Making the hospital tax exemption work for communities

An analysis of nonprofit hospitals in twenty states

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LOWN INSTITUTE

About the Lown Institute

The Lown Institute is an independent, nonpartisan think tank advocating bold ideas for a just and caring system for health. We envision a healthcare system focused on what's best for people, like hospitals caring for those most in need, patients living without fear of financial distress, and health professionals finding joy in their roles.

About this report

This report was supported by Arnold Ventures.

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Executive summary

Nonprofit hospitals fall billions short of giving back to communities what they receive in tax benefits.

$11.5 BILLION

COULD BE PUT BACK IN TO THE COMMUNITY

FOOD

HOUSING

ENERGY

DEBT

The Lown Institute examined the federal, state, and local tax benefits of more than 1,800 nonprofit hospitals across twenty states[1] and compared them to hospital spending on meaningful community investment. This analysis uses 2020–2022 data from Internal Revenue Service (IRS) tax returns, Centers for Medicare & Medicaid Services (CMS) hospital cost reports, and local property assessment portals.

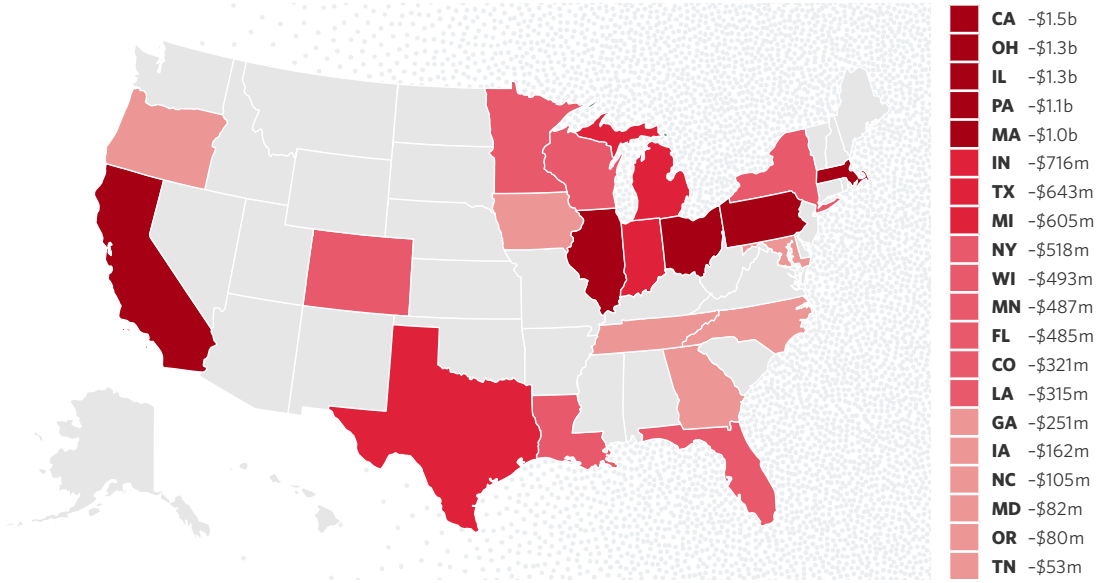
KEY TAKEAWAYS

- Most hospitals (54%) **received more in tax benefits** than they spent on meaningful community investments—what we call having a "fair share deficit." The total fair share deficit of these hospitals amounted to **$11.5 billion per year**.
- Twelve hospitals in our data set had fair share deficits **greater than $100 million**; these hospitals alone make up nearly 20% of the nation's total fair share deficit. Many of these hospitals made close to **$1 billion in profits**, own billions worth of tax-exempt property, and received hundreds of millions in donations each year.
- However, many other hospitals **gave back to communities** in excess of their tax breaks, what we call a "fair share surplus." Twenty-three hospitals in our data set had fair share **surpluses over $50 million**. In many cases, hospitals with large deficits and surpluses were located in the same metropolitan area.
- The amount of the fair share deficit is enough to feed more than a third of all food-insecure people in the country, build 150,000 more **affordable housing units**, triple clean energy investments in low-income communities, or **wipe out medical debt** for nearly 10 million Americans.

1 States included in this study: California, Colorado, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New York, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, Texas, and Wisconsin. The number of hospitals in this study accounts for 69% of private nonprofit hospitals in the U.S.

FAIR SHARE DEFICITS BY STATE *(Annual Average, 2020-2022)*

Of the 20 states studied, the fair share deficit exceeded $1 billion in five states: California, Illinois, Massachusetts, Pennsylvania, and Ohio.



Why not tax all hospitals? The tax-exempt status provides a framework for accountability and community partnership. Improving our nation's health requires optimizing the community benefit standard, not eliminating it.

HOW DO WE CLOSE SPENDING GAPS?

Fair share deficits reflect a lack of transparency and accountability around community benefits, as well as systemic inequalities in the hospital business model.

To close fair share spending gaps, policymakers can:

- → **Improve transparency** by requiring hospitals to report the value of community investments directly related to priority health needs identified in the community health needs assessments, the value of their tax breaks, and more details on their provision of free and discounted care.
- → **Increase accountability** by implementing minimum spending thresholds, expanding enforcement actions, and requiring medical debt protections such as financial assistance standards.

MAKING HOSPITAL PAYMENT MODELS EQUITABLE

Policymakers should address misaligned incentives in the hospital business model by encouraging "total cost of care" payment models, raising payment rates for underfunded services like primary care, and expanding Medicaid in every state to improve hospital financial stability and allow hospitals to invest in upstream community health needs.

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Introduction

The hospital community benefit standard can be a powerful tool for improving public health and health equity.

Why study community benefit spending?

Nearly 3,000 hospitals in the U.S. are private nonprofits exempt from most taxes, a benefit estimated at $24–$60 billion.[1] In exchange for these tax breaks, hospitals are expected to follow the Internal Revenue Service's (IRS) community benefit standard. Requirements include maintaining an open emergency department, having a financial assistance policy, and investing surplus funds toward patient care.[2]

Hospitals also must report to the IRS how much they spend to increase access to care and improve community health, known collectively as "community benefit spending." The Schedule H on Form 990 was created in 2008 for hospitals to report this spending, so stakeholders can better understand how tax-exempt hospitals are giving back.[3]

Loopholes and weak standards for community benefit have led to chronic underspending.

However, loopholes and lax enforcement have made it difficult to hold hospitals accountable for investing enough in communities, leading to the following issues:

MOST HOSPITALS DON'T SPEND ENOUGH ON COMMUNITIES

First, while hospitals are required to report their spending, there is no federal minimum amount hospitals have to dedicate to community benefits, which leads to underspending and variation. Studies have found that nonprofit hospitals don't spend significantly more on financial assistance compared to for-profits, and most spend less than they receive in tax breaks.[4] On average, hospitals spend 7–9% of their expenses on community benefits, but some hospitals spend nearly 20% of their budget on community benefits, while others report no spending at all.[5]

1 Matthews et al., 2022; Godwin et al., 2023; Rosenbaum et al., 2015
2 Internal Revenue Service, 2024
3 James, 2016
4 Matthews et al., 2022; Bai et al., 2021; Bruch & Bellamy, 2020; Godwin et al., 2023; Zare et al., 2021b
5 US Government Accountability Office, 2020; Young et al., 2018; Zare et al., 2021a

The majority of reported community benefit spending is unrelated to community health needs.

HOSPITAL SPENDING IS NOT TIED TO PRIORITY HEALTH NEEDS

Second, there is little incentive for hospitals to spend more on programs that have the greatest impact on community health. Hospitals are required to conduct regular Community Health Needs Assessments (CHNAs) to identify priority health needs in their community. However, there is no requirement that hospitals devote a certain amount of spending to addressing these needs.

In fact, the vast majority of reported community benefit spending goes to activities unrelated to the CHNA, such as Medicaid shortfall and health professions training. As a result, studies have found little alignment between community benefit spending and community health needs or outcomes.[6]

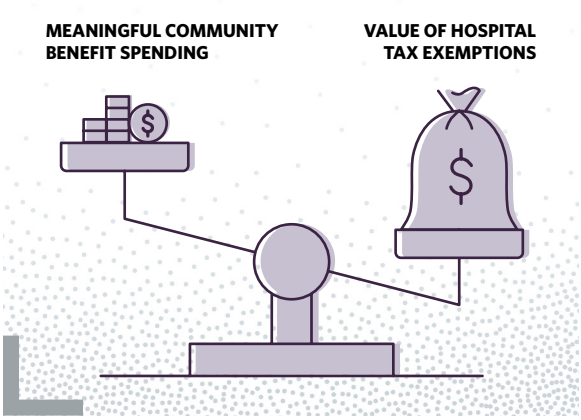
Hospitals could be spending billions more on mental health, food security, housing, and a plethora of other health and social needs. Improving the community benefit standard has the potential to greatly impact health.

Taking a closer look at fair share spending

To highlight these issues, the Lown Institute has reported on hospital "fair share spending"—a comparison of nonprofit hospital tax benefits to their spending on meaningful community investment—since 2021. This new analysis builds on previous research to calculate each specific category of tax breaks, providing more granular and actionable data for stakeholders.

We calculate fair share spending for hospitals in the following states, focusing on states where medical debt and community benefits have been key policy issues: California, Colorado, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New York, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, Texas, and Wisconsin.

Do hospitals pay their fair share?



The Lown Fair Share Spending measure evaluates how hospital tax benefits compare to their community investments.

6 Singh et al., 2015; Wen et al., 2023; Young et al., 2013; Young et al., 2018; Zare et al., 2021b

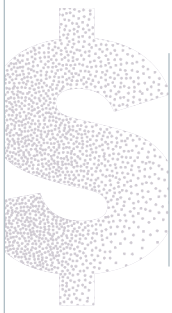
Methodology

Methodology

This analysis builds on previous research to calculate fair share spending—the difference between hospitals' meaningful community investment and the value of their tax exemptions—in twenty states.

Meaningful community investment

Nonprofit hospital community benefit spending is reported on IRS Form 990 Schedule H. We use IRS data for fiscal years ending 2020–2022. We linked Centers for Medicare & Medicaid Services (CMS) cost reports to IRS tax filings through an address-mapping algorithm.[1] We used three years of data to provide a more comprehensive picture and even out year-to-year income fluctuations.



This analysis includes categories of community benefit spending most likely to have a meaningful impact on community health.

COMMUNITY INVESTMENT CATEGORIES

We include the following IRS categories of community benefit most likely to have a direct and meaningful impact on community health, which we refer to as *meaningful community investment*:

- **Financial assistance**[2]—Free and discounted care provided to patients eligible for financial assistance under the hospital's policy. Reported as the cost to the hospital (not charges). Bad debt is not included.
- **Subsidized health services**—Clinical services that meet an identified community need and are provided despite a loss to the hospital. Examples include primary care clinics, addiction treatment, and neonatal care.
- **Community health improvement services**—Programs provided by the hospital for the purpose of improving health. Examples include health fairs, free immunizations, and interpreter services. Includes the operating costs of community benefit programs.
- **Cash and in-kind contributions**—Contributions made to other nonprofits to improve health. Contributions to affiliated medical schools or physician groups and other hospitals in this study were excluded.

1 CMS cost report version 05/21/24

2 Financial assistance is also commonly known as "charity care." In this report, we use the term financial assistance to be consistent with IRS language, and to avoid framing free or discounted care that patients are eligible to receive as "charity."

- **Community building activities**—Programs that address the social drivers of health, such as housing, community advocacy, and environmental initiatives, as reported on Schedule H Part II. Although this category is not always considered a community benefit, we include it because addressing the social drivers of health is critical for improving long-term community health.

EXCLUDED CATEGORIES OF COMMUNITY BENEFIT

Medicaid shortfall is the gap between hospitals' costs for serving Medicaid beneficiaries and payments received for these patients. While Medicaid shortfall represents nearly half of reported community benefit spending, researchers have found it problematic to include as a community benefit for the following reasons:[3]

- Most hospitals already make up for Medicaid shortfalls by charging privately insured patients higher prices and receiving other benefits such as disproportionate share hospital payments and 340B payments.
- Hospital losses on Medicaid patients do not go back into the community to improve health. Medicaid shortfall is an accounting measure, not direct spending.
- Hospitals with costs of care far higher than Medicaid payment rates will have a greater shortfall, regardless of the number of Medicaid patients served.
- States set their Medicaid rates at a level believed to be sufficient to cover hospital costs. If the IRS does not consider discounts for other insurers to be community benefits, it's unclear why Medicaid should be different.

Health education and research were excluded due to limited direct community health impact and existing Medicare reimbursement.

Health professions education and **research** were not included because it is not clear that these investments have a direct impact on community health. Only about one-quarter of resident physicians report practicing in underserved areas after their training and only 35% go on to practice primary care. Additionally, hospitals are already reimbursed for trainees through medical education payments they receive from Medicare, not all of which are reported on Form 990. While research funding is a public good, hospital research is rarely focused on community health needs or takes local input into account, making it unlikely to have a direct impact on community health.[4]

3 Wen et al., 2023; Kacik, 2018; Kacik, 2022
4 Garber & Saini, 2022

PRORATING PROCESS

Many hospitals file a combined Form 990 with other hospitals in a system. For these systems, community investment was prorated among hospitals based on their share of system financial assistance in cost reports. Bonds and donations were prorated based on hospitals' share of system revenue.

Tax exemption value

Our calculation of hospital tax exemption value draws from six previous analyses[5] and includes the following categories (See Appendix for more):

- **Federal corporate income tax**—Federal corporate income tax rate (21%) applied to net income from hospital cost reports, adjusted for prior year losses and other taxes paid
- **State corporate income tax**—State-specific corporate tax rate applied to net income from hospital cost reports, adjusted for prior year losses and other taxes paid
- **State & local sales tax**—State and local tax rates applied to supply expenses from American Hospitals Association survey
- **Property tax**—Local property tax rates applied to real property values from local assessment portals and value of equipment/inventory from cost reports
- **Tax-exempt bonds**—Difference between corporate and nonprofit bond interest rates, applied to outstanding bond liabilities from Form 990
- **Tax-exempt charitable donations**—Value of tax-exempt donations from Form 990, excluding government grants and in-kind donations, multiplied by the estimated marginal tax rate of donors
- **Federal unemployment tax exemption**—Federal unemployment tax rate applied to the first $7,000 of full time employee total

5 Plummer et al., 2024; Godwin et al., 2023; Zare et al., 2021b; Ernst & Young LLP, 2022; Herring et al., 2018; Rosenbaum et al., 2015

Limitations

Hospital data set. We include all hospitals in 20 states with both IRS Form 990 and CMS cost report data available from 2020–2022. We removed hospitals that closed, converted to for-profit, or were removed from Care Compare as of September 2024; however, there may be updates since then for which we have not accounted. We do not include certain hospitals that are publicly-owned and do not file a 990, nor do we include certain children's or cancer hospitals without cost report data, which may underestimate the fair share deficit.

Data availability and accuracy. Our results are limited by the availability and accuracy of the data used. Hospitals may undertake impactful community development activities that are not reported on the 990, such as local hiring and sourcing.[6] Hospitals are not required to have cost reports audited by independent accounting firms; therefore, there may be inaccuracies in the income reported. Property values in certain states were unavailable and had to be imputed.

Study assumptions. Similar to previous studies, we assume that hospitals' reported income would not significantly change if they were for-profit.[7] While hospitals would want to decrease their tax liability, they would also be under pressure from shareholders to make a profit. Our prorating method assumes that hospitals in group filings that spend more on financial assistance also spend more on other categories of community investment, although this may not always be the case.

Generalizability of findings. The years 2020–2022 were a unique time for hospitals, as they faced the COVID-19 pandemic and especially high labor costs. As hospital finances have stabilized in recent years, we would expect hospital tax benefits to increase. Continued research is needed to better understand trends in fair share spending over time.

6 Amoss, 2024
7 Herring et al., 2018; Plummer et al., 2024; Rosenbaum et al., 2015

Results

Results

More than 50% of hospitals in 20 states received more in tax benefits than they spent on meaningful community investment, what we refer to as having a "fair share deficit."

Among hospitals with fair share deficits, the total deficit was $11.5 billion per year. That's enough to:

- **Wipe out** medical debt for nearly 10 million Americans, or cover most unpaid bills sent to bad debt for patients eligible for financial assistance.[1]
- **More than double** the amount of grant funding awarded to state and local entities for substance abuse and mental health initiatives in 2024.[2]
- **Feed** 35% of all Americans facing food insecurity (about 15 million people).[3]
- **Increase** grant funding for coastal management programs tenfold to help protect vulnerable communities from flooding, or triple funding for clean energy programs in low-income communities.[4]
- **Build** 150,000 more affordable housing units and help another 75,000 low-income renters stay in their homes, or double funding allocated to homeless assistance.[5]

1 Rakshit et al., 2024; Dollar For, 2024
2 SAMHSA, 2024
3 Feeding America, 2024
4 Office for Coastal Management, 2024; U.S. Department of the Treasury, 2024
5 HUD, 2023; National Low-Income Housing Coalition, 2023

WE ESTIMATE

$36 BILLION

IN TAX EXEMPTION VALUE ACROSS ALL U.S. HOSPITALS

Hospitals received $26 billion in tax benefits per year

Our analysis finds that nonprofit hospitals benefited from substantial tax breaks in 2020–2022, totalling $26.0 billion per year in 20 states. On average, hospitals gained $14.2 million in tax benefits, a rate of $76,000 per bed or 4.2% of expenses. Assuming a similar rate in other states, we would expect a total tax exemption of $36.4 billion for all nonprofit hospitals. Tax benefits were concentrated among a small number of hospitals, with the top 1% of hospitals making up 17% of the total tax exemption value.

FEDERAL INCOME TAX WAS THE LARGEST CATEGORY OF TOTAL TAX EXEMPTION

Federal income tax made up the largest proportion of the total exemption, comprising 32% of the total. This benefit was driven by very high incomes at some hospitals. Six hospitals in our data set made at least $1 billion in a year from 2020–2022, according to CMS cost reports. Property and sales taxes were also substantial, making up 22% and 19% of the total tax exemption, respectively. Twenty hospitals in our data set own at least $1 billion worth of tax-exempt real estate.

VALUE OF NONPROFIT HOSPITAL TAX EXEMPTION *(Average, 2020–2022)*

	Tax exemption*	%*
Federal income tax	$8.3b	32%
Property tax	$5.8b	22%
Sales tax	$4.8b	19%
State income tax	$2.7b	10%
Value of tax-exempt donations	$2.7b	10%
Value of tax-exempt bonds	$1.7b	6%
Federal unemployment tax	$106m	0.4%
Total	**$26.0b**	**100%**

**Totals may not add up exactly due to rounding*

HOSPITALS SPENT

$22 BILLION

ON COMMUNITY INVESTMENT

Hospitals spent $22 billion on community investment

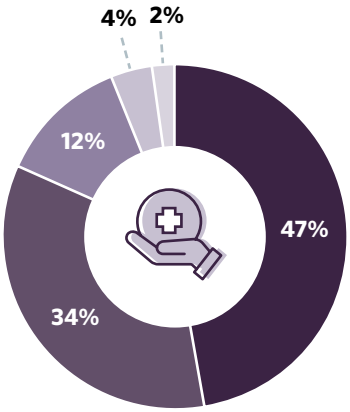
In total, hospitals in these states spent $22 billion on meaningful community investment each year. Community investment spending ranged from $0 (15 hospitals reported no spending) to $360 million for the highest spenders.

FINANCIAL ASSISTANCE AND SUBSIDIZED HEALTH SERVICES WERE THE LARGEST CATEGORIES

The largest proportion of community investment was spent on financial assistance, followed by subsidized health services. Despite hospitals and public health experts putting increased emphasis on social drivers of health in recent years, relatively little spending went to community health improvement or community building activities (categories of spending that encompass social supports).

In some non-expansion states, the need for financial assistance is crowding out hospitals' efforts to invest in health upstream.

The breakdown of community investment categories varied by state. Notably, in Texas, Tennessee, and North Carolina, at least 75% of total community investment went to financial assistance. High rates of financial assistance spending reflect a greater need for free and discounted care in states that have not expanded Medicaid. However, despite their hospitals devoting more to financial assistance, Texas, Tennessee, and North Carolina still have higher rates of medical debt than the national average, indicating that the need is greater than hospitals alone can provide.[6] The breakdown of community investment in these states suggests that the need for financial assistance is crowding out hospitals' efforts to invest in health upstream.



COMMUNITY INVESTMENT SPENDING OF NONPROFIT HOSPITALS

(Annual Average, 2020–2022)

	Spending	%
Financial assistance	$10.6b	47%
Subsidized health services	$7.7b	34%
Community health improvement services	$2.8b	12%
Cash and in-kind contributions	$961m	4%
Community building activities	$362m	2%
Total	**$22.4b**	**100%**

6 Urban Institute, 2024. Data collection was prior to North Carolina's Medicaid expansion.

MASSACHUSETTS GENERAL HOSPITAL

-$325 MILLION

ANNUAL FAIR SHARE DEFICIT

Hospitals with fair share deficits received $11.5 billion more in tax benefits than they spent on community investments.

The majority of hospitals in our data set (54%) received more in tax breaks than they gave back in community investment, what we call having a "fair share deficit."

HOSPITALS WITH LARGEST FAIR SHARE DEFICITS

Large academic medical centers in major cities top the list of general hospitals with the largest fair share deficits. Hospitals from Illinois, Massachusetts, and Pennsylvania make up half of the top 20 largest-deficit hospitals.

Many of these hospitals have big deficits due to their size and wealth, which result in enormous tax benefits. Others are outliers due to their particularly low community investment; six of these hospitals spent less than 1% of their expenses on community investment.

HOSPITALS WITH LARGEST FAIR SHARE DEFICITS *(Annual Average, 2020–2022)*

Fair share deficit		Community investment	Tax exemption
-$325m	Massachusetts General Hospital (MA)*	$90m	$415m
-$260m	Mayo Clinic Hospital, Saint Marys Campus (MN)*	$77m	$338m
-$247m	Hospital of the University of Pennsylvania (PA)ˆ	$8m	$255m
-$226m	Brigham and Women's Hospital (MA)*	$66m	$292m
-$207m	Cleveland Clinic Main Campus (OH)*	$101m	$307m
-$152m	Evanston Hospital (IL)ˆ	$47m	$198m
-$130m	Carle Health Methodist Hospital (IL)	$11m	$141m
-$129m	IU Health Methodist Hospital (IN)ˆ	$102m	$231m
-$104m	Cedars-Sinai Medical Center (CA)	$114m	$218m
-$101m	Orlando Health Orlando Regional Medical Center (FL)*ˆ	$114m	$215m
-$93m	Tisch Hospital (NY)ˆ	$195m	$288m
-$91m	Salem Hospital (MA)*	$12m	$103m
-$84m	Milton S. Hershey Medical Center (PA)	$18m	$103m
-$76m	University of Michigan Health - West (MI)	$5m	$81m
-$75m	Froedtert Community Hospital - New Berlin (WI)ˆ	$171k	$76m
-$74m	WellSpan York Hospital (PA)	$12m	$86m
-$71m	Advocate Christ Medical Center (IL)*	$25m	$95m
-$68m	Advocate Lutheran General Hospital (IL)*	$25m	$93m
-$65m	Our Lady of the Lake Regional Medical Center (LA)*ˆ	$7m	$73m
-$65m	Baylor University Medical Center (TX)*	$56m	$121m

**IRS information prorated across multiple hospitals based on share of system revenue*
ˆIncludes more than one hospital campus within same CMS ID

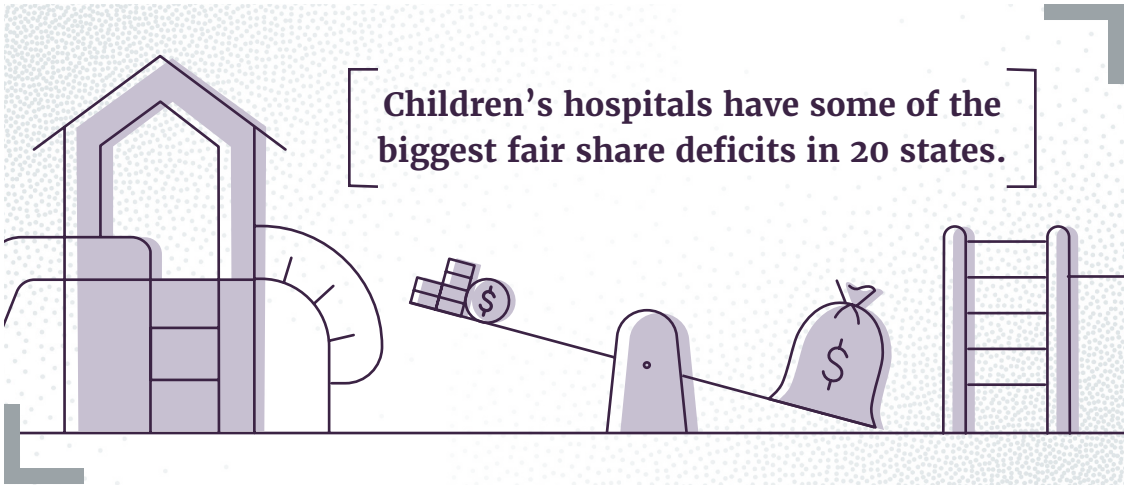
CHILDREN'S HOSPITALS WITH LARGEST FAIR SHARE DEFICITS

Children's hospitals have some of the largest fair share deficits in the 20 states studied, largely due to the high amounts of tax-exempt donations they receive. Three of these hospitals received at least $100 million in donations and six made at least $200 million in net income each year. Many of these hospitals also have substantial income and property; for example, Boston Children's Hospital owns about $2 billion in real estate and Nationwide Children's Hospital made over $350 million each year on average. All of these hospitals spent less on community investment than their state average rate.

CHILDREN'S HOSPITALS WITH LARGEST FAIR SHARE DEFICITS *(Annual Average, 2020–2022)*

	Fair share deficit		Community investment	Tax exemption
	-$121m	Nationwide Children's Hospital (OH)	$48m	$169m
	-$100m	Boston Children's Hospital (MA)	$43m	$143m
	-$91m	Cook Children's (TX)	$18m	$110m
	-$81m	Cincinnati Children's Hospital (OH)ˆ	$29m	$109m
	-$60m	Arthur M. Blank Hospital (fka Children's Egleston) (GA)*	$49m	$109m
	-$56m	Children's Scottish Rite Hospital (GA)*	$41m	$98m
	-$51m	Valley Children's Hospital (CA)*	$3m	$53m
	-$46m	Dell Children's Medical Center (TX)*	$17m	$63m
	-$45m	Children's Medical Center Dallas (TX)*	$24m	$69m
	-$37m	Saint Christopher's Hospital for Children (PA)	$5m	$43m

**IRS information prorated across multiple hospitals based on share of system revenue*
ˆIncludes more than one hospital campus within same CMS ID



46%

OF HOSPITALS HAD A FAIR SHARE SURPLUS

HOSPITALS WITH LARGEST FAIR SHARE SURPLUSES

While the majority of hospitals in our data set had a fair share deficit, other hospitals spent more on community investment than they received in tax breaks, what we call having a "fair share surplus." Certain states are highly represented on this list, with 14 hospitals from New York, Texas, North Carolina, or Florida.

Where did these hospitals spend their community investments? Ten hospitals spent the most on subsidized health services and seven spent the most on financial assistance. Examples of community investments from hospital 990s include: COVID-19 related testing and supplies; primary care clinics in underserved areas; patient navigation services; and case managers in the emergency department.

HOSPITALS WITH GREATEST FAIR SHARE SURPLUSES

(Annual Average, 2020–2022)

Tax exemption	Community investment		Fair share surplus
$52m	$269m	North Shore University Hospital (NY)ˆ	**$217m**
$85m	$237m	Long Island Jewish Medical Center (NY)ˆ	**$152m**
$56m	$191m	Grady Memorial Hospital (GA)*ˆ	**$135m**
$11m	$89m	Mount Sinai Hospital (IL)	**$78m**
$36m	$114m	Lakeland Regional Health Medical Center (FL)	**$78m**
$19m	$93m	Baptist Memorial Hospital - Memphis (TN)ˆ	**$74m**
$18m	$92m	One Brooklyn Health (NY)ˆ	**$74m**
$20m	$93m	CHRISTUS Spohn Hospital Corpus Christi - Shoreline (TX)*ˆ	**$73m**
$46m	$116m	UPMC Presbyterian (PA)*ˆ	**$70m**
$36m	$104m	Lenox Hill Hospital (NY)	**$67m**
$38m	$103m	Rochester General Hospital (NY)	**$65m**
$35m	$99m	WakeMed Raleigh Campus (NC)*ˆ	**$64m**
$21m	$84m	Mount Sinai Medical Center Of Florida (FL)	**$64m**
$46m	$109m	Methodist University Hospital (TN)ˆ	**$63m**
$77m	$134m	Memorial Hermann - Texas Medical Center (TX)*ˆ	**$57m**
$27m	$83m	Novant Health New Hanover Regional Medical Center (NC)*	**$56m**
$9m	$64m	Houston Methodist Baytown Hospital (TX)*	**$55m**
$31m	$85m	Mount Sinai Beth Israel (NY)ˆ	**$54m**
$13m	$66m	UPMC Western Maryland (MD)	**$53m**
$17m	$69m	New York-Presbyterian Queens (NY)	**$53m**

**IRS information prorated across multiple hospitals*
ˆIncludes more than one hospital campus within same CMS ID

-$1.5 BILLION

CALIFORNIA HAD THE LARGEST TOTAL FAIR SHARE DEFICIT AMONG 20 STATES STUDIED

CALIFORNIA, OHIO, ILLINOIS HAVE LARGEST TOTAL FAIR SHARE DEFICITS

Fair share deficits varied by state, with three states (Maryland, Oregon, and Tennessee) having deficits under $100 million and five states (California, Illinois, Massachusetts, Ohio, and Pennsylvania) with deficits over $1 billion.

Tax exemption value as a share of expenses ranged from 2.94% in Maryland to 6.82% in Texas. Community investment as a share of expenses ranged from 1.76% in Michigan to 7.01% in Maryland.

FAIR SHARE DEFICITS BY STATE

(Annual Average, 2020-2022)

	Fair share deficit		Number of hospitals	% hospitals with deficit	Tax exemption, share of expenses	Community investment, share of expenses
	-$1,537	California	191	53%	2.95%	2.40%
	-$321	Colorado	45	73%	5.54%	3.41%
	-$485	Florida	85	45%	3.70%	5.80%
	-$251	Georgia	81	30%	4.07%	6.64%
	-$1,259	Illinois	135	63%	5.15%	3.91%
	-$716	Indiana	74	66%	6.13%	4.03%
	-$162	Iowa	55	70%	5.03%	3.78%
	-$315	Louisiana	47	68%	5.36%	2.49%
	-$82	Maryland	46	18%	2.94%	7.01%
	-$1,018	Massachusetts	50	58%	4.94%	3.57%
	-$605	Michigan	110	75%	3.64%	1.76%
	-$487	Minnesota	104	55%	3.67%	4.07%
	-$518	New York	132	42%	3.10%	4.88%
	-$105	North Carolina	56	37%	3.31%	4.29%
	-$1,262	Ohio	133	74%	4.36%	2.45%
	-$80	Oregon	42	37%	3.43%	4.00%
	-$1,073	Pennsylvania	135	62%	3.66%	2.71%
	-$53	Tennessee	43	29%	3.29%	5.50%
	-$643	Texas	142	42%	6.82%	6.41%
	-$493	Wisconsin	117	61%	3.92%	3.40%

MARYLAND

Maryland's **global budget system** pays hospitals a set amount each year based patient volume, quality improvements, uncompensated care, and other metrics. This makes revenue predictable and has **kept hospital costs from rising** above target. Limiting hospital costs and reimbursing hospitals for uncompensated care may partly explain **Maryland's small fair share deficit**.[8]

WHAT EXPLAINS STATE VARIATION IN FAIR SHARE SPENDING?

Large state deficits in California, Illinois, Massachusetts, Ohio, and Pennsylvania are driven in part by state size and high tax exemptions at large hospitals (more than half of the hospitals on the largest-deficit list are in these states). In other states such as Indiana, Texas, and Colorado, high income and property values relative to hospital size lead to a high tax exemption rate. Alternatively, some states do not exempt hospitals from sales tax and others have low corporate income tax rates.

Differences in state policies also play a role. Six states in our data set had not expanded Medicaid from 2020–2022, which increases patients' need for financial assistance; as a result, most of these states had high rates of community investment. Yet Medicaid expansion alone does not explain fair share spending patterns. For example, expansion states Maryland and New York had high rates of community investment.

High spending rates in Maryland and New York may be in part due to financial assistance and other requirements in these states.[7] Additionally, Michigan, Louisiana, and Pennsylvania—which do not have similar standards—had some of the lowest rates of community investment in our study. However, again this pattern is not universal; California also had low rates of community investment despite having stricter requirements, which may reflect a need for patient screening or other implementation changes.

Discussion

The $11.5 billion gap between hospital tax breaks and community investment highlights important policy issues:

TRANSPARENCY IN COMMUNITY BENEFIT REPORTING

The lack of detail on Schedule H can make it difficult to understand how much hospitals spend on priority community health needs. Hospitals did not always provide details on which services were included as subsidized health services, despite reporting spending tens of millions in this category. Hospitals are instructed to only report spending on health services that serve an identified community need; however,

7 Kona & Raimugia, 2023; Community Catalyst, 2023.

8 Maryland HSCRC, 2024; Atlas, 2024; Maryland's global budget system accounts for hospital spending on financial assistance through increased reimbursement rates, which may not be taken into account in IRS Form 990. An examination of Maryland hospitals' community investment minus rate increases for financial assistance finds that the state's total fair share spending increases by $37 million, dropping only one spot in the state comparison.

some hospitals appear to be reporting losses on standard hospital services such as cardiology, cancer care, and in one case, plastic surgery. We also found that many hospitals included contributions on Schedule H to their affiliated medical school or physician practice, which may misrepresent their community benefit spending. Additionally, combined group returns make it difficult to assess individual hospital community investments.

ACCOUNTABILITY IN COMMUNITY BENEFIT SPENDING

There is no federal requirement for hospitals to spend a certain amount on community benefits, or that these programs address the health needs that matter most to communities. With no incentives to spend more in any critical areas, it is unsurprising that we find considerable variation in community investment. Despite some hospitals reporting no spending, the IRS did not revoke any hospital's tax-exempt status for failing to provide sufficient community benefits from 2010–2020.[9]

SYSTEMATIC INEQUITIES EMBEDDED IN THE HOSPITAL BUSINESS MODEL

We found that some of the largest fair share deficit hospitals and surplus hospitals are located in the same metro areas. This reflects a pattern in hospital markets in which higher-resourced hospitals are often inaccessible to low-income patients, while "safety net" hospitals that serve more of these patients operate on thin margins. Wealthier hospitals benefit more from the nonprofit tax exemption, resulting in higher fair share deficits, while safety nets benefit less despite giving more proportionally in financial assistance, resulting in fair share surpluses.

Some of the largest fair share deficit and surplus hospitals are in the same cities, reflecting financial inequality in these markets.

What drives this two-tiered system? Hospitals get paid the most to provide high-margin elective procedures to privately-insured patients and less for preventive and emergency care for other patients. This creates incentives for hospitals to consolidate to negotiate higher rates with insurers, and to target privately-insured patients by investing in affluent neighborhoods. At the same time, hospitals caring for more low-income patients often struggle to maintain financial stability. These factors drive some of the variation we see when comparing hospitals' tax exemptions to their community investments.

9 Lucas-Judy, 2023

Policy recommendations

Policy recommendations

Below are recommendations for addressing the lack of transparency and accountability around community benefit, and systemic inequities in the hospital business model.[1]

To improve transparency, the IRS could require hospitals to provide the following information on Schedule H:

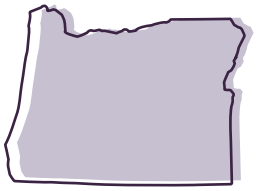
- CMS ID number
- Community benefit spending by facility
- Value of tax exemptions
- Service lines included as subsidized health services
- Top three health needs identified in the CHNA and spending on programs designed specifically to address those needs
- Number of financial assistance applications received, granted, and denied each year
- Number of extraordinary collection activities pursued

To ensure accountability for adequate community investment, the IRS should:

- Establish standards for financial assistance such as income eligibility thresholds, presumptive eligibility, and patient screening.
- Set a spending target for financial assistance and programs to address community health needs in the CHNA based on hospitals' size, financial health, and previous spending.
- Partner with CMS or other agencies to audit compliance. While IRS enforcement of community benefit standards appears to be improving[2], partnerships would help increase capacity.

States and localities could also:

- Leverage Certificate of Need regulations to require community investment as a condition of expansions.
- Implement payments in lieu of taxes to recoup foregone property taxes.
- Delineate requirements for hospitals to involve community groups in the CHNA process to encourage stronger hospital–community partnerships.



OREGON

Oregon sets **community benefit spending thresholds** based on hospitals' uncompensated care, patient revenue, and operating margin.[3]

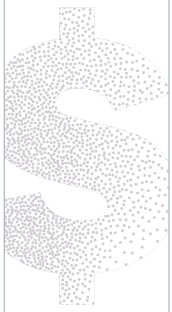
NORTH CAROLINA

North Carolina paired enhanced Medicaid reimbursements with **medical debt protections** in a carrot-and-stick approach.[4]

1 See Appendix for a list of existing state policies on community benefit & financial assistance
2 Daniels, 2024a
3 Oregon Health Authority, 2023
4 Daniels, 2024b

Policymakers should consider the following **systemic reforms** to better align incentives for hospitals with community needs:

- Support total cost of care models that equalize reimbursement rates across payers and set global budgets (like CMS' AHEAD model).[5] We cannot expect hospitals to care for all patients equally when they're paid more for privately-insured patients.
- Increase reimbursement for underfunded high-need services, such as behavioral healthcare, substance use treatment, and primary care. Policymakers have proposed doing this using savings from site-neutral payments.[6]
- Expand Medicaid in all states. Increasing insurance coverage would improve the financial health of fair share surplus hospitals that currently bear a disproportionate amount of financial assistance, reduce medical debt, and allow all hospitals to invest more in programs to improve community health upstream.
- Reduce excessive prices. High health care costs—driven in part by hospital consolidation and price increases—can erode communities' financial health. Policymakers should look to reduce cost through site-neutral payments, payment caps, price transparency, or limits on charges for low-income patients.[7]



Eliminating the tax exemption entirely would remove a crucial tool for accountability and community partnership, and would financially harm hospitals that are already leading on community investment.

Avenues for future research

As policymakers consider improvements to the community benefit standard and hospital payment models, continued research in these areas is essential. Future avenues of research could examine the effects of new state policies on fair share spending and health outcomes over time, and qualitative research into hospitals with fair share surpluses to identify best practices.

5 CMS, 2024
6 Cassidy & Hassan, 2024
7 Murray et al, 2024; Glied & Chandra, 2024; Community Catalyst, 2023.

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