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Do Nonprofit Hospitals Pay Their Way?

Data from California shed light on whether the benefit from nonprofit hospitals warrants their special tax status.

by Michael A. Morrisey, Gerald J. Wedig, and Mahmud Hassan

ABSTRACT: Using 1988 and 1991 data from nonprofit voluntary hospitals in California, we find that the vast majority of nonprofit hospitals provide community dividends in excess of the tax subsidies they receive. However, nearly 20 percent of nonprofit hospitals do not meet this standard. Further, those hospitals that do not meet the standard tend to not meet the standard over time. We recommend more explicit identification of the community dividends expected in return for special tax treatment and more explicit accounting on the part of nonprofit hospitals.

NONPROFIT VOLUNTARY HOSPITALS in the United States have long enjoyed favorable tax treatment. As 501(c)(3) organizations under the federal tax code, they are exempt from federal corporate income taxes. Similarly, states exempt them from state income taxes. Nonprofit hospitals typically are exempt from local property taxes and have access to tax-exempt debt. Tax-exempt debt allows hospitals to borrow money at rates that are typically two to three percentage points below those paid by equally risky enterprises. These tax subsidies are not trivial. John Copeland and Gabriel Rudney report aggregate annual tax subsidies to hospitals nationwide as high as $8.5 billion.¹

The tax subsidies enjoyed by nonprofit organizations have come under increasing scrutiny by researchers, state and federal legislative bodies, and the public at large.² In 1985 the Utah Supreme Court interpreted that state's constitution to require nonprofit hospitals to provide charity care to qualify for a property tax exemption. The state tax commission guidelines now require hospitals to give away services that at least equal the value of the tax exemption they receive. The U.S. General Accounting Office (GAO) also reported that at least seventeen states have considered or have enacted legislation to prevent unfair competition by nonprofits. Pennsylvania
hospitals have struggled to demonstrate their charitable efforts after a state court allowed a hospital to be taxed because it had strayed too far from its charitable mission. In June 1993 Texas enacted legislation requiring nonprofit hospitals to provide set amounts of care to the poor and uninsured. The value of charity care provided must be at least as large as the local and state tax exemptions received, or equal to at least 4 percent of hospitals' net revenue. More recently, *U.S. News and World Report* devoted a cover story to the growth of nonprofit organizations and the taxes they do not pay. The authors spotlighted hospitals, their unrelated business activities, and the question of the charitable purposes they allegedly do not always pursue.

The purpose of this DataWatch is to examine the issue of tax subsidies and community dividends from a more general empirical perspective. How much forgiveness of bad debt and charity care do private voluntary hospitals provide? How big are the income tax subsidies and property tax abatements that they receive? How large is the interest savings on tax-exempt debt? More importantly, to what extent do the community dividends of charity care and forgiveness of bad debt balance the tax subsidies? What are the characteristics of hospitals that fail to meet this community dividend standard, and are these the same hospitals over time?

**Data And Methods**

Our analysis uses data from 189 nonprofit voluntary community hospitals in California that provided continuous data between 1988 and 1991. We excluded the 119 investor-owned hospitals in the state because they do not receive tax subsidies. We excluded the eighty-nine state and local government hospitals because their missions and access to resources are very different from those of voluntary hospitals. The twenty-two Kaiser hospitals were excluded because they typically provide care only to their members. An additional twenty-seven hospitals had incomplete data.

The data came largely from the Annual Hospital Disclosure Report collected by the Office of Statewide Health Planning and Development (OSHPD). These financial reports provide balance sheet, income statement, and cash flow entries needed to infer a hospital's bad debt and charity care as well as its revenue flows. The disclosure reports also include supplemental information on individual bond issuances, together with their maturities and coupon rates, which enabled us to compute both taxable and tax-exempt bond levels.

We follow the convention of the literature in defining community benefits as uncompensated care. By this we mean the sum of bad debt and charity care. Charity care is usually defined as care given
with no expectation of receiving payment. Many have argued that hospital policies differ greatly on the conditions under which care is administratively considered charity. Some hospitals may code care as self-pay, then move the unpaid balance to past due, and eventually declare it bad debt. In many cases, it is believed that the hospital had no realistic hope of receiving payment. On this rationale, we too combine bad debt and charity care.

In our data the value of bad debt and charity care, hereafter referred to as uncompensated care, is determined by a hospital's billed charges for this care, stepped down to average costs using the hospital's overall operating-cost-to-charge ratio. This is certainly preferred to using billed charges. Full billed charges are often marketing fictions designed to allow a hospital to offer substantial “discounts.” David Dranove and colleagues have argued convincingly that while billed charges have increased dramatically in California, transaction prices among hospitals and private payers have risen much more slowly. Glenn Melnick and colleagues have demonstrated that actual preferred provider discounts in California reflect the relative market power of the hospitals and managed care firms. Arguably, we should use a market-determined price to estimate the value of the uncompensated care provided. Unfortunately, such data are not available to us.

Hospitals may provide other community dividends such as teaching, research, preventive services, and primary care in underserved areas. To the extent that they do, our measure is clearly an understatement. How large an understatement is not easily determined. Teaching costs have long been subsidized by Medicare. Substantial amounts of research are funded by the National Institutes of Health, drug companies, and other entities. The provision of screening and preventive services may be more akin to marketing efforts than to true community dividends.

**Income taxes.** Tax subsidies arise from three major sources: income taxes, tax-exempt bond financing, and property tax abatements. Nonprofit hospitals are exempt from federal corporate income taxes; they also are exempt from state income taxes. We estimated the income tax subsidies arising from the exemption from state and federal income taxes by computing the effective tax rate paid by investor-owned hospitals in California in each year and applying that rate to the revenue less expenses of nonprofit hospitals. This commits the sin of static analysis because we failed to allow for the changed behavior of nonprofit hospitals if they were to be taxed on their “profits.” However, nonprofit hospitals do not amass earnings for the purpose of rewarding shareholders. They spend funds that would have appeared as profits on good works,
particularly uncompensated care. These monies never appear as accounting profits that are subsequently distributed to the community. Since the uncompensated care never enters into the base upon which we compute the income tax subsidy, if anything we have understated the income tax subsidy.

**Tax-exempt debt.** Interest savings from the issuance of tax-exempt debt is the second-largest category of tax subsidy. It has been estimated that some 70 to 80 percent of U.S. nonprofit hospitals take advantage of such debt. We calculated the bond subsidy by extracting the debt levels from the California data set's supplementary detail. The supplement does not identify specific issues as tax-exempt or taxable. However, it does provide information on the date of issuance, the interest rate at the time of issuance, and the duration of the bond. We compared the interest rates on these hospital debt instruments with the interest rates on government bonds issued at the same time with similar maturities. Those with interest rates below the government rate were treated as tax-exempt. We computed the size of the interest rate subsidy as the face value of the bond times the difference between the reported interest rate and the rate on corporate A-rated bonds of similar duration. This is a conservative approach and likely understates the size of the interest rate subsidy. Most rated hospital bonds in the early 1980s were rated at A-minus or above; only 5 percent were rated below A-minus. If a hospital was less risky, and therefore had a higher bond rating, the interest rate subsidy would be greater than our estimate.

**Property tax** subsidy. The estimation of the property tax subsidy was more problematic. From each California county we obtained the property tax rate that would be applicable to hospitals. We also requested information on the assessed valuation of any hospital in each of the fifty-nine counties that was subject to the property tax. Twenty-five counties reported the assessed valuations on forty-six hospitals. We developed a predicting equation in which these assessed values were regressed on the net plant assets of each hospital and its age. We then used the coefficients from that equation to impute a property tax for each tax-exempt hospital in our sample.

**Results**

In 1991 an average nonprofit hospital in California received $1.58 million in subsidies (Exhibit 1). These subsidies increased with the size of the hospital. Hospitals with 100 beds or fewer averaged approximately $353,000 in subsidies, while large hospitals received nearly $4 million. However, major teaching hospitals (defined as
**EXHIBIT 1**
Average Tax Subsidies To Private Voluntary Hospitals in California, By Hospital Characteristics, 1991

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Income tax subsidy</th>
<th>Bond subsidy</th>
<th>Property tax subsidy</th>
<th>Total subsidies</th>
<th>Number of hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>$884 (1,273)</td>
<td>$437 (943)</td>
<td>$257 (315)</td>
<td>$1,579 (2,061)</td>
<td>189</td>
</tr>
<tr>
<td>0-100 beds</td>
<td>172 (326)</td>
<td>66 (101)</td>
<td>116 (82)</td>
<td>353 (408)</td>
<td>49</td>
</tr>
<tr>
<td>101-250 beds</td>
<td>654 (909)</td>
<td>267 (318)</td>
<td>219 (164)</td>
<td>1,138 (1,136)</td>
<td>70</td>
</tr>
<tr>
<td>251-400 beds</td>
<td>1,365 (1,588)</td>
<td>644 (621)</td>
<td>319 (218)</td>
<td>2,327 (1,807)</td>
<td>47</td>
</tr>
<tr>
<td>More than 400 beds</td>
<td>2,126 (1,529)</td>
<td>1,321 (2,268)</td>
<td>551 (707)</td>
<td>3,997 (3,714)</td>
<td>23</td>
</tr>
<tr>
<td>No teaching</td>
<td>741 (1,099)</td>
<td>292 (383)</td>
<td>210 (178)</td>
<td>1,243 (1,397)</td>
<td>156</td>
</tr>
<tr>
<td>Minor teaching</td>
<td>1,187 (1,592)</td>
<td>571 (716)</td>
<td>350 (269)</td>
<td>2,108 (1,768)</td>
<td>26</td>
</tr>
<tr>
<td>Major teaching</td>
<td>2,963 (1,733)</td>
<td>3,169 (3,549)</td>
<td>960 (1,143)</td>
<td>7,092 (5,486)</td>
<td>7</td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ calculations from California Annual Hospital Disclosure Report.

**NOTES:** Thousands of dollars; standard deviations are in parentheses. Subsidy columns do not add to total because of rounding.

those affiliated with the Council of Teaching Hospitals) are the largest beneficiaries of these tax subsidies. These typically are large facilities, are affiliated with a medical school, and offer a wide range of residency programs. These facilities received tax subsidies nearly seven times larger than those nonteaching hospitals received.

The combined federal and state subsidy imputed from income tax exemptions is the single largest subsidy. In 1991 it averaged $884,000. The interest rate subsidy obtained from issuing tax-exempt bonds represents about 27 percent of the tax subsidies obtained by nonprofit hospitals; we estimate the property tax subsidy to constitute about 16 percent of the overall tax subsidy, on average.

However, the various tax subsidies are not equally important to all types of nonprofit hospitals. The interest rate subsidies from tax-exempt debt are of only minor importance to small hospitals; they make up about 18 percent of their subsidies. In contrast, hospitals with more than 400 beds enjoy an interest rate savings on the order of $1.3 million. This is a third of the overall tax subsidy they receive. However, the major teaching hospitals depend most heavily
on the bond subsidies. For them, the interest rate savings in 1991 were greater than the income tax savings and nearly greater than the income and property tax subsidies combined.

It is worth noting, however, that the size of the subsidies varies widely within the classifications we present. This is consistent with the GAO study of income tax subsidies, which also found substantial variation among hospitals. In addition, the magnitude of the tax-exempt bond subsidy is not exogenously determined but varies with the extent that hospitals seek out tax-exempt funding sources. In related research, we have found that hospitals get access to tax-exempt funding even when they have sufficient capital to fund their projects internally. The effect is especially pronounced in chain hospitals. In this context, tax-exempt funding does not spur capital investment, but instead merely provides a financial subsidy to be spent at the hospitals discretion.

The tax subsidies (measured in 1991 dollars) were larger in 1988 than in 1991. We estimate that the average private voluntary hospital in California received more than $1.8 million in tax subsidies in 1988. However, while there continued to be considerable variation in the amount of tax subsidies received by individual hospitals, the relationship of the subsidies to hospital size and teaching status was very stable. Similarly, the mix of income tax, interest rate, and property tax subsidies was very similar in 1988 to that in 1991.

California hospitals did provide substantial amounts of community dividends. Indeed, on average, more than $3 million in uncompensated care was provided in 1991 (Exhibit 2). Major teaching hospitals provided nearly $15 million in uncompensated care.

On average, the amount of uncompensated care, measured on a cost basis, exceeded the tax subsidies by almost two to one. If one were to apply the “Texas standard,” that a hospital should provide charity care at least equal to the amount of tax subsidies it receives, the majority of California nonprofit hospitals would easily satisfy the standard. However, we estimate that 19.6 percent, one in five nonprofit hospitals, failed to meet that standard in 1991. The average shortfall was on the order of nearly $815,000. In the aggregate, this implies more than $40 million in apparent charity shortfalls in 1991. Although small hospitals were the most likely to miss the standard, the average amount by which their tax subsidies exceeded their uncompensated care was approximately $152,000. Larger hospitals that missed the standard tended to miss by much larger amounts.

The results in 1991 reflect a substantial improvement from the values in 1988. At that time, 39.6 percent of these same hospitals failed to meet our standard. However, small hospitals were the most likely to meet such a standard at that time.
One might suspect that failure to meet an uncompensated care standard has a large random component, in that it depends upon the people who present themselves for care at a hospital. If there are more indigent patients in one year, or if a handful of indigent patients have an exceedingly long stay, a hospital’s uncompensated care load may be unusually high or, in the opposite scenario, unusually low. Further, if a hospital recently obtained substantial new tax-exempt debt, its community dividends may not have risen yet to reflect the additional subsidy. A comparison of the hospitals that failed to meet our standard in each year suggests, however, that there is substantial persistence in missing the standard. In 1988 seventy-three hospitals had uncompensated care shortfalls. In 1991 only thirty-seven did. However, nearly two-thirds of those that are estimated to have had a shortfall in 1991 also had a shortfall in 1988.

Regression estimates. To better describe the circumstances of hospitals that failed to meet our uncompensated care standard, we estimated regressions of the hospitals 1991 uncompensated care, tax subsidy, and shortfall. These three factors are a function of hospital characteristics, market characteristics, and the lagged (1988) value.
of the hospitals uncompensated care, tax subsidy, and shortfall. Hospital characteristics included number of beds, whether it provided a minor or major amount of teaching, its occupancy rate, and the percentages of its admissions from Medicaid and Medicare.

We defined the hospitals market as the standard metropolitan area (SMA).\textsuperscript{16} We defined the few rural hospitals in our sample as part of the nearest SMA. Market variables were included to control for the “demand” for uncompensated care and were measured by the number of persons in the market with income below 200 percent of the federal poverty level, per capita income, the number of reported major crimes, and the number of fatal injuries. We included a wage index to control for differences in the costs of care. We also included three measures relating to market forces. First, the literature suggests that hospitals provide less uncompensated care when there is a public general hospital in the market.\textsuperscript{17} The literature also argues that a hospital may provide more charity care when other nonprofit hospitals provide more care.\textsuperscript{18} Finally, we included a measure of hospital competition, the Herfindahl Index. Greater hospital competition, particularly in California markets, may imply that a hospital’s profits (or surpluses) had been reduced and the hospital was unable to provide charity care.\textsuperscript{19} Because the level of uncompensated care provided by other hospitals is endogenous, we estimate the model via a two-stage least squares method.\textsuperscript{20}

In our regression, the uncompensated care equation is consistent with much of the empirical literature. Larger hospitals provided more uncompensated care, as did major teaching hospitals (Exhibit 3). Those hospitals with a larger share of their patient revenues from Medicaid also provided more uncompensated care. Those hospitals that provided more uncompensated care in 1988 also provided more in 1991. Further, when more uncompensated care was provided by other hospitals in the market, a given hospital provided less. Other variables, while statistically insignificant at conventional levels, typically had a sign consistent with expectations.

The tax subsidy equation demonstrates that major teaching hospitals receive substantial tax benefits; on average, a major teaching hospital with characteristics otherwise similar to the average community hospital received more than $2.7 million in additional tax subsidies in 1991. It is also the case that hospitals located in communities with more poor residents received greater tax subsidies; a 1 percent increase in the number of persons below 200 percent of the poverty level was associated with a 44.5 percent increase in tax subsidies. This suggests that state financing authorities may have implicitly targeted tax-exempt bond approvals to hospitals treating the poor.\textsuperscript{21}
## Exhibit 3
Regression Analysis of Uncompensated Care, Tax Subsidy, and Shortfall, California Hospitals, 1991

<table>
<thead>
<tr>
<th>Uncompensated care</th>
<th>Tax subsidy</th>
<th>Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lagged uncompensated care&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.54&lt;sup&gt;(.09)**&lt;/sup&gt;</td>
<td>-</td>
</tr>
<tr>
<td>Lagged tax subsidy&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-</td>
<td>.51&lt;sup&gt;(.04)**&lt;/sup&gt;</td>
</tr>
<tr>
<td>Lagged shortfall&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Beds</td>
<td>9.39&lt;sup&gt;(1.86)**&lt;/sup&gt;</td>
<td>-1.70&lt;sup&gt;(1.03)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Minor teaching (Yes = 1)</td>
<td>485.91&lt;sup&gt;(427.76)&lt;/sup&gt;</td>
<td>386.35&lt;sup&gt;(256.96)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Major teaching (Yes = 1)</td>
<td>4,276.09&lt;sup&gt;(931.23)**&lt;/sup&gt;</td>
<td>2,725.98&lt;sup&gt;(559.02)**&lt;/sup&gt;</td>
</tr>
<tr>
<td>Percentage Medicaid</td>
<td>18.26&lt;sup&gt;(10.85)*&lt;/sup&gt;</td>
<td>8.70&lt;sup&gt;(6.45)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Percentage Medicare</td>
<td>9.12&lt;sup&gt;(10.82)*&lt;/sup&gt;</td>
<td>2.12&lt;sup&gt;(6.48)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Occupancy rate</td>
<td>-9.35&lt;sup&gt;(9.78)&lt;/sup&gt;</td>
<td>2.39&lt;sup&gt;(5.83)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Public housing markets (Yes = 1)</td>
<td>-326.74&lt;sup&gt;(605.34)&lt;/sup&gt;</td>
<td>245.48&lt;sup&gt;(363.08)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Uncompensated care by others&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-.014&lt;sup&gt;(.008)*&lt;/sup&gt;</td>
<td>.002&lt;sup&gt;(.005)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Herfindahl Index</td>
<td>4.38&lt;sup&gt;(6.77)&lt;/sup&gt;</td>
<td>5.34&lt;sup&gt;(11.29)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Persons below 200% of poverty line&lt;sup&gt;a&lt;/sup&gt;</td>
<td>35.05&lt;sup&gt;(30.65)&lt;/sup&gt;</td>
<td>69.04&lt;sup&gt;(18.55)**&lt;/sup&gt;</td>
</tr>
<tr>
<td>Per capita income&lt;sup&gt;a&lt;/sup&gt;</td>
<td>92.60&lt;sup&gt;(74.37)&lt;/sup&gt;</td>
<td>26.73&lt;sup&gt;(44.67)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Major crimes reported&lt;sup&gt;a&lt;/sup&gt;</td>
<td>18.95&lt;sup&gt;(12.89)&lt;/sup&gt;</td>
<td>1.66&lt;sup&gt;(7.77)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Fatal injuries&lt;sup&gt;a&lt;/sup&gt;</td>
<td>426.43&lt;sup&gt;(1,054.22)&lt;/sup&gt;</td>
<td>-852.16&lt;sup&gt;(629.32)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Wage index</td>
<td>-2,051.39&lt;sup&gt;(L217.95)&lt;/sup&gt;</td>
<td>-194.72&lt;sup&gt;(724.01)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Constant</td>
<td>-230.35&lt;sup&gt;(1,925.25)&lt;/sup&gt;</td>
<td>-747.02&lt;sup&gt;($144.82)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Adjusted R&lt;sup&gt;2&lt;/sup&gt;</td>
<td>0.776</td>
<td>0.745</td>
</tr>
</tbody>
</table>

**Source:** Authors' calculations from California Annual Hospital Disclosure Report.

**Notes:** Standard errors in parentheses. N = 189.

<sup>a</sup>Thousands.

<sup>b</sup>Thousands: predicted value from first-stage regression.

<sup>*</sup>Significant at the 90 percent confidence level. **Significant at the 99 percent confidence level.
Exhibit 3 reports the regression results for the shortfall in uncompensated care—that is, the difference between the amount of the tax subsidy received and the amount of uncompensated care provided. A positive coefficient means that a hospital with this characteristic or with more of this particular attribute was more likely to receive tax subsidies that exceeded the value of the uncompensated care it provided. Negative coefficients suggest that the hospital was less likely to have an uncompensated care shortfall.

The coefficients generally have the expected effects. Major (and minor) teaching hospitals, for example, had smaller uncompensated care shortfalls. Hospitals with larger Medicaid shares had smaller shortfalls. Hospitals in metropolitan areas with more poor residents had larger shortfalls. However, all of these factors lacked statistical significance at the conventional level. This is essentially the story of our simple tabulations; that is, there is considerable variation within individual classifications of hospitals, and one cannot generalize about meeting a community dividend obligation across types of hospitals.

However, our regression also points out two important exceptions. First, and most importantly, the greater the shortfall that a hospital had in 1988, the greater the shortfall it had in 1991. Our strongest statistical finding is that hospitals that did not meet the threshold in 1988 tended to not meet the threshold in 1991. Those hospitals that met the threshold tended to meet it routinely, and those that did not satisfy the threshold tended to miss it consistently. Second, larger hospitals were more likely than small hospitals to provide uncompensated care in excess of their tax subsidies. Thus, if one wished to worry about the return the community gets from its grant of tax subsidies, attention should be focused initially on smaller hospitals with a pattern of limited uncompensated care.

**Conclusions**

Based on our analysis, it is clear that a large majority of nonprofit voluntary hospitals provide substantial uncompensated care. By the standard of providing enough care to at least cover the implicit value of the tax subsidies they receive, 80 percent of California hospitals paid their way in 1991.

What of the remaining 20 percent? There is no certain answer. Our measures of the income tax subsidy and particularly the property tax subsidy are flawed. These hospitals may not have had subsidies as large as we estimate. Furthermore, we measure only bad debt and charity care—uncompensated care. Hospitals often argue that they provide other community dividends; these hospitals may have done so. Their mix of community dividends may focus dispropor-
“One in five hospitals did not meet what we have simplistically called the ‘Texas standard’ for community dividends.”

tionately on things that we are unable to measure. Given our results, one might ask, particularly, what other community dividends are provided by small, largely urban hospitals?

Nonetheless, one in five hospitals did not meet what we have somewhat simplistically called the “Texas standard” for community dividends. Texas legislation requires, among other things, that non-profit hospitals provide uncompensated care at least equal to the value of the tax subsidies they receive. Given that 20 percent of hospitals did not meet this standard and that two-thirds of these same hospitals did not meet it three years earlier, one can fairly ask why such hospitals receive tax subsidies.

Given the size of the potential problem and its appearance across all strata of nonprofit hospitals, there is reason for concern. It is appropriate to ask nonprofit, tax-exempt hospitals to actively demonstrate that they do provide community dividends that justify their subsidies. Since federal, state, and county citizens have granted the tax subsidies, it is appropriate for them to better define what is expected from these organizations. As in Texas, uncompensated care may be the community dividend that is valued. It may be teaching and research. It may be prevention and community education programs. Whatever the expectation, it needs to be better articulated, and hospitals need to make it clear that they meet it.

It is important to note that we have taken a conservative approach both conceptually and empirically. We have potentially overstated the amount of uncompensated care provided by including bad debt as well as charity care in our measure. We have used assumptions about the nature of the tax breaks that tend to underestimate their size. More fundamentally, we have used a measure that relates a voluntary hospitals community dividends to the size of its tax subsidy. It has been argued that investor-owned hospitals provide as much uncompensated care as private voluntary hospitals do. However, this finding is conditional upon location, Investor-owned hospitals tend to locate in communities with less demand for charity care. An investigation of the locational choices of investor-owned hospitals is well beyond the scope of our analysis, but an argument can be made that the amount of community dividends provided by a tax-exempt hospital should be at least equal to the value of the tax subsidy plus the amount of community dividends provided by an investor-owned hospital in a similar market.
As a policy matter, it is appropriate to consider methods for the revocation of tax-exempt status. Hospitals that do not provide community benefits sufficient to balance their tax subsidies should not receive the subsidies. The policy could be changed in a variety of ways. One approach would be to revisit the tax codes and to define standards for tax exemption more narrowly and explicitly. A second approach would be to eliminate the entire concept of nonprofit enterprise and to replace it with tax deductions or credits based upon the measurable provision of community dividends. A third approach is to tie specific community dividends more explicitly to specific projects. We have some evidence that state finance authorities implicitly do this when they authorize the issuance of tax-exempt debt for hospitals. One can envision hospitals or other institutions competing for a limited pool of low-cost capital by providing additional community dividends if their projects are approved. In any event, the public's growing concern about the benefits of conferring nonprofit status, and our evidence that a substantial proportion of nonprofit hospitals do not meet an easily measured standard, suggest that it is time to examine the issue seriously.

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NOTES

10. Other tax subsidies include the exemption from sales taxes in some jurisdictions (although not California) and the deductibility of philanthropic contributions to hospitals. Copeland and Rudney, “Federal Tax Subsidies for Not-for-Profit Hospitals,” argue that the sales tax exclusion can have large effects. The philanthropic effect is probably small; see E.A. Sloan et al., “The Demise of Hospital Philanthropy,” *Economic Inquiry* (October 1990): 725–743.


19. We hasten to add that these measures of the demand for uncompensated care need not have a big impact on hospital shortfalls. If there is an implicit “market” for tax subsidies, a hospital with limited demand for charity care may not seek out (or be able to obtain) tax subsidies. The most obvious form of the implicit market for tax subsidies is in the tax-exempt debt market, where the state or local finance authority has the opportunity to tie community dividends to interest rate subsidies. See M. Hassan, G. J. Wedig and M.A. Morrisey, “Conditional Tax Exemption and the Output of Nonprofit Organizations: The Case of Hospital Charity Care” (Working paper, Lister Hill Center for Health Policy, University of Alabama at Birmingham, October 1995).


21. It also may suggest that our imputation of the property tax subsidy may overvalue property in low-income communities.