax on income from their endowments, a similar framework could apply to nonprofit hospitals with large investment

[22] 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).

assets. As our research shows, many large tax-exempt health systems hold billions of dollars in financial investments, generating significant tax-exempt returns. A caveat is that such a tax could potentially affect commercial prices.

Promote Competition

Nonprofit hospital tax exemption status originated when hospitals relied on volunteer labor to provided free care for the disadvantaged. Today, the hospital market is far more commercial. Nonprofit hospitals often engage revenue-enhancing activities typical of for-profit entities, including anti-competitive tactics and not offering charity care to eligible patients.[23,24] Yet, they retain tax benefits and are often protected by policymakers. For example, New York State allows only nonprofit and government hospitals to operate.

Government policies also favor hospitals and disadvantage independent physician practices and alternative facilities such as ambulatory surgery and imaging centers. Examples include the 340B Drug Pricing Program, site-based reimbursements, restrictions on physician-owned hospitals, the Stark Law, certificate of need (CON) laws, and Certificates of Public Advantage (COPA). Hospitals benefit from government-granted barriers and competitive advantages, while others are disincentivized or prevented from competing.

Competition forces all providers to innovate continuously, thereby lowering prices, improving quality, and expanding access. Therefore, Congress should consider leveling the playing field by removing anticompetitive regulations. This would allow physician practices and alternative facilities to instill competition and motivate all providers, including hospitals, to constantly improve, benefiting patients.

Fund Patients Directly

Nonprofit hospitals face significant operational challenges, including declining collection rates on medical bills and low reimbursement rates for many patients.[25] In return, they receive government appropriation and transfers (e.g., Disproportionate Share Hospital payments). In other words, taxpayers pay nonprofit hospitals to care for certain patients, and in exchange, hospitals receive government funding and regulatory protection, as analyzed by Hoover Institution economist John Cochrane.[26] This arrangement is highly inefficient—even for hospitals themselves—and create substantial opportunity cost for patients and society.

[23] https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html
[24] https://www.justice.gov/opa/pr/atrium-health-agrees-settle-antitrust-lawsuit-and-eliminate-anticompetitive-steering
[25] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2837042
[26] https://www.hoover.org/research/curse-cross-subsidies

Congress should consider directly subsidizing patients in need and allowing the market to achieve nondiscriminatory, affordable prices for all patients and payers through competition. Funding patients directly—putting money in their hands—would empower them to choose providers, align patient interests with those of providers, and motivate providers to innovate and improve both quality and affordability, focusing on attracting and retaining patients rather than merely complying to obtain government payments. Insurance-based access restrictions, such as prior authorization and network requirements, would largely disappear, disproportionately benefiting low-income populations. This structural reform would fundamentally transform the hospital market and benefit all Americans.

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