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THE CHARITABLE STATUS OF NONPROFIT HOSPITALS: TOWARD A DONATIVE THEORY OF TAX EXEMPTION

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Abstract: This Article examines the growing controversy over the multi-billion dollar charitable tax exemption enjoyed by nonprofit hospitals. It begins by articulating four criteria for evaluating a rationale of the charitable exemption: deservedness, incorporating the elements of worth and need; proportionality; universality; and historical consistency. The Article then employs these criteria to refute three conventional explanations of why nonprofit hospitals are exempt: because health care is a per se charitable activity; because the treatment of indigent patients relieves a government burden; and because nonprofit hospitals provide community benefits. The Article also uses these criteria to refute two academic theories: Boris Bittker's income measurement rationale and Henry Hansmann's capital subsidy theory.

This Article proposes a "donative theory" as an alternative rationale for the charitable exemption. The donative theory posits that "charity" describes an entity capable of attracting a substantial level of philanthropic support from the public at large. Donations exist where there is a combined failure of private markets and direct public funding to supply a shared public benefit at the optimally desired level. Donative institutions deserve a tax subsidy because the public's support signals their worth, and the free-rider tendency that affects all giving assures the need for an additional, shadow subsidy. The Article further demonstrates that the donative theory comports with the statutory scheme and the four centuries of legal history that shape the legal concept of charity. In particular, the donative theory provides the only explanation of the tax law's otherwise unjustifiable reliance on the law of charitable trusts.

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I. INTRODUCTION

Since the beginning of western civilization, religion, education, and other charitable activities have been exempt from various forms of taxation.[1] In the United States, federal tax law has relieved charitable

1. "Real property taxation, and exemption therefrom, seems to be about as old as history.... One historian reports that the 'economic equilibrium of the state was endangered' by the fact that the tax exempt temples owned fifteen percent of the cultivable land and vast amounts of slaves and other personal property during the reign of Ramses III about 1200 B.C." Sierk, *State Tax Exemptions of Non-Profit Organizations*, 19 CLEV. ST. L. REV. 281, 282 (1970). *See Ezra* 7:24 ("[I]t shall not be lawful to impose toll, tribute, or custom upon ... priests ... or ministers of the house of God ...."); *Genesis* 47:24 ("Joseph made it a law over the land of Egypt unto this day, that Pharaoh should have the fifth part; except the land of the priests only, which became not Pharaoh's ...."); A. BALK, THE FREE LIST: PROPERTY WITHOUT TAXES 20–21 (1971) (referring to history of ancient Egypt, Greece and Rome and concluding "[e]xemptions probably are as old as taxes").

England has had a charitable exemption in its income tax law since it was enacted in 1799 and reintroduced in 1842. M. CHESTERMAN, CHARITIES, TRUSTS AND SOCIAL WELFARE 58–59 (1979). British charities enjoy only a 50% exemption from local property taxes by right, but localities may exempt the remainder in their discretion. *Id.* at 243.

organizations from income tax since the law's inception,[2] and charities have enjoyed exemption from state and local property taxes even longer.[3] The long history of the charitable exemption has made it a virtually immutable part of the tax laws—so much so that the thought of taxing charitable organizations on the same basis as profit-making enterprises seems contrary to nature.[4] It is startling to learn, then, that we have no clear understanding of why the charitable exemption exists or what it covers.[5] Various commentators have observed: "despite th[e] long history of the tax [laws], or perhaps because of this long history, there is very little logic, or reason, or legislative history to support . . . the tax exemption";[6] "the statutory phrases 'exclusively

2. The earliest codification of an exemption for charitable entities appears to have been the Revenue Act of 1894, ch. 349, § 32, 28 Stat. 556 (1894). The complete history of the federal charitable exemption is traced in many sources, including Liles & Blum, *Development of the Federal Tax Treatment of Charities,* 39 LAW & CONTEMP. PROBS. 6 (Autumn 1975); Persons, Osborn & Feldman, *Criteria for Exemption Under Section 501(c)(3),* in 4 U.S. DEPT. OF TREASURY, RESEARCH PAPERS SPONSORED BY THE COMMISSION ON PRIVATE PHILANTHROPY AND PUBLIC NEEDS 1909, 1924–25 (1977) [hereinafter FILER COMMISSION PAPERS].

3. *See generally* J. JENSEN, PROPERTY TAXATION IN THE UNITED STATES (1931); Adler, *Historical Origin of the Exemption From Taxation of Charitable Institutions,* in WESTCHESTER COUNTY CHAMBER OF COMMERCE, TAX EXEMPTIONS OF REAL ESTATE: AN INCREASING MENACE 15–17 (1922).

4. Belknap, *The Federal Income Tax Exemption of Charitable Organizations: Its History and Underlying Policy,* in FILER COMMISSION PAPERS, *supra* note 2, at 2025, 2029–30 (by 1894, the custom of exempting education, religion, and care of the poor was "so grounded in the nature of our Government as to represent a practically irrevocable law"). Even those most critical of the exemption suggest its repeal in only the most tentative tones, preferring a reformulation instead. *See* A. BALK, *supra* note 1, at 128.

5. Modern scholars have a fair idea of the basis for the exemption in prior ages, but there is no agreement on its rationale in modern times. In ancient Egypt, Greece and Rome, temples and other religious institutions were not taxed because it was thought they were owned by the gods themselves and were thus beyond the reach of mortal taxing authorities. In medieval England, churches, monasteries and the like were not taxed, at first because in feudal times there was no centralized government capable of imposing such a tax; indeed, the churches themselves were a sort of taxing authority, collecting tithes from feudal lords. This power distribution changed dramatically later in England's history when churches were not only taxed but confiscated as part of the suppression of clerical power during the Reformation. However, the charitable exemption survived during this time by expanding its reach to secular charities as a way of further undermining the church's influence. In the American colonies, churches were at first not taxed because the colonies were established as theocracies and no government taxes itself. The religious exemption continued even after the constitutional adoption of the separation principle, though, largely for reasons of historical Anglo-American tradition. Thus, it was expanded to cover education and other secular charitable purposes because that was the pattern that prevailed in England at the time. The present form of charitable exemption is essentially unchanged from this time, when its political rationales disappeared. *See generally* A. BALK, *supra* note 1, at 23–27; Adler, *supra* note 3, at 14–80; Belknap, *supra* note 4, at 2027–28; Persons, Osborn & Feldman, *supra* note 2, at 1914, 1923; Stimson, *The Exemption of Property from Taxation in the United States,* 18 MINN. L. REV. 411, 416–18 (1934).

6. *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*]

used for charitable purposes' [and] 'purely public charity' seem to mean less than nothing";[7] and "think[ing] more seriously about what is meant by the concept of charity [is] a task that is about four hundred years overdue."[8]

A clear answer to this puzzle has tremendous practical importance to federal and state governments hard-pressed to balance strained budgets in the face of the steadily increasing size of the exempt sector,[9]

(statement of O. Donaldson Chapoton, Deputy Assistant Secretary, U.S. Department of the Treasury).

7. Comment, *Judicial Restoration of the General Property Tax Base,* 44 YALE L.J. 1075, 1087 (1935).

8. 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]; *see also* J. DOUGLAS, WHY CHARITY?: THE CASE FOR A THIRD SECTOR 55–56 (1983) ("[T]he question 'what is a charity?' is quite surprisingly difficult to answer. . . . Although the lawyers have been wrestling with the problem for centuries, they have not been able to define precisely what are the both necessary and sufficient conditions for charitable status."); B. WEISBROD, THE NONPROFIT ECONOMY 115 (1988) (" 'Nonprofits are a whole can of worms that Congress has yet to look at in a broad way. I have been blowing the trumpet for years to get lawmakers to spell out clearly what should be tax-exempt and what should not be.' ") (quoting former IRS Commissioner); Belknap, *supra* note 4, at 2031 (the original federal adoption of the exemption occurred "without debate and virtually without comment;" and "[t]he Congressional Record will be searched in vain for any fuller expression of the policy underlying the exemption" than so that these institutions " 'may not suffer under the bill' ") (quoting Congressman Tucker, who introduced the amendment containing the exemption); Bittker & Rahdert, *The Exemption of Nonprofit Organizations from Federal Income Taxation,* 85 YALE L.J. 299, 302 (1976) (Congress has groped along, "enunciat[ing] no developed theory"); Chisolm & Young, *Introduction to What is Charity?,* 39 CASE W. RES. 653, 655 (1989) ("[E]xamination of history has not yet given us a satisfying answer to the question, 'what is charity?' . . . [W]e find [in the IRC] . . . no systematic set of rules and policies thoughtfully derived from a careful rationale."); Hansmann, *Unfair Competition and the Unrelated Business Income Tax,* 75 VA. L. REV. 605, 635 (1989) [hereinafter Hansmann, *Unfair Competition*] ("The truly difficult and important issue involving the tax treatment of nonprofits concerns not the UBIT but rather the scope of the basic exemption that underlies it, and that is where future debate should focus.").

Professor Heller suggests that the charitable exemption is conventionally considered an "easy case" and maintains that only through a Critical Legal Studies (CLS) style of analysis is it possible to perceive the exemption's "indeterminacy." Heller, *Is the Charitable Exemption from Property Taxation an Easy Case? General Concerns About Legal Economics and Jurisprudence,* in ESSAYS ON THE LAW AND ECONOMICS OF LOCAL GOVERNMENTS 183, 185 (D. Rubinfeld ed. 1979). Heller misperceives both the conventional view of the exemption and the insights that CLS has to offer to this problem. Heller's own analysis reveals that it is not the exemption that he treats as the "easy case" but the taxation of property itself, for the core of his argument is focused on problems that exist with the a priori definition of a standard tax base, from which the exemption is a departure. He only briefly explains why the exemption is a "hard" case, see *id.* at 210–11, and the arguments he musters are ones that academicians and lawmakers have been conversant in since the seminal work of Professor Surrey on tax expenditures, see S. SURREY & P. MCDANIEL, TAX EXPENDITURES (1985).

9. "[T]he tax benefits granted to charities and other exempt organizations by the United States are almost unique in their generosity." Stone, *Federal Tax Support of Charities and Other Exempt Organizations: The Need for a National Policy,* 20 U.S. CAL. L. CENTER TAX INST. 27,

and to nonprofit organizations that increasingly must defend their favored tax status against the roving eyes of revenue-hungry tax collectors and legislators.[10] This topic also holds considerable intellectual challenge. The academic field of nonprofit enterprise has flowered during the past decade and a half as researchers from various disciplines began to recognize that this "third sector" of the economy (distinct from proprietary markets and government) has been neglected as a separate topic of serious inquiry. These pathbreaking scholars made impressive progress toward explaining why nonprofit organizations

30–31 n.11 (1968). "[B]y careful planning, one now can live much of his life on tax-exempt property." A. BALK, *supra* note 1, at 5; *see also* B. WEISBROD, *supra* note 8, at 62 (nonprofits "engage in hundreds of distinct activities; they are growing at the rate of thousands per year; they employ millions of workers; and they have hundreds of billions of dollars of annual revenues and assets").

According to one rough estimate, one-third of all property is tax exempt. Two-thirds of this amount, however, constitutes government property, generally not calculated in the tax base. A. BALK, *supra* note 1, at 11–12. Therefore, an estimate that is more representative for the present purposes is that approximately 10% of private property is exempt. *See* Gabler & Shannon, *The Exemption of Religious, Educational and Charitable Institutions From Property Taxation,* in FILER COMMISSION PAPERS, *supra* note 2, at 2535 (roughly one-ninth of private property is exempt); Stone, *supra,* at 31 (in the mid-1960s, the amount of income tax foregone, $5 billion, was enough to provide a 10% tax cut). Some have assigned much higher estimates to particular locales. *See* J. HELLERSTEIN & W. HELLERSTEIN, STATE AND LOCAL TAXATION 981 (5th ed. 1988) (in 1963–1964, "the value of exempt non-governmental property amounted to approximately 22 percent of the assessed value of all taxable property in Illinois, 19 percent in California, 36 percent in Florida, and 78 percent in Louisiana."). Accurate figures are difficult to obtain because tax assessors do not generally bother to value precisely exempt property.

The amount of exempt property has grown considerably over the past few decades, faster than the value of the tax base. *See* A. BALK, *supra* at 1; B. WEISBROD, *supra* note 8, at 62 (the number of exempt firms has tripled in 20 years whereas for-profit firms have only doubled in number over the same period); Gabler & Shannon, *supra,* at 2536–38. The number of categories of federally exempt activities has grown from 90 to 260 since 1965. U.S. GENERAL ACCOUNTING OFFICE, TAX POLICY: COMPETITION BETWEEN TAXABLE BUSINESSES AND TAX-EXEMPT ORGANIZATIONS, BRIEFING REPORT TO THE JOINT COMM. ON TAXATION 14 (Feb. 1987) [hereinafter GAO, TAX POLICY]. Correspondingly, the number of federally exempt entities has doubled over the last 20 years, to 866,000. *UBIT Hearings, supra* note 6, at 26.

The charitable exemption specifically is by far the largest component of the private exempt sector. Charitable organizations, now numbering 366,000, represent over two-fifths of all federally exempt entities and over half of the exempt sector's total receipts and assets (amounting to $114.6 billion and $176.3 billion respectively). *See* GAO, TAX POLICY, *supra,* at 15. "[T]he broad range of mutual benefit organizations exempt under provisions other than section 501(c)(3) and section 501(c)(4) accounted for only 10 percent of current operating expenditures of all nonprofits in 1984." *UBIT Hearings, supra* note 6, at 27.

10. *See infra* notes 48–52, 57–66 and accompanying text (concerning various court and legislative challenges to hospitals' tax exemption). A few scholars have advocated or suggested the outright repeal of the exemption. *See* Bennett, *Real Property Tax Exemptions of Non-Profit Organizations,* 16 CLEV.-MARSHALL L. REV. 150, 166 (1967) ("[A] solution would appear to be the abolition of all non-governmental property tax exemptions, completely."); Clark, *Does the Nonprofit Form Fit the Hospital Industry,* 93 HARV. L. REV. 1417, 1476 (1980) (suggesting repealing property tax exemption for hospitals); Stimson, *supra* note 5 (same).

exist, what their central characteristics are, and how they should be regulated.[11] These studies, however, have not satisfactorily explained why the tax system subsidizes[12] most nonprofits.[13]

This Article undertakes to answer two related inquiries: what organizations are charitable, and why are they exempt from taxation. Understanding the core concept of charity will facilitate identifying the rationale for exempting charities from taxation; this rationale will in turn guide us in applying the charitable category in borderline cases. Working in the opposite direction, identifying a correct rationale for the exemption will reveal—or at least permit the formulation of—a sensible definition of "charitable."

This Article approaches 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 manifestation of these issues in recent years. The Utah

11. The leading discussions include J. DOUGLAS, *supra* note 8; THE ECONOMICS OF NONPROFIT INSTITUTIONS (S. Rose-Ackerman ed. 1986); B. WEISBROD, *supra* note 8; Ellman, *Another Theory of Nonprofit Corporations,* 80 MICH. L. REV. 999 (1982); Hansmann, *The Role of Nonprofit Enterprise,* 89 YALE L.J. 835 (1980). *See generally* R. GASSLER, THE ECONOMICS OF NONPROFIT ENTERPRISE (1986); E. JAMES & S. ROSE-ACKERMAN, THE NONPROFIT ENTERPRISE IN MARKET ECONOMICS (1986); 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 19 (B. Gray ed. 1986).

12. Characterization of the tax exemption for charitable organizations and the tax deduction for charitable contributions as a "subsidy" raises certain issues that have remained at the core of debate among tax academics regarding the relationship of tax law to the exemption and deduction. While most tax commentators accept the "subsidy" characterization, *see, e.g.,* S. SURREY, PATHWAYS TO TAX REFORM 223 (1973); S. SURREY & P. MCDANIEL, TAX EXPENDITURES 219–20 (1985); Hochmann & Rodgers, *The Optimal Tax Treatment of Charitable Contributions,* 30 NAT'L TAX J. 1, 2 (1977); Thuronyi, *Tax Expenditures: A Reassessment,* 1988 DUKE L.J. 1155, others do not. For example, Boris Bittker has opined that the tax exemption is simply an outgrowth of the inability to accurately measure the income of nonprofit organizations. As a result, Bittker finds the exemption and charitable contribution deduction consistent with a taxing system that attempts to measure income. For a discussion of Bittker's theory, see *infra* notes 279–90 and accompanying text. *See, e.g.,* Bittker, *Charitable Contributions: Tax Deductions or Matching Grants?,* 28 TAX L. REV. 37 (1972). *See generally* C. KAHN, PERSONAL DEDUCTIONS IN THE FEDERAL INCOME TAX 88 (1960) (discussing rationales for the charitable contribution deduction). As explained *infra* notes 286–90, the income measurement theory does not provide a complete justification for the current scope of the exemption for charitable institutions. Therefore, this Article follows the predominant view that the exemption constitutes a subsidy, and seeks to justify the exemption on this basis. *See infra* note 69 and accompanying text.

13. *See UBIT Hearings, supra* note 6, at 37 (Statement of Deputy Assistant Secretary of the Treasury O. Donaldson Chapoton) ("[A] comprehensive review of the standards and the rationale for tax exemption has never been undertaken."); *id.* at 1864–65 (statement of Prof. Harvey P. Dale, N.Y.U. School of Law) ("[W]e do not have any careful and comprehensive rationale for the scope and operation of the tax exemption. We do not have any satisfactory theory, legal or economic, to apply in making judgments about it."); *see also supra* note 8.

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.[14] Since then, local taxing authorities in four other states have challenged hospitals' exempt status, and legislative reexaminations are pending or have occurred recently in over a dozen others.[15] Most recently, Congress is considering legislation that would entirely revamp the justification for the federal income tax exemption enjoyed by hospitals.[16] Second, justification of the charitable status enjoyed by nonprofits is imperative because hospital service is by far the single largest commercial activity that receives tax exempt status under the generic charitable label,[17] amounting to billions of dollars a year in lost revenue.[18] Third, scholars studying the nonprofit sector are particularly intrigued by markets like the hospital industry where proprietary, voluntary, and government institutions coexist.[19] These settings provide ideal

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

15. *See infra* notes 57–64 and accompanying text.

16. *See infra* notes 64 & 66, 151.

17. 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 . . . .").

18. 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,* 1990 TAX NOTES 1559, 1565. This number represents the sum of the following estimates: federal income tax, $1.6 billion; tax-exempt bonds, $1.7 billion; deductible charitable contributions, $1.2 billion (total federal, $4.5 billion); state and local income tax, $0.4 billion; property tax, $1.2 billion; sales tax, $2.4 billion (total state and local, $4.0 billion). *Id.; see also* Baldwin, *Legislatures, Agencies Debating Whether Not-For-profit Hospitals Deserve Their Tax-exempt Status,* MOD. HEALTHCARE, May 22, 1987, at 34, 37 (the sales tax exemption for hospitals amounts to an annual loss of $60 million in Oklahoma and $400 million in Florida); Clark, *supra* note 10, at 1417 & n.1 (the exemption for hospitals results in an estimated annual loss of $1 billion in property tax revenues alone); Falcone & Warren, *The Shadow Price of Pluralism: The Use of Tax Expenditures To Subsidize Hospital Care in the United States,* 13 J. HEALTH POL., POL'Y & L. 735, 740–52 (1988) (by a rough, liberal estimate, the hospital exemption costs $3 billion a year in income and property tax, $1.8 billion of this in federal income tax); Friedman, Hattis & Bogue, *Tax Exemption and Community Benefits of Not-For-Profit Hospitals,* in 11 ADVANCES IN HEALTH ECONOMICS AND HEALTH SERVICES RESEARCH (1990) 131, 136–38 (value of exemption in 1983–1985 estimated between $4.7 and $7.3 billion); Yoder, *supra* note 11, at 66 n.9 (the federal income tax exemption cost $1.6 billion in 1984, based on the average nominal tax rate for the six largest proprietary hospital companies, but only $922 million based on the tax rate for-profits actually paid as a result of various deferments). However, as a result of recent cost containment measures in various public and private reimbursement programs, hospitals are becoming less profitable than they had been in the recent past, reducing the value of the income tax exemption. Still, Copeland & Rudney, *supra,* at 1565, observe that the exemption would be worth $6.5 billion even if nonprofit hospitals had no surplus at all.

19. This Article uses "proprietary" to designate 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

laboratories for testing the comparative performance, and the relative merits, of these three forms of organization.

The specific issue of hospital tax exemption has heightened importance because it sits at the confluence of larger social policy issues. Thirty-seven million Americans have no private or governmental health insurance, a thirty percent increase from 1979.[20] Historically, the uninsured have relied heavily on the largess of private hospitals for critical care.[21] However, stringent reimbursement controls recently imposed by both private and governmental payors threaten to eliminate the ability of hospitals to cross-subsidize the care of the medically indigent from revenues generated by paying patients.[22] It is increasingly unrealistic to expect private hospitals to meet the public's demand for charity care, precisely at a time when the greatest need exists for such care.[23] Thus, at the core of the tax-exempt debate lies the issue whether nonprofit hospitals should continue to carry a significant share of this societal burden as payment for continued exemption.

The tax-exempt debate also implicates social policy related to proprietary incentive in medicine. The health care delivery system has experienced rampant commercialization during the past two decades, becoming what a leading critic has called a "medical-industrial complex."[24] This change is epitomized by the rapid growth of large proprietary hospital chains such as Hospital Corporation of America (HCA) and Humana.[25] Influential voices decry the corporatization of health care as inimical to the humanistic values traditionally held

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corporations codes. Government institutions are those owned or controlled by government entities. In a typical metropolitan area all three types of hospitals often coexist.

20. CONGRESSIONAL RESEARCH SERVICE, HEALTH INSURANCE AND THE UNINSURED: BACKGROUND DATA AND ANALYSIS 3 (May 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." Yoder, *supra* note 11, at 116 n.1.

21. J. BENNETT & T. DILORENZO, *supra* note 17, at 84 (quoting the American Hospital Association's (AHA) claim that nonprofit hospitals gave $22 billion in free medical care to the poor over a five-year period).

22. These developments are surveyed in Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment,* 137 U. PA. L. REV. 431, 435–37 (1988).

23. Sullivan & Moore, *A Critical Look at Recent Developments in Tax Exempt Hospitals,* 23 J. HEALTH & HOSP. L. 65, 66–71 (1990).

24. Relman, *The New Medical-Industrial Complex,* 303 NEW ENG. J. MED. 963 (1980).

25. *See* J. HOLLINGSWORTH & E. HOLLINGSWORTH, CONTROVERSY ABOUT AMERICAN HOSPITALS: FUNDING, OWNERSHIP AND PERFORMANCE 66–67 (1987) ("In 1985 HCA owned or managed 422 health care facilities, had revenues of $4.1 billion . . . and managed hospitals in more than half a dozen foreign countries.").

sacred in medicine, and thus view a limitation of tax exemption as a direct attack on this ideological position.[26] Others respond that the crisis gripping the health care system is due largely to the past absence of normal market forces, and thus see the exemption as a mindless subsidy that tilts the playing field in favor of inefficient providers.[27] "No study—of a hospital closing or a new technology in action—and few summaries of these issues manage to emerge without being cast in the language of good and evil, delight and doom, prudence and waste."[28] The convergence of these several currents of controversy render this seemingly mundane tax matter a provocative subject of study.

This Article begins with a survey of the current law and some criteria for evaluating theories of exemption. The Article then proceeds with a critique of both the conventional rationales for the charitable exemption and the existing academic theories. Finding these explanations unsatisfactory, the Article then develops an alternative rationale for the exemption. This "donative theory" of tax exemption maintains that nonprofit organizations should be considered charitable—and thus subsidized through the tax system—only if they are able to attract a substantial degree of donative support from the public.[29]

26. *See generally* Relman, *supra* note 24.

27. *See* Clark, *supra* note 10 at 1460–62 (detailing the theoretical advantages of proprietary incentive in hospital care); *infra* notes 202–213 and accompanying text. The gist of this debate, which is only caricatured in the text, is captured cogently in Yoder, *supra* note 11, at 3–4, especially in the exchange between Arnold Relman and Uwe Reinhardt reprinted in that volume, *id.* at 209, and in Schlesinger, Marmor & Smithey, *Nonprofit and For-Profit Medical Care: Shifting Roles and Implications for Health Policy,* 12 J. HEALTH POL., POL'Y & L. 427 (1987) and Marmor, Schlesinger, & Smithey, *A New Look at Nonprofits: Health Care Policy in a Competitive Age,* 3 YALE J. ON REG. 313, 314–19 (1986) [hereinafter Marmor].

28. Marmor, Schlesinger & Smithey, *Nonprofit Organizations and Health Care,* in THE NONPROFIT SECTOR: A RESEARCH HANDBOOK 221, 222 (W. Powell ed. 1987).

29. This Article restricts its examination to the theory of the exemption conferred through I.R.C. § 501(c)(3) and its analogues in state law. In short, this Article attempts to explain only the *charitable* exemption. Thus, this Article does not address other grounds for granting tax exempt status to noncharitable organizations. For instance, some nonprofits are considered "exempt" from income taxes because they earn no income. These private, dues-supported organizations—typified by labor unions, social clubs, and condominium associations—are referred to as "mutual benefit organizations" because they exist in order to allow their members to enjoy a benefit provided more efficiently on a collective basis than when purchased individually. *See* Ellman, *supra* note 11, at 1032–42 (explaining the distinction between charitable and mutual benefit nonprofits); Hansmann, *supra* note 11, at 892–93 (same); *see also* Bittker & Rahdert, *supra* note 8, at 304 (noting the inherent difficulty of measuring the "income" of many exempt entities). Their receipts do not constitute income because they merely pool already-taxed income prior to its collective consumption. As explained by one case, "where individuals have banded together to produce recreational facilities on a mutual basis, it would be conceptually erroneous to impose a tax on the organization as a separate entity. . . . No income of the sort usually taxed has been generated; the money has simply been shifted from one pocket

II. THE LEGAL AND ANALYTICAL FRAMEWORK

A. The Existing Law of Hospital Tax Exemption

1. Federal Law and the Per Se Exempt View

The most visible source of law for the charitable exemption is section 501(c)(3) of the Internal Revenue Code (I.R.C. or Code), which exempts from income taxes "[c]orporations . . . organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition . . . or for the prevention of cruelty to children or animals . . . ."[30] Legislative history, court decisions and secondary commentary establish that the term "charitable" is not intended to be distinct from the remainder of this rather peculiar grouping of activities. Instead, "underlying all relevant parts of the Code, is the intent that entitlement to tax exemption depends on meeting certain common-law standards of charity."[31] The specifically enumerated activities are presumptively eligible for exemption by virtue of this legislative declaration of their charitable status, as long as they meet other, organizational and operational requirements. The exemption also extends to other, nonenumerated organizations that pursue purposes the law considers charitable. This statutory formulation conveniently allows us to examine the single term "charitable," which

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to another, both within the same pair of pants. . . . [A]s to these funds the organization does not operate as a separate entity." McGlotten v. Connally, 338 F. Supp. 448, 458 (D.D.C. 1972); *see also UBIT Hearings, supra* note 6, at 34, 47.

This Article also does not address tax exemptions granted by states to attract profitable industries to certain communities, thereby stimulating the local economy and creating new jobs. This targeted form of exemption falls outside the scope of this Article because it is conferred on an ad hoc basis without regard to the charitable status of the enterprise. *See, e.g.*, N.Y. REAL PROP. TAX LAW §§ 489-aaa, 489-ddd(1)(b) (McKinney 1984) (50% tax exemption for new industrial or commercial construction, phased out over ten years).

30. I.R.C. § 501(c)(3) (1989). The statute continues by defining an exempt organization as one, "no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation . . . and which does not participate in, or intervene in . . . any political campaign on behalf of (or in opposition to) any candidate for public office."

31. Bob Jones Univ. v. United States, 461 U.S. 574, 586 (1983); *see* Treas. Reg. § 1.501(c)(3)-1(d)(2) (1959) ("The term 'charitable' is . . . not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of 'charity' as developed by judicial decisions."); B. HOPKINS, THE LAW OF TAX-EXEMPT ORGANIZATIONS 45 (4th ed. 1983) ("[T]he term 'charitable' may be considered a generic term and, in its expansive sense, may be read to include 'religious,' 'scientific,' 'educational,' and like purposes . . . ."); P. TREUSCH, TAX-EXEMPT CHARITABLE ORGANIZATIONS 118 (3d ed. 1988) (" '[C]haritable' purpose was a catch-all category for most of the more specific purposes that were later added.").

combines these various activities into a unified concept of 501(c)(3) exemption.[32]

Nonprofit hospitals, frequently termed "voluntary hospitals," have come to epitomize the type of activity encompassed by the generic concept of charity.[33] Nonprofit hospitals have been characterized as voluntary since the nineteenth century, when they were organized by religious societies, heavily funded by donations, and staffed by doctors who worked without compensation and nurses who worked for room and board as part of their lifetime commitment to a religious order devoted to caring for the poor.[34] The role of hospitals as "almshouses for the poor" changed rapidly during the first half of the twentieth

32. This concept of what constitutes a charitable organization also appears in the definition of "social welfare" organizations which are exempt under I.R.C. § 501(c)(4). *See UBIT Hearings, supra* note 6, at 46 (statement of O. Donaldson Chapoton) ("The term 'social welfare' as used in section 501(c)(4) is similar to 'charitable purposes' as used in section 501(c)(3) and there is a substantial degree of overlap between the two provisions."); Bittker & Rahdert, *supra* note 8, at 331 (same). Unlike charitable organizations exempt under I.R.C. § 501(c)(3), however, social welfare organizations are not eligible to receive tax-deductible donations. *See* I.R.C. § 170(c)(2) (defining a deductible charitable contribution). On the other hand, social welfare organizations are allowed to engage in certain political activities without sacrificing their exemption. *See* B. HOPKINS, *supra* note 31, at 309. *But see* P. TREUSCH, *supra* note 31, at 324–25 (excessive political activity may mean organization is no longer promoting social welfare); I.R.C. § 504 (prohibiting 501(c)(3) organization which has had its exempt status revoked due to excessive political activity from qualifying as 501(c)(4) social welfare organization).

33. Indeed, in about half of the states they are specifically enumerated along with churches and schools. *See* ALASKA STAT. § 29.45.030(a)(3) (1990); ARIZ. REV. STAT. ANN. § 42.271.A.5 (Supp. 1990); CAL. REV. & TAX. CODE § 214 (West 1987 & Supp. 1990); CONN. GEN. STAT. ANN. § 12-81(16) (West 1983); FLA. STAT. ANN. § 196.197 (West 1989); GA. CODE ANN. § 48-5-41(a)(5) (Harrison Supp. 1989); HAW. REV. STAT. § 246-32(a) (Supp. 1985); IDAHO CODE § 63-105K (1989); KAN. STAT. ANN. § 79-201b (1989); LA. REV. STAT. ANN. § 47:1703 (West 1990) (exempting property owned by nonprofit entity organized for "health" purposes per Louisiana Constitution art. 7, sec. 21); ME. REV. STAT. ANN. tit. 36, § 652(1)(K) (1990); MD. TAX-PROP. CODE ANN. § 7-202(b)(1) (1986); MINN. STAT. ANN. § 272.02 (West 1989 & Supp. 1991); MISS. CODE ANN. § 27-31-1(f) (Supp. 1990) (exempting hospitals which maintain one charity ward); MONT. CODE ANN. § 15-6-201(1)(c) (1989) (exempting nonprofit health care facilities); N.J. STAT. ANN. § 54:4-3.6 (West 1986); N.Y. REAL PROP. TAX LAW § 420-a(1)(a) (McKinney 1984); N.C. GEN. STAT. § 105-278.8 (1989); N.D. CENT. CODE § 57-02-08 (1983); OKLA. STAT. ANN. tit. 68, § 2405(j) (West 1966 & Supp. 1991); PA. STAT. ANN. tit. 72, § 5020-204(a)(3) (Purdon 1990); R.I. GEN. LAWS § 44-3-3(12) (1988); S.C. CODE ANN. § 12-37-220(A)(2) (Law. Co-op. Supp. 1989); S.D. CODIFIED LAWS ANN. § 10-4-9.3 (Supp. 1990) (exempting property used primarily for health care); TEX. TAX CODE ANN. § 11.18 (Vernon Supp. 1991) (exempting charitable organizations providing medical care); WASH. REV. CODE ANN. § 84.36.040 (1989); WIS. STAT. ANN. § 70.11(4m) (West 1989); WYO. STAT. § 39-1-201(a)(xxv) (1990).

It is ironic, but fitting, that one of the first locations where their charitable status has come under attack is Tennessee, the "Volunteer State." *See* Downtown Hosp. Ass'n v. Tennessee State Bd. of Equalization, 760 S.W.2d 954 (Tenn. App. 1988).

34. *See, e.g.*, Board of Review v. Provident Hosp. & Training School Ass'n, 233 Ill. 243, 84 N.E. 216, 217 (1908); Sisters of Third Order of St. Francis v. Board of Review, 231 Ill. 317, 83 N.E. 272, 273 (1907).

century with developments in anesthesia, surgical technique and other aspects of medical science that suddenly transformed hospitals from the dumping ground of humanity to the pinnacle establishment of the health care delivery system. Still, nonprofit hospitals continued in their voluntary tradition, despite opening their doors to paying patients and a secular staff, by maintaining their commitment to treat all patients regardless of their ability to pay and by their continued, if partial, reliance on volunteer labor.[35]

The voluntary nature of nonprofit hospitals, however, has steadily abated over the past generation as a consequence of widespread employer-provided health insurance and massive governmental programs such as Medicare (for the elderly and disabled) and Medicaid (for the poor). The advent of third-party payors transformed the character of the nonprofit hospital sector. Pressured by the emerging competition of investor-owned hospitals, nonprofit hospitals have increasingly taken on the appearance of business enterprises by serving mostly paying patients, decreasing their reliance on donations or volunteer labor, and striving to generate as much surplus revenue as possible through commercial transactions.[36] Still, nonprofit hospitals for a time have retained a remnant of their voluntary tradition by using these generous sources of reimbursement for paying patients to cross-subsidize care for those who fall through the insurance cracks. This remaining voluntary tradition threatens to collapse into a token effort as a result of the sweeping restrictions in public and private insurance over the past few years that have severely constrained the ability of hospitals to shift the costs of indigent care to paying patients.[37] The merger of the operational characteristics of nonprofit and proprietary hospitals that this trend portends (or, in the view of many, that has

35. The history of the hospital industry presented in this section is drawn from the following sources: C. ROSENBERG, THE CARE OF STRANGERS (1987) (history of American hospitals); P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 146–76, 430–38 (1982); R. STEVENS, IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY (1989).

36. "A corporate ethos originating among the investor-owned chains has spread throughout the health-care system." Light, *Corporate Medicine for Profit,* SCI. AM., Dec. 1986, at 38, 42. "Throughout the country voluntary hospitals are attempting to model themselves after for-profit hospitals." J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 129. "Even the health care vocabulary is changing, infused with businesslike terms . . . [such as] 'marketing,' 'market share,' 'industry,' 'profitability,' and 'productivity,' to cite a few." Jones, DuVal & Lesparre, *Competition or Conscience? Mixed-Mission Dilemmas of the Voluntary Hospital,* 24 INQUIRY 110, 113 (1987).

37. J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 137–38. *See generally* Sloan, Valvona & Mullner, *Identifying the Issues: A Statistical Profile,* in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 16, 27–28 (1986).

already occurred)[38] has forced voluntary hospitals to undertake a thorough self-examination that seeks to redefine their distinct "mission."[39]

These shifts in the character of the voluntary hospital sector are mirrored in the shift of the Internal Revenue Service's (IRS) position concerning the exempt status of nonprofit hospitals.[40] A 1956 ruling reflected traditional notions of charity by requiring exempt hospitals to treat indigent patients "to the extent of their financial ability."[41] In 1969, three years after the implementation of Medicare and Medicaid, the IRS altered its position regarding the standards for exemption in response to the hospital industry's complaint that these public programs had greatly reduced the demand for charity care and rendered the existing standard for exemption an anachronism.[42]

In Revenue Ruling 69-545,[43] the IRS abandoned the charity care requirement imposed in 1956 and adopted a "per se" rule of hospital

38. *See infra* notes 236–41 and accompanying text.

39. The leader in this effort is David Seay, of the United Hospital Fund. *See* Seay & Sigmond, *Community Benefit Standards for Hospitals: Perceptions and Performance,* FRONTIERS HEALTH SERVICES MGMT., Spr. 1989, at 3; Seay & Vladeck, *Mission Matters,* in IN SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS 1 (1988). *See generally* CATHOLIC HEALTH ASSOCIATION, THE SOCIAL ACCOUNTABILITY BUDGET (1989) (summary on file with *Washington Law Review*); AMERICAN HOSPITAL ASSOCIATION, COMMUNITY BENEFIT AND TAX-EXEMPT STATUS: A SELF-ASSESSMENT GUIDE FOR HOSPITALS (1988).

40. The following sources extensively discuss the history of the IRS rulings and their relationship to the history of the nonprofit hospital sector: Bromberg, *Financing Health Care and the Effect of the Tax Law,* 39 LAW & CONTEMP. PROBS. 156 (1975) [hereinafter Bromberg, *Financing Health Care*]; Bromberg, *The Charitable Hospital,* 20 CATH. U.L. REV. 237 (1970) [hereinafter Bromberg, *Charitable Hospital*]; Mancino, *Income Tax Exemption of the Contemporary Nonprofit Hospital,* 32 ST. LOUIS U.L.J. 1015 (1988); Note, *Nonprofit Hospitals and the State Tax Exemption: An Analysis of the Issues Since* Utah County v. Intermountain Health Care, Inc., 9 VA. TAX REV. 599 (1990).

41. Rev. Rul. 56-185, 1956-1 C.B. 202, 203. *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).

42. *Tax Reform, 1969: Hearings Before the Committee on Ways and Means,* 91st Cong., 1st Sess. 1427 (1969) (statement of Julius M. Griesman, attorney, AHA); *see* A. SOMERS, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY 41 (1969) ("Thanks to Medicare, Medicaid, and numerous other public and private mechanisms for financing care for the indigent and medically indigent, in a few years free hospital care will approach the vanishing point."); Comment, *Federal Income Tax Exemption For Private Hospitals,* 36 FORDHAM L. REV. 747, 764 (1968) ("[P]ublic programs for mandatory hospitalization insurance, as well as the ever increasing coverage of private insurance plans, threaten to leave hospitals without patients who require free or below-cost care."). Observe, though, that this argument falsely assumes that a hospital that experiences no demand for charity care would not meet the requirements of the 1956 ruling. To the contrary, see *infra* note 44.

43. 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 industry regarding the charity care requirement of Rev. Rul. 56-185 surfaced during House hearings on the 1969 tax

exemption: an entity engaged in the "promotion of health" for the general benefit of the community is pursuing a charitable purpose, even though a portion of the community, such as indigents, are excluded from participation.[44] In this particular ruling, the IRS 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.[45] Though the hospital in question did not regularly accept charity patients, several factors, including a board of directors drawn from the general community and an emergency room open to nonpaying patients, convinced the IRS that the exemption should be continued.[46] The per se standard was further entrenched by a 1983 ruling establishing that even hospitals with limited services and no open emergency room, such as cancer hospitals,

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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., 1st 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* STAFF OF SENATE COMM. ON FINANCE, 91st Cong., 1st Sess., REPORT ON MEDICARE AND MEDICAID PROBLEMS ISSUES AND ALTERNATIVES 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.

44. STAFF OF SENATE COMM. ON FINANCE, 91st Cong., 1st Sess., REPORT ON MEDICARE AND MEDICAID PROBLEMS, ISSUES AND ALTERNATIVES 55, 58 (Comm. Print 1970). It is possible to maintain, based on a different reading of these rulings, that they indicate very little shift in policy. The 1956 ruling did not necessarily require large amounts of free care by all tax-exempt hospitals. As explained in Eastern Kentucky Welfare Rights Ass'n v. Simon, 506 F.2d 1278, 1289–90 n.26 (1974), *vacated on other grounds*, 426 U.S. 26 (1976):

> [H]ospitals were required to provide free care only to the extent of their financial ability. Hospitals operating at a deficit would have no obligation under Ruling 56-185. In addition the Ruling qualified the "financial ability" standard by providing: "The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes.... It may also set aside earnings which it uses for improvements and additions to hospital facilities.... A nominal charity record for a given period of time, in the absence of charitable demands of the community, will not affect its right to continued exemption."

Nevertheless, it is clear that the 1956 ruling would not have allowed hospitals to refuse repeated demands for treatment by uninsured patients if hospitals had the financial capacity to meet those demands. *See* Bromberg, *Charity and Change: Current Problems of Tax Exempt Health and Welfare Organizations in Perspective*, in TAX PROBLEMS OF NON-PROFIT ORGANIZATIONS 1970, at 249, 256 (1970) (recounting history of revenue agents denying exemption to hospitals under 1956 ruling based on their lack of demonstrated charity care). In contrast, the 1969 ruling lets the hospital decide whether to devote surplus revenues to charity care or to hospital expansion. This Article therefore continues to treat these rulings as they have been uniformly characterized by other scholars in this field. *See generally supra* note 40.

45. Rev. Rul. 69-545, 1969-2 C.B. 117, 118.

46. *Id.*

could qualify for exemption merely by treating all patients able to pay.[47]

Public interest advocates mounted an aggressive challenge the lifting of the free care requirement for hospitals. In *Eastern Kentucky Welfare Rights Association v. Simon,*[48] these advocates succeeded in the district court, but they lost when the court of appeals upheld the government on the merits of its 1969 ruling. The Supreme Court dismissed the case on procedural grounds, reasoning that indigent residents who might one day require free hospital services lack standing to challenge a hospital's exemption,[49] thus effectively terminating all future attacks on the federal position. The D.C. Circuit's opinion nevertheless remains the most influential articulation of the per se exempt status of hospitals. The court reasoned that "the rationale upon which the [free 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]."[50] In essence, the court held that nonprofit hospitals are charitable even if they do not provide free care because the concept of what constitutes a charity must change "to recognize the changing

47. Rev. Rul. 83-157, 1983-2 C.B. 94. For a more detailed discussion of the 1956, 1969, and 1983 rulings, see Colombo, *supra* note 41, at 473–81.

48. 506 F.2d 1278 (1974), *vacated on other grounds,* 426 U.S. 26 (1976).

49. Simon v. Eastern Ky. Welfare Rights Org., 426 U.S. 26 (1976). The Court found that the connection between the government's ruling and any possible refusal of service to this class of patients was too remote and speculative to constitute a case or controversy. It reasoned that hospitals might choose to treat these plaintiffs anyway, or that they might choose to forego the exemption (and thus be under no duty to treat) if the government were to adopt the plaintiffs' position. The Court held that these two possibilities were so likely as to render "mere speculation" the possibility that the plaintiffs would be treated only if the government changed its position. This holding is so out of step with other precedents on causation in standing analysis that it is taken as establishing a sui generis rule that no one other than the taxpayer may challenge an IRS ruling. *Compare* United States v. Students Challenging Regulatory Agency Procedures (SCRAP), 412 U.S. 669 (1973) (standing exists for law students to challenge ICC's approval of a general, nationwide rate increase for railway freight based on the allegation that this action will lead to more litter in Washington, D.C. because it will raise the costs of recycling) *with* Allen v. Wright, 468 U.S. 737 (1984) (parents of black students have no standing to challenge IRS grant of tax exemption to racially discriminatory religious schools). *See generally* B. BITTKER, FEDERAL TAXATION OF INCOME, ESTATES AND GIFTS ¶115.9.4 (1981 & Supp. 1989).

50. *Eastern Ky.,* 506 F.2d at 1288–89; *see also* SHARE v. Commissioner of Revenue, 363 N.W.2d 47, 52 (Minn. 1985) ("[M]ajor changes in the area of health care . . . have necessitated changes as well in definitional predicates . . . ."); Medical Center Hosp. v. City of Burlington, 152 Vt. 611, 566 A.2d 1352, 1356 (1989) ("[W]e do not believe that we are . . . required to ignore the immense sociological and economic changes that have taken place in the health care profession . . . ."); *cf.* Utah County v. Intermountain Health Care, Inc., 709 P.2d 265 (Utah 1985) (changes in health care result in revoking charitable status).

economic, social and technological" environment in which hospitals now function.[51] This redefinition of charity is circular because it assumes the question that it purports to answer—whether hospitals should continue to enjoy charitable status. This view seems determined to reshape the concept of charity however necessary to fit the predominant pattern of what most nonprofit hospitals are currently doing. This unanalytic, question-begging approach characterizes much of the argument in favor of granting the exemption to hospitals.[52]

2. *State Law and the Charity Care Standard*

State statutes and constitutional provisions tend to follow a pattern nearly identical to I.R.C. section 501(c)(3). Many states automatically confer exemption from income tax on any organization that carries a federal section 501(c)(3) exemption.[53] Property tax exemptions exist

51. *Eastern Ky.*, 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); *see also* Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals*, 16 AM. J. L. & MED. 327, 331 (1990) ("Most articles have presupposed that tax exemption for hospitals is desirable . . . ."); *id.* at 379 ("We are invariably reminded that the conservative test is anachronistic . . . . While this is true, it does not necessarily follow that the changed circumstances still merit a tax exemption. Instead, perhaps the exemption is as anachronistic as the reasons that originally gave rise to it. Things that were once tax-exempt can become taxable if circumstances change . . . ."); *id.* at 380 ("The right question to ask is whether the exemption itself makes sense, and not whether the old beliefs about exemption are anachronistic.").

52. *See* Rammel & Parsons, Utah County & 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, 77 (1989) (arguing for revised definition of charity because "the *Utah County* court has articulated a standard for which compliance [by hospitals] is virtually impossible"); Mancino, *supra* note 40, at 1019-20 (maintaining that definition of charity must change to keep up with changes in hospital industry); Bromberg, *supra* note 44, at 249 (same).

53. *E.g.*, ALA. CODE § 40-18-32(11) (Supp. 1990); COLO. REV. STAT. § 39-22-117 (Supp. 1990); CONN. GEN. STAT. ANN. § 12-214(2) (West Supp. 1990); FLA. STAT. ANN. § 220.13(2)(h) (West 1989); GA. CODE ANN. § 48-7-25 (Harrison 1989); IDAHO CODE § 63-3026 (1989); ILL. ANN. STAT. ch. 120, ¶2-205(a) (Smith-Hurd Supp. 1990); KAN. STAT. ANN. § 79-32,113 (1989); KY. REV. STAT. ANN. § 141.040(g) (Michie/Bobbs-Merrill 1989); ME. REV. STAT. ANN. tit. 36, § 5102(6) (1990) (imposing tax only on corporations taxable under the I.R.C., thereby adopting I.R.C. § 501(c)(3) by implication); MD. TAX-GEN. CODE ANN. § 10-104 (1988); MASS. ANN. LAWS ch. 63, § 30 (Law. Co-op. Supp. 1990); MICH. COMP. LAWS ANN. § 206.201(1) (West 1989); MINN. STAT. ANN. § 290.05 (West 1989); MO. ANN. STAT. § 143.441.2.(1) (Vernon Supp. 1990); NEB. REV. STAT. § 77-2714 (1986); N.M. STAT. ANN. § 7-2-4 (Supp. 1990); N.D. CENT. CODE § 57-38-09 (1983); OKLA. STAT. ANN. tit. 68, § 2359 (West

by virtue of independent state law provisions,[54] but these are worded in a strikingly similar fashion: the predominant pattern confers the exemption on religious, educational and charitable organizations.[55] In interpreting these statutes, the vast majority of states adhere to the federal view that promotion of health for the general community constitutes a charitable purpose, regardless of whether the entity in question provides free or subsidized health care to the poor.[56] A small minority of states, however, cling to the view that health care delivery does not in and of itself deserve charitable status. These states require some additional contribution to society, such as charity care, before state law confers tax exempt status.[57] The leading judicial decision

1991); ORE. REV. STAT. § 317.080 (Supp. 1990); UTAH CODE ANN. § 59-7-105(1)(a) (1987); VA. CODE ANN. § 58.1-401(5) (Supp. 1990); W. VA. CODE § 11-24-5 (1987). It is especially curious to note that Utah, which automatically confers an income tax exemption on organizations meeting the requirements of I.R.C. § 501(c)(3) (and, by implication, the per se test), nevertheless has refused to follow the per se rule for the property tax exemption. *See infra* notes 58–62 and accompanying text.

In addition, a number of state income tax statutes which do not specifically refer to the I.R.C. nevertheless adopt exemption language virtually identical to I.R.C. § 501(c)(3). *E.g.*, ARIZ. REV. STAT. ANN. § 43-1201.4 (1980); ARK. CODE ANN. § 26-51-303 (1987); CAL. REV. & TAX CODE § 23701(d) (West Supp. 1990); DEL. CODE ANN. tit. 30, § 1902(b)(2) (1985); LA. REV. STAT. ANN. § 47:121(5) (West 1990); MISS. CODE ANN. § 27-7-29(a)(3) (Supp. 1990); MONT. CODE ANN. § 15-31-102(1)(d) (1989); N.H. REV. STAT. ANN. § 77:8 (1971); N.C. GEN. STAT. § 105-130.11(a)(3) (1989); VT. STAT. ANN. tit. 32, § 5811(3)(J) (1981).

54. Ginsberg, *The Real Property Tax Exemption of Nonprofit Organizations: A Perspective,* 53 TEMPLE L. Q. 291, 292 (1980) (every state has a statute on the subject and all but seven have a constitutional provision).

55. While the exact language sometimes varies (for example, use of the word "church" instead of "religious" or "benevolent" instead of "charitable"), and the statutory construction is sometimes oblique (Washington, for example, uses a separate statutory section for each type of exemption), all states except Maine and Vermont appear to follow this general regime in their property tax exemption statutes, and these states differ only in the omission of an exemption for general "educational" purposes. Maine's exemption statute, for example, contains a limited exemption for property owned by "colleges," but not schools generally. ME. REV. STAT. ANN. tit. 36, § 652 (1990). Similarly, Vermont exempts property owned or leased by "colleges, academies or other public schools" but does not appear to exempt property owned by *private* educational institutions. VT. STAT. ANN. tit. 32, § 3802(4) (1981). *See also* W. WELLFORD & J. GALLAGHER, UNFAIR COMPETITION? THE CHALLENGE TO TAX EXEMPTION app. A (1988) (50-state survey of the laws of charitable property tax exemption); Comment, *Nonprofit Hospitals: The Relationship Between Charitable Tax Exemptions and Care for Indigents,* 43 SW. L.J. 759, 774 (1989).

56. Rammell & Parsons, *supra* note 52, at 73–74. For a state-by-state analysis of property tax exemption laws as they apply to health care providers, see *Taxation,* in 2B HEALTH LAW CENTER, HOSPITAL LAW MANUAL 37-152 (1988).

57. Rammell & Parsons, *supra* note 52, at 74. For example, in *Hospital Utilization Project v. Pennsylvania,* 507 Pa. 1, 487 A.2d 1306 (1985), the Pennsylvania Supreme Court upheld the denial of tax exemption to a nonprofit provider of statistical analysis of patient treatment and cost data to hospitals because the services were provided on a fee-for-service basis. According to the court, one element favoring the classification of an entity as a charity under Pennsylvania law

supporting this view is *Utah County v. Intermountain Health Care, Inc.*[58]

In *Utah County,* the Utah Supreme Court affirmed a county board of equalization's denial of exempt status to two nonprofit hospitals, based primarily on their failure to render sufficient charity care. After examining the historical shift in the mission of nonprofit hospitals from treating the poor to treating the community at large, the majority noted that the hospitals in question derived virtually all their operating revenues from patient charges,[59] committed less than one percent of their gross revenues to charity care,[60] and charged patients prevailing market rates.[61] According to the majority, the hospitals "confuse[d] the element of gift to the community, which an entity must demonstrate in order to qualify as a charity under our Constitution, with the concept of community benefit, which any of countless private enterprises might provide."[62]

In the wake of *Utah County,* taxing authorities revoked the exempt status of nonprofit hospitals in Missouri, Pennsylvania, Tennessee and Vermont, but state courts reversed in almost every instance.[63] Recon-

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is that the entity "[d]onates or renders gratuitously a substantial portion of its services." *Id.* at 1317.

58. 709 P.2d 265 (Utah 1985).

59. *Id.* at 273.

60. *Id.* at 274.

61. *Id.* at 273.

62. *Id.* at 276. Utah hospitals attempted to reverse this decision through a referendum initiative that would have declared nonprofit hospitals per se exempt, but the measure was defeated by a 50.1% to 49.9% vote. Salt Lake County subsequently revoked the exemption of four other hospitals. *See* Jeppson, *A Time for Action by Not-For-Profit Hospitals,* FRONTIERS HEALTH SERVICES MGMT., Spr. 1989, at 40, 41; Rammell & Parsons, *supra* note 52, at 81.

63. Callaway Community Hosp. Ass'n v. Craighead, 759 S.W.2d 253 (Mo. App. 1988); St. Luke's Hosp. v. Board of Assessment Appeals, No. 88-C-2691 (Pa. C.P., Lehigh Co., Apr. 19, 1990); Downtown Hosp. Ass'n v. Tennessee State Bd. of Equalization, 760 S.W.2d 954 (Tenn. App. 1988); Medical Center Hosp. v. City of Burlington, 152 Vt. 611, 566 A.2d 1352 (1989); *see generally* NORTH CAROLINA CENTER FOR PUB. POL'Y RESEARCH, COMPARING THE PERFORMANCE OF FOR-PROFIT AND NOT-FOR-PROFIT HOSPITALS IN NORTH CAROLINA 159–66 (1989); Greene, *Governmental Units Challenge Not-For-Profits' Tax Exemptions,* MOD. HEALTHCARE, Dec. 4, 1987, at 67; Hudson, *Not-For-Profit Hospitals Fight Tax-Exempt Challenges,* HOSPITALS, Oct. 20, 1990, at 32–37; Hyman, *supra* note 51, at 345–46; Pear, *Tax Exemptions of Nonprofit Hospitals Scrutinized,* N.Y. Times, Dec. 18, 1990, at A1, col. 2, B17, col. 5 ("Local officials have tried to revoke tax exemptions from nonprofit hospitals in at least 12 states.").

Pennsylvania appears to be the only state other than Utah with a legal climate hostile to hospital tax exemption, although its precedents are presently much cloudier. In West Allegheny Hospital v. Board of Property Assessment, Appeals & Review, 500 Pa. 236, 455 A.2d 1170 (1982), the court upheld a hospital's exemption despite its low level of charity care. The same court, however, subsequently ruled that an organization providing administrative support to hospitals does not earn the exemption where the organization "has no . . . open-admissions policy . . . [and fails to prove that it] provides its services without regard to the [recipient's] ability to

sideration of tax exemption for health care providers also has been on the legislative agenda in more than a dozen states recently, although these efforts have generally proved unsuccessful.[64] The issue has also

pay." Hospital Utilization Project v. Commonwealth, 507 Pa. 1, 487 A.2d 1306, 1316 (1985). Following this apparent inconsistency, one Pennsylvania trial court has upheld a hospital's exemption, *St. Luke's Hospital, supra,* while another has revoked the exemption. School Dist. v. Hamot Medical Center, No. 138-A-2989 (Pa. C.P., Erie Co., May 18, 1990). *Hamot Medical Center,* however, presented unusually strong facts. The hospital failed to maintain an open admissions policy of any kind. Moreover, the hospital violated the prohibition on private inurement by transferring earnings to profit-making subsidiaries and by paying hospital executives excessive compensation. Nevertheless, the most recent decision denied an exemption to a diagnostic clinic solely on grounds of charity care, observing that "the Institute has failed to prove that it donated a 'substantial' portion of its services." *In re* Pittsburgh NMR Inst., 557 A.2d 220, 224 (Pa. Commw. Ct. 1990).

Taxing authorities in Pittsburgh succeeded in collecting increased revenues from the Presbyterian-University Hospital without revoking its exemption. The hospital agreed to pay $11 million over 10 years for city services. Conversation with Dan Pelligrini, City Attorney, Pittsburgh, Pa. (Aug. 17, 1988) (notes on file with the *Washington Law Review*); *see also* Robinson, *Via Donation or Tax, Cities Want More Revenues,* HOSPITALS, Mar. 20, 1989, at 55. Also, the Attorney General of Texas has sued Methodist Hospital of Houston, seeking to revoke its property tax exemption. State v. Methodist Hosp. Sys., No. 494,212 (126th Jud. Dist. Travis County, Tex. filed Nov. 26, 1990); *see also* Taylor, *Charity Begins in Court? Hospital Sued in Novel Lawsuit,* Nat'l L.J., Feb. 18, 1991, at 3, col. 1 (discussing *State v. Methodist Hosp. Sys.* and commenting: "This [case] represents a new legal avenue, a new hook for examining the charitable mission of a hospital. . . . There's no question everyone in the industry will be watching this case").

64. North Carolina Center for Pub. Pol'y Research, *supra* note 63, at 159–66 (summarizing the challenges to hospital exemptions across the country and discussing state-by-state activity in detail); Baldwin, *supra* note 18, at 37 (discussing challenges to hospital exemption initated by in the states of Florida and Oklahoma); Hudson, *supra* note 63, at 33 (same); Larkin, *Financial Success May Invite Local Tax Scrutiny,* HOSPITALS, Oct. 5, 1988, at 30 (discussing challenges pending in at least 20 state courts or legislatures); Robinson, *Via Donation or Tax, Cities Want More Revenues,* HOSPITALS, Mar. 20, 1989, at 55 (same); Seay & Sigmond, *supra* note 39, at 4–5 ("Currently, more than a dozen states have reexamined, or have begun to reexamine, the basic tax-exemption policies for voluntary hospitals, as have numerous cities, counties, and other municipalities.") (citing California, Iowa, Kansas, Minnisota, Mississippi, Pennsylvania, Tennessee, Utah, Vermont, Virginia, Washington, and West Virginia); Comment, *supra* note 55, at 779 ("A 1988 survey . . . reveals that at least nine states . . . are reevaluating charitable tax exemptions for nonprofit hospitals . . . ."). "In 1987, at least 13 states considered changes in the tax-exempt status of not-for-profit hospitals. Several states established study commissions to look into the [issue]." NORTH CAROLINA CENTER FOR PUB. POL'Y RESEARCH, *supra* note 63, at 159. *See generally* Barker, *Reexamining of 501(c)(3) Exemption of Hospitals as Charitable Organizations,* 1990 TAX NOTES 339, 346–47.

Since 1923, Alabama has required hospitals to meet a statutorily-defined level of charity care in order to receive a property tax exemption. *See* Gay v. State, 228 Ala. 253, 153 So. 767, 770 (1934). The current statutory provision exempts up to $75,000 worth of property used exclusively for hospital purposes, if at least "15% of the [hospital's] business" is the treatment of charity patients. ALA. CODE § 40-9-1 (Supp. 1990). Apparently, Alabama hospitals must annually certify compliance with this requirement to be eligible for the exemption. *Id.*

It is also noteworthy that "public opinion is closely divided over whether or not hospitals should pay taxes: 49 percent think they should; 43 percent do not." Seaver, *Are Hospitals Becoming Too Businesslike?,* HOSPITALS, Feb. 20, 1990, at 86.

attracted significant attention from Congress. One congressman has publicly questioned the continued need for tax exemption of nonprofit hospitals,[65] and two major legislative efforts to change hospital exemption standards are underway.[66]

Because subsequent courts have found the reasoning of *Utah County* unconvincing,[67] and because the reasoning of *Eastern Kentucky* is facially unsatisfactory,[68] proper resolution of the tax-exempt status of nonprofit hospitals is not likely to be based on whether health care is a per se charitable enterprise, or whether free services to the poor is the essence of the charitable exemption for hospitals. Moreover, resolving this conflict for hospitals requires an understanding of how charity is generally defined for tax purposes. This in turn requires the formulation of a comprehensive theory of what activities deserve subsidization

65. N.Y. Times, July 15, 1987, at A21, col. 1:

> [Congressman Stark, a] key member of a Congressional tax-writing committee said today that the Federal tax exemption for nonprofit hospitals was probably unwarranted because they generally did not provide substantial amounts of charitable care. . . . Mr. Stark, a Democrat, said it was unlikely that Congress would revoke the tax exemption for nonprofit hospitals. But he said such hospitals should be required to demonstrate the benefits they provide to the community through charitable care.

See also Sullivan & Moore, *A Critical Look at Recent Developments in Tax Exempt Hospitals,* 23 J. HEALTH & HOSP. L. 65 (1990) (IRS officials warning that hospitals that close their emergency rooms or dump emergency patients are threatening their exempt status).

66. In the current congressional session, Rep. Edward Roybal, Chairman of the House Committee on Aging, introduced the "Charity Care and Hospital Tax-Exempt Status Reform Act," H.R. 790, 102d Cong., 1st Sess., 137 CONG. REC. E395–97 (1991). This Bill would revoke a hospital's exemption or impose an excise tax unless the hospital could show it returned 85% of the value of all federal, state and local exemptions to the community through uncompensated care, unique community benefits or other services not provided by for-profit hospitals. For further description and analysis of this Bill, see *infra* note 151. In addition, Rep. Brian Donnelly, a member of the House Ways and Means Committee and a ranking Democratic member of the Subcommittee on Health, is preparing legislation that would incorporate ideas expressed by Thomas Barker, Rep. Donnelly's legislative director, in an article published in July, 1990. *See* Barker, *supra* note 64. Barker suggests a return to a charity care standard for exempt hospitals, albeit a more flexible standard than originally contained in Rev. Rul. 56-185, 1956-1 C.B. 202. Barker, *supra* note 64, at 350–51. Barker would also permit exemption for hospitals that could demonstrate "a significant and substantial community benefit," such as by being the sole community hospital as defined by Medicare. *Id.* at 351.

67. *See supra* note 63 and accompanying text. Even in Utah, the impact of the *Utah County* holding has been severely diluted by the set of standards subsequently issued to implement this decision. UTAH STATE TAX COMMISSION, NONPROFIT HOSPITAL AND NURSING HOME CHARITABLE PROPERTY TAX EXEMPTION STANDARDS (Dec. 18, 1990). These standards count as charity care not only the charge-based value of free services, but also the value of community service activities and the difference between the hospital's usual discounted charges and the amount it receives from Medicare and Medicaid. *Id.* at 4. Moreover, these standards credit as part of a hospital's "gift to the community" the donations of time and money the hospital *receives* from the community. *Id.* at 4–5. This latter provision absurdly views the exemption as a means to reimburse hospitals for another subsidy they receive.

68. *See supra* notes 51–52 and accompanying text.

through the tax system, in other words, why *any* nonprofit organization should be tax exempt.

B. The Criteria for Evaluating Theories of Exemption

Before undertaking a critique of the various bases for the charitable exemption, it is helpful to articulate the precise criteria that a successful theory for exemption should satisfy. Such a theory should: (1) identify activities deserving social subsidy, which entails a determination of both worthiness and neediness; (2) distribute the subsidy in rough proportion to the degree of deservedness; (3) explain both the income tax and the property tax exemption, and, ideally, explain the related charitable deduction as well as the various operational constraints that attach to charitable status; and (4) align generally with an intuitive concept of what constitutes a charity and the major historical categories of exempt entities.[69]

1. Deservedness

This Article follows the prevailing view that the charitable exemption constitutes an implicit government subsidy of the activities it covers because it deviates from the ordinary tax base—either income or property.[70] Accordingly, the exemption is justified only where there is a convincing showing that the activity in question deserves a social subsidy. There are two elements to deservedness: *worthiness* and *neediness.* At a minimum, exemption requires some reliable indication of which activities out of the vast array of human endeavors are socially worthy. But worthiness alone is not sufficient without neediness. An organization may be willing to continue its meritorious pursuits absent

69. 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 67, 76–78 (W. Powell ed. 1987); J. JENSEN, *supra* note 3, at 148:

> A valid case for exemption should have at least three aspects. In the first place, the property seeking exemption should be used in rendering a service affected with a bona fide public interest. . . . In the second place, the service deserving such subsidy must be incapable of being fostered adequately on a commercial, *quid pro quo* basis. . . . In the third place, the tax exemption method of subsidizing these services should not be used unless it can be done without serious disproportion between the benefits and costs to localities interested.

See also S. SURREY, *supra* note 12, at 134; S. SURREY & P. MCDANIEL, *supra* note 12, at 72–83.

70. Regan v. Taxation with Representation, 461 U.S. 540, 544–45 (1983) ("[T]ax exemptions . . . are a form of subsidy that is administered through the tax system . . . ."); *see supra* note 12. The contrasting view looks for a justification of the exemption that would explain why charitable income or property is not in the tax base to begin with. *See* P. SWORDS, CHARITABLE REAL PROPERTY TAX EXEMPTIONS IN NEW YORK STATE 200 (1981); *see also* Simon, *supra* note 69, at 75; *infra* notes 286–90 and accompanying text (developing further reasons for rejecting this minority view).

a subsidy. If so, a subsidy is a waste of scarce government resources that could be devoted to other, more productive causes. Even if the level of service provided by the nonprofit sector would diminish without the exemption, the exemption is not necessary unless neither the proprietary sector nor the government is capable of providing the same social benefits as efficiently. Ideally, therefore, the definition of charity should identify activities whose social benefits would be irreplaceably reduced absent the subsidy.

2. Proportionality

In addition to guarding against subsidization of activities that are unworthy or that simply 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, a proper concept of charity should at least roughly match the level of support to the level of deservedness. In fact, most theories for the exemption bestow tax relief in such a manner that "it would be sheer coincidence if the value of the tax exemption were to match the . . . actual needs for the service,"[71] or, more perversely, in a fashion that gives the greatest tax break to the least deserving.

Another way to capture the substance of the proportionality criterion is to ask whether it makes sense to administer a deserving subsidy through an income or property tax exemption. It is not enough to demonstrate that charitable institutions deserve government support; it is necessary to show that tax subsidies represent the most sensible vehicle for support, 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.[72]

71. Gabler & Shannon, *supra* note 9, at 2544.

72. A political cynic might contend that it is hopeless to formulate such a theory of charitable exemption because "charity" is nothing more than an empty label that politicians place on whatever activity they desire to subsidize, for reasons of political expediency, through the tax system rather than through direct appropriations. One might also take issue with this criterion less cynically by maintaining that the exemption is frequently the only way that deserving organizations can obtain government support because legislators fear the voter approbation that attends direct funding. These arguments are unconvincing for the following reasons.

First, the fact that political expediency might describe political reality at some level should not deter the formulation of a more principled application of the exemption. Idealism aside, such cynical characterizations of the charitable exemption are largely inaccurate. Legislators rarely determine charitable status; the decision generally rests with taxing authorities. Even if politicians were to make this choice, they might choose to fund the worthwhile activity in a direct fashion if a coherent theory of the exemption foreclosed a tax subsidy as an option. Where the legislature declined to subsidize the activity, and an unprincipled application of the exemption was the only available option, perhaps the activity does not deserve support. A tax subsidy is considered politically expedient precisely because it disguises a spending decision from

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. Organizations exempt under I.R.C. 501(c)(3) are generally eligible to receive tax deductible donations,[73] and charitable status usually results in exemption from state and local property, income, and sometimes sales tax as well. On the burden side of the equation, the charitable exemption imposes certain limitations on an organization's structure and on its scope of operation. It must be truly nonprofit, so that no earnings inure to the benefit of a private individual, and it may not engage in substantial political lobbying or in any political campaigning.[74] Moreover, the exemption does not extend to earnings derived from activities unrelated to its exempt purpose, even if those earnings ultimately support the exempt purpose.[75] A valid concept of charity or theory of exemption should offer a cogent explanation for these tax benefits and operational constraints.[76]

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the legislators' political constituency. S. SURREY & P. MCDANIEL, *supra* note 12, at 104. If an informed constituency objects to the expenditure, then any form of subsidy is improper. Witness, for instance, the pork barrel politics that transpired during the Tax Reform Act of 1986. J. BIRNBAUM & A. MURRAY, SHOWDOWN AT GUCCI GULCH 146–47 (1987).

73. *See* I.R.C. § 170(c) (1989).

74. I.R.C. §§ 501(c)(3). State exemption statutes which follow the language of I.R.C. § 501(c)(3) incorporate similar standards by implication. Other state property and income tax exemption statutes explicitly contain the inurement prohibition. *See, e.g.,* GA. CODE ANN. § 91A-1102(a)(5) (Harrison 1989); HAW. REV. STAT. § 246-32(e) (1985); WIS. STAT. ANN. § 70-11(4m) (West 1989). Even where the language is less precise, as in most state property tax exemption provisions, lack of private inurement is generally considered essential to "charitable" status. *See, e.g., In re* Claim of Assembly Homes v. Yellow Medicine County, 273 Minn. 197, 203–04, 140 N.W.2d 336, 340–41 (1966) (construing the words "purely public charity" as incorporating a prohibition against private inurement). *See generally* 2B HEALTH LAW CENTER, *supra* note 56, at 21. The same is true for the restriction on political activity. *See, e.g.,* Pennsylvania v. American Anti-Vivisection Soc'y, 32 Pa. Commw. 70, 377 A.2d 1378 (1977) (since primary activity of organization was political lobbying, organization was not a charity).

75. I.R.C. § 511–14. States generally do not have their own versions of the unrelated business income tax contained in I.R.C. § 511, although state law may provide that income of an exempt organization taxable under § 511 is also taxable at the state level. *See, e.g.,* ALA. CODE § 40-18-32(c) (Supp. 1990); ARIZ. REV. STAT. ANN. § 43-1231 (Supp. 1990). *See generally* W. WELLFORD & J. GALLAGHER, *supra* note 55, at app. A (surveying state tax exemption statutes).

76. Professor Harvey Dale disagrees with this universality criterion. Quoting the aphoristic wisdom of H.L. Mencken that "[f]or every complex problem, there is a solution which is simple, elegant, . . . and wrong," he maintains that the exemption is a creature of history, not logic, and advocates a case-by-case approach to applying the exemption that allows it to grow haphazardly like a coral reef. *UBIT Hearings, supra* note 6, at 1860, 1864 (statement of Harvey P. Dale, Professor of Law and Director, Study on Law and Philanthropy, N.Y.U. School of Law); *see also* H. Dale, Rationales for Tax Exemption 1 (Feb. 1, 1988) (unpublished manuscript) ("[N]o single rationale can or should be expected to explain or justify tax-exempt status. The not-for-profit

4. Historical Consistency

It is not our naive ambition either to repudiate the charitable exemption or to reformulate it to fit some overly fine sense of intellectual aesthetics. 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.[77] A successful theory, therefore, should be roughly consistent with the present scope of the exemption to encompass the major historical categories of exemption—religion, education, and social welfare. 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.

This Article proceeds through a systematic critique of the existing theories for the charitable exemption, employing these four criteria. It begins by examining the conventional rationales for hospital exemption: health care per se, free services to the poor, relief of government burden, and community benefit. It then addresses two unconventional theories advanced by academics: Professor Bittker's income measurement theory (that it is improper to conceive of charitable organizations as earning income) and Professor Hansmann's capital subsidy theory (that it is defensible to use the exemption to help certain nonprofit firms to overcome their comparative disadvantage in accessing capital markets). Finding these theories deficient, this Article then outlines a proposal for the donative theory of the charitable exemption.

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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.").

This theoretical agnosticism may be convincing in assessing the universe of exempt organizations, as legislators award peripheral exemptions for a variety of reasons unrelated to the charitable concept (such as to attract new industrial growth or to exempt organizations that do not earn income); *see supra* note 29. Dale's perspective, however, cannot suffice for the core charitable exemption that employs a structure purporting to define the scope of its benefits through the single concept of charity. Therefore, it demands a coherent, organizing rationale. It is possible that each limitation connected with the exemption (described in the preceding paragraph of text) can be sustained as a side constraint on the exemption, one whose justification is independent of the core rationale for the exemption. However, all these limitations are generally thought to derive from the concept of charity as that term has been developed through centuries of judicial decisions in the field of charitable trusts. *See infra* notes 97–107. This unitary construction requires that we search for a cohesive concept of what constitutes a charity and why it should be exempt. If no such unifying rationale for the charitable exemption exists, it should be abandoned and replaced by a structure that forthrightly acknowledges whatever the charitable label is masking.

77. This criterion does not seek to preserve 400 years of history merely for its own sake. Rather, it attempts to place history in its appropriate relationship to the charitable exemption.

III. A CRITIQUE OF TRADITIONAL THEORIES OF TAX EXEMPTION

A. Health Care Per Se and the Law of Charitable Trusts

The per se view of exemption employed by the IRS and a majority of states is not new; 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 lifted 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 its "generally accepted legal sense . . . as developed by judicial decisions,"[78] and the Supreme Court reiterated in 1983 that "underlying all relevant parts of the Code . . . [are] certain common-law standards of charity,"[79] they were referring to the law of charitable trusts, specifically, the 1601 Statute of Charitable Uses which first codified the legal concept of charity.[80] Nevertheless, commentators have generally ignored, or at least failed to explain, the relationship between this body of law and the rationale for tax exemption.[81]

1. Health Care Under the Statute of Charitable Uses

Many sources of charitable trust law establish that health care is a per se charitable enterprise, equivalent in its charitable stature to religion and education. This body of law came into prominence in 1601 with the Elizabethan Statute of Charitable Uses, which strengthened

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

79. Bob Jones Univ. v. United States, 461 U.S. 574, 586 (1983).

80. *Id.* at 588 ("The origins of [the] exemptions lie in the special privileges that have long been extended to charitable trusts."); Bittker & Rahdert, *supra* note 8, at 301; Liles & Blum, *supra* note 2, at 20–21; Thompson, *The Unadministrability of the Federal Charitable Tax Exemption: Causes, Effects and Remedies,* 5 VA. TAX REV. 1, 12–13 (1985). Further support for this proposition lies in the fact that Congress patterned the original income tax after the existing English model. *Bob Jones Univ.,* 461 U.S. at 589 n.13 ("[T]he list of exempt organizations appears to have been patterned upon English income tax statutes . . . ."). And, in the celebrated case of Commissioners v. Pemsel, 1891 App. Cas. 531 (H.L.), decided just three years before the 1894 Congressional enactment, the House of Lords declared that the same concept of charity would prevail throughout British law, applying equally to the law of charitable trusts and the law of tax exemption. *See* L. SHERIDAN & G. KEETON, THE MODERN LAW OF CHARITIES 29 (3d ed. 1983) (charity has "[a] [c]ommon [m]eaning for [a]ll [p]urposes"); *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."); Belknap, *supra* note 4, at 2031.

81. *Accord* Mancino, *supra* note 40, at 1017–18 (observing that academicians have overlooked the common law of charitable trusts); Thompson, *supra* note 80, at 7 (maintaining that IRS decisions have "blurred" the meaning of charity by departing from this body of common law precedent).

the mechanisms for preventing the misuse of assets given to charitable purposes. The statute's preamble catalogued the various purposes for which charitable trusts had until then been established. Despite its haphazard content, this listing has become a virtual oracle of charitable trust law, achieving an "immortality of definition" through centuries of decisions that looked to it to determine which trusts qualified for protection.[82]

Although the Statute of Charitable Uses does not explicitly establish that trusts to promote health care are charitable, the preamble does recite that charitable trusts have been established for the "relief of aged, impotent and poor people."[83] This language is ambiguous as to whether these purposes are recited conjunctively or disjunctively,[84] but it has been generally supposed that the latter was intended.[85]

This reading of the statute is confirmed in an earlier literary source, *Vision of Piers Plowman,* a fourteenth century epic poem that contains a remarkably similar catalogue of the worthy purposes for which rich merchants are counseled by *Truth* to leave their fortunes in order to gain full remission of their sins. This listing is explicit in its endorsement of gifts to "repair hospitals, [and] help sick people."[86] A contemporaneous legal source, the 1634 Irish Statute of Charitable Uses, similarly mentions dispositions for "the relief or maintenance of . . . impotent persons, or for the building, re-edifying or maintaining in

82. W. JORDAN, PHILANTHROPY IN ENGLAND 1480-1660, at 112 (1959). Jordan's discussion is typical of the reverential tones that trust law scholars use to describe the preamble. *Id.* at 112, 114 ("eloquent preamble," "almost casual but beautiful wording," and "sought to state and to ennoble aspirations which had become and were to remain central to the structure of the liberal society").

83. An Act To Redress the Mis-Employment of Lands, Goods and Stocks of Money Heretofore Given to Certain Charitable Uses (Statute of Charitable Uses), 1601, 43 Eliz., ch. 4, *reprinted in* 7 STAT. AT LARGE 43 (Eng. 1763). This preamble is widely quoted, both in the Middle English and in modern prose, by a number of secondary sources addressing charitable trust and charitable exemption law. *E.g.,* Bittker & Rahdert, *supra* note 8, at 331 n.81.

84. That is, it is unclear whether any one of these purposes standing alone is charitable, or whether Parliament meant to refer to a trust that pursues all three objectives. One might also question whether "impotent" only means disabled. The statute's only other reference to health care is peculiarly limited to the "[m]aintenance of sicke and maymed Souldiers and marriners." Statute of Charitable Uses, 1601, 43 Eliz., ch. 4, *reprinted in* 7 STAT. AT LARGE 43 (Eng. 1763).

85. Bromberg, *Financing Health Care, supra* note 40, at 167 n.57.

86. Langland, *Vision of Piers Plowman,* in THE VISION OF A PEOPLES CHRIST PIERS PLOWMAN 80 (F. Skeat ed. 1906), *quoted in* W. JORDAN, *supra* note 82, at 112; *see also* M. FREMONT-SMITH, FOUNDATIONS AND GOVERNMENT 24 (1965); Bittker & Rahdert, *supra* note 8, at 331 n.81.

repair of any . . . hospital,"[87] and other enactments from that era include hospitals within the scope of charitable dispositions.[88]

Any doubt that the Elizabethan preamble included health care generally and hospitals specifically was conclusively eliminated by subsequent case law in both England and America. Massachusetts Justice Gray included "relieving [ ] bodies from disease" in 1867, seventeen years before the federal exemption was first enacted, when he rendered what has become the classic American statement of charitable purposes.[89] The Supreme Court held over a century ago that a charitable trust is validly established to "erect[ ] a hospital for foundlings."[90] The leading modern British case holds that it "is now clearly established both in Australia and in England" that a "gift for the purpose of a hospital is prima facie a good charitable gift . . . because of the use of the word 'impotent' in the preamble to 43 Eliz. c.4."[91] Finally, the Restatement (Second) of Trusts and similarly authoritative treatises hold that a "trust for the promotion of health is charitable."[92]

2. *Deficiencies in Transplanting the Charitable Trust Definition*

Despite 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 deserv-

87. 1634, 10 Chas. 1, sess. 2, ch. 1, *quoted in* L. SHERIDAN & G. KEETON, *supra* note 80, at 30.

88. Several antecedents to the statute that provided more limited protection to charitable trusts confirm that by 1601 health care was an established charitable purpose. 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." W. JORDAN, *supra* note 82, at 114. In 1572, Parliament passed another act to assist benefactors "who wished to found hospitals and almshouses." *Id.* at 115. 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." *Id; see also* M. FREMONT-SMITH, *supra* note 86, at 26 (discussing the latter two statutes).

89. Jackson v. Phillips, 96 Mass. (14 Allen) 539, 556 (1867).

90. Ould v. Washington Hosp. for Foundlings, 95 U.S. 303, 308 (1877).

91. *In re* Resch's Will Trusts, [1969] 1 App. Cas. 514, 540 (P.C.).

92. RESTATEMENT (SECOND) OF TRUSTS § 372 (1959); *see* 4A A. SCOTT & W. FRATCHER, THE LAW OF TRUSTS § 368 (1989) [hereinafter SCOTT ON TRUSTS] ("So too, it is well settled that the promotion of health is a charitable purpose."); *id.* § 372 & 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); *see also* G. BOGERT, TRUSTS § 62 (6th ed. 1987); Bromberg, *The Charitable Hospital, supra* note 40, at 240, 244; Bromberg, *Financing Health Care, supra* note 40, at 167 (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").

edness criterion. Simply put, because charitable trust law serves a wholly different purpose than the charitable exemption, the trust definition of charity does not properly identify activities that deserve tax support.

Charitable trust law exists primarily to protect assets which founders choose to devote to worthy causes. Trust law provides this assistance by creating 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.[93] Unlike ordinary trusts, charitable trusts need not have definite, identifiable beneficiaries;[94] they may exist in perpetuity,[95] and, through the *cy pres* doctrine, courts will substitute a new, similar purpose to prevent them from failing when their stated purpose becomes impossible to achieve.[96] As a consequence of the limited resources required to meet these objectives of charitable trust law, it covers a far broader subject matter than is deserving of a tax exemption.

a. The Scope of Charity Under Charitable Trust Law

To understand the breadth of subject matter encompassed by the trust law concept of charity, it is necessary to place in proper context

93. Early English law developed a somewhat hostile attitude toward trusts (originally called "uses" as a consequence of their conveyance of legal title to a nominal owner "for the use of" another), because they originated in feudal times as devices for hiding land from creditors and the exactions of landlords. The fraud and confusion caused by these unrecorded separations of legal title from equitable title led to the 1535 Statute of Uses, which sought to abolish this device altogether by declaring that, for land transfers, the beneficiary holds legal title as well. But the statute failed under the strict construction of courts that continued to allow uses in personalty, and uses upon uses (in other words, a transfer of title to X for the use of Y, who holds for the use of Z). The term "trust" arose in Chancery as a means for distinguishing enforceable from unenforceable uses. Nevertheless, trust law continued to impose numerous and technical restrictions on these legal instruments. G. BOGERT, *supra* note 92, at §§ 7–13.

The more favorable treatment accorded charitable trusts evolved from the special treatment that ecclesiastical courts accorded devises for religious purposes. The Chancery courts carried on this tradition after the Reformation. L. SHERIDAN & G. KEETON, *supra* note 80, at 1–2; Persons, Osborn & Feldman, *supra* note 2, at 1916–17.

94. RESTATEMENT (SECOND) OF TRUSTS §§ 209–10.

95. *Id.* § 365. Although it is sometimes misleadingly said that charitable trusts are relieved from the application of the Rule Against Perpetuities, most trusts are not affected by the Rule since they vest immediately upon the testator's death. *See* G. BOGERT, *supra* note 92, § 68. A related limitation of greater importance derives from the law's general opposition to restraints on alienation: "A private trust cannot be created so that it must continue for an unlimited period of time . . . and [so] a provision that the trust shall never terminate even though all of the beneficiaries wish to terminate it . . . is invalid." RESTATEMENT (SECOND) OF TRUSTS § 365 comment a. This durational restraint is the principal limitation from which charitable trusts are relieved.

96. RESTATEMENT (SECOND) OF TRUSTS § 399.

the almost four centuries of case law after the Statute of Charitable Uses. A significant portion of Anglo-American judicial resources were devoted for a time to sorting out the concept of charity in trust law. Many decisions found trusts to be noncharitable. These restrictive decisions impose a host of arcane technicalities that derive from the law's attempt to define a term that is more properly viewed as being virtually without substantive content. The notion that charity is a limiting term arose from an historical accident centered on Parliament's passage of the 1736 Mortmain Act, which reoriented the significance of the charitable label.[97] This shift in the statutory context threw the meaning of charity into complete confusion, resulting in sporadically restrictive holdings such as the absurd decision that a trust for "benevolent" purposes does not fall within the Statute of Charitable Uses.[98]

The stream of irreconcilable holdings emanating from this and other equally inscrutable distinctions typifies the kind of law that gives attorneys a bad name. Through it all, judges claimed to be able to divine, but not define, the "spirit and intendment" of the Statute of Charitable Uses that constitutes the essence of the legal concept of charity.[99] George Keeton, a leading British authority, has characterized their efforts as "probably the worst exhibition of the operation of the technique of judicial precedent, which can be found in the law reports."[100]

Anglo-American law took a large step toward sorting out this confused body of law in *Commissioners v. Pemsel,*[101] perhaps the most celebrated case in the history of charitable trusts.[102] The distinguished jurist Lord McNaughten cut through centuries of mindless distinc-

97. The Mortmain statute responded to concerns at the time that the Church was pressuring individuals to leave unduly large bequests to it at the expense of their disinherited families. This legislation invalidated charitable bequests of land that were not executed through rigid formalities more than one year prior to death. G. JONES, HISTORY OF THE LAW OF CHARITY 1532-1827, at 109–10 (1969). To avoid these restrictions, "objects which were in danger of being [stigmatized] as charitable often sought to divest themselves of this unwelcome status." *Id.* at 128. Affected legatees maintained that challenged gifts were not "charitable," and courts, often struggling to uphold such gifts, began to draw unprincipled distinctions regarding what properly should be deemed charitable.

98. Morice v. Durham, 10 Ves. 521, 7 Rev. Rep. 232 (1804); *see* Scott, *Trusts for Charitable and Benevolent Purposes,* 58 HARV. L. REV. 548 (1945).

99. L. SHERIDAN & G. KEETON, *supra* note 80, at 11; *see* G. JONES, *supra* note 97, at 133 ("The equity, or 'spirit' of the preamble, as it was called, was elevated into the Delphic oracle of legal charity."); Persons, Osborn & Feldman, *supra* note 2, at 1914.

100. Persons, Osborn & Feldman, *supra* note 2, at 1915 (quoting older edition of Keeton's treatise).

101. 1891 App. Cas. 531 (H.L.).

102. Bob Jones Univ. v. United States, 461 U.S. 574, 589 (1983) ("These statements [in *Pemsel*] clearly reveal the legal background against which Congress enacted the first charitable exemption statute in 1894 . . . .").

tions by observing that the Statute of Charitable Uses was never intended to define charity but was merely illustrative of the broad range of particular objects of charitable trusts that happened to be in vogue at the time. Accordingly, he encapsulated the legal concept of charity in the following, enduring formulation: " 'Charity' in its legal sense comprises four principal divisions: trusts for the relief of poverty; trusts for the advancement of education; trusts for the advancement of religion; and trusts for other purposes beneficial to the community, not falling under any of the preceding heads."[103] In 1960, England's Nathan Commission adopted the *Pemsel* precedent in the Charities Act of 1960, which finally repealed the Statute of Charitable Uses.[104] Similarly, in the United States, the Restatement of Trusts adopted essentially the *Pemsel* formulation, including the residual category of "other purposes the accomplishment of which is beneficial to the community."[105]

This residual category has been interpreted very broadly. For example, courts have sustained as charitable a bequest for purposes as trivial as "provid[ing] fishing facilities for the inhabitants of a town."[106] The law of charitable trusts is willing to take such a generous view of the subject matter it protects because all that is at stake is the societal cost of the procedural protection attending these trusts, such as the additional case burden on courts hearing trust enforcement actions. No societal resources are committed to funding the trust, in contrast to the effect of a tax exemption. Given these relatively low stakes, trust law is able to rely for subject-matter limitation simply on the decision of public-spirited founders to endow whatever purpose they desire. As one court 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

103. *Pemsel,* 1891 App. Cas. at 583.
104. Persons, Osborn & Feldman, *supra* note 2, at 1915–16.
105. RESTATEMENT (SECOND) OF TRUSTS § 368(f) (1959).
106. *Id.* § 374 comment c, comment f; *see also* SCOTT ON TRUSTS, *supra* note 92, § 374.2.

> object, and neither *contra bonos mores* nor *contra legem,* will, in my opinion, be charitable in the eye of the law . . . .[107]

The essentially boundless nature of the subject matter considered charitable in trust law is manifest in the Restatement's residual definitional category, which in a tautological fashion covers any purpose "if its accomplishment is of such social interest to the community as to justify permitting the property to be devoted to the purpose in perpetuity."[108] This is no definition at all, for it explicitly eschews any attempt to subsume social policy judgments within a concept of charitable, as occurs with ordinary rule-based legal analysis.[109] Instead, the Restatement applies the term as a contentless label wherever its application seems justified as a matter of raw policy judgment.

This completely open-textured approach to defining the term "charitable" may be appropriate in trust law where the concern is *procedural* protection of an *individual* donor's gift to society. But reliance on these trust law precedents in tax law defies logic where the policy stakes are entirely different. Because a tax exemption represents a government subsidy, a proper concept of charity for tax exemption purposes must identify activities that deserve the *financial* support of *society.* This cannot be accomplished by relying on an expansive concept of charity that reaches all activities worthy of protection under trust law.

Most trust scholars would disagree with the assertion that the legal concept of charity has no boundaries, but this misses the point. The limits that trust law imposes are largely organizational and operational. Charitable status turns not so much on *what* is done but rather on *how* it is done. The guiding precept that emerges from centuries of abstruse case law is that charitable trusts must be created to provide public, not private, benefit.[110] This limitation requires that charities benefit the public at large rather than the founder or the founder's

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107. *In re* Cranston, [1897] 1 I.R. 431, 446–47 (Ir. H. Ct.), *quoted in* SCOTT ON TRUSTS, *supra* note 92, § 374.7; *see* RESTATEMENT (SECOND) OF TRUSTS § 374 comment l ("[T]he mere fact that a majority of the people and the members of the court believe that the particular purpose of the settlor is unwise or not adapted to the accomplishment of the general purposes, does not prevent the trust from being charitable.").

108. RESTATEMENT (SECOND) OF TRUSTS § 368 comment b, § 374.

109. *See* P. ATIYAH & R. SUMMERS, FORM AND SUBSTANCE IN ANGLO-AMERICAN LAW 5–11 (1987).

110. BLACK'S LAW DICTIONARY 312 (3d ed. 1933) defines charitable purposes as those "for a general public use . . . designed to benefit them from an educational, religious, moral or social standpoint."

family and friends.[111] Thus, charities must be nonprofit entities, their earnings may not inure to the benefit of any private individual, they may not engage in self-dealing transactions, they must serve a large group, and they may not pursue purposes that contravene public policy.[112]

With these operational constraints satisfied, however, virtually any substantive purpose will suffice. Charity is "broad enough to include whatever will promote, in a legitimate way, the comfort, happiness and improvement of an indefinite number of persons."[113] Students of the law of charity acknowledge that "[n]early everything produced by . . . private industry—ranging from buildings and food to books and music—contributes to our welfare."[114] This is why virtually no one has succeeded in giving "charity" in trust law some definitional content.[115] Instead, courts and commentators find themselves repeatedly forced to rest on the unilluminating platitude that "charity is an evolv-

111. For instance, a trust to maintain a public graveyard is valid, but one to maintain a particular tomb is not. RESTATEMENT (SECOND) OF TRUSTS § 376 comment a. For further elaboration of this distinction, see Atiyah, *Public Benefit in Charities,* 21 MOD. L. REV. 138 (1958).

112. *See* L. SHERIDAN & G. KEETON, *supra* note 80, at 32–50. *See generally* M. CHESTERMAN, *supra* note 1, at 316 (discussing the connection between these organizational limitations and the requirement of public benefit).

113. Harrington v. Pier, 105 Wis. 485, 520, 82 N.W. 345, 357 (1900); *see also* Ould v. Washington Hosp. for Foundlings, 95 U.S. 303, 311 (1877) (charity includes "anything that tends to promote the well-doing and well-being of social man"); Wilson v. First Nat'l Bank, 164 Iowa 402, 145 N.W. 948, 952 (1914) ("The word 'charity,' as used in the law, . . . includes substantially any scheme or effort to better the condition of society or any considerable part thereof.").

114. Comment, *Collaboration Between Nonprofit Universities and Commercial Enterprises: The Rationale for Exempting Nonprofit Universities from Federal Income Taxation,* 95 YALE L.J. 1857, 1864 (1986); *accord* J. JENSEN, *supra* note 3, at 148 ("In a sense, all legitimate economic activities are affected with a public interest."); Ginsberg, *supra* note 54, at 312 ("The very existence of land, whether left in its natural state or developed, is a benefit to society."); Thompson, *supra* note 80, at 14 ("[T]he catch-all category of charity—purposes beneficial to the community—is so broad, it can conceivably encompass almost any program to promote social welfare . . . .").

This truth is one of the classic lessons taught by the fundamental turn in Constitutional jurisprudence that occurred earlier this century when, after over half a century of Supreme Court efforts to confine social and economic legislation to businesses "affected with the public interest," Munn v. Illinois, 94 U.S. 113, 126 (1877), the Court abandoned substantive due process scrutiny with respect to such legislation, observing, "there is no closed class or category of businesses affected with a public interest . . . ." Nebbia v. New York, 291 U.S. 502, 536 (1934). Attempts to police the substantive limits of the exemption under the rubric of "public benefit" would be as flawed as the Supreme Court's attempt to police the substantive wisdom of economic and social legislation.

115. SCOTT ON TRUSTS, *supra* note 92, § 368 ("The truth of the matter is that it is impossible to frame a perfect definition of charitable purposes. There is no fixed standard to determine what

ing concept which must be allowed to change and expand in response to the needs of society."[116]

b. The Need for a Principle to Limit the Exemption

If the trust concept is imported into tax law, essentially any legitimate nonprofit institution that serves the public at large might be eligible for charitable tax exemption. This principle largely matches what has occurred in practice and thus meets at least the historical consistency criterion.[117] However a definition of charity that contains essentially no substantive limiting principle, and thus imposes minimal subject matter restrictions on which activities are exempt (i.e., restricts only how the activity is organized and carried out), must be rejected because such a definition contains no test to ascertain when the exemption is either deserved or proportionate to the benefit society receives. By classifying as "charitable" any activity which meets the inherent procedural restrictions of charitable trust law, this test potentially provides exempt status, and the accompanying tax subsidy, to activities that either might be provided just as well without a tax subsidy or to activities whose dollar value to the community is less than the amount of the foregone tax revenues.

Binding the law of tax exemption to the same category of activities covered by charitable trust law is thus manifestly absurd. This is especially so because 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 left her wealth in trust to promote the practice of veterinary medicine.

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purposes are charitable."); L. SHERIDAN & G. KEETON, *supra* note 80, at 26 ("Judges long ago abandoned the task of attempting to define what a charitable purpose is.").

For a particularly tortured attempt to tease some meaning out of the public benefit concept in the context of distinguishing between legitimate public interest law firms and those established to advance the interests of major commercial firms, see Houck, *With Charity for All*, 93 YALE L.J. 1415 (1984).

116. Persons, Osborn & Feldman, *supra* note 2, at 1909.

117. *See* A. BALK, *supra* note 1, at 86 ("It seems to have become progressively easier for almost any organization that engages in some activity of social or cultural significance to make the tax-free list . . . ."); Buchele, *Justifying Real Property Tax Exemptions in Kansas*, 27 WASHBURN L. REV. 252, 273 (1988) ("Almost every kind of organization not run for profit has sought to escape taxation as a charitable institution."); Hansmann, The Two Independent Sectors, *supra* note 8, at 4 ("[T]he exemptions have traditionally been read so broadly as to encompass nearly all nonprofits of any financial significance. . . . In general, the words 'nonprofit' and 'tax-exempt' have been coterminous."); Comment, *supra* note 7, at 1087 ("[A]lmost every kind of organization not run for profit and not exclusively a social or sporting club has sought to escape taxation as a charitable institution. The courts have had to flounder in a morass of strange facts . . . .").

Such a trust would be sustained as charitable.[118] Subsequently, any proprietor of an animal hospital who chose to organize as a legitimate nonprofit operation would qualify for exemption from federal income tax, local property tax, and possibly state income and sales taxes as well, even if the firm relied entirely on borrowed capital and charged full market rates to all of its customers.[119]

Such a potentially limitless extension of the exemption may at first seem like a small risk because adopting the nonprofit form requires the organizer to forgo any share of the profits, a sacrifice that most persons would not care to make absent an overriding commitment to benefitting the public. However, businesses do exist from which organizers expect nothing more than full compensation for their labor; such organizers would benefit by adopting a genuinely nonprofit form of business that automatically ensures a substantial social subsidy, even if they are thereby denied any return on capital.[120] Physician group practices are just such a business. Even in a proprietary form, the practice group essentially pays physician members the share of the group income attributable to their patients,[121] a remuneration system that is not sacrificed by adopting the nonprofit form. Consequently, physician groups have a strong incentive to seek property tax exemption for their real estate holdings, and sales tax exemption for their purchase of equipment and supplies.[122]

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118. *See* University of London v. Yarrow, 24 Eng. Rep. 649 (Ch. 1857) (upholding a trust to establish a veterinary institute).

119. Even absent an established precedent in trust law, tying the exemption to the charitable trust definition of charity would permit exemption in cases where merely theorizing that if a trust for the same purpose were established, it would provide sufficient public benefits to deserve protection from the Rule Against Perpetuities. *See* Warren, Krattenmaker & Snyder, *Property Tax Exemptions for Charitable, Educational, Religious and Governmental Institutions in Connecticut,* 4 CONN. L. REV. 181, 238 & n.212 (1971) (exemption for boy scout camp upheld because "an institution is charitable when its property and funds are devoted to such purposes as would support the creation of a valid charitable trust;" citing similar holdings for dining rooms, women's residences, museums and the like).

120. An example pertinent to hospitals comes from the conversion of for-profit hospitals to a nonprofit status. There have been several recent instances where the owners of a proprietary hospital who wished to sell were unable to find a willing buyer at a sufficient price, so instead they formed a nonprofit corporation to buy the assets of the hospital at their appraised price and to give back to the owners a management contract. Conversation with Richard McAlee, Esquire, Baltimore, Md. (Nov. 15, 1990) (notes on file with the *Washington Law Review*). It is easy to see how such a transaction might lead to abuse of the exemption.

121. Any other form of distribution might violate fee splitting and referral fee prohibitions. *See generally* Hall, *Making Sense of Referral Fee Statutes,* 13 J. HEALTH POL., POL'Y & LAW 623 (1988).

122. In most cases, an income tax exemption would not be relevant to a group of physicians because they usually organize in an entity, such as a partnership or S corporation, that is not subject to a separate income tax. Instead, group earnings are taxed only to the individuals on a pass-through basis. *See generally* W. MCKEE, W. NELSON & R. WHITMIRE, FEDERAL

Hospitals may be under an equally powerful incentive to adopt the nonprofit form merely to enjoy the exemption's subsidy. This incentive is likely because doctors strongly influence the organizational form of hospitals and doctors have strong reasons to prefer a tax-subsidized hospital. The financial success of a hospital depends on its ability to attract competent doctors who in turn provide paying patients.[123] Doctors in turn prefer hospitals with the most sophisticated equipment and the broadest range of services, regardless of the profitability of these amenities. Doctors are generally unconcerned about hospital profits because their income generated from patient fees allows them to remain financially independent of hospitals. Because doctors incur no cost from adopting the nonprofit form, they have a much stronger reason to prefer a tax subsidy than do the corporate organizers of hospitals. For hospitals this means that there is a particularly pressing need to guard against a self-justifying concept of charity that allows any activity to qualify automatically by virtue of its nonprofit status.[124]

TAXATION OF PARTNERSHIPS AND PARTNERS ¶ 1.01(1) (Supp. 1989). Using an exempt entity, however, may permit doctors a tax advantage on earnings reinvested in capital equipment. While depreciation deductions would permit a tax-free recovery of equipment costs over time, in a taxable entity the value of the deductions will never equal the initial after-tax cost of the capital investment. Suppose, for example, that a typical group practice requires $1 million in equipment. One method for acquiring this equipment would be for the doctors to purchase it with after-tax dollars. If the tax rate were 50%, the doctors would have to earn initially $2.0 million to pay $1 million in taxes and have $1 million left for the capital investment. Over a period of years the doctors would receive $1 million in depreciation deductions that will permit the free recovery of the $1 million invested in equipment. The "extra" $1 million needed at the beginning, however, will not be recovered. Moreover, cost recovery is available only over time, meaning that the deductions are worth less than the investment on a present-value basis. In a tax-exempt entity, however, only $1 million is needed to invest $1 million. The "extra" $1 million can then be invested in still more equipment (nicer offices?) or else paid out to the doctors as additional "profits." Moreover, exemption may be important because structural limitations on the partnership or S corporation form of business may require a "regular" corporate entity. S corporations, for example, are limited to 35 shareholders, I.R.C. § 1361(b)(1)(A) (1989), so a group practice with more than 35 doctors would need the exemption to avoid a separate corporate tax.

123. *See infra* notes 223–28 and accompanying text.

124. Hansmann, *supra* note 11, at 868:

> It is . . . as if a foundation, tax-exempt and supported in part by public contributions, were to build office space and then lease it at cost, or less, to Wall Street law firms. One would not expect to see the lawyers in a hurry to have the foundation converted into an ordinary profit-making landlord.

The exemption's influence on doctors' preferences under conventional financial arrangements is evidenced by the different behavior of doctors when they desire to invest in hospitals. In those instances, they abandon the nonprofit ethic and the exemption subsidy in favor of organizing their own proprietary hospitals. *See generally* Marmor, Schlesigner & Smithey, *supra* note 28; Relman, *Dealing With Conflicts of Interest,* 313 NEW ENG. J. MED. 749 (1985).

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. A careful analysis of IRS decisions in the health care field, for example, reveals that the federal government does not respect in practice the per se characterization that it espouses in theory. Through a multitude of rulings the IRS has developed the position that only inpatient hospital service—not health care per se—is exempt; the IRS consistently refuses to extend the exemption to physician groups,[125] and consistently imposes more exacting exemption requirements on health maintenance organizations (HMOs), nursing homes, and other nonhospital health care services.[126] For example, the IRS has ruled that a nonprofit pharmacy is disqualified from the charitable exemption even though supplying drugs is as intimately connected with health care as administering drugs, and even though pharmacy sales within a hospital are exempt.[127] A similar dichotomy exists in some state law decisions, which impose more demanding requirements for exemption of nonhospital services.[128] Recently, Congress also displayed antipathy to the logical implications of the health care per se principle when it voted in 1986 to remove the exemption

125. The IRS refuses to exempt physician groups under the theory that they serve the private interests of doctors rather than the public's interest in health care; but this is transparently incorrect. As long as physician groups are willing to accept anyone in the community able to pay and in need of care, there is no distinction between the public quality of services delivered by physician groups or hospitals. It is true that group practices pay doctors handsome salaries; but doctors also earn handsome incomes from hospitals. Remuneration for services rendered should not defeat nonprofit or charitable status unless the amount paid exceeds the fair market value of the services. *See* Colombo, *supra* note 41, at 492–98.

126. *See generally id. passim.*

127. Federation Pharmacy Servs. v. Commissioner, 72 T.C. 687 (1979), *aff'd,* 625 F.2d 804 (8th Cir. 1980); *see also* Colombo, *supra* note 41, at 485–92, 512–21.

128. Maryland property tax statutes, for example, specifically exempt property used for hospital purposes, and exempt property used for general charitable purposes. MD. TAX-PROP. CODE ANN. § 7-202 (1986). A recent Maryland case nevertheless held that the property of an HMO was not exempt because the HMO was not "charitable" despite its unrestricted membership (consisting at the time of some 65,000 Maryland residents). Montgomery County v. Group Health Ass'n, 308 Md. 151, 517 A.2d 1076 (1986). Similarly, some states have taken the position that rental of office space by hospitals to physicians for private practice violates exemption requirements, notwithstanding the fact that such space is used to provide general health care. *See* Greater Anchorage Area Borough v. Sisters of Charity of the House of Providence, 553 P.2d 467 (Alaska 1976); Genesee Hosp. v. Wagner, 47 A.D.2d 37, 364 N.Y.S.2d 934 (1975); Gifford Memorial Hosp. v. Randolph, 119 Vt. 66, 118 A.2d 480 (1955). Nursing homes sometimes also face disparate state treatment. Fairview Haven v. Department of Revenue, 153 Ill. App. 3d 763, 506 N.E.2d 341 (1987) (no exemption unless nursing home accepts some charity patients); Lutheran Home v. Board of Assessment, 100 Pa. Commw. 244, 515 A.2d 59 (1986) (same).

from Blue Cross/Blue Shield and from TIAA/CREF[129] because it viewed selling insurance as an inherently "commercial" activity,[130] a charge that is equally applicable to all forms of health care business, including hospitals.[131]

It is evident from these varied sources that courts, legislatures, and taxing authorities are searching for a limiting principle that will define which activities deserve the exemption and which do not.[132] For reasons that remain unarticulated, they find that doctors, pharmacies, and insurance companies—which are fully capable of functioning without a subsidy—do not merit exemption, even though they are organized and operated in the same fashion as nonprofit hospitals. These decisions are reasoned on bases that in some cases are unprincipled, in others inconsistent, and in others undiscernible. Thus, while the prevalent instinct to constrain the boundaries of the exemption is correct, these decisions fail to isolate and articulate a workable limiting principle.[133]

The scope and content of a proper limiting principle is the subject of the remainder of this Article. At this point, the Article has only estab-

129. Teachers' Insurance and Annuity Association/College Retirement Equities Fund (TIAA/CREF) is the life insurance and retirement annuity company that serves most nonprofit educational institutions.

130. *See* HOUSE COMM. ON WAYS AND MEANS, TAX REFORM ACT OF 1985, H.R. REP. NO. 426, 99th Cong., 1st Sess. 664 (1985) (codified at 26 U.S.C. § 501(m) (1988)) (it is "inappropriate" to exempt an "inherently commercial" activity, such as selling insurance "to the general public at a price sufficient to cover the costs of insurance"); *UBIT Hearings, supra* note 6, at 991 (statement of Gabriel Rudney) (discussing this legislative action).

131. Indeed, overturning Rev. Rul. 56-185, 1956-1 C.B. 202, is implicit in the pending Charity Care and Hospital Tax-Exempt Status Reform Act, H.R. 790, 102d Cong., 1st Sess., 137 CONG. REC. E395–97 (1991) (discussed *infra* note 151 and accompanying text).

132. *See* Buchele, *supra* note 117, at 273 ("The extended scope of humanitarian functions necessary to qualify for exemption must be defined or limited in some way. Otherwise all property owners would . . . claim tax exemption."); Fox, *The Uneasy Law of Real Estate Tax Exemptions in Pennsylvania,* 39 U. PITT. L. REV. 175, 248–49 (1977) ("Although the rationale of the court is far from clear, it is apparent that the court was seeking to limit the extent of activities which could qualify as charitable . . . [based] upon the court's view of public policy."); Ginsberg, *supra* note 54, at 312 ("[O]f itself, the [public] benefit theory is too broad to be useful. . . . [It] must be coupled with corollary propositions relating to the nature of the benefits . . . that would be useful to a court or tax assessor making case-by-case determinations of exempt status . . . ."); Thompson, *supra* note 80, at 53 (1985) ("[T]he danger is that the charitable exemption will . . . become an unlimited and undefinable concept.").

Professor Thompson misperceives the nature of the problem; he maintains that the boundless nature of charity can be avoided by relying on "the common law legal concept of charity." *Id.* This Article, however, explains that the scope of charity at common law was also without bounds.

133. For instance the current position of the IRS, that nonprofit hospitals deserve the subsidy and nonprofit physician groups do not, Colombo, *supra* note 41, at 492–98, does not resolve the exempt status of hospital/physician joint ventures that proliferate in the current reimbursement environment. *See* Hall, *supra* note 22, at 493.

lished that virtually everyone who has given thought to the matter recognizes that some substantial subject matter limits must be imposed on the charitable exemption. As a consequence, the health care per se position drawn from charitable trust law—to which many decisions pay lip service—cannot be sustained,[134] and in fact is not followed.

B. Charity Care and the Relief of Government Burden

1. The Basic "Quid Pro Quo" Theory

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 should be 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 that absent exemption would be the burden of government—treatment of uninsured patients for example. In the words of Senator Hollis, "[f]or every dollar" of taxes forgone "the public gets 100 per cent" return in the form of free hospital services.[135] Relief of the government's obligation to care for the poor or to provide other social services is the most widely accepted general theory for the exemption in the modern state,[136] and it is essentially the theory adopted with respect to health care providers in *Utah County*.[137] It is also the primary rationale for

134. It is possible to reach the per se exempt position through routes other than the law of charitable trusts. These alternate theories are discussed as variants of the community benefit theory. *See infra* notes 258–68 and accompanying text (discussing the public trust variant); *infra* notes 269–76 and accompanying text (discussing the plow-back variant).

135. 55 CONG. REC. S6728 (1917) (statement of Sen. Hollis). The Senator made these comments in reference to the charitable deduction, not the exemption; but the Supreme Court has applied the same rationale to both as they are in pari materia. *See* Bob Jones Univ. v. United States, 461 U.S. 574, 590 (1983).

136. *See, e.g.*, McGlotten v. Connally, 338 F. Supp. 448, 456 (D.D.C. 1972) ("The rationale for allowing the deduction of charitable contributions has historically been that by doing so, the Government relieves itself of the burden of meeting public needs which in the absence of charitable activity would fall on the shoulders of the Government."); Legat v. Adorno, 138 Conn. 134, 83 A.2d 185, 191 (1951) ("The grant of tax exemption to . . . hospitals . . . encourages and facilitates their performance of a governmental duty which would otherwise have to be performed by the state."); H.R. REP. NO. 1860, 75th Cong., 3d Sess. 19 (1938) ("The exemption from taxation of money or property devoted to charitable and other purposes is based upon the theory that the Government is compensated for the loss of revenue by its relief from the financial burden which would otherwise have to be met by appropriations from public funds . . . ."); B. HOPKINS, *supra* note 31, at 6–7.

137. 709 P.2d 265, 269 (Utah 1985). However, the Utah court failed to consider the specific measure of deservedness required, as developed in the text that follows.

pending legislation that would reform the exempt status of nonprofit hospitals.[138]

This section proceeds by first examining how the quid pro quo theory applies to hospitals. It explains precisely how the theory should operate if it is to satisfy the deservedness criterion and demonstrates that nonprofit hospitals by and large fail to meet the proper test. It then turns to a theoretical assessment of the validity of the theory. This assessment reveals that the failure of hospitals to satisfy the quid pro quo test should not foreclose their exemption because, under our criteria for evaluation, the charity care standard is not an adequate statement of the exclusive basis for the exemption.

2. *Deficiencies in Applying the Theory to Nonprofit Hospitals*

a. *Deservedness*

When applied to nonprofit hospitals, the relief of government burden theory encounters major problems under the deservedness criterion. To satisfy this criterion, the health care sector must show that the service on which exemption is based (free care for the poor) would be irreplaceably compromised without the subsidy. While empirical evidence establishes that nonprofit hospitals give away a significant portion of their services,[139] 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, the relief of government burden theory can meet the deservedness criterion only if nonprofit hospitals provide a greater proportion in uncompensated care than the for-profit hospitals.[140]

To illustrate, if for-profit hospitals give away four percent of their care in the form of bad debts, nonprofit hospitals must show that they

138. *See infra* note 151 (summarizing the Charity Care and Hospital Tax-Exempt Status Reform Act, H.R. 790, 102d Cong., 1st Sess., 137 CONG. REC. E395–97 (1991)).

139. J. BENNETT & T. DILORENZO, *supra* note 17, at 84 (quoting the AHA's claim that nonprofit hospitals gave $22 billion in free medical care to the poor over a five-year period).

140. *Accord* Hyman, *supra* note 51, at 361; *see* Relman, *Are Voluntary Hospitals Caring for the Poor?*, 318 NEW ENG. J. MED. 1198, 1199 (1988) (tax exemption would be "troubling" and "hard to justify" if nonprofits are not doing more for the poor than for-profits).

It is insufficient to speak of nonprofit hospitals doing their "fair share." *See* Yoder, *supra* note 11, at 113 ("It is, accordingly, difficult even in theory to provide a standard for determining whether a particular hospital has done its 'fair share' of charity care or, indeed, whether the notion of 'fair share' makes sense . . . ."). The required standard is capable of quantification at a level independent of prevailing local demand for charity care. The measure of performance should not be fixed to local needs, but to the value of the exemption. Thus, even concrete percentages, such as 3% of operating expenses required under the Hill-Burton Act, 42 C.F.R. § 124.503 (1979), or the 15% of revenues required by Alabama, *supra* note 64, are arbitrary unless based on a comparative estimate of charity care provided by for-profits.

give away a higher percentage to meet the threshold test of deservedness. This comparison with for-profit hospitals is necessary under the government burden theory because, without nonprofits, the full amount of the free care for-profits provide would not fall on the government.

Moreover, a certain portion of free care provided by nonprofits is not voluntarily given 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."[141] This fact presents a second justification for deducting from the nonprofits' free care ledger the proportionate amount of free care rendered by for-profits. The bad debt component of uncompensated care represents an ordinary cost of doing business borne by nonprofits and for-profits alike. Deducting from the 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.[142]

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141. Simpson & Lee, Nonprofit Community Hospital Tax Exemption: Issues for Review 10 n.14 (May 1987), *reprinted in UBIT Hearings, supra* note 6, at 778 n.14. As one court criticized, "[t]hese 'uncompensated care' patients . . . are aggressively pursued by [the hospital] through every avenue of the collection process. [The hospital] has sued the very patients that it would now have this court deem objects of charity." School Dist. v. Hamot Medical Center, No. 138-A-1989, slip op. at 14 (Pa. Ct. C.P., Erie Co., May 18, 1990).

142. Accordingly, the term "charity care" generally signifies services for which the hospital requests no compensation. In contrast, "uncompensated care" or "free care" signifies bad debts plus true "charity care."

Some hospitals attempt to claim "contractual adjustments" as charity care. Contractual adjustments represent the difference between a hospital's normal charges and the amount the hospital agrees to accept from a third-party payor. *See* Rammell & Parsons, *supra* note 52, at 80. Because for-profit hospitals treat the same proportion of Medicare and Medicaid patients as nonprofits, *see* Sloan, *Property Rights in the Hospital Industry,* in HEALTH CARE IN AMERICA 103, 135 (1988), and negotiate discounts with private insurance companies, these contractual adjustments generally are the same for both sectors. Therefore, most authorities disregard contractual adjustments in these calculations. *See* Yoder, *supra* note 11, at 98; Simpson & Lee, *supra* note 141, at 778 n.14; Sloan, Valvona & Mullner, *supra* note 37, at 16. *See generally* Lewin & Associates, Setting the Record Straight: The Provision of Uncompensated Care by Not-For-Profit Hospitals 28 (1988) (unpublished).

Measuring the value of charity care—charges or costs, and if costs, average or marginal—presents another complication. Most studies use the hospital's normal charge structure, which represents the most generous measure of the hospital's sacrifice. Some analysts, however, complain that this measure of charity care disproportionately benefits proprietary hospitals because they tend to have a somewhat higher mark-up of charges over costs. *See* Lewin, Eckels & Miller, *Setting the Record Straight: The Provision of Uncompensated Care by Not-For-profit Hospitals,* 318 NEW ENG. J. MED. 1212, 1215 (1988). The alternative, however, is to use costs as a measure, in which case it would be inappropriate to use average rather than marginal costs. *See* Hyman, *supra* note 51, at 361; Hyman, *Letter to Editor,* 319 NEW ENG. J. MED. 1486 (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 tolerate the imperfection inherent in the charge measure. (One possible adjustment would

Using this measure of deservedness, the existing empirical evidence fails to confirm that nonprofits provide greater relief than for-profits of the government burden of delivering health care to the impoverished and uninsured. One national study indicates that "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."[143] What differences exist appear to be narrowing under the influence of cost containment pressures from private and government insurers, such that, in the aggregate, nonprofit hospitals are providing proportionately *less* uncompensated care than their for-profit competitors.[144]

These aggregate, national comparisons have been criticized as unrepresentative because for-profit hospitals are unevenly distributed 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 mostly in southern and western states that tend to have less generous Medicaid programs for the poor and, thus, a greater demand for indigent care by private hospitals. In contrast, nonprofit hospitals are more evenly dispersed across the fifty states, which means that their average national uncompensated care statistics are diluted by those states where there is much

involve discounting 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.)

143. J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 106–07. The leading study found "no clear difference between for-profits and not-for-profits," the former supplying 3.7% of their care for free in 1983 and the latter 4.2%. By comparison, the figure for public hospitals is 11.5%. Yoder, *supra* note 11, 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."). The numbers were even closer when this study was repeated in 1985. U.S. GENERAL ACCOUNTING OFFICE, PUBLIC HOSPITALS: SALES LEAD TO BETTER FACILITIES BUT INCREASED PATIENT COSTS 46 (June 1986) (voluntary hospital sector provided 4.6% free care versus 4.3% for investor-owned hospitals; citing data from AHA indigent care survey). For 1988, these numbers were estimated to be 4.8% for nonprofits, 5.2% for for-profits. *See* 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]; *see also* Herzlinger & Krasker, *Who Profits from Nonprofits?*, 65 HARV. BUS. REV. 93, 103 (1987) ("[F]or-profits gave slightly more access to patients who carry little or no health insurance than did the nonprofits."); Sloan, Valvona & Mullner, *supra* note 37, at 24.

144. Thus the difference in 1983, one year prior to the enactment of Medicare Diagnosis-Related Groups (DRGs), was 0.5% in favor of non-profits, but only 0.3% in 1985, one year after DRGs. Yoder, *supra* note 11, at 102. In 1988, the AHA estimated that the non-profit percentage of total revenue attributable to uncompensated care was .4% *less* than that of for-profit hospitals (4.8% versus 5.2%). GAO REPORT, supra note 143, at 2.

less need for private hospital charity. This study demonstrates that, in a selection of four states where for-profits compete with nonprofits, nonprofit hospitals outperform proprietary institutions at a level ample to meet the deservedness criterion at its threshold.[145] Accordingly, the existing studies lend mixed support to the proposition that voluntary hospitals generally provide charity care at a level that would be irreplaceably reduced absent a tax subsidy.

Proponents of hospital exemption frequently attempt to circumvent these inconclusive statistics by positing a notion of deservedness that is not grounded on a strict "quid pro quo" formulation. This alternative theory requires only that tax-exempt hospitals maintain an "open-door" policy, accepting every patient seeking admission regardless of ability to pay.[146] Hospitals contend that maintaining an open admissions policy meets their social responsibility because hospitals treat all indigent patients who actually seek care. Anything more would require hospitals to provide more free care than is demanded.

Even assuming that nonprofit hospitals practice an open door policy as fervently as they preach it,[147] there are two difficulties with this formulation of the government burden theory. First, this formulation does not require a showing that hospitals actually relieve a government burden.[148] If the need for free care ever becomes so slight that hospitals are prevented from establishing that they render a quid pro quo for the exemption, then no significant government burden exists for hospitals to relieve. Realistically, there will always be ample opportunity to dispense free care, but this open-door formulation

145. Lewin, Eckels & Miller, *supra* note 142, at 1213–14 (in Florida, North Carolina, Tennessee and Virginia, the uncompensated care burden is 50% to 90% higher at nonprofit hospitals than at investor-owned hospitals).

146. The IRS effectively applied the "open door" policy prior to the 1969 ruling by acknowledging in decisions under the 1956 ruling that the exemption would still exist even without demand for free care. *See* Comment, *supra* note 42, at 758. *See generally supra* note 44. Other examples of courts that adopt or suggest the view that an open-door policy is sufficient include: Hart v. Taylor, 301 Ill. 344, 133 N.E. 857 (1921); West Allegheny Hosp. v. Board of Property Assessment, Appeals & Review, 500 Pa. 236, 455 A.2d 1170 (1982); Medical Center Hosp. v. City of Burlington, 152 Vt. 611, 566 A.2d 1352 (1989). "The Vermont court indicated clearly and succinctly that the main determinant of a charitable hospital was the availability rather than the actual amount of free care." O'Donnell & Taylor, *The Bounds of Charity: The Current Status of the Hospital Property-Tax Exemption,* 322 NEW ENG. J. MED. 65, 66 (1990).

147. The GAO Report found that "many [nonprofit] hospitals' admissions and transfer policies limit elective care for those unable to pay." GAO REPORT, *supra* note 143, ¶23,526.

148. One might contend that nonprofit hospitals relieve government burden even when they serve only paying patients because the government has an interest in fostering the delivery of health care. This rationale ignores the deservedness criterion. Nonprofits do not earn the exemption from paying patients unless their services are superior to those supplied by for-profits, a contention addressed as the "community benefit" theory. *See infra* Section III.C. The present discussion is restricted to the government burden theory as it applies to free hospital services.

allows nonprofit hospitals to shirk their social responsibility by providing less than their share of community needs. This is true because by convention the hospital corporate entity is passive with respect to patient admissions. Hospitals generally accept only those patients admitted by members of the medical staff. Because doctors in private practice have neither legal obligation, moral dictate, nor financial incentive to accept charity cases,[149] hospitals will not have a significant charity census unless they take affirmative steps to treat uninsured patients, such as requiring doctors to accept some charity work as a condition of medical staff privileges.[150]

b. Proportionality

Doubts about the ability of hospitals to justify their exempt status under the deservedness component of the government burden theory are settled by the poor performance of nonprofit hospitals with respect to the proportionality criterion. Even if the value of charity services delivered to the poor and uninsured would be irreplaceably reduced absent a tax subsidy, hospitals still must establish that the value of the subsidy roughly matches the level of deservedness; if not, hospitals fail to satisfy the proportionality criterion. This test requires at a minimum that the value of free care provided by exempt hospitals, above a representative proportion of free care rendered by similar for-profits, match the loss of tax revenues to the government.[151]

149. Agnew v. Parks, 172 Cal. App. 2d 756, 343 P.2d 118, 123 (1959); Childs v. Weis, 440 S.W.2d 104 (Tex. Ct. App. 1969). Principle VI of the AMA Code of Medical Ethics, however, suggests an ethical duty to treat *emergency* patients because it permits doctors to turn down patients only in *non*emergency situations: "A physician shall, . . . except in emergencies, be free to chose whom to serve . . . ." T. BEAUCHAMP & J. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS app. II, at 332 (2d ed. 1983); *see also* May, *Code, Covenant, Contract, or Philanthropy,* HASTINGS CENTER REP., Dec. 1975, at 29.

150. Thus, the GAO Report concluded that "some [nonprofit] hospitals lack proactive goals or policies for nonemergency indigent care . . . [and] did not generally have strategic goals designed to expand or improve indigent access to care." GAO REPORT, *supra* note 143, ¶23,528.

The deceptiveness of an "open-door" policy is documented by the track record of hospitals under the Hill-Burton Act of 1946, Pub. L. No. 79-725, § 601, 60 Stat. 1040 (codified as amended at 42 U.S.C. §§ 291, 291a (1989)). For a time, Hill-Burton regulations required hospitals that received grants under the program to opt between providing 3% of their annual operating costs as charity care and maintaining an open door policy. 42 C.F.R. §§ 53.111, 53.113 (1973). Sixty percent of hospitals chose the open door option; yet provision of uncompensated care remained at very low levels. Dowell, *Hill-Burton: The Unfulfilled Promise,* 12 J. HEALTH POL., POL'Y & L. 153, 157 n.16 (1987). For example, "[i]n Alabama, the 136 'open door' facilities provided a total of $25,636 worth of uncompensated care, an average of $190 each." *Id.* In response to widespread evidence of a similar ilk, the government repealed the open door option in 1979. *Id.* at 158.

151. Expressed in terms of an equation where U_n represents uncompensated care (charity care plus bad debts) provided by nonprofit hospitals, U_f is the uncompensated care provided by for-

Unfortunately, much of the data measuring uncompensated care that researchers have generated in recent years does not directly

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profit hospitals, and T_n is the tax relief enjoyed by nonprofit hospitals—all in terms of a percentage of revenues—the tax exemption is fully earned only if:

$$U_n - U_f > T_n$$

The Charity Care and Hospital Tax-Exempt Status Reform Act, H.R. 790, 102d Cong., 1st Sess., 137 CONG. REC. E395–97 (1991), proposes an approach that matches uncompensated care to the value of the exemption. The Bill, however, fails to require nonprofit hospitals to exceed the base of uncompensated care provided by equivalent for-profit hospitals. The Bill also requires only 50% of the exemption be earned through uncompensated care, leaving the remainder to unspecified "community benefits." *Id.* § 1(a). Curiously the Bill compares nonprofit performance to for-profit in this second category of community benefits. The following are the core provisions of this proposed legislation:

> (1) An organization which operates a hospital shall not be exempt from tax under [§ 501] unless [it] (A) . . . has an open-door policy toward Medicare and Medicaid patients and . . . (B) provides in a nondiscriminatory manner sufficient qualified charity care and provides sufficient qualified community benefits . . . .
>
> . . . .
>
> (2)(B)(i) The determination under paragraph (1)(B) shall be based on whether—(I) the hospital's unreimbursed qualified charity care costs are 50 percent or more of the value of the hospital's exempt status for the taxable year, and (II) the hospital's unreimbursed qualified community benefits costs are 35 percent or more of the value of the hospital's exempt status for the taxable year. (ii) For purposes of this subparagraph, the term "qualified charity care costs" means the aggregate of—(I) the hospital's costs in providing health care without charge to persons with no or a limited ability to pay or at a discount based on the ability to pay, (II) the hospital's costs in providing health care for which the charge was deducted as a bad debt, [and] (III) the excess of the hospital's costs in providing health care to Medicaid patients over the reimbursements for such care. . . . (iii) [T]he term "qualified community benefits costs" means . . . the hospital's unreimbursed costs in providing those community benefits *not customarily provided by hospitals which are not exempt from tax* . . . .

Id. (emphasis added). The Bill then prescribes a method for determining each hospital's target percentage, based on a national average value of the exemption (federal, state and local). In addition, the Bill allows the IRS to impose an excise tax in the amount of any hospital's shortfall, rather than denying it exempt status altogether. In attempting to account for 50% and 35% of the value of the exemption, the Bill does not require initially a justification for the remaining 15%, presuming that nonprofits make up this difference through other, intangible benefits not provided by for-profits. For informational purposes, the Bill requires hospitals to document annually "the community benefits . . . which are not customarily provided by [for-profit] hospitals . . . and which are not taken into account [elsewhere in the Bill]." *Id.* § 1(b). This information would provide the basis for Congress to determine whether this presumption should continue. Conversations with Gary A. Christopherson, Director, Health Legislation, House Select Committee on Aging (Oct. 11, 1990 & Jan. 7, 1991) (notes on file with the *Washington Law Review*).

Proposals made by Thomas R. Barker, legislative director to Representative Brian Donnelly, that will be the basis of legislation to be introduced this session, are also based upon the historic "relief from government burden" theory. Barker suggests that Congress adopt a modified charity care standard as the basic test for exemption, requiring that hospitals show they devote "more than an insubstantial portion" of their revenues to charity care in order to receive exemption. Barker, *supra* note 64, at 350–51. To counter the argument that certain hospitals may be located in geographic areas where there is little need for charity care, Barker would give the IRS flexibility in implementing the "more than insubstantial standard," suggesting as one approach for measuring charity care need the disproportionate patient percentages used by Medicare to determine

respond to an analysis of the proportionality criterion because it does not measure the value of the tax relief given nonprofit hospitals. From the fragmentary evidence available, it appears that nonprofit hospitals do not provide incremental free care services that match their foregone tax revenues.[152] The only extensive study that directly measures the tax savings[153] conservatively estimates that California nonprofit hospitals gave $82 million in charity care in 1984–1985 and saved $300 million in federal and state tax revenue.[154]

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reimbursement rates. *Id.* Barker would also permit hospitals that flunk this test to qualify for exemption if they could demonstrate "significant and substantial community benefit," such as being the sole community hospital as defined by Medicare. *Id.* at 351.

Unlike Roybal's Bill, however, which attempts to match the economic benefit of exemption to the cost of charity care, Barker's proposals essentially are a return to a charity care standard that has no relationship to the value of the exemption. These proposals, therefore, suffer from the same serious proportionality defects as current law, and would not meet the baseline test of requiring hospitals to demonstrate that the incremental free care provided at least matches the economic benefit of exemption.

In addition, the Utah State Tax Commission recently issued a set of guidelines implementing a charity care standard with which nonprofit hospitals and nursing homes must comply for property tax exemption. *See supra* note 67. Like the Roybal Bill, the Utah standards require hospitals to prove that the value of the services they return to the community equals the full value of the exemption. The Utah standards, however, suffer from two defects. First, the Utah standards measure only the value of the property tax exemption. Second, they employ an overly generous measure of the value of charity care services. *Id.*

152. D. Falcone, America's National Health Insurance Program: The Political Economy of Tax Expenditures on Hospital Care 10 (Jan. 4, 1988) (unpublished manuscript) (whatever comparative advantage nonprofits have on free care, "the amount uncovered will not offset even conservative estimates of hospital tax expenditures").

153. The results of this study are confirmed by smaller-scale studies of individual or groups of hospitals. A study of 11 nonprofit and 4 for-profit hospitals in Utah found that nonprofits received an estimated $24 million in tax relief while delivering a total of $15.7 million in uncompensated care in 1986. Pace Management Services, 1986 Financial/Charity/"Social Overhead" Performance of Wasatch Front [Utah] Hospitals 3 (1989) (unpublished study performed by private consulting firm). This aggregate fails to deduct the proportionate amount of uncompensated care provided by the for-profits. In this instance for-profits provided slightly more such care (3.46% of net revenue as against 3.21%), *id.* at 2. Thus, the precise comparison would reflect $24 million in tax assistance versus $0 of incremental free care. *See also* U.S. General Accounting Office, Proposed Job Design: Nonprofit Hospitals' Charitable Role 7 (1989) (unpublished draft) ("[S]tudies examining hospitals in Texas and Florida showed that once adjustments had been made for tax subsidies or income taxes paid, investor-owned hospitals provided as much, or slightly more uncompensated care than nonprofit hospitals."). A similar study of all Tennessee hospitals based on 1983 data reached the opposite conclusion, finding that "not-for-profit hospitals contribute more in uncompensated care to the community than proprietaries incur in the form of bad debts and taxes." Hospital Alliance of Tennessee, Comparative Economic Performance Among Tennessee's Proprietary and Not-For-Profit Hospital Sectors 4 (Nov. 1984) (unpublished report prepared by Booz-Allen & Hamilton, Inc.). However, this finding is misleadingly based on an aggregation of private nonprofit hospitals with governmental hospitals. Conversation with David Locke, Vice President, Hospital Alliance of Tennessee, Inc. (Dec. 18, 1989) (notes on file with the *Washington Law Review*).

154. Simpson & Lee, *supra* note 141, at 778. The measure of charity care used is the excess of uncompensated care (valued at each hospital's standard charges) provided by nonprofits over

The California study may not represent the nation generally because California has an atypically generous Medicaid program that reduces demand for charity care.[155] Comparisons in other states reveal that nonprofit hospitals provide significantly more free care than for-profits.[156] These comparisons, however, do not measure the magnitude of this increment against the amount of tax loss. When this comparison is made on a national level, nonprofit hospitals provided an increment of uncompensated care above that provided by for-profits, in the following amounts: 1982—$1.06 billion; 1981—$0.51 billion; 1980—$0.41 billion.[157] These amounts are dwarfed by the $8.5 billion estimate of the annual value of the charitable exemption.[158] The same comparison can be approximated by adding the percentage of revenue for-profit hospitals typically forego by providing free care to the percentage of revenue they pay in taxes.[159] The proportion of free care nonprofits provide would have to equal or exceed this sum.[160] The

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that provided by for-profits. Lost taxes are based both on 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 gifts and subsidies that California nonprofits received in 1984–1985. *Id.* 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, *supra* note 142, at 28. 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.

155. Lewin, Eckels & Miller, *supra* note 142, at 1214.

156. *Id.* at 1213–14 (the uncompensated care burden in several states is 50% to 90% higher at nonprofit hospitals than at investor-owned hospitals: 7.6% vs. 4.9% in Florida; 6.7% vs. 4.2% in North Carolina; 5.0% vs. 4.8% in Tennessee; and 7.0% vs. 3.7% in Virginia); Sloan, Valvona & Mullner, *supra* note 37, at 18 (Vanderbilt University Hospital provided $16 million uncompensated care in 1982—13% of its gross inpatient revenue—but since then it has adopted explicit limits on free care).

157. These numbers are derived from data collected by the AHA, as reported in NORTH CAROLINA CENTER FOR PUBLIC POLICY RESEARCH, *supra* note 63, at 48. The AHA declined to provide similar data for subsequent years.

158. *See supra* note 18. This estimate is based upon annual data from 1986 and 1988.

159. This formula assumes that nonprofits are relieved from approximately the same proportion of taxes as for-profits pay. This formula presents a fair approximation for income and property taxes combined because even though nonprofits may have proportionately less income than for-profits, nonprofits tend to have higher valued property than for-profits. *See* Hansmann, *The Effect of Tax Exemption and Other Factors on the Market Share of Nonprofit Versus For-Profit Firms,* 40 NAT'L TAX J. 71, 80 (1987). Relman argues against crediting for-profits with their tax bills in making these free care comparisons because taxes do not result in more health care. Relman, *Investor-Owned Hospitals and Health-Care Costs,* 309 NEW ENG. J. MED. 370, 371 (1983). The purpose of accounting for taxes in this discussion, however, is not to determine who provides the most care for indigents; instead, it is to measure whether the excess in free care provided by nonprofits is sufficient to earn tax relief.

160. In terms of our previous equation, and adding the assumption that $T_n = T_f$, the exemption is fully earned only if:

$$U_n > U_f + T_f$$

result on a national level does not justify providing a tax exemption to nonprofits.[161] The scattered data on a local level are also equally unconvincing.[162] When measured at an individual hospital level, however, many particular institutions, especially urban teaching hospitals, may meet this standard.[163]

3. *Deficiencies as a General Theory of Exemption*

The failure of most voluntary hospitals to justify their exempt status under the relief of government burden theory does not, by itself, invalidate the theory as a general explanation for charitable tax exemption. On the contrary, the solution to the difficulties surveyed thus far is simply to refuse to apply the theory to the particular nonprofit hospitals that fail the test. Further examination, however, reveals that the government burden conception of charity fails at a theoretical level as

161. For the four largest investor-owned multihospital companies (Hospital Corporation of America (HCA), Humana, National Medical Enterprises (NME), and American Medical International (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." Yoder, *supra* note 11, at 114. Even this unfavorable comparison fails to account for property taxes paid by the proprietary hospitals, which would substantially increase the nonprofit deficit.

162. 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% versus 10.3%, of net revenue). Pace Management Services, *supra* note 153, at 3. Data reported for 1984 by the NORTH CAROLINA CENTER FOR PUBLIC POLICY RESEARCH, *supra* note 63, at 168–91, revealed one county, Wake County, where 4.0% of the care rendered by the nonprofit hospitals was uncompensated but, for the investor-owned hospital, more than three times this amount—14.1% of its gross patient revenues—were attributable to taxes plus uncompensated care.

For five selected states (California, Florida, Iowa, Michigan and New York), 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 143, ¶23,523. However, this comparison failed to account for the value of the property tax exemption, the charitable deduction, or tax-exempt bond financing. It also failed to measure nonprofit uncompensated care against a base from representative for-profit hospitals. The comparison therefore fails to report data relevant to the proper application of the government burden/charity care standard.

163. This is suggested by the GAO finding that, when it arrayed individual hospitals by their percentage of uncompensated care, the upper quartile provided from three to nine times greater free care than the lower quartile. GAO REPORT, *supra* note 143, ¶23,521. A sample of 1987 and 1988 data from four large nonprofit hospitals in Arizona found one that provided less net, incremental uncompensated care (measured against a state-wide average of six investor-owned hospitals, which was 3.0%) than the value of its property tax exemption, but three others that provided substantially more uncompensated care—from 4 to 8 times the value of the property tax exemption. However, this study did not attempt to measure any other component of the value of the exemption. Data collected by Mark Hall in preparation for this Article (on file with the *Washington Law Review*).

an exclusive statement of the general basis for tax exemption.[164] Therefore, hospitals' failure to comply should not be conclusive of their claim to exempt status. The government burden theory encounters its primary difficulties under the proportionality and historical consistency criteria.[165]

a. Proportionality

Where the government burden theory is based on the provision of charity care, it fails to meet the proportionality criterion because of its perverse tendency to operate in a regressive fashion, awarding the largest subsidy to those organizations that least need it. Students of "tax expenditure" analysis will recognize that a general tax exemption suffers from the same "upside down" effect as many tax deductions:[166] those entities with the highest net revenues or the greatest value of otherwise-taxable property receive the greatest amount of subsidy, yet these are the entities that least need support.[167] From the standpoint of equity among different tax-exempt entities, the result of the general tax exemption is that entities that are the "poorest" in either an

164. This does not mean that charity care cannot serve as a sufficient standard. *See infra* note 198.

165. The charity care theory is also defective because it would deny hospitals a fair opportunity to meet the standard in rate-regulated states where all charity care is automatically reimbursed, either by being built into each hospital's rate base (and therefore being explicitly passed on to other payers), or by being explicitly reimbursed from an uncompensated care pool that is funded through surcharges on hospital charges. *See* G. ANDERSON, J. LAVE, C. RUSSE & P. NEUMAN, PROVIDING HOSPITAL SERVICES: THE CHANGING FINANCIAL ENVIRONMENT 151–52 (1989) (describing these methods of reimbursing charity care in New York, Massachusetts, New Jersey and Maryland). Moreover, the observation that "free care" by rate-regulated hospitals is not truly uncompensated reveals the weakness of the charity care theory even for unregulated hospitals, because unregulated hospitals also pass on the costs of free care to other patients through their pricing structures. *See* Hadley & Feder, *Hospital Cost Shifting and Care for the Uninsured,* HEALTH AFF., Fall 1985, at 4; Kramon, *Coaxing the Stanford Elephant to Dance,* N.Y. Times, Nov. 11, 1990, § 3, at 1, col. 2 (Stanford Medical Center charges privately insured caesarean patients almost twice the cost of the operation to recoup the cost of treating uninsured patients.)

The charity care theory is also sometimes criticized because it might result in a hospital "jump[ing] back and forth across the line of charitability from one year to the next." O'Donnell & Taylor, *supra* note 146, at 67; *see also* Medical Center Hosp. v. City of Burlington, 152 Vt. 611, 566 A.2d 1352, 1355 (1989) (under this approach, "uncertainty would reign, with taxability determined on a yearly basis depending on economic factors not within the control of any one person or organization"). This defect, however, is merely a matter of administration. It is not necessary to evaluate a hospital's exempt status each year, or even to determine exemption on a hospital-specific basis.

166. *See* S. SURREY & P. MCDANIEL, *supra* note 12, at 72.

167. At a tax rate of 34%, for example (the current maximum corporate rate), an entity with net revenues of $1 million receives a tax subsidy of $340,000, while an entity with net revenues of $100,000 receives a subsidy of just $34,000.

income or property tax sense, and thus most in need of government assistance to serve impoverished and uninsured patients, receive the least government assistance. Because uncompensated care is an expense item, those hospitals with the most net revenues are more likely to have actually rendered the least free care, all other things being equal. Similarly, for the property tax exemption, those nonprofit hospitals that retain the most net surplus for capital expansion, rather than using surplus to support the poor, will enjoy the largest subsidy.[168] The same is true for any theory of exemption which ties the availability of exemption to an expenditure of resources by the exempt entity.[169]

These problems might be ameliorated if the exemption were administered on a hospital-specific, annual basis, requiring each hospital to demonstrate yearly its delivery of free care in an increment sufficient to earn the subsidy.[170] In such a system, a hospital with sufficient net revenues would receive a tax benefit exactly equal to the dollar value of charity care provided by the hospital.[171] Nevertheless, such a system would not help those entities that had insufficient revenues to fully benefit from a tax exemption.[172] Hence, even this theoretical system

168. The first source to note this regressive effect was Note, *Exemption of Education, Philanthropic and Religious Institutions from State Real Property Taxes,* 64 HARV. L. REV. 288, 294 (1950); *see also* Warren, Krattenmaker & Snyder, *supra* note 119, at 300.

169. Suppose an entity receives a charitable exemption for providing housing for the urban poor. Rev. Rul. 70-585, 1970-2 C.B. 115. If its net revenues were zero because it uses its income to subsidize the housing, the value of the income tax exemption would be zero.

170. Alabama, for example, permits a property tax exemption only if the hospital demonstrates that 15% of its "business" constitutes free care. Each hospital must certify annually to the tax commissioner that this test is met. ALA. CODE § 40-9-1(2) to -1(3) (Supp. 1990); Gay v. State, 228 Ala. 253, 153 So. 767, 770–71 (1934). The pending Charity Care and Hospital Tax-Exempt Status Reform Act, H.R. 790, 102d Cong., 1st Sess., 137 CONG. REC. E395–97 (1991), proposes a more elaborate version of this same approach. *See supra* note 151.

171. Assume for example that Hospital *A* has $1 million in net revenue. The value of a tax exemption on this net revenue at current corporate rates is $340,000. It would be possible to design a system which conditioned the exemption on the hospital's ability to demonstrate that it provided incremental free care worth $340,000. If this were done on an annual basis, the exemption would match perfectly the proportionality criterion for this entity.

172. To take an extreme example, a tax exemption would prove worthless to a nonprofit hospital that gave away so much free care that its net revenues were zero.

Even if these proportionality problems could be overcome, the charity care theory is still defective in that there is no guarantee that hospitals receiving a subsidy will in fact devote the subsidy to indigent care. The subsidy comes in the form of an unrestricted grant. Indeed, one empirical study of a block grant program operated in New York concluded that unrestricted subsidies to hospitals "did not directly increase the amount of uncompensated care . . . . [The] hospitals retained the unrestricted subsidies, used them to purchase goods other than uncompensated care, or both." K. Thorpe & C. Phelps, The Social Role of Not-For-Profit Organizations: Hospital Provision of Charity Care 10, 13 (Dec. 15, 1989) (unpublished manuscript).

would suffer proportionality problems. Such a system would also be more cumbersome to administer than the current system.[173]

The second troubling aspect of the government burden theory under the proportionality criterion stems from the intergovernmental nature of the tax exemption subsidy and the multi-jurisdictional nature of many traditionally charitable services. Specifically, the burdens relieved are not necessarily those of the taxing authority that grants the exemption. Instead, one governmental unit may be enjoying the charitable services supported by another's subsidy. This phenomenon has been explored most comprehensively in the context of the property tax exemption for education, where, for instance, it is extremely difficult to maintain that the City of New Haven receives a fair quid pro quo for Yale University's exemption via the City's relief from the burden of operating a university of international stature. Clearly, the government burden would be borne at a state or perhaps national level absent the tax subsidy.[174]

These observations do not have quite the same force in the hospital arena, for the burden of hospital care historically is shared to a much greater degree among federal, state, and local governments. Nevertheless, it is likely that in many situations a large, regional hospital, particularly one affiliated with a medical school, will draw disproportionate support from its local municipal tax base.

As noted in Section II.B., one measure of proportionality is to consider whether the particular form of subsidy that the theory contemplates might be more rationally administered through a system of direct subsidies.[175] This is an apt comparison for health care services

173. *See, e.g.*, The Charity Care and Hospital Tax-Exempt Status Reform Act, H.R. 790, 102d Cong., 1st Sess., 137 CONG. REC. E395–97 (1991) (summarized *supra* note 151); St. Luke's Hosp. v. Board of Assessment, No. 88-C-2691 (Pa. Ct. C.P., Lehigh Co., Apr. 19, 1990) (adopting a highly complex, legislative-type rule, to account for the value of community and charity services provided by a hospital); *see also supra* note 64.

Another corrective technique would be to replace the exemption with a tax credit, guaranteeing proportionate support to each hospital by allowing each to subtract the exact amount or a defined portion of its annual charity care from its tax liability. But a tax credit is not just a minor repair; it is a repudiation of the exemption, because it replaces the exemption with a system that is, in effect, simply another means for administering a direct subsidy. Moreover, unless the law contains a concept of a "refundable credit"—i.e. provides a cash refund to entities with no tax liability—the system would still suffer from proportionality problems. *See generally* S. SURREY & P. MCDANIEL, *supra* note 12, at 108–11.

174. *See* Note, *Alternatives to the University Property Tax Exemption*, 83 YALE L.J. 181, 184–85 (1973); *accord* Belknap, *supra* note 4, at 2033 ("[T]he City of Cambridge clearly is not giving the exemption [to Harvard] as a quid pro quo for being relieved from a burden that it would otherwise have to assume.").

175. For authorities advocating this alternative, see, e.g., Brannon & Strand, *Alternative Approaches to Encouraging Philanthropic Activities*, in FILER COMMISSION REPORTS, *supra* note

because the state and federal governments in fact provide direct subsidies through the Medicaid program, as do many municipalities.[176] A direct subsidy is infinitely more sensible than the exemption. It easily accommodates the widely varying needs for charity care over time and among different localities according to demographic factors, such as the employment rate, the generosity of the particular state's Medicaid program and the presence of local municipal hospitals.[177] A direct subsidy spreads the burden of taxation for these services more fairly across the community than a system that effectively taxes only those who are sick.[178] It is also just as easy or difficult to administer properly.[179]

Yet another alternative that potentially offers even greater efficiency is for the government to directly treat the indigent, as it does on a large scale through the public hospital system, community health centers, Veterans Administration hospitals and the Indian Health Service. Direct provision of service is a far more targeted means of administering charity care than the charitable exemption.

b. Historical Consistency and the Gift-to-the-Community Formulation

The relief of government burden theory is also deficient as a general theory of exemption because it circumscribes the field of charitable activity too narrowly as compared with the traditional categories of exemption, thus failing the historical consistency criterion.[180] The prime example of a charitable activity that cannot be explained under the relief of government burden rationale is religion, an activity for

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2, at 2361; Gabler & Shannon, *supra* note 9, at 2544; Stimson, *supra* note 5, at 423; Note, *supra* note 174, at 181.

176. *See* Sioux Valley Hosp. Ass'n v. Yankton County, 424 N.W.2d 379 (S.D. 1988) (county must pay for emergency hospitalization of indigent); Blendon, Aiken, Freeman, Kirkman-Liff & Murphy, *Uncompensated Care by Hospitals or Public Insurance for the Poor,* 314 NEW ENG. J. MED. 1160 (1986). Also, a number of states have begun to subsidize indigent care through hospital rate regulation. *See* Dowell, *State Health Insurance Programs for the Uninsured Poor,* 23 CLEARINGHOUSE REV. 141 (1989).

177. *See* Warren, Krattenmaker & Snyder, *supra* note 119, at 301.

178. *See infra* note 198.

179. S. SURREY & P. MCDANIEL, *supra* note 12, at 100–02 (observing that degree of administrative complexity is not a function of the method of subsidy); Warren, Krattenmaker & Snyder, *supra* note 119, at 296 (apparent simplicity of the tax subsidy is illusory since it is purchased at the price of a sacrifice in monitoring and accuracy).

180. *See* Belknap, *supra* note 4, at 2033 ("[T]he quid pro quo explanation of tax exemptions . . . is not adequate as a justification of the privilege in some of the most important segments of the general area under discussion. It is evident that the tax exemption privilege has much deeper roots than the quid pro quo theory would admit."); Warren, Krattenmaker & Snyder, *supra* note 119, at 240.

which there is not only no governmental obligation but an outright prohibition on governmental involvement. The government burden theory might accommodate this anomaly as sui generis in our governmental structure,[181] except that there are many other instances of traditionally exempt functions that cannot properly be said to constitute a governmental responsibility. Referring to the listing in section 501(c)(3),[182] only education clearly appears to fit the characterization of a traditional government responsibility, and even it is not a traditional function of the federal government.[183]

A somewhat modified version of the government burden theory, known as the "gift-to-the-community" formulation, avoids some of the deficiencies of the pure "quid pro quo" version by encompassing any free service, regardless of whether the particular service is one the government traditionally has provided.[184] This accords with the assumption that the government has a strong interest in the relief of poverty even if the government is not affirmatively obliged to directly render the particular form of relief. This theory avoids the problematic requirement of the strict formulation of the government burden theory that assumes the government would provide the same service absent the exemption. In contrast, under the gift-to-the-community variant, a charitable service merits subsidization if the government merely has the power to supply the free service itself.[185]

This variation of the charity care theory, however, does not come any closer to qualifying hospitals for the exemption. Also, as a general theory of exemption, it continues to suffer from the "upside down" effect and the other proportionality problems noted above. The overriding defect, however, is that this variant fails even at its primary point of attempted rehabilitation—historical consistency.

181. Indeed, throughout much of the long history of the exemption, religion has been deemed within the province of government. *See supra* note 5.

182. I.R.C. § 501(c)(3).

183. Belknap, *supra* note 4, at 2033. Moreover, education may not, strictly speaking, be a government "obligation," because the government is under no constitutional duty to affirmatively protect or enhance the welfare of its citizenry. DeShaney v. Winnebago County Dep't of Social Servs., 489 U.S. 189 (1989); Wideman v. Shallowford Community Hosp., Inc., 826 F.2d 1030 (11th Cir. 1987).

184. *See* Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 269–70 (Utah 1985) (charity requires a "gift to the community" that "can be identified either by a substantial imbalance in the exchange between the charity and the recipient of its services *or* in the lessening of a government burden" (emphasis added)).

185. Or, in the special case of religion, it would have the power but for a specific preclusion. Ginsberg, *supra* note 54, at 308 ("It appears to be sufficient that the function being performed is one that might otherwise be performed at public expense.").

One could argue for a theory of charitable exemption that extends to the relief of poverty in any manner, based on the Statute of Charitable Uses,[186] the principal source of the law's concept of charity.[187] This statute was enacted in conjunction with the Elizabethan Poor Laws,[188] which sought to address the critical problems faced by the increasingly destitute populations in urban centers. The Poor Laws placed the responsibility on local towns to care for their indigent residents. At the same time the Statute of Charitable Uses sought to lessen this local governmental burden by strengthening the role of private philanthropy. The historical connection between these two statutes demonstrates that the original notion of charity was principally concerned with the relief of poverty.[189]

This notion prevailed for only a comparatively short time, however. In *Commissioners v. Pemsel,*[190] Lord McNaughten captured centuries

186. An Act To Redress the Mis-Employment of Lands, Goods and Stocks of Money Heretofore Given to Certain Charitable Uses (Statute of Charitable Uses), 1601, 43 Eliz. 1, ch. 4, *reprinted in* 7 STAT. AT LARGE 43 (Eng. 1763).

187. *See supra* note 82 and accompanying text.

188. An Act for the Relief of the Poor, 1601, 43 Eliz. 1, ch. 2., *reprinted in* 7 STAT. AT LARGE 30 (Eng. 1763).

189. *See* M. CHESTERMAN, *supra* note 1, at 56–57 ("[A]ccording to the intentions of the Elizabethan legislature and the authoritative contemporary interpretation, the 1601 preamble's concept of 'charitable' contained a 'public benefit' requirement calling for benefit to the poor . . . . Without this, the Act's objective of lightening the burden of parish poor relief . . . would not be achieved."); G. JONES, *supra* note 97, at 22–23 (discussing the connection between the Elizabethan Poor Laws and the Statute of Charitable Uses); L. SHERIDAN & G. KEETON, *supra* note 80, at 8–9 (same); Adler, *supra* note 3, at 59, 80:

> To prevent vagabondage and begging the state undertook [in the Poor Law] to maintain only the poor and impotent, the utterly helpless. Those in a position to pay have, therefore, no claim on state support. In housing such inmates an institution is in no way relieving the state of a burden which the latter has ever undertaken to bear.

Relief of poverty was also the concept of charity that originally prevailed in IRS rulings during the first half of this century. *See* Eastern Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278, 1286 & n.13 (D.C. Cir. 1974), *vacated on other grounds,* 426 U.S. 26 (1976); Liles & Blum, *supra* note 2, at 20–21. Finally, care for the indigent was at the core of the rationale for granting hospitals immunity from tort liability in some states when the doctrine of charitable immunity still existed. *See* Ponder v. Fulton-DeKalb Hosp. Auth., 256 Ga. 833, 353 S.E.2d 515, 516 ("The proper standard for an equal protection analysis of the charitable immunities doctrine is whether it bears a rational relationship to the public policy of care for indigent persons."), *cert. denied,* 484 U.S. 863 (1987); Morton v. Savannah Hosp., 148 Ga. 438, 96 S.E. 887, 887–88 (1918) (charitable immunity attaches only to treatment of nonpaying patients); Adams v. University Hosp., 122 Mo. App. 675, 99 S.W. 453, 454 (1907) (the purpose of the charitable immunity is to prevent funds from being "diverted from such kindly purposes" as "administering relief to those in need"). *But see* City of Richmond v. Richmond Memorial Hosp., 202 Va. 86, 116 S.E.2d 79, 83 (1960) ("[S]everal tort cases . . . establish that hospitals . . . are 'charitable' institutions despite the fact that they charge all who can afford to pay."); Southern Methodist Hosp. & Sanitorium v. Wilson, 51 Ariz. 424, 77 P.2d 458 (1938) (same), *overruled on other grounds,* Ray v. Tuscon Medical Center, 72 Ariz. 22, 230 P.2d 220 (1951).

190. 1891 App. Cas. 531 (H.L.).

of precedent in rejecting the relief of poverty as the sole ground for charitable classification.[191] Nor has the concept of poverty relief governed the law of charity in modern times. The other bedrock charitable purposes, religion and education, serve the rich as well as the poor. Even when hospitals were considered paradigms of charitable organizations, they 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.[192]

The same observation is true for charities generally, which have devoted only a small portion of their resources to social services for

191. *See generally* M. CHESTERMAN, *supra* note 1, at 54–57 (discussing the "distortion" of the charity concept that occurred during the eighteenth century).

192. Stevens, *Voluntary and Governmental Activity,* HEALTH MATRIX, Spr. 1985, at 26, 28; *see also Southern Methodist Hosp.,* 77 P.2d at 460–61 (charitable hospital rendered "very little free medical or hospital attendance . . . to anyone"); *City of Richmond,* 116 S.E.2d at 82 ("The framers of the (1902) Constitution presumably knew that such charitable organizations as YMCA's, asylums, and hospitals customarily charge for services . . . ."); J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 30 (at the time the IRS issued Rev. Rul. 56-185, 1956-1 C.B. 202, almost 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"); D. ROSNER, A ONCE CHARITABLE ENTERPRISE: HOSPITALS AND HEALTH CARE IN BROOKLYN AND NEW YORK, 1885-1915, at 8–9, 36–61 (1982) (various economic and technological forces transformed New York hospitals from classic charities to business organizations during the 1890s); P. STARR, *supra* note 35, at 146 ("[I]n 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"); R. STEVENS, *supra* note 35, at 23 ("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 . . . ."); 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 201, 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."); Mancino, *supra* note 40, at 1057. 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 particular desires of ethnic and religious groups. P. STARR, *supra* note 35, at 150, 169–72.

the poor since the seventeenth century in England and since the advent of the massive governmental welfare programs in the United States.[193]

One might attempt to rebut these historical authorities by observing that they establish only 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."[194] Likewise, the government burden theory, including its gift-to-the-community variant, does not require total devotion to relief for the poor,[195] only sufficient free services to match the level of deservedness to the level of subsidy. Nevertheless, the law of charities has long held that charitable trusts need not serve the poor at all.[196] Indeed, several of the classic instances of tax-exempt organizations in modern times serve the rich almost exclusively.[197] Accordingly, a conception of charity limited to free services to the poor would dramatically alter the current scope of the exemption.

In sum, both the traditional formulation of the relief of government burden theory and the gift-to-the-community variant are not only unsatisfactory as an explanation for the exemption of voluntary hospitals, but they also fail the proportionality and historical consistency criteria from the standpoint of a general theory of tax exemption. For these reasons, they are unacceptable both as justifications for the

193. Roberts, *A Positive Model of Private Charity and Public Transfers,* 92 J. POL. ECON. 136, 141 (1984) ("[p]rivate charity in the United States is approximately zero" in the sense of helping the poor; only 10% of donations go to "social services" and only a fraction of that amount goes to the poor); *id.* at 147 & n.147 (in England after 1660, "payments under the Poor Law became almost everywhere the ordinary source of relief for indigence with private charity a supplementary source of varying importance, called on for great efforts only in times of extraordinary distress").

194. Note, *Hospitals, Tax Exemption, and the Poor,* 10 HARV. C.R.-C.L. L. REV. 653, 679 (1975) (emphasis added).

195. *See* Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 282 (Utah. 1985) (Stewart, J., dissenting) ("Charitable hospitals need not be self-liquidating.").

196. For holdings and statements to this effect in the context of hospitals, see *Southern Methodist Hosp. & Sanitorium v. Wilson,* 51 Ariz. 424, 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. . . ."), *overruled on other grounds,* Ray v. Tuscon Medical Center, 72 Ariz. 22, 230 P.2d 220 (1951); *Evangelical Lutheran Good Samaritan Soc'y v. Board of County Comm'rs,* 219 N.W.2d 900, 909 (N.D. 1974) ("[A]n 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 . . . ."); *In re* Resch's Will Trusts, [1969] 1 App. Cas. 514, 544 (P.C.); RESTATEMENT (SECOND) OF TRUSTS § 376 comment c (1959); SCOTT ON TRUSTS, *supra* note 92, § 372.

197. *See* B. HOPKINS, *supra* note 31, at 80–83; Simon, *supra* note 69, at 85 (property tax exemption historically applied to "schools for the sons of gentlemen").

exemption of nonprofit hospitals and as general theories on which to base eligibility for tax exemption. 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.[198]

198. Rejecting free care as a necessary standard for the exemption does not necessarily preclude its serving as a sufficient standard. If the test is both properly formulated and met by a particular hospital (i.e., the hospital demonstrates that it dispenses an incremental level of charity care equal in dollar value to the value of the exemptions), granting the exemption is not bad public policy, despite the several possible reasons why one might have qualms about the government supporting a nonprofit institution that subsidizes the poor solely from sales to paying patients. In the hospital context, one might object that this form of redistribution through cross-subsidization, which, in contrast with government taxation, conceals from patients and insurers their support of a system that cares for the poor by "taxing" the sick. *See* P. FELDSTEIN, HEALTH CARE ECONOMICS 268–69 (1979) (criticizing hospital internal cross-subsidization); Phelps, *Cross-Subsidies and Charge-Shifting in American Hospitals,* in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 108 (1986) (same); Clark, *supra* note 10, at 1438–39, 1467 (describing as "elitist" the "minigovernment" model of hospital exemption which fosters redistribution of income through covert "taxation," effectively "disenfranchising" the public); Posner, *Taxation by Regulation,* 2 BELL J. ECON. & MGMT. SCI. 22 (1971) (seminal discussion of the economic effect of hidden taxation). However, this form of redistribution by voluntary private transaction, unlike government taxation, is not coerced. Moreover, if the hospital did not treat the poor, its pricing behavior for paying patients would not necessarily be any less irrational or exploitive. It would only make different use of the profits.

The second basis for concern about government support for private redistributional schemes is that such schemes may not be structured to yield optimal benefits, and may deter the government from undertaking this function in a superior fashion. For instance, to the extent government relies on private hospitals to meet the health care needs of uninsured patients, it fosters an irrational public health policy that treats members of this population only when medical conditions deteriorate to a very severe level. Nothing, however, prevents the government from requiring hospitals to meet part of their free care obligation in an outpatient setting that offers preventative and primary care services. Indeed, the Utah County Tax Commissioner bargained for this precise solution in negotiating a settlement with the hospital company involved in the Utah County case. Tolchin, *Hospitals Use Charity To Fend Off Tax Collectors,* N.Y. Times, May 3, 1988, at C3, col. 1 ("For reasons not altogether altruistic, Intermountain Health Care Inc. recently opened a clinic here to treat homeless men and women . . . [it] began providing health care at a local soup kitchen and at a center for Indochinese refugees [a]nd it expanded health services on Indian reservations and for the rural poor.").

The third criticism of using the charitable tax exemption to support free care dispensed by private hospitals is that the exemption allows the government to shift to private industry its responsibility to subsidize this care directly. *See* Yoder, *supra* note 11, at 195 ("Ensuring adequate health care is a societal obligation, and government should make provision for its financing when private coverage is lacking."). The government, however, does directly fund health care for the poor at some level. Even if greater government involvement existed, there would always be a role for private hospitals to play, for instance in treating transients, illegal aliens, and others who may fall through the cracks of government programs. *See* Sager, *Prices of Equitable Access: The New Massachusetts Health Insurance Law,* 18 HASTINGS CENTER REP. 21 (1988) (Massachusetts provides comprehensive health care coverage largely by using the tax system to impose the responsibility for health insurance on private employers).

C. *Community Benefit and the Nonprofit Ethic*

1. *The Community Benefit Theory*

Nonprofit hospitals face a pair of correlative problems under the two conventional theories of exemption examined thus far. Nonprofits easily satisfy the health care per se theory, but that theory, applied logically, does not test whether they earn the exemption. In contrast, the relief-of-poverty branch of the government burden theory, which does contain such a test, is too demanding for most hospitals in the present health care economy. Recognizing these twin difficulties, the nonprofit hospital sector maintains that the proper test for the exemption should consider whether they benefit the community in a variety of ways less obvious or tangible than direct charity care, such as providing services superior to that of investor-owned hospitals, responding to community needs better than for-profits, or fostering desirable medical values in ways that proprietary medicine does not.

Unlike the per se theory drawn from trust law, the community benefit theory does not automatically validate the exemption of any nonprofit activity. Instead, this theory seeks to identify particular nonprofit activities in which the community values the special quality or ethic that the nonprofit enterprise offers.[199] In the hospital context,

199. 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 fellowmen, . . . 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 men.

Trustees of the First Methodist Episcopal Church v. City of Atlanta, 76 Ga. 181, 192–93 (1886). Of like mind, but of less apocalyptic manner is Belknap, *supra* note 4, at 2033–35:

> The true explanation, and the only principle that affords a complete justification covering the entire field of [charitable] exemptions . . . is that government relieves from the tax burden religious, educational, and charitable activities because it wishes to encourage them as representing the highest and noblest achievements of mankind[,] . . . activities which by common understanding are agreed to rate among the highest in the scale of social values.

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 "metabenefits," 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 "metabenefits." 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

the community benefit theory maintains that nonprofits are socially privileged by virtue of their superior quality of service or the superior ethic of nonprofit medicine.[200] As summarized in the preeminent study of organizational form in medicine:

> [S]ome observers believe that the rise of for-profit health care threatens the values and ideals that should guide . . . health care organizations. . . . It is feared that something essential will be lost if a service ethos—expressed in terms such as caring, community responsiveness, fiduciary responsibility—is abandoned or replaced with a principle based on economic goals.[201]

The theory of exemption based on the superiority of the nonprofit ethic in medicine comes closer to meeting the deservedness criterion than the per se approach because it requires a positive demonstration of a community benefit that profit-making firms do not offer.[202] Thus,

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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, 605–06 n.266 (1990); *see also* Walz v. Tax Comm'r, 397 U.S. 664, 672–73 (1970) ("[C]ertain entities that exist in a harmonious relationship to the community at large, and that foster its 'moral or mental improvement,' should not be inhibited in their activities by property taxation . . . . The State has an affirmative policy that considers these groups as beneficial and stabilizing influences in community life . . . ."); *cf.* E. JAMES & S. ROSE-ACKERMAN, *supra* note 11, at 3 (proposing a view of nonprofits that "emphasizes the independent role of ideology as a fundamental justification for [their] existence and a basic explanation of their behavior"); *id.* at 51:

> We believe that a key feature of nonprofit production is ideology. . . . [M]any organizations are nonprofit because their founders have a set of strongly felt beliefs which motivate them more than money alone. The kind of services they chose to produce [and] the consumers who prefer these services . . . are directly tied to the founders' beliefs.

200. The leading advocates of this position are AMERICAN HOSPITAL ASSOCIATION, *supra* note 39; Seay & Sigmond, *supra* note 39, at 3; Seay & Vladeck, *supra* note 39; *see also* Falcone & Warren, *supra* note 18, at 735–36 ("[P]luralism in health services delivery is desired and has a price which Americans . . . have agreed to pay via tax expenditures . . . ."); Horwitz, *Corporate Reorganization: The Last Gasp or Last Clear Chance for the Tax-Exempt Nonprofit Hospital,* 13 AM. J. L. & MED. 527, 558–59 (1988) ("[C]ommitment . . . to service, rather than to profit, even if greater in spirit than in deed, may be enough to warrant retention of the nonprofit concept."). *See generally* Hyman, *supra* note 51, at 363–76 (explaining and critiquing this position).

201. Yoder, *supra* note 11, at 182.

202. The proposed Charity Care and Hospital Tax-Exempt Status Reform Act, H.R. 790, 102d Cong., 1st Sess., 137 CONG. REC. E395–97 (1991) (discussed *supra* note 151), adopts this approach to justifying up to half the value of exemption.

Similarly, the proposals of Thomas Barker, described, *supra,* note 151, would make community benefit an explicit alternative for exemption, permitting hospitals who failed the charity care standards to qualify for exemption if they could demonstrate a "significant and substantial community benefit" by serving, for example, as the sole community hospital as defined by the Medicare statutes. Barker, *supra* note 64, at 351. Barker, however, would not accept as community benefits certain services currently touted as such by nonprofit hospitals, such as weight loss clinics, "stop smoking" clinics, or cholesterol-screening clinics operating at

tax exemption proponents maintain that nonprofit hospitals provide many unique benefits besides free care: they support physician education and medical research;[203] provide a full range of services regardless of each service's profitability;[204] and support community health education and preventative services such as childbirth classes, meals for the elderly, and immunization clinics.[205] More amorphously, they claim to foster an ethos more conducive to proper medical practice than that prevailing in profit-oriented environments.[206]

The community benefit theory also avoids the difficulty that the relief-of-poverty justification faces under 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 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 can render to the community.[207]

2. *Deficiencies in the Community Benefit Theory*

a. *Deservedness*

Closer examination of this theory reveals that it also suffers from serious infirmities, primarily under the deservedness and proportionality criteria. With respect to deservedness, the community benefit theory should show that the social benefits claimed by nonprofit firms

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local shopping malls. Barker observes that hospitals often make money on such services, which at the very least provide free advertising for the hospital and its physicians. *Id.*

203. Seay & Vladeck, *supra* note 39, at 6–7.

204. *Id.* Examples of services that are usually unprofitable include burn units, trauma centers, and neonatal intensive care. *Id.*

205. AMERICAN HOSPITAL ASSOCIATION, *supra* note 39, at 36–38. Nonprofit sceptics, however, discredit the deservedness of these services, observing that many are undertaken primarily for marketing purposes. *See supra* note 202.

206. Jones & Du Val, *supra* note 192, at 230 ("[T]he voluntary hospital embodies a set of values in health care that helps quicken the conscience of the community concerning the sick and poor and inspires a vision of what medicine and health care can accomplish for mankind, beyond what the marketplace demands . . . ."); Wikler, *The Virtuous Hospital: Do Nonprofit Institutions Have a Distinctive Moral Mission?*, in IN SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS 127, 142 (1988) ("Nonprofit hospitals are often regarded as better for society than for-profit hospitals precisely because they aspire to, and often do, achieve virtue.").

207. For the same reason, this theory addresses the universality criterion by seeking to justify both types of exemption. It also has the potential to explain a number of the restrictions on these exemptions such as the prohibition on lobbying and the restraint on unfair competition, because these restrictions are apparently 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. *See supra* note 110 and accompanying text.

would be lost without the exemption. Without this "but for" connection, the economic benefit of tax exemption is a windfall. In the context of hospitals, it is necessary to ask first, why voluntaries are preferred to proprietaries, and second, why the exemption is needed to secure this preference. These two inquiries mirror the "worthiness" and "neediness" components of the deservedness criterion discussed earlier. The extensive literature devoted to both the theoretical and the empirical dimensions of these two inquiries reveals no support for the proposition that whatever social benefits are provided by the nonprofit form in medicine would disappear absent a tax exemption.

Scholars of the nonprofit enterprise have long been fascinated with the hospital industry because it provides an intriguing mix of all three sectors of the economy operating in tandem: proprietary, government, and nonprofit firms.[208] These scholars have developed several competing theories to explain why nonprofit hospitals have historically outnumbered for-profits.[209] Some explanations relate to a plausible community benefit, while others do not. The theories that find no inherent benefit in the nonprofit form directly refute the worthiness component of the community benefit theory; those that support the notion of social benefit inherent in the nonprofit form must still pass the "but for" (neediness) component of the deservedness criterion.

1) Negative Theories of Nonprofit Dominance

Theories that are neutral or adverse to nonprofits discern no rationale for preferring 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, and transportation.[210] These nonprofit skeptics offer essentially two rationales for the dominance of the nonprofit form. First, some theorists blame the tax exemption and other forms of unjustified governmental favoritism for the prevalence of nonprofit hospitals.[211] Nonprofit

208. Over the past fifty years, the relative mix of these three sectors has remained remarkably stable, as follows (in number of beds): public (governmental) hospitals—20% to 25%; voluntary hospitals—around 70%; proprietary hospitals—from 5% to 10%. J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 20–21.

209. For an historical overview of nonprofit dominance, see Marmor, *supra* note 27, at 321–25.

210. P. FELDSTEIN, HEALTH CARE ECONOMICS 198, 218 (2d ed. 1983) ("[If] it is immoral to profit from sickness, why then can people profit from hunger and the need for shelter?"); Hansmann, *supra* note 11, at 880–81; Sloan, *supra* note 142, at 109 ("[M]ost physicians, dentists, optometrists, and pharmacists work for proprietary firms, that many nursing homes are for-profit, [and] drug and medical devices are manufactured by such firms . . . .").

211. *See In re* Advisory Opinion to the House of Representatives Bill 85-H-7748, 519 A.2d 578 (R.I. 1987) (upholding the constitutionality of proposed legislation that would deny licensing

skeptics therefore characterize the exemption for hospitals as an anachronism that remains "in large part as a consequence of institutional inertia,"[212] or even as a mindless subsidy that perpetrates a "fraud" on the public.[213]

Others maintain the "parasitic hypothesis" that nonprofit hospitals proliferate because doctors prefer nonprofits for reasons of economic

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to publicly traded health care facilities); Bays, *Why Most Private Hospitals are Nonprofit,* 2 J. POL'Y ANALYSIS & MGMT. 366, 367 (1983) (the National Labor Relations Act explicitly exempted nonprofit hospitals until 1974); *id.* at 377 ("[H]ospital planning agencies appear to have a bias against for-profit hospitals, according to anecdotal evidence."); *id.* ("[i]n 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); Foster, *Hospitals and the Choice of Organizational Form,* 3 FIN. ACCOUNTABILITY & MGMT. 343, 353–54 (1987) (discussing various barriers to entry by for-profits); Hall, *supra* note 22, at 509–17 (discussing the inhibiting effect that the corporate practice of medicine doctrine has on proprietary enterprise in health care); Marmor, Schlesinger, & Smithey, *supra* note 28, at 224–27 (discussing the preferential treatment nonprofits receive from the Hill-Burton hospital construction program and from Blue Cross/Blue Shield); Steinwald & Neuhauser, *The Role of the Proprietary Hospital,* 35 L. & CONTEMP. PROBS. 817, 835 n.27 (1970) (documenting the preferential treatment nonprofits receive from hospital planning agencies); Note, *The Quality of Mercy: "Charitable Torts" and Their Continuing Immunity,* 100 HARV. L. REV. 1382 (1987) (documenting the modified survival of charitable tort immunity for nonprofit hospitals). *See generally* Clark, *supra* note 10, at 1474.

Empirical evidence fails to either confirm or refute the hypothesis that the exemption alone accounts for a significant portion of nonprofit hospital market share. The only study on point concluded, 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, *supra* note 159, at 76–77. The quality of the data supporting these findings, however, fails to meet standard tests for statistical significance. *Id.*

212. Hansmann, *The Evolving Law of Nonprofit Organizations: Do Current Trends Make Good Policy?,* 39 CASE W. RES. L. REV. 807, 814 (1989); *see also* Foster, *supra* note 211, at 353–54.

213. Clark, *supra* note 10, at 1447. Clark does not squarely endorse these terms—he uses them only to characterize what he describes as the "exploitation hypothesis;" but he is clearly more sympathetic to this hypothesis than the competing "fiduciary hypothesis." An even more forthright critic is Hyman, *supra* note 51, at 374 ("By disguising themselves as non-exploitative agents, the nonprofit hospitals add deceit to their offenses.").

Herzlinger and Krasker are perhaps the most notorious critics of nonprofits. They claim to document that "nonprofits have not fulfilled their social promise" and "do more to maximize the welfare of the physicians who are their main consumers." Herzlinger & Krasker, *supra* note 143, at 104. Further, they contend that "many emotional protests against for-profits may be attempts by the medical profession to preserve a cozy arrangement." *Id.* To the extent that this study relies on empirical findings rather than on theoretical assumptions, it has been subject to sharp attack. *See, e.g.,* Reinhardt, *Flawed Methods Cripple Study on Not-For-Profits,* HOSPITALS, Apr. 20, 1987, at 136 (suggesting that this study would not meet the standards required of "a Princeton undergraduate [who] proposed to perform this sort of analysis" and accusing the authors of "bend[ing] empirical findings to preconceived notions"); N.Y. Times, Apr. 2, 1987, at D1, col. 2, D8, col. 5 ("The authors' bias for privatization screams out from every page of the study. I'm concerned by the apparent attempt to propagate personal bias in the guise of science." (quoting health economist Uwe Reinhardt)). There is, however, no dispute that Herzlinger and Krasker accurately reflect a respectable theoretical position.

self-interest inconsistent with socially optimal patient care. The two principal theories[214] that rely on physician self-interest are the "physician control theory" and the "managerial prestige theory." These differ in that the first posits physicians' financial interest as the primary determinant of hospital organization and operation, whereas the second views physician interest as derivative of nonprofit managers' utility function.[215]

The physician control theory holds that physicians prefer nonprofits because this institutional form tends to increase physicians' control over the financial affairs of hospitals by virtue of the absence of any shareholders with overriding or competing authority.[216] The resulting managerial laxity is said to allow doctors to control their competitors' access to the medical staff or to direct hospital pricing decisions to their own advantage.[217]

The "managerial prestige" theory of nonprofit preference posits that physicians enjoy derivative benefits from the way in which nonprofit managers naturally tend to behave. According to one leading explanation, "the utility of hospital administrators is a function of the status

214. Another "negative" theory for nonprofit preference on the part of physicians posits simply that physicians benefit from the exemption itself, as well as from other preferential forms of social subsidy such as volunteer labor and research funding. Bays, *supra* note 211, at 377 (these various subsidies "lower the total cost of the complementary hospital inputs and therefore increase the price that physicians can charge" across the board). Because this theory is derivative of other preferential phenomena discussed elsewhere, *see supra* note 211, it is not given independent treatment here, although it may represent the most convincing reason for the nonprofit preferences of doctors. *See supra* notes 120–24 and accompanying text.

215. *See generally* P. FELDSTEIN, *supra* note 198, at 212–23.

216. Pauly & Redisch, *The Not-For-Profit Hospital as a Physicians' Cooperative*, 63 AM. ECON. REV. 87 (1973); *see also* Blumstein & Sloan, *Antitrust and Hospital Peer Review*, L. & CONTEMP. PROBS., Spr. 1988, at 7, 19–20.

217. Bays, *supra* note 211, at 377 ("[P]hysicians as a group prefer nonprofit hospitals not because they are allergic to the notion of profit, but because restrictions against for-profit hospitals have been one way of controlling entry."); Clark, *supra* note 10, at 1436–37, 1441–47.

This explanation is flawed on two counts. First, to a large degree, doctors prefer *not* to be involved in hospital financial matters. Thus it has been said that they use their influence purposefully to avoid the day-to-day details of hospital management. Hall, *supra* note 22, at 440. Second, to the extent doctors do desire control, private standards of hospital accreditation—on which the medical profession has a major influence—guarantee largely the same degree of control over both types of hospitals. *Id.* at 528–30; Majone, *Professionalism and Nonprofit Organizations*, 8 J. HEALTH POL., POL'Y & LAW 639, 654 (1984). Even absent these standards, there is no solid documentation that nonprofit hospitals give more managerial control to doctors. *See* P. STARR, *supra* note 35, at 165 ("Oddly enough, proprietary hospitals [during the first half of the century] were one of the main ways of resisting corporate domination and establishing professional control."); Alexander, Morrisey & Shortell, *Physician Participation in the Administration and Governance of System and Freestanding Hospitals: A Comparison by Type of Ownership*, in INSTITUTE OF MEDICINE, FOR PROFIT ENTERPRISE IN HEALTH CARE 402, 408 (B. Gray ed. 1986) (for-profits "appear to have greater physician representation on hospital governing boards").

of the hospitals in which they serve" and "the status of a hospital is assumed to vary directly with the range of services available and the extent to which expensive and highly specialized equipment and personnel . . . are available."[218] Nonprofit hospitals are thought to spend more than for-profits on physician and patient amenities because they are required to retain their earnings within the institution. In economic jargon, it is said that nonprofit institutions are "volume maximizers" or "output maximizers," rather than profit maximizers.[219] The same notion is captured in the colloquialism accusing hospital managers of suffering from an "edifice complex." However expressed, the result is that nonprofit hospitals are charged with a "bias against producing low-quality products, even if they are demanded by a certain segment of the population," and are blamed for "the often maligned duplication of sophisticated and expensive equipment," both of which represent a "misallocation of resources."[220]

2) Positive Theories of Nonprofit Dominance

Theories that support nonprofit enterprise in medicine hold 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 explains that

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218. Lee, *A Conspicuous Production Theory of Hospital Behavior,* 28 S. ECON. J. 48, 49 (1971).

219. Newhouse, *Toward a Theory of Nonprofit Institutions: An Economic Model of a Hospital,* 60 AM. ECON. REV. 64, 64–65 (1970).

220. *Id.* at 69, 70, 73. This theory cannot completely explain the predominance of nonprofit hospitals because at bottom the managerial motives it posits are not fundamentally different than those prevailing at proprietary hospitals. The theory of managerial prestige attributes hospital behavior to that which pleases doctors, because the size and quality of a hospital's medical staff is the principal determinant of its prestige. *See* Lee, *supra* note 218, at 49 ("In order to attract and maintain physicians, [nonprofit] hospitals are responsive to the demand of their medical staffs."). But the size and quality of the medical staff also determine a hospital's profitability, so one would expect largely the same physician-pleasing behavior from both sectors.

Another branch of the managerial behavior theory is based on the observation that the convention of separate billings for doctor and hospital services masks the economic reality that the patient is paying a joint price for a single product. Accordingly, doctors have an incentive to prefer the organization that charges the least, leaving most of the joint price for them to capture. Nonprofits are thought to price lower, at least for hospital services that have a large physician participation such as surgery, because they are less concerned about profit margins. *See* Bays, *supra* note 211, at 372; Hansmann, *supra* note 11, at 866.

This explanation assumes, however, that nonprofits are less interested in making money than for-profits. In fact, nonprofits also desire to earn a surplus; they simply have different "utility functions," i.e., different uses for the money, such as facility expansion. *See* P. FELDSTEIN, *supra* note 198, at 215–18. It also assumes that market constraints have traditionally operated to cap the total price for the "joint product." In fact, the hospital price historically has imposed no constraint on doctors' charges because independent sources of reimbursement have not been sufficiently price sensitive.

patrons tend to favor the nonprofit organizational form when complex and difficult-to-evaluate services are involved. Patrons prefer nonprofits because they have less trust in firms whose profit incentive provides them a stronger bias to behave opportunistically. Hansmann maintains nonprofits enjoy greater public confidence because a "nondistribution constraint" attaches to nonprofit status, precluding anyone from having a private interest in the organization's economic performance and requiring the institution to retain any net income to further its public service mission.[221]

Hansmann's trust theory for the existence of nonprofit enterprise has superficial appeal in the medical arena because health care is a service that is difficult for consumers to evaluate.[222] It is thus surprising that Hansmann finds his theory a poor fit in the hospital industry.

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221. The strongest application of this "trust theory" for the existence of nonprofit enterprises explains why donors choose to make contributions exclusively to nonprofits when they desire to support traditional charitable services such as disaster relief and care for the poor. Hansmann characterizes donors as "purchasing" these relief services for others, and observes that, as a consequence of the third-party nature of this transaction, donors are not in a position to monitor whether and how effectively the desired aid is rendered. *See generally* Hansmann, *supra* note 11.

Red Cross, for instance, is in the business of "selling" disaster relief services to contributors for delivery to third-party beneficiaries. As the contributors generally have no way of determining the quality of Red Cross's relief services or whether such services actually are performed, the "consumer" (the contributor) cannot engage in comparative shopping. As a result, the consumer is better off buying such services from a nonprofit entity, since the prohibition on the distribution of profits by a nonprofit to private individuals (the prohibition against private inurement) gives the consumer some assurance that the money "paid" for the service will actually be used for the service.

This trust explanation also holds for two-party commercial transactions in which consumers purchase services for themselves that are difficult to evaluate because of the intangible nature of the services. Prominent examples include child care and education. *See* B. WEISBROD, *supra* note 8, at 6, 23; Hansmann, *supra* note 11, at 862–72. As these services are typically purchased on behalf of someone else in the family, they too are not pure two-party transactions, which may partially explain the difficulty of monitoring these services. Krashinsky, *Transaction Costs and a Theory of Nonprofit the Organization,* in THE ECONOMICS OF NONPROFIT INSTITUTIONS 114, 117 (S. Rose-Ackerman ed. 1986).

For a partial rebuttal of the trust theory and a development of a theory that explains the existence of mutual benefit organizations, the other major category of nonprofits, see generally Ellman, *supra* note 11.

222. *See* Arrow, *Uncertainty and the Welfare Economics of Medical Care,* 53 AM. ECON. REV. 941 (1963). Health care is difficult to monitor because of its inherently complex and qualitatively subjective nature, and because an individual patient rarely has an opportunity to experience how an alternative provider would have treated the same ailment. *See* B. WEISBROD, *supra* note 8, at 46. It might also be observed that health care is usually purchased through third-party transactions, by virtue of the payment coming from the insurance company, but this is an inappropriate characterization for these purposes because the insurer merely indemnifies the patient (or hospital) for the choice of care made and does not itself make the purchase. However, to the extent that insurance companies are becoming increasingly selective in which hospitals to cover, as through so-called "preferred provider organizations" (PPOs), then perhaps there is some merit to this third-party characterization.

The reason the trust theory does not readily extend to hospitals is that patients rarely undertake to evaluate hospital services independently. Instead, they rely heavily on the judgment of their physicians in selecting a hospital. Indeed, it is sometimes said that the true consumers of hospital services are doctors, not patients.[223] Because patients tend to follow the advice of learned intermediaries, the difficulty of lay evaluation of hospital care is corrected without adopting the nonprofit form.

This explanation stops short of a full examination of the trust theory's application to hospitals because it fails to inquire whether doctors also have socially valued reasons to prefer nonprofit hospitals—reasons equivalent to consumer trust. According to one body of scholarship, doctors and, by derivation, patients, do have such reasons. Patients trust their doctors' choice of hospitals in part because doctors are perceived to be guided by a professional ethos binding them to ethical norms of fiduciary responsibility to their patients. Hence, doctors have good reason to promote practice environments that foster this professional ethos. Nonprofits are considered "superior from the point of view of professional ideology and practice"[224] because "[m]any features that are generally considered to be specific characteristics of the professions—altruism, autonomy, an 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."[225] Nonprofit hospitals stress these values because they tend to attract the managers whose values correspond with those of the founder.[226] 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."[227] This professional ethic theory contrasts with the physician control theories already discussed in that it maintains that

223. *See* Hansmann, *supra* note 11, at 866–68; Newhouse, *supra* note 219, at 72.

224. Majone, *supra* note 217, at 639.

225. *Id.* at 640.

226. *See* D. YOUNG, IF NOT FOR PROFIT, FOR WHAT? (1983) (developing this sorting theory in some detail).

227. Majone, *supra* note 217, at 654. The same point is made with negative emphasis as follows:

> [P]rofit-making organizations do not possess the appropriate characteristics required for the social control function in the health care system. This is so mainly because the decision-making mechanism in profit-making organizations is inherently at cross purposes with the unique characteristics of the health care segment of society—namely, the unusual and personal nature of the physician-patient relationship and the centrality of health and disease to individuals and to society.
>
> Nonprofit organizations, on the other hand, do seem to possess—at least potentially—the social control mechanism required to protect individual patients and society.

physicians are primarily concerned with the *clinical* as opposed to the *financial* control of their practice.[228]

Although this theory supports the notion that there is an inherent social benefit in the nonprofit form, the theory fails to satisfy the neediness ("but for") component of the deservedness criterion. The reason for this failure is that *why* nonprofits *exist* is a fundamentally different question than *whether* they should be *exempt,*[229] a point that many writings on the subject fail to recognize.[230] Even assuming that the favorable view of nonprofit hospitals is accurate and that it is possible to confirm the production of sufficient net benefits to earn the exemption's subsidy, the deservedness criterion would still not be met because, a priori, there is no reason to assume that nonprofits would not continue to predominate absent the subsidy. Indeed, there is every reason to suppose the contrary.[231] The favorable view holds that non-

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Greenlick, *Profit and Nonprofit Organizations in Health Care: A Sociological Perspective,* in IN SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS 155, 175 (1988).

228. Majone, *supra* note 217, at 654 ("Professionals in for-profit organizations must submit to managerial controls, enforced by a central monitor who is responsible to the stockholders and is motivated to overrule the professionals whenever their interests and attitudes come into conflict with the goal of profit maximization.").

229. B. WEISBROD, *supra* note 8, at 88 ("Public policy can be devised simply to permit nonprofit organizations to exist; to permit nonprofits to compete with for-profit firms; to provide for public subsidies for nonprofits; or to provide for specific forms of subsidies. . . .").

230. *E.g.,* Falcone & Warren, *supra* note 18, at 740 (justifying the exemption because "Americans have demanded pluralism in hospital care," as if the issue were whether nonprofit hospitals should exist at all); Guggenheimer, *Making the Case for Voluntary Health Care Institutions: Policy Theories and Legal Approaches,* in IN SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS 35, 36–41 (1988) (defending the exemption merely by observing why nonprofit hospitals should exist); Horwitz, *supra* note 200, at 558–59 (arguing for "retention of the nonprofit concept," again, as if the issue were whether nonprofit hospitals should be banned).

231. Hyperbolic fears, sometimes expressed as "complete proprietary corporate control over the distribution of American health care," are entirely unfounded. Dolenc & Dougherty, *DRGs: The Counterrevolution in Financing Health Care,* HASTINGS CENTER REP. June 1985, at 19, 27. "[T]he American people never came close to giving up their voluntary community hospitals and private medical practitioners for an investor-dominated, professional management structure whose goal has been the maximization of profit." Ginsberg, *For-Profit Medicine: A Reassessment,* 319 NEW ENG. J. MED. 757, 760 (1988); *accord* Marmor, *supra* note 27, at 348 ("Both sides view the recent growth of the for-profit sector as foreshadowing a system-wide transformation—and perhaps even a complete conversion to proprietary auspices—of the health industry. In fact, it seems quite unlikely that such radical changes will occur."); *id.* at 320–33 (rise of proprietary hospitals is only a minor fluctuation in cyclical pattern that has prevailed throughout the century); Seay, Vladeck, Kramer, Gould & McCormack, *Holding Fast to the Good: The Future of the Voluntary Hospital,* 23 INQUIRY 253 (1986) (for-profit hospitals continue to operate at the industry's periphery; no major change in their relative numbers for 20 years). The hysteria over for-profit medicine has resulted more from the rapid consolidation of proprietary hospitals into large corporate chains than from an absolute increase in their proportion of the market. Even the consolidation phenomenon is overstated because nonprofits have more than twice as many

profits 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.[232] In these circumstances, a subsidy provides a complete windfall.[233]

This observation, first made clearly by Professor Hansmann, holds true for any number of services that we might prefer to purchase from nonprofit firms, owing to our greater trust that they act less opportunistically.[234] Since consumers are free to make this purchasing decision themselves and have every incentive to do so, they need no encouragement from the government. Any such support would not only be wasteful, it would inappropriately hinder those whose preferences differ by lessening or eliminating their access to a proprietary provider.

It is surprising that this point is not better recognized. Elsewhere, government is not in the habit of paying large amounts of scarce public funds as gratuitous rewards for good deeds.[235] It is socially desirable to mow our lawns, but no one thinks to reward us for this community benefit, nor do we think to ask for any such reward. No more should the government forego billions of dollars in revenue from nonprofit hospitals for the simple reason that society values their services. 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 also because the theory is 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 the theory does not attempt to identify them.

3) The Empirical Evidence

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

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beds in corporate chains as for-profits, a number that has almost doubled since 1970. Yoder, *supra* note 11, at 27–30.

232. Professor Jensen made this point 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 extending it beyond the point where the beneficiaries will pay for it.

Jensen, *supra* note 3, at 148.

233. *See* S. SURREY & P. MCDANIEL, *supra* note 12, at 82.

234. *See supra* note 221 and accompanying text.

235. The *Minneapolis Star* once asked facetiously: "Is just being a 'nice guy' enough to get you on the property-tax free list?" A. BALK, *supra* note 1, at 81; *see also* Stone, *supra* note 9, at 45.

the empirical dimensions of this nonprofit/for-profit hospital debate. By and large, the literature demonstrates that the two 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."[236] For the most significant measures of hospital performance—quality and cost[237]—there is little or no difference between the two sectors.[238] Likewise, for the more amorphous grouping of services referred to as community programs—health screening, community education, immunizations, temporary housing, transportation, and the like—nonprofit and for-profit hospitals perform approximately the same.[239] Hospital behavior is remarkably uniform because the two sectors share identical sources of financing: private and public health insurance.[240] The operational incentives created by these sources of

236. Yoder, *supra* note 11, at 191.

237. J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 111–14; Yoder, *supra* note 11, at 76–77 (nonprofits are somewhat less costly, controlling for size and patient mix, but the annual increase in costs for the two sectors is the same); *id.* at 138 ("Evidence now available does not support the fear that for-profit health care is incompatible with quality of care, nor the belief that public ownership might provide some assurance of quality."); Schlesinger, Marmor & Smithey, *supra* note 27, at 437; Sloan, *supra* note 142, at 130 ("In summary, empirical research to date suggests that for-profit and voluntary hospitals are quite similar in terms of accounting cost."); *id.* at 132 ("Considering results from all of the studies, it appears that efficiency differences between private not-for-profit and for-profit hospitals are small, at most.").

A recent study, however, found that mortality rates were significantly higher at for-profit hospitals in 1986 (121 deaths per 1,000 patients, versus 114 for nonprofits). Hartz, Krakauer, Kuhn, Young, Jacobsen, Gay, Muenz, Katzoff, Bailey, & Rimm, *Hospital Characteristics and Mortality Rates,* 321 NEW ENG. J. MED. 1720, 1720 (1989). There is some question, though, whether this study properly adjusts for severity of illness. *See* Green, Wintfeld, Sharkey, & Passman, *The Importance of Severity of Illness in Assessing Hospital Mortality,* 263 J. A.M.A. 241 (1990) (HCFA's mortality data, on which the prior study was based, "does not adequately account for patient severity").

238. *See* J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, 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."); Ermann & Gabel, *Multihospital Systems: Issues and Empirical Findings,* HEALTH AFF., Spr. 1984, at 50 (review of over 400 studies and articles; concludes the two sectors are largely the same); Horwitz, *supra* note 200, at 531 ("The nonprofit hospital offers, looks like, acts like, and imitates the for-profit hospital in every way except for the distribution of excess revenue . . . ."); Marmor, *supra* note 27, at 334–39.

239. The GAO found that a majority of both types of hospitals offered a wide range of community services, but that nonprofits are modestly more likely to do so than for-profits. GAO REPORT, *supra* note 143, at 4. However, nonprofit hospitals "were equally likely to charge a fee for community services [and] more likely to cover the costs of providing the services." *Id.*

240. *See generally* J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25.

revenue tend to swamp whatever contrasting incentives exist by virtue of organizational form, a likely result in any industry.[241]

Nonprofit defenders observe that these studies were conducted before private and public reimbursement systems placed hospitals under great financial pressure. With the advent of increasingly stringent reimbursement controls, the defenders claim the performance of the two sectors is likely to diverge as proprietary hospitals sacrifice quality of care and comprehensiveness of services for profitability.[242] It is, however, a matter of pure assertion that nonprofit hospitals will not be equally sensitive to reimbursement constraints. This assertion is belied by the very premise that the behavior of both sectors has been molded into similar patterns in the past by financial considerations.[243] Even if nonprofit hospitals respond differently, it is at least arguable whether a response is socially desirable if it ignores the intent of these reimbursement reforms to foster market-like incentives in health care and to eliminate excessive duplication, unnecessary services, and inefficient cross-subsidization. Thus, what some observers will characterize as "profiteering," others will view as necessary economizing.

Defenders of the voluntary sector respond that the assertions of similarity are flawed because the studies control for an excessive number of variables in a manner 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; they are important variables that hospitals affect by how they choose to spend surplus revenue.[244]

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241. Sloan, *supra* note 142, at 138–39.

242. *E.g.*, Relman, *supra* note 159, at 372:

> Now that we appear to be on the threshold of a new era of prospective payment, incentives will probably change, and the profitablity of the investor-owned hospitals may come to depend on their ability to control costs rather than on . . . the manipulation of prices. It will be interesting to see what happens then.

243. *See* J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 128–29 (nonprofits and proprietaries both respond to reimbursement limits with automated management, elimination of unprofitable services, diversification, aggressive marketing, and reduced charity care); Friedman & Shortell, *The Financial Performance of Selected Investor-Owned and Not-For-Profit System Hospitals Before and After Medicare Prospective Payment*, 23 HEALTH SERVS. RES. 237 (1988) (ownership type had no independent effect on initial hospital response to Medicare payment reform).

244. As explained in Ermann & Gabel, *supra* note 238, at 59:

> The studies suffer from one serious methodological flaw. [Multi-hospital] systems do not randomly choose where to locate, but self-select into favorable market areas . . . with lower Medicaid and indigent patient loads. Systems also purchase or build hospitals with certain services and size, avoiding large tertiary care hospitals with heavy research and teaching commitments. Studies which compare an experimental group (system hospitals) with a

Facility size and location have independent importance because these characteristics do not vary randomly across the two sectors, and they are positively associated with hospitals' level of technological sophistication and the number of unprofitable services. 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, expensive, and sometimes unprofitable services, such as premature nurseries, burn units, and magnetic resonance imaging.[245] For similar reasons, the two sectors differ even more dramatically in their support of medical education and research.[246] There is not complete agreement, however, over the significance of even these performance differences.[247]

These hotly contested issues need not be resolved in a manner that attracts substantial consensus. It is sufficient for 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 that it offers. Without 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.

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matched control group (independent hospitals) may find no differences simply because the matching process eliminated hospitals providing different services or teaching programs.

245. *See* J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 108–10; Schlesinger, Marmor & Smithey, *supra* note 27, at 437; Shortell, Morrison, Hughes, Friedman, Coverdill & Berg, *The Effects of Hospital Ownership on Nontraditional Services,* 5 HEALTH AFF., 97, 101 (1986) (nonprofits provide 50% more "alternative services" than for-profits; for-profits offer 60% fewer unprofitable services than nonprofits).

246. J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 109 (only 1% of for-profits have residency programs, compared to 22% of nonprofits); Yoder, *supra* note 11, at 142.

247. *See* Yoder, *supra* note 11, at 142–43 (observing that lower level of research may be due to past refusal of funding sources—including the National Institutes of Health, the nation's largest source of biomedical research funds—to support for-profit institutions); *id.* (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 met with intense opposition; citing Hospital Corp. of America's attempt to buy Harvard's McLean Hospital); Hansmann, *supra* note 159, at 80 (suggesting that differences in locational preference may result from the exemption itself simply because the property tax exemption makes higher-taxed, inner-city land more attractive to nonprofits than to for-profits); Simpson & Lee, *supra* note 141, at 780 (concerning unprofitable services, "given the well-documented excess hospital capacity in the U.S., we are skeptical of any argument that maintaining services for which there is insufficient demand constitutes a public service"); *id.* (superior educational and research programs do not earn the exemption because they receive substantial independent support from public sources).

b. Proportionality

In addition to failing the deservedness criterion, the community benefit theory has difficulty meeting the proportionality criterion, primarily because the less tangible benefits to which it refers are either difficult to quantify in monetary terms or are inherently unquantifiable. There is no methodologically sound way to measure the soft values that inhere in the claim of a superior nonprofit medical ethic. Without such quantification, it is impossible to verify whether society is receiving its money's worth from the exemption.

David Seay, of the United Hospital Fund, claims to have devised a quantifiable measure of commitment 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."[248] These "key elements," however, simply ask hospitals to identify community needs, develop programs to meet those needs, and make changes in the hospital's mission statement, governance structure, and organization necessary to carry out a program of community responsiveness. These standards do not quantify the community needs that are met and, more importantly, do not measure whether nonprofit hospitals are outperforming for-profits in meeting community needs.[249]

As Professor Bittker has expressed, "Lacking a method for measuring these appealing but elusive virtues, one must perforce rely on intuition in comparing the achievements of private charities with those of government [and profit-making enterprises], when they are performing similar functions."[250] Not every decision of government need be made

248. Seay & Sigmond, *supra* note 39, at 30.

249. Indeed this statement of the community benefit standard describes precisely, although in somewhat foreign terminology, what for-profit hospitals do when they sell their services to the community. *See* Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 276 (Utah 1985):

> [The defendant hospitals] confuse the element of gift to the community . . . with the concept of community benefit, which any of countless private enterprises might provide. We have no quarrel with the assertion that [the hospitals] meet great and important needs of persons within their communities for medical care. Yet this . . . cannot be the sole distinguishing characteristic that leads to an automatic property tax exemption. . . . Such a "usefulness" rule would have to be equally applied to for-profit hospitals . . . which also provide medical services to their patients.

250. Bittker & Rahdert, *supra* note 8, 332–33; *see also* R. STEVENS, *supra* note 35, at 354 ("[H]istory 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 program or method."); Bromberg, *Charitable Hospital, supra* note 40, at 248–51 (characterizing the community benefit standard as "existential"); Ginsberg, *supra* note 54, at 315 ("It would be difficult to state a vaguer test than 'other purposes the accomplishment of which is beneficial to the community'. . . ."); Wikler, *supra* note 206, at 153 ("Hospitals . . . aspiring to virtue face

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 to apply a legislative mandate.[251] 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 legitimately concerned with substantive public policy—the task of determining what constitutes socially worthy activity across the broad range of nonprofit enterprise.[252] This arrangement has a high potential for producing capricious results,[253] a potential that has been 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.[254] Among

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further problems in defining and calibrating virtuous character. It is an elusive concept."); Reinhardt, *Charity at a Price,* N.Y. Times Book Rev., Aug. 20, 1989, at 14 (The "ideals of private 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 . . . ."). Even 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 4–5.

251. *See generally* Dripps, *Delegation and Due Process,* 1988 DUKE L.J. 657; Pierce, *The Role of Constitutional and Political Theory in Administrative Law,* 64 TEX. L. REV. 469 (1985); Schoenbrod, *The Delegation Doctrine: Could the Court Give It Substance?,* 83 MICH. L. REV. 1223 (1985); Symposium, *The Uneasy Constitutional Status of the Administrative Agencies: Part I, Delegation of Powers to Administrative Agencies,* 36 AM. U.L. REV. 295 (1987). The Supreme Court recently observed that such a role is particularly troubling with respect to the religious exemption because "inquiry into the particular contributions of each religious group 'would introduce an element of governmental evaluation and standards as to the worth of particular social welfare programs, thus producing a kind of continuing day-to-day relationship which the [first amendment] policy of [religious] neutrality seeks to minimize.' " Texas Monthly, Inc. v. Bullock, 489 U.S. 1, 22 n.2 (1989).

252. Persons, Osborn & Feldman, *supra* note 2, at 1942 (IRS is forced to become the "arbiter of the public good"); Warren, Krattenmaker & Snyder, *supra* note 119, at 302, 309 (describing as "legislative abdication" the decision to leave these important social policy decisions to the lowest level of the administrative echelon); *see* Fox & Schaffer, *Tax Policy as Social Policy: Cafeteria Plans, 1978–1985,* 12 J. HEALTH POL., POL'Y & LAW 609, 633, 653 (1987) (exploring this phenomenon in the context of tax deductions for health insurance).

253. *See* Thompson, *supra* note 80, at 56 (accusing the IRS of having decided "to abandon completely any attempt to administer the exemption and [having decided to] treat cases on an ad hoc, nonanalytical basis . . . using definitional strategies based on subjective, unarticulated factors rather than on objective, verifiable criteria").

254. Rev. Rul. 69-268, 1969-1 C.B. 160; Rev. Rul. 85-110, 1985-2 C.B. 166; *see* Colombo, *supra* note 41, at 514–17.

exempt organizations generally, the IRS has a long history of ad hoc and inconsistent determinations concerning which activities must provide free services to qualify for an exemption.[255]

A second reason the community benefit theory of the charitable exemption abdicates governmental responsibility is that the theory leaves decisions concerning priorities for spending the subsidy to the private entities that receive it. Thus, assuming that taxing authorities are capable of judging which industries are better structured on a nonprofit basis, once this determination is made, any further decisions about how the subsidy is spent are left to the firm's managers, constrained only by the requirements of maintaining nonprofit status. Thus, hospital managers can choose to use the subsidy to support facility refurbishment rather than meet the more pressing need of treating greater numbers of uninsured patients. This abdication of national health care policy to private parties is especially bizarre considering the many facets of the health care crisis that demand immediate government redress.[256] In short, given the inherent difficulty in quantifying the socially desirable values of the nonprofit form and the degree of government abdication in administering the exemption, there can be no assurance that the level of support provided by an exemption even roughly matches the level of deservedness.

3. *Variants of the Community Benefit Theory*

The primary strand of the community benefit theory seeks to justify selective coverage of nonprofit organizations by maintaining that the special ethic of nonprofit enterprise is important only in certain activities, and then devising a means to identify those activities—a highly problematic undertaking. Two variants of the community benefit theory attempt to avoid this difficulty by maintaining that these special qualities inhere in all nonprofit organizations, in whatever activities they are engaged. These two variants—the "public trust" theory and

255. Hospitals need not provide any free care except in the emergency room, nursing homes may refuse uninsured patients at the outset but may not discharge patients for failure to pay, public interest law firms may receive compensation for only half the costs of their services, consumer credit counseling agencies must discount all their services, and grocers serving low-income customers may not charge anything. *See* B. HOPKINS, *supra* note 31, at 104 (describing IRS's "illogical and unfair discrimination" among activities that may charge fees for their services); Persons, Osborn & Feldman, *supra* note 2, at 1940, 1941, 1949 (discussing various rulings and noting a "considerable degree of ad hoc line-drawing by the IRS . . . in this area"); Simon, *supra* note 69, at 85.

256. The two principal aspects of this crisis are uncontrollable health care inflation and 35 million people without any public or private insurance coverage. M. HALL & I. ELLMAN, HEALTH CARE LAW AND ETHICS IN A NUTSHELL 3–6 (1990).

the "plowback" theory—might be rejected as merely artful ways of restating the discredited per se theory drawn from charitable trust law;[257] however, because their rationales are different, they require separate responses.

a. The Public Trust Theory

The "public trust" variant of the community benefit theory holds that all legitimate nonprofits earn the charitable exemption by virtue of state law provisions that impose more stringent organizational and operational constraints on nonprofit than for-profit enterprises to ensure increased attention to community interests.[258] For example, managers of nonprofit corporations have a fiduciary responsibility to the public to exercise care in managing the corporation's assets, a public trust duty enforceable by state attorneys general. The exemption might be viewed as an exchange for the imposition of these greater public responsibilities.[259]

However, this public trust theory also fails the deservedness test. Although the law remains somewhat unsettled, nonprofit organizations simply are not under any unique corporate duties.[260] Nonprofits generally owe no greater fiduciary responsibility to the public than for-profits owe to their shareholders.[261] A number of older cases, drawing by analogy from the law of charitable trusts, have applied heightened "trust-like" duties to nonprofit corporations classified as charitable;[262] but "the modern trend is to apply corporate rather than trust principles in determining the liability of the directors of charitable corporations, because their functions are virtually indistinguishable from those of their 'pure' corporate counterparts."[263] The leading decision,

257. *See supra* notes 78–80 and accompanying text.

258. Guggenheimer, *supra* note 230, at 48–49; Seay & Vladeck, *supra* note 39, at 15–17.

259. Ellman, *supra* note 11, at 1006 n.22 (collecting cases). Heightened community responsiveness by nonprofit hospitals is apparent in West Virginia where nonprofits must draw 40% of their governing board members from designated groups that represent the community at large. The court that sustained this measure against an equal protection challenge brought by the nonprofits (who claimed it discriminated in favor of for-profit hospitals) relied in part on the observation that the tax exemption compensates nonprofits for this organizational burden. American Hosp. Ass'n v. Hansbarger, 600 F. Supp. 465, 473 (N.D.W.V. 1984), *aff'd*, 783 F.2d 1184 (4th Cir.), *cert. denied*, 479 U.S. 820 (1986).

260. The West Virginia statute for hospitals is limited to that activity and that state. *See also* Ellman, *supra* note 11, at 1006 n.23 (discussing the "unusual" California nonprofit law that adopts a special standard of self-dealing).

261. Ellman, *supra* note 11, at 1006 n.25; Hansmann, *Reforming Nonprofit Corporation Law*, 129 U. PA. L. REV. 497, 567 (1981).

262. Ellman, *supra* note 11, at 1006 n.22.

263. Stern v. Lucy Webb Hayes Nat'l Training School for Deaconesses & Missionaries, 381 F.Supp. 1003, 1013 (D.D.C. 1974). The distinction between trusts and corporations recognizes

for instance, judged a nonprofit hospital's managers by the same rules concerning mismanagement and delegation of duties that govern all corporations.[264] Even where this decision is not followed, the additional restrictions placed on "noncharitable" nonprofits do not accrue to the net benefit of society. Instead, the restrictions exist primarily to compensate for the fact that nonprofit managers are not subject to shareholder oversight and therefore they may present a greater risk of misbehavior than managers of investor-owned companies.[265]

Implicit in much of the argument that underlies the public trust variant is that nonprofits somehow better represent the entire community's interests precisely because they do not have to answer to private shareholders. This assumption peculiarly posits that the interests of shareholders and customers of proprietary establishments differ from the interest of the public at large. Granting this assumption, nonprofits are under the same distorting influences. Those nonprofits that primarily sell products and services must also satisfy the demands of their customers. Moreover, nonprofits must respond to the demands of the investment community because commercial nonprofits still must rely on borrowed capital to substitute for lack of equity or donated capital.[266] The similarity in the sources of operating and capital funds helps to explain the essentially indistinguishable behavior of the two hospital sectors,[267] in particular, their eagerness to earn a profit.[268]

"the fact that corporate directors have many areas of responsibility, while the traditional trustee is often charged only with the management of the trust funds and can therefore be expected to devote more time and expertise to that task." *Id.* at 1013. It may also simply recognize the fact that it is rational to give the founder of a charity a choice between two organizational forms, one that is more flexible but less protective than the other.

264. *Id.*

265. *See* C. HAVIGHURST, HEALTH CARE LAW AND POLICY 209 (1988); Karst, *The Efficiency of the Charitable Dollar: An Unfulfilled State Responsibility,* 73 HARV. L. REV. 433, 436 (1960) (charities lack any "interested . . . individual to call the charitable fiduciary to account"); *cf.* Hansmann, *supra* note 262, at 568 (arguing for stricter trust standards for nonprofits because "the patrons of a nonprofit are generally much less able to look out for themselves than are the shareholders in a business corporation"). A prime example of such a compensatory rule is the authority of state attorneys general to challenge nonprofits for breach of their duties. A second example is a prophylactic rule against self-dealing transactions by nonprofit directors. *See* Ellman, *supra* note 11, at 1007–08.

266. Wikler, *supra* note 206, at 148:

> True, bondholders do not vote, but since institutional behavior must be geared toward meeting the expectations of future bondholders, the interests and wishes of the investor community influence hospital behavior without a direct vote. For most intents and purposes, then, voluntary and for-profit hospitals have become more or less the same . . . .

267. *See supra* notes 236–41 and accompanying text.

268. *See* J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 64 ("[I]n the past two decades it has become increasingly clear that voluntary and public hospitals have similar motives. Their desire is to acquire reserves, a form of profit, which have become an important

b. The "Plow-back" Theory

The plow-back theory represents a second attempt to salvage the community benefit theory by resurrecting the per se theory of exemption. It argues that all nonprofits deserve a public subsidy because they plow their income back into a public institution rather than dispersing it to private investors.[269] Professor Atkinson recently published the most sophisticated development of this theory.[270] He argues that the ongoing devotion of earnings to the institutional goals of any nonprofit organization is deserving of subsidy because it represents, in effect, an altruistic decision for nonprofit organizers to forgo profits. "Under the altruism theory, the presumption would be that any activity carried on altruistically [i.e., on a nonprofit basis] is worthy of encouragement through tax exemption."[271] "The altruism theory would exempt [any organization whose income] . . . is being used to subsidize consumption by someone other than those who control the organization. . . . Under this theory, there would be no inquiry into the merits of such [consumption], no search for public benefits flowing from it. The metabenefit of altruistic production would suffice."[272]

There are two crucial flaws in this thoughtful statement of the plow-back theory,[273] both of which implicate the criterion of deservedness. First, because the theory eschews examination of the worth of the *primary* benefits that nonprofits provide (for example, any attempt to show that nonprofit hospitals are better than for-profits), but instead relies on the *secondary* benefits of the nonprofit form, proponents of this theory must demonstrate why we should value this "metabenefit." Atkinson balks at this critical juncture. Conceding that "[i]t would be

source of capital expansion in the past."); Yoder, *supra* note 11, at 86, 185, 202 n.7 (in several recent years, nonprofit income was proportionately greater than for-profit income); Chang & Tuckman, *The Profits of Not-For-Profit Hospitals,* 13 J. HEALTH POL., POL'Y & L. 547, 549–50 (1988) (nonprofits earned 14.8% from Medicare in 1985 versus 17.9% by proprietary hospitals).

269. Levinsky, *Letter to the Editor,* 318 NEW ENG. J. MED. 1486 (1988); Mancino, *supra* note 40, at 1070–71; *see* Seay & Vladeck, *supra* note 39, at 17–18.

270. Atkinson, *supra* note 199.

271. *Id.* at 629.

272. *Id.* at 619.

273. In addition, this theory fails the historical consistency and universality criteria. It is not historically correct because it contradicts the established understanding that "charitable" encompasses a smaller set of activities than do all nonprofits; otherwise the very complex structure that differentiates among the various forms of tax exemption, *see* Simon, *supra* note 69, would be largely redundant. Universality is not met because the argument that nonprofits deserve exemption if they put their profits to good use would apply to profits so devoted regardless of the source of those profits. This theory thus contradicts the imposition of any "unrelated business income" tax, and would return the law to its pre-1950 stage where exemption was determined by a "destination-of-income" test. *Cf.* Trinidad v. Sagrada Orden de Predicadores, 263 U.S. 578 (1924).

logical for me here to prove that altruism [in the special sense of forgoing the distribution of profits] really is a good thing and thus worthy of tax favors," he states that the task "is too ambitious" because it entails ascertaining "what is ultimately good." He therefore leaves the matter to one of "faith, of freely chosen values and visions."[274]

The sweeping expansion of the multi-billion dollar public subsidy suggested by Atkinson's argument cannot be sustained by a mere leap of faith. To assume without argument or explanation that society places great value on nonprofit enterprise per se, simply because no profit is distributed, is to adopt a question-begging posture that argues in favor of expanding the exemption based on a bare description of the present state of the nonprofit sector.[275]

The second, and more fundamental, flaw in the argument for subsidizing the altruism common to all nonprofits is that it does not explain the need for a subsidy. It merely describes the fact that nonprofit organizations are required by law to plow their earnings back into the enterprise. Even assuming the worth of this devotion of profits to any endeavor that presently or in the future might be encompassed within the broad scope of the nonprofit sector, we still must ask why is a tax subsidy necessary to achieve this result? The plow-back variant is as silent on this question as is the main line of the community benefit theory.[276]

4. Recapitulation

The various strands of the community benefit theory constitute the nonprofit sector's most sophisticated attempt to justify the present scope of the exemption. This theory makes its case on the inherently unquantifiable values that nonprofit enterprise serves. There is considerable merit to the view that nonprofit organizations offer advantages over both proprietary markets and the government; otherwise we would not have such a large nonprofit sector. On the other hand, the size of the nonprofit sector may largely result from the exemption

274. *Id.* at 630. He continues: "I must admit my suspicion that the question of inherent goodness may not be subject to proof, in the case of either altruism or other proposed desiderata." *Id.*

275. *See supra* notes 50–52 and accompanying text.

276. This is not to say that these questions require a negative answer. Indeed, the donative theory of exemption presented in this Article shares much in common with Atkinson's altruism theory. Both theories advocate subsidizing activities motivated by altruism. But, a careful development of why this is appropriate reveals precisely what counts as a donation. For instance Atkinson incorrectly counts as a donation the forced retention of earnings by nonprofits, a point developed in a subsequent article. *See* M. Hall & J. Colombo, The Donative Theory of the Charitable Exemption (forthcoming).

itself. The existence of both possibilities demands some demonstration that society needs the exemption to effectuate its preference for the higher values and greater diversity that nonprofits offer. Because the community benefit theory is unable to provide a convincing response, it fails to establish a coherent basis for the exemption. Having exhausted the conventional rationales for the charitable exemption, we turn to less conventional theories propounded by academics.

D. Academic Theories

1. Bittker's Income Measurement Theory

Academics have devoted less attention to the charitable tax exemption than to related topics, such as the deduction for charitable donations[277] and the general theory of nonprofit enterprise.[278]

Professor Bittker offered the first notable,[279] comprehensive treatment of the federal income tax exemption in 1976.[280] Along with his student George Rahdert, Professor Bittker developed the theory that charitable organizations are exempt from corporate income tax because it is difficult to apply conventional accounting concepts of revenue and expense to much of their receipts and expenditures.[281] For instance, it is awkward to classify donations as income because they would seem to be gifts excluded from income under section 102 of the Code.[282] More serious characterization problems exist on the expense side. Ordinary principles of tax law would inappropriately hold that disbursements to beneficiaries of the charity are not deductible as "ordinary and necessary business expenses," because an entity that does not seek profit is generally not considered to engage in a "trade or business" under section 162.[283]

277. *E.g.*, Gergen, *The Case for a Charitable Contributions Deduction*, 74 VA. L. REV. 1393 (1988); McDaniel, *An Alternative to the Federal Income Tax Deduction in Support of Private Philanthropy*, in TAX INSTITUTE OF AMERICA, TAX IMPACTS ON PHILANTHROPY (1972).

278. *See supra* note 11.

279. Less ambitious, but still useful, theoretical discussions of the federal exemption are found prior to Bittker's work in Persons, Osborn & Feldman, *supra* note 2; Belknap, *supra* note 4; and after his work in J. DOUGLAS, *supra* note 8, ch. VIII; Dale, *supra* note 71; Simon, *supra* note 69; Stone, *supra* note 9; *see also infra* note 291.

280. Most discussions of the property tax exemption focus narrowly on the details of particular statutory and decisional law of an individual state. *E.g.*, Buchele, *supra* note 117; Sierk, *supra* note 1. The few universal or theoretical analyses of the property tax exemption proceed along the conventional lines previously discussed. *See* P. SWORDS, *supra* note 70; Ginsberg, *supra* note 54; Stimson, *supra* note 5; Warren, Krattenmaker & Snyder, *supra* note 119; Note, *supra* note 168.

281. Bittker & Rahdert, *supra* note 8.

282. *See id.* at 308.

283. *Id.* at 310 and authorities cited therein.

To the extent that this "income measurement" theory argues that true charities are not taxed on their income because they in fact earn no income, it is consistent with the theory for exemption of non-charitable organizations—so-called mutual benefit organizations such as social clubs and condominium associations—which are viewed as pooling assets prior to consumption rather than earning income.[284] This commonality in theory suggests a degree of universality that other theories do not share, since all other theories, including our own developed later in text, are limited to the charitable exemption.[285]

This "income measurement theory," however, is ultimately unconvincing. Professor Hansmann, also of the Yale Law School faculty, persuasively demonstrated that the theory is simply incorrect as applied to many of the traditional categories of 501(c)(3) exempt organizations, particularly those such as hospitals that rely predominantly on the sale of goods and services rather than on donations, so called "commercial nonprofits."[286] The theory, moreover, does not attempt to define charity—the operative statutory concept—other than as any activity for which it is difficult to measure income. Bittker's theory is at odds with the consistent understanding in the legislative history and decisional law that the charitable exemption exists as a form of subsidy.[287] In essence, then, the income measurement theory attempts to avoid the deservedness and proportionality criteria altogether.

The income measurement theory also falls short of the universality criterion since it does not even purport to explain the property tax exemption; there is no more difficulty measuring the value of charitable property than property owned by IBM or AT & T.[288] The theory

284. *See supra* note 29.

285. *See generally* Bittker & Rahdert, *supra* note 8, at 307–14.

286. Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation,* 91 YALE L.J. 54, 59–61 (1981). "[N]ot-for-profit organizations can and do make profits . . . in the customary accounting sense of the term. Indeed, in 1984 the average total net margin . . . of U.S. hospitals, most of which are not-for-profit, was 6.2% . . . ." Yoder, *supra* note 11, at 9.

287. According to Bittker and Rahdert, "The exemption . . . is neither a special privilege nor a hidden subsidy. Rather, it reflects the application of established principles of income taxation to organizations which . . . do not seek profit." Bittker & Rahdert, *supra* note 8, at 357–58. *Contra* notes 12, 70, *supra,* and accompanying text; *see also* note 12, *supra*; *cf.* Thuronyi, *Tax Expenditures: A Reassessment,* 1988 DUKE L.J. 1155 (stressing the subsidy nature of tax loopholes).

288. One could construct a variant theory that attempts to justify the property tax exemption based on tax, as opposed to social, policy. That theory would hold that tax equity requires taxation according to the ability to pay, and property devoted to charitable purposes is least able to pay; but such a theory would not survive scrutiny either. *See* Warren, Krattenmaker & Snyder, *supra* note 119, at 289–91 (articulating, but rejecting, this theory). Essentially, this theory is an alternate explanation for the relief-of-poverty theory that was rejected in Section III

also offers little explanation for the various limitations on the income tax exemption[289] and it offers no explanation for the deduction for charitable contributions that follows automatically from exempt status.[290]

2. *Hansmann's Capital Subsidy Theory*

Professor Hansmann's alternative theory suffers from many of the same defects. In the second comprehensive article to address the federal charitable exemption,[291] he develops a "capital subsidy" theory that justifies the exemption because it assists nonprofits in overcoming the comparative barriers they face in capital markets by virtue of the "nondistribution constraint" disabling them from offering profit shares to private investors.[292] Hansmann's explanation elegantly addresses the proportionality criterion. Assuming ideal market conditions, Hansmann demonstrates that the income tax exemption provides the most capital subsidy to nonprofits when the industry faces increasing consumer demand, and hence the greatest capital needs exist. This is true because an increase in demand results in an increase in tax-exempt earnings. Correlatively, the subsidy phases out as capital needs lessen in times of reduced consumer demand.[293]

Hansmann's capital subsidy theory, however, has severe shortcomings in other respects, as Hansmann recognizes.[294] Under the deserv-

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because (1) it is too narrow to satisfy the major categories of the exemption, which extend beyond relief of the poor, and (2) the exemption is regressive under this theory since it provides the most relief to the wealthiest organizations. *See supra* notes 190–98 and accompanying text.

289. For instance, if the exemption exists because the entity has difficulty measuring income, why should it matter whether the entity is, for example, engaged in legislative lobbying (an activity which ordinarily would deny an entity exempt status under § 501(c)(3))?

Nevertheless, the theory does have the advantage of explaining the tax on unrelated business income, to the extent that "unrelated" might be taken to mean "easy to measure" under this definition of who is a charity.

290. The donative theory developed in Section IV, *infra*, suggests that Bittker's theory is actually closer to the mark than this (and his) description portrays. The primary difficulty in applying traditional concepts of income to charities lies in how to characterize donations to the institution. Thus, to the extent Bittker's theory supports exemption for only donative nonprofits, it is consistent with the donative theory. However, his theory fails to account for the use of the exemption as a subsidy, and it fails to explain why a subsidy should be given to donative nonprofits. As a result, it fails to identify which nonprofits, in borderline situations, should be classified as charitable.

291. After Hansmann's work, the literature remained essentially silent on this topic until Atkinson, *supra* note 199. Atkinson's theory, which deserves coequal status with these earlier "academic theories," is not discussed here because his analysis relates to the community benefit theory. *See supra* notes 269–76 and accompanying text.

292. Hansmann, *supra* note 287, at 72–75.

293. *Id.* at 76–85.

294. *See supra* note 234 and accompanying text.

edness criterion, the theory offers no test for determining the existence and scope of a capital disadvantage. Nonprofit hospitals, for instance, appear to suffer no capital funding shortage at all.[295] Extending this determination to other nonprofit activities imposes the burdensome task of verifying capital disadvantage in each instance.[296]

Hansmann's theory is also flawed under the proportionality criterion. Although the subsidy modulates to fluctuations according to the level of capital need within one organization over time, it is not sensitive to differences in capital need among different deserving nonprofits. This defect exists because the theory uses income as a proxy for capital need. However, one organization with heavy capital needs may have little income (and hence a small subsidy), while another with only slight needs may have a large income. Therefore, as Hansmann concedes, the exemption operates as an "extremely crude mechanism" for conferring the subsidy.[297] A much more direct and efficient method for subsidizing capital formation exists through direct construction grants or tax-exempt bonding, as has occurred on a massive scale in the hospital industry.[298] Hansmann's theory does not explain why the income tax exemption should be used in preference, or even as a supplement, to these other methods that respond much more precisely to variations in the need for capital.

Nor does Hansmann's theory satisfy the universality criterion. Like Bittker's theory, it attempts to justify only the income tax exemption. Indeed, it operates perversely with respect to the property tax exemption, which gives the greatest subsidy to those organizations with the most capital resources. Finally, Hansmann fails to address the historical consistency criterion. He offers no evidence that Congress, courts or taxing officials have ever considered the exemption as a subsidy for

295. *See generally* D. COHODES & B. KINKEAD, HOSPITAL CAPITAL FORMATION IN THE 1980s (1984). This situation may change, though, as a result of sweeping limitations in public and private health insurance. *See* J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 40–42. On the other hand, continuing a capital subsidy would defeat the purpose of these reimbursement reforms, namely to eliminate excess duplication and force hospitals to operate more efficiently.

296. Hansmann's theory also requires identification of those activities that are more efficiently provided by the nonprofit form. *See* Hansmann, *supra* note 287, at 66, 85–89. This determination is no easier under Hansmann's theory than under the community benefit theory discussed *supra* Section III.C.

297. Hansmann, *supra* note 287, at 92.

298. *See id.* at n.113 (discussing direct capital subsidies to hospitals through the Hill-Burton hospital construction funding program during the 1950s and 1960s); Schramm, *The Legal Identity of the Modern Hospital: A Story of Evolving Values,* in IN SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS 65, 74 (1988) (one-third of hospital construction in 1980 was supported by tax-exempt municipal bonds; in 1985, the $30 billion in hospital bonds accounted for nearly 20% of all municipal bond sales).

capital formation. More troubling, the theory ignores the statutory language by failing to develop a workable definition of charity; the only concept of charity it offers is those socially valuable nonprofits that suffer a comparative disadvantage in capital markets. Thus, it is inaccurate to characterize Hansmann's capital subsidy explanation as a theory of the charitable exemption at all, for it is only a sophisticated explanation of one—but not necessarily the only—*effect* of the exemption. Hansmann's theory does not identify which organizations should receive capital subsidies. We must look elsewhere in order to develop an understanding of charity that helps us answer the more fundamental question of identification.

IV. THE DONATIVE THEORY OF THE CHARITABLE TAX EXEMPTION

A. Introduction

The present contest over hospital tax exemption has reached a stalemate. The theories of charitable exemption that nonprofit hospitals advocate to rationalize their exemption—health care per se and community benefit—fail to establish a basis for determining deservedness or proportionality. The alternative theories, which disqualify hospitals—charity care and Hansmann's capital subsidy theory—are equally flawed. They either fail under the proportionality criterion to establish a logical basis for subsidy through the tax system, or they are at odds with the notion of an exemption that applies to "charitable" organizations. Moreover, they explain only a small portion of the interrelated aspects of the taxation of exempt organizations, violating the principles of historical consistency and universality.

This same stalemate exists for justifying the exemption of charitable organizations generally. Defining charitable in the popular sense of poverty relief is countered by examples of symphonies and prep schools; broadening the exemption to cover the relief of any government burden overlooks the separation of church and state; and the search for a concrete sense of community benefit fails to keep the exemption within administrable bounds. In frustration, most conventional thinkers have resorted to a superstitious faith in the mystical guidance of the 1601 Statute of Charitable Uses, while academicians have proposed theories that ignore our basic intuitions about what constitutes a charity.

These failures of the several conventional and academic theories of exemption require that we search for a new theory of exemption[299] 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 reveals that the primary rationale for the charitable exemption is to subsidize those organizations capable of attracting a substantial level of donative support from the public, a theory that has not previously received full articulation and development.[300] This section proceeds by first describing the two foundations for the donative theory: (1) economic theory concerning the socially valuable reasons for the existence of nonprofit organizations; and (2) charitable trust law, from which tax exemption jurisprudence draws its concept of charity. This section then demonstrates that the exemption of donative organizations presents a concept of charity that best meets the four criteria developed above—deservedness, proportionality, universality, and historical consistency. This section concludes by examining how hospi-

299. Buchele, *supra* note 117, at 272–73, suggests that a single, comprehensive theory is not necessary because these various theories, although individually flawed, fit together in a pattern of concentric circles that adequately explain the universe of charitable exempt organizations. Thus, at the center, it does not make sense for the government to tax itself by including public facilities in the tax base. As an extension of this logic, the government does not tax private facilities that provide services the government would otherwise have to assume. In the outer ring of the circle, the government does not tax "humanitarian activities" serving a government interest. Buchele admits, though, that the circle of "humanitarian activities" is far too broad. He also does not address the failure of the government burden theory (the second ring) to meet the proportionality criterion. These and other defects are not offset by the concentric nature of the theories.

300. Several major antecedent works, however, point the way to this theory. Professor Hansmann's acknowledgement that the exemption is justified for donative nonprofits comes closest to the donative theory of exemption. Hansmann, *supra* note 11, at 887–889. However, Hansmann's rudimentary discussion fails to capture important aspects of the justification for subsidizing donative nonprofits through the tax system rather than through direct government grants, fails to tie the donative exemption to the law of charitable trusts, and fails to demonstrate the ability of the donative theory to integrate all major components of the taxation of charitable organizations.

Economist Burton Weisbrod, whose work also influenced this theory, more thoroughly establishes the theoretical groundwork for subsidizing donations, but he does so in the limited context of the charitable *deduction.* He does not extend his explanation to the exemption, and does not incorporate the common law concept of charity. Another major work upon which the donative theory relies, but which also falls short of recognizing the full dimensions of the theory, is that of James Douglas. *See* J. DOUGLAS, *supra* note 8; *see also* note 290, *supra* (acknowledging the contributions of Bittker and Rahdert to this theory).

Finally, Professor Atkinson's work also stresses the role of altruism. His theory is directed principally to categorizing the types of altruism that exist in nonprofit organizations; he does not develop a normative argument to explain why the exemption should attach to altruistic activities. *See supra* notes 272–76 and accompanying text. As a consequence, Atkinson's work departs from the donative theory developed in this Article by extending the exemption to essentially all legitimate nonprofits.

tals fare under this theory and by briefly mentioning issues that remain for further exploration.

B. The Positive Economic Theory of Nonprofit Organizations

A stimulating body of economic and political theory has emerged over the past decade attempting to explain why the United States has such a large "third sector" as an alternative to proprietary firms and the government. This literature has developed a combined theory of market and government failure: nonprofits arise where the two principal sectors of society fail adequately to supply desired goods and services. Different categories of nonprofits result from different forms of market and government failure. The particular application of the twin-failure theory most fruitful for present purposes is that which explains the existence of donative nonprofits. This branch of the positive theory of nonprofit enterprise, lying at the intersection of classic microeconomic and public choice theory, identifies the best case for a tax exemption subsidy.

1. Market Theory

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.[301] Pure public goods in the economic sense are those characterized by two conditions: 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 anyone else. Impure public goods partake of these characteristics to a lesser degree. Classic examples of nearly pure public goods include air pollution control, border defense, and legislative lobbying. The private market is incapable of supplying pure public goods at any level regardless of their value 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.

This market failure exists because the durability and the indivisibility of public goods present a severe free-rider problem. As a consequence of durability, consumers realize that if anyone else pays, they can take a free ride. As a consequence of indivisibility, consumers

301. Leading discussions of the public goods theory of the existence of nonprofit enterprise include B. WEISBROD, *supra* note 8, at 59–60; B. WEISBROD, THE VOLUNTARY NONPROFIT SECTOR (1977); Gergen, *supra* note 277, at 1397–99; Hansmann, *supra* note 11, at 848; Krashinsky, *supra* note 221, at 119–21.

realize that if they pay, everyone else can take a free ride on them. Even if some consumers are willing to pay for a public good, they will pay much less than is necessary to produce the good at its socially optimal level because of its large "positive externalities." As a result, coercion or voluntarism are the only means for providing public goods at an optimal level.

Coercion is discussed below. As for voluntarism, it is sufficient to observe that classic economic theory is imperfect since some people are willing to overcome severe free-rider incentives by taking a collective view that induces them to contribute individually to the production of a broad social benefit. Thus, donors contribute to education, which entails the public good of raising society's level of knowledge and bolstering the economy with skilled workers. Another classic object of philanthropy—disaster relief and aid to the poor—provides the public good of assuaging society's collective concern over the plight of the nation's or world's destitute.[302]

2. *Public Choice Theory*

Classical economics tells us that providing public goods is the quintessential role of government, since the government is able to correct the free-rider defect through its power to tax—in essence coercing the public's purchase of public goods. Why then should donors ever need to contribute to the private production of public goods? The answer lies in the vagaries of majoritarian voting logic, which result in the government systematically undersupplying certain public goods. Economist Burton Weisbrod first had this insight.[303] Employing public choice theory, he demonstrated that certain blocs of voters will predictably lack the voting strength to force the government to meet their public good needs. This is true because governmental decisions in a democracy are roughly shaped by the desires of the majority of the electorate.[304] The government will therefore supply any given public

302. *See* P. SWORDS, *supra* note 70, at 217–21 (discussing public goods nature of poverty relief, education, and cultural activities); Roberts, *supra* note 193, at 139 (characterizing redistribution to the poor as a "public good" for which the "private solution is inefficient"). *See generally* J. DOUGLAS, *supra* note 8, at 57–58 (observing that the Statute of Charitable Uses contains several obvious instances of public goods).

303. *See generally* B. WEISBROD, *supra* note 301, at 53–61; Weisbrod, *Toward a Theory of the Voluntary Non-Profit Sector,* in ALTRUISM, MORALITY, AND ECONOMIC THEORY 171 (E. Phelps ed. 1975).

304. One might attempt to turn the government failure explanation against the donative theory by maintaining that this line of public choice analysis would validate a decision by a majority of the electorate to support another theory of the exemption or to support extending the exemption to an industry (say, hospitals) that does not meet the donative criterion. However this observation is unresponsive to the issue at hand because it is made at a metalevel of analysis that

good at a level approximating that desired by the median voter. As illustrated in *Figure 1* for a hypothetical public good, if the government were to move much beyond the median demand to a level of production Qb, then the number of voters who prefer a lower level of the public good would vote down the increase (Vnb versus Vpb). Conversely, high demanders prevent the government from lowering the provision of public goods to, say, Qa (Vpa versus Vna). As a result, the voting equilibrium settles near the middle of the range of voter tastes (Qm).

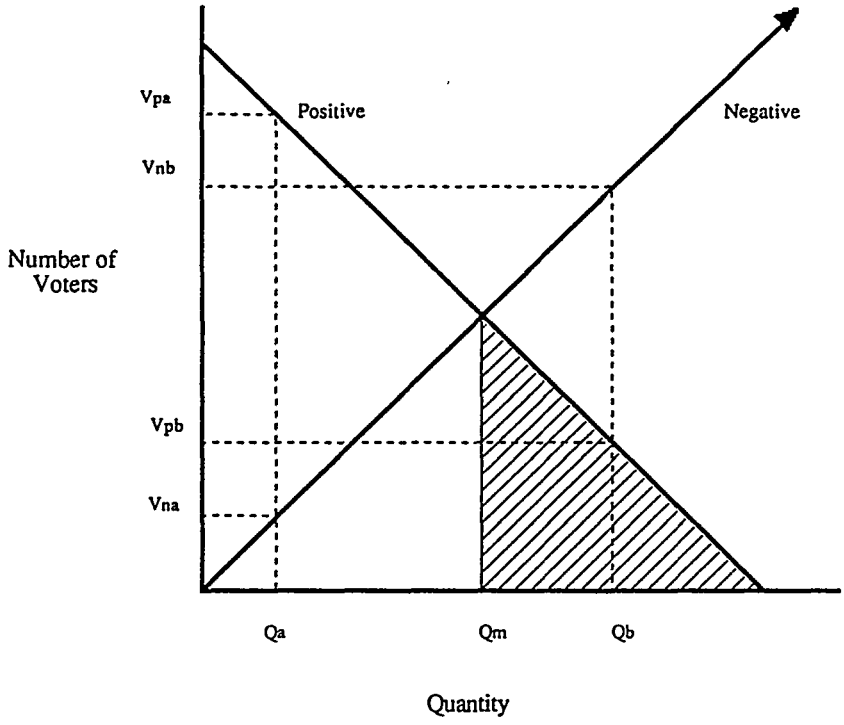

Figure 1 - Quantity of a public good suplied by government as a function of positive and negative voter demand

considers whether the charitable exemption should be abandoned altogether, or whether there are other distinct categories of exemption other than charities. This Article takes the charitable exemption as a given—for it is the form of the exemption that the electorate has in fact validated—and proposes a theory of exemption and a concept of charity that best explain its function.

This system of majoritarian politics works reasonably well provided the desire for a public good is fairly homogeneous. In that case, the level of median demand is close to the level of demand at either extreme.[305] This logic does not hold, though, for public goods for which there are heterogeneous, widely divergent tastes. In such situations, voting logic predicts an undersupplied minority of high demanders, indicated by the shaded area of *Figure 1.* This supramedian group has no ready alternative other than to make voluntary contributions to a private organization.[306]

3. The Charitable Exemption and Deduction as Shadow Subsidies

Government failure combined with market failure provides the most rigorous case for private donations. This combination of theories explains why some nonprofits exist and the function they serve. Yet this explanation does not demonstrate why these nonprofits should be subsidized. The critical insight derives from the preceding economic analysis that demonstrates that the classic instances of giving are characterized by a free-rider effect. Donors partially overcome 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 falls short of inducing all consumers to contribute commensurate with their level of benefit.

Where donative support for public goods exists, one can therefore anticipate persistent undersupply of that good. This is illustrated in *Figure 2,* where Qg represents the level of a hypothetical public good provided by the government, and Qd the additional quantity produced through private donations. The shaded area represents a remaining level of unsatisfied demand. Some form of funding is needed that matches private donations with an additional subsidy to amplify the

305. The positive-voter line would be more vertical; the negative line would be lower and more horizontal.

306. Confirmation of the relationship between government failure and donative behavior comes from observing whether rapid drops in donative activity follow sharp increases in government spending. Several economists have posited that government spending has a "crowding out" effect on donations, such that as government spending increases, the need for charities to solicit donations, and the willingness of donors to give, diminishes. *See, e.g.,* Abrams & Schmitz, *The Crowding-Out Effect of Governmental Transfers on Private, Charitable Contributions,* in THE ECONOMICS OF NONPROFIT INSTITUTIONS 303 (S. Rose-Ackerman ed. 1986). One study confirms this crowding-out thesis with data relating to the drop in giving to social welfare services following the government's New Deal programs that grew out of the Depression. Roberts, *supra* note 193. However, other studies have found less crowding out effect than theorists have posited. *See* Andreoni, *Giving and Impure Altruism: Applications to Charity and Ricardian Equivalence,* 97 J. POL. ECON. 1447 (1989).

donations, in order to take up the slack left by the free-rider disincentive and move the level of production further toward Qs.

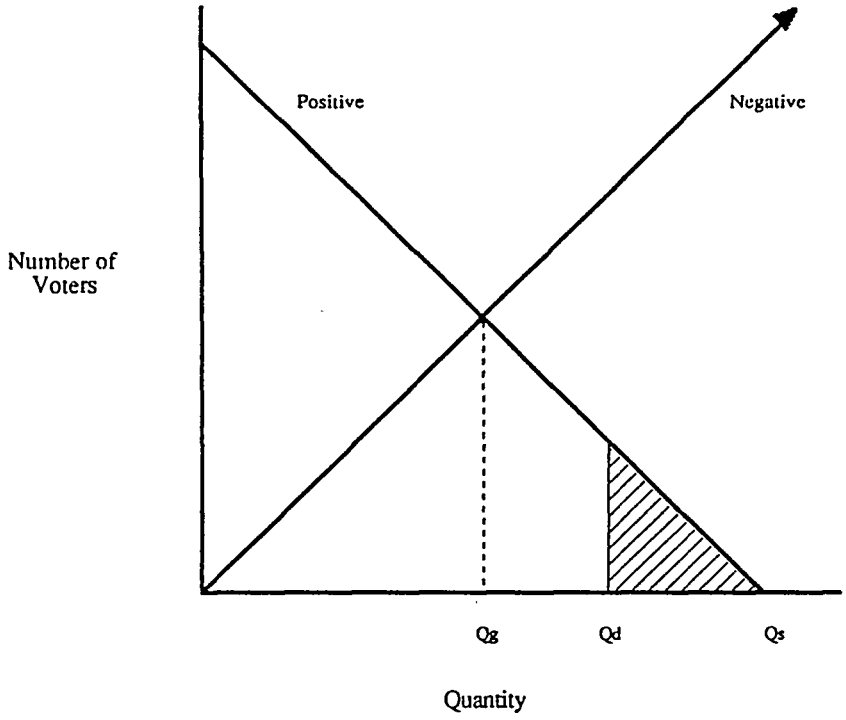

Figure 2 - The effect of donations and a donative subsidy on the production of a public good

This matching, or shadow subsidy, function is precisely the explanation that Weisbrod has offered for the charitable deduction.[307] A deduction from personal income taxes for donations to charities is, in economic analysis, a system that provides a proportionate government subsidy for each dollar of private philanthropy. Thus, in a thirty percent tax bracket, a taxpayer who donates $100 is in effect contributing only $70, because, absent the donation, the taxpayer would have paid $30 in tax on those earnings.[308] By forgiving part of the tax bill, the government is in effect providing the taxpayer with a rebate in lieu of

307. B. WEISBROD, *supra* note 8, at 29–30.

308. McDaniel, *supra* note 277, at 174 ("The deduction for charitable contributions is simply a mechanism whereby the federal government matches private donations to charity. . . . The taxpayer is denominated the paying agent for the government's share and is given the right to designate where that share will go.").

writing a check directly to the charity. This government assistance is funded by increasing the tax burden on the public, including those members of the public who take a free ride by choosing not to donate.[309]

Weisbrod's insights about the deduction can be extended to the exemption from income and property taxes. The exemption is also capable of providing a form of shadow subsidy if it is administered with this donative theory in mind. 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 it would be if it, or its earnings, were taxed.[310] Unlike the deduction, though, the exemption lacks a sliding scale quality because it is applied in an all-or-nothing fashion that is not tailored to the precise level of donative support. This defect is easily moderated by applying the exemption only to those specific portions of property, and the income derived therefrom, that receive some defined level of donative support.[311] Alternatively, degrees of exemption can be awarded according to the degree of donative support.[312]

C. *The Donative Element in Charitable Trust Law and Other Precedents*

An appealing feature of the donative theory of the charitable exemption is that, while its economic justification is rigorous and sophisticated, it leads to a fundamentally basic and intuitive concept of charity—a concept that reaffirms the popular sense of charity as "the

309. B. WEISBROD, *supra* note 8, at 30 ("Tax subsidies therefore represent, in effect, contributions from low demanders to stimulate the high demanders to contribute.").

310. *Id.* at 29 (tax subsidies "increase the amount of output the donor can buy for any given donation").

311. The property and income tax exemptions are currently administered in a similar fashion. Only the portion of property and income related to an exempt purpose qualify for exempt status. This is the function of the unrelated business income tax contained in I.R.C. §§ 511–14 (1989).

312. In fact federal tax law already distinguishes among levels of donative support in administering the charitable *deduction.* It allows individuals to deduct contributions up to 50% of their adjusted gross income (AGI) for donations to churches, schools, hospitals, medical research entities, and any other entity which receives a "substantial part of its support" from public contributions or the government. I.R.C. § 170(b)(1)(A)(vi) (1989). In contrast, the maximum deduction for contributions to other charities is limited to 30% of AGI. The regulations establish one-third of receipts as a safe-harbor for meeting this "substantial [donative] support" test. Treas. Reg. § 1.170A-9(e)(2) (1973). A similar kind of "sliding scale" could be designed for the tax exemption, permitting full exemption for entities which receive over one-third of their income from public support, and something less than full exemption for other entities, diminishing to zero exemption where there is only negligible public support.

impulse to give."[313] The public goods explanation for donative behavior is captured in the popular conception of altruism that reflects a donor's disregard of the narrow perspective of economic self-interest and, in the very etymology of philanthropy, the love of mankind. It is incontrovertible that society has an interest in encouraging giving and supporting the objects of philanthropy.[314] It is thus serendipitous that a more conventional analysis of precedent and history confirms the common sense notion of giving as the archetype of charity.[315]

1. The Role of Donations in Charitable Trusts

The connection between tax law and trust law, discussed in Section III.A., emerges as one of the great puzzles of the charitable exemption.[316] Anglo-American law has employed a uniform concept of charity for centuries. Yet even casual examination of these two bodies of law reveals that they serve disparate purposes. Charitable trust law addresses the proper purposes for which the law will relieve a trust from the requirements of having definite beneficiaries, a limited duration, and an achievable purpose. These comparatively minor concerns allow trust law to consider as charitable any purpose that provides a conceivable social benefit; trust law can afford to be lenient because enforcing a benefactor's disposition of his own assets imposes relatively minor public costs. It seems absurd, then, to adopt this same sweeping concept of charity—one that encompasses essentially any

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

314. *See* Atkinson, *supra* note 199, at 628–30 (taking the worth of altruism as a given).

315. Legal and historical precedent also confirm the government failure component of the donative theory. The core of this rationale is contained in the Supreme Court's explanation that "charitable exemptions are justified on the basis that the exempt entity confers a public benefit—a benefit which the society or the community may not itself choose or be able to provide, or which supplements and advances the work of public institutions already supported by tax revenues." Bob Jones Univ. v. United States, 461 U.S. 574, 591 (1983).

The government failure rationale is further confirmed by the history of the charitable exemption, which has its strongest application to religion, the dominant form of charity throughout the ages. As summarized *supra* note 5, in ancient Egypt, Greece and Rome, temples were exempt because it was thought beyond the power of man to tax gods—an extreme form of government failure. The religious exemption carried over into medieval England for the simple reason that there was no centralized government capable of imposing a tax. In the American colonies, which were established as theocracies, churches were not taxed because no government thinks to tax itself. After the constitutional adoption of the separation principle, though, the religious exemption is justified by the prohibition on government supporting religion's worthwhile activities in any more direct manner. *See* Walz v. Tax Comm'n, 397 U.S. 664 (1970) (upholding constitutionality of charitable exemption applied to religion). The government failure theory is but a weaker version of this modern rationale applied to forms of governmental incapacity other than direct prohibition of funding.

316. *See generally* notes 78–134 and accompanying text.

activity that benefits the public at large in any manner—to justify a tax exemption that costs the public billions of dollars in lost tax revenue each year. Yet this is precisely what virtually every tax law authority ostensibly advocates.[317]

The notion of a uniform concept of charity is so entrenched that a successful theory of the exemption must offer a satisfactory explanation of the relevance of trust law. Only the donative theory connects these two bodies of law in a sensible fashion. It does so by focusing 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 evaluate what purposes are of sufficient public importance to deserve special legal protection is that the self-sacrifice entailed in forming a trust without private benefit provides safe assurance that its founder has considered the object's deservedness. As one early decision 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 benefit 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.[318]

In other words, the conception of charity embodied in trust law can afford to be essentially boundless because it contains the inherent limitation that a donor must be willing to divert his wealth from himself or his family to support the public purpose in question. Therefore, tax exemption 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. To avoid doing so, tax exemption law must define a charitable purpose as one that the public perceives to be sufficiently meritorious to warrant sacrificing a significant amount of personal resources to support it.[319]

This simple observation is made even more apparent by reexamining the foundational trust law authorities with the donative factor in mind.[320] Many of the leading authorities that articulate a boundless

317. *See supra* notes 78–80 and accompanying text.

318. *In re* Cranston, [1898] 1 I.R. 431, 446 (Ir. H. Ct.).

319. Not only must tax law retain the element of a gift, but, because a tax exemption entails a public subsidy rather than just the protective function served by the trust law, *see supra* notes 107–08 and accompanying text, the decision by a single donor to sacrifice personal assets is not enough to justify an exemption. Rather, the tax law must in some manner identify activities which the public in general has chosen to support.

320. In addition to the observations made in the following text, trust law reinforces the public goods component of the donative theory because the legal concept of public benefit that defines

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.[321] 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."[322] The leading modern British case that establishes the per se charitable status of hospitals declares that "a gift for the purpose of a hospital is prima facie a charitable gift."[323] Even those authorities that do not speak explicitly in terms of a gift implicitly recognize this element by reminding us that the definition of charitable is in the context of a trust established for the stated purpose.[324]

2. *The Role of Donations in Tax Exemption Precedents*

The donative theory is also confirmed by the central categories of charitable activity established in tax exemption law. Religion and education, the two categories that uniformly enjoy per se charitable status, are traditional recipients of large amounts of philanthropy.[325] One might object that the per se exemptions conferred on these two activities refute the donative theory because they seem to declare that

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charitable trusts seems to capture the same notion as the economic concept of positive externalities that describes the market failure inherent in public goods (those for which the benefits to others are much larger than the benefits captured by the price charged to an individual purchaser). *See* J. DOUGLAS, *supra* note 8, at 19.

321. Modern English quotation taken from Persons, Osborn & Feldman, *supra* note 2, at 1913.

322. Jackson v. Phillips, 96 Mass. (14 Allen) 539, 556 (1867) (emphasis added); *see also* BLACK'S LAW DICTIONARY 212 (5th ed. 1979) (defining "charitable" as "every gift for a general public use").

323. *In re* Resch's Will Trusts, [1969] 1 App. Cas. 514, 540 (P.C.) (emphasis added).

324. *E.g.*, RESTATEMENT (SECOND) OF TRUSTS § 372 (1959) ("A trust for the promotion of health is charitable.").

Also, the element of gift is fundamental to tort law's former willingness to clothe charities with immunity: " 'If an organization for charitable purposes founded upon the bounty of others who supply funds for the purpose of administering relief . . . may have its funds diverted from such kindly purpose, would it not inevitably operate to close the purses of the generous and benevolent who now do much to relieve the suffering of mankind?' " Dille v. St. Luke's Hosp., 196 S.W.2d 615, 617 (Mo. 1946) (quoting Adams v. University Hosp., 122 Mo. App. 675, 99 S.W. 453, 454 (1907)).

325. In 1988, religion received 46.2% of all gifts, amounting to $48.21 billion. Education received $9.78 billion. GIVING USA, THE ANNUAL REPORT ON PHILANTHROPY FOR THE YEAR 1988, at 9 (1989).

churches and schools are eligible for exemption regardless of their donative support. However, the statutory enumeration of religion and education creates only a presumption of exempt status; the enumeration is still subject to baseline requirements implicit in the common law concept of charity. In *Bob Jones University v. United States,*[326] for instance, the Supreme Court upheld the authority to deny the charitable exemption on public policy grounds to racially discriminatory private schools, despite the statute's omission to impose a general public policy requirement. The Court reasoned that the public policy screen is one of the "certain common-law standards of charity" drawn from charitable trust law that "under[lie] all relevant parts of the Code."[327] Likewise, the donative aspect of the trust law concept of charity underlies all enumerated categories of charitable organizations. Hospitals that enjoy per se charitable status under some state constitutional and statutory provisions[328] therefore should still be required to meet this basic requirement of charitable status, just as they are still bound by general public policy dictates and required to serve the public at large.

The existence of this systemic limitation of the charitable exemption is not left to mere speculation. State court decisions provide significant precedential support for the donative element of the charitable exemption despite their apparent endorsement of a more sweeping per se view of exemption.[329] In particular, many of the state court decisions that most liberally extend the exemption to hospitals are, upon closer examination, premised on a donative theory. For instance, *City of Richmond v. Richmond Memorial Hospital,*[330] one of the leading cases thought to establish hospitals as per se exempt regardless of their willingness to treat indigent patients, observed that "these hospitals were built through charitable impulses. Over thirty thousand charitably inclined citizens contributed to the construction."[331]

326. 461 U.S. 574 (1983).

327. *Id.* at 586.

328. *See supra* note 33.

329. *See generally* W. WELLFORD & J. GALLAGHER, *supra* note 55, at 134 ("Many states take into account the level of charitable support an organization receives in determining whether it is charitable.").

330. 202 Va. 86, 116 S.E.2d 79 (1960).

331. *Id.* at 82; *see id.* at 80 ("[S]ome 33,000 individuals and businesses contribut[ed] approximately $4,000,000 in the fund-raising campaign."). Similarly, the Nebraska Supreme Court, which is often cited for its classic statement of the per se view, *see Young Men's Christian Ass'n v. Lancaster County,* 106 Neb. 105, 111, 182 N.W. 593, 595 (1921), *observed in St. Elizabeth Hosp. v. Lancaster County,* 109 Neb. 104, 189 N.W. 981 (1922), that the entity in question was founded from many small donations, and that the hospital was run by nuns who contributed their services for free. "Charitable gifts and gratuitous services are contributed to the welfare of

The donative theory also finds explicit precedential support in the federal sphere. One study of federal tax exemption rulings concluded that "there is a strong tendency on the part of the IRS to require that a charitable organization embody to some degree a donative factor."[332] More recently, Congress expressed implicit support for the donative theory by denying the federal exemption to certain inherently commercial activities.[333] In 1986, Congress withdrew the charitable exemption from "commercial-type insurance"[334] and in 1987 held extensive hearings inquiring into the concern that tax-exempt nonprofits are engaged in a vast array of commercial activities that constitute unfair competition with proprietary businesses.[335] The essence of commercial activity is the sale of goods and services on a quid pro quo basis. Commercial nonprofits are thus polar opposites of those that raise their revenues through donations. Therefore, rejection of the

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society." *St. Elizabeth Hosp.*, 189 N.W. at 982; *see also* Southern Methodist Hosp. v. Wilson, 51 Ariz. 424, 77 P.2d 458, 460–461 (1938) (hospital charitable despite rendering "very little free medical or hospital attendance to anyone," but "the property which it took over [when it converted to charitable status] was heavily burdened with debt, and . . . there were various contributions made from time to time amounting to forty to fifty thousand dollars in all"), *overruled on other grounds*, Ray v. Tuscon Medical Center, 72 Ariz. 22, 230 P.2d 220 (1951); Fredericka Home for the Aged v. San Diego County, 35 Cal. 2d 789, 221 P.2d 68, 71 (1950) (citing fact that 35% of income of entity came from endowments and donations as evidence of charity); *In re* Appeal of Sunny Ridge Manor, Inc., 106 Idaho 98, 675 P.2d 813, 816 (1984) (noting paucity of donations in denying exempt status); Mayo Found. v. Commissioner of Revenue, 306 Minn. 25, 236 N.W.2d 767, 773 (1975) (noting importance of support by "benevolent contributions" to assessment of charitable status); Oregon Methodist Homes, Inc. v. Horn, 226 Or. 298, 360 P.2d 293, 303 (1961) (home for aged not exempt, in part because "there are no gifts of land and buildings; no endowment fund; no gifts from outsiders to offset the operating losses"); *In re* Prange's Will, 208 Wis. 404, 243 N.W. 488, 491 (1932) ("A hospital which pays no dividends and is largely supported by donations is a charitable institution."); *cf.* Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 273 (Utah 1985) (level of donations important factor in determining charitable status).

332. Persons, Osborn & Feldman, *supra* note 2, at 1947–48. For example, *Harding Hosp. v. United States*, 505 F.2d 1068, 1077 (6th Cir. 1974), used the lack of charitable donations to support the denial of exempt status for a specialized psychiatric hospital. The lack of contributions was also noted by the Eighth Circuit in denying an exemption to a nonprofit pharmacy. Federation Pharmacy Servs. v. Commissioner, 625 F.2d 804, 808 (8th Cir. 1980); *see* W. WELLFORD & J. GALLAGHER, *supra* note 55, at 97 (1988) (noting a number of federal cases outside the health care field in which lack of charitable donations was a contributing factor to denial of exemption); *see also* Fides Publishers Ass'n v. United States, 263 F.Supp. 924 (N.D. Ind. 1967); Easter House v. United States, 12 Ct. Cl. 476 (1987); EST of Hawaii v. Commissioner, 71 T.C. 1067, 1081 (1979); B.S.W. Group v. Commissioner, 70 T.C. 352, 359 (1978); Bromberg, *Financing Health Care, supra* note 40, at 180.

333. *See* W. WELLFORD & J. GALLAGHER, *supra* note 55, at 95–97; Note, *Religious Nonprofits and the Commercial Manner Test*, 99 YALE L.J. 1631, 1632, 1640 (1990).

334. I.R.C. § 501(m) (1989). Congress had in mind the 501(c)(3) exemption for the Teacher's Insurance Annuity Association and the § 501(c)(4) exemption for Blue Cross/Blue Shield. *See* TAX REFORM ACT OF 1985, H.R. REP. NO. 426, 99th Cong., 1st Sess., at 663 (1985).

335. *UBIT Hearings, supra* note 6.

exemption for commercial activity can be seen as a tacit endorsement of the donative standard.

As a consequence of these many avenues of precedential and historical support for the donative theory of the exemption, it is already embodied in the present structure of the charitable exemption. Thus, applying the notion explicated in *Bob Jones University* and the IRS regulations that "certain common-law standards of charity" drawn from charitable trust law "under[lie] all relevant parts of the Code,"[336] the donative theory could be adopted and implemented without further legislative directive.[337]

D. The Donative Theory's Scorecard

1. Deservedness

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 stems from the public's recognition of a socially valued service, the donative theory assures that donations are directed to activities worthy of subsidy. And because those worthy activities that rely on voluntary support systematically receive less support than society as a whole desires, donative activities need to be subsidized.

The donative theory avoids the difficulties that other theories face in establishing exemption deservedness because it does not require a government official to determine need or worth on an activity-specific basis. For instance, the community benefit theory forces us into a morass of conflicting data and theory over the desirability of the nonprofit form in medicine;[338] likewise, Hansmann's capital subsidy theory requires us to isolate those socially valued nonprofits that need a capital subsidy to help them compete on an even footing with proprietary enterprise.[339] The donative exemption employs a mechanism that makes these intensely empirical determinations automatically by targeting, within the universe of activities that conceivably deserve support, those activities that actually earn the exemption by providing services that are not otherwise available. This theory also actively

336. Bob Jones Univ. v. United States, 461 U.S. 574, 586 (1983).

337. Although the IRS possesses the authority to interpret and exercise the charitable exemption consistent with the donative theory presented in this Article, it is perhaps undesirable for the IRS to implement such a major change on its own initiative.

338. *See supra* Section III.C.

339. *See supra* note 296.

induces those nonprofit firms with sagging support to search out new ways to satisfy public needs.[340]

2. *Proportionality*

On first inspection, the donative theory appears to meet the proportionality criterion only roughly. Unlike the charitable deduction, the exemption does not automatically match donations dollar for dollar by a proportionate amount of tax support. Nevertheless, the exemption fares passably well for the property tax exemption because the amount of property a donative nonprofit holds is proportionate to the amount of contributions it receives.[341] For income tax, the connection between the size of the subsidy (determined roughly by earned surplus) and the criterion for deservedness (donations) is much more attenuated.[342] At least it can be said, in contrast with some of the theories of the exemption explored above,[343] that the correlation between earnings and donations is not perverse. Instead, donations have an unpredictable, or at best a neutral, relationship to the income tax subsidy. As a result, the subsidy is not so much disproportionate as nonexistent.

Even this level of compromise in proportionality seems unsatisfactory until one realizes that the donative theory, despite these imperfections, provides the most accurate measure of deservedness available. This insight is revealed by Weisbrod's explanation of government failure. The principal litmus test for proportionality is whether, assuming

340. B. WEISBROD, *supra* note 8, at 7 ("An organization that relies on donations to aid the poor must tailor the form of that aid to the wants of prospective donors, who are, in effect, the economic demanders of the organization's services.").

341. For similar reasons, the subsidy under the sales tax exemption for *purchases* is also proportionate to the level of donations.

342. Generally, gifts are not considered as income to the recipient. I.R.C. § 102 (1989). Even if they were, they would likely be entirely offset by the expense entailed in the organization's provision of its services for free. Therefore, purely donative organizations would receive no implicit subsidy at all. For mixed donative and commercial nonprofits that potentially earn taxable income, such as education and the performing arts, analysis of the proportionality criterion is more complex because the relationship between the indicium of deservedness and the level of subsidy may turn on whether donations are devoted to capital or operating costs. A nonprofit that applies its contributions to capital funding needs is likely to generate more revenues. Schools with the largest endowments are thus likely to have the most tuition-paying students because they will have the largest facilities. However, there still may not be a positive relationship to taxable income because even donated capital assets generate depreciation expenses to offset the enhanced revenues. Donations applied to operating costs can paradoxically result in less taxable income since funds spent on the organization's revenue-producing activities are deductible as business expenses. Stated differently, organizations that need to devote donations to operating expenses probably generate no operating surplus. The fact that they need to solicit donations indicates that, over the long run, their business receipts are less than their expenses.

343. *See supra* notes 166–69, 185 and accompanying text.

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, direct government aid must be unavailable because it is the failure of the government to serve a high-demanding minority that leaves 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 thus satisfied because, instrinsically, no more accurate mechanism for direct government support is available in cases where the donative theory applies.

3. *Universality and Historical Consistency*

The earlier discussion observed the complementary aspects of the donative tax subsidy: the charitable *deduction* is directed to the *donor* to stimulate making the gift while the *exemption* goes to the *recipient* to enable the gift to go further.[344] This symmetrical aspect of the donative theory provides one of its greatest strengths. Unlike all other theories of the charitable exemption, it 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 universality is critical to a successful theory of charity because, under the structure of the federal and most state codes, all three tax benefits follow automatically once the organization is characterized as charitable. Only by defining charities as organizations that receive substantial donative support is it possible to make sense of the unified federal/state, exemption/deduction structure.

A further dimension of the donative theory's universality is its ability to explain the value-added tax exemption that many states confer on sales *to* charities.[345] This exemption from *paying* sales tax provides

344. *See supra* note 310 and accompanying text.

345. Thirty-four states and the District of Colombia grant nonprofits exemption from paying sales taxes. ALA. CODE § 40-23-5(m) (Supp. 1990); ARIZ. REV. STAT. ANN. § 42-1321(5) (1980); ARK. CODE ANN. § 26-52-401(21) (Supp. 1989) (exempting sales to hospitals); COLO. REV. STAT. § 39-26-114(1)(a)(II) (Supp. 1990); CONN. GEN. STAT. ANN. § 12-412(5) (West Supp. 1990); D.C. CODE ANN. § 47-2005(3) (1990); FLA. STAT. ANN. § 212.08(7)(m) (West 1989); GA. CODE ANN. § 91A-4503(g) (Harrison Supp. 1989); HAW. REV. STAT. 237-23(8) (Supp. 1989); IDAHO CODE § 63-3622o (Supp. 1990); ILL. ANN. STAT. ch. 120, ¶441(b) (Smith-Hurd Supp. 1990); IND. CODE ANN. § 6-2.5-5-25(a)(1) (Burns 1989); KAN. STAT. ANN. § 79-3606(b) (1989); KY. REV. STAT. ANN. § 139.470 (Baldwin 1990); ME. REV. STAT. ANN. tit. 36, § 1760(16) (1990); MD. TAX-GEN. CODE ANN. § 11-204 (Supp. 1990); MASS. ANN. LAWS ch.

a form of matching subsidy that assists donations in being more productive by relieving them of the tax that otherwise is imposed when the donations are used to purchase supplies. Notably, the donative theory would not provide strong support for a value-added tax exemption on sales *by* nonprofits since such an exemption would target primarily commercial nonprofits.[346] Consistently, very few states exempt charities from *charging* sales tax.[347]

Finally, the discussion of charitable trust law and other precedents demonstrates that the donative theory meets the historical consistency criterion. It offers a concept of charity that comports with intuition and fits well with the classic applications of the exemption—religion, education, relief of the poor, and the fine arts. But does it justify extending the exemption to modern hospitals?

E. How Hospitals Measure Up

1. The Low Level of Present Hospital Donative Support

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, hospitals receive sufficient government funding 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.

Hospital services primarily consist of patient care sold through ordinary commercial transactions. Nevertheless, several hospital services

64H, § 6(e) (Law. Co-op. Supp. 1990); MICH. COMP. LAWS ANN. § 205.54a (West Supp. 1990); MINN. STAT. ANN. § 297A.25 (West Supp. 1991); MISS. CODE ANN. § 27-65-111(a) (1972); MO. ANN. STAT. § 144.030.2.(19) (Vernon Supp. 1990); NEB. REV. STAT. § 77-2704 (1986); N.J. STAT. ANN. § 54:32B-9(b)(1) (West 1986); N.M. STAT. ANN. § 7-9-29 (1990); N.Y. TAX LAW § 1116(a)(4) (Consol. 1987); OHIO REV. CODE ANN. § 5739.02 (Anderson Supp. 1989); PA. STAT. ANN. tit. 72, § 7204 (Purdon 1990); R.I. GEN. LAWS § 44-18-30 (Supp. 1990); S.D. CODIFIED LAWS ANN. § 10-45-10 (1989); TENN. CODE ANN. § 67-6-322(a)(8) (1989); TEX. TAX CODE ANN. § 151.310(a)(1) (Vernon Supp. 1991); UTAH CODE ANN. § 59-12-104(8) (Supp. 1990); VT. STAT. ANN. tit. 32, § 9743(3) (Supp. 1990); VA. CODE ANN. § 58.1-608 (Supp. 1990); WIS. STAT. ANN. § 77-54(9a)(f) (West 1989); WYO. STAT. § 39-6-405(a) (1990). Delaware, Montana, New Hampshire and Oregon do not have a sales tax at all.

346. Donative nonprofits also raise revenue from sales, such as tuition paid to schools and ticket sales by the performing arts. Most value-added taxes however do not include such services in the tax base. Even if they did, an exemption would still fail the proportionality criterion discussed in the following text.

347. Only seven states provide general exemptions for sales by charitable organizations. ARK. CODE ANN. § 26-52-401(3) (Supp. 1989); IND. CODE ANN. § 6-2.5-5-26(a)(1) (Burns 1989); IOWA CODE ANN. § 422.45(3) (West 1990); N.J. STAT. ANN. § 54:32B-9(b)(1) (West 1986); N.Y. TAX LAW § 1116(a)(4) (Consol. 1987); UTAH CODE ANN. § 59-12-104(8) (Supp. 1990); VT. STAT. ANN. tit. 32, § 9743(3) (1981).

are candidates for classic public good characterization. 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 most hospital services with public good characteristics—research, physician education, and the treatment of indigent patients—exist disproportionately in voluntary hospitals.[348] These are also precisely the services that nonprofit hospitals use to justify the exemption under the conventional government burden and community benefit theories.[349]

But it is not enough to demonstrate the existence of substantial public goods production to justify a tax subsidy. The subsidy is deserved only if 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 from public donations.[350] This was not always the

348. B. WEISBROD, *supra* note 301, 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 . . . .

See also Weisbrod, *supra* note 303, at 193.

349. *See supra* notes 203–05, 245–47 and accompanying text. However, the superior performance record of nonprofits in treating indigent patients is not nearly as clear. *See supra* notes 143–45 and accompanying text.

350. For no apparent reason, statistics on giving as a percentage of hospital revenues are imprecise, but the discrepancies are immaterial for present purposes. The National Association of Hospital Development (NAHD) reports that, in fiscal 1987–88, its 1,425 member hospitals received 1.6% of their "total budgets" (expenditures) from cash donations. Telephone conversation with Ron Childress, NAHD Communications Manager (Jan. 22, 1990) (notes on file with the *Washington Law Review*); *see also* G. ANDERSON, J. LAVE, C. RUSSE & P. NEUMAN, *supra* note 165, at 147–48 ("[B]y 1985, philanthropy represented less than 1.3 percent of funds used for hospital care . . . ."); Yoder, *supra* note 11, at 100, table 5.2 (in 1983, nonprofit hospitals received 0.4% of revenues from contributions—$370.9 million in all); Herzlinger & Krasker, *supra* note 143, at 95 (donations amounted to only 1% of total hospital expenses in 1983, from a selected sample of nonprofit chain hospitals); *UBIT Hearings, supra* note 6, at 183 (statement of Marion R. Fremont-Smith, Independent Sector) (2% of 1982 hospital revenue came from private contributions); *id.* at 996 (statement of Bradford H. Gray, Institute of Medicine) ("Charitable contributions used to be an important source of funds for hospitals, but they have now declined to less than one-half of 1 percent of hospital revenues . . . .").

Scattered information from individual hospitals confirms these national aggregates. In 1988, SamCor, one of the southwest's largest nonprofit chains, raised less than one-half of one percent of its revenues from donations. 1988 SAMCOR ANNUAL REPORT 19, 28 ($2,156,000 in donations out of $560,611,000 in total operating receipts). A group of 11 nonprofit hospitals in Utah received approximately 1% of their 1986 revenues from donations and endowment income. Pace Management Services, *supra* note 153. Vanderbilt University Hospital received $259,000 in gifts in 1987, as against $237 million in revenues budgeted for 1988, a ratio of one to one thousand. Vanderbilt University Medical Center: Facts 1988 at 5 (copy of pamphlet on file with the *Washington Law Review*).

case. At the turn of the century, hospitals depended on philanthropy for roughly one-quarter to one-third of their operating budget and for the bulk of their capital funds.[351] Tracing the history of the deterioration of hospital giving and the changing characteristics of the nonprofit hospital sector over time helps to confirm the rationale for supporting only donative institutions.

The primary impetus for the growth of the voluntary hospital sector prior to World War II was the desire of diverse ethnic and religious groups to create institutions that would cater to their distinct treatment needs without discrimination. The early growth of voluntary hospitals after the turn of the century "reflected the idiosyncratic qualities of the community they served."[352] Thus, Catholics desired a hospital where last rites would be administered and Jews desired one where the staff spoke Yiddish and served kosher food.[353]

These distinctive characteristics allowed voluntary hospitals to appeal to defined interest groups for strong philanthropic support to ensure that treatment would be available when the need arose.[354] This association between heterogeneity in demand for hospital services and the strength of donative support confirms the role public choice theory plays in explaining the existence of philanthropy as a response to government failure.

As a result of the third-party reimbursement structure that developed after World War II, hospitals no longer suffer significantly from government or market failure. Private insurance spread rapidly during the 1950s and the government began directly funding a substantial portion of hospital operations through Medicare and Medicaid in the 1960s. The government also increased direct subsidies to specific public good activities, such as hospital construction, medical research and education. As a consequence, nonprofit hospitals no longer depended on donative support to expand. Moreover, third-party sources of

351. J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 29 (in 1904, voluntary hospitals received 36% of revenues from gifts); *id.* at 92 ("During the late 1920s almost three-quarters of capital for hospital construction came from philanthropy . . . .").

352. Rosner, *Heterogeneity and Uniformity: Historical Perspectives on the Voluntary Hospital,* in IN SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS 87, 93 (1988). Strong confirmation of the role of religious and ethnic ideology and the influence of societal heterogeneity on the pattern of hospital development comes from a cross-national study that found that "in all countries with one prevalent religion, hospitals were run by the government, . . . but where competition existed among religious groups, they retained control of hospitals to protect and extend their sphere of influence." P. STARR, *supra* note 35, at 176 (describing study in W. GLASER, SOCIAL SETTINGS AND MEDICAL ORGANIZATIONS: A CROSS-NATIONAL STUDY OF THE HOSPITAL (1970)).

353. P. STARR, *supra* note 35, at 169–70, 173; Clark, *supra* note 10, at 1458.

354. J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 5–6, 24–25, 37.

funding replaced the quasi-insurance function that donations served of securing a future source of services.[355] This displacement of charitable giving has caused hospital philanthropy to decay rapidly since 1968, with a half-life of about five years.[356] Either hospitals have felt little need to solicit philanthropic support, or if they have sought it, the public has seen little need to contribute.[357] Coincident with these changes, the character of nonprofit hospitals has become remarkably homogeneous. One noted medical historian comments that "[b]y the mid-1960s, . . . the notion of an institution closely connected to its community seemed like a romantic remnant of a 'pre-scientific' era."[358]

Hospitals 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.[359] But until the pinch becomes severe enough to motivate hospitals to enter the philanthropy market more aggressively, and donors to respond with more enthusiasm, these assertions are irrelevant under the donative theory. 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 sufficiently supported in more direct ways. Accordingly, there is a weak case for supplementing this support with a tax subsidy.[360]

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355. *See* Foster, *supra* note 211, at 348–50.

356. D. COHODES & B. KINKEAD, *supra* note 295, at 23; J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 37 ("By 1981, philanthropic contributions to hospitals . . . [were] less than one-fourth of the level when Medicare began."); Yoder, *supra* note 11, at 55 (philanthropy, as a percentage of funding for hospital construction, decreased from 21% in 1968, to 10% in 1973, to 6% in 1978, to 4% in 1981); Foster, *supra* note 211, at 350–51. *See generally* J. Terenzio, *A Survey of the History and Current Outlook of Philanthropy as a Source of Capital for the Needs of the Health Care Field,* in HEALTH CARE CAPITAL: COMPETITION AND CONTROL (1978).

357. *See* F. Sloan, J. Hoerger, M. Morrisey & M. Hassan, The Demise of Hospital Philanthropy (Jan. 1989) (developing and documenting this "crowding out" thesis) (unpublished manuscript on file with the *Washington Law Review*).

358. Rosner, *supra* note 352, at 122.

359. Dyer, *Hospitals Saw Patient Margin Vanish in 1988,* HOSPITALS, May 5, 1989, at 56.

360. The same lack of donative support for certain non-hospital health care providers (such as HMOs, physician practice 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. In a prior article, Professor Colombo argued that the IRS could not consistently adhere to a per se theory of exemption for hospitals while continuing to deny exemption to these other health care providers. *See generally* Colombo, *supra* note 41. The remedy for this inconsistency suggested in that article, to extend the exemption to all legitimate nonprofit providers of health care services, was premised on the continuation of the per se theory of exemption. *Id.* at 523. That article also recognized, however, that

2. *The Possibilities for Hospital Exemption*

Despite the presently low level of proportionate donative support for hospitals, it is misleading to conceive of hospitals as receiving no such support. In fact, the aggregate level of donations is quite large.[361] While donative 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 disregard this support simply because it represents a small portion of the nonprofit operation. Fortunately, the donative theory is capable of fine-tuning its application to account for degrees of support. First, it is hardly necessary for hospitals to receive 100% of their revenues from donations. Few traditionally charitable organizations do.[362] The precise threshold of donative support required to qualify for charitable status is ultimately a legislative or administrative policy decision; however, one might speculate that a threshold based on the level of support hospitals received when they were still considered classic charities—on the order of 30% for capital funds—would represent a reasonable application of the donative theory.[363]

Hospitals that fail to meet this threshold for their overall operations may qualify for the exemption if they are capable of segregating those

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reconsideration of the fundamental basis of the exemption offers another solution. Reevaluation of the exemption resolves the inconsistency by denying exemption to all forms of commercial health care enterprise.

361. The 1,425 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. Telephone conversation with Ron Childress, NAHD Communications Manager (Jan. 22, 1990) (notes on file with the *Washington Law Review*).

362. W. WELLFORD & J. GALLAGHER, *supra* note 55, at 29:

> A common misconception . . . is that once there was a golden age when charitable organizations in the United States raised funds almost exclusively through the generosity of the public and the benevolence of a few great philanthropists. . . . Even before the Civil War, charities relied to some extent on fees to support activities and programs ranging from publication and distribution of religious tracts to organization and maintenance of food relief for the poor. After the Civil War, fees played a central role in expanding educational and medical services, in initiating school lunch and work training programs, and in developing social casework programs.

See id. at 45–46, 58–59.

363. *See* Foster, *supra* note 211, at 351, table 1 (during the post-war era until 1968, philanthropy provided from 20% to 30% of hospital construction funding); *supra* note 351. Another indication that this level is appropriate is the test currently used for giving more favored status to some charities for purposes of capping the level of contributions that individuals may deduct in computing their income tax. Individuals may deduct up to 50% of their adjusted gross income for contributions to charities that receive at least one-third of their support from the public; but only up to 30% of their income for charities that receive less than one-third of their support from the public. *See supra* note 312. For further development of the appropriate threshold, see M. Hall & J. Colombo, The Donative Theory of the Charitable Exemption (forthcoming).

activities that attract the most donative support into separate corporate entities.[364] For instance, oncology and pediatric services are popular objects of hospital giving, particularly when combined into children's cancer units.[365] Moreover, a taxing authority may make the same accounting adjustment even without formal corporate segregation.[366] The extent to which particular nonprofit hospitals might qualify for the exemption depends in large part on the details of administering a donative theory of exemption, details to be developed in a subsequent article.[367]

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364. *See* J. HOLLINGSWORTH & E. HOLLINGSWORTH, *supra* note 25, at 30 (very little giving to hospital operating budget, or even to a general endowment; instead, donations are usually for specified purposes, such as to endow a particular service or facility). This approach of subdividing hospitals into service units is consistent with the approach often taken of apportioning the property tax exemption according to the particular assets or operations of an entity that are allocated to charitable purposes. Using donative support as the measure of charitable apportionment solves the difficult problem of evaluating which assets are so used.

365. For instance, while this Article was being written, the hospital that successfully defended an attack on its exempt status in *Medical Center Hospital v. City of Burlington,* 152 Vt. 611, 566 A.2d 1352 (1989), ran the following quarter-page advertisement in the *Burlington (Vt.) Free Press,* Sunday, June 4, 1989, at D10:

> When our children hurt, we all hurt.
>
> [Pictures of four bandaged and ill infants]
>
> Help them. Give generously. . . . Your money buys equipment and programs for MCHV's children's cancer clinic, burn prevention program, poison center, and intensive care nursery.

See also UBIT Hearings, supra note 6, at 938–39 (statement of Shriners Hospitals for Crippled Children) (in 1987, 22 hospitals provided "totally free hospital care for children in need," as a result of $140 million of gifts and $279 million of endowment income).

366. The 1983 reform of the Medicare payment system for hospitals (known as the "DRG" reimbursement system, for "diagnosis-related groups") might facilitate such an accounting process because it forms the basis for measuring revenues on a service-specific basis. Vladeck, *Medicare Hospital Payment by Diagnosis-Related Groups,* 100 ANN. INT. MED. 576 (1984). Thus, a hospital might be able to exempt a portion of its patient care revenue by demonstrating that it receives substantial donative support for a burn unit and a neonatal intensive care unit, without having to separately incorporate these integral parts of its operation.

367. The present Article presents only the basic contours of the donative theory. Full understanding and implementation of the theory require consideration of additional theoretical and practical issues. The theoretical issues that remain include: Should the donative theory count all contributions even if they are motivated by selfish or evil ends? Is the theory based purely on efficiency grounds or does it include a moral dimension? Might it be used to justify an exemption for all nonprofits under the argument that every nonprofit donates its earnings to itself? Does the donative theory justify other elements of the charitable tax exemption—such as the exemption's restriction to nonprofit entities, the limitation on political activity, and the unrelated business income tax—or are these side constraints that are unconnected to the core theory? Other issues center around practical problems that exist in the implementation of the donative theory: What should be the required quantum of donative support? Should it be measured on an industry or on an institution-specific basis? When and how often in the life of the institution should it be measured? Should the exemption apply different measures to different sources of donations, such as foundations, bequests and large donors? Do grants count? Donated labor? Will the donative theory encourage more fund raising abuse? These issues await

V. CONCLUSION—REFINING AND IMPLEMENTING THE DONATIVE THEORY

We have reached the donative theory of the charitable exemption by proceeding in two analytical modes: whittling away and building up. A negative analysis demonstrates the deficiencies of other theories; a positive analysis demonstrates the strengths of the donative theory. Others who have reflected on the rationale for the charitable exemption have taken 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 framing of the issue has caused commentators to overlook the merits of using donations as the basic standard for applying the exemption. The donative theory should not be taken for granted. Understanding its strength illuminates whether there should be an exemption at all and, if so, how it should be properly administered.

Nowhere is this more evident than in the case of nonprofit hospitals. Commentators who judge the issue of exemption for hospitals by inquiring whether they uniquely provide a community benefit are asking a question for which the evidence is largely subjective. By asking instead whether the public chooses to support nonprofit hospitals with donations, it is possible to evaluate the need for tax subsidization on a more objective basis. Precisely how much donative support is needed to qualify for the exemption, and exactly what counts as a donation, turn on questions of theory and administration that await further development and that, ultimately, must be resolved in the political arena. These further undertakings will be worth the effort if we have chosen to pursue a concept of charity that is correct at its core.†

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our sequel. *See* M. Hall & J. Colombo, The Donative Theory of the Charitable Exemption (forthcoming).

† As this article was going to press, Representative Donnelly introduced H.R. 1374, 102d Cong., 1st Sess., 137 CONG. REC. E896 (1991), which incorporates some of the suggestions published by his legislative director in Barker, *supra* note 64, as described *supra* notes 66, 151 and 202. If enacted into law, this bill would require nonprofit hospitals to maintain their exempt status by either: (1) devoting 5% of gross revenues to charity care apart from bad debts and contractual allowances, or (2) devoting 10% of gross revenues to primary health care or substance addiction treatment in medically underserved areas of the country. A hospital would not have to meet those requirements, however, if it is a sole community hospital, or if it treats a disproportionate share of low income patients, as defined under Medicare statutes. The Secretary of Health and Human Services would be authorized to issue regulations that distinguish bad debt from charity care for purposes of the 5% threshold. Moreover, the IRS may designate other community services that qualify for the 10% threshold.