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DO FIDUCIARY DUTIES CONTAINED IN FEDERAL TAX LAWS EFFECTIVELY PROMOTE NATIONAL HEALTH CARE POLICIES AND PRACTICES?

Nina J. Crimm

INTRODUCTION

Contemporary nonprofit hospitals are big, complicated, and highly regulated businesses. As health providers, both acute care and specialized hospitals must contend with and operate under continuous tensions and pressures. These strains arise as a result of intertwined external and internal factors. Among these factors is the complicated and ever-changing world of medicine, including its ethical, moral, and technological challenges; its research advances; and its progress in treatments. Other components include a hospital's diverse patient population, the patients' physical and psychological care-taking needs, and the asymmetry of information between patients and health care providers. Financial and human resource constraints, cost containment concerns, the regulatory environment, and staffing competence are additional contributing elements. These many considerations have helped to shape not only public health care policies and practices for hospitals generally, but also the policies and practices of each particular hospital.

Every hospital's governing board, entrusted with the development and oversight of many critical overarching hospital policies and practices, undertakes wide-ranging complex governance and corporate

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1 Professor of Law, St. John's University School of Law; L.L.M. in Taxation, Georgetown University (1982); J.D., M.B.A., Tulane University (1979); A.B., Washington University (1972). I wish to thank Daniel S. Strouse for his helpful comments.

The nonprofit hospital may be independent or part of a health care system. While virtually all acute care hospitals have emergency rooms or urgent care facilities, a specialized hospital, such as an eye, ear, nose and throat hospital, may or may not have such facilities.

2 Henry B. Hansmann, The Role of Nonprofit Enterprise, 89 Yale L.J. 835, 866 (1980) (stating that often patients do not have the required knowledge to question the care they receive).
management decisions and actions.\textsuperscript{3} For each of these tasks, the governing board, both as a group and individually, stands ultimately accountable for the nonprofit hospital to a broad spectrum of stakeholders or constituents.\textsuperscript{4} The complexity of a governing board's accountability is accentuated by a common hospital governance structure, atypical of most industries in the § 501(c)(3) sector.\textsuperscript{5} Through sharing and delegation arrangements, the institutional governance structure vests in one of the hospital's major stakeholders, the medical staff, the formal and informal authority over many medical policy matters.\textsuperscript{6} Those governance configurations and relationships poten-

\textsuperscript{3} The governing board is responsible for the formulation of the hospital's mission and goals, as well as the strategies to accomplish them. An extremely critical facet of the board's ultimate institutional responsibilities is the establishment and implementation of policies and procedures that ensure health care will be provided without ethical or moral compromise to patients. See infra note 6 and accompanying text (commenting on the role of a hospital's medical staff over medical care policy matters). Also, the governing board must determine strategies and adopt policies for acquiring adequate and stable financial and human resources, ensuring the integrity of the organization's image, creating performance effectiveness and efficiency expectations and guidelines, and monitoring and overseeing the institution's well being with respect to finances, programs and initiatives. See Berit M. Lakey, Nonprofit Governance: Steering Your Organization with Authority and Accountability (2000).

\textsuperscript{4} Stakeholders of nonprofit hospitals include donors; the public whose tax dollars subsidize them through tax exemptions; patients who have a stake in services received; and physicians, nurses and other employees who have a stake in the services performed. For comment on the formal and informal authority of a hospital's medical staff, see infra note 6. Additionally, the business community and employers, accrediting organizations, and governmental agencies are constituents to whom the hospital is accountable. For discussion of the stakeholders and constituents of hospitals, see Susan Koskoff Glazer & J. Richard Gaintner, Hospital Administrators in an Era of Change and Increasing Responsibility, in Accountability and Quality in Health Care: The New Responsibility 147, 150-51 (Leona E. Markson & David B. Nash eds., 1995).

\textsuperscript{5} While this structure can be viewed as somewhat unique to hospitals, it can be analogized to the institutional structure present at universities where the governing board has the final responsibility for corporate and administrative governance and the faculty has formal and informal authority over many academic matters.

\textsuperscript{6} Typically, the allocation of responsibilities and powers is shared among the governing board, the chief executive officer, and the medical staff, which operates as a separate unit. See Clark C. Havighurst et al., Health Care Law and Policy 596-97 (2d ed. 1998). The medical staff is integral to the hospital and its operations. Its responsibilities are defined by the medical staff bylaws. The medical staff carries out its duties through a variety of committees that focus primarily on the provision of medical care, quality of health care, medical records, ethical issues, credentials of staff, etc. The hospital's governing board includes representation from its medical staff. Normally the medical staff representative will serve as a member of governing board committees that have oversight responsibility for patient care, staffing, physician privileges, and other medical care policy matters. See George D. Pozgar & Nina Santucci Pozgar, Legal Aspects of Health Care Administration 201-04,
tially pose extraordinary challenges and strong support for the hospital's governing board as it fulfills its duty of ultimate responsibility for the functioning of the hospital.\(^7\)

Thus, board members' positions, decisions, actions, and stakeholders create an extensive web of behavioral parameters: moral, social, and legal fiduciary obligations that are perhaps more complex than those applicable to the governing body of almost any other category of tax-exempt § 501(c)(3) organization.\(^8\) The moral and social fiduciary obligations are far more intangible than the legal fiduciary duties. They arise as a result of the fiduciary position itself, regardless of the existence or absence of specific statutes and regulations imposing legal fiduciary duties. These duties of performance are informal expectations or professional norms that internally motivate board members to make decisions and transact hospital business with integrity, honesty, trustworthiness, and in the interests of stakeholders and constituents.\(^9\) The obligations exist among the sitting board members as well as between the governing board and stakeholders and constituents. As a result, each board member is accountable, and must be responsive, to every other board member, the public, patients, medical staff, and government and private regulators.


The governing board's legal responsibility for the operation of the hospital and the provision of patient care was clarified almost forty years ago in Darling v. Charleston Community Memorial Hospital, 211 N.E.2d 253 (Ill. 1965), cert. denied, 383 U.S. 946 (1966). This case held that it is the hospital governing board's responsibility to establish procedures and mechanisms for the medical staff to evaluate, counsel, and where necessary, take action when an unreasonable risk of harm to a patient arises as a result of the medical treatment given by a physician with staff privileges.

The institutional power structure typical of nonprofit hospitals may sometimes trigger competing interests, particularly financial interests. The Internal Revenue Code requires an arm's-length relationship between physicians and hospitals. See I.R.C. § 501(c)(3) (2000) (forbidding private inurement in the earnings of a tax-exempt corporation). But see infra notes 70-71 and accompanying text (suggesting that it would appear that the aims of a medical staff who operate in a § 501(c)(3) hospital environment largely would align with the provision of medical care consistent with the hospital's tax-exempt mission).

The complex accumulation of fiduciary duties for hospital governing bodies results from a continuously changing health care industry and the highly regulated health care environment, as well as the complex web of stakeholders and constituents.

The collection of legal fiduciary duties is established through a multitude of corporation, taxation, labor, and health care laws and regulations. As a result, board members are answerable to regulatory officials vested with oversight authority. Depending upon the nature of a particular decision, accountability is to one or multiple officials, including the state attorney general, the state tax commissioner, local property tax authorities, the state health commissioner, the secretary of state or corporation counsel, Health and Human Services employees, the commissioner of the Internal Revenue Service (IRS), or other government or private authority.

The expansive potential array of existing fiduciary obligations and the multiple levels of officials responsible for fiduciary supervision raises the question of whether more would be better. Because volumes could be written in response to the question, this short essay is narrowly focused on the fiduciary duties created under state nonprofit corporation statutes and federal tax laws.

The essay concentrates first on whether the fiduciary responsibilities of the governing board of a tax-exempt § 501(c)(3) hospital under

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10 Common law principles and doctrines also are involved.
11 For comment on the general fiducial oversight responsibilities of attorneys general, see infra note 36-37 and accompanying text.
12 State tax commissioners generally have oversight responsibilities for granting and monitoring exemptions from state income and sales taxes. These state exemptions largely follow the federal tax exemption determinations.
13 The local tax authority has oversight responsibility for granting and monitoring tax exemptions for property taxes.
14 State health commissioners are generally responsible for determining whether nonprofit hospitals within their jurisdictions comply with numerous state health laws.
15 The secretary of state or corporation counsel monitors corporations' annual reporting documents and supervises the issuance of articles of incorporation.
17 For discussion of general fiduciary oversight responsibilities of the commissioner of the Internal Revenue Service, see infra notes 53-54 and accompanying text.
18 A hospital's governing body is responsible for satisfying accreditation requirements. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a private organization, is the recognized accrediting agency. Albeit not without criticism, "in recognition of the broad acceptance of JCAHO within the hospital segment, . . . under [the] Medicare statute, JCAHO accredited hospitals are deemed to meet most requirements for Medicare certification." See BARRY R. FURROW ET AL., HEALTH LAW 9-10 (2d ed. 2000).
current federal tax laws effectively promotes national health care policies and practices. Then it considers whether expansion of the duties imposed by federal tax statutes would further contribute to the advancement of our health care goals by promoting more publicly beneficial health care policies and practices of § 501(c)(3) hospitals. This issue is especially timely because, once again, Congress is debating whether to expand the IRS’s oversight role over the broad spectrum of tax-exempt § 501(c)(3) charitable organizations and their governing boards. Of particular note, Congress is considering legislation to create a new federal fiduciary duty of care for governing boards of § 501(c)(3) organizations based on a standard similar to the one contained in many state substantive nonprofit corporation statutes. Recent empirical evidence, however, suggests that current moral, social, and legal fiduciary duties suffice to ensure that governing bodies of § 501(c)(3) hospitals already seriously pursue their responsibilities to further their hospitals’ charitable health care missions, and consequently to advance national health care policy. With respect to § 501(c)(3) hospitals, the benefit of the proposed additional federal tax legislation is, therefore, highly questionable. As discussed below, in search of a largely non-existent problem in the § 501(c)(3) hospital industry, the proposed regulatory tool supplies an essentially redundant remedy outside the traditional competencies of the IRS.


21 See infra notes 73-85 and accompanying text.

22 Jill R. Horwitz, Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals, 50 UCLA L. REV. 1345 (2003) (looking at profitable and unprofitable services offered by for-profit, nonprofit, and government hospitals). But see Regina E. Herzlinger & William S. Krasker, Who Profits from Nonprofits?, HARV. BUS. REV., Jan.-Feb.1987, at 93 (presenting an old and much criticized study suggesting that nonprofit hospitals do not contribute to the community sufficiently to warrant tax subsidization). For further discussion of Professor Horwitz’s empirical study, see infra notes 65-67 and accompanying text.
PUBLIC HEALTH CARE POLICY -- MISSIONS OF HOSPITALS

There is no one formal national public health care policy. Extracting from the rhetoric of public debate and state and federal legislation, it appears that the overall vision for health care is to strive to deploy medical resources in a rational manner in order to maximize treatment and care benefits in the best interests of patients and to advance medical science education and innovation. To carry out this apparent goal, the basic aims of any nonprofit or for-profit hospital are to provide "its" patient population access to health care, and to ensure patients' security and best interests through the delivery of ethical medical care and quality treatment. These objectives incorporate economic, social, and moral notions. In this regard, the more prevalent contemporary nonprofit hospital \(^{23}\) distinguishes itself from its for-profit brethren \(^{24}\) by a dominant ethical, moral, or social motive, \(^{25}\) which plays out through a decidedly public beneficial or charitable purpose. \(^{27}\) The mission may be to advance health care and enhance

\(^{23}\) See INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 232 (2001) (defining quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.").


\(^{25}\) A for-profit hospital is organized and operated to provide medical care to patients, but it intends to earn a profit for distribution to shareholders. Hence, in providing health care, it seeks to accomplish its profit motive through its selection of services and treatments offered and its targeted patient population largely capable of providing compensation for services rendered.

\(^{26}\) See HOWARD L. OLECK & MARTHA E. STEWART, NONPROFIT CORPORATIONS, ORGANIZATIONS & ASSOCIATIONS 16 (6th ed. 1994). The authors write: "[m]otive is the acid test of the right to nonprofit status, in most cases. When altruistic, ethical, moral, or social motives are the clearly dominant ones in an enterprise, that enterprise is nonprofit." \(id\). Thus, the contemporary nonprofit hospital is inevitably publicly beneficial or charitable.

\(^{27}\) State statutes do not uniformly require that a nonprofit organization be organized and operated for charitable or other publicly beneficial purposes. Some state statutes, such as those enacted by Massachusetts and New York, specifically delineate acceptable publicly beneficial purposes. \(But see, e.g., CAI. CORP. CODE \(\S\) 5111 (West 1990 & Supp. 2004). Some state statutes, such as those enacted by Massachusetts and New York, specifically delineate acceptable publicly beneficial purposes. MASS. GEN. LAWS ANN. ch. 180, \(\S\) 4(a)-(n) (West 1998); N.Y. NOT-FOR-PROFIT CORP. ACT \(\S\) 201(b) (McKinney 1997). Other states are less specific and, indeed, may specify only that the nonprofit corporation's activities must be lawful.
service delivery through resident training programs, research initiatives, implementation of costly and "state of the art" medical technology, unprofitable treatments and medical services, care of broad and diverse patient population, including indigents, or a combination of these.28

Because the hospital’s governing board incorporates social and ethical notions into the nonprofit hospital’s mission to a greater extent than a proprietary hospital, it struggles with a variety of additional tensions and pressures. Although these challenges would suggest that states’ substantive nonprofit laws would employ a higher standard in measuring whether nonprofit hospital governing boards satisfy their legal fiduciary duties, generally this is not the case.

STATE LAWS ESTABLISHING GOVERNING BOARD’S FIDUCIARY DUTIES IN MANAGING NONPROFIT HOSPITALS’ AFFAIRS

Our federal system vests authority within the states to enact and enforce substantive laws on the formation, operation, termination, and other aspects of nonprofit organizations. Because essentially all nonprofit acute care and specialty hospitals are formed under state laws as corporations rather than as trusts,29 discussion here is confined to incorporated nonprofit hospitals and state laws applicable to the fiduciary duties of governing boards in managing such hospitals’ affairs.

During each stage of a corporation’s existence – formation, operation, and termination – the governing board, as its entrusted pilot, must make innumerable decisions on a variety of matters. Repeatedly through the operating life of a hospital its board defines the hospital’s long- and short-range institutional goals including: the potential community of patients to serve and the types of health care service and

E.g., REVISED MODEL NONPROFIT CORPORATION ACT, § 3.01(a) (1987) (hereinafter RMNCA).

28 Indeed, as one scholar’s recent empirical study has demonstrated, although for-profit hospitals serve seemingly similar functions and social needs, their behaviors are quite different. See Horwitz, supra note 22, at 1366-76.

29 See ARTHUR F. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 103, 107 (2d ed. 1988). Although most nonprofit organizations today are formed as corporations, some are organized as charitable trusts governed by state common law.

The minimum fiduciary standards for members of governing boards of incorporated nonprofits are more lenient than for trustees of charitable trusts. The fiduciary duty standards of directors of nonprofit corporations have evolved to now generally resemble those of directors of for-profit corporations. See Horwitz, supra note 22, at 1380-81; Evelyn Brody, The Limits of Charity Fiduciary Law, 57 MD. L. REV. 1400, 1426-27 (1998).
treatment priorities; engages in strategic planning; identifies appropriate allocations of financial resources to services; and ensures that hospital fund balances (that is, profits) do not inure to the private benefit or gain of any person. The board and its administrative and medical staff delegates determine procedures for hiring and evaluating performance of administrators and staff personnel. The governing board plans means of raising capital and operating funds, oversees assets and financial dealings, and ensures compliance with all laws, regulations, and accreditation standards. Perhaps one of the most important functions of a hospital’s board is its responsibility to patients, particularly through its oversight of quality of care delivery standards and its development, and delegated institutionalization, of ethical and moral accountability initiatives. A board also may be confronted with deciding whether to dissolve its nonprofit hospital. In that event, it again confronts a range of decisions, such as the appropriate structure (merger, consolidation, conversion to for-profit status, etc.), the proper valuation of assets, and how to ensure dedication of hospital assets for acceptable charitable purposes.

Such decisions unequivocally are enormously important to the institution. As a result, most states have promulgated rules designed to provide behavioral parameters for board members in their fiduciary decision-making roles. While these fiduciary duty statutes are not

30 The “nondistribution constraint” on hospital profits is a main feature of the nonprofit organizational structure. See, e.g., N.Y. NOT-FOR-PROFIT CORP. ACT § 204 (McKinney 2004). Organizing documents of the nonprofit corporation provide for organizational adherence to the “nondistribution constraint.” See MARION R. FREMONT-SMITH, GOVERNING NONPROFIT ORGANIZATIONS 152 (2004). Two states, Delaware and Kansas, do not have nonprofit corporation statutes. In those states, hospitals are incorporated and operated under business corporation laws, but a provision in their articles of incorporation must affirm that they are not formed for private profit and are constrained from distributing profits for private benefit. See id. at 152, 514-17. All other states and the District of Columbia have enacted some form of nonprofit corporation act. Seven states adopted the American Bar Association’s (A.B.A.’s) Model Nonprofit Corporation Act, and currently almost two dozen states have enacted laws that essentially parallel the A.B.A.’s 1987 RMNCA. See id. at 152. The RMNCA contains a nondistribution constraint provision. RMNCA, § 13.01 (1987).

The nondistribution constraint provision does not prohibit the payment of reasonable compensation to directors, officers, and personnel. See, e.g., N.Y. NOT-FOR-PROFIT CORP. ACT § 515(b) (McKinney 2004).

31 Statutes in all but four states also require that at termination of the nonprofit hospital, liquid and nonliquid assets cannot be diverted to benefit individuals. See FREMONT-SMITH, supra note 30, at 319. These statutes comport with the concept of the “nondistribution constraint” imposed on nonprofit organizations during their operational existence. See infra note 30 and accompanying text.

32 As of January 1, 2003, forty-eight states had codified some version of the duty of loyalty and forty-three states had codified some form of the duty of care. See
uniform among the states, all aim specifically to ensure directors’ adherence to the organizational mission and to protect stakeholders and institutional well-being and security. They have the secondary socially valuable effect of safeguarding the reputation of the nonprofit hospital industry and the broader nonprofit sector. Legislatures, courts, state enforcement officials, and scholars frequently categorize the fiduciary duties broadly as duties of loyalty and care.

The duty of loyalty has two main components. The first prong is the obligation of obedience. It requires governing board members to fulfill the particular dictates of the nonprofit hospital’s charter and to refrain from substantial deviation from the institutional purposes stated in its governing documents. In other words, there is mission accountability. The second component is the obligation of each mem-

FREMONT-SMITH, supra note 30, at 207, 218.

The New York Not-For-Profit Corporation Act is illustrative. Sections 204, 508 and 515 of the New York Not-For-Profit Corporation Act permit a nonprofit corporation to earn profits but constrain their use to maintaining, expanding, or operating the organization’s lawful activities, and they otherwise prohibit distribution of organizational profits. N.Y. NOT-FOR-PROFIT CORP. ACT §§ 204, 508, 515 (McKinney 2004). The duty of loyalty is distinctly presented in § 715, which restricts conflict of interest transactions and contracts between the nonprofit corporation and its directors. Similarly, § 716 prohibits organizational loans to fiduciaries. Other provisions set forth additional administrative responsibilities of governing board members, including prudent investment decisions (§ 512), asset purchases (§ 509), and investment management delegation (§ 514). The standard by which directors are measured in upholding their fiduciary duties is codified in § 717(a). That provision requires that each governing body member discharge all duties in “good faith and with that degree of diligence, care and skill which ordinarily prudent men would exercise under similar circumstances.” Id.

Some similar provisions are found in the RMNCA, which has been adopted in numerous states. See supra note 30. In particular, § 13.01 of the RMNCA constrains distribution of income and assets; § 8.31 imposes conflict of interest rules, and § 8.30(a) delineates the fiduciary duty of care standard of “good faith,” “care that an ordinarily prudent person in a like position would exercise under similar circumstances,” and belief that the decision or action is “in the best interests” of the nonprofit corporation. As a general matter, the good faith and ordinary or reasonable prudence standard subjects governing board members to personal liability for ordinary negligence, the same standard applicable to directors of business corporations. Nonetheless, some courts have held members personally liable only for gross negligence or willful misconduct. Compare Stern v. Lucy Webb Hayes Nat’l Training Sch. for Deaconesses and Missionaries, 381 F. Supp. 1003 (D. D.C. 1974) (holding that trustees breached their fiduciary duties in failing to supervise the management of the institution’s investments) with Beard v. Achenbach Mem’l Hosp. Ass’n, 170 F.2d 859 (10th Cir. 1948) (holding that directors’ use of corporation funds were not grossly negligent and did not constitute a breach of their duties as fiduciaries).

33 Some scholars and courts have categorized this obligation to carry out the charitable mission of the hospital and not to permit substantial deviation from its charitable purposes as a separate duty of obedience. See, e.g., DANIEL L. KURTZ, BOARD LIABILITY: GUIDE FOR NONPROFIT DIRECTORS 84-85 (1988).
ber to deal fairly and with undivided loyalty toward the nonprofit hospital. Loyalty accountability encompasses the necessity to place the corporation’s financial interest above personal interests when a conflict of interest arises.\textsuperscript{34}

Moreover, each governing board member must discharge all decisions and actions, as well as their delegation, with due care. State laws codify the minimum threshold standard of this duty of care. Statutes typically require a fiduciary to exercise all retained and delegated governance and managerial responsibilities in good faith, in the nonprofit organization’s best interest, and with the care of an ordinarily prudent person in a similar position under like circumstances.\textsuperscript{35}

State laws provide for monitoring of compliance and for punishment in the event of noncompliance with these affirmative duties. Authority to supervise fiduciaries’ conformity with these laws and to take action in the event of a breach commonly resides in the state attorney general.\textsuperscript{36} States generally permit the attorney general to redress the breach by bringing a court action against a board member to compel an accounting for the decision or transaction, to cancel con-

\textsuperscript{34} See Horwitz, supra note 22, at 1380; Brody, supra note 29, at 1427-28. The nonprofit corporate duty of loyalty permits a director of a nonprofit corporation to enter into transactions with the nonprofit organization as long as the personal interest is fully disclosed to disinterested directors and the interested director abstains from the decision-making process with respect to the problematic transaction. By comparison, if the organizational form is a trust, the common law fiduciary duty of loyalty imposes a strict prohibition against a trustee’s self-dealing in transactions where conflicts of interest arise, regardless of the potential financial fairness or favorableness to the trust. See Horwitz, supra note 22, at 1380-81; Brody, supra note 29, 1419-22. The trust settlor, however, can modify this absolute prohibition in the trust instrument. See id. at 1420.

\textsuperscript{35} See, e.g., RMNCA § 8.30(a). The standard of care established by state law, either business corporation or nonprofit corporation statutes, is less stringent than the standard of care that a trustee owes to a trust. Under trust laws, the duty of care requires a trustee to behave with respect to the affairs of the trust as would a prudent person dealing with his own property. See Brody, supra note 29, at 1422; Horwitz, supra note 22, at 1381.

Pursuant to the “business judgment rule” invoked by many state courts, a member of the board is protected from liability arising from errors in judgment if he or she acts in good faith, with honesty, without divided loyalty, and in the decision-making process has taken appropriate steps to be informed of the facts relevant to the decision. See, e.g., Alpert v. 28 Williams St. Corp., 473 N.E.2d 19, 26 (N.Y. 1984); Auerbach v. Bennett, 393 N.E.2d 994, 1000 (N.Y. 1979); Stern, 381 F. Supp. at 1013-15; Achenbach Mem’l Hosp. Ass’n, 170 F.2d at 862.

\textsuperscript{36} See FREMONT-SMITH, supra note 30, at 305-14. See, e.g., N.Y. NOT-FOR-PROFIT CORP. ACT §§ 112, 720(b) (McKinney 1997) (delineating attorney general’s power to maintain actions and proceedings). The legal literature includes many criticisms on, and explanations of, the insufficiency of monitoring and enforcement of these laws by attorneys general. See, e.g., Nina J. Crimm, Why All is Not Quiet on the “Home Front” for Charitable Organizations, 29 N.M. L. REV. 1 (1999).
veyances or assignments of institutional assets, to enjoin unlawful conveyances or assignments of organizational property, to reimburse the corporation, and to replace the wrongdoer.37

Many board decisions and actions frequently relate to compliance with multiple regulatory provisions beyond state substantive fiduciary duty laws, including federal, state, or local tax laws, state and federal solicitation statutes, state health laws, Medicare laws, and accreditation rules. Consequently, another official or officials may also have oversight responsibility. One such official is the commissioner of the IRS, who is charged with determining nonprofit hospitals’ initial and continuous deservedness of tax-exempt status under I.R.C. § 501(c)(3) and with enforcing federal tax laws that contain some fiduciary duties correlative to those described above under state statutes.

FEDERAL INCOME TAX EXEMPTION

Almost eighty years before Congress enacted the first federal tax exemption for charitable organizations in 1894,38 the U.S. Supreme Court recognized health care delivery as inherently charitable in nature, and hospitals as eleemosynary organizations.39 As a result, nonprofit hospitals became, and continue to be treated as, presumptively eligible for tax exemption under I.R.C. § 501(c)(3).40 Nonetheless, each hospital as an entity must qualify for tax-exempt status pursuant to I.R.C. § 501(c)(3), which requires the hospital, regardless of its place of formation and operation, to be:

organized and operated exclusively for religious, charitable, scientific, . . . or educational purposes . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial activities of which is carrying on propaganda, or otherwise attempting, to influence

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37 See Edith L. Fisch et al., Charities and Charitable Foundations 549-50 (1974). See, e.g., N.Y. Not-For-Profit Corp. Act §§ 719, 720 (McKinney 1997). Additionally, an attorney general can bring actions to dissolve the nonprofit corporation or to restrain corporate activities. See, e.g., id. at § 112.

38 Tariff Act of Aug. 27, 1894, ch. 349, § 32, 28 Stat. 509, 556 (codified as amended at I.R.C. § 501(c)(3)). The first federal tax exemption for corporations “organized and operated exclusively for religious, charitable or educational purposes, no part of the net income of which inures to the benefit of any private stockholder or individual” was enacted several years later. Corporation Tax Act of 1909, ch. 6, § 38, 36 Stat. 11, 113 (1909).


40 Essentially all acute care nonprofit hospitals are tax-exempt under I.R.C. § 501(c)(3). See Horwitz, supra note 22, at 1383.
legislation . . . , and which does not participate in, or intervene in . . . any political campaign.\textsuperscript{41}

The focus of the statute is on the institution's mission and activities. Compliance with the statute is the responsibility of the hospital's governing board. In that regard, the institutional activities reflect the board's adherence to that duty. Consequently, the statute also implicitly functions to establish behavioral parameters for decisional and transactional responsibilities of board members in their capacities as fiduciaries.\textsuperscript{42} Each board member must act unwaveringly to ensure that the hospital maintains its § 501(c)(3) tax-exempt status.

For purposes of this essay, the two critical criteria of the statute are the "charitable purpose" requirement and the private inurement prohibition.\textsuperscript{43} Central to qualification for tax exemption is the statutory requirement that the hospital be "organized" and "operated" exclusively for "charitable" purposes.\textsuperscript{44} The charitable purpose concept reaches far beyond the notion that a nonprofit corporation must be formed and operated for lawful purposes and that its profits cannot inure to the private benefit of any individual. According to the IRS, a "charitable" hospital must benefit the community by the promotion of health care to a sufficiently broad population.\textsuperscript{45}

\textsuperscript{41} I.R.C. § 501(c)(3) (2000).
\textsuperscript{43} This essay does not discuss additional components of the statute, namely restrictions on political activities (campaigning and lobbying). The § 501(c)(3) statutory restrictions on political activities, however, implicate the fiduciary duty of loyalty. If a board allows hospital representatives to engage in impermissible levels of political activities on behalf of the hospital, even if the intention is specifically to further the hospital's mission and goals, such actions would be illegal under § 501(c)(3). Because state laws forbid corporate charters to allow illegal acts, a board member cannot permit such acts without breaching the duty of loyalty. No standard of care is contained in § 501(c)(3) with respect to the political activities limitations; however, U.S.C. § 4955, enacted in 1987 specifies the standard as one of knowledge. I.R.C. § 4955(a)(2) (2000), added by Pub. L. No. 100-203, 101 Stat. 1330, § 10712(a) (1987).
\textsuperscript{44} If the hospital is a teaching hospital affiliated with a university and its tax-exempt status is based on the university's educational tax exemption, then the board must act to ensure compliance with the educational purpose permitted under § 501(c)(3).
\textsuperscript{45} The meaning of the term "charitable" for § 501(c)(3) purposes lacks precision and has always been considered to evolve with societal changes and needs. The IRS has intentionally refrained from assigning a fixed and immutable definition. See Legislative Activity by Certain Types of Exempt Organizations: Hearings before the
Commentators have suggested that the implicit fiduciary obligation with respect to the charitable purpose centerpiece is the duty of loyalty, and in particular the obligation to formulate and obey the dictates of the organization’s charitable charter. As a result of this obligation, in crafting the hospital’s particularized health care goals and the contours of its policies and practices, the hospital governing board cannot substantially deviate from furthering its ethical, social, and moral responsibilities to the community in which it operates. These concerns must be reflected in shaping the board’s many specific decisions involving the hospital’s long- and short-range goals: the

*House Comm. on Ways and Means, 92d Cong., 5 (1972) (Statement of Edwin S. Cohen, Assistant Secretary of the Treasury for Tax Policy) (“We have tried to avoid interpreting the word ‘charitable’ in a fixed, immutable fashion. As the courts have done in many nontax settings, we have tried to give it a meaning that changes and expands as the needs of society change and expand”). Nonetheless, the IRS has issued several important revenue rulings informing that a “charitable hospital” requires it to benefit the community (“community benefit standard”) by the promotion of health care to a broad population. Until Medicare and Medicaid, the community benefit standard required a hospital to be “operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay.” Rev. Rul. 56-185, 1956-1 C.B. 202. After the government instituted Medicare and Medicaid, Treasury revised the community benefit standard from one based on charity care to a standard requiring a hospital to operate an emergency room open to nonpaying patients, to possess a governing board drawn from the general community, and to have an open (nondiscriminatory) medical staff, and to provide nondiscriminatory treatment to Medicare and Medicaid patients. Rev. Rul. 69-545, 1969-2 C.B. 117. After release of Revenue Ruling 69-545, the Circuit Court of the District of Columbia reiterated the notion that the meaning of “charitable” must evolve with the “changing economic, social and technological” realities of society. E. Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278, 1288-90 (D.C. Cir. 1974), *vacated on other grounds*, Simon v. E. Ky. Welfare Rights Org., 426 U.S. 26 (1974). Accordingly, with the growth of ambulatory and specialized hospitals, in 1983 Treasury refined the requirements of Revenue Ruling 69-545 to permit hospitals without emergency rooms to show that the need for emergency services was adequately provided in the community. Rev. Rul. 83-157, 1983-2 C.B. 94. Revenue Ruling 69-545, as amplified by Revenue Ruling 83-157, remains the established community benefit standard for hospitals today. For a discussion of the community benefit standard and its deficiencies with respect to hospitals, see Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 364-67 (1991).

In addition to the community benefit standard, public policy prohibiting discrimination based on race or national origin has been applied to determine educational institutions’ deservedness of § 501(c)(3) tax-exempt status. Bob Jones Univ. v. United States, 461 U.S. 574, 590-600 (1983); Green v. Connally, 330 F. Supp. 1150 (D.D.C 1971), *aff’d sub nom.* Coit v. Green, 404 U.S. 997 (1971). The law remains unclear as to whether that public policy should be applied to other institutions, such as hospitals, in determining their tax-exempt status.

patient population to serve; the types of health care services and treatment priorities to offer; the basis on which to offer services and treatments, whether on an emergency care basis or exclusively non-urgent care; the extent to allocate support to certain kinds of innovative technology, research, or education; and the procedures and standards for hiring qualified medical staff on a nondiscriminatory basis.\(^\text{47}\) Nonetheless, there is no explicit or implicit standard of care contained in § 501(c)(3) by which to measure whether a board’s behavior satisfies its § 501(c)(3) fiduciary duty of loyalty.\(^\text{48}\) This is where the intangible duties of performance have a role.

The public, patients, medical staff, regulators, and sitting members of the governing board hold each board member to the duties of performance: to make decisions and transact the business of being a charitable entity in the stakeholders’ best interests with integrity, honesty, and trustworthiness. These constituents have the power to judge, and a board member’s failure to satisfy them can result in non-legal sanctions, such as stigmatization, shame, decreased esteem, loss of prestige, and dishonor.\(^\text{49}\) Section 501(c)(3), however, does not provide authority to the commissioner of the IRS to impose tangible punishment on any board member for failure to satisfy the duties of performance. Instead, § 501(c)(3) confines the commissioner’s authority to judging the institution and whether it has sufficient community benefit attributes to retain its tax-exempt status.\(^\text{50}\)

The second requirement of the § 501(c)(3) criteria is the prohibition against private inurement (nondistribution constraint).\(^\text{51}\) Board members are responsible for ensuring that hospital profits do not privately benefit insiders. The duty of loyalty here is apparent, but there is no standard of care contained in the statute. As a result, until 1996 with the enactment of § 4958, the public, patients, and regulators relied on the board to refrain from prohibited private distributions. They could only hold board members to the intangible standards of their duties of performance: integrity, honesty, and trustworthiness. They could only punish by stigmatizing, shaming, and dishonoring the offender. Punishment under § 501(c)(3) for a governing board’s dis-

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\(^\text{47}\) See supra note 45 and accompanying text (discussing the community benefit standard).

\(^\text{48}\) See Simon, supra note 42, at 88.


\(^\text{50}\) See I.R.C. § 501(c)(3) (2000).

\(^\text{51}\) Almost a quarter of a century ago, the scholar Henry Hansmann labeled the § 501(c)(3) private inurement restriction as the “nondistribution constraint.” Hansmann, supra note 2, at 838.
loyalty by failing to ensure satisfaction of the private inurement requirement was confined to an IRS revocation of the hospital’s § 501(c)(3) tax-exempt status.\textsuperscript{52}

The severity of revoking the institution’s tax exemption, the remedy’s failure to deter and punish the responsible wrongdoers, and consequently the commissioner’s hesitancy to impose the remedy, led Congress to enact the I.R.C. § 4958 “intermediate sanctions.”\textsuperscript{53} Congress intended these monetary sanctions, in the form of excise taxes, as a means to punish the actual offenders for relatively minor or isolated incidents of transactions resulting in impermissible financial private benefit to certain parties.\textsuperscript{54} The statute targets two categories of wrongdoers: the individual who allows the impermissible excess benefit to occur (“managers,” including board members)\textsuperscript{55} and the party impermissibly benefited (“disqualified person”). A “disqualified person” includes a person in a position to exercise “substantial

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\textsuperscript{52} A breach of loyalty could lead to an action for personal liability under the state fiduciary duty of obedience, loyalty, and care statutes. See supra notes 32-35 and accompanying text discussing the state fiduciary duty statutes. Breach of state fiduciary duties can result from a board member’s behavior that jeopardizes a nonprofit hospital’s tax-exempt status under federal, state, or local tax laws. See James J. Fishman & Stephen Schwarz, Nonprofit Organizations: Cases and Materials 152 (1995) (discussing the six basic functions of board members), citing William G. Bowen, Inside the Boardroom: Governance and Directors and Trustees 18-20 (1994). The state attorney general typically would be the party to bring an action against the offending board member. See, e.g., N.Y. Not-For-Profit Corp. Act § 720(a) (McKinney 1997).

\textsuperscript{53} I.R.C. § 4958 (1996). Prior to enactment of § 4958, Congress had not envisioned the IRS as a significant overseer of public charities’ governing bodies’ fiduciary responsibilities and behavior. Yet, Congress previously had intended the IRS to perform this role with respect to private foundations’ management. See I.R.C. §§ 4941-4945 (2000).

\textsuperscript{54} Since enactment of § 4958, questions have been raised as to when the IRS will utilize that provision as the only sanction, when it will pursue revocation of tax-exempt status, and when it might undertake both. The Treasury indicated in the Preamble to temporary regulations, which preceded the § 4958 final regulations, that it will publish guidance as to when excess benefit transactions will rise to the level of necessitating revocation of the tax-exempt status of the organization. T.D. 8920, 2001-1 C.B. 654. Although the Preamble listed four general factors that would be considered, the IRS intends to provide more detailed guidance, in part based on experience that it gains as it administers § 4958. The only Tax Court case to date deciding § 4958 issues is Caracci v. Commissioner, 118 T.C. 379 (2002) (ruling that each of the disqualified persons was jointly and severally liable for the excise taxes under § 4958 due to the excess benefits resulting from an asset transfer). The IRS is currently working on its project to give guidance. See Fred Stokeld, Guidance to Address Revocation, Excise Taxes, Says IRS Official, 104 Tax Notes 470 (2004).

\textsuperscript{55} Members of the governing body are organizational managers for purposes of the statute. I.R.C. § 4958(f)(2) (2000).
influence" over the affairs of the § 501(c)(3) organization, such as a member of the governing board, officers, or their delegates.

Section 4958 specifies a standard by which the IRS can judge whether a board member has satisfied his fiduciary responsibilities to the hospital in his decision-making processes. It is based on the board member’s "knowing participation" in approving a transaction that economically produces "excess benefits" to any disqualified person. Therefore, if a board member knowingly approves a transaction that results in financial self-dealing or in other private inurement to himself, another board member, or other insider, he breaches a § 4958 statutory duty of loyalty to the hospital.

56 The statutory definition of "disqualified persons" includes (1) persons in a position to have "substantial influence over the organization's affairs, (2) family members of persons in positions of "substantial influence" over the affairs of the organization, and (3) entities that are thirty-five percent controlled directly or indirectly by all such persons. I.R.C. § 4958 (f)(1)(2000). Per Treas. Reg. § 53.4958-3(c)(1)-3(g) (2002), Ex. 3, individuals on the governing body entitled to vote on organizational matters are considered per se to have "substantial influence" over the organization's affairs. Section 4958 applies to both § 501(c)(3) public charities and § 501(c)(4) organizations. I.R.C. § 4958 (e)(1) precludes application to private foundations, where the self-dealing rules of I.R.C. § 4941 apply.

57 Knowing participation requires three criteria and includes affirmative action, silence, or inaction where there is a duty to speak or act. Treas. Reg. § 53.4958-1(d)(3) (2002). According to the Treasury regulations, knowing participation results if the individual (1) has actual knowledge of sufficient facts so that the transaction would be an impermissible "excess benefit" transaction based only on those facts; (2) is aware that the transaction may violate § 4958, and (3) either negligently fails to reasonably attempt to determine if the transaction is an impermissible "excess benefit" transaction or is actually aware that it is such an impermissible "excess benefit" transaction. Treas. Reg. § 53.4958-1(d)(4) (2002). See infra note 58 for a definition of an "excess benefit" transaction.

58 An "excess benefit transaction" is one in which the economic benefit provided directly or indirectly by an applicable exempt organization to or for the use of a "disqualified person" exceeds the consideration received by the tax-exempt organization in the transaction. I.R.C. § 4958(c)(1) (2000); Treas. Reg. § 53.4958-4(a)(1) (2002).

59 Separate excise taxes may be imposed on a disqualified person and on each participating organization manager under I.R.C. § 4958(a). With respect to an organization manager, an excise tax of ten percent of the excess benefit amount may be imposed, up to a limit of $10,000 per excess benefit transaction. I.R.C. § 4958(a)(2), (d) (2000); Treas. Reg. §§ 53.4958-1(d)(7), (8) (2002). Two tiers of excise taxes may be imposed on a disqualified person who has entered into an excess benefit transaction. A disqualified person is first subject to a tax of 25% of the excess benefit, and if not corrected timely, a 200% excise tax can be imposed on the uncorrected portion of the excess benefit. I.R.C. §§ 4958(a)(1), (b), (f)(6) (2002); Treas. Reg. §§ 53.4958-1(c)(1)-1(c)(2)(i) (2002).

Now, for the same transgression, a wrongdoer might become personally liable for infractions of both state statutes and federal tax law. A board member's decision to permit an "excess benefit" transaction is also a decision that commonly
Currently there are few federal tax statutes that impose intermediate sanctions on board members of a § 501(c)(3) "public charity," including a hospital, who breach fiduciary duties other than the duty to loyally prohibit private inurement.\(^{60}\) The commissioner of the IRS has no recourse directly against a board member who is otherwise financially disloyal, fails to appropriately pursue the charitable goals and mission, or is deficient in devising plans to ensure quality services in the best interest of beneficiaries.

While the media has reported scandals in the nonprofit sector pertaining to governing boards' breaches of fiduciary duties, the vast majority has been for financial self-dealing and private inurement rather than for non-financial deficiencies, such as failures to define short and long range institutional goals in order to carry out or move the charitable mission of the organization forward.\(^{61}\) Indeed, drawing on newspaper reports of scandals in charities between 1995 and 2002, scholar Marion Fremont-Smith's recent empirical study revealed that of a total of fifty-four reported instances of breaches of fiduciary duties by governing board members and corporate officers, only five involved a failure to carry out the organization's charitable mission.\(^{62}\) In each of those five cases, officers, and not board members, of the charitable organization failed to pursue charitable activities with government funds provided by the Department of Housing and Urban Development.\(^{63}\) Not one case of breach of loyalty for failure to carry out the organization's charitable purpose involved a hospital.\(^{64}\) There-

violates state statutory fiduciary duties of loyalty, obedience, and care. While the standard and punishment under the federal tax statute are uniform and jurisdiction to punish attaches regardless of the offender's domestic location, the standard and power to punish a wrongdoer and the remedy under state fiduciary laws depend on the state.\(^{60}\)

Section 4955 provides excise taxes on managers who knowingly and willfully permit the § 501(c)(3) organization to expend funds for participation or intervention in a political campaign on behalf of a candidate for public office. I.R.C. § 4955 (2000).\(^{61}\) See Marion R. Fremont-Smith & Andras Kosaras, Wrongdoing By Officers and Directors of Charities: A Survey of Press Reports 1995-2002, 42 EXEMPT ORG. TAX REV. 25, 25 (2003) (identifying "152 incidents involving civil or criminal wrongdoing, with six of them in both categories ... 104 that involved criminal activity, and fifty-four involved breaches of the duties of loyalty and care — self-dealing, failing to carry out the mission of the charity, and negligent management of assets.").\(^{62}\) \(^{63}\) Id.\(^{64}\)

Five cases involved a hospital or hospital foundation. All five of those concerned misuse of funds by officers, such as corporate president or executive director, and not by a board member. Some of the cases involved criminal misappropriation of funds, including charges of theft, fraud, and money laundering. The one case reported as involving an operating hospital concerned the president of Logan General Hospital in West Virginia. He was charged with diverting hospital funds for a failed
fore, with respect specifically to § 501(c)(3) hospitals, should there be concern that governing boards are failing to adequately and appropriately define and pursue the hospitals' charitable purposes? The question becomes, should Congress provide the IRS with authority to hold fiduciaries personally liable for such failures?

**DO FIDUCIARY DUTIES CONTAINED IN FEDERAL TAX LAWS EFFECTIVELY PROMOTE NATIONAL HEALTH CARE POLICIES AND PRACTICES?**

The fact that the commissioner of the IRS lacks plenary power over hospital board members to regulate their fiduciary behavior may not be especially troubling. A recent empirical study by Professor Jill R. Horwitz supports the notion that nonprofit hospitals' governing boards make health care policy and practice decisions that do advance their hospitals' charitable health care missions. After dismissing as too narrow the much touted "uncompensated" patient care financial measure of community benefit, Professor Horwitz examines the for-profit hospital venture, as well as fraud, money laundering, and failure to withhold payroll taxes. See id. at 41.

Horwitz, supra note 22. Professor Horwitz also found that, consistent with "the theory that government hospitals are hospitals of last resort," they generally provide more unprofitable health care services to indigent and underinsured patients than nonprofit hospitals. Id. at 1364.

Several years ago, I suggested that an evolving health care world calls for a broader interpretation of the meaning of "charitable" for § 501(c)(3) exemption purposes than "charity" care or "uncompensated" medical care, the "community benefit" standard on which the IRS, courts, and some commentators concentrate. Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-For-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 B.C. L. REV. 1 (1995). See supra note 45 (discussing the “community benefit” standard. Although I believe that narrow vision of community benefit is misplaced, recently a number of class action cases have been filed claiming that named hospitals do not deserve § 501(c)(3) tax-exempt status for lack of providing “uncompensated care.” See Fred Stokeld, *More Nonprofit Hospitals Sued*, 104 TAX NOTES 902 (2004) (reporting on forty-four class action lawsuits in twenty-three states claiming that the hospitals failed to fulfill their obligations to provide charity care under § 501(c)(3)). For further discussion of non-profit hospital class action litigation and a collection of current cases, see http://www.nfllitigation.com.

The empirical literature has utilized strikingly different definitions of "uncompensated" care. Some studies include only care provided to poor and uninsured patients, while numerous studies also count care given to insured patients for which the charges eventually prove to be uncollectible bad debt. See, e.g., Frank Sloan, *Not-for-Profit Ownership and Hospital Behavior*, in 1B HANDBOOK OF HEALTH ECON. 1141 (Anthony J. Culyer & Joseph P. Newhouse eds. 2000) (typically defining uncompensated care as the sum of charity care and bad debt); U.S. GENERAL ACCOUNTING OFFICE, NONPROFIT HOSPITALS AND THE NEED FOR BETTER STANDARDS FOR TAX EXEMPTION, H.R. DOC. NO. 90-84, at 2 (1990), reprinted in MEDICARE &
types of medical treatments and services offered by hospitals. In particular, Professor Horwitz finds that nonprofit hospitals, virtually all tax-exempt under § 501(c)(3), generally offer more unprofitable services to patients than equivalent proprietary hospitals. She asserts that the difference in “hospital purposes likely drive these results.”

Consistent with Professor Horwitz’s assertion and the logical extension of her findings is the notion that the nonprofit hospitals’ governing boards are consciously piloting the hospitals to satisfy the dictates of their hospitals’ charitable charters and to comply with the nondistribution constraint. One can speculate that, at least in part, the governing board’s efforts result from the special institutional governance structure of § 501(c)(3) hospitals. As a result of that structure of shared and delegated authority, the medical staff can present challenges to the governing board where provoked by behavior perceived as exceeding acceptable power boundaries and by acts of financially entrepreneurial physicians who must be restrained from usurping control of the hospital. Nonetheless, even while guarding

MEDICAID GUIDE ¶ 38,608; Frank A. Sloan et al., Identifying the Issues: A Statistical Profile, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 16 (Frank A. Sloan et al. eds., 1986). Thus, dependable industry-wide comparative data on the extent of indigent care provided by nonprofit and for-profit hospitals is difficult to attain. Reliance on “uncompensated” care as the primary measure of community benefit is inappropriate for other reasons. The amount of “uncompensated” care can vary depending upon the location of a hospital, including its proximity to a government hospital, its urban or rural setting, etc. See Theodore R. Marmor et al., A New Look at Nonprofits: Health Care Policy in a Competitive Age, 3 YALE J. ON REG. 313, 337 (1986). Moreover, many other factors can impact the amount of “uncompensated” care that a hospital is willing and able to provide, such as a hospital’s commitment to financially support its community educational function, its resident program, its acquisition of state-of-the-art technology, its research, and other functions beneficial to the community.

Professor Horwitz suggests, and I agree, that providing emergency room or other care to the indigent “should not be the sole, or even the primary, measure” of community benefit. Horwitz, supra note 22, at 1358. She points out that emergency room treatment may not be the “best method, or even a good method, of making and keeping people healthy.” Id. That would be a goal to which our nation’s health care policy should aspire! Certainly, it is accessibility to quality medical care that is important.

Horwitz, supra note 22, at 1376.

Professor Evelyn Brody suggested that the nondistribution constraint is unnecessary for remedying the asymmetric informational position of patients. Evelyn Brody, Agents Without Principals: The Economic Convergence of the Nonprofit and For-Profit Organizational Forms, 40 N.Y.L. SCH. L. REV. 457, 463-65 (1996). The restriction is important, however, to ensure that governing boards dedicate organizational assets to further the exempt mission.

See supra notes 5-7 and accompanying text.

To comport with § 501(c)(3), the IRS takes the position that the physicians must maintain an arm’s-length relationship with the hospital so that the charitable
its authority and prerogatives over medical care policy matters, the medical staff may actually be an active and cooperative force that facilitates the governing board’s decision-making and transactional processes of shaping and pursuing the hospital’s health care mission.  

The medical staff’s presence also might serve as a mechanism to trigger the attention of the governing board to its moral and social fiduciary duties of performance.

Moreover, it is plausible, but unproved, that the governing board’s conscious effort is motivated partially by the federal tax laws’ fiduciary duty of loyalty. It is a difficult, if not an improbable, task to discern the extent to which the fiduciary duties under federal tax laws, as separate from those under state nonprofit laws, influence decision-making processes of hospital board members. In other words, do the fiduciary responsibilities that result under federal tax laws add value that promotes nonprofit hospital boards’ efforts to construct policies and achieve practices that advance “charitable” health care purposes in alignment with national health care goals? Perhaps the answer lies in an empirical study constructed to compare decision-making patterns of hospital board members in the states whose laws do not contain a nondistribution constraint or a public or community benefit purpose requirement with boards’ behavioral patterns in the states that expressly embrace the requisites. Absent such a study, the question remains unanswered.

At this point what is important is that typically § 501(c)(3) hospital boards take their fiduciary responsibilities seriously. If the outcomes of Professor Horwitz’s study can be used as a measure of the behavior of nonprofit hospital boards, § 501(c)(3) hospital boards do further the basic goals of public health care policy by aggressively pursuing achievement of their hospitals’ decidedly public beneficial goals and purposes.


Perhaps today with physicians’ awareness of the tax-exempt rules, fewer financially entrepreneurially inclined physicians join the medical staff of a § 501(c)(3) hospital. In that event, a medical staff who affirmatively chooses to operate and carry out its functions in the § 501(c)(3) hospital environment likely has medical care interests and goals largely aligned with the board-determined hospital goal and priorities. (The alignment should result from the fact that the physicians affirmatively have sought practice privileges with the knowledge that the hospital is a § 501(c)(3) organization. That is not to say that there may not be financial tensions and frictions.).

It would be logical that the state nonprofit corporation laws, which are founded upon the same charitable notions and common law of charitable trusts as those on which § 501(c)(3) is based, would generate the same or similar results.
This result is particularly significant now that Congress is debating again the oversight role that the IRS should have over charitable organizations. In its June 22, 2004, White Paper, the staff of the Senate Finance Committee proposed legislative reformation to expand the IRS’s authority over governance processes of the broad spectrum of § 501(c)(3) organizations’ governing boards. The White Paper fails to distinguish between highly-regulated industries, such as hospitals, and less regulated industries, such as soup kitchens or museums. Consequently, without adequate consideration, it proposes to burden all industries equally with more regulation, regardless of whether a particular industry lacks or engenders serious need of a specific regulatory constraint or whether a proposed provision is essentially duplicative of existing laws now administered by the states.

Of particular note for this essay, the White Paper proposes legislation to create a federal duty of care based on a standard similar to the one contained in many states’ nonprofit corporation statutes. The

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73 See Charity Oversight and Reform: Keeping Bad Things from Happening to Good Charities: Hearing Before the Senate Comm. on Fin., supra note 20. See also supra note 19 (discussing prior periods of Congressional debate of the proper IRS oversight role over charitable organizations).


75 Among the White Paper proposals, IRS oversight of an accreditation program for charitable organizations, five-year reviews of a § 501(c)(3) organization’s deservedness of tax-exempt status, and control over the composition of § 501(c)(3) organizations’ governing boards. Id. at 1, 12-14. The White Paper further suggests legislative reformation to add stricter rules against self-dealing similar to those applied to private foundations, including imposition of excise taxes on offenders. Id. at 3-4. It also proposes legislation to propose certain good governance practices. Id. at 8, 12-14. Some of these good governance practices are duplicative or weaker than those to which some public charities currently voluntarily abide as prescribed by various watchdog organizations or as proposed by state legislatures. For a summary of and citation references to such alternatives, see Michael Anft & Grant Williams, Redefining Good Governance: Charities Make Big Changes to Improve Accountability, CHRON. PHILAN., at 6, Aug. 19, 2004; Michael Anft & Grant Williams, States Propose New Accountability Regulations for Nonprofit Groups, CHRON. PHILAN. 8 (Aug. 19, 2004); Michael Anft & Grant Williams, Nonprofit Accountability and Federal Law: Sources of Information, CHRON. PHILAN. 10 (Aug. 19, 2004); Rachel Emma Silverman, Charities Start to Grade Themselves, WALL ST. J., Aug. 18, 2004, at D1.

Of special note for hospitals, the White Paper proposes the development of standards for review by state and federal authorities of conversions from the nonprofit corporate form to the for-profit corporate form, more stringent self-dealing and excess benefit transaction rules with respect to severance arrangements, and completion of conversion conditioned upon IRS approval. White Paper, supra note 74 at 7.

76 White Paper, supra note 74 at 12. This proposal appears to amount to a backhand way of signaling that states are not effectively enforcing the fiduciary duty of care. See supra note 36 (commenting that critics have suggested that state attor-
proposed provision would require each board member to perform responsibilities in "good faith; with the care an ordinarily prudent person in a like position would exercise under similar circumstances; and in a manner the director reasonably believes to be in the best interests of the mission, goals, and purposes of the corporation." Board members with special skills or expertise would be held to a duty to utilize those skills or that expertise. Federal liability would be imposed personally upon any board member who breaches the duty of care.

In her testimony before the Senate Finance Committee, Professor Evelyn Brody wisely asserted that any legislative reforms should be confined to enhancing the IRS's ability to manage and enforce the tax-exemption regime. Indeed, the primary business and expertise of the IRS is the collection of tax revenues and administration of the rules regarding tax-exempt organizations. Until eight years ago with the addition of I.R.C. § 4958, Congress had empowered the IRS in administering laws and regulations affecting § 501(c)(3) public charities to focus predominantly on the entity and not on the decision-making and transactional processes of the institution's governing board members. To extend the IRS's administration beyond its main competence may be not only inefficient but also an improvident use of its acknowledged deficient and overburdened compliance-monitoring resources.

Moreover, Congress should be mindful that the role of the IRS in administering a federal duty of care similar to the standard contained in state fiduciary laws could be wastefully duplicative of the role of attorneys general in enforcing their state statutes. If weak monitor-
ing and enforcement by state attorneys general is the problem that Congress would seek to remedy by creating a new federally punishable duty of care, it should rethink the approach. In this regard, the staff of the Senate Finance Committee more appropriately proposes to provide funding to states for oversight of tax-exempt organizations and to empower the IRS to more readily share information with state attorneys general.

At this time, particularly as the nonprofit sector attempts to improve its reputation and image by voluntarily increasing self-regulation, it may not be advantageous for Congress to further burden the IRS with regulating decision-making and transactional processes of public charities’ governing boards. At least in the § 501(c)(3) hospital segment, the evidence indicates that governing boards do carry out their responsibilities to further their hospitals’ charitable purposes. Where hospitals’ charitable missions are properly pursued by governing boards’ conscious efforts, board members do shape hospital policies and practices compatibly with a large part of our overall public health care policy goals of striving to deploy medical resources in a rational manner in order to maximize treatment and care benefits in the best interests of patients and to advance medical education and innovation. Congress needs sounder rationales and firmer evidence of necessity before supporting an increased role for the IRS in this area, especially as applied to governing boards of § 501(c)(3) hospitals.

different. The commissioner of the IRS now primarily considers institutional activities (those products of fiduciary behaviors) for purposes of institutional qualification for tax-exempt status. State attorneys general are concerned with fiduciaries’ behaviors and the overall institutional product of that behavior.

See Oversight Report, supra note 81, at 26-31 (criticizing the IRS’s lack of sharing of information with states attorney general).

White Paper, supra note 74, at 15. One might quibble, however, with the adequacy of the proposed amount of funding.

Id. at 16. Currently, I.R.C. § 6104(c) substantially restricts the IRS’s ability to share information with the state attorneys general. For example, the IRS cannot share information with state authorities as a federal income tax exemption qualification investigation proceeds.

See Rachel Emma Silverman, Charities Start to Grade Themselves, WALL ST. J., Aug. 18, 2004, at D1 (reporting public charities concerned about image are voluntarily adopting good governance accountability standards and programs).

The costs associated with additional regulation may not result in sufficient added benefit to warrant the new rules. See generally RICHARD A. EPSTEIN, SIMPLE RULES FOR A COMPLEX WORLD 6-7, 94-97 (1995) (questioning the utility of increasing regulatory structures and cost/benefit analysis).