# Reassessing the Value of Nonprofit Hospital Tax Exemptions:

## Community Benefit or Missed Opportunity?

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*Testimony of Christopher M. Whaley presented before the House Ways and Means Subcommittee on Oversight on nonprofit hospital tax exemptions on September 16, 2025*

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*Reassessing the Value of Nonprofit Hospital Tax Exemptions:*
*Community Benefit or Missed Opportunity?*

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[1]The opinions and conclusions expressed in this testimony are the author's alone and do not necessarily reflect those of Brown University, the Brown University School of Public Health, or any of the research sponsors.

[2]The Center for Advancing Health Policy through Research (CAHPR) at the Brown University School of Public Health is dedicated to generating research that informs policies aimed at reducing costs, improving patient well-being, and driving meaningful transformations in U.S. health care delivery. Our work focuses on the design of insurance plans and their interactions within the health care market, employing a unique approach that integrates quantitative policy analysis with legal evaluation. This combined methodology helps identify the most effective legal and regulatory changes to create a significant impact. While this testimony is not a research publication, it is informed by relevant research conducted by CAHPR and its affiliates.

Chairman Schweikert, Ranking Member Sewell, and distinguished members of the committee, thank you for the opportunity to testify today. My name is Christopher Whaley. I am an associate professor of Health Policy at the Brown University School of Public Health and Associate Director of the Center for Advancing Health Policy through Research (CAHPR). My research focuses on how to reduce health care costs, the role of price transparency, and the impacts of evolving health care markets. The remarks I deliver today are in my personal capacity as an expert on US health care markets and are informed by several recent studies from my colleagues and me examining nonprofit hospitals, market consolidation, and price growth. I will make three points:

1. Commercial hospital prices have increased by more than 220% since 2000, outpacing overall inflation nearly threefold. This growth is largely driven by hospital mergers and vertical integration, which raise prices without improving quality and strain affordability for patients, employers, and taxpayers.
2. Despite receiving more than $37 billion annually in federal and state tax benefits, nonprofit hospitals' community benefit spending falls short by more than $25 billion per year relative to the value of their tax exemption.
3. There are many ways Congress could help ensure that the substantial tax benefits nonprofit hospitals receive translate into tangible improvements for patients and communities.

## Hospital Price Growth and Consolidation

I first want to acknowledge the importance of access to high-quality and affordable health care for all Americans. Regardless of geographic region or income, access to hospital care is critical for Americans. Hospitals deliver life-saving care that makes us all healthier and improves our well-being. Hospitals are also a key source of employment. In many localities, the local hospital is the largest employer. And the US hospital sector is among the largest in the economy. Hospital care accounts for over $1.5 trillion in annual spending, approximately 31% of health care spending, and alone 5.2% of US GDP.[3]

Growth in prices threatens the affordability of hospital care in the United States. Over the last two decades, commercial prices for hospital care have increased rapidly. According to an analysis conducted by the American Enterprise Institute, prices for hospital care have increased faster than in any other sector of the U.S. economy.[4] Since 2000, hospital prices have increased by over 220%, nearly three times overall inflation growth. Hospital price growth outpaces that in high-technology areas, such as general medical services, consumer electronics, and computer software.

Why are prices growing so rapidly? The U.S. hospital market is characterized by two unique features. First, it has been shaped by decades of consolidation, resulting in a landscape that is highly concentrated. As highlighted in Figure 1, the U.S. has seen over 2,000 hospital mergers since 2001. Nearly all U.S. hospital markets exceed the market concentration definitions used by regulators such as the Department

[3] Centers for Medicare & Medicaid Services. National health expenditure data. Centers for Medicare & Medicaid Services. Published December 18, 2024. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

[4] Perry M. Chart of the Day . . . or Century? American Enterprise Institute - AEI. Published July 23, 2022. https://www.aei.org/carpe-diem/chart-of-the-day-or-century-8/

of Justice and Federal Trade Commission to classify highly concentrated markets (Figure 2).[5] A large set of rigorous studies conclusively demonstrates that hospital mergers raise prices without improving quality.[6,7] In part due to decades of consolidation, patients with commercial insurance pay approximately 250 percent of what Medicare pays for hospital care.[8] High commercial insurance prices are paid both by patients through cost-sharing payments, but also through higher premiums and lower wages.[9] Operating margins for commercially insured patients receiving care at system-affiliated hospitals are over 40 percent.[10] My research also shows how hospital mergers increase financial instability among neighboring hospitals.[11]

In addition to hospital mergers, health care markets have become highly vertically consolidated. The share of U.S. physicians employed by a hospital or health system conglomerate has roughly doubled since 2010, with over half of U.S. physicians now working for a health system. My research shows that acquiring physician practices presents hospitals with an arbitrage opportunity to exploit the site-of-care payment differential by charging higher hospital-based rates for routine outpatient services performed by or referred by acquired physicians.[12,13,14,15] The Congressional Budget Office estimates that addressing site-of-care payment differentials could reduce Medicare spending by over $150 billion.[16] My research highlights that these savings would likely extend beyond Medicare and also benefit patients with commercial and employer-sponsored insurance[17].

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[5] Fulton BD. Health Care Market Concentration Trends In The United States: Evidence And Policy Responses. *Health Aff (Millwood)*. 2017;36(9):1530-1538. doi:10.1377/hlthaff.2017.0556

[6] Whaley C, Singh Y, Fuse Brown EC, Reddy M, Perkins J, Rooke-Ley H. *Addressing Healthcare Consolidation in the U.S-Potential Policy Options for a Competitive and Transparent Future Policy Brief*. The Center for Advancing Health Policy through Research (CAHPR); 2024. https://cahpr.sph.brown.edu/sites/default/files/documents/CAHPR_Health%20Care%20Consolidation_Policy%20Brief.pdf

[7] Liu, Jodi L., Zachary M. Levinson, Annetta Zhou, Xiaoxi Zhao, PhuongGiang Nguyen, and Nabeel Qureshi, Environmental Scan on Consolidation Trends and Impacts in Health Care Markets. Santa Monica, CA: RAND Corporation, 2022. https://www.rand.org/pubs/research_reports/RRA1820-1.html.

[8] Whaley CM, Kerber R, Wang D, Kofner A, Briscombe B. Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. RAND Corporation. Published December 10, 2024. Accessed September 3, 2025. https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html.

[9] Arnold D, Whaley C. Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages. *SSRN Electronic Journal*. Published online 2020. doi:https://doi.org/10.2139/ssrn.3657598

[10] Whaley C, Bartlett M, Bai G. Financial Performance Gaps Between Critical Access Hospitals and Other Acute Care Hospitals. *JAMA Health Forum*. 2024;5(12):e243959. Published 2024 Dec 6. doi:10.1001/jamahealthforum.2024.3959

[11] Arnold D, Radhakrishnan N, Whaley C. Foisted: The Spillover Effects of Hospital Mergers on Costs and Utilization . *SSRN*. Published online May 22, 2025. doi:https://doi.org/10.2139/ssrn.5265291

[12] Whaley CM, Zhao X. The Effects of Physician Vertical Integration on Referral Patterns, Patient Welfare, and Market Dynamics. *J Public Econ*. 2024;238:105175. doi:10.1016/j.jpubeco.2024.105175

[13] Richards MR, Seward JA, Whaley CM. Treatment consolidation after vertical integration: Evidence from outpatient procedure markets. *J Health Econ*. 2022;81:102569. doi:10.1016/j.jhealeco.2021.102569

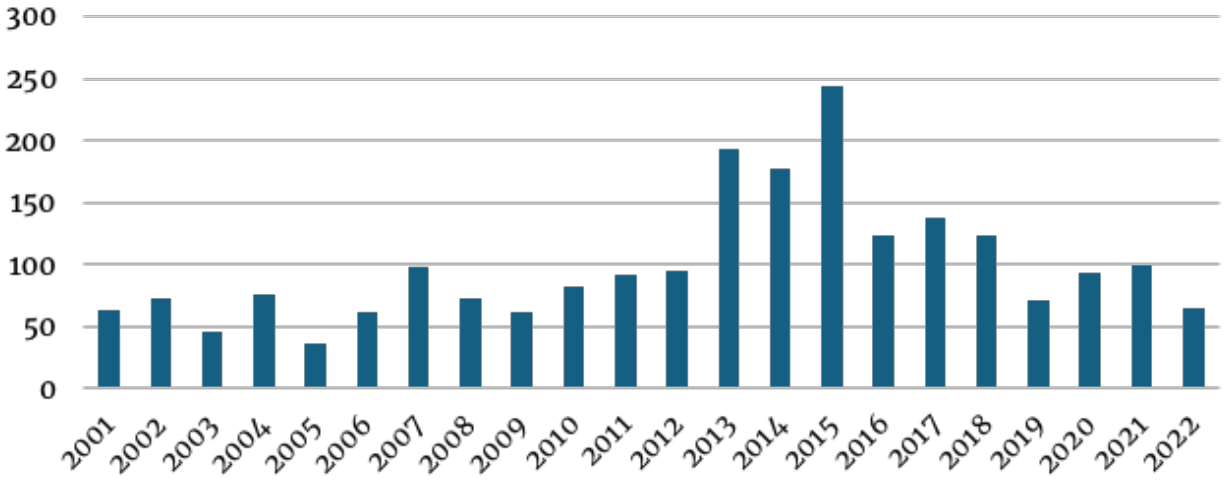
[14] Whaley CM, Zhao X, Richards M, Damberg CL. Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration. *Health Affairs*. 2021;40(5):702-709. doi:https://doi.org/10.1377/hlthaff.2020.01006

[15] Whaley C, Singh Y, Fuse Brown EC, Reddy M, Perkins J, Rooke-Ley H. *Addressing Healthcare Consolidation in the U.S-Potential Policy Options for a Competitive and Transparent Future Policy Brief*. The Center for Advancing Health Policy through Research (CAHPR); 2024. https://cahpr.sph.brown.edu/sites/default/files/documents/CAHPR_Health%20Care%20Consolidation_Policy%20Brief.pdf

[16] Congressional Budget Office (CBO). Reduce Payments for Hospital Outpatient Departments | Congressional Budget Office. cbo.gov. Published December 12, 2024. https://www.cbo.gov/budget-options/60908

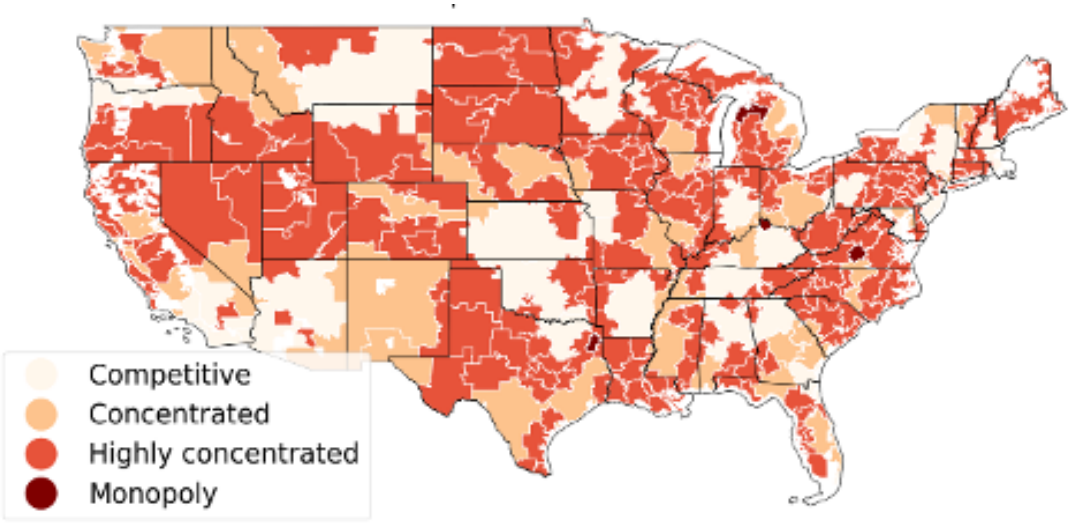
[17] Richards MR, Seward JA, Whaley CM. Removing Medicare's outpatient ban and Medicare and private surgical trends. Am J Manag Care. 2021 Mar;27(3):104-108.

**Figure 1: Annual Number of U.S. Hospital Mergers**




Source: Analysis of American Hospital Association data

**Figure 2: Hospital Market Concentration by Geographic Market**




Source: Analysis of 2022 American Hospital Association data. Geographic markets defined using Hospital Referral Regions (HRRs). Market concentration is defined using the Hirschman Herfindahl Index (HHI), with ranges of Competitive (less than 1,800), Concentrated (1,800 to 2,500), Highly concentrated (above 2,500), and Monopoly (10,000).

Second, US hospitals vary between for-profit and nonprofit firms. 61 percent of US hospitals are tax-exempt, compared to 17 percent of hospitals that are for-profit and 22 percent that are government hospitals. Like nonprofits in other industries, nonprofit hospitals have the financial benefit of not paying taxes, including federal, state, local, and municipal taxes.[18] Tax exemptions include corporate income,

[18] Godwin J, Levinson Z, Hulver S. The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020 | KFF. KFF. Published March 14, 2023. Accessed September 12, 2025. https://www.kff.org/health-costs/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/

unemployment, and property taxes. In addition, tax-exempt hospitals may receive tax-exempt charitable donations and issue tax-exempt bonds. Nonprofit hospitals' tax exemptions are divided almost equally between federal and state taxes. Notably, nonprofit hospitals also have access to the 340B discount program, which allows hospitals and associated entities to purchase drugs at rebated prices. Additionally, many tax-exempt hospitals have also been dually classified as both rural and urban hospitals, allowing them to receive increased Medicare payments.[19]

## Scope and Value of Hospital's Nonprofit Tax Exemption

Nonprofit hospitals play a critical role in providing patient care and employment to health professionals. The favorable tax exemption of nonprofit status creates a large financial benefit to nonprofit hospitals. Recent estimates value the collective financial value of nonprofit exemptions exceeding $37 billion per year.[20] This value has steadily increased from $7.8 billion in 1994,[21] $12.6 billion in 2002,[22] and $24.6 billion in 2011.[23] In return for tax exemption, the IRS requires that nonprofit hospitals be organized and operated with the purpose of primarily benefiting the community.[24] Yet, this does not appear to be the case. While hospitals provide community benefit spending, research suggests that the value of tax exemption exceeds community benefit spending by over $25 billion per year.[25] This discrepancy has led to bipartisan efforts to increase oversight of tax-exempt hospitals and to further regulate their financial assistance and debt collection practices.[26]

As part of their tax exemption, hospitals are required to offer financial assistance and charity care to patients who may not be able to afford care.[27] Yet, many consumers report difficulty in obtaining required financial assistance or even find tax-exempt hospitals suing patients to collect medical debt that is not actually owed.[28] Other reports find that nearly half of tax-exempt hospitals send medical bills to lower-income patients who should qualify for financial assistance.[29] Yet there has been little or no enforcement of compliance with tax-exemption requirements..

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[19] Wang Y, Perkins J, Whaley CM, Bai G. Sharp Rise In Urban Hospitals With Rural Status In Medicare, 2017–23. *Health Affairs*. 2025;44(8):963-969. doi:https://doi.org/10.1377/hlthaff.2025.00019

[20] U.S. Nonprofit Hospitals Received More than $37 Billion in Total Tax Benefits in 2021 | Johns Hopkins Bloomberg School of Public Health. Johns Hopkins Bloomberg School of Public Health. Published September 26, 2024. https://publichealth.jhu.edu/2024/us-nonprofit-hospitals-received-more-than-37-billion-in-total-tax-benefits-in-2021

[21] Gentry WN, Penrod JR. The Tax Benefits of Not-for-Profit Hospitals. National Bureau of Economic Research. doi:https://doi.org/10.3386/w6435

[22] *Nonprofit Hospitals and the Provision of Community Benefits*. Congressional Budget Office (CBO); 2006. https://www.cbo.gov/sites/default/files/109th-congress-2005-2006/reports/12-06-nonprofit.pdf

[23] Rosenbaum S, Kindig DA, Bao J, Byrnes MK, O'Laughlin C. The Value Of The Nonprofit Hospital Tax Exemption Was $24.6 Billion In 2011. *Health Aff (Millwood)*. 2015;34(7):1225-1233. doi:10.1377/hlthaff.2014.1424

[24] Warren E, E. Grassley C. Letter to IRS on Nonprofit Hospitals. United States Senate. Published November 19, 2024. https://www.warren.senate.gov/imo/media/doc/letter_to_irs_on_nonprofit_hospitals1.pdf

[25] Lown Institute. Nonprofit hospitals receive billions more in tax breaks than they invest in their communities. Lown Institute Hospital Index. https://lownhospitalsindex.org/hospital-fair-share-spending-2024/

[26] Warren E, E. Grassley C. Letter to IRS on Nonprofit Hospitals. United States Senate. Published November 19, 2024. https://www.warren.senate.gov/imo/media/doc/letter_to_irs_on_nonprofit_hospitals1.pdf

[27] I.R.C. § 501(r); 26 C.F.R. § 1.501(r)-1 to -7.

[28] *Fair Debt Collection Practices Act*. Consumer Financial Capital Bureau; 2024. https://files.consumerfinance.gov/f/documents/cfpb_fdcpa-2024-annual-report_2024-09.pdf

[29] Rau J. Patients Eligible For Charity Care Instead Get Big Bills. KFF Health News. Published October 14, 2019. https://kffhealthnews.org/news/patients-eligible-for-charity-care-instead-get-big-bills/

Nonprofit hospitals in the United States do not appear to operate meaningfully differently than for-profit hospitals.[30] High-level comparisons between US for-profit and nonprofit hospitals are presented in the following table (Table 1). Across these dimensions, nonprofit and for-profit hospitals are similar. In some cases, for example charity care, non-profit hospitals provide *less* community benefits than for-profit hospitals.

**Table 1: Characteristics of Nonprofit and For-profit Hospitals**

| Measure | Nonprofit hospitals | For-profit hospitals |
|---|---|---|
| ***Patient experience*** | | |
| *% of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)* | 69.9% | 66.2% |
| *% of patients who reported YES, they would definitely recommend the hospital* | 68.7% | 64.6% |
| *% of patients who reported the nurse always communicated well* | 63.5% | 62.2% |
| *% of patients who reported the doctor always communicated well* | 78.5% | 76.5% |
| *% of patients who reported receiving help when needed* | 78.3% | 76.1% |
| ***Financial and operating metrics*** | | |
| Operating margin | 10.6% | 13.5% |
| Charity care payer mix | 2.0% | 3.2% |
| Medicaid payer mix | 17.2% | 17.5% |
| Commercial prices relative to Medicare | 252% | 256% |
| Market share | 21% | 16% |

Sources: NASHP 2023 (bed size, operating margin, charity care payer mix), AHA FY 2023 (market share), CMS Hospital Compare 2023 (patient experience measures), RAND Hospital study (commercial prices)
Notes: Market shares calculated using Hospital Referral Regions (HRRs) as the geographic market.

## Market Behavior and Use of Public Subsidies

Tax-exempt hospitals operate and provide levels of care quality and charity care that are similar to for-profit hospitals. Yet, the substantial financial advantage of tax-exempt hospitals has led to concerns that quality should be *higher*. If community investment is not larger and quality is not superior, where are the extra dollars from these financial advantages going? Critics have raised concerns that financial resources may be used in ways that do not directly benefit patient care. A few of these concerns are described below.

*Executive Compensation*

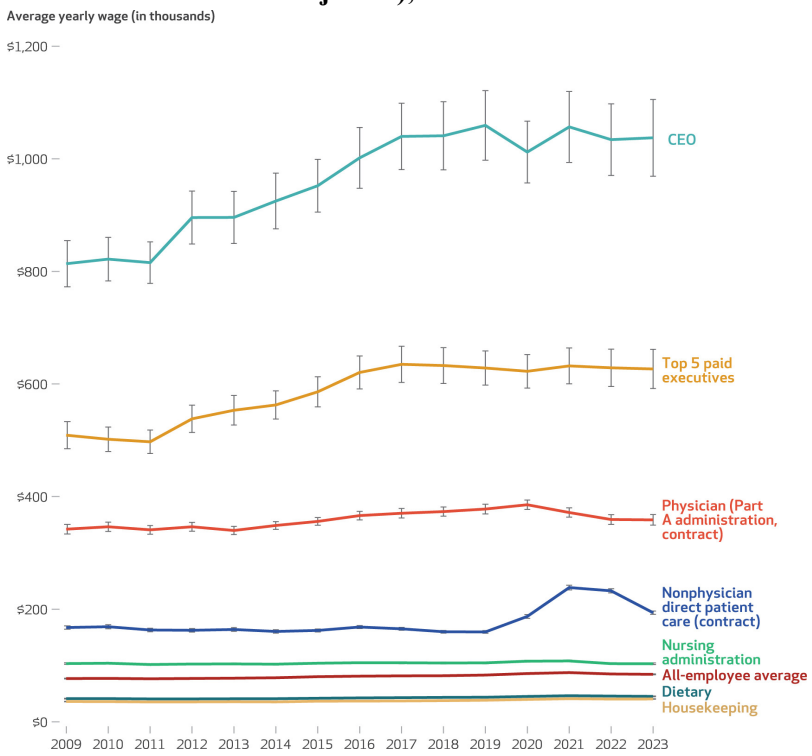
Recent research highlights that executive and CEO pay at non-profit hospitals has steadily increased since 2009 (Figure 3).[31] Several notable examples highlight the growing disparity between tax-exempt hospital

[30] Lakdawalla D, Philipson T. The nonprofit sector and industry performance. *Journal of Public Economics*. 2006;90(8-9):1681-1698. doi:https://doi.org/10.1016/j.jpubeco.2005.11.004

[31] Rosenbaum S, Kindig DA, Bao J, Byrnes MK, O'Laughlin C. The Value Of The Nonprofit Hospital Tax Exemption Was $24.6 Billion In 2011. *Health Aff (Millwood)*. 2015;34(7):1225-1233. doi:10.1377/hlthaff.2014.1424

executives and clinicians pay. For example, the Lown Institute highlights several tax-exempt hospital pay packages exceeding $20 million annually.[32]

**Figure 3: Wage changes across employee categories in US nonprofit hospitals, by year (inflation adjusted), 2009–23**




Source: Pay Gap Between Nonprofit Hospital CEOs And Employees Grew, 2009–23. Fang et al. *Health Affairs* 2025 44:8, 953-962

## *Investment Vehicles*

At the same time that prices are rising, many tax-exempt hospitals also hold tremendous financial assets and investments. The ten largest health systems alone have total financial assets of over $310 billion.[33] Total hospital assets exceed $1.5 trillion.[34] These investments play crucial roles for tax-exempt health systems. For example, my research highlights how recent financial losses at tax-exempt hospitals were due to declining stock market valuations, rather than changes in clinical or operating expenses.[35] Non-

[32] Garber J. Housing, retirement, and other perks for hospital CEOs. Lown Institute. Published April 24, 2024. Accessed September 12, 2025. https://lowninstitute.org/housing-retirement-and-other-perks-for-hospital-ceos/

[33] Largest And Global Sovereign Wealth Fund Institute | SWFI. Sovereign Wealth Fund Institute. Published 2025. Accessed September 12, 2025. https://www.swfinstitute.org/fund-rankings/healthcare-foundation

[34] Teeple S, Andy C, Schpero WL, Chatterjee P. What explains the growth in hospital assets from 2000 through 2019? A decomposition analysis. *Health Aff Sch*. 2025;3(2):qxaf004. Published 2025 Feb 5. doi:10.1093/haschl/qxaf004

[35] Whaley CM, Demirkan S, Bai G. What's Behind Losses At Large Nonprofit Health Systems? *Health Affairs Forefront*. Published online March 24, 2023. doi:https://doi.org/10.1377/forefront.20230322.44474

profit hospitals have invested these assets in private equity and related financial vehicles,[36,37] which have raised concerns for policymakers. A key policy question is the extent to which patients and payers should finance the future operational stability of multi-billion-dollar investment accounts by paying high prices. While the COVID-19 pandemic financially burdened hospitals, these facilities were given generous federal subsidies and did not have to draw down on investment accounts to support operations.[38]

Other potentially questionable expenses include marketing and other miscellaneous costs. Several tax-exempt hospital systems sponsor local sports teams and stadiums.[39] The NYU Langone system drew attention for sponsoring an advertisement in this year's Super Bowl.[40] The Northwell Health system has constructed a production studio to develop movies with *Netflix*.[41] While these may be beneficial to the respective hospitals, it is unclear whether they fulfill the public and charitable mission for which tax-exempt status is granted.

### *340B Program*

In addition to spending and investment practices, policymakers have also focused on programs that generate significant revenue for tax-exempt hospitals, most notably the 340B drug discount program, which allows participating providers to purchase medications at rebate-discounted prices. While initially limited to a small number of community health providers following its launch in 1992, changes to eligibility, including the expansion of eligibility to contract pharmacies, have led to substantial growth in the number of participating providers and the size of the 340B subsidy. A recent report from the Congressional Budget Office (CBO) finds that the 340B program now accounts for $43.9 billion in drug purchases, an increase of nearly 600% from $6.6 billion in 2010.[42] Many drugs purchased through the 340B program are heavily marked-up. Sales of 340B drugs are an estimated $124 billion.[43]

Participation in 340B potentially benefits patients through reduced costs for cancer patients, lower-income patients, and high-needs patients. However, my research finds that rather than create savings for

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[36] Zhang RC. The Catholic hospital system Ascension is running a Wall Street-style private equity fund. STAT. Published November 16, 2021. Accessed March 14, 2025. https://www.statnews.com/2021/11/16/ascension-running-wall-street-style-private-equity-fund/

[37] Baldwin T. Ascension Financial Letter. United States Senate. Published November 13, 2023. https://www.baldwin.senate.gov/imo/media/doc/ascension_financial_letter_final.pdf

[38] Buxbaum JD. Enhanced COVID-19 Provider Relief, Hospital Finances, and Care for Medicare Inpatients. *JAMA Health Forum*. 2025;6(3):e250046. Published 2025 Mar 7. doi:10.1001/jamahealthforum.2025.0046

[39] Vollers AC. Nonprofit hospitals spend millions on stadium naming rights, raising eyebrows • Stateline. Stateline. Published August 1, 2025. Accessed September 12, 2025. https://stateline.org/2025/08/01/nonprofit-hospitals-spend-millions-on-stadium-naming-rights-raising-eyebrows/

[40] Goldstein J. A Lawmaker Blasted a Hospital's Super Bowl Ad. Then He Changed His Tune. *The New York Times*. https://www.nytimes.com/2025/04/29/nyregion/nyu-langone-ad-super-bowl-congressman.html. Published April 29, 2025.

[41] Bruce G. From New York to Netflix: How Northwell built a global brand. Becker's Hospital Review | Healthcare News & Analysis. Published August 7, 2025. Accessed September 12, 2025. https://www.beckershospitalreview.com/digital-marketing/from-new-york-to-netflix-how-northwell-built-a-global-brand/

[42] *Growth in the 340B Drug Pricing Program*. Congressional Budget Office (CBO); 2025. https://www.cbo.gov/system/files/2025-09/60661-340B-program.pdf

[43] Martin R, Karne H. *The 340B Drug Discount Program Grew to $124B in 2023* . IQVIA; 2024. https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2024/iqvia-update-on-size-of-340b-program-report-2024.pdf

patients, hospitals participating in 340B have the highest prices for administered drugs.[44] Relative to Medicare's uniform payment of average sale price (ASP) plus 6 percent, 340B hospitals charge prices of nearly 300 percent of ASP. The profit margin on a drug administered at a 340B hospital is nearly 700 percent. Additionally, 340B-participating hospitals retain approximately 65 percent of drug spending, which is over 40 percent more than non-340B hospitals. Other studies find the rapid growth of the 340B program fuels consolidation and leads hospitals to acquire independent oncologists and other physicians.[45] 340B costs are also passed along to enrollees through higher insurance premiums. One study estimates that 340B increases 340B premiums by nearly $350 million per year.[46]

## There are several options Congress could consider to help ensure that the substantial tax benefits nonprofit hospitals receive translate into tangible improvements for patients and communities.

I'll conclude with several recommendations Congress could consider to address the issues I have highlighted and ensure that nonprofit hospitals better adhere to the community benefit mission:

### *Strengthening Oversight of Tax-Exempt Hospital Community Benefit Obligations*

High and rapidly rising prices, which differ enormously from one hospital to another but are not related to quality or cost, and are disclosed only after the fact, combined with substantial investment accounts, create the perception that some tax-exempt hospitals are operating with a profit motive. To ensure that tax-exempt hospitals fulfill their charitable mission, Congress could establish defined standards for financial assistance and benefits to the community health sector.

For example,minimum levels of charity care based on tax-exemption value, standardizing eligibility thresholds for financial assistance, improving transparency through standardized public reporting, and directing and funding federal agencies to monitor and enforce compliance. Congress and regulators could also authorize intermediate sanctions, such as an excise tax, on violations, rather than terminating an entity's tax-exemption. Bipartisan calls for these reforms already exist, reflecting a shared interest in making sure the significant tax benefits hospitals receive translate into tangible benefits for the communities they serve.[47]

### *Promoting Competition and Preventing Future Harmful Consolidation*

To more broadly ensure that U.S. health care markets deliver high-quality and affordable care, Congress and federal regulators should consider policies that prevent harmful consolidation in both the delivery and insurance systems while preserving beneficial forms of integration. This includes strengthening antitrust scrutiny for transactions that currently fall below federal reporting thresholds, expanding site-neutral payment policies to remove incentives for hospital-physician consolidation, and banning anticompetitive

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[44] Robinson JC, Whaley C, Dhruva SS. Hospital Prices for Physician-Administered Drugs for Patients with Private Insurance. *The New England Journal of Medicine*. 2024;390(4):338-345. doi:https://doi.org/10.1056/nejmsa2306609

[45] Desai S, McWilliams JM. Consequences of the 340B Drug Pricing Program. *N Engl J Med*. 2018;378(6):539-548. doi:10.1056/NEJMsa1706475

[46] Gray C. *The Incidence of the 340B Program: The Effects of Contract Pharmacies on Part D Premiums and Reimbursements*. 2023. https://spaces-cdn.owlstown.com/blobs/knf2d2xvoyv7fegggf5xwbc0gz2x

[47] Warren E, E. Grassley C. Letter to IRS on Nonprofit Hospitals. United States Senate. Published November 19, 2024. https://www.warren.senate.gov/imo/media/doc/letter_to_irs_on_nonprofit_hospitals1.pdf

contract terms, like all-or-nothing clauses and anti-tiering provisions.[48] Together, these steps could help preserve competition, protect patient choice, and ensure that consolidation serves the interests of communities rather than corporate bottom lines.

### *Ensuring 340B Resources are Used to Directly Benefit Patients*

As a way of addressing concerns that 340B rebate dollars are not directly benefiting patients, Congress could address several key aspects of the 340B program.[49] First, Congress could ensure improved transparency on each hospital's 340B financial benefit, and what 340B resources are spent on. Second, Congress could narrow 340B eligibility requirements, including restricting the eligibility of non-market contract pharmacies. Finally, 340B discounts could be extended directly to patients to lower the costs of their medications and improve their ability to access affordable care.

### *Codifying and Continuing to Strengthen Price Transparency Initiatives*

Congress can also consider codifying and standardizing existing price transparency policies.[50] While often opaque, current Transparency-in-Coverage (TiC) data presents an opportunity for employers, researchers, and regulators to monitor US health care prices. Entrepreneurs can use the TiC data to design efficient provider networks and create patient-friendly applications. Congress can ensure that hospitals report required rates accurately and in a timely manner.

Existing employers and policymakers have already used these types of transparency data to substantially reduce spending, while preserving quality. For example, Oregon public employees implemented a reference-based pricing model, which achieved over $100 million in savings in its first two years,[51] with no change in hospital quality or staffing. My colleagues and I estimate that if this model were implemented nationally, it could reduce US health care spending by over $7 billion.[52] Other states have elected to more directly apply price thresholds to all commercial prices. While these policies represent a significant intervention into health care markets, policymakers, ranging from Indiana to Vermont, reason that US hospital markets are currently flawed enough to warrant such intervention.

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[48] Whaley C, Singh Y, Fuse Brown EC, Reddy M, Perkins J, Rooke-Ley H. *Addressing Healthcare Consolidation in the U.S-Potential Policy Options for a Competitive and Transparent Future Policy Brief*. The Center for Advancing Health Policy through Research (CAHPR); 2024. https://cahpr.sph.brown.edu/sites/default/files/documents/CAHPR_Health%20Care%20Consolidation_Policy%20Brief.pdf

[49] Whaley C, Mook C. *340B Drug Pricing Program.* The Center for Advancing Health Policy through Research (CAHPR); 2025. Accessed September 12, 2025. https://cahpr.sph.brown.edu/sites/default/files/documents/Policy%20Briefs/340B_Policy%20Brief.pdf

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