April 28, 2023

House Ways and Means Oversight Subcommittee Hearing on Tax-Exempt Hospitals and the Community Benefit Standard

On Wednesday (April 26), the House Ways and Means Oversight Subcommittee held a hearing entitled, "Tax Exempt Hospitals and the Community Benefit Standard." The hearing considered the benefits provided by non-profit hospitals to American communities in contrast to the cost of their tax-exempt status to American taxpayers. In particular, discussion focused on how the IRS determines tax-exempt status, including the community benefit standard and whether the current reporting requirements (i.e., "Schedule H") are sufficient.

Lawmakers heard testimony from a panel of four witnesses, including a representative from the Government Accountability Office (GAO), academics and a representative from the American Hospital Association (AHA). Witnesses spoke to the immense value that tax-exempt status afforded to these non-profit hospitals, however some also noted the "variability" across different hospitals in meeting the community benefit standard, recommending several reforms.

- *For more information*: Hearing on Tax-Exempt Hospitals and the Community Benefit Standard - House Committee on Ways and Means

Opening statements

Subcommittee Chairman David Schweikert (R-AZ): Schweikert began by noting the "incredibly valuable" tax exemptions available to many hospitals. The subcommittee chairman then referenced findings showing substantial variation in the value of charity care and community benefits across non-profit hospitals, suggesting "significant deficits in community benefits provided as compared to the value of some hospitals' tax exemption." He also referenced contradictory findings from AHA which instead found community benefits "massively exceed[ed] the value provided by hospitals' tax exemption." Schweikert suggested the "lack of clear guidelines from Congress and the IRS about what constitutes a community benefit" is responsible for the "wide variation." Full statement.

Subcommittee Ranking Member Bill Pascrell (D-NJ): Pascrell characterized tax exempt hospitals as "the very corner stone of our hospital system" which "deliver unmatched benefits." However, he also noted the failings of many non-profit hospitals which "can and must do better." Pascrell suggested that the "opaque ownership" of hospitals is a result of private equity "placing profits over patients" and he likened such ownership to a "Russian nesting doll." The subcommittee ranking member stated problematic trends such as "bankruptcies, facility closures, fired workers, neglected patients and damaged communities" necessitated further investigation and that he is "committed to robust oversight of our tax-exempt hospitals."

Committee Chairman Jason Smith (R-MO): The Chairman characterized the hearing as "an issue that is of great importance to American's health…because of their particular importance to many communities across this country" which is "particularly true in rural areas." Noting the significant value of the tax-exempt status of "almost 60 percent of hospitals in the U.S." Smith raised concerns over the "inadequate" value of community benefits. He also noted the "aggressive billing practices, executive compensation in the millions of dollars, and abuses in the 340B program." He concluded by suggesting that the hearing was an opportunity to address any

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issues with legislation and echoed Schweikert when stating, "we must be sure that the laws, rules, and regulations under which they operate are clear and effective." Full statement.

Witness testimony

Jessica Lucas-Judy, Director, Strategic Issues, U.S. Government Accountability Office: Ms. Lucas-Judy provided an overview of GAO's 2020 report on the requirements that hospitals must meet to be eligible for tax-exempt status as well as the challenges these requirements present to the IRS. She noted that in defining the community standard, the IRS doesn't have authority to define specific charitable activities. Rather, that eligibility factors used by the IRS were merely "examples" and that a "lack of clarity creates challenges." Notably, she cited the report's finding that 30 tax-exempt hospitals reported no community benefit spending in 2016 and other hospitals as being at risk of non-compliance. In this regard, Lucas-Judy provided several recommendations: Congress should specify the specific activities that are considered to provide community benefit; the IRS should update its forms and instructions to ensure community benefit information is clear and easily identified; and that the IRS should establish a process to determine hospitals at risk of non-compliance. Full statement.

Ge Bai, Professor of Accounting and Health Policy, John Hopkins University: Dr. Bai commented on the social contract between taxpayers and tax-exempt hospitals and secondly, questioned whether there is evidence that tax exempt hospitals fulfilled this obligation. Firstly, she highlighted the many direct and indirect benefits that non-profit hospitals receive from their tax-exempt status, including a lower cost of borrowing, access to the 340B program, receipt of tax-deductible charitable contributions and exemption from property tax. However, Dr. Bai suggested that non-profit hospitals "have not yet provided more than for-profit hospitals overall." She cited a 2018 study she collaborated on, to note that for "every $100 dollar expense incurred by non-profit hospitals they only provided $2.30 for charity care but for-profit hospitals provided $3.80." She noted a similar result in Medicaid shortfall. She concluded that "evidence suggests that tax-exempt status does not provide assurance that non-profit hospitals will provide sufficient benefit or behave in a way consistent with their charitable mission." Full statement.

Zachary Levinson, Project Director, Kaiser Family Foundation (KFF): Dr. Levinson noted the "large role that tax exemption may play in the financial health of these facilities" on the basis that the value of tax exemptions represented over 40% of these hospital's earned net income. He spoke about charity care as one example of the community benefit provided by non-profit hospitals, noting KFF's estimate that $16 billion was spent on charity care in 2020, which is less than their $28 billion estimate of the cost to the taxpayer. Though, he also noted the other activities which provide a community benefit, including funding of training and medical research or offering unprofitable services. Dr. Levinson suggested that community benefit spending may "vary substantially across hospitals" and that proposals such as expanding requirements for charity care programs, requiring a minimum spend on community benefits and requiring greater community involvement in hospital decision making have been proposed as solutions. However, he also emphasized that such policies "inevitably involve trade-offs" such as hospitals cutting costs by discontinuing certain services. Dr. Levinson concluded that "strengthening community benefit standards" could increase the provision of benefits important to communities and protect prioritized services from cost-cutting attempts. Full statement.

Melinda (Mindy) Reid Hatton, General Counsel, AHA Secretary, American Hospital Association (AHA): Ms. Hatton presented a more optimistic viewpoint on the value of tax-exempt hospitals as providing a "valuable vital service to their patients" and said there is "no doubt that these hospitals meet and exceed any requirements." Hatton suggested that in 2019 tax-exempt hospitals "devoted nearly 14% of their total expenses to community benefit programs" and also referenced a study which "demonstrated that the return to taxpayers for hospital's federal tax exemption is 9 to 1…a remarkable return." Further, she referenced data collected by AHA indicating that the amount of community benefit spending has "remained steady between 11 and 14%" since 2009. She also

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emphasized the importance of non-profit hospitals in being able to meet the "needs of unique communities they serve" which has been enabled by the flexibility of the community benefit standard. However, she concluded by noting that there should be "more emphasis on the value of social determinants of health," that Schedule H (i.e., Form 990) "should and could be more user friendly for communities" but that "setting minimum dollar thresholds would not be helpful or prudent." Full statement.

Q&A

Subcommittee Chair Schweikert questioned Lucas-Judy on what changes could be made to IRS documentation to which the GAO witness replied that it is difficult for hospitals to know "what to include where on the form" and agreed with Schweikert that a working group to update the design of the form would be helpful. Schweikert then questioned Dr. Bai on her research methodology. Dr. Bai noted the challenges of collecting this data because disclosed accounting income is different to taxable income and secondly that delays in IRS processing further limited this effort. However, she suggested there is no reason to believe that the results from her 2018 study had changed in 2019 or 2020 and that there is also no evidence that non-profit hospitals provided more Medicaid shortfall than for-profit.

Subcommittee Ranking Member Pascrell first asked Hatton to describe projects non-profit hospitals have undertaken to address health challenges in the wake of COVID-19. She cited initiatives including developing testing kits, providing "innovative" vaccine sites and working with public health agencies. Pascrell also asked about the provision of unreimbursed services during the COVID-19 pandemic, however Hatton suggested this information is not yet available. Dr. Bai added that overall profitability of hospitals increased during the pandemic as a result of the relief money they received. Pascrell concluded his questioning by asking about how the "crisis" in the health care workforce has impacted non-profit hospitals. Hatton noted that many community benefit efforts were being redirected to train individuals in an attempt to alleviate shortages.

Rep. Brian Fitzpatrick (R-TX) asked how the amount of community benefit provided by tax-exempt hospitals has changed over the years. Hatton answered that the amount has remained steady between 11% and 14% and that about half of that was for financial assistance programs. Fitzpatrick continued questioning the AHA witness, asking how the national uninsurance rate reaching an all-time low impacted the amount of community benefits. Hatton answered that it isn't known for certain but that more individuals qualified for Medicaid and that there may be more underpayments in the future.

Rep. Judy Chu (D-CA) questioned Hatton on the importance of sustaining the flexibility of the community benefit standard, who answered that this is "essential to allowing communities of all sizes to prioritize those health issues they can tackle." Chu further asked whether Schedule H captured the amount hospitals were contributing. Hatton suggested it is probably an undercount and that the importance of capturing that information on the form should be clearer to those filling it out. Chu noted that in recent years some non-profit hospitals engaged in anti-competitive practices and asked Lucas-Judy what changes to Schedule H she recommended, including on the "narrative issue". This witness suggested that the "community benefit itself isn't a standard, it's a series of examples" with some factors on the form "close-ended" and others a "more open-ended narrative," which leaves the IRS with a "facts and circumstances determination in each case."

Rep. Greg Steube (R-FL) began by noting that some non-profit hospitals weren't providing the "charity care their status requires" and provided the example of hospitals routinely telling emergency responders to take homeless patients to other hospitals as well as aggressive billing behavior. He asked the witnesses to expand on this and comment on the impact when charitable care is not provided. Dr. Bai noted that hospitals have 100% discretion in designing eligibility criteria which allows for obscurity and aggressive techniques while Dr. Levinson added that

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financial assistance policy requirements were limited. These witnesses suggested that the most direct impact is on patients.

Rep. Brad Schneider (D-IL) commented on the resource challenges faced by hospitals, particularly in rural communities. Hatton responded that these issues were exacerbated by the pandemic and that the main problem is a lack of training slots. Schneider then asked about Schedule H and whether it is a fair snapshot, to which Lucas-Judy suggested that the form attempts to capture very complicated information. Schneider and the witness agreed that better numbers and more transparency are necessary.

Rep. Claudia Tenney (R-NY) also asked how to improve Schedule H and whether there is a reporting difference amongst urban and rural hospitals. GAO witness Lucas-Judy suggested that this distinction wasn't part of their review and regarding Schedule H, that it isn't being effectively used by the IRS for oversight and that Congress could help by providing more definition around community benefits.

Rep. Suzan DelBene (D-WA) questioned Lucas-Judy on the GAO's recommendation that the IRS assess community benefits at a facility rather than collective organization level. This witness suggested that it would improve transparency. DelBene then queried how the federal government could increase oversight of these hospitals to ensure consistent practices. Hatton suggested there is already a lot of oversight between Schedule H and community health needs assessments.

Rep. Michelle Fischbach (R-MN) described small rural hospitals as a "staple of the community," helping bridge gaps and treat the opioid crisis. Fischbach asked the witnesses how the health care landscape has changed since tax-exemption was made available. Dr. Bai noted that the portion of revenue sourced from non-charitable activities has changed and that community benefit standards should be updated to be consistent. She further added that there is little evidence that the IRS will revoke a hospitals tax-exempt status, describing enforcement as not being a "credible threat."

Rep. Gwen Moore (D-WI) asked about the dynamic reporting of health care that targets social determinants of health and whether institutions were allowed to demonstrate the impact of their efforts. Hatton suggested that the amount spent on social determinants may not be reflected in reporting. Dr. Bai noted that the reporting is already very complex and adding complexity makes the system "regressive."

Rep. Beth Van Duyne (R-TX) said she has "serious concerns about the IRS guidelines" currently in place to identify whether hospitals are meeting the community benefit standard. She also noted that it appears individuals have more paperwork to fill out to receive financial aid than a hospital is required to fill out to receive non-profit status. Van Duyne asked whether there is something Congress could do to reduce the practice of hospitals using paperwork trails to avoid payment of financial aid. Dr. Bai suggested that any "red line" requirements should be decided at a state level.

Rep. Nicole Malliotakis (R-NY) asked Lucas-Judy whether the rate at which Medicaid patients are being treated is considered in the IRS evaluation of community benefits. She suggested the community benefit standard is very open ended, though noted there were some additional reporting requirements introduced by the Affordable Care Act. Hatton said that Medicare and Medicaid underpayments are included on Schedule H and there is credit for this. Malliotakis then asked about the advantages of Congress enacting changes that require non-profit hospitals to provide detailed budget plans. Dr. Bai suggested there could be unintended consequences and may result in "good performers" reducing their charity care.

Rep. Gregory Murphy (R-NC) asked about the purpose of non-profit hospitals having offshore financial accounts. Dr. Bai answered that there is evidence of non-profits engaging in activity that would be expected of a for-profit organization. Murphy was also highly critical of the "absurd" compensation received by CEOs, which he said was

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at the expense of the people who take care of patients. Hatton commented that the process for setting executive compensation is a fair and independent process.

Rep. Kevin Hern (R-OK) suggested hospitals play a "very important role" in local communities but that there are "bad actors". He noted the abuse of programs such as 340B as "totally unacceptable" and his interest in rooting out the bad actors. He asked Dr. Bai the extent to which the incentives provided are making it difficult for small hospitals to survive or enter the marketplace. Dr. Bai suggested that the current regulations are "policy failures" making it hard for small players to compete and are responsible for increased M&A and high prices. Hern then asked how Congress could improve reporting to get a better picture of the community benefit, to which Dr. Bai suggested "add several lines" and let hospitals self-report.

If you have questions, please contact Heather Meade or Heather Bell.

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