The State of U.S. Charity Care:

SOLUTIONS TO IMPROVE THE PATIENT EXPERIENCE AND achieve MORE EQUITABLE HEALTH OUTCOMES

HEALTH EQUITY COLLABORATIVE

White Paper

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The Health Equity Collaborative

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About the Author

The Health Equity Collaborative (HEC) is a diverse community comprised of dozens of national, public health, patient advocacy, and multicultural organizations that are committed to supporting equity and combating disparities experienced by underserved populations. HEC is a project of MANA Action, a 501c4 not-for-profit organization.

Introduction

Most hospitals offer some amount of charity care – free or discounted healthcare services for uninsured or low-income individuals. Non-profit hospitals must provide charity care as a condition of their tax-exempt status. This paper recounts the history of charity care policy in the U.S. and explains how the system evolved to the point that, today, it fails to benefit many of the people it is intended to support. This paper shows how financial gains of many non-profit hospitals are not substantially reinvested in the communities that host them, how non-profit hospitals vary widely in the amount of charity care they offer, and how a generous prescription drug discount program benefits many healthcare providers and pharmacies that do not provide proportionate levels of charity care. Finally, this paper further outlines a several policy reforms to increase and improve charity care in underserved communities.

SECTION ONE

The Origin and Evolution of Hospital Charity Care

Many hospitals and other healthcare providers offer free or discounted services to people who cannot afford to pay for their medical care, primarily due to low income or lack of health insurance. This ‘charity care’ is intended to ensure people have access to – and receive – the care they need—regardless of their ability to pay.

Before 1969, the Internal Revenue Service (IRS) required hospitals to provide free or heavily discounted services to indigent patients in order to maintain tax-exempt status. By 1969, both the Medicare and Medicaid programs were established, providing insurance for much – but not all – of the country's low-income population. With millions more Americans having health insurance, hospitals successfully lobbied the IRS to relax its requirements for tax-exempt status. The IRS' new rule required hospitals to provide a "community benefit" to qualify. What qualified as a community benefit, however, was largely determined by hospitals, and the system was, unsurprisingly, abused. As noted in an expansive exposé in *Politico* titled, 'How hospitals got richer off Obamacare,' "Many hospitals included new construction, capital expenditures, and even executive perks as community benefits."[1]

As the Affordable Care Act (ACA) health insurance marketplace went into effect and as states expanded Medicaid, fewer people remained in need of charity care providers (CCPs). This development was expected, as the ACA led to increased insurance coverage for millions of Americans. In fact, the focus of many CCPs shifted in part toward helping patients enroll in one of the new insurance options.[2]

An ACA regulation also updated charity care requirements for non-profit hospitals to maintain their tax-exempt status. To meet the "charity care" standard set by the ACA and thus qualify for tax-exempt status, hospitals must conduct a 'community health needs assessment,' produce a corresponding implementation strategy, develop a financial assistance policy for emergency and other necessary care, and comply with limits on charges to people eligible for financial assistance, including billing and collection practices. Notably, the ACA set no minimum value of community benefits a hospital must provide to qualify for tax-exempt status.[3]

New community health needs assessments and implementation strategies are required every three years, with failure to comply resulting in a $50,000 excise tax. Written financial assistance policies must outline eligibility criteria, explain the application process, include emergency and other necessary care, and explain how financial assistance policies will be widely publicized in the communities the policies cover. Emergency and other necessary services may not be billed at a rate higher than that for insured persons, and dramatic collections actions may not begin before determining whether a patient may qualify for financial assistance.[4]

The ACA also created a new requirement for the IRS, ostensibly intended to ensure hospital compliance with the new rules.

> *The ACA requires that the secretary of the treasury, in consultation with the secretary of health and human services, submit to Congress an annual report that includes information on the levels of charity care, bad debt expenses, unreimbursed costs for care provided to beneficiaries of means-tested government programs (for example, Medicaid), and unreimbursed costs for care provided to non-means-tested program beneficiaries (for example, Medicare), rendered by private and government-owned nonprofit hospitals. The report must also provide information on the costs incurred by private tax-exempt hospitals for community benefit activities.*[5]

During the COVID-19 pandemic, many charity care programs underwent significant changes. A 2022 study published in JAMA Network found that of the 151 charity care policy documents it reviewed, 127 were revised from 2019 to 2021. Revisions sometimes increased patient eligibility, and sometimes restricted it. Overall, only 31 percent of the hospitals surveyed had become more 'generous,' defined by the study as having expanded access to financial assistance. 8 percent of hospitals studied had

OVERALL, ONLY 31% OF THE HOSPITALS SURVEYED HAD BECOME MORE 'GENEROUS,' DEFINED BY THE STUDY AS HAVING EXPANDED ACCESS TO FINANCIAL ASSISTANCE.

become more restrictive. One-third of hospitals showed minimal change, while it was unclear what direction, if any, 12 percent of the hospitals had trended. The study also concluded:

> *"unpublicized or vague eligibility criteria may limit patients' understanding of charity care policies and conceal the full extent of charity care policy changes over time." Furthermore, the study found that even when an insured patient may be technically eligible, the fine print of insurance policies restricted patients' access to charity care. In general, the study found that confusion created in vague or opaque eligibility criteria could deter patients from pursuing or accessing charity care.*[6]

The uncertainty surrounding charity care, and eligibility for this care, is due in large part to broad federal government definitions of what charity care entails. Today, the only standard commitment necessary for a hospital to maintain its nonprofit, tax-exempt status is the community health needs assessment. *Health Affairs* has noted:

> *Exemptions from income taxes for charitable institutions date back to the first income tax code enacted in 1913. In 1954 Section 501(c)(3) of the Internal Revenue Code was codified and provided for the exemption from federal income tax for organizations that operated exclusively for religious, charitable, scientific, or educational purposes. Prior to 1969, to qualify for tax-exempt status a hospital had to provide, "to the extent of its financial ability, free or reduced-cost care to patients unable to pay for it." In 1969 this charitable care standard was replaced with a more general requirement that compelled hospitals to engage in activities that benefit the communities they serve. Under the "community benefit" standard, spending that promotes community health, in addition to charity care, counts toward meeting the requirements for tax exemption.*[7]

TODAY, THE ONLY STANDARD COMMITMENT NECESSARY FOR A HOSPITAL TO MAINTAIN ITS NONPROFIT, TAX-EXEMPT STATUS IS THE COMMUNITY HEALTH NEEDS ASSESSMENT.

In 2008, the "IRS added a requirement that hospitals submit additional information regarding community benefits."

> *Schedule H categories of community benefit activities include the net, unreimbursed costs of charity care (providing free or discounted services to patients who qualify under the hospital's financial assistance policy); participation in means-tested government programs, such as Medicaid; health professions education; health services research; subsidized health services; community health improvement activities; and cash or in-kind contributions to other community groups (such as donating funds to a community health screening event or hosting a blood drive). Hospitals can also claim what the IRS terms* community building activities*, such as investments in housing or environmental improvements, if they separately submit evidence documenting the relationship between such investments and health improvement.*

In addition to federal requirements, "many states have their own community benefit laws that vary substantially from state to state in scope and detail, including the amount and type of evidence that must be reported, and that may exceed requirements of federal law."[8] A 2013 *New England Journal of Medicine* study found enormous variation in the percentage of total hospital expenditures devoted to community benefits. The vast majority of that spending was for patient services, not improving overall community health. The study also found that state, but not federal, reporting requirements are closely tied to the level of community benefit provided by non-profit healthcare providers.[9]

An article in University of California Berkeley-affiliated TBG insights sums up a major shortcoming in current charity care policy: "Apart from a mandatory community health needs assessments, financial assistance policies and billing procedures are independently determined by each hospital. Furthermore, because there are no set minimum expenditures for charity care, hospitals are not held accountable if they skimp on providing the free services required to maintain their nonprofit status."[10]

SECTION TWO

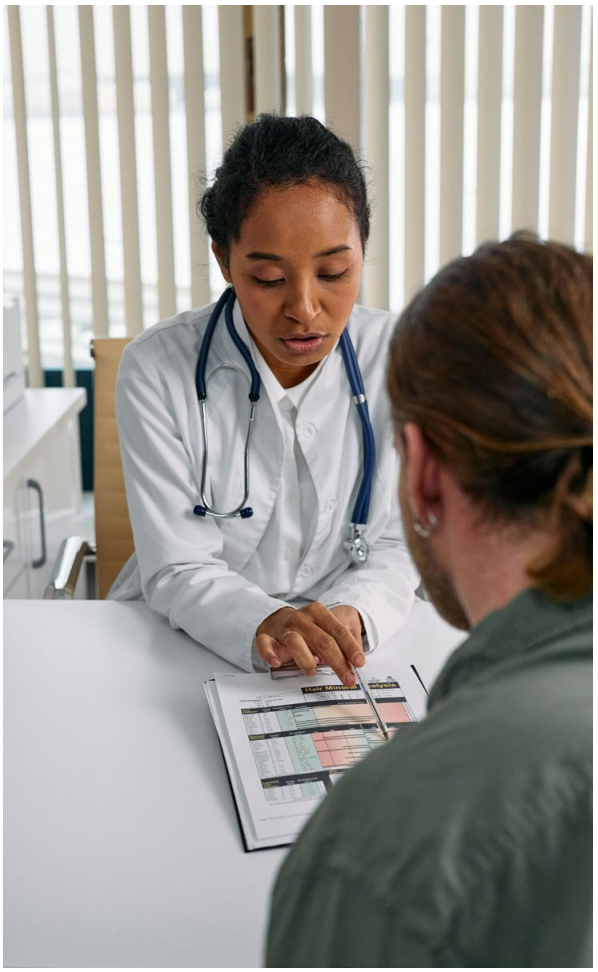
The Current State of the Charity Care Model

The profits of nonprofit hospitals have steadily increased following the ACA's Medicaid expansion. Many hospital systems have consolidated, while shifting the cost of uncompensated care to taxpayers has become common, further padding hospital bottom lines. Meanwhile, the provision of charity care and community benefits has often declined, while individuals' medical debts have soared.

MEANWHILE, THE PROVISION OF CHARITY CARE AND COMMUNITY BENEFITS HAS OFTEN DECLINED, WHILE INDIVIDUALS' MEDICAL DEBTS HAVE SOARED.

In 2019, hospitals had their most profitable year on record in 2019, with a profit margin at 6.5 percent of operating costs. According to Kaiser Health News, "total margins, which include income from investments, were even higher."[11] The Kaiser Family Foundation (KFF) noted that "many medical systems have strengthened their market power in recent years by consolidating, buying up smaller hospitals and physician practices, which enables the hospital systems to charge even more."[12]

According to KFF, in 2022, 41 percent of adults, and 57 percent of those with household incomes below $40,000 "have some level of medical debt, owing an estimated $195 billion or more in total." KFF also reported, in 2024, that one in seven adults said they have delayed hospital services in the past year due to cost. KFF concluded, "there is no apparent relationship between the profits of hospitals in a market and how much medical debt residents have."[13]



A Third Way essay highlights the fact that within that 41 percent of adults with medical debt, there are "higher shares of Black and Hispanic adults impacted." It also states, "Half of nonprofit hospital systems billed low-income patients that should've qualified for charity care in 2019. And when their patients can't pay, they often come after them using a slew of tactics, some of which break existing regulatory requirements."[14]

2.6%

In all, **charity care** represented an average of **2.6 percent of hospitals' operating expenses**.[15]

While hospital profits and medical debt have seen steady increases, recent trends in charity care are mixed, at best. In a 2022 analysis, KFF found that "half of all hospitals reported that charity care costs represented 1.4% or less of their operating expenses in 2020, though the level of charity care varied substantially across facilities." For nine percent of hospitals, charity care represented 7 percent of operating expenses. In all, charity care represented an average of 2.6 percent of hospitals' operating expenses.[15] KFF explained the causes for the dramatic variation in charity care as a percent of hospitals' total operating expenses.

> *Variation in charity care levels across hospitals likely reflects differences in their missions and business practices; the need for charity care among patients; and federal, state, and local policies and regulations. The Medicare Payment Advisory Commission (MedPAC) has noted that the current method for calculating charity costs favors hospitals with higher markups, and it has recommended revisions that would put hospitals on more equal footing and reduce reported charity care costs on average.*[16]

A 2023 article in *Health Affairs* notes:

> *Research has found that 86 percent of nonprofit hospitals did not provide more charity care than the value of their tax exemption. Moreover, nonprofit hospitals have been found to have lower ratios of charity care to total expenses than for-profit hospitals. In this study we compared the changes in charity care spending versus cash reserve balances associated with changes in profits from 2012 to 2019. We found that increases in profit at nonprofit hospitals were not correlated with increases in charity care.*[17]

The *Health Affairs* article also mentions that hospitals use cash reserves for facility maintenance and upgrades, to cover unexpected revenue shortfalls, and to achieve a higher credit rating. It goes on, however, to ask the question, if increased profits are

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being used more to grow cash reserves than to increase charity care, this "would call into question the justification for favorable tax treatment of nonprofit hospitals."[18]

Another reason this tax-exempt status should be questioned extends beyond non-profit hospitals' failure to increase charity care alongside their profits. This reason is that many hospitals have been using cash reserves to expand in areas outside the very communities their tax status requires them to benefit.

> *Although hospitals must maintain cash reserves to weather financial crises, they may also be borrowing on these reserves to build facilities in new locations to expand their market share. These new locations are often in wealthier areas, and hospitals' prioritizing market expansion over community benefits invalidates their rationale for favorable tax treatment.*[19]

The Third Way essay brings declines in charity care into greater focus:

> *As tax breaks neared $30 billion among all nonprofit hospitals in 2020, only $16 billion was provided in charity care. While charity care is not the only type of community benefit nonprofit hospitals may provide, it is the most effective method for ensuring patients have access to affordable care. Over time, the tax benefits for these hospitals have grown from $19.4 billion in 2011 to $28.1 billion in 2020, a 45% increase. Despite this trend, a study shows no accompanying growth in charity care. The vast majority (86%) of nonprofit hospitals did not provide more charity care than the value of their tax exemption. When hospitals do report charity care, it is reported at the higher prices for uninsured patients rather that the lower net-costs negotiated for insured patients. In 2020, the Government Accountability Office reported at least 30 hospitals that spent zero dollars in total community benefits. Later in 2023, they testified to Congress that community benefit standards lack clarity and are difficult for the IRS to administer.*[20]

SECTION THREE

Compounding the Problem: The 340B Drug Pricing Program

UNCHECKED EXPANSION AND MISUSE

The 340B Drug Pricing Program aims to help participating hospitals serve low-income and vulnerable patients. Under the program, pharmaceutical manufacturers must provide significant discounts — averaging nearly 60 percent — for certain medicines purchased for those patients. In return, 340B providers are expected to help patients in financial need receive the discounted outpatient medicine and services — including through charity care.[21]

The benefit of discounted pharmaceutical prices through the 340B program, much like the tax-exempt status for nonprofit hospitals, is meant to be conveyed only if hospitals are meeting certain requirements to serve patients in financial need.

The 340B program has grown dramatically — 19 percent annually from 2010 through 2021, according to the Congressional Budget Office. Nearly three quarters of this spending was attributable to cancer drugs, anti-infectives, and immunosuppressants.[22]

The Alliance for Integrity and Reform notes:

> *At $54 billion in annual discounted sales, the 340B program is now larger than Medicaid and Medicare Part B, making it the second largest U.S. federal prescription drug program. While the program was initially targeted to grantees and frontline safety-net hospitals, 340B has become concentrated among disproportionate share hospitals (DSHs), which comprise 80% of all 340B purchases. There is no requirement for 340B hospitals to use the discounts they receive to help low-income patients afford their medicines; consequently, growth in annual discounted 340B sales has not translated into higher charity care levels at hospitals in the 340B program.*[23]

An analysis by Avalere found that in fiscal year 2021:

- More than two-thirds of 340B DSH hospitals provided charity care at below the national average of 2.5 percent of operating costs
- More than one-third of 340B DSH hospitals provided charity care equal to less than 1 percent of operating costs, with a growing number of hospitals dropping to this level
- 25 percent of 340B DSH hospitals accounted for 80 percent of charity care offered by all 340B DSH hospitals[24]

340B eligibility requirements help explain why many of these hospitals offer so little charity care. A DSH is so designated because it serves a large percentage of Medicaid and low-income Medicare patients. This disproportionate share helps make these hospitals eligible for the 340B program and its discounted pharmaceuticals. Due to Medicaid expansion resulting from the Affordable Care Act, more hospitals have become eligible for the 340B program. The amount of charity care provided to patients who are uninsured or otherwise in need is not factored into these hospitals' eligibility.[25] At the same time, a new report from the American Society of Health Economists have found massive cancer drug price markups and increased cancer drug use by 340B hospitals, often in wealthier areas—suggesting the program is being used outside its intended scope as a means to pad bottom lines.[26]

Earlier this year, in a response to U.S. Senate request, we, the Health Equity Collaborative, wrote:

> *The 340B program currently permits covered entities to build large contract pharmacy networks without demonstrating access needs for vulnerable populations. This is incentivizing a steady, unchecked, expansion of the program. Between 2010 and 2022, the number of 340B-eligible pharmacies participating in contract arrangements grew from less than 1% to more than 40%. Today, the 340B program accounts for approximately 7% to 8% of the total U.S. drug market. This growth has been largely driven by a handful of for-profit, publicly traded pharmacy chains, including CVS Health, Walgreens, Cigna, and Walmart (some of which own or are affiliated with a pharmacy benefit manager (PBM). As the number of contract pharmacies has grown, more and more are being located in wealthier and less diverse areas—a direct contradiction to the intention of the program.*[27]

340B hospitals are also tax-exempt, non-profit hospitals. As discussed in previous sections of this paper, non-profit hospitals are required to provide care to uninsured, low-income patients. They must widely publicize the availability of this care, and they must not engage in unreasonable collection tactics with patients who are unable to pay their medical bills. The American Medical Association makes similar recommendations, but in the end, there is little enforcement to ensure these requirements and prohibitions are adhered to.

SECTION FOUR

Reform Options for Congress

As discussed throughout this paper, weaknesses in charity care policy center around the absence of information to effectively make, enact, and enforce policies that increase access to healthcare services and otherwise benefit underserved communities. Effective reforms, therefore, would elicit information about how current charity care programs function—including eligibility criteria, application procedures, health outcomes, and financial burdens on patients receiving charity care. This information is critical to ensuring the vast tax benefits going to hospitals are closely tied to improving the lives of people and communities in need. The following reforms would help ensure charity care policy works as intended.

REQUIRE ADDITIONAL TRANSPARENCY OVER HOSPITAL BILLING, CHARITY CARE PROGRAMS & MEDICAL DEBT COLLECTION PRACTICES

Hospitals receiving Medicare funds must submit cost reports to the federal government. The data hospitals submit, however, is often years old and lacking the detail necessary to assess compliance with charity care requirements.[28] A reformed system would require more timely and detailed information in these reports.

Additionally, KFF has noted:

> *IRS Form 990s are also not subject to the same rigorous auditing process as audited financial statements and do not include government and for-profit hospitals and health systems. Nonprofit health systems do not typically break out information for individual hospitals, and they may provide information through multiple reports that would need to be combined to evaluate the overall health system. As of early March 2024, IRS Form 990 data were available online in a machine-readable form for all or nearly reporting entities for fiscal year 2021 but were unavailable for most entities for fiscal year 2022.*[29]

IRS Form 990s also require information about the community benefits a hospital provides. Reforms should not only require breaking out timely information by individual hospital, they should require detailed information about community benefits provided, by each hospital, in an easily accessible (and understandable) format. Similarly, audited financial statements, credit ratings, and data used in third party financial platforms should be more timely, individualized, and accessible.[30]

Financial reporting requirements should also include medical debt collection practices, hospital by hospital. Hospitals should further demonstrate whether they take debt collection efforts to varying degrees, depending on patients' ability to pay.

FINANCIAL REPORTING REQUIREMENTS SHOULD ALSO INCLUDE MEDICAL DEBT COLLECTION PRACTICES, HOSPITAL BY HOSPITAL. HOSPITALS SHOULD FURTHER DEMONSTRATE WHETHER THEY TAKE DEBT COLLECTION EFFORTS TO VARYING DEGREES, DEPENDING ON PATIENTS' ABILITY TO PAY.

Finally, the federal government, or states, should gather more information about hospitals' eligibility criteria for charity care, its application procedures for charity care, and its efforts to publicize its charity care options, as well as quantifications of applications, including rates of and reasons for denials and appeals. This quantification should include specific information about application outcomes and costs, how they vary by patient characteristics, and the amounts billed to patients after they have received charity care discounts.

Increased transparency will allow policymakers, community leaders, and hospitals, themselves, to better educate patients about charity care options, learn more about how nonprofit hospitals are, in fact, using dollars spent for charity care and supposed community benefit, and to learn where efforts might be increased to address areas outside direct treatments, such as social determinants of health in a hospital's community.[31]

ENFORCE TRANSPARENCY REQUIREMENTS

Increasing transparency requirements will only be effective if the requirements are enforced both readily and sufficiently. A February 2024 report by Patient Rights Advocate found that, three years into the Centers for Medicare & Medicaid Services' Hospital Transparency Rule, only 34.5 percent of the 2,000 hospitals surveyed were in full compliance with the rule. Of the well over 1,000 hospitals not in full compliance, only 14 were penalized—an enforcement rate of less than 2 percent.[32] Enforcement of the CMS transparency rule must be more consistent. Penalties for noncompliance, too, must be large enough to affect hospital behavior. The current maximum penalty of $2 million should increase substantially, given the far larger profits of many hospitals.

Bipartisan legislation in Congress, the PRICE Transparency Act 2.0, would address hospital noncompliance with transparency requirements. Among other measures, this legislation would:

- Require hospitals to meet data sharing standards.
- Require prices and negotiated rates to be machine-readable
- Increase transparency requirements for imaging centers, ambulatory surgical centers, and diagnostic labs
- Require the listing of prices for 300 shoppable services, and all shoppable services by 2025
- Require hospital executives to attest that the prices it reports are complete and accurate
- Require hospitals to link to a consumer-friendly document that clearly explains the hospital's charity care policy, including its discounted prices
- Increase the maximum penalty for hospital noncompliance to $10 million.[33]

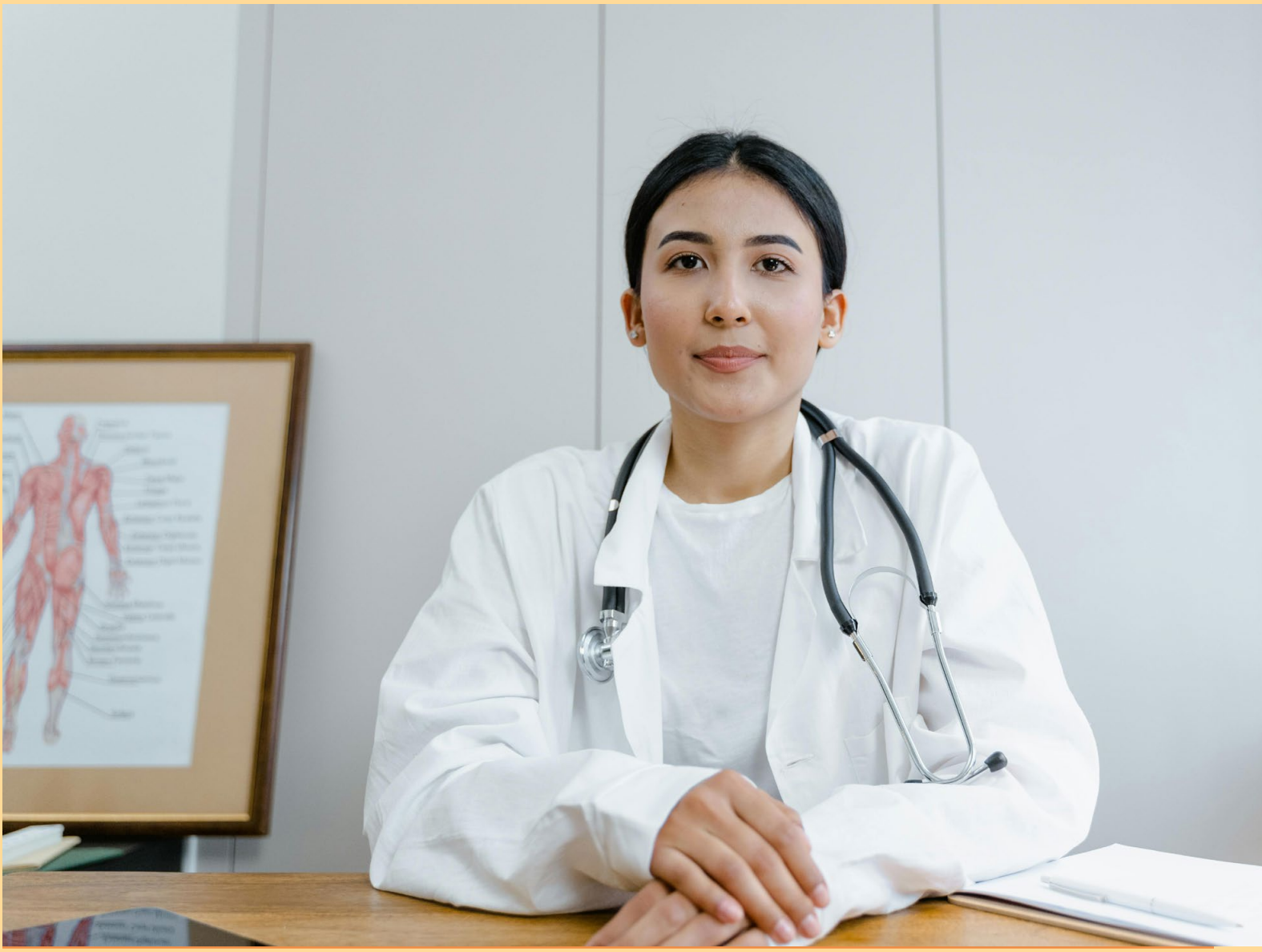
CREATE A NATIONAL STANDARD FOR CHARITY CARE

The IRS has no specific, "quantitative requirements for the community benefits that nonprofit hospitals must provide."[34] (i.e. there is no standard for charity care.) Yet given the billions of dollars saved by these hospitals due to their tax-exempt status, they should be held to higher standards in providing charity care fulfilling their community benefit requirements. Hospitals' community health needs assessments should be required to outline health disparities in the communities where they are located, and produce implementation strategies tailored to those communities' specific needs. These strategies must include details about their implementation, including measuring changes over time. This individualized approach would be far more effective in serving underserved communities, which vary in the specifics of their circumstances, compared to a one-size-fits-all approach.

A national standard for charity care should also link hospital profits to a minimum level of charity care and community benefit (that includes addressing social determinants of health in the community where the hospital is located). As a recent article in health care notes, with "operating profits for nonprofit hospitals growing, the share of community health benefits they provide should also be growing to justify their favorable tax treatment."[35]

> **A NATIONAL STANDARD FOR CHARITY CARE SHOULD ALSO LINK HOSPITAL PROFITS TO A MINIMUM LEVEL OF CHARITY CARE AND COMMUNITY BENEFIT**

YET GIVEN THE BILLIONS OF DOLLARS SAVED BY THESE HOSPITALS DUE TO THEIR TAX-EXEMPT STATUS, THEY SHOULD BE HELD TO HIGHER STANDARDS IN PROVIDING CHARITY CARE FULFILLING THEIR COMMUNITY BENEFIT REQUIREMENTS.



REFORM THE 340B DRUG PRICING PROGRAM

The 340B program's current design allows eligible hospitals to benefit from discounted drug prices without meeting a certain threshold or standard for charity care. A report from The New England Journal of Medicine report concluded, "Financial gains for hospitals have not been associated with clear evidence of expanded care or lower mortality among low-income patients."[36] We, the Health Equity Collaborative, have pointed out that, instead of helping low-income patients, "hospital executives across the country are exploiting a multi-billion-dollar federal program that was created to help vulnerable American patients—especially those in communities of color."[37]

The 340B program should be a true safety-net program for patients, not a profit-enhancer for hospitals. As a 2023 Third Way report notes, "patients must be front and center of any meaningful reform to 340B. Low-income and uninsured patients should receive discounts when they purchase their prescription at the pharmacy counter." Third Way also advocates, "Congress should require 340B hospitals to distribute discounts to patients on a sliding scale based on patients' income."[38]

In addition to passing discounts along to patients, Medicare should not overpay 340B providers for discounted drugs. Third Way makes the following case:

> *Addressing Medicare's reimbursement for 340B drugs would limit hospital incentives for prescribing more or higher-cost drugs that increase costs for patients and the taxpayer. Rural and safety net hospitals would be exempt from these adjustments to preserve access to hospital care for those communities.*[39]

Third Way and others also argue for standards that ensure 340B entities are serving underserved patients in the communities where they are located. Additionally, efforts must be made to strengthen hospital eligibility standards, establish stricter reporting requirements for 340B eligible hospitals, reign in abuses by contract pharmacies that work with 340B hospitals, and enhance federal administration and oversight of the 340B program.

IN ADDITION TO PASSING DISCOUNTS ALONG TO PATIENTS, MEDICARE SHOULD NOT OVERPAY 340B PROVIDERS FOR DISCOUNTED DRUGS.

Lack of transparency, however, remains an obstacle to reform. John Michael O'Brien, President and CEO of the National Pharmaceutical Council, wrote in 2022:

> *The data released on 340B to date indicate there are fundamental questions about this program that need to be answered. I commend every team of researchers that has attempted to peer into 340B's murky waters, because it is a big challenge. But it's critical to answer these questions because, as my colleagues and I often say, good policy requires thorough research.*
>
> *If hospitals, contract pharmacies, and third-party administrators have more data that can add more detail to this discussion, the research community must be given access to it so their work can restore confidence that the program is helping those it is supposed to help.*[40]

The 340B ACCESS Act would require many of these reforms. In addition to requiring discounts to be passed along to their intended beneficiaries, this legislation would:

- Require each hospital's 340 'child site' to offer as much Medicaid and charity care (as a percentage of revenue) as its parent hospital, or the average level for hospitals in the state (whichever is higher)
- Create new requirements to ensure contract pharmacies offer affordability assistance
- Prevent middlemen (such as PBMs) from abusing the 340B system by siphoning off savings intended for patients in need
- Create a 340B data clearinghouse
- Require additional reporting from 340B hospitals, including the total acquisition cost and reimbursement for 340B discounted medicines and the total amount spent to administer the 340B program. Additionally, grantees subject to reporting would report how they are using their 340B margin.
- Increase federal oversight of the 340B program[41]

Conclusion

Charity care in the U.S. has undoubtedly declined in both quantity and quality. The extent of this decline remains to some degree unknown due to a lack of transparency about how different charity care programs work. Still, ample data exists showing charity care programs are not always used to benefit patients and communities in need. The 340B drug pricing program is a prime example of a program that gets abused to put profits over people in need.

An important step in guaranteeing a strong charity care system is the provision of data on how hospitals define and implement both charity care and community benefits. Nonprofit hospitals and other beneficiaries of tax breaks or discounted pharmaceuticals must be forthcoming with information about how they are serving the people in need who live in the communities where these beneficiaries are located. This information must include definitions of eligibility, efforts to make local patients aware of available services, and medical debt collection practices. New standards and requirements must be set for hospitals and pharmacies. Enforcement must be consistent and impactful.

With transparency, clear and uniform standards, and rigorous oversight and enforcement, the U.S. can restore charity care to its critical place in our healthcare system and improve health and opportunity for all Americans.

REFERENCES

1. Diamond, D. (2017, July). How hospitals got richer off Obamacare. Politico. [Link]

2. Crawford, M. (2016, July). The Evolution of Charity Care Programs to Support Enrollment in Health Coverage. Center for Health Care Strategies. [Link]

3. James, J. (2016, February). Nonprofit Hospitals' Community Benefit Requirements. Health Affairs. [Link]

4. James, J. (2016, February). Nonprofit Hospitals' Community Benefit Requirements. Health Affairs. [Link]

5. James, J. (2016, February). Nonprofit Hospitals' Community Benefit Requirements. Health Affairs. [Link]

6. Goodman, C. (2022, September). Comparison of US Hospital Charity Care Policies Before vs After Onset of the COVID-19 Pandemic. JAMA Network Open. [Link]

7. James, J. (2016, February). Nonprofit Hospitals' Community Benefit Requirements. Health Affairs. [Link]

8. James, J. (2016, February). Nonprofit Hospitals' Community Benefit Requirements. Health Affairs. [Link]

9. James, J. (2016, February). Nonprofit Hospitals' Community Benefit Requirements. Health Affairs. [Link]

10. The Berkeley Group. (2020, Fall). The Problem of Charity Care at Nonprofit Hospitals: What Can We Do? TBG Insights. [Link]

11. Levey, N. (2022, September). Few Places Have More Medical Debt Than Dallas-Fort Worth, but Hospitals There Are Thriving. KFF Health News. https://kffhealthnews.org/news/article/medical-debt-hospitals-dallas-fort-worth/

12. Lopes, L. (2024, March). Americans' Challenges with Health Care Costs. Kaiser Family Foundation. [Link]

13. Lopes, L. (2024, March). Americans' Challenges with Health Care Costs. Kaiser Family Foundation. [Link]

14. Third Way. (2024, February). A National Charity Care Law to Improve Nonprofit Hospitals. Third Way. [Link]

15. Levinson, Z. (2022, November). Hospital Charity Care: How It Works and Why It Matters. Kaiser Family Foundation. [Link]

16. Levinson, Z. (2022, November). Hospital Charity Care: How It Works and Why It Matters. Kaiser Family Foundation. [Link]

17. Jenkins, D. (2023, June). Nonprofit Hospitals: Profits And Cash Reserves Grow, Charity Care Does Not. Health Affairs. [Link]

18. Jenkins, D. (2023, June). Nonprofit Hospitals: Profits And Cash Reserves Grow, Charity Care Does Not. Health Affairs. [Link]

19. Jenkins, D. (2023, June). Nonprofit Hospitals: Profits And Cash Reserves Grow, Charity Care Does Not. Health Affairs. [Link]

20. Third Way. (2024, February). A National Charity Care Law to Improve Nonprofit Hospitals. Third Way. [Link]

21. Alliance for Integrity and Reform. (2023, October). Charity Care at 340B Hospitals is on a Downward Trend. Alliance for Integrity and Reform. [Link]

22. Sachs, R. (2024, June). Spending in the 340B Drug Pricing Program, 2010-2-21. Congressional Budget Office. [Link]

23. Alliance for Integrity and Reform. (2023, October). Charity Care at 340B Hospitals is on a Downward Trend. Alliance for Integrity and Reform. [Link]

24. Alliance for Integrity and Reform. (2023, October). Charity Care at 340B Hospitals is on a Downward Trend. Alliance for Integrity and Reform. [Link]

25. Alliance for Integrity and Reform. (2023, October). Charity Care at 340B Hospitals is on a Downward Trend. Alliance for Integrity and Reform. [Link]

26. Nordyke, R. (2024, June). Drug Markups Under the 340B Program Are Higher for Covered Entities Serving Wealthier Areas. American Society of Health Economists. [Link]

27. Health Equity Collaborative (2024, April). Addressing the Bipartisan Senate Request for Information on the 340B Program. Health Equity Collaborative.

28. Hulver, S. (2024, March). Gaps in Data About Hospital and Health System Finances Limit Transparency for Policymakers and Patients. Kaiser Family Foundation. [Link]

29. Hulver, S. (2024, March). Gaps in Data About Hospital and Health System Finances Limit Transparency for Policymakers and Patients. Kaiser Family Foundation. [Link]

30. Hulver, S. (2024, March). Gaps in Data About Hospital and Health System Finances Limit Transparency for Policymakers and Patients. Kaiser Family Foundation. [Link]

31. Huang, A. (2019, November). The Problem of Charity Care at Nonprofit Hospitals: What Can We Do? The Berkeley Group. [Link]

32. Patient Rights Advocate (2024, February). NEW REPORT: Just 34.5% of reviewed hospitals fully compliant with federally-mandated price transparency rule. Patient Rights Advocate. [Link]

33. Office of U.S. Senator John Hickenlooper. (2024, January). Hickenlooper, Braun, Sanders, Grassley, Smith Introduce Landmark Bill to Make Health Care Costs Transparent. Office of U.S. Senator John Hickenlooper. [Link]

34. Jenkins, D. (2023, June). Nonprofit Hospitals: Profits And Cash Reserves Grow, Charity Care Does Not. Health Affairs. [Link]

35. Jenkins, D. (2023, June). Nonprofit Hospitals: Profits And Cash Reserves Grow, Charity Care Does Not. Health Affairs. [Link]

36. Desai, S. (2018, January). Consequences of the 340B Drug Pricing Program. The New England Journal of Medicine. [Link]

37. Health Equity Collaborative. Congress Must Amend the 340B Program to Bring Justice to Communities of Color. [Link]

38. Wofford, D. (2023, November). Fixing a Critical Safety Net Program: 340B. Third Way. [Link]

39. Wofford, D. (2023, November). Fixing a Critical Safety Net Program: 340B. Third Way. [Link]

40. O'Brien, J. (2022, October). After 30 years of 340B, it's time for data and an honest conversation. STAT. [Link]

41. ASAP 340B. The 340B ACCESS Act Ensures the 340B Program Benefits Patients and True Safety-Net Providers. [Link]