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MODERNIZING NORTH CAROLINA'S NONPROFIT SOCIAL CONTRACT

Aligning Hospital Tax Exemptions with Public Benefit

Policy Report | March 2026

KEY FINDING

North Carolina nonprofit hospitals receive approximately $1.8 billion in annual tax exemptions while providing roughly $1.1 billion in charity care—leaving an estimated $700 million gap between public subsidy and direct assistance to patients.

North Carolina can do better.

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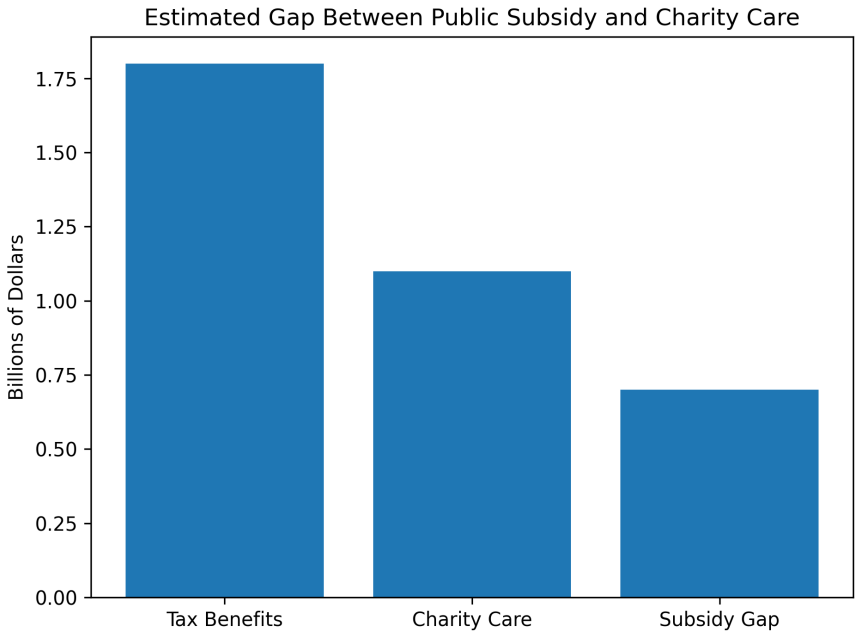
Executive Summary

Nonprofit hospitals occupy a uniquely privileged position in the American healthcare system. Their exemption from federal, state, and local taxes—combined with access to tax-exempt bond financing and the deductibility of charitable donations—represents a substantial 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. The expectation is simple: the value of the subsidy should be matched or exceeded by measurable public benefit.

In North Carolina, nonprofit hospital systems receive billions of dollars in tax advantages each year. A widely cited analysis commissioned by the North Carolina State Health Plan estimated that nonprofit hospitals collectively receive approximately $1.8 billion annually in federal, state, and local tax exemptions. [1]

Yet evidence suggests that the community benefits delivered in return—particularly charity care for low-income patients—often fall short of that figure. Researchers reviewing North Carolina hospital financial filings found that nonprofit hospitals provide charity care worth substantially less than the estimated value of their tax subsidies. [2]



At the same time, hospital systems report strong operating margins, significant asset growth, and executive compensation levels comparable to large corporate enterprises.

These trends raise an important policy question:

Does North Carolina's nonprofit hospital framework still reflect its original public purpose?

This report argues that the state should modernize the nonprofit hospital social contract by aligning tax privileges with measurable community benefit. Clear standards for charity care, stronger transparency requirements, and enforceable accountability mechanisms would ensure that public subsidies generate meaningful public return.

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1. Tax Exemption as Public Investment

Tax exemption for nonprofit hospitals is best understood as a form of public spending. When hospitals are exempt from property taxes, corporate income taxes, and certain sales taxes—or receive refunds on those taxes—the state effectively subsidizes those institutions. The financial consequences are borne by other taxpayers or reflected in reduced public services.

The magnitude of this subsidy is substantial. In North Carolina alone, nonprofit hospitals receive an estimated $1.8 billion in annual tax benefits, including federal tax exemption, state tax exemptions, and local property-tax relief. [3]

These benefits are justified by the expectation that nonprofit hospitals will provide community benefits that offset the public investment.

Historically, that benefit was primarily defined as charity care—medical treatment provided without charge to patients unable to pay.

Over time, however, the definition expanded to include broader categories of community benefit, such as health education, community outreach programs, and subsidized clinical services. While these activities can provide value, the broader definition has also made it more difficult to determine whether the public is receiving a return on its investment. Researchers examining hospital financial reports have found that many nonprofit hospitals spend less on charity care than the value of the tax exemptions they receive. [4]

This imbalance lies at the center of the policy debate.

Estimated Tax Benefits vs Charity Care Provided by North Carolina Nonprofit Hospitals

Category	Estimated Annual Amount
Total Tax Benefits Received	**$1.8 billion**
Charity Care Provided	**~$1.1 billion**
Gap Between Subsidy and Charity Care	**~$700 million**

Source: North Carolina State Health Plan hospital finance analysis. [5]

The chart illustrates the central challenge confronting policymakers. Nonprofit hospitals collectively receive tax benefits that exceed their spending on charity care by hundreds of millions of dollars annually.

2. Federal Law and the Community Benefit Standard

Nonprofit hospitals receive federal tax exemption under Section 501(c)(3) of the Internal Revenue Code. Historically, hospitals were expected to provide free care to patients who could not afford treatment. However, during the latter half of the twentieth century, federal regulators adopted a broader "community benefit" standard that allowed hospitals to qualify for tax exemption through a range of activities intended to improve community health.

The Affordable Care Act introduced additional requirements intended to strengthen accountability. Nonprofit hospitals must now conduct community health needs assessments, establish financial-assistance policies, and limit aggressive debt-collection practices.

Yet federal law still does not establish minimum charity-care requirements. Hospitals retain broad discretion in determining how much charity care they provide, provided they demonstrate some form of community benefit. As a result, states have become increasingly important in defining expectations for nonprofit hospital behavior.

3. North Carolina's Nonprofit Hospital Landscape

North Carolina's hospital sector is overwhelmingly nonprofit. More than 85 percent of hospitals in the state operate as nonprofit institutions, benefiting from extensive tax advantages while claiming charitable missions. However, oversight of charity-care obligations remains limited.

A major analysis conducted for the North Carolina State Health Plan found that most nonprofit hospitals provide charity care worth far less than the tax benefits they receive. [6]

The report also found evidence that some hospitals billed patients who were eligible for financial assistance. In certain cases, between 12 percent and nearly 30 percent of hospital bad debt came from patients who qualified for charity care. [7]

In other words, hospitals that had received tax subsidies to provide care for low-income patients sometimes billed those same patients for services. North Carolina currently lacks a centralized state authority responsible for systematically evaluating whether nonprofit hospitals' community benefits justify their tax exemptions.

If nonprofit hospitals receive billions in tax subsidies each year, should the state require a minimum level of charity care or community benefit in return?

4. Case Study: ECU Health

One of the most prominent nonprofit hospital networks in North Carolina is **ECU Health**, headquartered in Greenville.

Formerly known as Vidant Health, ECU Health operates a large academic health system serving eastern North Carolina. The network includes nine hospitals, more than 1,400 hospital beds, and a workforce exceeding 12,000 employees. Together these facilities provide healthcare services to more than 1.4 million residents across 29 counties in the eastern part of the state. [8]

The system's flagship institution, ECU Health Medical Center, serves as a Level I trauma center and teaching hospital for the Brody School of Medicine at East Carolina University, making it a critical regional hub for specialized medical care. [9] For many rural communities in eastern North Carolina, ECU Health represents the only access to advanced medical services.

Financial filings illustrate the scale and complexity of the organization. According to IRS Form 990 data compiled by ProPublica's Nonprofit Explorer, ECU Health Community Hospitals reported $596.8 million in revenue and $562.7 million in expenses in fiscal year 2024, generating net income of approximately $34 million. [10] The organization reported total assets of roughly $383 million and net assets exceeding $247 million.

Like most nonprofit hospitals, the overwhelming majority of ECU Health's revenue comes from patient services rather than charitable donations. Nearly 97 percent of revenue is derived from healthcare services, reflecting the operational reality of modern nonprofit hospitals.

5. Case Study: Atrium Health

Another major nonprofit healthcare system in North Carolina is Atrium Health, headquartered in Charlotte. Atrium operates dozens of hospitals and hundreds of outpatient care locations across several states. Following its 2022 merger with Advocate Aurora Health, the combined system—known as Advocate Health—became one of the largest nonprofit healthcare systems in the United States.

The scale of Atrium Health reflects broader trends within American healthcare. Over the past two decades, hospital consolidation has produced increasingly large nonprofit systems with substantial financial resources and significant market power.

These systems often function in many respects like major corporate healthcare organizations. They negotiate reimbursement rates with private insurers, manage large physician networks, and operate sophisticated specialty-care programs.

While consolidation can generate efficiencies and support medical innovation, it also raises questions about whether nonprofit tax exemptions remain aligned with the operational realities of modern healthcare systems.

6. Executive Compensation in Nonprofit Hospitals

Executive compensation has become one of the most visible features of the modern nonprofit hospital sector. Across North Carolina, hospital executives frequently earn salaries that rival those of corporate healthcare leaders. A statewide analysis found that the average nonprofit hospital CEO earned approximately $3.4 million in 2020, while the top 40 hospital executives collectively received more than $77 million in compensation. [11]

These figures far exceed compensation levels typical in most nonprofit sectors. Hospital leaders argue that such salaries reflect the complexity of managing large healthcare organizations that employ thousands of workers and operate multi-billion-dollar budgets. Critics counter that compensation at this level raises questions about whether nonprofit hospitals continue to operate primarily as charitable institutions.

Financial disclosures from ECU Health illustrate these dynamics.

According to IRS filings, the system reported approximately $3.29 million in executive compensation in its most recent Form 990 filing. [12] Several senior physicians and administrators earned salaries in the range of $350,000 to $475,000 annually, while system-wide leadership compensation was significantly higher. ECU Health's chief executive officer, Dr. Michael Waldrum, earned approximately $1.78 million in 2023. [13]

Executive Compensation Comparison Selected NC Nonprofit Hospital Systems

Organization	CEO Compensation
Atrium Health	~$5–6 million
Novant Health	~$4–5 million
Duke Health System	~$3–4 million
ECU Health	~$1.7–2 million

Sources: IRS Form 990 filings and hospital compensation disclosures.

Aligning Incentives

Some policy analysts suggest tying executive compensation incentives to measurable public-benefit outcomes such as charity-care spending, medical-debt reduction, or community health investments.

7. Consequences for Patients and Communities

The imbalance between tax subsidies and charity care has real consequences for patients. Medical debt remains a major problem in North Carolina. Recognizing the scale of the issue, the state launched a major initiative in 2024 aimed at reducing medical debt and encouraging hospitals to adopt more patient-friendly billing policies.

The program has already eliminated more than $6.5 billion in medical debt for approximately 2.5 million residents. [14]

While this initiative represents an important step forward, it also highlights the underlying structural issue: many patients continue to accumulate medical debt despite living in a state where most hospitals operate as tax-exempt nonprofit organizations.

8. A Framework for Reform

North Carolina does not need to dismantle the nonprofit hospital model. Instead, policymakers should focus on modernizing the framework that governs nonprofit hospital tax privileges.

Reform should begin by clarifying the expectations attached to tax exemption. Establishing minimum charity-care standards tied to hospital revenue or tax benefits would ensure that public subsidies generate measurable public benefit.

Transparency should also be strengthened. Hospitals should provide clear public reporting on charity-care spending, community-benefit investments, executive compensation, and lobbying expenditures.

Finally, the state should establish an independent authority responsible for evaluating hospital community-benefit claims and enforcing compliance.
These reforms would not undermine nonprofit hospitals. Instead, they would reaffirm the principle that public subsidies should produce public value.

Conclusion: Restoring the Social Contract

Nonprofit hospitals play a vital role in American healthcare. They provide emergency services, train physicians, conduct research, and deliver care to vulnerable populations. But their privileged tax status was never intended to be permanent or unconditional. It was always a social contract. Taxpayers provide financial support through exemptions and subsidies. In return, nonprofit hospitals provide meaningful public benefit.

In North Carolina today, that contract is increasingly out of balance.
Modernizing the state's nonprofit hospital framework would ensure that nonprofit hospitals once again fulfill the mission that justified their tax-exempt status in the first place.

Footnotes

1. North Carolina State Health Plan and Johns Hopkins Bloomberg School of Public Health, *North Carolina Hospitals: Charity Care Case Report*, Office of the State Treasurer, 2021.
2. Ge Bai, Gerard Anderson, and colleagues, analysis of North Carolina hospital financial filings conducted for the North Carolina State Health Plan, finding charity care spending often significantly below the value of tax exemptions.
3. North Carolina State Health Plan, *North Carolina Hospitals: Charity Care Case Report*, estimating that nonprofit hospital systems received more than **$1.8 billion in federal, state, and local tax exemptions** annually.
4. Johns Hopkins Bloomberg School of Public Health / North Carolina State Health Plan hospital finance analysis showing that many nonprofit hospitals spent **less than 60% of the value of their tax exemptions on charity care**.
5. North Carolina State Health Plan, *North Carolina Hospitals: Charity Care Case Report*, summary of estimated tax benefits and charity care spending across nonprofit hospitals in the state.
6. North Carolina Department of State Treasurer and State Health Plan analysis of nonprofit hospital tax exemptions and charity care levels.
7. North Carolina State Health Plan, *Hospital Bad Debt and Charity Care Report*, finding that **between roughly 12% and 30% of hospital bad debt may come from patients eligible for charity care**.
8. ECU Health, "About ECU Health," system profile describing its network of hospitals, workforce, and regional service area across eastern North Carolina.
9. East Carolina University Brody School of Medicine and ECU Health Medical Center institutional descriptions identifying the facility as a **Level I trauma center and teaching hospital** affiliated with the university.
10. ProPublica, *Nonprofit Explorer*, IRS Form 990 filings for ECU Health Community Hospitals (latest available fiscal year financial disclosures).
11. *Charlotte Observer* and statewide nonprofit compensation analyses of hospital executive salaries in North Carolina (2020 hospital executive compensation review).
12. IRS Form 990 filings for ECU Health Community Hospitals, executive compensation disclosures.
13. ECU Health Form 990 disclosures and public reporting on compensation of CEO Dr. Michael Waldrum (2023 filing).
14. Associated Press, "North Carolina effort wipes out $6.5B in medical debt for 2.5M people," reporting on the state medical-debt relief initiative.

About the Author

Peter J. Pitts is President of the Center for Medicine in the Public Interest, a nonprofit research organization focused on promoting informed healthcare policy and advancing patient-centered innovation in medicine. He previously served as Associate Commissioner of the U.S. Food and Drug Administration and was a member of the U.S. Senior Executive Service, where he worked on issues involving drug safety, risk communication, and patient engagement in regulatory decision-making.

In addition to his leadership at the Center for Medicine in the Public Interest, Pitts is a Visiting Professor at the University of Paris Medical School, an Honorary Professor at Sefako Makgatho Health Sciences University in Pretoria, South Africa, and a Research Fellow at the U.S.–Israel Education Association.

He serves on the Council for International Organizations of Medical Sciences (CIOMS) Expert Working Group focused on advancing patient involvement in the development and safe use of medicines and is a member of the United States Pharmacopeia Drug Shortage Task Force.

Pitts has written extensively on healthcare policy, regulatory science, pharmaceutical innovation, and patient engagement. His peer-reviewed work has appeared in leading journals including *The Lancet, Health Affairs, the Journal of the American Medical Association, Nature Biotechnology, NEJM Catalyst, Vaccines, Therapeutic Innovation & Regulatory Science,* and *the Journal of Commercial Biotechnology*. He serves as Associate Editor of *Therapeutic Innovation & Regulatory Science*, the official journal of the Drug Information Association, and sits on the editorial advisory boards of *The Patient* and *the Journal of Commercial Biotechnology.*

A widely recognized commentator on healthcare policy, Pitts' analysis has appeared in major national and international media outlets including The New York Times, The Wall Street Journal, The Washington Post, The Financial Times, The Economist, Time, Newsweek, STAT, and BioCentury. He has also appeared on BBC World Service, CNBC, Bloomberg, PBS NewsHour, NBC Dateline, and Sky News.

Pitts is the author of several books on healthcare policy and leadership, including Prescient and Possible, The Next Normal, The Value Equation, and Common-Sense Healthcare for Common Sense Americans. A graduate of McGill University, he lives in New York City.