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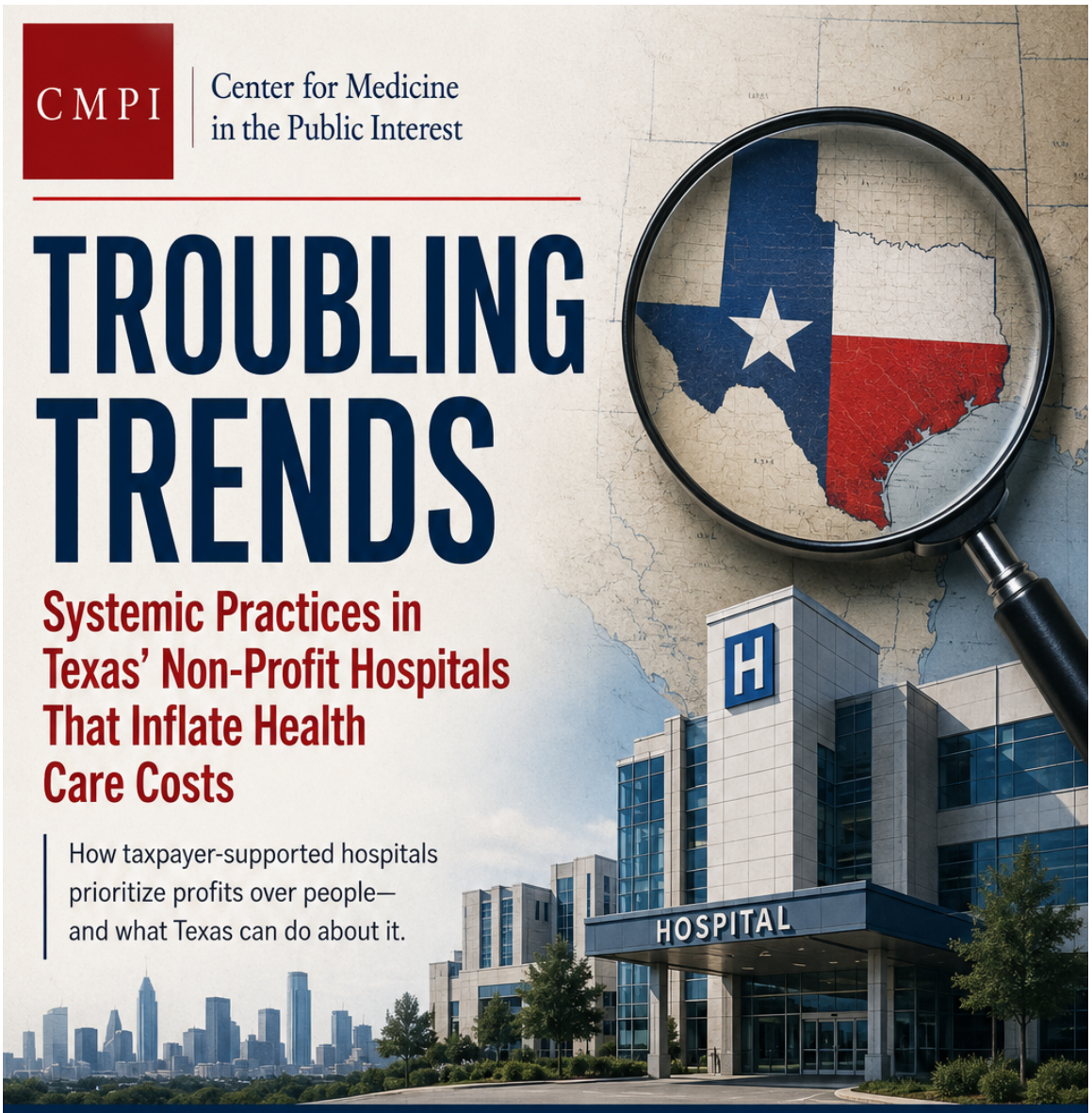
TROUBLING TRENDS

Systemic Practices in Texas' Non-Profit Hospitals That Inflate Health Care Costs

How taxpayer-supported hospitals prioritize profits over people—and what Texas can do about it.



COSTS WITHOUT ACCOUNTABILITY

Billions in tax benefits, yet charity care remains a fraction of need.

PRICES WITHOUT TRANSPARENCY

Texans can't compare hospital prices—making markets impossible.

COMMUNITIES LEFT BEHIND

Limited Medicaid access and underinvestment worsen health inequities.

POLITICAL POWER, PUBLIC SUBSIDIES

Hospital systems spend big to protect the status quo—and their bottom line.

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Troubling Trends: Systemic Practices in Texas' Non-Profit Hospitals That Inflate Health Care Costs

Executive Summary

Texas is home to some of the nation's largest, wealthiest, and most influential not-for-profit hospital systems. Collectively, these institutions receive billions of dollars in federal, state, and local tax preferences intended to support charitable missions, expand access to care, and improve the health of the communities they serve. Yet many increasingly resemble sophisticated commercial enterprises, generating substantial operating surpluses, expanding through acquisitions, compensating senior executives at levels comparable to Fortune 500 corporations, and exercising significant political influence while providing levels of charity care that often fall well below the value of the public subsidies they receive.

This report examines the structural incentives that permit these practices to persist. It argues that the central challenge facing Texas healthcare is not simply the cost of medical treatment, but the growing disconnects between the public obligations associated with tax-exempt status and the financial behavior of many nonprofit hospital systems. Financial strength is not the problem. Nonprofit hospitals require capital to invest in new facilities, recruit physicians, support research, and respond to public health emergencies. The larger question is whether institutions benefiting from substantial taxpayer support continue to return public value commensurate with those subsidies.

Several trends emerge consistently across Texas. Large nonprofit systems increasingly concentrate on commercially insured patients while limiting participation in lower-paying Medicaid networks. Charity care expenditures frequently represent only a small fraction of overall operating revenues despite rapidly expanding margins and investment portfolios. Hospital pricing remains opaque despite federal transparency requirements, making meaningful comparison shopping virtually impossible for patients, employers, and policymakers. Executive compensation continues to rise while medical debt remains a leading cause of financial hardship for Texas families.

At the same time, hospital associations and individual systems devote substantial resources to lobbying and political advocacy designed to preserve existing reimbursement structures and tax advantages. These developments have consequences extending well beyond hospital balance sheets. They influence insurance premiums, state Medicaid spending, employer healthcare costs, physician practice patterns, and ultimately the affordability of healthcare throughout Texas. They also raise increasingly difficult questions about whether current standards governing nonprofit status continue to reflect the expectations of taxpayers who effectively subsidize these institutions through forgone tax revenue.

The evidence presented in this report suggests that existing oversight mechanisms have not kept pace with the evolution of modern nonprofit healthcare systems. Federal and state regulators continue to evaluate hospitals largely through standards developed decades ago, even as many nonprofit systems have become multibillion-dollar regional enterprises operating across multiple states and competing aggressively for market share. Greater transparency, clearer accountability standards, and more objective measures of community benefit would strengthen—not weaken—the nonprofit hospital sector by ensuring that public confidence keeps pace with institutional growth.

Texas has long positioned itself as a national leader in healthcare innovation, biomedical research, and medical education. Applying the same commitment to transparency, accountability, and measurable public benefit would reinforce that leadership while ensuring that tax-exempt hospitals fulfill both the letter and the spirit of their charitable missions.

Background and Context

Texas occupies a singular place in American healthcare. It has one of the nation's fastest-growing populations, the largest uninsured population in the United States, several internationally recognized academic medical centers, and some of the country's largest not-for-profit hospital systems. Those realities create extraordinary opportunities for medical innovation, but they also expose longstanding tensions between public policy and institutional economics.

Tax-exempt hospitals were granted special legal status because lawmakers concluded that organizations devoted to charitable purposes deserved relief from taxation. The underlying premise was straightforward. Revenue forgone by governments would be returned to communities through free and reduced-cost care, investments in public health, medical education, and services that private markets alone could not sustain. Tax exemption was never intended to function as a permanent competitive advantage. It was a public bargain.

That bargain has become increasingly difficult to evaluate. Over the past two decades, many nonprofit hospitals have evolved into large regional enterprises with multibillion-dollar revenues, sophisticated investment portfolios, and extensive physician networks. Some operate across several states. Others own insurance products, outpatient surgery centers, specialty pharmacies, research institutes, and venture investment arms. These are no longer institutions whose finances can be understood simply by examining inpatient admissions and emergency department visits.

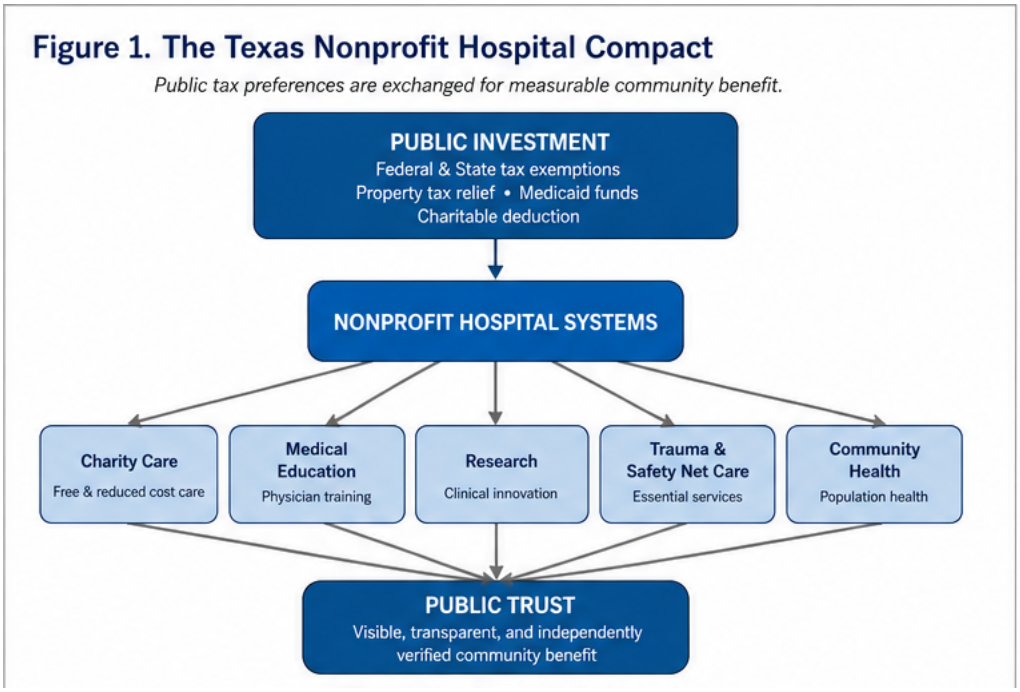
Texas illustrates this transformation particularly well. The state's largest nonprofit systems oversee billions of dollars in annual operating revenue while continuing to benefit from broad exemptions from federal income taxes, state taxes, and, in many jurisdictions, local property taxes. Those exemptions represent a substantial public investment. Whether

communities receive equivalent value in return deserves careful examination rather than assumption.

The discussion has often become polarized. Hospital leaders point to trauma centers, graduate medical education, uncompensated emergency care, and investments in sophisticated clinical services as evidence that tax-exempt status remains fully justified. Critics counter that aggressive consolidation, growing market power, rising executive compensation, and comparatively modest charity care have shifted institutional priorities away from community benefit and toward financial performance. Both perspectives contain elements of truth. Neither tells the entire story.

What deserves closer attention is the cumulative effect of these trends. As hospitals consolidate, negotiating leverage shifts toward larger systems, increasing their ability to command higher commercial reimbursement rates. Those costs eventually appear in employer-sponsored insurance premiums, household healthcare spending, and state healthcare budgets. Patients rarely see these negotiations directly, but they experience their consequences every time premiums increase or deductibles rise.

Transparency has not kept pace. Despite federal requirements intended to make hospital pricing more accessible, meaningful price comparisons remain elusive. Published chargemasters seldom reflect what patients ultimately pay, negotiated commercial rates are difficult to interpret, and many consumers discover the true cost of care only after treatment has been completed. A market cannot function efficiently when buyers have little practical ability to understand prices before making decisions.



Texas also presents distinctive access challenges. The state continues to have one of the highest uninsured rates in the nation, and Medicaid reimbursement remains comparatively low for many services. Hospitals argue, with considerable justification, that commercial insurance often subsidizes losses associated with treating Medicaid beneficiaries and uninsured patients. Yet that economic reality also creates incentives to favor patients covered by higher-paying commercial plans. The resulting imbalance affects where patients receive care, which physicians participate in Medicaid networks, and how healthcare resources are distributed across communities.

These issues do not suggest that nonprofit hospitals have abandoned their public missions. Many continue to provide outstanding clinical care, support important research, and serve as anchors within their communities. The question is more practical than philosophical. Have existing standards kept pace with the size, complexity, and economic influence of today's nonprofit hospital systems? Put differently, are taxpayers receiving the level of public benefit they were promised in exchange for billions of dollars in tax preferences?

The sections that follow examine that question through publicly available financial records, government reports, independent analyses, and academic research. Rather than focusing on isolated controversies, the report considers recurring patterns that, taken together, suggest the need for a more rigorous understanding of what tax-exempt status should require in twenty-first-century healthcare.

Troubling Trends in the Lone Star State

Texas has never lacked for excellent hospitals. MD Anderson, Houston Methodist, Baylor Scott & White, Texas Children's, UT Southwestern, Memorial Hermann, and Christus Health have earned national reputations for clinical excellence, biomedical research, physician training, and patient care. Their contributions are substantial and deserve recognition.

That makes the questions raised in this report more important, not less. The issue is not whether these institutions save lives. They do, every day. Nor is it whether they should be financially healthy. Modern medicine requires enormous investments in technology, facilities, research, and skilled personnel. Hospitals operating on the edge of insolvency cannot fulfill their missions. The concern is different. It is whether organizations granted extraordinary public benefits continue to deliver extraordinary public value.

Tax exemption is not an entitlement. It is a public compact. Governments forego billions of dollars in tax revenue because nonprofit hospitals are expected to return that value to the communities they serve through charity care, education, research, public health programs, and access for patients who otherwise might have nowhere to go. That exchange only works if the public receives benefits roughly equivalent to what taxpayers surrender. Increasingly, that assumption deserves closer examination.

Many of Texas' largest nonprofit systems report healthy operating margins, growing reserves, expanding real estate holdings, and ambitious construction projects. Several have become dominant regional healthcare enterprises with considerable leverage over insurers, employers, and physician practices. Financial success, standing alone, is not evidence of misconduct. It does, however, invite a straightforward question. As these institutions become larger and more prosperous, are their charitable obligations expanding at the same pace?

Independent analyses suggest they often are not. Studies comparing tax benefits with community investment have found that many nonprofit hospitals provide less charity care than the value of the tax advantages they receive. Others devote comparatively modest resources to free care while expanding profitable service lines aimed at commercially insured patients. The resulting gap has become known as the "Fair Share Deficit"—the difference between the value of tax exemptions and the value returned to the public through community benefit. Texas appears repeatedly in those analyses.

At the same time, patients continue to face prices that are difficult to predict before treatment. Federal price transparency regulations were intended to expose negotiated hospital prices to public view, encouraging competition and allowing employers and families to make informed decisions. Compliance has improved since the rules first took effect, but meaningful transparency remains uneven. Hospital pricing is still opaque enough that comparison shopping for many services remains more aspiration than reality. The state's healthcare market has also become more concentrated. Consolidation has produced larger systems capable of spreading costs, recruiting specialists, and investing in advanced technologies. Those efficiencies can benefit patients. They can also strengthen hospitals' negotiating position with commercial insurers, increasing reimbursement rates that eventually find their way into premiums paid by employers and families. Economists have documented this relationship for years. Texas has not escaped it.

The same pattern appears in executive compensation. Running a multibillion-dollar health system requires experienced leadership, and competitive compensation is hardly surprising. Yet when executives at tax-exempt institutions receive compensation measured in the millions while charity care remains comparatively modest and medical debt continues to burden working families, public skepticism is inevitable. The question is not whether executives are overpaid. It is whether compensation reflects the public purposes that justify nonprofit status.

None of these developments should be viewed in isolation. Taken individually, each can be defended. Together, they describe a healthcare marketplace that increasingly rewards financial performance while relying on a regulatory framework built for a very different era. The following sections examine these trends in greater detail, beginning with a question that sits at the center of the debate: whether economic incentives are quietly reshaping who receives care, where they receive it, and under what financial terms.

1. Prioritizing High Payment Rates Over Serving Patients

Texas presents hospital executives with an unusually difficult economic equation. The state has the nation's largest uninsured population and has not expanded Medicaid under the Affordable Care Act. Hospitals therefore shoulder significant uncompensated care while receiving comparatively low reimbursement for many Medicaid services. Those financial realities are genuine and should not be dismissed. They also create powerful incentives that shape institutional behavior.

The result is a healthcare marketplace in which commercially insured patients often become the financial engine supporting the rest of the enterprise. Every large health system understands this arithmetic. Private insurance generally reimburses hospitals at rates well above Medicare and Medicaid. As commercial reimbursement becomes increasingly important to operating margins, competition naturally shifts toward attracting patients with private coverage and expanding the service lines that generate the strongest returns.

That shift can be seen across Texas. Major nonprofit systems have invested heavily in suburban campuses, ambulatory surgery centers, cardiovascular institutes, orthopedic programs, oncology networks, and specialty hospitals serving rapidly growing metropolitan areas. Those investments improve access for many Texans. They also tend to follow commercially insured populations rather than communities with the greatest unmet healthcare needs.

Meanwhile, access problems persist for Medicaid beneficiaries. Texas physicians continue to cite low Medicaid reimbursement as one of the principal reasons for limiting participation in Medicaid networks. For patients, the consequences are familiar: longer waits for appointments, fewer participating specialists, and greater reliance on emergency departments for care that could have been delivered earlier in an outpatient setting. Those access barriers are particularly pronounced in rural communities and rapidly growing urban counties where physician shortages already strain the healthcare system.

The issue extends beyond physician participation. Hospital systems also make strategic decisions about where to build facilities, which clinical programs to expand, and which populations to target. New cancer centers, orthopedic institutes, cardiac programs, and outpatient surgical facilities rarely appear by accident. They are capital investments expected to generate returns over decades. Unsurprisingly, those investments tend to follow favorable payer mixes.

None of this is unique to Texas. Health economists have described these incentives for years. What distinguishes Texas is the scale of the challenge. No other state combines such a large uninsured population with so many financially successful nonprofit hospital systems. That combination places unusual pressure on the social compact underlying tax exemption.

Hospitals understandably argue that commercial revenue subsidizes trauma care, neonatal intensive care, graduate medical education, burn centers, and other services that frequently lose money. There is truth in that argument. Cross-subsidization has long been part of American healthcare finance. The question is whether the balance has shifted too far. If tax-exempt hospitals increasingly organize their growth strategies around commercially insured patients while Medicaid beneficiaries struggle to obtain timely access to physicians and specialty care, policymakers are justified in asking whether existing measures of community benefit adequately capture an institution's public obligations. Charity care alone may no longer be a sufficient metric. Access itself deserves greater attention.

Texas law already requires nonprofit hospitals to demonstrate community benefit through one of several statutory standards tied to charity care, government-sponsored indigent care, or the value of their tax exemptions. Compliance with those requirements, however, does not necessarily answer a broader policy question. A hospital may satisfy the letter of the statute while still directing the overwhelming share of its capital investment toward markets with the strongest financial returns.

That distinction matters. Tax exemption was designed to encourage charitable institutions, not simply financially successful ones. As nonprofit health systems continue to expand across Texas, policymakers should examine not only how much community benefit hospitals report, but also where care is delivered, which patients gain access, and whether investment decisions reinforce—or reduce—existing disparities.

2. Billions in Tax Benefits, Billions in Public Expectations

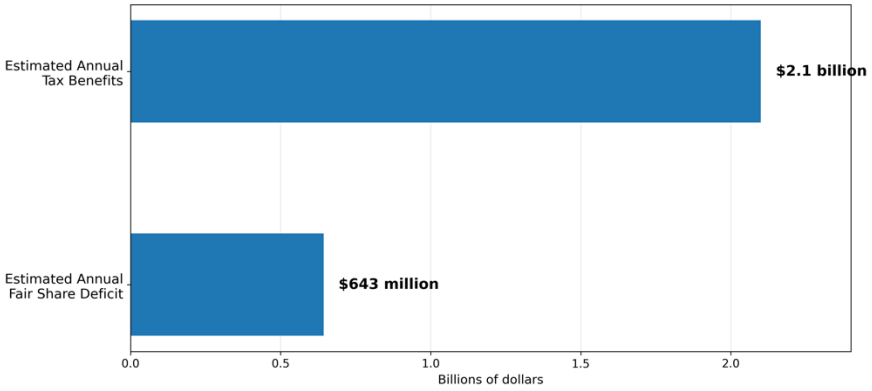
Texas nonprofit hospitals receive an estimated **$2.1 billion in tax benefits each year** through exemptions from federal and state income taxes, local property taxes, tax-exempt bond financing, charitable contributions, and other preferential tax treatment. Those benefits represent one of the largest indirect public investments in the state's healthcare system. They are not grants, but they have the same practical effect. Taxpayers forego revenue with the expectation that nonprofit hospitals will return comparable value through charity care and meaningful community investment. Whether that exchange is occurring has become increasingly difficult to answer in the affirmative.

A 2025 analysis by the Lown Institute examined **148 private nonprofit hospitals in Texas** using IRS Form 990 filings, Medicare cost reports, and local property tax records covering the years 2020 through 2022. The findings raise important questions about whether current oversight adequately measures public benefit. Among the report's principal findings:

- **Texas nonprofit hospitals receive approximately $2.1 billion in tax benefits annually.**
- **Forty-two percent** of nonprofit hospitals spent less on meaningful community investment than the value of the tax advantages they received.

- The resulting statewide **Fair Share Deficit totals approximately $643 million every year.**
- More than **80 percent** of reported community-benefit spending consisted of financial assistance and clinical care, while comparatively little was directed toward broader public health initiatives such as housing, nutrition, transportation, violence prevention, or other social determinants of health.

Figure 2. Public Tax Benefits and Estimated Fair Share Deficit



Source: Lown Institute, Texas State Report (2025). Analysis of 148 Texas nonprofit hospitals using IRS Form 990 filings, Medicare cost reports, and local property tax records (2020–2022). Approximately 42% of hospitals generated a Fair Share Deficit.

These figures deserve attention because they describe a structural issue rather than isolated institutional failures.

A Fair Share Deficit does not mean that a hospital violates the law or fails to provide valuable services. Nor does it suggest financial misconduct. It simply measures whether the value returned to the community equals or exceeds the value of the tax preferences received. By that measure, a substantial share of Texas nonprofit hospitals fall short. The magnitude is difficult to ignore.

A statewide deficit of $643 million annually would be sufficient to eliminate medical debt for roughly **one million Texans**. The same resources could finance thousands of additional maternal health professionals, expand behavioral health capacity, or substantially increase community-based disease prevention programs in many of the state's medically underserved counties.

Texas is hardly unique. Nationally, the Lown Institute estimates that nonprofit hospitals in twenty states collectively generate an annual Fair Share Deficit of **$11.5 billion**, with **54 percent** of hospitals returning less in community investment than they receive in tax benefits.

Hospital leaders dispute these conclusions. The American Hospital Association argues that studies using the Fair Share methodology undervalue important contributions such as medical education, research, trauma services, Medicaid shortfalls, and other activities that

are difficult to quantify but central to many hospitals' public missions. The Association maintains that nonprofit hospitals provide community benefits that exceed the value of their tax exemptions and that the methodology employed by Lown captures only part of that contribution.

That criticism deserves consideration. Research hospitals, Level I trauma centers, neonatal intensive care units, transplant programs, and graduate medical education all produce substantial public value. Any assessment of nonprofit performance should acknowledge those contributions.

The broader policy question nevertheless remains. If taxpayers subsidize nonprofit hospitals through more than **$2 billion in annual tax preferences**, should the public rely primarily on self-reported community benefit data, or should there be more objective standards for measuring whether those subsidies produce proportional public value? That question lies at the center of the nonprofit hospital debate in Texas.

3. Where the Money Goes

Texas' largest nonprofit health systems are not institutions struggling to remain solvent. They are among the state's largest private enterprises, managing billions of dollars in annual revenue, extensive real estate portfolios, sophisticated investment funds, and workforces measured in the tens of thousands. Their financial strength is not itself evidence of misplaced priorities. In many respects, it reflects decades of successful management, strong clinical reputations, and the confidence of patients and physicians alike. The question is whether public accountability has kept pace with institutional growth.

Memorial Hermann Health System offers an illustration of that evolution. During fiscal year 2024, the system reported approximately $8.6 billion in operating revenue, generated an operating surplus of roughly $233 million, and finished the year with nearly $15 billion in total assets and almost $10 billion in net assets. Those figures place Memorial Hermann among the largest nonprofit healthcare organizations in the United States. Its President and Chief Executive Officer received compensation exceeding $6 million during the same reporting period.

Memorial Hermann is hardly an outlier. Baylor Scott & White Health, Houston Methodist, CHRISTUS Health, Texas Children's Hospital, and several other nonprofit systems oversee enterprises measured in the billions of dollars. Their annual capital budgets finance new hospitals, outpatient campuses, specialty institutes, physician acquisitions, research facilities, and advanced diagnostic technologies. These investments have expanded access to care, strengthened clinical capabilities, and helped position Texas as one of the nation's leading healthcare markets.

Growth, however, also changes market dynamics. As health systems acquire hospitals, physician practices, ambulatory surgery centers, imaging facilities, and specialty clinics,

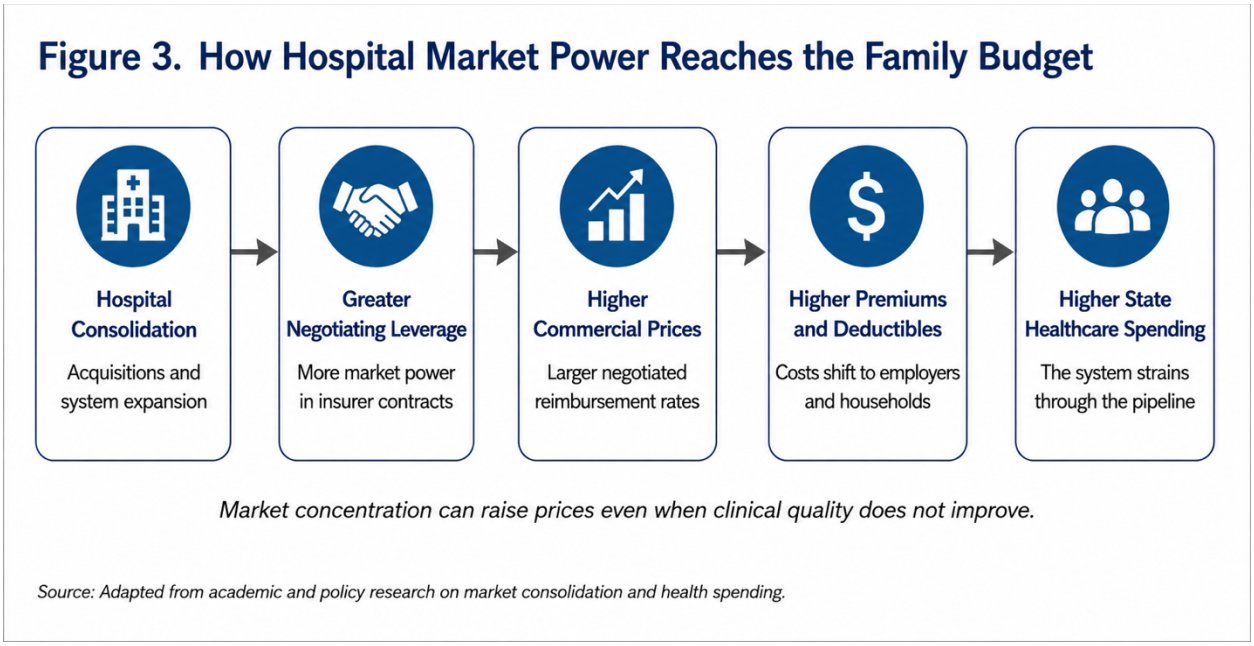
they gain greater negotiating leverage with commercial insurers. Numerous economic studies have reached the same conclusion: increased hospital concentration is commonly associated with higher negotiated commercial reimbursement rates, while evidence of corresponding improvements in quality is considerably less consistent. Those additional costs rarely remain confined to hospital balance sheets. They eventually appear as higher insurance premiums, larger deductibles, increased employer healthcare spending, and rising costs for state employee health plans.

Financial success also influences executive compensation. Boards overseeing organizations of this size understandably seek experienced executives capable of managing complex clinical, financial, and operational responsibilities. Compensation packages exceeding several million dollars annually have therefore become increasingly common throughout nonprofit healthcare.

Large organizations require experienced leadership, disciplined financial management, and sustained capital investment. None of that is controversial. The more difficult question is whether institutions that increasingly resemble large commercial enterprises should continue to be evaluated under standards developed for a very different era of nonprofit healthcare.

The Lown Institute's analysis illustrates the point. Among the 148 Texas nonprofit hospitals it examined, 42 percent generated a Fair Share Deficit, producing an estimated statewide shortfall of approximately $643 million each year between the value of tax benefits received and measurable community investment. Reasonable observers may disagree with aspects of the methodology, and many hospitals correctly point to research, trauma care, graduate medical education, and other public services that are difficult to capture through financial metrics alone. Even so, the analysis raises an important policy question: should taxpayers rely primarily on institutional self-reporting to determine whether public subsidies are producing proportional public value?

Ultimately, this is not an argument against financially successful nonprofit hospitals. Texas benefits from institutions capable of investing in advanced medicine, supporting biomedical research, training the next generation of physicians, and responding to public health emergencies. Financial strength makes those contributions possible. It also increases the importance of demonstrating, through clear and objective measures, that the public continues to receive value commensurate with the substantial tax preferences these institutions enjoy.



4. Price Transparency: Better Than Most States Is Not Good Enough

Congress and two administrations have embraced the same principle: patients should know what healthcare costs before they receive it. Since January 2021, hospitals have been required to publish machine-readable files containing negotiated commercial rates, discounted cash prices, and gross charges, together with consumer-friendly pricing information for hundreds of "shoppable" services. The objective was straightforward. Healthcare cannot function as a competitive market if prices remain hidden until weeks after treatment.

Texas has made measurable progress. According to Turquoise Health, roughly **75 percent of Texas hospitals are compliant or substantially compliant** with the federal Hospital Price Transparency Rule, a better record than many other states. The Texas Hospital Association has pointed to that performance as evidence that hospitals have invested significant resources to meet federal requirements and improve consumer access to pricing information.

Compliance, however, should not be confused with transparency. The practical question facing a patient is not whether a hospital has uploaded a machine-readable file measured in gigabytes. It is whether that patient can determine, with reasonable confidence, what a colonoscopy, knee replacement, MRI, cardiac catheterization, or uncomplicated delivery will actually cost before deciding where to receive care. For many Texans, the answer remains no.

Negotiated prices often vary dramatically among hospitals located only a few miles apart. Recent analyses of publicly available Texas pricing files found that identical outpatient procedures frequently differed by several hundred percent depending upon the institution, the insurer, and the contract involved. Even within the same metropolitan area, negotiated prices for routine imaging studies, laboratory services, and outpatient procedures often showed little relationship to either quality or complexity. Examples are not difficult to find.

Using hospital-published pricing files from the Dallas-Fort Worth market, one independent analysis found negotiated prices for vaginal delivery ranging from approximately **$5,100** at one hospital to more than **$13,000** at another. Brain MRI prices in the same market varied from well under **$1,000** to more than **$3,000** depending upon the hospital, while gross charges remained substantially higher. Similar variation has been documented in San Antonio, where cash prices, negotiated rates, and chargemaster prices for identical services frequently differed by multiples rather than percentages.

Hospital executives correctly note that healthcare pricing is inherently complicated. Individual contracts differ by insurer, benefit design, geographic market, case complexity, physician fees, and patient cost-sharing. Those variables are real. They do not explain why two hospitals serving the same community can negotiate reimbursement rates that differ by several-fold for the same procedure.

Price disclosure helps employers negotiate. It gives insurers additional information. Researchers can finally examine negotiated reimbursement instead of relying on chargemasters that almost no one paid. Those are important advances. Patients, however, generally require care where their physician practices, where their insurer has contracted, or where an emergency occurs. Price transparency may improve markets at the margins, but it does not create a functioning consumer marketplace where meaningful competition remains limited.

Texas illustrates both the promise and the limitations of transparency policy.
The state has moved further than many of its peers in publishing negotiated prices. At the same time, the Trump Administration recently warned **more than 500 hospitals nationwide** that they could face substantial financial penalties for failing to comply fully with federal transparency requirements. **Texas accounted for the largest number of hospitals receiving warning notices**, underscoring both the size of the state's hospital sector and the continuing difficulty of translating statutory compliance into meaningful public disclosure.

The larger issue extends beyond disclosure. When one hospital receives substantially higher reimbursement than another for performing the same service, the additional cost rarely disappears. It is reflected in employer-sponsored insurance premiums, higher deductibles, larger state employee health expenditures, and ultimately the cost of doing business in Texas. Hospital prices do not remain inside hospital walls. They ripple through the broader economy.

That’s why transparency should be viewed as a beginning rather than an end. Publishing prices is useful. Understanding why those prices differ so dramatically, and whether those differences reflect better care or simply greater market leverage, is the more important policy question.

5. The CEO Pay Ledger

Running one of America's largest health systems is a demanding job. Boards understandably compete for experienced executives capable of overseeing multibillion-dollar organizations, recruiting physicians, financing expansion, maintaining bond ratings, and navigating an increasingly difficult reimbursement environment. No one expects those responsibilities to be compensated modestly. The issue is not whether nonprofit executives should be well paid. The issue is what taxpayers should reasonably expect in return from organizations relieved of billions of dollars in taxation because they exist to serve charitable purposes. The financial scale of Texas' largest nonprofit systems illustrates the point.

Memorial Hermann Health System reported approximately **$8.6 billion in operating revenue** during fiscal year 2024 and ended the year with nearly **$15 billion in total assets**. It’s President and Chief Executive Officer received compensation exceeding **$6 million**, according to the system's IRS Form 990.

Texas Children's Hospital remains one of the country's premier pediatric institutions and one of the largest children's hospitals in the world. In its most recent federal filing reports compensation for their President and Chief Executive Officer received approximately **$6.3 million** in salary, retirement benefits, and other compensation. Several other senior executives each received total compensation exceeding **$2 million**.

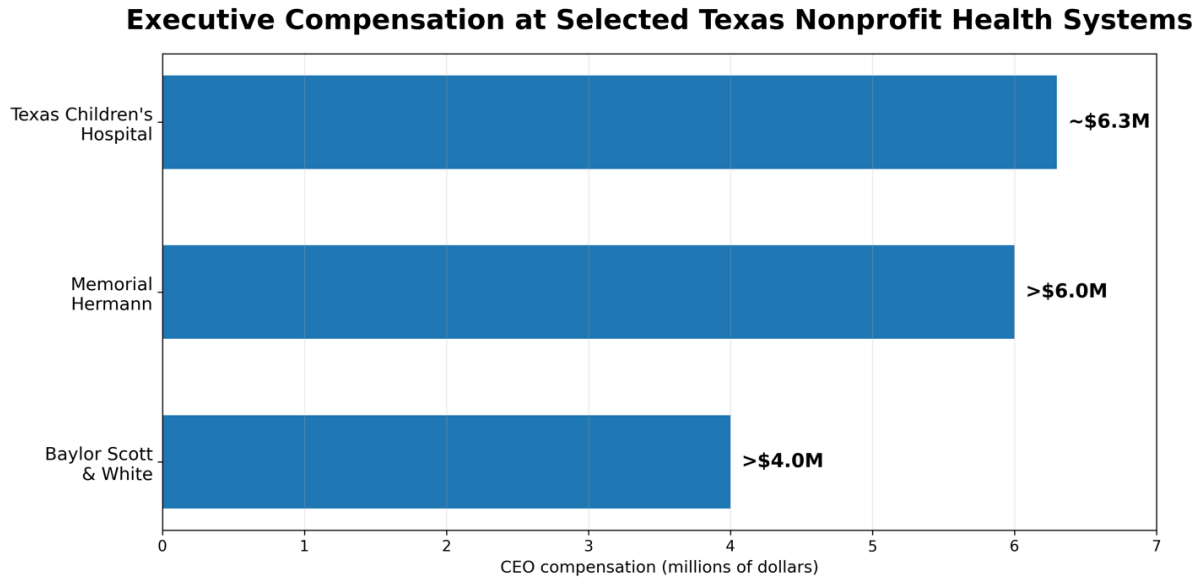
At **Baylor Scott & White Health**, one of the nation's largest nonprofit integrated health systems, the Chief Executive Officer received more than **$4 million** in reportable compensation and benefits. Other senior executives reported compensation approaching or exceeding **$1 million** annually.

Viewed individually, none of these figures is remarkable. Organizations generating billions of dollars in annual revenue routinely compensate senior leadership at levels comparable to major private corporations. Hospital trustees often argue that competitive compensation is necessary to recruit executives capable of managing increasingly complex enterprises. That explanation has merit. The comparison becomes more difficult, however, when viewed alongside the financial privileges unique to nonprofit hospitals. Public companies answer to shareholders and pay corporate income taxes. Nonprofit hospitals answer to community boards and pay little or no federal income tax because Congress concluded that their charitable activities justify preferential treatment. Executive compensation therefore cannot be viewed in isolation from tax policy.

IRS rules recognize this distinction. Tax-exempt organizations are prohibited from providing "excess benefit transactions" to insiders, and executive compensation is expected to be reasonable when measured against similarly situated organizations. In practice, hospital boards generally satisfy this requirement by commissioning compensation studies prepared by outside consultants, who compare salaries with those paid by peer institutions. The process is legally defensible. It also has an unintended consequence. If every board seeks to compensate its chief executive above the median of an already highly paid peer group, compensation inevitably trends upward across the sector.

The result has been a steady escalation in executive pay throughout nonprofit healthcare. At the same time, Texas nonprofit hospitals collectively receive an estimated **$2.1 billion** in annual tax preferences, while the Lown Institute estimates an annual statewide **Fair Share Deficit of approximately $643 million**. Those two figures are unrelated in a legal sense. They are closely related in the court of public opinion. Taxpayers inevitably compare multimillion-dollar executive compensation with the charitable obligations that justify tax exemption in the first place.

That comparison is sometimes uncomfortable, but it is unavoidable. The question is not whether Dr. Callender, Mr. Wallace, or other healthcare executives earned their compensation. Boards of directors have already answered that question. The policy question is different. Should institutions benefiting from extraordinary public subsidies be held to a higher standard of public accountability than organizations operating under ordinary corporate tax rules? Reasonable people may disagree about the answer.



Context: Memorial Hermann reported approximately 8.6*billioninannualrevenueand*14.9 billion in total assets.
Source: Most recent publicly available IRS Form 990 filings cited in the report.

6. Political Influence and Lobbying

Healthcare is one of the largest industries in Texas. It is also among the most politically active. Hospital systems have every right to participate in the legislative process. They operate under laws enacted in Austin and Washington, receive substantial Medicare and Medicaid reimbursement, and are directly affected by changes in tax policy, workforce regulation, physician licensure, graduate medical education, and insurance markets. It would be surprising if they were absent from those debates. The question is one of scale.

The Texas Hospital Association is among the state's most influential healthcare advocacy organizations. It represents more than 400 hospitals and health systems and maintains a constant presence before the Legislature, state agencies, and Congress. During every legislative session, the Association advocates on issues ranging from Medicaid reimbursement and trauma funding to workforce shortages, certificate-of-need alternatives, telemedicine, and hospital finance. Individual hospital systems supplement those efforts with their own government affairs offices and outside lobbying firms. The cumulative effect is considerable.

According to the Texas Ethics Commission, hospital systems, trade associations, insurers, pharmaceutical companies, physician organizations, and related healthcare interests collectively spend **tens of millions of dollars each election cycle** attempting to influence state policy. Healthcare consistently ranks among the largest sectors represented before the Texas Legislature, reflecting both the size of the industry and the financial stakes attached to public policy.

There is nothing improper about lobbying itself. Legislators benefit from technical expertise when considering complicated healthcare legislation. Hospitals often possess information unavailable elsewhere, particularly regarding disaster preparedness, trauma systems, rural healthcare, and workforce shortages. The concern arises when organizations receiving substantial public subsidies devote significant resources to preserving financial advantages that may not align with broader public interests.

Tax-exempt hospitals occupy a distinctive position. They are private institutions, but they receive substantial public support through tax preferences unavailable to ordinary corporations. They argue, correctly, that those tax preferences are earned through community service. That claim inevitably invites another question. Should organizations benefiting from those subsidies face greater transparency regarding their political activities than institutions operating under ordinary corporate tax rules?

Federal law already prohibits tax-exempt charitable organizations from participating directly in political campaigns. Lobbying, however, is permitted so long as it does not become a substantial part of an organization's activities. In practice, much advocacy occurs through state hospital associations, coalitions, and affiliated organizations, making

it difficult for taxpayers to understand the full scope of policy activity supported, directly or indirectly, by tax-exempt healthcare institutions. Transparency would benefit everyone. Hospitals could demonstrate that their advocacy focuses primarily on patient care, access, workforce development, and public health. Taxpayers could better understand how publicly supported institutions participate in shaping healthcare policy. Legislators would gain a clearer picture of who is advocating for particular proposals and why. Greater disclosure would not discourage participation. It would strengthen public confidence in it.

7. Transparency and Accountability

Every discussion about nonprofit hospitals eventually returns to the same question. What does the public receive in exchange for billions of dollars in tax preferences? The answer has become harder to measure than it should be.

Federal law requires nonprofit hospitals to report community benefit spending through IRS Form 990 and Schedule H. Texas law establishes additional standards governing charity care and community benefit. Medicare cost reports provide another source of financial information. Hospitals publish audited financial statements, annual reports, community health needs assessments, and, more recently, pricing information required under federal transparency regulations. There is no shortage of disclosure – but there is a shortage of clarity.

The problem is not that hospitals refuse to report information. The problem is that the information appears in different formats, under different accounting conventions, and often measures different things. A community member attempting to determine how much charity care a hospital provided, how much value it received from tax exemption, what it spent on community health programs, or how executive compensation compares with charitable expenditures quickly encounters a maze of reports prepared for different audiences under different reporting standards.

The result is predictable. Even sophisticated policymakers often reach different conclusions while examining the same institution. Consider charity care. One hospital may emphasize the value of uncompensated care calculated from billed charges. Another reports costs rather than charges. A third combines Medicaid shortfalls, graduate medical education, research expenditures, and community outreach under a single community benefit figure. Each presentation may satisfy applicable reporting requirements. None allows an easy comparison across institutions.

The same inconsistency appears in discussions of financial performance. Hospitals generally emphasize operating margin because it reflects the performance of core healthcare operations. Critics often focus on total margin because investment income and other non-operating revenue have become increasingly important to many large systems. Both measures are legitimate. They answer different questions.

Transparency should reduce uncertainty. Too often it merely redistributes it. This matters because nonprofit hospitals increasingly resemble regional economic institutions rather than traditional charitable organizations. Memorial Hermann, Baylor Scott & White, Houston Methodist, CHRISTUS Health, and Texas Children's collectively employ tens of thousands of Texans, purchase billions of dollars in goods and services, finance major construction projects, operate research enterprises, and influence healthcare markets extending well beyond their immediate communities. Institutions of that scale require equally sophisticated public accountability.

None of this requires additional bureaucracy. It requires better measurement. Financial markets long ago developed standardized accounting principles that allow investors to compare companies operating in different industries and different parts of the country. Healthcare has never developed a comparable framework for measuring public benefit. Instead, hospitals satisfy overlapping federal and state reporting requirements that frequently produce data that are technically accurate but difficult to interpret. The consequence reaches beyond academic debate.

Tax exemption is ultimately a public judgment. Legislatures grant it. Local governments honor it through property tax exemptions. Congress maintains it through the Internal Revenue Code. Taxpayers finance it by accepting reduced public revenue. Those taxpayers should not need specialized accounting expertise to understand whether the bargain is working as intended.

Texas is well positioned to lead that discussion. The state already possesses the data. Hospitals report extensive financial information each year. Federal agencies publish Medicare cost reports. IRS filings are publicly available. Independent organizations such as the Lown Institute, KFF, RAND, and ProPublica have demonstrated that meaningful comparisons are possible when data are presented consistently. The remaining challenge is less technical than institutional. The information exists. It simply has not been organized around the question taxpayers are most likely to ask.

Did the public receive value commensurate with the public investment? That question cannot be answered by a single financial ratio. Nor can it be answered solely by measuring charity care. Modern nonprofit hospitals educate physicians, conduct research, maintain trauma systems, prepare for disasters, and support services that private markets alone would be unlikely to sustain. Those activities deserve recognition. They also deserve consistent measurement.

A tax exemption is not a certificate of virtue. It is recognition that an institution performs public functions that justify preferential treatment under the law. Public confidence depends not only on those functions being performed, but on citizens being able to see that they are being performed. That confidence has become an increasingly valuable public asset. It should be measured with the same care as operating margins, bond ratings, and investment returns.

Conclusion

The debate over nonprofit hospitals is often framed as a choice between supporting healthcare institutions and demanding greater accountability. That is a false choice. Texas depends on strong hospitals. Few states have invested more heavily in biomedical research, graduate medical education, trauma systems, pediatric medicine, transplantation, or cancer care. The state's leading nonprofit health systems have helped build that foundation. Their physicians, nurses, researchers, and employees have earned the public's confidence many times over.

The purpose of this report is not to suggest that every nonprofit hospital underperforms its charitable mission. Many almost certainly exceed it. The challenge is that current reporting standards make those distinctions difficult to evaluate consistently

The issue examined in this report is different. It concerns the obligations that accompany public privilege. Tax exemption is one of the most valuable public benefits government can confer on a private institution. Unlike a grant or an appropriation, it seldom appears in an annual budget debate. The subsidy is largely invisible. It arrives as revenue that government agrees not to collect. Over time, those decisions amount to billions of dollars that remain in hospital balance sheets rather than public treasuries. That arrangement has served the country well for generations. It deserves to continue. It also deserves periodic examination.

The modern nonprofit hospital bears little resemblance to the charitable institutions that shaped today's tax laws. Many have become regional enterprises with revenues measured in the billions, sophisticated investment portfolios, integrated physician networks, research divisions, insurance products, and growing influence over local healthcare markets. Their scale has changed. Their financial sophistication has changed. Public expectations have changed as well. The legal framework has changed very little, and that gap explains much of the current debate.

Hospitals frequently respond that they provide benefits which accounting systems cannot fully capture. They point to trauma centers, neonatal intensive care, medical education, disaster preparedness, clinical research, and care delivered regardless of a patient's ability to pay. They are correct. Those services create enormous public value. Any serious discussion must acknowledge them.

Existing reporting requirements answer that question only imperfectly. Community benefit is reported differently from one institution to another. Charity care is measured under different accounting conventions. Executive compensation is publicly disclosed but rarely viewed alongside tax benefits or community investment. Pricing information is increasingly available, yet meaningful comparisons remain difficult. The data exist. They simply do not fit together. That’s a policy problem, not a political one.

Texas has an opportunity to lead rather than react. Better measurement would strengthen public confidence without diminishing hospital independence. Uniform reporting standards would improve comparisons without dictating business decisions. Independent evaluation of community benefit would protect taxpayers while recognizing the extraordinary contributions made by institutions that genuinely fulfill their charitable missions. Those reforms would not make hospitals less competitive. They would make public policy more credible.

Healthcare increasingly depends on public trust. Patients trust physicians with their lives. Investors trust audited financial statements. Bond markets trust standardized accounting. Regulators trust evidence developed through transparent scientific methods. Taxpayers deserve the same clarity when judging whether nonprofit hospitals continue to merit the substantial public support they receive and that is ultimately the issue.

Public trust is not sustained by tax exemption alone. It is sustained by demonstrating that public investment continues to produce measurable public benefit. That is the challenge facing Texas and, increasingly, nonprofit healthcare nationwide.

The question is not whether Texas has excellent nonprofit hospitals. It plainly does.
The question is whether the standards used to judge those institutions have kept pace with what they have become. The answer to that question will shape more than tax policy. It will influence public confidence in one of the state's most important civic institutions for years to come.

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Further Reading, Data Sources, and Public Resources

Nonprofit Hospitals and Community Benefit

- **Lown Institute – Hospital Fair Share Spending Project**
  https://lowninstitute.org/projects/hospital-fair-share-spending/
- **Lown Institute – Texas Fair Share Report (PDF)**
  https://lownhospitalsindex.org/wp-content/uploads/2025/04/Texas_state-report.pdf
- **Lown Institute – National Fair Share Report (PDF)**
  https://lownhospitalsindex.org/wp-content/uploads/2025/04/fair-share-2025-national-report-20250409.pdf
- **IRS Schedule H (Form 990) – Hospitals**
  https://www.irs.gov/forms-pubs/about-schedule-h-form-990

Hospital Finance and Tax Policy

- **Congressional Budget Office (CBO)**
  https://www.cbo.gov
- **Government Accountability Office (GAO)**
  https://www.gao.gov
- **Medicare Payment Advisory Commission (MedPAC)**
  https://www.medpac.gov
- **KFF (formerly Kaiser Family Foundation)**
  https://www.kff.org

Hospital Consolidation and Competition

- **Federal Trade Commission – Health Care Competition**
  https://www.ftc.gov
- **U.S. Department of Justice Antitrust Division**
  https://www.justice.gov/atr
- **RAND Health Care Research**
  https://www.rand.org/health-care.html
- **Health Care Cost Institute**
  https://healthcostinstitute.org

Hospital Price Transparency

- **CMS Hospital Price Transparency Initiative**
  https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency
- **Turquoise Health**
  https://turquoise.health
- **PatientRightsAdvocate.org**
  https://www.patientrightsadvocate.org

Executive Compensation and Governance

- **IRS Tax Exempt Organization Search**
  https://www.irs.gov/charities-non-profits/tax-exempt-organization-search
- **Candid (GuideStar)**
  https://www.candid.org
- **ProPublica Nonprofit Explorer**
  https://projects.propublica.org/nonprofits

Texas Healthcare

- **Texas Hospital Association**
  https://www.tha.org
- **Texas Health and Human Services Commission**
  https://www.hhs.texas.gov
- **Texas Department of State Health Services**
  https://www.dshs.texas.gov
- **Texas Ethics Commission**
  https://www.ethics.state.tx.us
- **Texas Comptroller of Public Accounts**
  https://comptroller.texas.gov

Federal Data Sources

- **CMS Hospital Cost Reports (HCRIS)**
  https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports
- **American Community Survey (U.S. Census Bureau)**
  https://www.census.gov/programs-surveys/acs
- **Bureau of Labor Statistics**
  https://www.bls.gov
- **National Academy of Medicine**
  https://nam.edu
