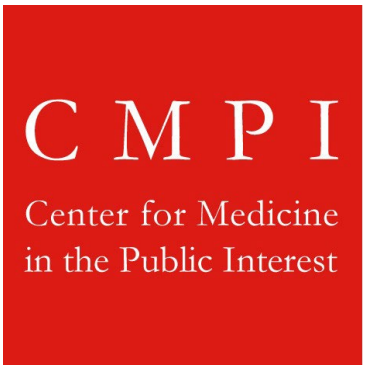

RESTORING THE NONPROFIT HOSPITAL SOCIAL CONTRACT

Maryland HB 1136/SB 832 and the Case for a Performance-Conditioned Tax Exemption

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Overview: Unmasking the Real Cost Drivers in Maryland's Nonprofit Hospitals

Marylanders are told that nonprofit hospitals exist to serve the public good. In exchange for generous tax breaks, public subsidies, and charitable donations, these institutions are supposed to provide affordable care, charity treatment, and meaningful investments in community health.

The evidence, however, tells a different story. Across Maryland, and the nation, many nonprofit hospitals now operate less like charities and more like aggressive, highly protected corporations. They maximize revenue, minimize obligations to the poor, and leave taxpayers to make up the difference. That disconnect is helping drive higher health care costs and widening inequities in who gets care.

Nonprofit hospitals enjoy enormous public benefits: exemption from federal, state, and local taxes; access to tax-free bond financing; and billions in government payments. In return, they are supposed to deliver charity care and community benefits that justify those privileges.

Nationally, however, nearly 80% of nonprofit hospitals spend less on community benefit than the value of their tax breaks, creating what researchers call a $25.7 billion "fair share deficit." Maryland performs better than the national average, but not well enough to keep taxpayers at ease. According to the Lown Institute,18% of Maryland's nonprofit hospitals

still fail to give back as much as they receive. (The Lown Institute is a nonpartisan healthcare think tank focusing on reducing unnecessary, low-value care.)

One striking example: In 2022, at the height of the COVID-19 crisis, University of Maryland Medical Center ran a $42 million fair-share deficit—receiving more in public subsidies than it spent on meaningful community investment. That is not charity. It is a tax scam.

Even more troubling, many Maryland hospitals are actively pulling away from the very patients they were created to serve. Medicaid and uninsured patients are increasingly avoided because they are less profitable than privately insured patients. Hospitals instead prioritize elective procedures, specialty services, and facility expansions that attract higher-paying insurers.

Some hospitals have even been documented suing low-income patients for medical debt, including people who may have qualified for free or discounted care. Johns Hopkins Health System was publicly criticized for aggressive debt collection practices that resulted in wage garnishments and liens against vulnerable patients. That behavior that is indistinguishable from that of a for-profit debt collector.

This is happening because neither federal nor Maryland law clearly requires hospitals to provide a minimum level of charity care in exchange for tax exemption. As the Johns Hopkins Bloomberg School of Public Health has noted, the result is a system riddled with loopholes and wide variations in what hospitals contribute to the communities that support them.

If hospitals are not spending their money on charity, where is the money going? Increasingly, it is going to expansion projects, market consolidation, and real estate speculation. Hospitals pour billions into new buildings, acquisitions, and advertising designed to boost market share and negotiating power over competitors in the healthcare space, not access to care.

In Baltimore, for example, nonprofit hospitals have agreed to contribute $6 million annually to the city—but they consume an estimated $47 million in city services, leaving taxpayers to fill a $41 million gap. Again, that is a tax scam masquerading as community benefit.

This model has real consequences. First, it erodes public trust. When “nonprofit” hospitals behave like Wall Street firms, the public is rightly skeptical of their charitable claims. Second, it restricts access to care. Low-income patients face longer waits, fewer service options, and greater financial risk because hospitals systematically favor wealthier patients. Third, it undermines health policy. Taxpayers are effectively subsidizing institutions that are not meeting their obligations while health care costs continue to rise.

Maryland can do better, but it requires political will. The state should set enforceable charity-care minimums tied to hospital size and community need, require full transparency

on community benefit spending, executive pay, and lobbying, down to the ZIP-code level, link tax exemptions to performance so hospitals that do not give back lose their special privileges, and mandate independent audits to ensure compliance with nonprofit standards.

Nonprofit hospitals were never meant to be lightly regulated corporate empires with charitable branding. They were created to serve the public, not exploit it.
Until Maryland restores accountability, taxpayers will keep paying more while getting less.

Report Executive Summary

Nonprofit hospitals occupy a uniquely privileged position in American health care. Their exemption from federal, state, and local taxation—combined with access to tax-exempt bond financing and the deductibility of charitable contributions—represents a substantial and ongoing public subsidy. These benefits are not honorary distinctions. They are fiscal instruments designed to advance public purposes. When governments forgo tax revenue, they are making a deliberate investment decision, premised on the expectation that the value of the subsidy will be matched or exceeded by measurable public benefit.

In Maryland, nonprofit hospitals receive approximately $587 million annually in tax benefits (5). While many institutions report substantial community investment, recent analysis demonstrates that 18% operate with measurable "fair share deficits," producing an aggregate shortfall of approximately $82 million per year between public subsidy and quantifiable community benefit (5). At the same time, executive compensation at certain major hospital systems exceeds $3 million annually, significantly surpassing statewide nonprofit and hospital CEO benchmarks.

Maryland House Bill 1136/Senate Bill 832 responds to this imbalance by conditioning state tax exemption on measurable performance thresholds. Under the legislation, hospitals would be required to provide community benefit equal to either 100% of the value of tax benefits received or 5% of net patient revenue, with at least 4% devoted to charity care. This monograph argues that performance-conditioned exemption is legally sound, fiscally proportionate, administratively feasible, and nationally replicable. It modernizes—rather than dismantles—the nonprofit hospital social contract by aligning public subsidy with public return.

I. Tax Exemption as Public Investment

Tax exemption for nonprofit hospitals is best understood as a public expenditure rather than a symbolic designation. Public finance scholarship treats tax expenditures as functionally equivalent to direct spending programs, since foregone revenue must be offset elsewhere in the fiscal system (8). When hospitals are exempt from property, income, and

sales taxes, the financial consequence is borne by other taxpayers or reflected in reduced public services.

The economic scale of nonprofit hospital tax exemption nationally is substantial. One widely cited estimate placed the annual value of nonprofit hospital tax exemption at $24.6 billion in 2011 (8). More recent analyses suggest that the figure is significantly higher (10). These findings underscore that exemption is not marginal—it is a major component of the health care financing landscape.

The central policy question is therefore straightforward: does the magnitude of public subsidy correspond to measurable public benefit?

This inquiry is not an indictment of nonprofit medicine. Rather, it reflects a recognition that flexibility without enforceable reciprocity risks undermining public trust. In Maryland's current fiscal environment—marked by structural budget pressures, Medicaid redeterminations, and heightened scrutiny of tax expenditures—legislators are increasingly examining whether exemption remains appropriately calibrated to performance.

II. The Legal Evolution of the Community Benefit Doctrine

Federal tax exemption for nonprofit hospitals arises under Section 501(c)(3) of the Internal Revenue Code. Historically, exemption was tied directly to charity care. Revenue Ruling 56-185 required hospitals to operate "to the extent of their financial ability" for those unable to pay (1). This standard created a measurable link between fiscal privilege and service to indigent populations.

In 1969, Revenue Ruling 69-545 replaced that requirement with a broader community benefit doctrine (2). Hospitals could qualify by promoting health in general, maintaining open emergency rooms, and operating under community governance structures. Quantitative charity-care thresholds were eliminated.

The Affordable Care Act later introduced Section 501(r), which imposed additional requirements related to financial assistance policies, billing practices, and community health needs assessments (3). However, Congress did not establish minimum charity-care percentages. Federal law today permits significant discretion.

States retain authority to define and condition their own tax exemptions. The Supreme Court has long recognized that tax benefits constitute forms of subsidy that may be conditioned on compliance with public policy objectives (4). Conditioning state-level exemption on measurable community investment is therefore constitutionally permissible. Maryland House Bill 1136/Senate Bill 832 operate squarely within this legal framework.

II. The Maryland Landscape

Maryland provides an instructive case study. Nonprofit hospitals in the state receive approximately $587 million annually in tax benefits (5). These include local property tax exemptions, state sales tax exemptions, state income tax exemptions, federal income tax benefits, and access to tax-exempt bond financing.

Hospitals report approximately $1.1 billion annually in community benefit spending (5). On aggregate, this appears to exceed the value of tax benefits. However, institutional variation complicates the picture. Eighteen percent of nonprofit hospitals operate with measurable fair share deficits, producing an aggregate shortfall of approximately $82 million annually (5).

Empirical literature has long documented variability in community benefit provision across nonprofit hospitals (6,9). Some institutions significantly exceed measurable thresholds; others provide levels of community benefit comparable to for-profit facilities (6). The existence of variance raises policy concerns when exemption is presumed rather than conditioned.

Maryland's data do not demonstrate systemic collapse. Rather, they reveal asymmetry. Without quantitative standards, institutions operating below parity retain identical fiscal privileges as those exceeding expectations.

III. Executive Compensation and Institutional Incentives

Executive compensation provides additional context for evaluating nonprofit accountability. IRS Form 990 data show executive compensation exceeding $3.6 million at certain Maryland hospital systems. While such compensation may comply with federal excess benefit transaction standards, its coexistence with measurable fair share deficits raises legitimate policy questions.

Research examining nonprofit hospital behavior suggests that executive compensation often correlates more strongly with institutional size and revenue growth than with measurable improvements in charity care or community health outcomes (6,7). Organizational incentives matter. When fiscal privilege is not conditioned on measurable community investment, revenue expansion may become the dominant performance metric.

Hospitals in Maryland have some of the highest pay equity ratios (i.e., large CEO pay relative to average worker pay). Maryland stands out in Lown Institute analysis because Maryland nonprofit hospital CEOs tend to have among the highest relative compensation

ratios in the country. For example, according to the ProPublica nonprofit database of IRS 990 filings:

- Mohan Suntha, MD, President and CEO, University of Maryland Medical System, received about **$3,669,040** in total compensation.
- Kenneth A. Samet, CEO and President, MedStar Health Inc, had total compensation of **$7,083,748** in the most recent filing.
- Bert W. O'Malley, MD, President and Chief Executive Office of the University of Maryland Medical Center, reported total compensation of **$1,795,984** for the **fiscal** year ending June 2024,

The literature comparing nonprofit and for-profit hospital behavior has consistently found that ownership status alone does not guarantee superior charity-care performance (6,9). If nonprofit status is to justify exemption, measurable reciprocity must be demonstrable. HB 1136 does not regulate compensation directly. Instead, it recalibrates incentives by linking fiscal privilege to measurable community investment.

V. Municipal Fiscal Externalities

The fiscal implications of exemption extend beyond state budgets to municipal governments. Baltimore nonprofit hospitals hold billions in tax-exempt property. Municipalities must provide police protection, fire services, and infrastructure maintenance regardless of tax status.

When exemption exceeds measurable local return, fiscal strain shifts to other taxpayers. National discussions of nonprofit hospital tax exemption increasingly emphasize local fiscal equity concerns (10). Maryland's legislative approach offers a systematic solution grounded in measurable reciprocity rather than ad hoc negotiation.

VI. Administrative Feasibility Under the Global Budget Model

Maryland's all-payer global budget model provides predictable revenue streams. Because revenue targets are established prospectively, hospitals can plan community investment obligations with clarity.

Administrative oversight is already centralized through the Health Services Cost Review Commission. Reporting mechanisms exist. Conditioning exemption on measurable thresholds is therefore administratively feasible within Maryland's regulatory structure.

VII. Modernizing Maryland's Nonprofit Social Contract

Maryland House Bill 1136/Senate Bill 832 require nonprofit hospitals to provide annual community benefit equal to either 100 percent of the value of tax benefits received or 5 percent of net patient revenue, with at least 4 percent devoted to charity care.

The statute incorporates reporting requirements, verification procedures, and cure provisions. Rural hospitals are exempted to protect access in vulnerable communities. The design reflects proportionality. Institutions exceeding thresholds face no disruption. Institutions below parity are afforded opportunity to adjust. Revocation of exemption follows persistent noncompliance.

The legislation restores reciprocity without dismantling nonprofit status.

VIII. National Implications

Nationally, nonprofit hospital tax exemptions are estimated in the tens of billions of dollars annually (8,10). As fiscal pressures intensify, states are increasingly examining tax expenditure policy.

Maryland's approach offers a replicable framework. Quantitative thresholds enhance transparency and comparability. They reduce ambiguity and reinforce public trust. The principle underlying reform is durable: public subsidy should not exceed public return.

Conclusion

The nonprofit hospital social contract rests on reciprocity. Tax exemption is not an entitlement; it is a conditional privilege grounded in public trust. Maryland's documented fair share deficit (5), executive compensation patterns (6,7), and municipal fiscal strain justify recalibration.

Maryland House Bill 1136/Senate Bill 832 restore alignment between public subsidy and measurable public benefit. In an era of heightened scrutiny of tax expenditures and growing concern about fiscal equity, conditioning exemption on performance is responsible governance.

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10. Bai G, Yehia F, Anderson GF. The $38 billion question: are tax-exempt hospitals meeting their charitable obligations? Health Affairs Blog. 2021.

Further Reading

The policy questions surrounding nonprofit hospital tax exemption, community benefit standards, and tax expenditure accountability sit at the intersection of health economics, nonprofit governance, public finance, and regulatory law. Readers seeking additional scholarly and policy context may consult the following works:

- Nonprofit Hospital Tax Exemption and Community Benefit
  Bai G, Anderson GF. A more detailed understanding of factors associated with hospital profitability. *Health Affairs*. 2016;35(5):889–897.

- Bai G, Yehia F, Anderson GF. Are nonprofit hospitals truly nonprofit? *Health Affairs Blog*. 2021.

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- Young DR. *If Not for Profit, for What? A Behavioral Theory of the Nonprofit Sector Based on Entrepreneurship.* 3rd ed. Lanham (MD): Lexington Books; 2017.

- Lown Institute. *Making the Hospital Tax Exemption Work for Maryland: An Analysis of Nonprofit Hospital Tax Exemptions and Community Investments, 2020–2022*. Brookline (MA): Lown Institute; 2025.

These works provide empirical analyses of nonprofit hospital behavior, the valuation of tax exemptions, and comparative assessments of ownership models in American health care.