Medical Care Research and Review
2022, Vol. 79(3) 458–468

DOI: 10.1177/10775587211039695
journals.sagepub.com/home/mcr
SAGE

Comparison of Trends in Nonprofit Hospitals' Charity Care Eligibility Policies Between Medicaid Expansion States and Medicaid Nonexpansion States

Ge Bai, PhD, CPA[1,2], Hossein Zare, PhD, MS[2,3], Matthew D. Eisenberg, PhD[2], Daniel Polsky, PhD[1,2], and Gerard F. Anderson, PhD[2]

Abstract

Nonprofit hospitals provide charity care to financially disadvantaged patients according to their self-designed eligibility policies. The Affordable Care Act may have prompted nonprofit hospitals to adopt more generous eligibility policies, but no prior research has examined the longitudinal trend. The expansion of Medicaid coverage in many states has been found to reduce charity care provision, but it is unclear whether the change in charity care eligibility policies differed between Medicaid expansion and nonexpansion states. Using mandatory tax filings, we found that both hospitals in Medicaid expansion states and hospital in nonexpansion states adopted more generous eligibility policies in 2018 than in 2010, but the change was greater in the former for discounted charity care; while the former provided less charity care regardless of their policy changes, the latter provided more when their policies became more generous. This study has implications for policy discussions on the justification of nonprofit hospitals' tax-exempt status.

Keywords

charity care, nonprofit hospitals, charity care eligibility policy, Medicaid expansion

Background

The Affordable Care Act (ACA) added four requirements related to charity care for nonprofit hospitals that receive tax exemption under Internal Revenue Code Section 501(c)(3): (1) conducting a community health needs assessment, (2) establishing a written charity care policy and providing charity care accordingly to eligible patients, (3) limiting charges to eligible patients, and (4) restricting extraordinary billing and collections against eligible patients (U.S. Congress, 2010). Many states and state hospital associations have enacted their own disclosure and provision requirements on hospital charity care (The Hilltop Institute, 2016). These federal and state actions improved transparency and scrutiny over charity care activities, which may have prompted nonprofit hospitals to adopt more generous charity care eligibility policies over time. However, this topic has not been empirically examined in the academic literature.

Charity care eligibility policies are determined by the hospital, can be changed at any time, and directly influence charity care provision. For example, a hospital may increase its family income threshold for free charity care from below 250% to below 300% of the Federal Poverty Guidelines (FPG). Holding other things equal, a more generous policy would expand the number of patients potentially qualifying for charity care and result in greater charity care provision. Each year nonprofit hospitals whose charity care policies are based on a certain percentage of the FPG must report the specific percentages on Internal Revenue Service (IRS) Form 990 Schedule H, for free and discounted charity care separately (IRS, 2020b).

Beginning in 2014, the ACA provides states with financial assistance to expand Medicaid coverage to low-income

This article, submitted to *Medical Care Research and Review* on January 14, 2021, was revised and accepted for publication on July 26, 2021.

[1]Johns Hopkins Carey Business School, Baltimore, MD, USA
[2]Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA
[3]University of Maryland Global Campus, MD, USA

Corresponding Author:
Ge Bai, Johns Hopkins Carey Business School and Johns Hopkins Bloomberg School of Public Health, Johns Hopkins University, 100 International Drive, Baltimore, MD 21202, USA.
Email: gbai@jhu.edu

populations. Nonprofit hospitals in Medicaid expanding states may be induced to adopt more generous eligibility policies for charity care if their goal is to maintain target levels of charity care provision. Although previous studies found that Medicaid expansion was associated with lower charity care provision (Bai et al., 2020; Callison et al., 2021; Dranove et al., 2016; Kanter et al., 2020; Santos et al., 2021), it remains unclear whether this phenomenon occurred in spite of the increasing generosity of hospitals' charity care eligibility policies. This study aims to fill this knowledge gap by examining the change in charity care eligibility policies in Medicaid expansion states and nonexpansion states and the relationship between changes in charity care eligibility policies and the actual provision of charity care.

It is worth noting the differences in how charity care, bad debt, uncompensated care, and community benefit are measured. Charity care differs from bad debt in that hospitals do not expect payment for services designated as charity care but have initially expected and sought payment for accounts receivable written off as bad debt (Bai et al., 2020; Bai et al., 2021; Congressional Budget Office, 2006). Uncompensated care refers to the amount of services for which hospitals do not receive compensation, such as charity care and bad debt (Dranove et al., 2016). Community benefit is defined by the IRS (2020d) as activities that nonprofit hospitals perform to broadly promote the health of the community. Community benefit includes charity care, payment-cost differentials from public programs, community health improvement, subsidized health services, health professions education, and research (IRS, 2020c).

New Contributions

Prior research has demonstrated the distinctive patterns in charity care provision between hospitals in Medicaid expansion states and hospitals in Medicaid nonexpansion states—following the expansion, the former provided less charity care, whereas charity care provision of the latter remained relatively stable (Bai et al., 2020; Callison et al., 2021; Dranove et al., 2016; Kanter et al., 2020; Santos et al., 2021). Research on nonprofit hospitals' charity care eligibility policy has been sparse, with Goodman et al. (2020) the only study to date to our knowledge. They found that in 2016, nonprofit hospitals' charity care eligibility policies were on average more generous in Medicaid expansion states than in nonexpansion states (Goodman et al., 2020). However, whether hospitals' charity care eligibility policies changed over time and whether the change, if any, differed between Medicaid expansion states versus nonexpansion states remains unexplored. In this study, we examined the change in charity care eligibility policy from 2010 to 2018 among 1,216 nonprofit hospital organizations that used the FPG to determine their eligibility policies in both years and its implications on charity care provision. This study extends the literature on nonprofit hospitals' charity care eligibility policy and the literature on the impacts of Medicaid expansion on hospital behaviors.

Method

Data and Sample

We obtained IRS Form 990 Schedule H for nonprofit hospitals from 2010 to 2018 from Candid (merged from Foundation Center and GuideStar; Candid, 2020). Form 990 is the annual IRS (2020a) filing required for tax-exempt organizations with at least $200,000 in gross revenue and $500,000 in total assets. Each year applicable nonprofit hospital organizations—including acute care, psychiatric hospitals, postacute hospitals, and other specialty hospitals—must report their charity care policy (free and discounted care separately) and provision (free and discounted care combined) on Schedule H of Form 990 (IRS, 2020c). Hospitals that are affiliated with the same organization and share the same Employer Identification Number do not file separately. Year 2010 is the second year since the IRS required mandatory filing of Schedule H for nonprofit hospitalss and the year when the ACA was enacted. Year 2018 is the most recent year for which complete national data are available.

Since this study focuses on the change in charity care policies, we examined hospital organizations (hereafter, hospitals, for simplicity), regardless of service type, that used FPG-based eligibility policies for free and discounted charity care in 2010 and 2018. The sample selection process was listed in Table 1. The sample included 800 hospitals located in 31 states and the District of Columbia that had implemented the expansion of Medicaid eligibility by the end of 2018 and 416 hospitals located in 19 nonexpansion states. The Medicaid nonexpansion states include Alabama, Florida, Georgia, Idaho, Kansas, Maine, Missouri, Mississippi, North Carolina, Nebraska, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.

Variable Measurement

Consistent with prior literature that examines hospital charity care, we used charity-care-to-expense ratio to measure the amount of charity care provided by a hospital (Bai et al., 2020; Bai et al., 2021; Bruch & Bellamy, 2020; Kanter et al., 2020). On Form 990 Schedule H Part I line 7a, the amount of charity care provision is reported in column (c). We divided it by the total expense (Form 990 line 18) to derive the charity-care-to-expense ratio.

Charity care includes only the cost of free and discounted services (without intention to collect) provided to patients who have met the hospitals' charity care eligibility policy (IRS, 2020b). Bad debt expense, payment-cost differentials from certain public insurance plans, self-pay discount, and contractual adjustments with private insurance plans are not

Table 1. Sample Selection.

Data	2010	2018
No. of hospitals in the raw data	2,564	2,257
No. of hospitals that did not use % FPG as their charity care policies in either or both years	486	594
Subtotal	2,078	1,663
No. of hospitals included in the raw data of both 2010 and 2018	1,242	
No. of hospitals that changed reporting state	21	
No. of hospitals with greater than 100% charity-care-to-expense ratios in either or both years	5	
No. of hospitals in the sample	1,216	

Note. The average charity-care-to-expense ratio was not statistically significantly different between the hospitals in our sample and the hospitals that did not use % FPG as criteria ($p = .61$ in 2010; $p = .65$ in 2018). FPG = Federal Poverty Guidelines.

accounted for as charity care. When calculating the amount of charity care provided, the IRS (2020b) requires each hospital to convert gross charges for charity care to cost by using its specific cost-to-charge ratio, adding Medicaid provider taxes, fees, and assessments and subtracting any direct offsetting payment from the patient, payer, or related programs.

Charity care eligibility policies are reported on line 3a (free care) and line 3b (discounted care) of Schedule H Part I. Hospitals that use FPG to determine eligibility can choose from three options (100%, 150%, and 200%) for free charity care and five options (200%, 250%, 300%, 350%, and 400%) for discounted charity care. If none of the options is applicable, a percentage is specified. Hospitals can use factors other than FPG, or in addition to FPG—such as an asset test—to determine charity care eligibility.

Table 2. Definition of Groups in the Change of Charity Care Eligibility Policy.

Group	Free charity care FPG %	Disounted charity care FPG %
More generous	2018 > 2010	2018 > 2010
	2018 > 2010	2018 = 2010
	2018 = 2010	2018 > 2010
Less generous	2018 < 2010	2018 < 2010
	2018 < 2010	2018 = 2010
	2018 = 2010	2018 < 2010
The same	2018 = 2010	2018 = 2010
Other	2018 > 2010	2018 < 2010
	2018 < 2010	2018 > 2010

Note. 2018 and 2010 represent the FPG % for that year. FPG = Federal Poverty Guidelines.

Statistical Analysis

We examined the distribution of free and discounted FPG-based charity care eligibility policies in 2010 and in 2018, for all hospitals in the sample and by the Medicaid expansion status of the state where a hospital is located. We compared the average change in % FGP between hospitals in Medicaid expansion states and hospitals in nonexpansion states. Based on the options listed on Schedule H, we categorized the policies into four types for free charity care: (1) <100% FPG, (2) ≥100% and <150% FPG, (3) ≥150% and <200% FPG, and (4) ≥200% FPG and six types for discounted charity care: (1) < 200% FPG, (2) ≥200% and <250% FPG, (3) ≥250% and <300% FPG, (4) ≥300% and <350% FPG, (5) ≥350% and <400% FPG, and (6) ≥400% FPG.

Next, we compared each hospital's change in charity care policy between 2010 and 2018 and categorized hospitals into four mutually exclusive groups: *more generous*, *less generous*, *the same*, and *other*. The definition for each group was presented in Table 2. Within each group, we calculated the average charity-care-to-expense ratio for 2010 and 2018. For a robustness check, we repeated these analyses using a more restrictive sample—hospitals that had used percentages of FPG to determine charity care eligibility every year from 2010 to 2018 (490 hospitals in Medicaid expansion states and 273 hospitals in nonexpansion states).

Finally, we examined how the change in charity care eligibility policy and provision were correlated with the change in uninsured rates across and within Medicaid expansion and nonexpansion states. For expansion and nonexpansion states, respectively, we split the states into two groups based on their changes in uninsured rates from 2010 to 2018 (Kaiser Family Foundation, 2021). We analyzed how the average charity-care-to-expense ratio changed and how hospitals that adopted more generous eligibility polices were distributed between the groups.

Results

As presented in Figure 1, from 2010 to 2018, nonprofit hospitals in the sample adopted more generous charity care eligibility polices. The proportion of hospitals that adopted the most generous edibility policy as designated on Schedule H increased from 58% to 68% for free charity care (≥200% FPG) and from 28% to 38% for discounted charity care (≥400% FPG). However, their average charity-care-to-expense ratio decreased from 2.1% to 1.7% ($p < .001$). Figure 2 shows that hospitals in Medicaid expansion states

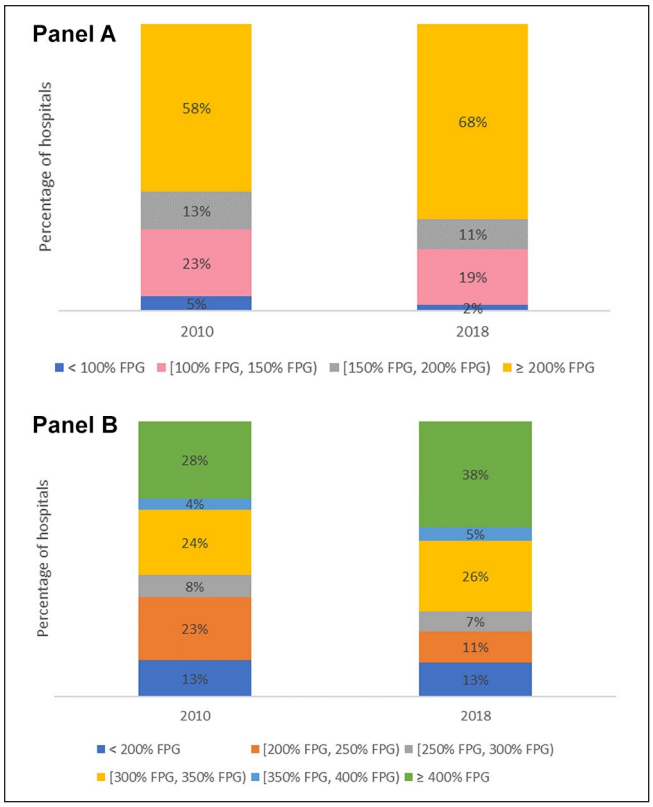

Figure 1. Distribution of charity care eligibility policies in nonprofit hospitals, 2010 versus 2018.
Panel A: Free charity care eligibility policies.
Panel B: Discounted charity care eligibility policies.

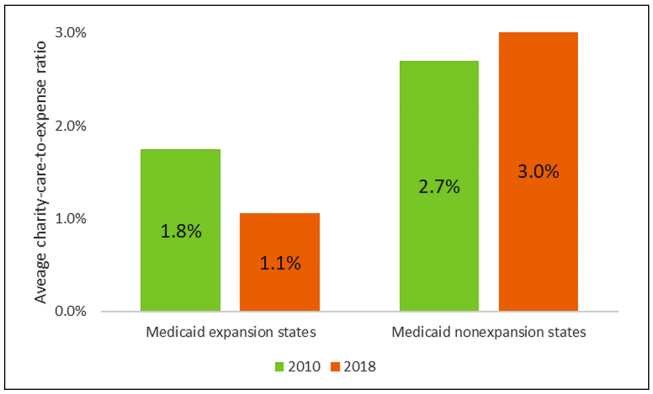

Figure 2. Average charity-care-to-expense ratios in nonprofit hospitals, 2010 versus 2018, by Medicaid expansion status.
Note. We used a *t* test on the following pairs for 2018 versus 2010: hospitals in all states ($p < .001$), hospitals in Medicaid expansion states ($p < .001$), and hospitals in Medicaid nonexpansion states ($p = .15$).

had an average charity-care-to-expense ratio of 1.8% in 2010 versus 1.1% in 2018 ($p < .001$), whereas hospitals in nonexpansion states had an average charity-care-to-expense ratio of 2.7% in 2010 versus 3.0% in 2018 ($p = .15$).

Figure 3 presents the change in the distribution of FPG-based eligibility policies for free charity care. Both hospitals

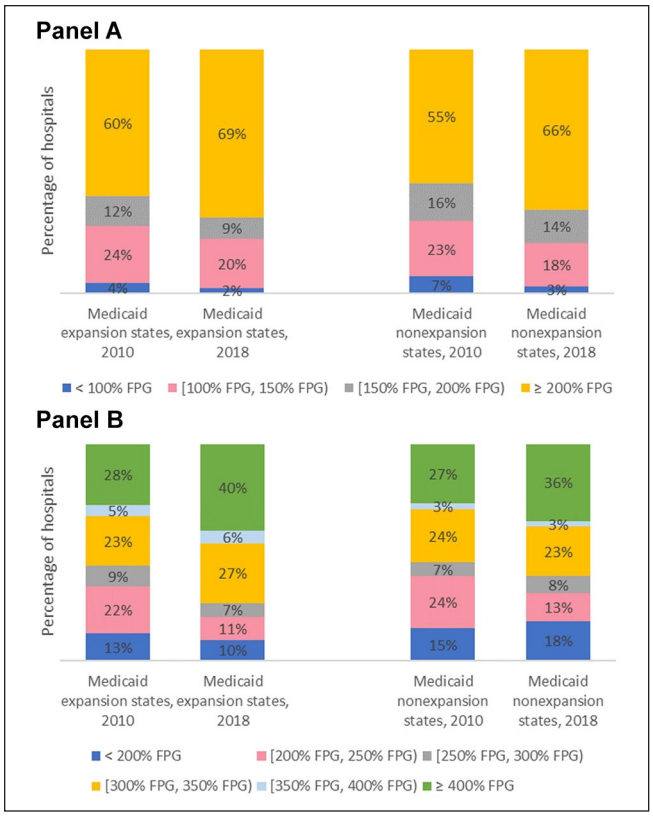

Figure 3. Distribution of charity care eligibility policies in nonprofit Hospitals, 2010 versus 2018, by Medicaid expansion status.
Panel A: Free charity care.
Note. The average change of edibility policy for free charity care from 2010 to 2018 for hospitals in Medicaid expansion states versus hospitals in nonexpansion states: 5.6% versus 7.4% ($p = .76$).
Panel B: Discounted charity care.
Note. The average change of edibility policy for discounted charity care from 2010 to 2018 for hospitals in Medicaid expansion states versus hospitals in nonexpansion states: 34.3% versus 5.3% ($p < .001$).

in Medicaid expansion states and hospitals in nonexpansion states adopted more generous policies in 2018 as compared with 2010: 69% versus 60% of the former and 66% versus 55% of the latter chose ≥ 200% FPG. The average change in % FPG was similar (5.6% vs. 7.4%; $p = .76$). For discounted charity care eligibility policies, hospitals in Medicaid expansion and hospitals in nonexpansion states became more generous, but the trend was more salient for hospitals in Medicaid expansion states—the proportion of hospitals that adopted ≥ 300% FPG increased from 56% in 2010 to 73% in 2018 for hospitals in expansion states and from 54% to 62% for hospitals in nonexpansion states. In addition, the proportion of hospitals that chose the least generous criterion (< 200% FPG) decreased from 13% to 10% for expansion states but rose from 15% to 18% for nonexpansion states. The average change in % FPG was higher in expansion states than in nonexpansion states (34.3% vs. 5.3%; $p < .001$).

From 2010 to 2018, among the 800 hospitals in Medicaid expansion states, 39% became more generous, 13% became

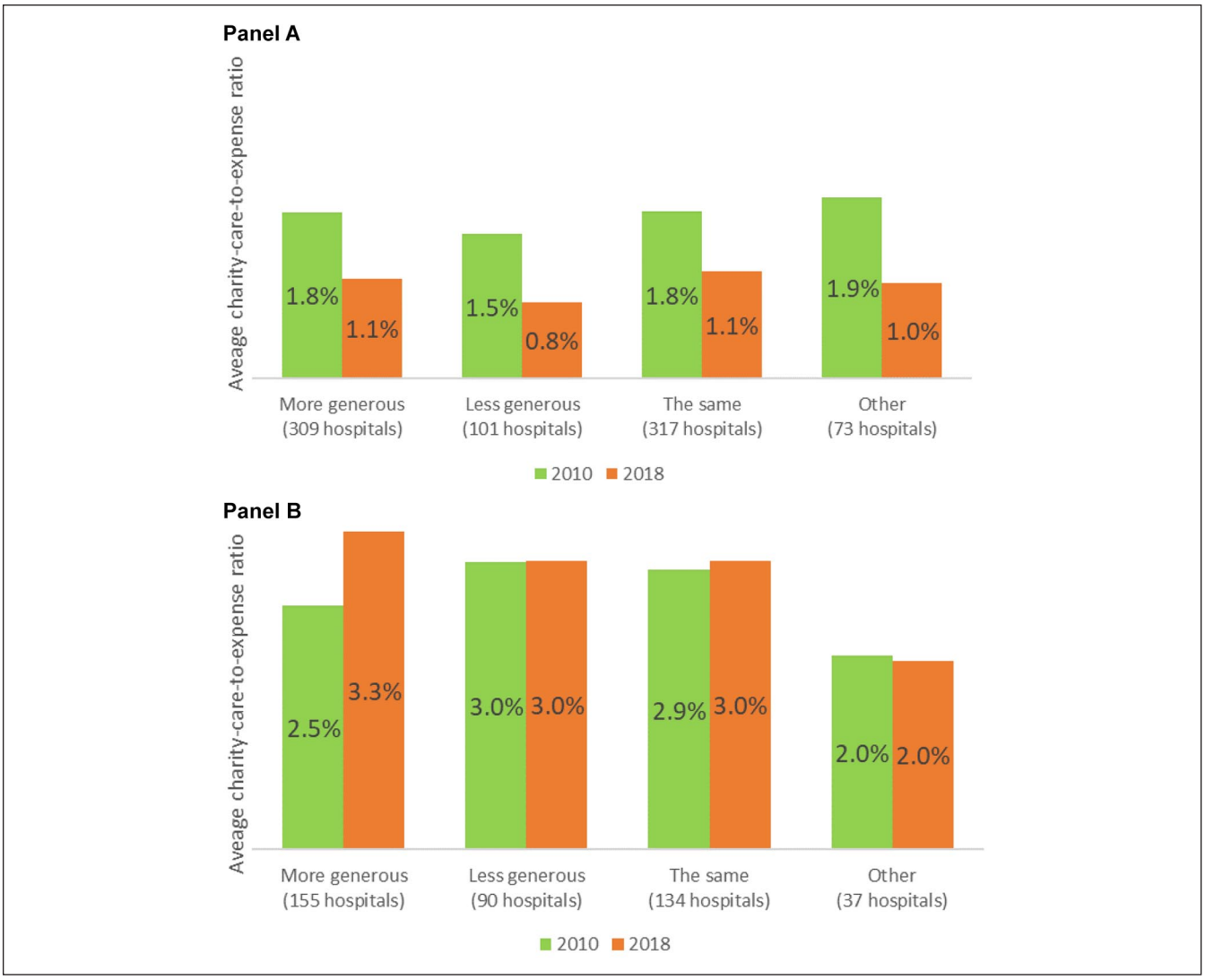

Figure 4. Change in charity care provision versus change in eligibility policy in nonprofit hospitals, 2010 versus 2018.
Panel A: Medicaid expansion states.
Note. We used a *t* test on the following pairs for 2018 versus 2010: more generous ($p < .001$), less generous ($p < .001$), the same ($p < .001$), and other ($p < .001$).
Panel B: Medicaid nonexpansion states.
Note. We used a *t* test on the following pairs for 2018 versus 2010: more generous ($p = .03$), less generous ($p = .96$), the same ($p = .73$), and other ($p = .84$).

less generous, and 40% remained the same; among the 416 hospitals in Medicaid nonexpansion states, 37% became more generous, 22% became less generous, and 32% remained the same (Figure 4). In Medicaid expansion states, the average charity-care-to-expense ratios of hospitals in all four groups—more generous, less generous, the same, and other—were significantly lower in 2018 than in 2010 (from 1.8% to 1.1%, 1.5% to 0.8%, 1.8% to 1.1%, and 1.9% to 1.0%, respectively; $p < .001$). In nonexpansion states, hospitals that became more generous on average had a higher charity-care-to-expense ratio in 2018 than in 2010 (3.3% vs. 2.5%; $p = .03$); the three remaining groups of hospitals on average did not experience a statistically significant change in charity care provision. These results were robust when we analyzed the 763 hospitals that had been consistently using percentages of FPG to determine their charity care eligibility policy every year from 2010 to 2018 (see the appendix).

Table 3 presented how changes in charity care eligibility policies and provision are correlated with changes in uninsured rate. From 2010 to 2018, the average uninsured rate dropped from 13.3% to 6.6% across Medicaid expansion states and from 15.7% to 10.6% across nonexpansion states. Hospitals in Medicaid expansion states that experienced larger drops in uninsured rates had a greater decrease in the average charity-care-to-expense ratio than other hospitals in expansion states (1.9%-1.1% vs. 1.4%-1.0%). In contrast,

Table 3. Changes of Uninsured Population.

Medicaid expansion status	Year	States	Average uninsured%	Average charity-care-to-expense ratio (%)
Yes	2010	16 States with large drops in uninsured % (486 hospitals)	16.0	1.9
		15 States and DC with small drops in uninsured % (314 hospitals)	10.5	1.4
		All 31 states and DC (800 hospitals)	**13.3**	**1.8**
	2018	16 States with large drops in uninsured % (486 hospitals)	7.2	1.1
		15 States and DC with small drops in uninsured % (314 hospitals)	6.0	1.0
		31 States and DC (800 hospitals)	**6.6**	**1.1**
No	2010	9 States with large drops in uninsured % (188 hospitals)	18.9	3.4
		10 States with small drops in uninsured % (228 hospitals)	12.8	2.1
		All 19 states (416 hospitals)	**15.7**	**2.7**
	2018	9 States with large drops in uninsured % (188 hospitals)	12.5	4.0
		10 States with small drops in uninsured % (228 hospitals)	8.9	2.2
		All 19 states (416 hospitals)	**10.6**	**3.0**

Note. Average uninsured % was calculated at state level. Average charity-care-to-expense ratio was calculated at the hospital level. For Medicaid expansion states, among the 309 hospitals that became more generous over time, 188 hospitals (61%) belonged to the top half states with high changes in uninsured %; among the 101 hospitals that became less generous, 56 hospitals (55%) belonged to these states. For Medicaid nonexpansion states, among the 155 hospitals that became more generous overtime, 56 hospitals (36%) belonged to the top half states with high changes in uninsured %; among the 47 hospitals that became less generous, 23 hospitals (49%) belonged to these states. Boldening is to facilitate 2010-2018 comparison. We also estimated a bivariate regression model at the state level for Medicaid expansion states and nonexpansion states, respectively, with the 2010-2018 change in a state's uninsured % as the independent variable and the 2010-2018 change in a state's average charity-care-to-expense ratio as the dependent variable. For Medicaid expansion states, the coefficient on the change in a state's uninsured % is 16.38 ($p = .01$). For Medicaid nonexpansion states, the coefficient on the change in a state's uninsured % is −4.75 ($p = .83$). Due to the measurement noise of hospital location, caution is needed in interpreting these results.

hospitals in nonexpansion states that experienced larger drops in uninsured rates had a greater increase in their average charity-care-to-expense ratio than other hospitals in nonexpansion states (3.4%-4.0% vs. 2.1%-2.2%). Moreover, in Medicaid expansion states, hospitals that became more generous were more likely to be located in states that experienced larger drops in uninsured rates than hospitals that became less generous (61% vs. 55%). The opposite was observed for hospitals in Medicaid nonexpansion states (36% vs. 49%). Due to the measurement noise of hospital location (discussed below), caution is needed in interpreting these results.

Discussion

U.S. nonprofit hospitals adopted more generous charity care eligibility policies in 2018 than in 2011, which was likely due to the increased transparency and scrutiny imposed by the ACA. The average increase in policy generosity for discounted charity care was greater for hospitals in expansion states than for hospitals in nonexpansion states. However, from 2010 to 2018, regardless of how eligibility policies changed, hospitals in expansion states provided less charity care—even for hospitals that adopted more generous policies, their change in policies appeared to be insufficient for them to return to their previous levels of charity care. In contrast, hospitals in nonexpansion states that adopted more generous policies provided more charity care.

This study has several important limitations. Comparison between Medicaid expansion versus nonexpansion ignores other important differences in health policy across hospitals. All analyses were conducted at the hospital organization level to be consistent with the reporting format of Form 990. The number of hospitals included in Form 990 is frequently missing—for example, 761 hospitals in the sample (63%) did not have that information in 2010. This limitation prevented us from examining time trends based on each hospital's system status.

Some hospitals sharing the same Employer Identification Number were located in states with different Medicaid expansion status. As a result, our identification of hospitals in Medicaid expansion versus nonexpansion states might be imperfect. We examined the three hospital organizations with the largest reported numbers of facilities in 2018 Form 990s. A total of 100%, 100%, and 95% of facilities of these organizations (all located in expansion states as per Form 990s), respectively, were located in expansion states. This evidence offered some confidence in the expansion versus nonexpansion categorization of multifacility hospital organizations. However, the between-state comparison results (as shown in Table 3) can be subject to substantial measurement noises because facilities within the same organization can be dispersed across states that belong to different groups categorized by the change in uninsured rates.

This study was confined to the hospitals that utilized policies incorporating percentages of FPG. The eligibility

criteria used by other hospitals are not reported on Form 990 Schedule H. Form 990 does not contain the specific dollar amount of free charity care provision or discounted charity care provision, which created a challenge to examine the relationship between charity care policy and provision by the type of charity care.

This study, limited by its descriptive nature, is unable to quantitatively estimate the relationships among charity care eligibility policies, charity care provision, Medicaid expansion, the change in uninsured population, and other hospital characteristics. Therefore, this study cannot determine what factors caused the changes in eligibility policies or quantify the consequences of the changes. A comprehensive difference-in-differences research design and regression analysis with robust identification strategies are promising future research areas of study/research.

In light of these limitations, this study contributes to the literature on the impacts of Medicaid expansion on hospital behavior. Medicaid expansion did not boost the provision of other types of community benefit and was associated with higher hospital profit (Bai et al., 2020; Blavin, 2016; Callison et al., 2021; Dranove et al., 2016; Kanter et al., 2020; Santos et al., 2021; Young et al., 2018). Medicaid expansion, funded by taxpayer dollars, essentially generated tax-exempt profit for nonprofit hospitals (Dranove et al., 2016). Our findings suggest that the decreasing charity care provision for hospitals in Medicaid expansion states is likely due to their low charity care burden, and thus implementing a more generous charity care policy might not significantly increase their charity care provision.

This study is relevant to the policy discussion on the justification of nonprofit hospitals' tax-exempt status. Nonprofit hospitals have been deviating from focusing on delivering care to vulnerable patients for free, the original justification for tax exemption status (Bai et al., 2021; Herring et al., 2018; Hyman, 1990; Reinhardt, 2000; Rubin et al., 2015; Santos et al., 2021; Schneider, 2007). Nonprofit hospitals are also not more likely than for-profit hospitals to provide more charity care when gaining market power (Capps et al., 2020). Currently, nonprofit hospitals justify their tax-exempt status through the provision of community benefit (IRS, 2020d). However, as our study suggested, the sensitivity of charity care provision to a hospital's edibility policy is influenced by external factors, and thus community benefit may not accurately reflect a hospital's community-oriented efforts. As the IRS is facing substantial challenges to oversee nonprofit hospitals' community benefit activities and determine their tax-exempt eligibility (Government Accountability Office, 2020), policy makers may potentially consider revisiting the tax exemption rules for nonprofit hospitals.

Appendix

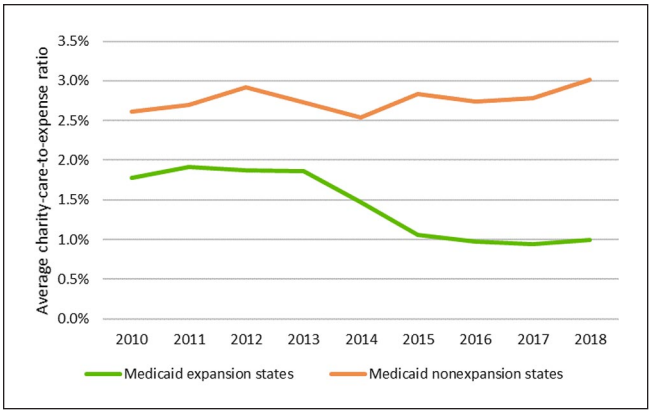

Figure 1. Average charity-care-to-expense ratios of nonprofit hospitals, 2010-2018.
Note. We used *t* test on the following pairs for 2018 versus 2010: hospitals in Medicaid expansion states ($p < .001$) and hospitals in Medicaid nonexpansion states ($p = .16$).

Figure 2. Distribution of free charity care eligibility policy of nonprofit hospitals, 2010-2018.
Panel A: Medicaid expansion states.
Panel B: Medicaid nonexpansion states.

Figure 3. Distribution of discounted charity care eligibility policy of nonprofit hospitals, 2010-2018.
Panel A: Medicaid expansion states.
Panel B: Medicaid nonexpansion States.

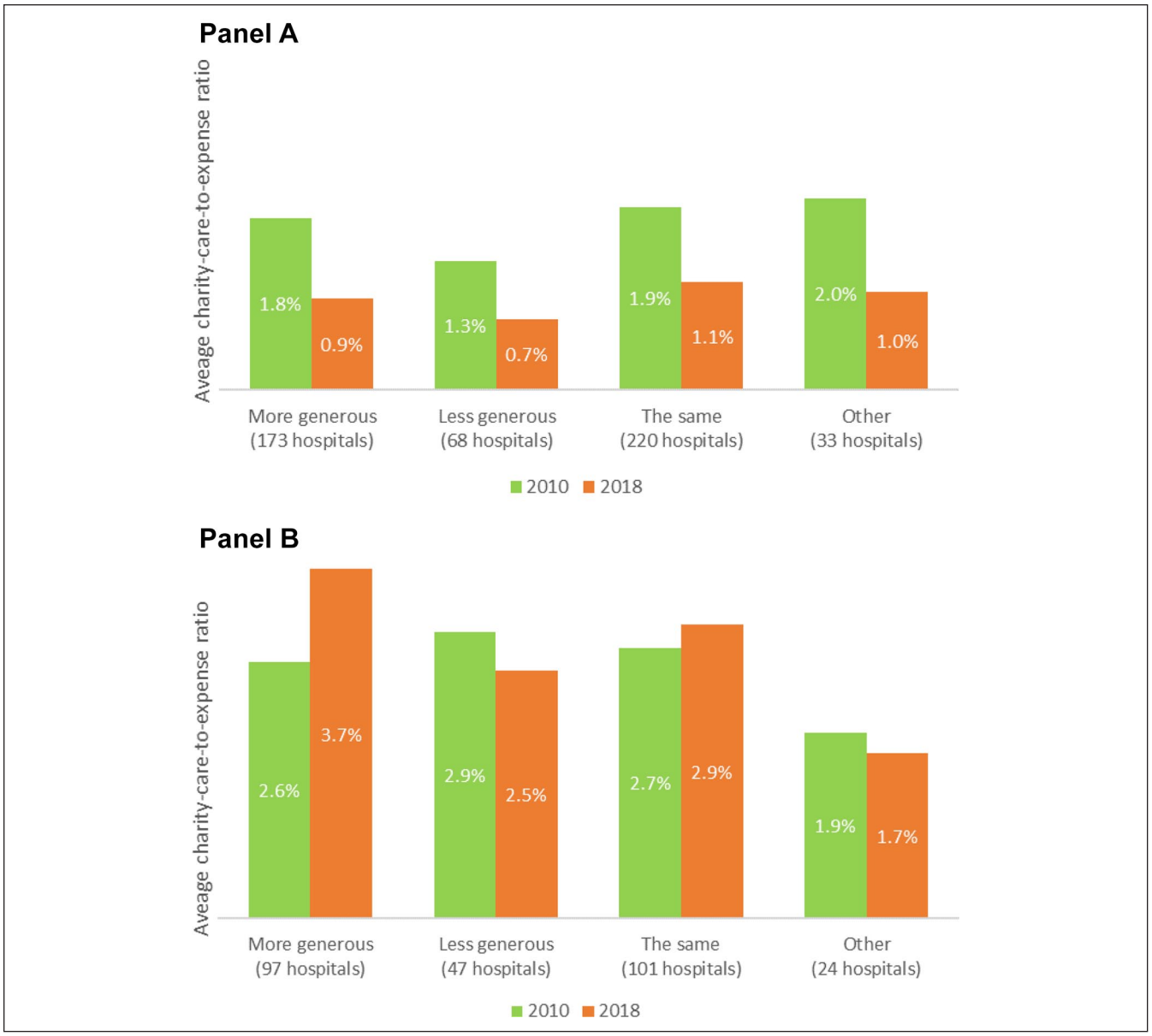

Figure 4. Change in charity care versus change in eligibility policy of nonprofit hospitals, 2010 versus 2018.
Panel A: Medicaid expansion states.
Note. We used a *t* test on the following pairs for 2018 versus 2010: more generous ($p < .01$), less generous ($p < .01$), the same ($p < .01$), and other ($p < .01$).
Panel B: Medicaid nonexpansion states.
Note. We used a *t* test on the following pairs for 2018 vsercus 2010: more generous ($p = .04$), less generous ($p = .05$), the same ($p = .49$), and other ($p = .51$).

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support: Ge Bai, Hossein Zare, and Daniel Polsky received funding from the Episcopal Health Foundation and the Commonwealth Fund for this project. All authors received support from Arnold Ventures.

References

Bai, G., Yehia, F., & Anderson, G. F. (2020). Charity care provision by US nonprofit hospitals. *Journal of the American Medical Association Internal Medicine*, *180*(4), 606-607. https://doi.org/10.1001/jamainternmed.2019.7415

Bai, G., Zare, H., Eisenberg, M. D., Polsky, D., & Anderson, G. F. (2021). Analysis suggests government and nonprofit hospitals' charity care is not aligned with their favorable tax treatment. *Health Affairs*, *40*(4), 629-636. https://doi.org/10.1377/hlthaff.2020.01627

Blavin, F. (2016). Association between the 2014 Medicaid expansion and US hospital finances. *Journal of the American Medical Association*, *316*(14), 1475-1483. https://doi.org/10.1001/jama.2016.14765

Bruch, J. D., & Bellamy, D. (2020). Charity care: Do nonprofit hospitals give more than for-profit hospitals? *Journal of General Internal Medicine*. Advance online publication. https://doi.org/10.1007/s11606-020-06147-9

Callison, K., Walker, B., Stoecker, C., Self, J., & Diana, M. L. (2021). Medicaid expansion reduced uncompensated care cost at Louisiana hospitals. *Health Affairs*, *40*(3), 529-535. https://doi.org/10.1377/hlthaff.2020.01677

Candid. (2020). *About us*. https://candid.org/about

Capps, C. S., Carlton, D. W., & David, G. (2020). Antirust treatment of nonprofits: Should hospitals receive special care? *Economic Inquiry*, *58*(3), 1183-1199. https://doi.org/10.1111/ecin.12881

Congressional Budget Office. (2006). *Nonprofit hospitals and the provision of community benefits*. https://www.cbo.gov/sites/default/files/109th-congress-2005-2006/reports/12-06-nonprofit.pdf

Dranove, D., Garthwaite, C., & Ody, C. (2016). Uncompensated care decreased at hospitals in Medicaid expansion states but not at hospitals in nonexpansion states. *Health Affairs*, *35*(8), 1471-1479. https://doi.org/10.1377/hlthaff.2015.1344

Goodman, C. W., Flanigan, A., Probst, J. C., & Brett, A. S. (2020). Charity care characteristics and expenditures among US tax-exempt hospitals in 2016. *American Journal of Public Health*, *110*(4), 492-498. https://doi.org/10.2105/AJPH.2019.305522

Government Accountability Office. (2020). *Opportunities exist to improve oversight of hospitals' tax-exempt status*. https://www.gao.gov/assets/710/709468.pdf

Herring, B., Gaskin, D., Zare, H., & Anderson, G. F. (2018). Comparing the value of nonprofit hospitals' tax exemption to their community benefits. *Inquiry: The Journal of Health Care Organization, Provision, and Financing*, *55*, 1-11. https://doi.org/10.1177/0046958017751970

The Hilltop Institute. (2016). *Community benefits state law profiles*. https://www.hilltopinstitute.org/our-work/hospital-community-benefit/

Hyman, D. A. (1990). The conundrum of charitability: Reassessing tax exemption for hospitals. *American Journal of Law & Medicine*, *16*(3), 327-380.

Internal Revenue Service. (2020a). *2019 Instructions for Form 990 return of organization exempt from income tax*. https://www.irs.gov/pub/irs-pdf/i990.pdf

Internal Revenue Service. (2020b). *2020 instructions for Schedule H (Form 990)*. https://www.irs.gov/pub/irs-pdf/i990sh.pdf

Internal Revenue Service. (2020c). *About Schedule H (Form 990), hospitals*. https://www.irs.gov/forms-pubs/about-schedule-h-form-990

Internal Revenue Service. (2020d). *Charitable hospitals: General requirements for tax-exemption under Section 501(c)(3)*. https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3

Kaiser Family Foundation. (2021). *Health insurance coverage of the total population*. https://www.kff.org/other/state-indicator/total-population

Kanter, G. P., Nabet, B., Matone, M., & Rubin, D. M. (2020). Association of state Medicaid expansion with hospital community benefit spending. *Journal of the American Medical Association Network Open*, *3*(5), e205529. https://doi.org/10.1001/jamanetworkopen.2020.5529

Reinhardt, U. (2000). The economics of for-profit and not-for-profit hospitals. *Health Affairs*, *19*(6), 178-186. https://doi.org/10.1377/hlthaff.19.6.178

Rubin, D. B., Singh, S. R., & Young, G. J. (2015). Tax-exempt hospitals and community benefit: New directions in policy and practice. *Annual Review of Public Health*, *36*, 545-557. https://doi.org/10.1146/annurev-publhealth-031914-122357

Santos, T., Singh, S., & Young, G. J. (2021). Medicaid expansion and not-for-profit hospitals' financial status: National and state-level estimates using IRS and CMS data, 2011-2016. *Medical Care Research and Review*. Advance online publication. https://doi.org/10.1177/10775587211009720

Schneider, H. (2007). Paying their way? Do nonprofit hospitals justify their favorable tax treatment? *Inquiry*, *44*(2), 187-199. https://doi.org/10.5034/inquiryjrnl_44.2.187

U.S. Congress. (2010). *Compilation of Patient Protection and Affordable Care Act*. http://housedocs.house.gov/energycommerce/ppacacon.pdf

Young, G. J., Flaherty, S., Zepeda, E. D., Singh, S. R., & Cramer, G. R. (2018). Community benefit spending by tax-exempt hospitals changed little after ACA. *Health Affairs*, *37*(1), 121-124. https://doi.org/10.1377/hlthaff.2017.1028