Modern Theories of Hospital Tax Exemption*

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1. This paper is based on an article coauthored with John D. Colombo at the University of Illinois College of Law, published as *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307-411 (1991).

I. Introduction

A. The Importance of the Question

This paper undertakes to answer the dual inquiries "What are charitable organizations" and "Why are they exempt from taxation." I treat these as two organically related questions. Obtaining a clear view of the core concept of charity will greatly facilitate identification of the rationale for exempting charities from taxation, which rationale will in turn guide us in applying the charitable category in borderline cases. Or, working in the opposite direction, if we can formulate a correct rationale for the exemption, we will then know (or at least be able to manufacture) a sensible definition of "charitable."

This paper undertakes to answer these questions in the context of the exempt status of nonprofit hospitals, a context chosen for several reasons. First, recent challenges to hospitals' tax exemption provide the most visible eruption of these issues in recent years. The Utah Supreme Court shook the voluntary hospital sector to its core in 1985 by becoming the first court in modern times to revoke a hospital's exemption for its failure to provide a sufficient level of charity care.[2] Local taxing authorities have challenged hospitals' exempt status in at least five other states since,[3]

2. Utah County v. Intermountain Health Care, Inc., 709 P.2d 265 (Utah 1985).

3. The vast majority of states adhere to the federal view that the promotion of health for the general community is a charitable purpose, regardless of whether the entity in question provides free or subsidized health care to the poor. A small minority of states, however, cling to the view that health care is not in and of itself deserving of charitable status and that some additional contribution to society, such as charity care, is a required element of tax exemption under state law. P. Rammell & J. Parsons, Utah County &
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and legislative reexaminations are pending or have occurred recently in over a dozen others. Most recently, Congress is considering two bills that would entirely revamp the basis for hospital exemption from federal income tax.[4] In Revenue Ruling 69-545,[5] the IRS abandoned the charity care requirement it had imposed on hospitals in

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Intermountain Health Care: Utah's Unique Method for Determining Charitable Property Tax Exemption--A Review of its Mandate and Impact, 22 J. Health & Hosp. L. 73-74 (1989). In the wake of Utah County, taxing authorities revoked the exempt status of nonprofit hospitals in Missouri, Tennessee and Vermont, but the courts reversed in each instance. Callaway Community Hospital Ass'n v. Craighead, 759 S.W.2d 253 (Mo. App. 1988); Downtown Hospital Ass'n. v. Tennessee State Board of Equalization, 760 S.W. 2d 954 (Tenn. App. 1988); Medical Center Hospital of Vermont, Inc. v. Burlington, 566 A.2d 1352 (Vt. 1989). A challenge by the state attorney general is pending in Texas. State v. Methodist Hosp. Sys., No. 494,212 (126th Jud. Dist. Travis County, Tex. filed Nov. 26, 1990)

Pennsylvania appears to be the only state other than Utah with a legal climate hostile to hospital tax exemption, although its precedents presently are much cloudier. See West Allegheny Hosp. v. Board of Property Assessors, 455 A.2d 1170 (Pa. 1982) (hospital exempt despite low level of charity care); Hospital Utilization Project v. Commonwealth, 507 Pa. 1, 487 A.2d 1306 (1985) (suggesting that a hospital must have an "open admissions policy" that does not discriminate on the basis of the ability to pay). But see J. Simpson & S. Strum, How Good a Samaritan? Federal Income Tax Exemption for Charitable Hospitals Reconsidered, 14 U. Puget Sound L. Rev. 633, 647 (1991) (concluding, based on cases over the past 50 years including many where the issue was not in dispute, that "[i]n the majority of jurisdictions where the question of free care has been raised in the hospital context, the provision of charity care and the accessibility of the hospital to indigent patients continue to be determinative, or at least important, criteria for entitlement to tax exemption.") For a state-by-state analysis of property tax exemption laws as they apply to health care providers, see Health Law Center, Hospital Law Manual, "Taxation" at 37-152 (1988). See generally, Jay Greene, Governmental Units Challenge Not-for-profits' Tax Exemption, 17 Mod. Healthcare, No. 25 (Dec. 4, 1987), p. 67.

4. H.R. 790, 102d Cong., 1st Sess., 137 Cong. Rec. E395-97 (1991) [the Roybal Bill] and H.R. 1374, 102d Cong., 1st Sess., 137 Cong. Rec. E896 (1991) [the Donnelly Bill].

5. Rev. Rul. 69-545, 1969-2 C.B. 117. The timing of this ruling in relation to the legislative calendar in 1969 is curious, to say the least. After complaints by the hospital

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1956[6] and adopted a "per se" rule of hospital exemption: an entity engaged in the "promotion of health" for the general benefit of the community is pursuing a charitable purpose merely by treating all patients in the community who are able to pay.[7] The per se standard was further entrenched by a 1983 ruling which established that even hospitals with limited practice specialties and no open emergency room, such as cancer hospitals, could qualify for exemption merely by treating all patients able to pay.[8] The pending federal legislation would reverse these long-established standards.

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industry regarding the charity care requirement of Rev. Rul. 56-185 surfaced during House hearings on the 1969 tax reform legislation, the House passed a version of tax reform legislation which included a specific exemption for "hospitals" in a revised § 501(c)(3). H.R. 13270, 91st Cong., 1 Sess., § 101(j) (1969). Rev. Rul. 69-545 was issued prior to Senate debate on the tax reform bill, and when the issue arose in the Senate, the Finance Committee decided to delete this provision from the Senate version of the legislation in light of the IRS action, and to reconsider the issue in connection with upcoming debates on the scope of Medicare. See Medicare and Medicaid, Problems, Issues and Alternatives, Report of the Staff to the Senate Committee on Finance, 91st Cong., 1st Sess. 55 (Comm. Print 1970). In this report, the staff severely criticized the breadth of the 1969 ruling, id. at 58, but no further legislative action was taken. This opaque legislative background sheds no light on whether Congress agreed with the 1969 ruling.

6. Rev. Rul. 56-185, 1956-1 C.B. 202. See generally, Colombo, Are Associations of Doctors Tax Exempt? Analyzing Inconsistencies in the Tax Exemption of Health Care Providers, 9 Va. Tax Rev. 469 (1990).

7. The Service stressed that the promotion of health for the general benefit of the community had long been recognized as a charitable purpose under the common law of charitable trusts. 1969-2 C.B. at 118.

8. Rev. Rul. 83-157, 1983-1 C.B. 94. For a more detailed discussion of the 1956, 1969 and 1983 rulings, see Colombo, supra note 6; Fox & Schaffer, Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts, 16 J. Health Pol. Pol'y & L. 251 (1991).

The second reason for focusing on the hospital industry is that it constitutes by far the single largest commercial activity that enjoys tax exempt status under the generic charitable label,[9] amounting to billions of dollars a year in lost revenue.[10] Therefore, an inquiry into the justification for its charitable status is imperative. Third, nonprofit scholars are most intrigued by industries where proprietary, voluntary, and government institutions coexist,[11] for these settings provide the best laboratories for testing the comparative performance, and the relative merits, of these three forms of organization. Finally, the specific issue of hospital tax exemption has heightened importance because it sits at the confluence of larger social policy issues. A staggering 37 million Americans have no health insurance from either private or government sources, a 30 percent increase from 1979.[12] Stringent reimbursement

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9. J. Bennett & T. DiLorenzo, Unfair Competition: The Profits of Nonprofits 73 (1989) ("Although nonprofit hospitals comprise less than three percent of all nonprofit organizations, they dominate the sector's expenditures: In 1982, nonprofit hospitals accounted for more than half of all nonprofit-sector expenditures.").

10. Presently, the figure that has the widest currency places the value of the exemption at $8.5 billion. Copeland & Rudney, Federal Tax Subsidies for Not-for-Profit Hospitals, 1009 Tax Notes 1559, 1565 (1990).

11. "Proprietary" designates privately-owned, for-profit institutions. Following the convention in the hospital industry, the term "voluntary" is used interchangeably with "nonprofit" to designate privately-owned institutions incorporated under state not-for-profit corporations codes. Government institutions are those owned or controlled by government entities. In a typical metropolitan area, all three types of hospitals often coexist.

12. Congressional Research Service, Health Insurance and the Uninsured iii (June 1988). "In addition, there are millions of underinsured people, whose limited insurance puts them at substantial risk of having out-of-pocket expenses upwards of 10 percent of their total income. The best data on this topic . . . found that depending on the definition used, from 5 to 18 percent of the population under age 65 was underinsured."

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controls recently imposed by both private and governmental payors threaten to eliminate hospitals' ability to cross-subsidize the care of the medically indigent from revenues generated by paying patients.[13] Thus, it is increasingly unrealistic to expect private hospitals to meet the public's demand for charity care, precisely at the time that the greatest need exists for such care.

B. The Criteria for Evaluating Theories of Exemption.

Before undertaking a critique of the various bases for the charitable exemption, it is helpful to establish a firm understanding of the criteria that a successful theory for exemption should meet. Ideally, such a theory should have four attributes: (1) deservedness: identifying those activities that are both worthy of and in need of a social subsidy; (2) proportionality: distributing the subsidy in rough proportion to the degree of deservedness; (3) universality: offering a sensible explanation for both the income tax and the property tax exemption, and, ideally, explaining the related charitable deduction as well as the various operational constraints that attach to charitable status; and, (4) historical consistency: aligning with an intuitive concept of what constitutes a charity and with the major historical categories of exempt

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12.(...continued)
The Nonprofit Sector: A Research Handbook (W. Powell, ed. 1987); Yoder, Economic Theories of For-Profit and Not-for-Profit Organizations, in Institute of Medicine, For Profit Enterprise in Health Care 117 n.1 (B. Gray ed. 1986).

13. These developments are surveyed in Hall, Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment, 137 U. Penn. L. Rev. 431, 435-37 (1988).

entities.[14]

(1) Deservedness. The exemption is justified only where there is a convincing showing that the activity in question is deserving of a social subsidy. There are two elements to deservedness: worthiness and neediness. We first need some reliable indication or assessment of which activities out of the vast array of human endeavors are socially worthy. But worthiness alone is not enough without neediness, for the organization might be perfectly willing to continue in its meritorious pursuits absent the subsidy. If so, a subsidy becomes a waste of precious government resources that surely could be devoted to other, more productive causes. In particular, it is important to recognize that, even if the level of service provided by the nonprofit sector would diminish without the exemption, the exemption is not necessary unless we know that the proprietary sector or the government is incapable of providing the same social benefits just as efficiently. Ideally, therefore, the definition of charity should identify activities whose social benefits would be irreplaceably reduced without the subsidy.

(2) Proportionality. In addition to guarding against subsidization of unworthy

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14. Some of these criteria have been suggested previously in Simon, The Tax Treatment of Nonprofit Organizations: A Review of Federal and State Policies, in The Nonprofit Sector: A Research Handbook (W. Powell, ed. 1987), at 67, 76-78; J. Jensen, Property Taxation in the United States 148 (1931). See also S. Surrey & P. McDaniel, Tax Expenditures 72-83 (1985); and S. Surrey, Pathways to Tax Reform 134 (1973). But see Dale, Rationales for Tax Exemption (1988) (unpublished manuscript) ("no single rationale can or should be expected to explain or justify tax-exempt status. The not-for-profit sector of our society is complex and varied; its lineage is ancient. It would be unreasonably simplistic to expect to capture its essence or justification within the compass of any theory.").

activities or activities that do not need support, an ideal concept of charity in the tax exemption arena should guard against oversubsidizing (or undersubsidizing) those activities that are deserving. In other words, we need a concept of charity that at least roughly matches the level of support to the level of deservedness. Another way to capture the substance of the proportionality criterion is to ask whether it makes sense to administer a deserving subsidy through a tax exemption (either income or property). It is not enough to demonstrate that charitable institutions deserve government support; it is necessary to show that the most sensible vehicle for support is a tax subsidy, that is, that some form of direct grant might not more accurately approximate the optimal level of support or that direct government provision of the same service is not preferable.

(3) Universality. Classification as a charitable organization carries with it not only exemption from the federal corporate income tax but also a host of other benefits and responsibilities. The basic federal income tax exemption, I.R.C. 501(c)(3), also defines those organizations eligible to receive tax deductible donations, and charitable status usually results in exemption from state property tax (and sometimes state income and sales taxes) as well. On the burden side of the equation, the charitable exemption imposes certain limitations on an organization's structure and scope of operations. It must be truly nonprofit, so that no earnings inure to the benefit of a private individual; it may not engage in political lobbying; and the exemption does not extend to earnings from activities that are unrelated to its exempt purpose (even though those earnings ultimately support the exempt

purpose). A successful theory of exemption (or, a concept of charity) should offer a coordinated explanation for most or all of these tax benefits and operational constraints.

(4) Historical Consistency. The charitable exemption has evolved throughout centuries of experience to take on an almost universal presence and shape. A complete reformulation, or abandonment, is impossible to contemplate for both political and pragmatic reasons. Therefore, a successful theory, in addition to meeting the previous criteria, should be roughly consistent with the present shape of the exemption, that is, the major historical categories of exemption (primarily, religion, education, and social welfare organizations). Ideally, it should also comport with at least a general, unstudied sense of why the exemption exists and what it attempts to do. In short, the theory should be intuitively correct.

II. The "Per Se" Theory of Hospital Exemption

The D.C. Circuit's opinion in the Eastern Kentucky Welfare Rights litigation, which upheld the 1969 revenue ruling, remains the most influential authority for the per se exempt status of hospitals. The court reasoned that "the rationale upon which the [charity care] definition of 'charitable' was predicated has largely disappeared," and that "[t]o continue to base the 'charitable' status of a hospital strictly on the relief it provides for the poor fails to account for these major changes in the area of health

care [such as Medicare and Medicaid]."[15] At the heart of this reasoning is the following, blatantly circular argument: nonprofit hospitals are charitable despite their lack of charity care because the concept of what constitutes a charity must change "to recognize the changing economic, social and technological" environment in which hospitals now function.[16] This redefinition of charity obviously assumes the question that it purports to be answering -- whether or not hospitals should continue to enjoy charitable status -- since it seems determined to reshape the concept of charity however necessary to fit the predominant pattern of what most nonprofit hospitals are currently doing. This entirely unanalytic, question-begging approach characterizes much of the pro-hospital argument for exemption.

Nevertheless, the per se view of exemption adhered to by the IRS and a majority of states is not newly formed; it derives from an impressive and ancient lineage in the law of charitable trusts. When Congress first enacted the charitable exemption in 1894 as part of the original income tax law, it adapted its concept of charity whole cloth from this established body of precedent. Thus, when the IRS published regulations in 1959 stating that charitable is to be understood according to

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15. Eastern Kentucky Welfare Rights Ass'n v. Simon, 506 F.2d 1278, 1288-89 (1974), vacated on other grounds, 426 U.S. 26 (1976).

16. Eastern Kentucky, 506 F.2d at 1288. As explained by the leading contrary opinion, hospitals "argue that . . . the universal availability of insurance . . . make[s] the idea of a hospital solely supported by philanthropy an anachronism. We believe this argument itself exposes the weakness in the [hospitals'] position. It is precisely because such a vast system of third-party payers has developed . . . that the historical distinction between for-profit and nonprofit hospitals has eroded." Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 274 (Utah 1985).

its "generally accepted legal sense . . . as developed by judicial decisions,"[17] and the Supreme Court reiterated in 1983 that "underlying all relevant parts of the Code . . . [are] certain common-law standards of charity,"[18] they were referring to the law of charitable trusts, specifically, the 1601 Statute of Charitable Uses which first codified the legal concept of charity.[19] Although the Statute of Charitable Uses does not explicitly establish that trusts to promote health care are charitable,[20] other enactments from about the same time included hospitals within the scope of

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17. Treas. Reg. § 1.501.(c)(3)-1(d)(2) (1959).

18. Bob Jones University v. U.S., 461 U.S. 574, 586 (1983).

19. Id. at 588 ("The origins of [the] exemptions lie in the special privileges that have long been extended to charitable trusts."); Bittker & Rahdert, The Exemption of Nonprofit Organizations from Federal Income Taxation, 85 Yale L.J. 300-01 (1976); Thompson, The Unadministrability of the Federal Charitable Tax Exemption: Causes, Effects and Remedies, 5 Va. Tax Rev. 1, 12+n13 (1985); Liles & Blum, Development of the Federal Tax Treatment of Charities, 39 Law & Contemp. Probs. 6 (Autumn 1975) at 20-21. Further support for this proposition is found from the fact that Congress patterned the original income tax after the existing English model, Bob Jones University v. U.S., 461 U.S. 574, 589 n.13 (1983) ("the list of exempt organizations appears to have been patterned upon English income tax statutes"), and, in the celebrated case of Commissioners v. Pemsel, [1891] A.C. 531, the House of Lords established just three years before the 1894 Congressional enactment that the same concept of charity would prevail throughout British law, both for purposes of the law of charitable trusts and for tax exemption. See Belknap, The Federal Income Tax Exemption of Charitable Organizations: Its History and Underlying Policy, in Filer Commission Papers, at 2031; L. Sheridan & G. Keeton, The Modern Law of Charities 29 (3d ed. 1983) (charity has "a common meaning for all purposes"); id. at 299 ("There is, in English law, only one definition of a charity. If an institution is a charity for purposes of general activity and administration, it is a charity for income tax purposes.").

20. It refers to the "relief of aged, impotent [disabled] and poor people" and the "maintenance of sick and maimed soldiers and mariners" as charitable purposes.

charitable trusts.[21] Following these and other authorities, the Restatement (second) of Trusts and similarly authoritative treatises uniformly hold that a "trust for the promotion of health is charitable."[22]

Despite the unanimity of authority that charitable trust law views the promotion of health as per se charitable, there are considerable theoretical difficulties in blithely extending this per se approach to tax exemption. The primary deficiency is encountered under the deservedness criterion. Simply put, because charitable trust law serves a wholly different purpose than the charitable exemption, the trust

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21. Several antecedents to the statute that provided more limited protection to charitable trusts confirm that health care was an established charitable purpose by 1601. One act early in the reign of Henry V created a charitable commission to attempt to remedy the decay of hospitals that had been established by wealthy benefactors "for the sustenance of impotent persons, lazars, witless men, poor women with child, and the poor generally." In 1572, Parliament passed another act to assist benefactors "who wished to found hospitals and almshouses." Further, an act in 1597 "relieved founders of hospitals, almshouses, and houses of correction" from the necessity of "obtaining a special royal license or an act of Parliament to achieve incorporation." W. Jordan, Philanthropy in England 1480-1660, at 114-15 (1959). See also M. Fremont-Smith, Foundations and Government 26 (1965) (discussing the latter two statutes).

22. § 372. See also 4A A.W. Scott & W. F. Fratcher, The Law of Trusts (1989), at § 368 [hereinafter, Scott on Trusts] ("So too, it is well settled that the promotion of health is a charitable purpose."); id. at 191-93 & n. 1 ("A trust for the promotion of health is a charitable trust" even though the statute mentions only soldiers and mariners; citing "numerous" cases); G. Bogert, Trusts § 62 (6th ed. 1987); Bromberg, The Charitable Hospital, 20 Cath. U.L. Rev. 240, 244 (1970) [hereinafter Bromberg, Charitable Hospital]; Bromberg, Financing Health Care, Financing Health Care and the Effect of the Tax Law, 39 Law & Contemp. Probs. at 167 (1975) [hereinafter Bromberg, Financing Health Care] (citing cases to show that "English law has long interpreted the charitable purpose enumerated in the preamble . . . in the disjunctive, thereby permitting a charitable trust to operate for the benefit of sick or aged persons without reference to their financial condition").

definition of charity does not properly identify those activities that deserve tax support. Charitable trust law's primary goal is to protect assets which founders (usually in wills, but sometimes inter vivos) choose to devote to worthy causes. Trust law provides this assistance by creating more rigorous enforcement mechanisms to police abuses of these socially worthy trusts (such as authorizing attorneys general to bring enforcement actions) and by exempting such trusts from some of the technical requirements that apply to ordinary trusts.

These comparatively minor concerns allow trust law to consider as charitable any purpose that provides any conceivable social benefit because it costs the public little simply to enforce a benefactor's disposition of his own assets. As a consequence, charitable trust law covers a far broader subject matter than is deserving of a tax exemption.[23] Courts, for example, have sustained as charitable a bequest for purposes as trivial as establishing a home for animals, promoting vegetarianism, and "provid[ing] fishing facilities for the inhabitants of a town."[24] The law of charitable

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23. This is especially so recognizing that a trust law precedent established by the decision of a single donor would have the effect of exempting an entire industry from taxation. Suppose, for instance, that a successful veterinarian, enthralled with her life's profession, left her wealth in trust to promote the practice of veterinary. Such a trust would be sustained as charitable. See London Univ. v. Yarrow, [1857] 1 De G. & J. 72 (upholding a trust to establish a veterinary institute) [cited in M. Chesterman, Charities, Trusts and Social Welfare at 168 (1979). Thereafter, any animal hospital proprietors who chose to organize as a legitimate nonprofit operation would qualify for exemption from federal income tax, local property tax, and possibly a host of state income and sales taxes, even if the organizers relied entirely on borrowed capital and charged full market rates to all of their customers.

24. Restatement, Restatement (Second) of Trusts § 374 (1959), comments c & f; Scott on Trusts, supra note 22, at 210-11.

trusts is willing to take this generous view of the subject matter it protects because no societal resources are committed to funding the trust, in stark contrast to the effect of a tax exemption. Given the relatively low stakes, trust law is able simply to rely for subject-matter limitation on the decision of a public-spirited founder to give to whatever purpose she desires.[25]

It seems absurd, then, for purposes of the tax exemption, to adopt whole cloth this same sweeping concept of charity -- one that encompasses essentially any activity that benefits the public at large in any manner -- where the public cost is billions of dollars in lost tax revenue each year. A definition of charity that contains essentially no substantive limiting principle and thus imposes minimal subject matter restrictions on which activities are exempt (only restrictions on how the activity is organized and carried out), must be rejected for tax exemption purposes because it contains absolutely no test for when the exemption is deserved or is proportionate to the benefit society receives. Consequently, virtually everyone who has given thought to

25. As one court has explained:

> What is the tribunal which is to decide whether the object is a beneficent one? It cannot be the individual mind of a Judge . . . . On the other hand, it cannot be the vox populi, for charities have been upheld for the benefits of insignificant sects, and of peculiar people. It occurs to me that the answer must be--that the benefit must be one which the founder believes to be of public advantage, and his belief must be at least rational, and not contrary either to the general law of the land, or to the principles of morality. A gift of such a character, dictated by benevolence, believed to be beneficent, devoted to an appreciably important object, and neither contra bonos mores nor contra legem, will, in my opinion, be charitable in the eye of the law.

In re Cranston, [1898] 1 I.R. 431, 446-47, quoted in Scott on Trusts, supra note 22, at 229.

the matter recognizes that some substantial subject matter limits must be imposed on the charitable exemption.[26] Two competing theories are presently dominating the debate: a return to the charity care requirement, or the articulation of some, more amorphous "community benefit" that nonprofit hospitals provide.

III. Charity Care and the Relief of Government Burden

A. Deficiencies in Applying the Theory to Nonprofit Hospitals.

The conventional alternative to the position that health care is a per se charitable enterprise is that only those organizations devoted to serving the poor are eligible for the charitable exemption, in keeping with the popular conception of charity. The essence of this theory is that tax exemption exists as a quid pro quo for the production by the private, nonprofit sector of goods and services which, absent exemption, would be the burden of government -- here, treatment of uninsured patients.

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26. The inadequacy of a concept of charity that mechanically refers to trust law precedents is acknowledged at least implicitly by the failure to follow it consistently, even by those who seemingly advocate this approach. Close analysis of IRS decisions in the health care field, for example, shows that the federal government does not take seriously in practice the per se characterization that it espouses in theory. Essentially, the IRS has developed through a multitude of rulings the position that only inpatient hospital services are exempt -- not health care per se -- for it consistently refuses to extend the exemption to physician groups, and it imposes more exacting exemption requirements on HMOs, nursing homes, and other nonhospital health care services. Colombo, <u>supra</u> note 6. Thus, for instance, the IRS has ruled that a nonprofit pharmacy is flatly disqualified for charitable exemption even though supplying drugs is just as intimately connected with health care as administering them (and even though pharmacy sales <u>within</u> a hospital are exempt). Federation Pharmacy Services v. Comm'r., 72 T.C. 687 (1979) <u>aff'd</u>, 625 F.2d 804 (8th Cir. 1980).

The relief of government burden theory encounters major problems under the deservedness criterion when applied to nonprofit hospitals. In order to meet this criterion, the health care sector must be able to show that the service on which exemption is based (free care for the poor) would be irreplaceably reduced without the subsidy. While the empirical evidence establishes that nonprofit hospitals do give away a significant portion of their services,[27] for-profit institutions do so as well in the form of write-offs for bad debts. Because for-profit hospitals exist as a ready substitute for nonprofits, in order for the relief of government burden theory to meet the deservedness criterion nonprofit hospitals must provide an increment in uncompensated care greater than the proportion of free care provided by for-profit hospitals. This comparison with for-profit hospitals is necessary under the government burden theory because, absent nonprofits, the full amount of their free care would not fall on the government.

A second justification for deducting from the nonprofit's free care ledger the proportionate amount of free care rendered by for-profits is that a certain portion of free care by nonprofits is not voluntarily given away in the spirit of charity but merely reflects "a business decision that the cost of attempting to collect on a debt is greater than the potential gain."[28] This bad debt component of uncompensated care is an

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27. J. Bennett & T. DiLorenzo, supra note 9, at 3 (quoting the American Hospital Association as claiming that nonprofit hospitals gave $22 billion in free medical care to the poor over the past five years).

28. Simpson & Lee, Nonprofit Community Hospital Tax Exemption: Issues for Review (West. Consortium for the Health Professions 1987), at 10-11, reprinted in UBIT (continued...)

ordinary cost of doing business borne by nonprofits and for-profits alike. Deducting from nonprofits' free care figure the proportion of free care rendered by for-profit hospitals is justifiable under the approximation that essentially all for-profit free care constitutes bad debt (which is consistent with the view that those in the nonprofit sector take of proprietary hospitals).[29] Using this measure of deservedness, the

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28.(...continued)
Hearings, Unrelated Business Income Tax: Hearings Before the Subcomm. on Oversight of the House Comm. on Ways and Means, 100th Cong., 1st Sess. 11 (1987) [hereinafter UBIT Hearings], at 769.

29. Accordingly, the term "charity care" is generally understood to mean (and is used in this text to signify) services for which the hospital intends no compensation from the outset, whereas "uncompensated care" or "free care" means bad debts plus true "charity care." Nevertheless, of the two pending federal bills, only the Donnelly bill would make this measure correctly. The Roybal bill counts all uncompensated care in the aggregate toward meeting a hospital's tax exemption requirement, including the shortfalls between the amount hospitals would like to bill patients and the amount they voluntarily receive from government programs -- so-called "contractual adjustments." This latter amount is mistaken since for-profit hospitals treat the same proportion of Medicare and Medicaid patients as do nonprofits, and since they also negotiate discounts with private insurance companies. Therefore, these contractual adjustments generally are the same for both sectors and so it is appropriate to disregard them in these calculations, as most authorities agree. See Chisago Health Serv. v. Com'r of Revenue, 462 N.W.2d 386 (Minn. 1991).

Another complicating factor is what measure to use for the value of charity care: charges or costs, and if costs, average or marginal. Most studies use the hospital's normal charge structure, which is the most generous measure of the hospital's sacrifice, but some analysts complain that this disproportionately benefits proprietary hospitals since they tend to have a somewhat higher mark-up of charges over costs. See Lewin & Associates, Setting the Record Straight: The Provision of Uncompensated Care by Not-For-Profit Hospitals 1215 (1988) (unpublished). If costs are to be used, though, it seems indefensible to use average rather than marginal costs. See Hyman, Letter to Editor, 319 New Eng. J. Med. 1485 (1988) (responding to Lewin). The more appropriate cost measure -- marginal costs -- would greatly increase the level of charity care needed to justify the exemption. Therefore, nonprofits may have to live with the imperfection inherent in the charge measure. (One possible adjustment is to discount the charge measure by the hospital's average negotiated discount with insured patients, but this should have no great effect since both sectors grant approximately the same discounts.)

existing empirical evidence is inconclusive. It indicates that, on a national level, "most voluntary and proprietary hospitals [are] very similar in their willingness to treat patients freely. . . . [F]or the nation as a whole there appear[s] to be only small differences between voluntary and proprietary hospitals in access to care."[30] What differences exist appear to be narrowing, under the influence of cost containment pressures from private and government insurers.[31] However, these aggregate, national comparisons have been criticized as unrepresentative because of the uneven distribution of for-profit hospitals across the country. In a study commissioned by the Volunteer Trustees of Not-for-Profit Hospitals Foundation, Lewin & Associates observed that for-profits are concentrated in southern and western states, which tend to have much less generous Medicaid programs for the poor and, thus, a much greater demand for indigent care by private hospitals, whereas nonprofit hospitals,

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30. J. Hollingsworth & E. Hollingsworth, Controversy About American Hospitals: Funding, Ownership and Performance 106-07 (1987). The leading study found "no clear difference between for-profits and not-for-profits," the former supplying 3.7 percent of their care for free in 1983 and the latter 4.2 percent. By comparison, the figure for public hospitals is 11.5 percent. Institute of Medicine, supra note 12, at 102 ("Overall, the national data from AHA surveys provide weak support for the hypothesis that for-profit hospitals do less than not-for-profit hospitals to meet the needs of patients who are unable to pay."). A more recent analysis by the Prospective Payment Review Commission, based on 1984-1989 data from AHA surveys, found that nonprofits spent 4.6% of their total expenses on uncompensated patient care, as compared with 4.3% of forprofit hospital expenses.

31. Thus, the difference in 1983, one year prior to the enactment of Medicare DRGs, was .5 %, but only .3 % in 1985, one year after DRGs. Institute of Medicine, supra note 30, at 102. More recently, the AHA estimated that, in 1988, nonprofits provided .4% *less* of the revenues in uncompensated care than did for-profit hospitals (4.8% versus %.2%). GAO Report, U.S. Government Accounting Office, Nonprofit Hospitals and the Need for Better Standards for Tax Exemption, Rep. No. 90-84, at 2 (May 30, 1990), reprinted in Medicare & Medicaid Guide ¶ 38,608 [hereinafter GAO Report], at 2.

which are much more evenly dispersed, have their national uncompensated care average diluted by the hospitals in states where there is much less need for private hospital charity. This study demonstrates that, in a selection of four states where for-profits compete head-on with nonprofits, the nonprofit hospitals do outperform proprietary institutions at a level ample to meet the deservedness criterion.[32] Accordingly, the existing studies give mixed support for the proposition that voluntary hospitals generally are providing a service (charity care) which would be irreplaceably reduced in the absence of a tax subsidy.

The doubts that remain under the relief of government burden theory on the deservedness score are settled by nonprofit hospitals' poor performance in relation to the proportionality criterion. Here, the question is not only whether services to the poor would be irreplaceably reduced absent a tax subsidy, but also, whether the subsidy roughly matches the level of deservedness, that is, whether the value of deserving services is at least equal to the value of the tax exemption.[33]

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32. Lewin, Eckeles & Miller, The Provision of Uncompensated Care by Not-for-profit Hospitals, 318 New Eng. J. Med. 1212, 1213-14 (1988) (in Florida, North Carolina, Tennessee and Virginia, the uncompensated care burden is 50 to 90 percent higher at nonprofit hospitals than at investor-owned hospitals). Another rehabilitative study found that, measured by number of patients rather than amount of foregone revenue, nonprofits served 2 percent more of their patients for free than for-profits between 1979 and 1984 (approximately 4 % vs. 6 %). Frank, Salkever, & Mullan, Hospital Ownership and the Care of Uninsured and Medicaid Patients: Findings from the National Hospital Discharge Survey, 14 Health Policy 1 (1990). See generally B. Gray, The Profit Motive and Patient Care 99-105 (1991) (discussing these and other studies).

33. This essentially is the approach proposed by the Roybal bill pending in Congress. It would require a hospital-specific measurement of the value of the exemption and then would require hospitals to show that they paid back 85 percent of this amount in the

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Unfortunately, much of the uncompensated care data that researchers have generated in recent years is not directly responsive to an analysis of the proportionality criterion because it does not account for the size of the tax relief given nonprofit hospitals. From the fragmentary evidence that is available, though, it appears that nonprofit hospitals do not provide incremental free care in an amount that matches the foregone tax revenues.[34] The only extensive study that directly makes the required measurement found that, by conservative estimate, California nonprofit hospitals in 1978 gave $100 million in charity care as against $440 million of foregone federal and state tax revenue.[35]

33.(...continued)
form of uncompensated care or the costs of certain community services. (The remaining 15 percent is forgiven on the assumption that hospitals provide certain unmeasurable benefits.) The Donnelly bill, in contrast, would adopt the legislative presumption that the exemption is worth 5 percent of a hospital's gross revenues. This is an attractive solution to the complexities of measuring hospital-specific exemption values, and it is the operating rule-of-thumb that prevailed within the IRS prior to the 1969 revenue ruling.

34. Falcone, America's National Health Insurance Program: The Political Economy of Tax Expenditures on Hospital Care 10 (1988) (whatever comparative advantage nonprofits have on free care, "the amount uncovered will not offset even conservative estimates of hospital tax expenditures").

35. Simpson & Lee, supra note 28, at 11. The measure of charity care used is the excess of uncompensated care (valued at each hospital's standard charges) provided by nonprofits over that provided by for-profits. Lost taxes are based on both patient and nonpatient revenue. The figure for charity care does not account for the large discount (averaging 19%) that California hospitals give to most payors, nor does it account for the $16 million in nonearmarked gifts and subsidies that California nonprofits received that year. This study's measure of foregone taxes has been criticized for using the maximum corporate tax rate, unadjusted for tax credits and deferrals, which substantially reduce the income tax burden at most for-profit hospitals. Lewin & Associates, Setting the Record Straight: The Provision of Uncompensated Care by Non-for-Profit Hospitals 28 (1988) (unpublished). However, these flaws do not affect the study's estimate of property taxes foregone, and they are not sufficient to make up the four-fold differential between tax relief and charity care.

The experience in California may not represent the nation generally because it has an atypically generous Medicaid program, which reduces the demand for charity care. Comparisons in some other states reveal that nonprofit hospitals provide significantly more free care than for-profits,[36] but these comparisons do not measure the magnitude of this increment against the amount of tax loss. This comparison can be approximated by adding the percentage of revenue for-profits forego by providing free care to the percentage of revenue they pay in taxes. (This assumes that nonprofits are relieved from approximately the same proportion of taxes as for-profits pay.) The proportion of free care nonprofits provide would then have to equal or exceed this sum. The result, on a national level, does not support nonprofits,[37] and the scattered data on a local and individual-hospital level is equally unavailing.[38]

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36. Lewin, Eckeles & Miller, supra note 32, at 13 (1988) (the uncompensated care burden in several states is 50 to 90 percent higher at nonprofit hospitals than at investor-owned hospitals: 7.6% vs. 4.9% in Florida; 6.7% vs. 4.2% in North Carolina; 10.5% vs. 4.8% in Tennessee; and 7.0% vs. 3.7% in Virginia).

37. For the four largest investor-owned multihospital companies (HCA, Humana, NME, and AMI), in 1983, "the sum of income taxes and uncompensated care (5.6 percent of gross revenues) exceeded the 4.1 percent of gross revenues that not-for-profit hospitals accounted for as uncompensated care." Institute of Medicine, supra note 30, at 12. Even this unfavorable comparison fails to account for property taxes paid by the proprietary hospitals, which would increase the nonprofit deficit substantially more.

38. A study of 11 nonprofit hospitals and 4 for-profits in Utah found that, in 1986, the nonprofits provided only one-third the amount of uncompensated care that for-profits incurred in free care plus taxes (3.2 percent versus 10.3 percent, of net revenue). Pace Management Services, unpublished data.

For five selected states (CA, FL, MI, IO, and NY), the GAO compared uncompensated care by nonprofit hospitals with their estimated income tax liability and found that, by this measure, only 15% of the hospitals failed to pay back their exemption. GAO Report, supra note 31, at 12. However, this comparison failed to account for the value of the property tax exemption, the charitable deduction, or tax-exempt bond

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B. Deficiencies As an Exclusive Theory of Exemption.

The failure of voluntary hospitals to measure up under the relief of government burden theory should not be conclusive of their claim to exempt status because the charity care standard is a sufficient, but not exclusive, basis for the exemption. In Commissioners v. Pemsel, Lord McNaughten captured centuries of precedent in rejecting the relief of poverty as the sole ground for charitable classification.[39] Nor has the concept of aid to the poor dominated the law of charity in more modern times. The bedrock charitable purposes, religion and education, serve the rich as well as the poor. Even hospitals during much of the time they were considered classic instances of charitable organizations were not pure charities in the popular sense of serving predominantly the poor. As Rosemary Stevens has explained:

> Voluntary hospitals were never really charities. . . . Sometimes one thinks back over hospital history and there is this vague notion that there was once something called a voluntary hospital, which the leading donor of the town gave to the community and all it did was to give away care. This is absolutely untrue. . . . We have always had a very entrepreneurial voluntary sector in this country with respect to the attraction of private patients. . . . They were marketing their services very early, looking to government agencies for support and lobbying vigorously for such money.[40]

38.(...continued)
financing. It also failed to measure nonprofit uncompensated care against a base from representative for-profit hospitals. Therefore, this report fails to make the proper comparison.

39. See generally M. Chesterman, supra note 23, at 9 (1979) (discussing the "distortion" of the charity concept that occurred during the 18th century).

40. Stevens, Voluntary and Governmental Activity, 3 Health Matrix, No. 1 (Spring 1985), at 26, 28. See also Southern Methodist Hospital v. Wilson, 77 P.2d 458, 460-61 (1938) (charitable hospital rendered "very little free medical or hospital attendance to anyone"); City of Richmond v. Richmond Mem. Hospital, 202 Va. 86, 116 S.E.2d 79, 82 (1960) ("The
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One might attempt to rebut these historical authorities that diminish the relief-of-poverty foundation of charity by observing that they only establish that charities need not exclusively serve the poor; none "supports the much bolder proposition that a nonprofit hospital is a charitable organization even it if provides no care for the poor."[41] Nevertheless, the law of charities has long held that charitable trusts need

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40.(...continued)
framers of the (1902) Constitution presumably knew that such charitable organizations as YMCA's, asylums, and hospitals customarily charge for services"); R. Stevens, In Sickness and in Wealth: American Hospitals in the Twentieth Century 23-24 (1989) [In Sickness and in Wealth] ("Income from paying patients . . . represented almost half of the budgets of nonsectarian private [nonprofit hospitals] in 1904 and almost three-fourths that of the 'ecclesiastical' institutions."); D. Rosner, A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York 1885-1915 (1982), at 8-9, 36-61 (various economic and technologic forces transformed N.Y. hospitals from classic charities to business organizations during the 1890s); Mancino, Income Tax Exemption of the Contemporary Nonprofit Hospital, 32 St. Louis U.L.J. 1057 (1988); Jones & Du Val, What Distinguishes the Voluntary Hospital in an Increasingly Commercial Health Care Environment?, in In Sickness and in Health: The Mission of Voluntary Health Care Institutions 209 (1988) (in 1904, "as much as 43 percent of [nonprofit] hospitals' income came from paying patients and 30 percent from government. In fact, for much of their history, voluntary hospitals have had to strive to be businesslike in order to survive and prosper."); Hollingsworth, supra note 30, at 12 (at the time the IRS issued Rev. Rul. 56-185, three-fourths of the patients at nonprofit hospitals were insured); id. at 93 (in 1935, voluntary hospitals "in a number of [small] midwestern cities . . . provided only 10 percent of their services to nonpaying patients"); P. Starr, The Social Transformation of American Medicine 146 (1982) ("in a matter of decades, roughly between 1870 and 1910, hospitals moved . . . from charities, dependent on voluntary gifts [to] market institutions, financed increasingly out of payments from patients"); id. at 160-61 (at the turn of the century, "the old rhetoric of charitable paternalism was superseded by a new vocabulary of scientific management and efficiency"). Paul Starr further explains that voluntary hospitals did not evolve directly from almshouses, as is often supposed; instead, the almshouses were the foundation of the public hospital system whereas the voluntary sector arose from the more particularistic desires of ethnic and religious groups. Id. at 150, 169-72.

41. Note, Hospitals, Tax Exemption, and the Poor, 10 Harv. C.R.C.L. Rev. 653, 679 (1975). See also Simpson & Strum, supra note 3.

not serve the poor at all (or, at most, only in token amounts),[42] and several of the classic instances of tax-exempt organizations in modern times serve the rich almost exclusively (the performing arts and prep schools, for instance).[43] Accordingly, a conception of charity limited to free services to the poor would radically alter the current scope of the exemption.

IV. Community Benefit and the Nonprofit Ethic.

A. The Merits of the Community Benefit Theory

Because a successful theory of charitable exemption must encompass more than free services to the poor and the relief of government burden, nonprofit organizations should be allowed to demonstrate that they earn their subsidy by benefitting the community in other ways. The nonprofit hospital sector maintains that it benefits the community in a variety of ways that are less obvious or tangible than providing charity care -- by providing a service whose quality is superior to that of

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42. For holdings and statements to this effect in the context of hospitals, see In re Resch's Will Trusts, [1969] 1 A.C. 514, 544; Evangelical Lutheran Good Samaritan Society v. Board of City Commissioners, 219 N.W. 900, 909 (N.D. 1974) ("an institution which is engaged in the charitable purpose of supplying care and attention to the aged . . . does not lose its charitable character . . . because it has never provided care for a patient on a free basis"); Southern Methodist Hospital v. Wilson, 77 P.2d 458, 462 (1938) ("If the purpose of the institution is one which is recognized in law as charitable, . . . we think the institution is properly characterized as a charitable one, notwithstanding the fact that it charges for most, if not all, of the services which it may render"); Restatement, supra note 22, at 255, § 376, comment c; Scott on Trusts, supra note 22, at 194.

43. B. Hopkins, B. Hopkins, The Law of Tax-Exempt Organizations 45 (4th ed. 1983), at 80-81; Simon, supra note 14, at 85 (property tax exemption historically applied to "schools for the sons of gentlemen").

investor-owned hospitals, by being more responsive to community needs than for-profits, or by fostering desirable medical values in ways that proprietary medicine does not. Both of the pending federal bills recognize this dimension, at the same time that they impose charity care standards.[44]

The community benefit theory is appealing on several levels. Unlike the per se theory drawn from trust law, the community benefit theory does not automatically validate the exemption for any nonprofit activity.[45] Instead, this theory seeks to identify those nonprofit activities in which we value the special quality or ethic that

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44. The Roybal bill allows up to 50 percent of the value of the exemption to be paid back in the form of explicit or implicit community benefit services. The Donnelly bill provides an alternative qualifying route that nonprofit hospitals are exempt if they devote 10 percent of their budgets to carefully defined community services. Paradoxically, though, the Donnelly bill does not allow hospitals to qualify based on the alternatives that they are educational or research institutions. However, the Donnelly bill is much more liberal than it first appears, for it contains certain obscure provisions that would allow the vast bulk of hospitals to qualify simply by serving a reasonable number of low-income Medicaid and Medicare patients. See generally Colombo & Hall, The Future of Tax Exemption for Nonprofit Hospitals and other Health Care Providers, forthcoming in Health Matrix.

45. Therefore, it comes close to meeting the deservedness criterion. The community benefit theory also nicely addresses the proportionality criterion. Because this theory postulates that a benefit inheres in all of the organization's services, a subsidy matched to the size of the operation -- as the income tax and property tax exemptions generally are -- is well calibrated to the extent of deservedness under this theory. The more property a nonprofit hospital has and the more income it earns, the more superior services it is (in all probability) rendering to the community. For the same reason, this theory meets the universality criterion to a degree, since it seeks to justify both types of exemption. It also has the potential for explaining a number of the restrictions on these exemptions, such as the prohibition on lobbying and the restraint on unfair competition, since these restrictions apparently are designed to protect the public's interest. This theory also comports with the historical consistency theory to the extent that it draws from the notion of public benefit that exists in charitable trust law.

nonprofit enterprise offers.[46] In the hospital context, tax exemption proponents maintain that nonprofits support physician education and medical research, they provide a full range of services regardless of each service's profitability, they support community health education and preventative services such as childbirth classes, meals for the elderly, and immunization clinics, and, more amorphously, they claim to foster an ethos that is more conducive to proper medical practice than that which prevails in profit-oriented environments.

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46. Perhaps the most forceful statement of the community benefit theory, made in the context of religious institutions, is that nonprofit institutions promote values

> such as benevolence, charity, generosity, love of our fellowman, . . . and all those comely virtues and amiable qualities which clothe life 'in decent drapery' and impart a charm to existence, . . . furnish a sure basis on which the fabric of civil society can rest and without which it could not endure. Take from it these supports, and it would tumble into chaos and ruin. Anarchy would follow order and regularity, and liberty, freed from its restraining influence, would soon degenerate into the wildest license, which would convert the beautiful earth into a howling pandemonium fit only for the habitation of savage beasts and more savage man."

Trustees of the First Methodist Episcopal Church v. City of Atlanta, 76 Ga. 181, 193 (1886). Professor Atkinson provides another, more measured, but particularly clear description of this view (which is not his own):

> Charities are said to provide what I will call "meta-benefits," benefits that derive not from what product is produced or to whom it is distributed, but rather from how it is produced or distributed. Traditional theory has identified two ways charities provide such "meta-benefits." In the first place, they are said to deliver goods and services more efficiently, more innovatively, or otherwise better than other suppliers. In the second place, their very existence is said to promote pluralism and diversity, which are taken to be inherently desirable. This theory . . . rests on the fairly explicit premise that not only particular goods and services, but also particular modes of supplying them, can be identified as especially good for the public under neutral principles administrable by a government agency, the Internal Revenue Service, subject to judicial review.

Atkinson, Altruism in Nonprofit Organizations, 31 B.C.L. Rev. 501, 605+n06 n.266 (1990).

B. Deficiencies in the Community Benefit Theory.

Closer examination of this theory, however, reveals that it too suffers from crippling defects, primarily under the deservedness and proportionality criteria. With respect to deservedness, we must ask, first, why voluntaries are to be preferred to proprietaries, and, second, why the exemption is needed to secure this preference. These two components of the inquiry mirror the "worthiness" and the "neediness" components of the deservedness criterion. Scholars of nonprofit enterprise have developed several competing theories to explain why nonprofit hospitals have historically predominated over for-profits. Obviously, those theories that find no inherent benefit in the nonprofit form directly refute the worthiness component of the community benefit theory, while those that support the notion of social benefit inherent in the nonprofit form still must pass the "but for" (neediness) component of the deservedness criterion.

1. Theoretical Literature

Theories that are neutral or adverse to nonprofits find no good reason to prefer this organizational form in medicine, observing that health care is no more ethically incompatible with profit motivation than are other essential goods and services such as food, shelter, transportation, and pharmaceuticals. These nonprofit skeptics offer essentially two rationales for the dominance of the nonprofit form. First, some of these theorists see the explanation for the prevalence of nonprofit hospitals simply in the subsidy conferred by the tax exemption itself and the variety of other forms of unjustified favoritism exhibited by the law.[47] Others maintain the "parasitic" view that nonprofit hospitals proliferate because doctors prefer nonprofits for reasons of economic self-interest that are inconsistent with socially optimal patient care. The two principal theories that rely on physician self-interest are the "physician

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47. Bays, Why Most Private Hospitals are Nonprofit, 2 J. Policy Anal. & Mgt. 366, 377 (1983) ("hospital planning agencies appear to have a bias against for-profit hospitals, according to anecdotal evidence."); id. at ("In some states, . . . Blue Cross originally refused reimbursement to for-profit hospitals or reimbursed them at a lower rate than [] nonprofit hospitals," a pattern that the original Medicare reimbursement formula copied). See generally, Clark, Does the Nonprofit Form Fit the Hospital Industry, 93 Harv. L. Rev. 1474 (1980) (suggesting repealing property tax exemption for hospitals). The available empirical evidence fails to either confirm or deny the hypothesis that the exemption alone accounts for a significant portion of nonprofit hospital market share. The only study on point found, using 1975 data, that the property tax exemption has a modest differential effect (accounting for 6.3% of the nonprofit market share in an average state) while the corporate tax exemption has almost no effect. Hansmann, The Two Independent Sectors, A Paper Presented at the Independent Sector Spring Research Forum 5 (Mar. 17, 1988) (unpublished manuscript on file with the Washington Law Review) [hereinafter Hansmann, The Two Independent Sectors] at 71. However, the quality of the data supporting these findings was such that neither meets standard tests for statistical significance. Id.

control theory"[48] and the "managerial prestige theory."[49] These differ in that the first posits physician financial interest as the primary determinant of hospital organization and operation (physicians preferring nonprofits because they are easier to gain control of) whereas the second views physician interest as derivative of nonprofit managers' utility function, in that physicians prefer management whose principal goal is to expand the facilities, however excessively.[50]

Theories that support nonprofit enterprise in medicine maintain that this organizational form predominates because it is preferred by patients and doctors for socially valued reasons. One such theory is drawn from Professor Hansmann's pioneering work in which he explained (for nonprofits generally) that patrons tend to favor this organizational form when complex and difficult-to-evaluate services are involved. Prime examples include day care and education.[51] Hansmann's trust theory does not fit hospitals readily is that patients rarely undertake to evaluate hospital services independently. Instead, they rely heavily on their physicians, for whom the judgment is less opaque. Nevertheless, doctors also may have socially valued reasons to prefer hospitals, reasons equivalent to consumer trust. According

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48. Pauly & Redisch, The Not-for-Profit Hospital as a Physicians' Cooperative, 63 Am. Eco. Rev. 87 (1973). See Blumstein & Sloan, Antitrust and Hospital Peer Review, 51 L. & Contemp. Prob. 7, 19-20 (1988).

49. Newhouse, Toward a Theory of Nonprofit Institutions: An Economic Model of a Hospital, 60 Am. Eco. Rev. 64 (1970).

50. See generally P. Feldstein, Health Care Economics 268+n69 (1979), at 212-23 (2d ed. 1983).

51. Hansmann, supra note 47; B. Weisbrod, The Nonprofit Economy 115 (1988), at 6, 23.

to one body of scholarship, doctors (and by derivation, patients) have good reason to promote practice environments that foster a professional ethos that binds them to ethical norms of fiduciary responsibility. Nonprofits are alleged to be "superior from the point of view of professional ideology and practice" because "[m]any features that are generally considered to be specific characteristics of the professions -- altruism, autonomy, and emphasis on quality of service, and a certain anti-market and anti-bureaucratic ethos -- have also been singled out, quite independently, as the raisons d'etre of nonprofit institutions."[52] Nonprofit hospitals lay more stress on these values because they tend to attract through a natural sorting process the managers whose values are in sync with those of the founders'.[53] For these reasons, "the nonprofit nature of a service organization tends to reinforce the fiduciary component in the relationship with clients, thus increasing professional authority and autonomy."[54] This professional ethic theory contrasts with the physician control theories discussed above in that it posits that physicians desire to control the clinical as opposed to the financial aspects of practice.

While this last explanation supports the notion that there is an inherent social benefit in the nonprofit form, it fails to satisfy the neediness (but for) component of the deservedness criterion. The reason for this failure is that why nonprofits exist is a

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52. Majone, Professionalism and Nonprofit Organizations, 8 J. Health Pol., Pol'y & Law 640 (1984). (1984).

53. See D. Young, If Not for Profit, for What? (1983) (developing this sorting theory in some detail).

54. Majone, supra note 52, at 640, 654.

fundamentally different question than whether they should be exempt, a point that many writings on the subject fail to recognize. Even if we were assured that the favorable view of nonprofit hospitals is accurate (and we could quantify that it produces sufficient net benefits to earn the exemption's subsidy), the deservedness criterion would still not be met because there is no reason a priori to believe that nonprofits would not continue to predominate absent the subsidy. Indeed, there is every reason to suppose to the contrary. The favorable view holds that nonprofits prevail in medicine because this is the socially valued preference of doctors and patients. But if there is no obstacle to effectuating these preferences, then there is no reason to subsidize them.[55] In these circumstances, a subsidy is a complete windfall. In sum, the community benefit theory fails -- not only because of the difficulties it encounters in documenting the amorphous nature of the claimed benefits, but more so because it is entirely insensitive to whether a public subsidy is necessary to produce those benefits. Obstacles to the optimal provision of some nonprofit goods and services may exist, but this theory does not attempt to identify them.

2. Empirical Literature

The conclusion that the positive theories of nonprofit dominance fail the deservedness criterion is bolstered by an extensive literature exploring the empirical

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55. Professor Jensen made this very point graphically clear over 50 years ago:

> [T]he service deserving [a tax subsidy] must be incapable of being fostered adequately on a commercial, quid pro quo basis. . . . Transportation is a necessary public service, but it is not, ordinarily, necessary to subsidize it. The state has no interest in expanding it beyond the point where the beneficiaries will pay for it.

Jensen, supra note 14, at 148.

dimensions of this nonprofit/for-profit hospital debate. By and large, this literature demonstrates that the two hospital industry sectors are remarkably similar in their performance characteristics. The overriding consensus of these studies is that "available evidence on differences between for-profit and not-for-profit health care organizations is not sufficient to justify a recommendation that investor ownership of health care organizations be either opposed or supported by public policy."[56] For the most significant measures of hospital performance -- quality and cost -- there is little or no difference between the two sectors.[57] Hospital behavior is remarkably uniform because the sources of financing for hospital care for each sector are essentially identical: private and public health insurance. The operational incentives created by these sources of revenue tend to swamp whatever contrasting incentives exist by virtue of organizational form.

Defenders of the voluntary sector respond that the assertions of similarity are marred by the studies' controlling for an excessive number of variables in a manner

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56. Institute of Medicine, supra note 30, at 191.

57. See Hollingsworth, supra note 30, at 86, 116 ("An analysis of the behavior of hospitals in the three sectors [including public hospitals] during the past fifty years demonstrates that they have become increasingly similar. The differences that persist are small in comparison with the vast differences that existed fifty years ago."); Horwitz, Corporate Reorganization: The Last Gasp or Last Clear Chance for the Tax-Exempt Nonprofit Hospital, 13 Am. J. L. & Med. 531 (1988) ("the nonprofit hospital looks like, acts like, and imitates the for-profit hospital in every way except for the distribution of excess revenue"); Marmor, Schlesinger & Smithey, Nonprofit Organizations and Health Care, in The Nonprofit Sector: A Research Handbook 334-39 (W. Powell ed. 1987); Ermann & Gabel, Multihospital Systems: Issues and Empirical Findings, 3 Health Affairs, No. 1, at 50 (Spring 1984) (review of over 400 studies and articles; concludes the two sectors are largely the same). See generally B. Gray, supra note 12, at 106-110.

that masks important differences between the two sectors. This is persuasive. For instance, it may be the case that, controlling for facility size and location, the two sectors have very similar service mixes, but hospital size and location are not irrelevant or purely exogenous hospital characteristics. Instead, they are important dependent variables that hospitals affect by how they choose to spend their surplus revenue. Facility size and location have independent importance because these characteristics do not vary randomly across the two sectors and they are positively associated with the hospitals' level of technological sophistication and the number of unprofitable services. Thus, because nonprofit hospitals tend disproportionately to be larger in size and to locate in urban, inner-city areas, they tend to have a proportionately greater number of novel and expensive services (such as premature nurseries, burn units, and magnetic resonance imaging), some of which are unprofitable.[58] For similar reasons, the two sectors differ even more dramatically in their support of medical educational and research programs.[59] However, there is not complete agreement over the significance of even these performance

58. See Hollingsworth, supra note 30, at 108-110; Shortell, Morrison, Hughes, Friedman, Coverdill & Berg, The Effects of Hospital Ownership on Nontraditional Services, 5 Health Affairs, No. 4 (Winter 1986), at 97 (nonprofits provide 50 % more "alternative services"; for-profits offer 50 % fewer unprofitable services); Schlesinger, Marmor & Smithey, supra note 57.

59. Hollingsworth, supra note 30, at 109 (only 1 percent of for-profits have residency programs, compared to 22 percent of nonprofits); Institute of Medicine, supra note 12, at 142.

differences.[60]

I will not pretend to be able to resolve these hotly contested issues in a manner that will attract any degree of consensus. Rather, it is sufficient for the present purposes to observe that neither the positive theories of nonprofit dominance nor the empirical evidence supports the proposition that, absent tax exemption, nonprofit medical care would lose whatever superiority of quality or ethic it has. Without a showing that the exemption overcomes a barrier that creates suboptimal production of the desired service, it is equally likely that the subsidy causes too high a level of production -- in short, too much of a good thing. Accordingly, the community benefit theory fails the deservedness criterion.

3. Proportionality

In addition to failing the deservedness criterion, the community benefit theory has difficultly in meeting the proportionality criterion. The primary issue here is that the less tangible benefits it refers to are difficult to quantify, or inherently unquantifiable. There is no methodologically sound way to measure the soft values that inhere in the claim of a superior nonprofit medical ethic. David Seay, with the United Hospital Fund, claims to have devised a quantifiable measure of commitment

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60. See Institute of Medicine, supra note 12, at 142-43 (observing that lower level of research may be due to past refusal of funding sources -- including the National Institute of Health, the nation's largest source of biomedical research funds -- to support for-profit institutions) (in the last couple of years, since this discrimination has ceased, "investor-owned hospital companies have greatly increased their involvement in education and research"); id. at 145 (when for-profit hospitals have tried in the past to acquire teaching hospitals, they have been met with intense opposition; citing Hospital Corporation of America's attempt to buy Harvard's McLean Hospital).

to community values by articulating the "key elements of a community benefit standard for hospitals . . . in quite specific terms . . . [that] demonstrate that . . . the notion of community benefit [is] not necessarily soft or ambiguous."[61] But saying it's so doesn't make it so. These "key elements" simply ask hospitals to identify community needs, develop programs to meet those needs, and make any changes in the hospital's mission statement, governance structure, and organization necessary to carry out a program of community responsiveness. These standards contain no quantification of the community needs being met and, more importantly, no comparative measurement whatsoever of whether nonprofit hospitals are outperforming for-profits in meeting community needs.[62]

As Professor Dale has expressed, "Lacking a method for measuring these appealing but elusive virtues, one must perforce rely on intuition in comparing the achievement of private charities with those of government [and profit-making enterprises], when they are performing similar functions."[63] Not every decision of

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61. Seay & Sigmond, supra note 39, at 30; id. at 51 (claiming to have repudiated the notion that community benefit is "a soft, 'warm, fuzzy' concept, not deserving of explicit support in the form[] of money.").

62. Indeed, this statement of the community benefit standard precisely describes (although in somewhat foreign terminology) just what for-profit hospitals do when they sell their services to the community.

The two pending federal bills attempt to correct for this problem by, in the Roybal bill, limiting qualifying community benefit services to those not offered by similar for-profit hospitals, and in the Donnelly bill by designating a very limited list of specific services that qualify.

63. Dale, supra note 14, at 9, n.10. See also R. Stevens, supra note 35, at 354 ("history has shown that these words [community, voluntary and charity] have long had vague, emotive meanings. They have expressed a rhetoric of intention . . . rather than any exact

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government need be made by calculator, particularly social policy decisions made by Congress, but a standard that relies entirely on intuition is inappropriate in an administrative arena that requires courts and agencies repeatedly to apply a legislative mandate. The degree of legislative abdication inherent in the community benefit standard is particularly troubling considering that it leaves to tax collectors rather than departments of government concerned with more substantive aspects of public policy the task of determining what constitutes socially worthy activity across the very broad range of nonprofit enterprise.[64]

V. The Donative Theory of the Charitable Tax Exemption.

The theories of charitable exemption under which hospitals have a fighting chance -- health care per se and community benefit -- are each flawed by their failure

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63.(...continued)
program or method."); Reinhardt, Charity at a Price, New York Times Book Rev., Aug. 20, 1989, at 14 (the "ideals of charity and voluntarism . . . act as the opiate of the American public, deluding a basically decent people into believing that . . . deeply troubling social problems requiring whole dollars for their solution can[] be adequately addressed with just two bits' worth of trickle-down generosity").

The hospital sector well illustrates the need for a measurable standard of nonprofit superiority since even the defenders of the exemption concede that "self-satisfaction and self-righteousness . . . is perhaps an occupational hazard" among nonprofit hospital administrators, who tend to "have an almost reflexive belief in the inherent superiority of voluntary health care." Seay & Vladeck, supra note 39, at 5.

64. This arrangement has a high potential for producing capricious results, a potential that has been fully realized in the hospital context. The IRS has ruled, for instance, that hospital cafeteria sales are exempt because they keep doctors close to the hospital in the event of an emergency, but that income from a hospital's laboratory services for its doctors' office patients is not exempt even though the hospital provides this service as a convenience to keep the doctors in an adjoining medical office building. Rev. Rul. 69-268, 1969-1 C.B. 160; Rev. Rul. 85-110, 1985-2 C.B. 166. See Colombo, supra note 6.

to establish any basis for determining deservedness or proportionality. However, the alternative theory that would disqualify hospitals -- charity care -- cannot serve as the exclusive basis for exemption. This stalemate requires that we search for a new theory of exemption that satisfactorily ties together a convincing understanding of why nonprofit organizations exist, why they should be tax exempt, and the origins of the legal concept of charity. This theoretical rebuilding leads to the conclusion that the primary basis for the charitable exemption is to subsidize those organizations that are capable of attracting a substantial level of donative support from the public, a theory that has not previously received full articulation and development.[65] This theory is capable of serving either as an adjunct to more conventional theories by identifying particular hospital services that count toward exemption, or as the grand, unifying theory for exempting all charitable organizations.

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65. However, several major, antecedent works point the way to this theory, primarily, those authored by Burton Weisbrod, Henry Hansmann, and James Douglas. Also, Professor Atkinson's theory developed simultaneously also stresses the role of altruism.

A. The Donative Theory Described

1. The Positive Economic Theory of Nonprofit Organizations.

A stimulating body of economic and political theory has developed a combined market/government failure theory to explain the existence of donative nonprofit organizations: donatives arise where the two principal sectors of society fail adequately to supply desired goods and services. The primary economic explanation for the willingness to contribute voluntarily to certain causes is the desire to overcome the private market's undersupply of what economists refer to as "public goods."[66] Pure public goods in the economic sense are those characterized by the two conditions of durability and indivisibility: the good does not wear out as others use it, and its nature is such that, once produced for one consumer, it is impossible to exclude its consumption by any other consumer. Impure public goods partake of these characteristics to some lesser degree. Classic examples of nearly pure public goods include air pollution control, border defense, and legislative lobbying. The private market cannot be expected to supply pure public goods at any level, regardless of how valuable they are, because no one has an incentive to pay their proportionate share of the benefit, and the supply of impure public goods similarly can be expected to be suboptimal. As a result, the only means for optimal provision

66. Leading discussions of this public goods theory of the existence of nonprofit enterprise include Hansmann, supra note 47, at 848; B. Weisbrod, supra note 51, at 59-60; B. Weisbrod, The Voluntary Nonprofit Sector (1977); Krashinsky, Transaction Costs and a Theory of Nonprofit the Organization, in The Economics of Nonprofit Institutions 119, 121 (S. Rose-Ackerman ed. 1986); Gergen, The Case for a Charitable Contributions Deduction, 74 Va. L. Rev. 1397-99 (1988).

of public goods are coercion or voluntarism.

As for voluntarism, it is sufficient to observe that classical economic theory is imperfect since some people are willing to overcome these severe free rider incentives by taking a collective view that induces them to contribute individually to the production of a broad social benefit. But why should donors ever need to contribute to the private production of public goods when classic economics tells us that public good provision is the quintessential role of government, which is able to correct the free rider defect simply through its power to tax, in essence coercing the public's purchase of public goods? The answer lies in the vagaries of majoritarian voting logic, which result in the government systematically undersupplying certain public goods. University of Wisconsin economist Burton Weisbrod was the first to make this insight.[67] Employing public choice theory, he demonstrated that certain blocs of voters will predictably lack the voting strength to require the government to meet their public good needs. This is so because governmental decisions in a democracy are roughly shaped by the desires of the majority of the electorate. It follows that the government will supply any given public good at a level that approximates that desired by the median voter. Thus, for public goods accompanied by heterogenous, widely divergent tastes, although there may be some level of government provision, voting logic dictates that there will be a large, undersupplied minority of high demanders. This supramedian group has no ready alternative other than to make

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67. See generally B. Weisbrod, supra note 66, at 53-6; Weisbrod, Toward a Theory of the Voluntary Non-Profit Sector, in Altruism, Morality and Economic Theory (E. Phelps, ed. 1975).

voluntary contributions to a private organization.

2. **The Charitable Exemption and Deduction as Shadow Subsidies.**

Government failure combined with market failure provides the most rigorous description of the case for private donations. This combination of theories nicely explains why (some) nonprofits exist and the useful function they can serve, but this explanation does not yet demonstrate why nonprofits should be subsidized. The critical insight comes from the preceding economic analysis, which instructs us that the classic instances of giving are characterized by a free rider effect. Donors partially overcome the market disincentives that attach to public goods, but, unlike the government, which enjoys the coercive power of taxation, nonprofit providers of public goods must rely on persuasion, which inevitably will fall short of inducing all consumers of a voluntarily supported public good to contribute fully the value they actually derive. Therefore, what is needed is some form of funding that matches private donations with an additional subsidy to amplify them somewhat, in order to take up the slack left by the free rider disincentive and move the level of production further toward the socially optimal level.

This matching or shadow subsidy function is precisely the explanation that Weisbrod has offered for the charitable deduction.[68] Weisbrod's insights can be extended to the exemption from income and property taxes. Exempting donative nonprofits from income and property taxation helps to remedy the systematic underprovision of public goods by allowing the donation to be more productive than

68. Weisbrod, supra note 51, at 29-30.

it would be if it, or its earnings, were taxed.[69]

69. Unlike the deduction, though, the exemption lacks an inherent sliding scale quality because it is applied in an all-or-nothing fashion, rather than being tailored to the precise level of donative support. But this defect could be corrected by administering the exemption so that it applies only to those specific portions of property (and the income derived therefrom) that have been donated (or that have received some defined level of substantial donative support), much as we currently exempt only those portions of property and income that are related to an exempt purpose.

3. The Donative Theory's Scorecard

The donative theory of the charitable exemption offers an elegant rationale for subsidizing the objects of donative activity, one that fully meets the deservedness criteria in both its worthiness and neediness components. Because the impulse to give comes from the public's recognition of a socially valued service, we can be confident that donations are directed to objects that are worthy of subsidy. And because those worthy activities that are forced to rely on voluntary support systematically receive less support than society as a whole desires, donative activities need to be subsidized. And, unlike all other theories of the charitable exemption, the donative theory convincingly satisfies the deservedness criterion for both the income tax exemption and the property tax exemption at the same time that it justifies the charitable deduction. This symmetrical aspect of the donative theory provides one of its greatest strengths.[70]

An appealing feature of the donative theory of the charitable exemption is that

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70. The theory struggles somewhat under the proportionality test, since those institutions that have the highest level of donations are least likely to earn income. However, the property tax exemption will tend to be proportional to the amount of donations an organization receives. Moreover, the principal litmus test for proportionality is whether, assuming a given activity deserves subsidy, the exemption is a more sensible means to administer the subsidy than a direct government grant. The "twin failure" rationale underlying the donative theory confronts this inquiry directly. It reveals that, where substantial donations exist, we know that direct government aid is unavailable because it is the failure of the government that has left donors with no other alternative than to make voluntary contributions. In essence, the donative theory is designed to cover only cases where the tax subsidy is necessarily a second best solution because the theory excludes all cases where the government in fact subsidizes directly in sufficient amount. Proportionality is satisfied, then, because, by definition, no more accurate mechanism for direct government support is possible in cases where the donative theory applies.

it leads to a fundamentally simple and intuitive concept of charity -- one that reaffirms the popular sense of charity as "the impulse to give."[71] It also is capable of explaining the tax law's reliance on trust law for its concept of charity. The donative theory succeeds in connecting these two bodies of law in a sensible fashion by focusing our attention on the donative aspect of trust creation to reveal the following, crucial limiting principle contained in charitable trust law: The reason that trust law does not attempt to evaluate what purposes are of sufficient public importance to deserve special legal protection is that it can safely rely on the self-sacrifice of the trust's founder to have sufficiently considered the object's deservedness, as long as the trust confers a community rather than a private benefit.[72] Therefore, tax exempt law blunders terribly if it transplants trust law's concept of charity without maintaining this crucial limiting principle -- the self-sacrifice entailed in a gift.

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71. Persons, Osborn & Feldman, supra note 2, at 1911; id. at 1945 (discussing "unselfish giving" as central to the charitable concept).

72. See In re Cranston, [1898] 1 I.R. 431, 446, quoted supra at note 25.

This simple observation is resoundingly clear after reexamining the foundational trust law authorities with the donative factor in mind. Many of the leading authorities that articulate a boundless, public benefit concept of charity qualify their description of charity with the proviso that a gift be devoted to the stated purpose. The listing of charitable purposes in the 1601 Statute of Charitable Uses, the seminal codification of the legal concept of charity, is explicitly premised on giving. The statute's preface stated as its rationale for creating a rigorous enforcement mechanism for charitable trusts that "lands, goods, . . . [and] money . . . have been heretofore given . . . by sundry [] well disposed persons" to these purposes. The seminal American decision defined "a charity, in the legal sense, . . . as a gift, to be applied . . . for the benefit of an indefinite number of persons." Jackson v. Phillips, 14 Allen, Mass., 539, 556 (1867) (emphasis added).

D. How Hospitals Measure Up.

Nonprofit hospitals nicely illustrate the full dimension of the donative theory. Although they appear on first inspection to be good candidates for the receipt of charity because many of their services have strong public good characteristics,[73] hospitals receive sufficient direct subsidies that they have almost no need to solicit donations. Thus, while they display many of the classic incidents of market failure, they are not affected by severe government failure. Medical research, physician education, and the treatment of indigent patients all share attributes of classic public goods. These are also precisely the services that nonprofit hospitals are said to perform more than for-profits. But it is not enough to demonstrate the existence of substantial public good production to justify a tax subsidy. The subsidy is deserved only if we believe that the government is supplying these goods at a suboptimal level, as demonstrated by actual public contributions to make up the difference. Today, nonprofit hospitals receive (in proportionate terms) only negligible support -- one to two percent of their budgets -- from public donations.[74]

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73. Indeed, Burton Weisbrod uses the hospital industry as one of the principal confirmations of his public goods rationale for the existence of nonprofit enterprise by demonstrating that hospital services with public good characteristics are almost uniformly found to exist disproportionately in voluntary hospitals. Weisbrod, supra note 66, at 3, 80-81, 93-98 (using 1969 data, "we find that the nine particular services/facilities--out of a total of thirty-one--that had been judged a priori to be primarily private in character are found disproportionately in the for-profit hospitals, while the twenty-two services that had been judged to have the greatest degree of collective-good quality are found disproportionately in the governmental and voluntary nonprofit hospitals"); Weisbrod, supra note 67, at 193.

74. Hall & Colombo, supra note 1, at 406 n.350; E. Ginzberg, Philanthropy and Nonprofit Organizations in U.S. Health Care: A Personal Retrospective, 28 Inquiry 179 (1991) (in 1990, philanthropy accounted for 1 % of operating expenses and 5% of capital expenditures).

Hospitals relied much more heavily on donations prior to World War II, but as a consequence of widespread public and private health insurance and government grant programs such as Hill-Burton (now supplanted by tax-deductible bond financing), hospitals no longer need donative support to expand, nor are donors any longer motivated by the quasi-insurance function of securing a future source of services. This governmental displacement of charitable giving has caused hospital philanthropy to decay rapidly since 1968, with a half-life of about five years.

Hospitals will complain that this government generosity is quickly ending, eliminating their ability to cross-subsidize many underfunded but desirable services from the ample surplus previously generated by insured patients. But until the pinch becomes severe enough to motivate hospitals to enter the philanthropy market more aggressively and donors to respond with more enthusiasm, this is just talk, not action. At present, the lack of donative support is evidence either that nonprofit hospitals do not provide a service materially different than that otherwise available, or that, if they do, they are amply supported in more direct ways. Accordingly, there is a weak case for supplementing this support with a tax subsidy.[75]

Despite the presently low level of proportionate donative support for hospitals,

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75. The same lack of donative support for certain non-hospital health care providers (such as HMO's, doctor practices associations, nonprofit pharmacies, and nursing homes) indicates that the IRS's current posture of attempting to deny exemption to these entities may be the right result reached on the wrong analytical grounds.

it is misleading to conceive of hospitals as receiving no such support. In fact, the aggregate level of donations is quite large.[76] While this support may not be sufficient to qualify all of the nonprofit hospital sector's holdings and earnings for property and income tax exemption, it also seems unfair to discount this support entirely simply because it is a small portion of the overall large operation. The donative theory is quite capable of fine-tuning its application to account for degrees of support. First, it is hardly necessary for hospitals to receive 100 percent of their revenues from donations. Few traditionally charitable organizations do so. The threshold of donative support required to qualify for charitable status is ultimately a legislative or administrative policy decision, but it might be quite low -- on the order of 30 percent -- judging from the level of support hospitals received when they were still considered classic charities.[77] Second, even for hospitals that fail to meet this threshold for their overall operations, if they are capable of segregating those activities that attract the most donative support (pediatric oncology wards, for instance) into separate corporate entities, then those portions might qualify. Moreover, it is perfectly acceptable for a favorably inclined taxing authority to make the same accounting allocation even without formal corporate segregation. Where hospitals come out on balance depends in large part on the details of administering a

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76. The 1425 member hospitals of the National Association of Hospital Development received $1.90 billion cash donations in fiscal 1987-88, an average of $1.3 million each.

77. See Hall & Colombo, The Donative Theory of the Charitable Tax Exemption, forthcoming, *Ohio St. L. J.*

donative theory of exemption.[78]

V. Conclusion

Others who have reflected on the rationale for the charitable exemption have had a tendency to take for granted the case for applying the exemption to donative institutions; their primary focus has been to consider whether to broaden the exemption beyond this base that, apparently, has universal acceptance. This conception of the issue has caused commentators to overlook the merits of the donative theory as the basic standard for the exemption. This is a mistake. Understanding the strength of the rationale supporting the donative theory reinforces, by contrast, the weakness of the alternative theories. Moreover, careful development of the donative theory instructs us whether there should be an exemption at all and how the exemption is properly administered.

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78. For further development of these details, see Hall & Colombo II, supra note 77.