AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

September 25, 2025

The Honorable David Schweikert
Chairman
Oversight Subcommittee
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Terri Sewell
Ranking Member
Oversight Subcommittee
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Schweikert and Ranking Member Sewell:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,300 family physicians and medical students across the country, I write in response to the Subcommittee's hearing titled "Virtue Signaling vs. Vital Services: Where Tax-Exempt Hospitals are Spending Your Tax Dollars."

Non-profit hospitals play an integral role in communities across the country, providing economic opportunity, health care services, and numerous other resources and supports that positively invest in the health and well-being of individuals and families. More than half of the nation's hospitals are non-profit entities. These institutions employ thousands of family physicians across the country, which allows many of them the opportunity to participate in the Public Service Loan Forgiveness program and practice in communities that would otherwise be financially detrimental for them. Further, many serve as critical residency training sites for physicians. Protecting the viability and success of non-profit hospitals is of significant interest to family physicians, patients, and entire communities. This is why the AAFP advocates for a policy environment which incentivizes and holds them accountable for meeting their commitment to reinvest revenue back into the community and patient care, not the pockets of shareholders and administrators.

One of the key policy mechanisms that is available to non-profit hospitals are tax exemptions, including state, federal, and local. Tax exemptions can be essential to the financial survival of non-profit hospitals across the country, particularly in rural and medically underserved communities. We firmly believe that the tax-exempt status of non-profit hospitals that are fulfilling their commitment to advancing the health and well-being of their communities should not be subject to threat simply because they uplift the patient-physician relationship and offer comprehensive, patient-centered, evidence-based care.

In exchange for tax exemptions, which totaled $37.4 billion in 2021[i], non-profit hospitals are required to provide charitable contributions to the community. However, we are concerned by growing evidence that non-profit hospitals receiving tax exemptions are not prioritizing this responsibility. One study of tax-advantaged hospitals found that 24 percent received more tax benefits than they spent on community benefits, and 81 percent received more than they spent on charity care.[ii] Some research has suggested that non-profit hospitals commit a similar or, in some cases, a smaller share of their operating expenses to charity care

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and unreimbursed Medicaid costs (one of the most common community benefit activities) when compared to for-profit hospitals.[iii,iv,v] Meanwhile, compensation for CEOs of nonprofit hospitals and medical systems increased 30 percent between 2012 and 2019.[vi] In some cases, the highest paid non-profit hospital CEOs made 60 times the hourly pay of general hospital workers.[vii]

In March 2024, the AAFP conducted a survey of members requesting information about their experiences with health care consolidation. Anecdotal comments from the survey cited disconnects between the stated mission of non-profit health systems and decisions to close local services that were less profitable. Survey comments expressed physician views that centralized decisions from health system leaders prioritized profits over patient care.

Research indicates non-profit hospitals have higher operating margins than for-profit hospitals, and these surpluses are used to increase cash reserve balances, not to provide charity care.[viii] The same study found that a one dollar increase in profit was not associated with a statistically significant increase in charity care for non-profit hospitals, while for-profit hospitals had a four-cent increase in charity care for every additional dollar of profit.[ix]

Hospital financial reserves can help non-profit health systems maintain solvency during downturns or emergencies, such as the COVID-19 public health emergency.[x] However, some large systems direct cash reserves to launch venture capital funds.[xi,xii] There is no evidence that gains from these investment funds are used to maintain or expand charity care during economic downturns. For example, one system reporting operating losses in 2023 cited significant gains in an associated investment fund, but funding for charity care was still cut that year.[xiii]

To be federally-tax exempt, non-profit hospitals must meet the general requirements applied to all 501(c)(3) organizations, as well as two hospital-specific requirements: 1) they must meet the "community benefit standard" evaluated by the Internal Revenue Service (IRS), and 2) they must comply with requirements specified under I.R.C. § 501(r). The community benefit standard is a test the IRS uses to determine whether a hospital is organized and operated for the charitable purpose of promoting health. The following factors are used to demonstrate community benefit:

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

However, even with the above list, there remains a lack of specificity about what services qualify or how many of them tax-exempt non-profit hospitals must provide. There is no federal minimum community benefit standard spending threshold or requirement that they must meet to maintain their tax exemptions. Additionally, there is no explicit definition of what a community benefit is. This has led to significant variations across states and areas in how much non-profit hospitals are reinvesting into the community. Some states have implemented requirements for non-profit hospitals to provide a certain minimum level of

charity care or community benefits, but no states tie meeting this requirement to maintaining a hospital's tax-exempt status.[xv]

To ensure that tax-advantaged hospitals are truly meeting their mission, the Academy strongly encourages Congress to pursue the following policy recommendations:

- **Implement greater transparency and accountability through more explicit community benefit standard requirements**. Specifically, Congress should establish a federal minimum benchmark for hospital spending toward community benefit activities. Examples of metrics states have used include "in an amount equivalent to the hospital's property tax liability in the absence of exemption" and "in an amount equivalent to 5 percent of the hospital's operating expenses."

  Further, there should be a clear definition of what specific activities and services meet the community benefit standard. This will help ensure that data collection and analysis are all operating from the same uniform definition. Lawmakers should also explore tying the level of charity care and community benefits provided to the value of the tax exemptions received, ensuring that non-profit hospitals are always providing more in benefits than they receive in advantages. Importantly, the unique challenges facing rural hospitals and the communities they serve should be factored into any such policy proposals.

- **Prohibit the use of overly restrictive non-compete agreements by non-profit hospitals.** As the landscape of employment for physicians has shifted toward employment, noncompete agreements in health care threaten to disrupt patient access to physicians, deter advocacy for patient safety, limit physicians' ability to choose their employer, stifle competition, and contribute to an increasingly concentrated healthcare market. In the absence of prohibiting their usage across all non-profit hospital physician contracts, lawmakers could consider tying a hospital's tax-exempt status to their inclusion of non-profit agreements within physician employment contracts.

- **Ensure oversight agencies, such as the Federal Trade Commission and the Department of Justice, have the appropriate resources to monitor and pursue bad actors as needed.** We have also urged the Departments of Justice and Health and Human Services and the Federal Trade Commission to increase monitoring of tax-exempt health systems to ensure profits are used to reinvest in it the organization's stated mission to provide care, not channeled to speculative investments.

- **Require more accurate and updated data reporting by non-profit hospitals.** Specifically, policymakers should require hospitals to disclose their estimated tax benefits so that community benefits and tax exemptions can be compared. We also encourage updates to Schedule H of Form 990 so that community benefits are reported at the individual hospital facility level – as the Government Accountability Office has recommended[xvi] – rather than across the entire hospital organization. This

would provide greater transparency as an aggregated total does not capture what benefits are flowing down to each individual community.

- **Reevaluate definitions and determinations used by federal agencies to ensure that hospitals are appropriately identified as "rural."** This can be especially important for supporting and expanding primary care residencies at non-profit hospitals and other settings in rural areas. The AAFP supports proposed policy changes to the definition of rural hospitals to align with other CMS defined criteria as an area with less than 50,000 people.[xvii] True rural, non-profit hospitals and community-based residency programs should receive special consideration for the distribution of Graduate Medical Education (GME) slots. The current classification used to define rural for GME and other programs should be reevaluated to ensure that care, especially primary care, is accessible to these underserved communities.

Thank you for convening this timely and important conversation. We look forward to working with you to advance necessary reforms to ensure that tax-exempt non-profit hospitals are meeting their mission and investing in the health and well-being of their patients and communities, instead of their pocketbooks. Should you have any questions, please contact Megan Mortimer, Manager of Legislative Affairs, at mmortimer@aafp.org.

Sincerely,

Steve Furr, MD, FAAFP
American Academy of Family Physicians, Board Chair

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