[University of Dayton Law Review](https://ecommons.udayton.edu/udlr)

[Volume 20](https://ecommons.udayton.edu/udlr/vol20) | [Number 1](https://ecommons.udayton.edu/udlr/vol20/iss1) Article 7

10-1-1994

Integrated Delivery Systems — The "Promised Land" of Health Care: Obtaining a Federal Income Tax Exemption as a Nonprofit Organization under Section 501(c)(3) of the Internal Revenue Code

Valerie N. Hosfeld
University of Dayton

Follow this and additional works at: https://ecommons.udayton.edu/udlr

Part of the Law Commons

Recommended Citation

Hosfeld, Valerie N. (1994) "Integrated Delivery Systems — The "Promised Land" of Health Care: Obtaining a Federal Income Tax Exemption as a Nonprofit Organization under Section 501(c)(3) of the Internal Revenue Code," *University of Dayton Law Review*: Vol. 20: No. 1, Article 7.
Available at: https://ecommons.udayton.edu/udlr/vol20/iss1/7

This Comment is brought to you for free and open access by the School of Law at eCommons. It has been accepted for inclusion in University of Dayton Law Review by an authorized editor of eCommons. For more information, please contact mschlangen1@udayton.edu, ecommons@udayton.edu.

INTEGRATED DELIVERY SYSTEMS—THE "PROMISED LAND" OF HEALTH CARE: OBTAINING A FEDERAL INCOME TAX EXEMPTION AS A NONPROFIT ORGANIZATION UNDER SECTION 501(c)(3) OF THE INTERNAL REVENUE CODE

I. INTRODUCTION

Section 501, an apparently innocuous section in the Internal Revenue Code, provides an income tax exemption that significantly benefits a multitude of nonprofit organizations.[1] Section 501 exempts certain organizations from income taxation.[2] Section 501(a) of the Code provides that an organization shall be exempt from income taxation if it is a corporation organized and operated exclusively for charitable purposes and if no part of its net earnings inure to the benefit of any private shareholder or individual.[3] Health care nonprofit organizations operating as "charitable" represent one percent of those organizations qualifying for exemption from federal income taxation.[4] Nonprofit health care organizations, in turn, account for *almost one half* of the revenues of all charitable organizations.[5] Indeed, health care is the sin-

---

1. *Intermediate Sanctions Bill Could Be Introduced This Year, Says IRS's Sullivan*, 93 Tax Notes Today 236-5, Nov. 18, 1990, *available in* LEXIS, Taxana Library, TNT File [hereinafter *Intermediate Sanctions*]. *See generally* Boris I. Bitker & George K. Rahdert, *The Exemption of Nonprofit Organizations from Federal Income Taxation*, 85 YALE L.J. 299, 330-48 (1976).

2. I.R.C. § 501(a) (1988). Section 501(a) states that "[a]n organization described in subsection (c) [relating to nonprofit activities] . . . shall be exempt from [income] taxation . . . unless such exemption is denied under section 502 or 503." *Id.*; *see* I.R.C. § 501(a) (1988) for full text.

3. I.R.C. § 501(c)(3) (1988). The Code exempts an organization from federal income tax liability if the organization exhibits the following characteristics:

> (3) Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition, . . . or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, . . . and which does not participate in, or intervene in, . . . any political campaign on behalf of (or in opposition to) any candidate for public office.

Id. This Comment shall refer to such organizations as "nonprofit(s)." Any designation of an organization as "tax-exempt" shall refer to the federal tax exemption provided for in section 501(c)(3) of the Internal Revenue Code.

4. Note, *Developments in the Law—Nonprofit Corporations*, 105 HARV. L. REV. 1578, 1629 n.116 (1992) [hereinafter *Nonprofit Corporations*] (citing Robert Pear, *Tax Exemptions of Nonprofit Hospitals Scrutinized*, N.Y. TIMES, Dec. 18, 1990, at A1, B17).

5. *Id.* at 1629 n.116. Furthermore, because a health care organization is nonprofit does not necessarily indicate that it provides more charitable care. For example, national data does not indicate a significant difference in the amount of uncompensated care between nonprofit hospitals

Published by eCommons, 1994

gle largest commercial activity receiving tax exemption under the generic "charitable" label.[6]

Because federal tax-exempt status provides abundant benefits, organizations seek out ways in which to structure themselves to qualify for tax-exempt status.[7] Hospitals are among the most common nonprofit health care entities.[8] Health Maintenance Organizations (HMOs)[9] may also qualify for tax exemption.[10] HMO efforts to qualify

---

and for-profit hospitals. Robert A. Boisture, *Assessing the Impact of Health Care Reform on the Formation of Tax-Exempt Health Care Providers and HMOs*, SPECIAL REPORTS, 94 Tax Notes Today 41-30, Mar. 2, 1994, *available in* LEXIS, Taxana Library, TNT File (citing *For-Profit Enterprise in Health Care*, INSTITUTE OF MEDICINE, 1986). Uncompensated care consists of charity care plus losses due to bad debts. *Id.* Finally, hospital quality indicators show no difference between nonprofit and for-profit hospitals. *See id.*

6. Richard Steinberg, *What is Charity? Implications for Law and Policy: Economic Perspectives on Regulation of Charitable Solicitation*, 54 CASE W. RES. L. REV. 775, 790 (1981). The Joint Committee on Taxation estimates the annual dollar amount of revenue foregone by the federal government by "allowing tax-exempt health care providers to receive deductible contributions and to issue tax-exempt bonds [to be] $8.8 billion and $10.8 billion respectively." Boisture, *supra* note 5. Nonprofit hospitals gain an estimated six to eight percent advantage over their profit-seeking counterparts. *Id.*

7. See *infra* notes 130-44 and accompanying text for a discussion of the numerous advantages of being an exempt organization.

8. Henry Hansmann, *What is Charity? Implications for Law and Policy: the Evolving Law of Nonprofit Organizations: Do Current Trends Make Good Policy?*, 54 CASE W. RES. L. REV. 807, 813-14 (1989); *CBO Looks At Rationale For Health Care Institutions' Tax Exemptions*, 94 Tax Notes Today 158-21, Aug. 12, 1994, *available in* LEXIS, Taxana Library, TNT File.

9. The Health Maintenance Act of 1973 defines an HMO as a public or private entity, organized under the laws of any state, which provides basic and supplemental health services to its members in a specific manner and which is organized and operated in a specific manner. 42 U.S.C. § 300e(a) (1988). An HMO must provide basic health services. *Id.* § 300e(b). Members pay periodic and fixed fees in return for these basic services. *Id.* § 300e(b)(1). The HMO may require a member to pay a reasonable deductible when health services are obtained from a non-HMO physician. *Id.* § 300e(b)(1)(D). The HMO may make an additional charge for supplemental health services that it must provide. *Id.* § 300e(c). An HMO must ensure that 90% of basic service care to members is administered by members of: its staff; a medical group; an individual practice association; a physician or other health professional with whom it has contracted; or any combination thereof. *Id.* § 300e(b)(3)(A). Infrequently used physicians, however, are not considered in the percentile calculation. *Id.* § 300e(c).

An HMO must satisfy various organizational and operational requirements. *Id.* § 300e(c). An HMO must have a fiscally sound operation and adequate provisions against insolvency risk. *Id.* § 300e(c)(1)(A). The HMO must have satisfactory administrative and managerial arrangements. *Id.* § 300e(c)(1)(B). In addition, an HMO must assume the full financial risk for providing basic health services. *Id.* § 300e(c)(2). The HMO may obtain insurance, however, or make other arrangements in order to insure the cost of basic health services it provides to its members. *Id.* § 300e(c)(2)(A). But, the HMO must assume the risk for a minimal amount of the cost of the services. *Id.* § 300e(c)(2)(D). Furthermore, the HMO must generally enroll persons who are representative of the various age, social, and income groups within the geographical area served by the HMO. *Id.* § 300e(c)(3)(A). The HMO may not expel or refuse to re-enroll any member because of health status or requirements for health services. *Id.* § 300e(c)(4). The HMO must be organized in a manner that provides members with meaningful procedures for hearing and resolving grievances and maintain an ongoing quality assurance program for services. *Id.* § 300e(c)(5),

https://ecommons.udayton.edu/udlr/vol20/iss1/7

for tax-exempt status,[11] however, may be limited by physician inurement conflicts[12] and the absence of a requisite charitable purpose.[13] Hospitals and HMOs are just two of the many types of organizations in

---

(6). Finally, the HMO must adopt an arrangement to protect members from incurring liability for payment of fees that are the legal obligation of the HMO. *Id.* § 300e(c)(7).

10. *See, e.g.*, Sound Health Ass'n v. Commissioner, 71 T.C. 158 (1978). Sound Health Association was the first HMO granted tax-exempt status under 501(c)(3). Loren C. Rosenzweig, *Geisinger, HMOs and Health Care Reform*, TAXES—THE TAX MAGAZINE, Jan. 1994, at 22.

11. In early 1990, 575 HMOs existed nationwide, of which approximately one-third were tax-exempt. *Joint Committee on Taxation Releases Analysis of Tax Provisions in the Administration's Health Care Bill*, 90 TAX NOTES TODAY 253-21, Dec. 14, 1993, *available in* LEXIS, Taxana Library, TNT File [hereinafter *Joint Committee Report*].

12. The nonprofit organization's earnings may not "inure" to the benefit of any individual, but the corporation may still accumulate earnings. *See generally Nonprofit Corporations*, *supra* note 4, at 1582. For an explanation of inurement, see *infra* notes 46-66 and accompanying text. The federal tax code permits a nonprofit corporation to "make a profit" and yet continue to qualify for exempt status. *Id.* at 1582. The nonprofit organization, similar to other corporations, must cover its long-term expenditures in order to survive economically. *Id.* The restriction on the nonprofit organization is its ability to distribute earnings. *Id.* The nonprofit organization may not distribute earnings, either directly or indirectly, by overpaying employees, suppliers, creditors, or directors. *Id.* Such distribution is considered inurement. The views of industry critics condemn nonprofit organizations as "end running" around section 501 of the Code without fear of any real threat of penalty under the current laws. *See infra* notes 305-09 and accompanying text. Section IV speculates as to the potential for reform that may result. *See infra* notes 335-38 and accompanying text.

13. Rosenzweig, *supra* note 10, at 22. An HMO has two options for obtaining tax-exempt status. First, the HMO can show that it performs services that are an "integral part of its [existing] tax-exempt affiliates." *Id.* This option is derived from Treasury Regulation section 1.502-1(b). *Id.* at 23. *See also* Treas. Reg. § 1.502-1(b) (1994). "Under this regulation, a subsidiary organization that is not exempt by virtue of its own activities qualifies for exemption if its activities form an integral part of the exempt activities of the exempt parent." Rosenzweig, *supra* note 10, at 23 (citing Treas. Reg. § 1.502-1(b) (1994)). "[But,] if these activities would form an unrelated trade or business if carried on by the parent, the subsidiary may not take advantage of the integral part theory." *Id.* The parent must also closely control and supervise the subsidiary under the integral part theory. Usually, the Service grants tax exemption under the integral part theory to a subsidiary that engages in activities solely for the parent's benefit. *Id.* Activities of an HMO formed by a hospital are usually too far-reaching to qualify for tax exemption. *Id.*

The other means of qualifying for tax-exempt status is for an HMO to demonstrate that, regardless of whether or not it has affiliates who may or may not be tax-exempt, it merits tax exemption because it is organized and operated exclusively for tax-exempt purposes. *Id.* Generally, an HMO providing benefits to enough members of the community, so that there is a relief to the community *as a whole*, can establish the requisite exempt purpose. *Id.* at 25. The promotion of health in the community satisfies the exempt purpose. *Id.* at 23. Traditionally, an HMO could show that, even though it actually only served its members, because it potentially served an unlimited class of people, the HMO was engaged in the promotion of health within the community. *Id.* The Third Circuit recently overturned the Tax court, however, and held that the "community" that benefits from an HMO seeking tax-exempt status must be more than just the HMO's members. Geisinger Health Plan v. Commissioner, 985 F.2d 1210, 1218 (3d Cir. 1993). The Tax court's holding significantly increases the difficulty of meeting the requirements for tax-exempt status as an HMO.

Another reason that HMOs are often not tax-exempt under section 501(c)(3) or (4) is that an organization cannot qualify under either subsection if any substantial portion of its activities consist of providing commercial-type insurance. I.R.C. § 501(m)(1) (1988).

Published by eCommons, 1994

the health care industry that may satisfy the requirements for tax-exempt status. Recently, potentially tax-exempt hybrid entities have evolved, the most popular of which is the Integrated Delivery System (IDS).[14] Some industry analysts believe that the IDS is a prelude to the future of health care reform.[15] Health care reform proposals currently being debated assume the eventual consolidation of health care providers into large regional organizations.[16] Tax-exempt status for health care organizations, therefore, has significant implications as providers position themselves for national health care reform.[17] Since the Internal Revenue Service already has ruled favorably on the tax-exempt status of one model of an IDS, the IDS type of organization possesses great potential.[18]

No precise definition of an IDS exists. An IDS can be as simple as a physician's agreement to provide health care services or it may entail a more elaborate arrangement whereby a separate corporation is formed.[19] The corporation then enters into agreements with parties.[20] The term IDS is not a technical tax term. Rather, the term IDS describes the unique product that results from negotiations between one or more hospitals and a number of physicians to provide health care on a mutual basis[21] under contracts with either third-party payors[22] or employers.[23] Because the arrangement involves providing both hospital

---

14. An IDS is an organization in which health care providers agree to get together and share in costs and returns. *See infra* notes 19-26 and accompanying text.

15. Leo T. Crowley, *Tax Exemption and Integrated Delivery Systems*, N.Y. L.J., July 29, 1993, at 3. As providers begin to accept the full risk of providing both physician and hospital components of health care, the restructuring of health care results in IDSs. *IRS Weighs Revocation or Closing Agreements For Improper Activities*, 20 Pens. & Ben. Rep. (BNA) 1790 (Aug. 16, 1993) [hereinafter *Improper Activities*].

16. *Improper Activities*, *supra* note 15. One commentator describes a "wholesale restructuring" of our nation's health care. *National Reform Will Come, But Watch Local Markets First*, Modern Healthcare, Feb. 14, 1994, at 58 [hereinafter *Local Markets*]. Tomorrow's hospital is described, not as "the hub" of health care delivery as it is today, but only as "an important component of a full-service network designed to attract managed-care contracts." *Id.*

17. *Id.; see also Local Markets*, *supra* note 16, at 58.

18. This is called a Foundation Model IDS, discussed *infra* note 128 and accompanying text.

19. See *infra* notes 120-29 and accompanying text for a discussion of the various types of IDSs.

20. *See infra* note 128-29 and accompanying text.

21. *Recent IDS Exemption Ruling Example of Approach IRS Taking, Official Says*, Daily Rep. for Execs. (BNA) No. 26-D77, at G-26 (Feb. 11, 1994). When used in the health care industry, the term "mutual basis" denotes two parties acting together to provide health care. Interview with Chris E. Davis, District Sales Manager, Klais & Company, in Dayton, OH (Feb. 17, 1994) (consulting firm for companies regarding health care decisions).

22. HMOs or insurance companies are examples of third-party payors in this context. Interview with Chris E. Davis, *supra* note 21.

23. *Non-Profit Hospitals' Acquisitions of Practices*, Mass. Law. Weekly, Jan. 10, 1994, at 11.

https://ecommons.udayton.edu/udlr/vol20/iss1/7

and physician services, the arrangement is described as *integrated*.[24] Moreover, "it is integrated for the *delivery* of health care services."[25] Finally, the integrated delivery arrangement is referred to as a *system* because it often contains numerous relationships forming a health care package.[26]

This Comment explains the nature of an IDS and its advantages. This Comment then analyzes the critical issues involved when an IDS seeks to obtain and maintain its tax-exempt status. Section II examines the history of section 501(c)(3) of the Internal Revenue Code and the requirements that nonprofit organizations currently must meet to obtain an exemption from federal income taxation under section 501(c)(3).[27] Section II further defines an IDS and describes the various models of IDSs.[28] In addition, Section II addresses the reasons that IDSs are becoming increasingly popular arrangements in the health care field.[29] Section III examines crucial exemption determination rulings that suggest some of the dangers to avoid in structuring an IDS.[30] Section III also suggests techniques for organizers to employ to increase the chance of obtaining tax-exempt status.[31] Section III predicts future problems that could plague IDSs due to the extensive national concern and controversy focused upon the tax-exempt status of nonprofit health care organizations.[32] Section III examines how the future problems are aggravated by deficiencies in the regulation of nonprofit organizations under current law.[33] Finally, this Comment concludes that the IDS will be the mode of delivery for a significant portion of this Nation's health care in the future.[34]

II. BACKGROUND

Section 501(c)(3) of the Code explicitly provides an "organizational" and "operational" two-pronged test that an organization must meet in order to qualify for tax-exempt status.[35] Treasury regulations,[36]

---

24. Bernard J. Smith, CONFERENCE ON HEALTH CARE, TAX EXEMPTION OF INTEGRATED DELIVERY SYSTEMS, Sept. 20, 1993, at 2.
25. *Id.*
26. *See id.* at 3.
27. *See infra* notes 35-114 and accompanying text.
28. *See infra* notes 115-29 and accompanying text.
29. *See infra* notes 130-44 and accompanying text.
30. *See infra* notes 145-206 and accompanying text.
31. *See infra* notes 207-96 and accompanying text.
32. *See infra* notes 297-334 and accompanying text.
33. *See infra* notes 297-334 and accompanying text.
34. *See infra* notes 335-38 and accompanying text.
35. I.R.C. § 501(c)(3) (1988).
36. See *infra* note 49 for discussion of the weight of Treasury regulations.

Published by eCommons, 1994

having the weight of law, and revenue rulings,[37] which are explanatory but not binding, elaborate on important issues a health care organization seeking tax exemption must address in efforts to meet the express critera of the Code. Moreover, a large body of common-law interpretations of the various intricacies of tax exemption for health care organizations provide guidance in the formation of a tax-exempt IDS.[38] To date, it is possible for an IDS to be structured in a manner which will allow the IDS to utilize section 501(c)(3).[39] Not all IDS organizations will meet the requirements for tax exemption. Tax exemption, however, is only one of the advantages of the IDS. Depending upon the priorities of those organizing an IDS, a superior result may be achieved by foregoing tax exemption and the accompanying restrictions while still choosing the IDS organizational form.[40]

A. History of Internal Revenue Code Section 501(c)(3) and Requirements for Achieving Section 501(c)(3) Status

Health care nonprofit organizations obtain exemption from federal income taxation under subsections 501(a) and 501(c)(3) of the Code.[41]

---

37. See *infra* note 49 for discussion of the weight of revenue rulings.

38. *See, e.g.*, United States v. American College of Physicians, 475 U.S. 834 (1986); Trinidada v. Sagrada Orden, 263 U.S. 578 (1923); Harding Hosp. v. United States, 505 F.2d 1068 (6th Cir. 1974); Elisian Guild Inc. v. United States, 412 F.2d 121 (1st Cir. 1969); American Academy v. Commissioner, 92 T.C. 1053 (1989); World Family Corp. v. Commissioner, 81 T.C. 958 (1983); Dumaine Farms v. Commissioner, 73 T.C. 650 (1980).

39. *See infra* notes 145-284 and accompanying text.

40. *See infra* notes 285-96 and accompanying text.

41. I.R.C. § 501(a), (c)(3) (1988). The Revenue Act of 1894 contained the earliest codification of an exemption for charitable entities. Revenue Act of 1894, ch. 349, 32, 28 Stat. 556 (1894). The following sources provide comprehensive histories of the federal charitable exemption: HALL, *A Historical Overview of the Private Nonprofit Sector*, in THE NONPROFIT SECTOR: A REASEARCH HANDBOOK 3 (W. Powell ed. 1987); Laura Brown Chisolm, *Politics and Charity: A Proposal for Peaceful Coexistence*, 58 GEO. WASH. L. REV. 308 (1989); Mark A. Hall and John D. Colombo, *The Donative Theory of the Charitable Tax Exemption*, 52 OHIO ST. L.J. (1991); Hansmann, *supra* note 8; Sierk, *State Tax Exemptions of Non-Profit Organizations*, 19 CLEV. ST. L. REV. 281, 282 (1970); Tommy F. Thompson, *The Unadministrability of the Federal Charitable Tax Exemption: Causes, Effects & Remedies*, 5 VA. TAX REV. 1 (1985).

The nonprofit organization covered by section 501(c)(3) and discussed in this Note must be distinguished from the nonprofit organization that provides a private benefit to shareholders or members. A section 501(c)(4) organization is not taxable, but it is distinct from 501(c)(3) organizations. In order for a section 501(c)(4) organization to obtain tax exemption, it must show that it is operated to promote social welfare. Smith, *supra* note 24, at 61. The promotion of social welfare requires "that the organization engage in activities promoting the common good and general welfare of the community at large." *Id.* An organization will not qualify under section 501(c)(4) if it merely carries on a trade or business with the general public in a manner similar to a for-profit business. *Id.* The section 501(c)(4) organization may not solicit tax deductible contributions to raise capital. *See* I.R.C. §§ 501, 170 (1988 & Supp. IV 1992). Moreover, the section 501(c)(4) organization does not obtain state and local property tax exemptions or tax-exempt financing. Smith, *supra*, at 61. These nonprofit private organizations are described in section 501(c)(4)-(10). I.R.C. § 501(c)(4)-(10). Examples of section 501(c)(4)-(10) entities include civic organizations,

https://ecommons.udayton.edu/udlr/vol20/iss1/7

These health care organizations are frequently granted nonprofit status.[42] The Code does not explicitly state that providing health care is a qualified exempt purpose, but the Code does allow charitable activity as a permissible exempt purpose.[43] Therefore, organizations frequently obtain their exemption by possessing a charitable purpose.[44] The Code does not define "charitable," but simply lists "exempt organizations" in broad terms.[45] The related Treasury regulations elaborate on the specific requirements that an organization must meet in order to obtain tax-exempt status, much of the focus being upon the pursuit of charitable goals.[46] Common law has shaped the precise meaning of the term "charitable."[47] Generally, the Service has found that organizations operated and organized to pursue health care objectives meet the criteria

---

labor or agricultural organizations, pension plans, chambers of commerce, clubs, fraternal orders, and voluntary employees' beneficiary associations. *See* I.R.C. § 501(c)(4)-(10) (1988 & Supp. IV 1992).

42. Historically, charities have been exempt from tax. Bob Jones Univ. v. United States, 461 U.S. 574, 588 (1983). Granting exemption to charities is a tradition deeply rooted in the history of our Nation. *Id.* The exemption stems from the belief that charity bestows a benefit upon society. *Id.* at 589. The rationale for granting the exemption to charities incorporates the belief that exposure of the charity to public scrutiny as well as the charity's dependence upon public support, purportedly keeps them from committing abuses. *See* Quarrie v. Commissioner, 603 F.2d 1274 (7th Cir. 1979); *see also* Enterprise Ry. Equip. Co. v. United States, 161 F. Supp. 590 (1958). Congress also sanctioned the exemption to encourage organizations to provide charitable services for the public that the government did not undertake. Rosenzweig, *supra* note 10, at 21. An in-depth analysis into the rationale for the charitable exemption is beyond the scope of this Comment. For varying explanations of the policy and criticisms of the propriety of granting exemption to health care nonprofit organizations and accompanying opinions on the propriety of the policy, see: *Nonprofit Corporations*, *supra* note 4; Hall & Colombo, *supra* note 41; Mark A. Hall and John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward A Donative Theory of Tax Exemption*, 66 WASH L. REV. 307 (1991); and Leslie Espinoza, *Straining the Quality of Mercy: Abandoning the Quest for Informed Charitable Giving*, 64 S. CAL. L. REV. 605 (1991).

43. Furnishing medical care and operating a not-for-profit hospital has long been considered a charitable purpose even though section 501(c)(3) does not explicitly state that fact. *Joint Committee Report*, *supra* note 11. In contrast, no historical precedent exists establishing the provision of managed care, such as that provided by HMOs, as a charitable purpose. *See id.*

44. I.R.C. § 501(c)(3) (1988 & Supp. IV 1992). The Code lists many exempt purposes: "religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition . . . or for the prevention of cruelty to children or animals . . . ." *Id.* The charitable category is only one of several "purposes" that an organization may pursue to obtain tax exempt status. This Comment examines only the "charitable" category since health organizations commonly use the charitable purpose to obtain exempt status. Moreover, the rationale behind granting exempt status for other permissible categories is virtually the same. *See supra* note 42 and accompanying text.

45. I.R.C. § 501(c)(3).

46. *See* Treas. Reg. § 1.501(c)(3)-1 (1988).

47. *See infra* notes 88-93 and accompanying text.

Published by eCommons, 1994

of "charitable" required in the Code, Treasury regulations, and common law.[48]

To seek tax-exempt status, an IDS solicits the Service for a ruling on whether it qualifies for exemption.[49] First, the potential IDS must explain to the Service how it will be organized and operated and must

---

48. This Service finding cannot be applied to recent IDS organizations. Whether an IDS will be granted tax-exempt status is still uncertain because of the variety of IDSs, their relatively new arrival to the health care environment, and the small number of IDSs currently in existence.

49. Treas. Reg. § 1.501(a)-1 (1994); Rev. Rul. 76-34, 1976-2, C.B. 656; Treas. Reg. § 1.501(c)(3)-1(a)(1) (1994). Congress has authorized the Treasury Department to make regulations governing collection of internal revenue; the Constitution authorizes Congress to make all laws necessary for executing powers vested in the government or any department. Boske v. Comingore, 177 U.S. 4511 (1900). Incidental to the Commissioner's authority to administer the tax law, the Commissioner possesses the ability to make regulations for taxpayer information, guidance of revenue collectors, and realization of taxing acts. Spreckels v. Commissioner, 119 F.2d 667 (11th Cir. 1941), *aff'd*, 315 U.S. 626 (1941). Section 7805 of the Code codified the common law which provides that the Secretary of the Treasury has the authority to prescribe rules and regulations that are necessary. I.R.C. § 7805(a) (1988 & Supp. IV 1992). When the Commissioner of the Service promulgates a regulation, it is with the concurrence of the Secretary of the Treasury. Francisco Sugar Co. v. Commissioner, 47 F.2d 555 (2d Cir. 1901). Consistent with the Code, the U.S. Supreme Court has held that Treasury regulations have the force of law and courts must take judicial notice of their existence. Wilkins v. United States, 96 F. 837 (3d Cir.), *cert. denied*, 175 U.S. 727 (1819); *see also* Loose-Wiles Biscuit Co. v. Rasquin, 20 F. Supp. 805 (E.D.N.Y. 1937), *aff'd*, 95 F.2d 438 (2d. Cir.), *cert. denied*, 305 U.S. 611 (1938); Williams v. Commissioner, 44 F.2d 467 (8th Cir. 1930); Burnet v. Petroleum Exploration, 61 F.2d 273 (4th Cir.), *aff'd*, 288 U.S. 467 (1902). The regulation must be consistent with the statute because the regulation is deemed to have been given legislative approval, and to that extent, is part of the law. Deshler Hotel Co. v. Busey, 36 F. Supp. 392 (S.D. Ohio 1941), *aff'd*, 130 F.2d 187 (6th Cir. 1942).

The U.S. Supreme Court recently reaffirmed that regulations and interpretations which continue for a long time without substantial change and apply to unamended or substantially reenacted statutes are deemed to have congressional approval and the effect of law. Cottage Savings Ass'n v. Commissioner, 499 U.S. 554, 556 (1991); *see also* Helvering v. Winmill, 305 U.S. 79, 83 (1983); United States v. Correll, 389 U.S. 2199 (1967). Tax regulations promulgated under section 7805 of the Code, however, even if found to implement congressional mandate, set the framework for judicial analysis, but they do not displace it. United States v. Cartwright, 411 U.S. 546 (1973). Courts will give weight to an administrative agency's consistent interpretation of regulations, but the door is not closed to a judicial determination of the invalidity of a regulation in clear conflict with the statute. Helvering v. Hallock, 309 U.S. 106, 118-22 (1940). Moreover, while the Secretary of the Treasury has discretion in prescribing that the ruling is retroactive in effect, a court will review the Secretary's decision for abuse. Farmer's & Merchant's Bank v. United States, 476 F.2d 406 (4th Cir. 1973); *see also* Woodward v. United States, 322 F. Supp. 332 (W.D. Va.), *aff'd*, 445 F.2d 1406 (4th Cir. 1971).

Conversely, revenue rulings are official Service interpretations of internal revenue laws, related statutes, tax treaties, and regulations previously published in the Bulletin. Rev. Proc. 86-15, 1986-1 C.B. 544. The Bulletin is the authoritative instrument of the Commissioner of the Service for publication of official rulings and procedures of the Service. *Id.* The IRS publishes the revenue rulings to promote the purpose of uniform application of the tax laws and to assist taxpayers on obtaining maximum voluntary compliance. *Id.* Revenue rulings invoked by the Service in litigation are not binding upon the court. Beneficial Found., Inc. v. United States, 8 Cl. Ct. 639 (1985). If a taxpayer, however, invokes a previously published ruling and it addresses issues similar to those in the taxpayer's case, the ruling will normally be treated as dispositive. *Id.*

https://ecommons.udayton.edu/udlr/vol20/iss1/7

supply the Service with any additional information that the Service requests.[50] The Service will then rule on whether to grant tax-exempt status via a determination letter (determination ruling) sent to the applicant.[51] The determination ruling summarizes the organization of the entity.[52] Finally, the Service publishes the determination ruling in the Cumulative Bulletin.[53]

An organization applying for a section 501(c)(3) exemption bears the burden of establishing, on the basis of all the facts and circumstances, that it meets the applicable exemption requirements.[54] Among other things, to qualify for tax exemption under section 501(c)(3), a nonprofit organization must satisfy the two-pronged requirement of the Treasury regulations.[55] The organization must be both: (1) *organized* "exclusively for furtherance of one or more of the purposes" stated in section 501(c)(3); and (2) *operated* "exclusively for furtherance of one or more of the purposes" stated in section 501(c)(3).[56]

The first prong of the regulations contains a restriction on the entity's organization.[57] To meet the first prong, the entity must limit its organizational purpose to one or more of the permissible listed purposes, and must not substantially engage in activities that are not in furtherance of its exempt purpose.[58] Additionally, the entity's articles of organization must provide for the distribution of the entity's assets for a public or charitable purpose upon dissolution.[59] Thus, the first

50. Treas. Reg. § 1.501(a)-1.

51. *Id.*

52. *Id.*

53. *Id.*

54. INTERNAL REVENUE SERVICE EXEMPT ORGANIZATIONS CPE TECHNICAL INSTRUCTION PROGRAM TEXTBOOK (§ 501—Tax-Exempt Organizations), 93 Tax Notes Today 189-16, Oct. 1, 1993, *available* in LEXIS, Taxana Library, TNT File [hereinafter TECHNICAL INSTRUCTION MANUAL]; *see also* Postal Mut. Indem. Co. v. Commissioner, 147 F.2d 583 (5th Cir. 1945); Scholarship Endowment Found. v. Nicholas, 106 F.2d 552 (10th Cir. 1939); Gagne v. Hanover Water Works, 92 F.2d 659 (1st Cir. 1937); United States v. Stiles, 56 F. Supp. 881 (W.D. Ark. 1944); Mutual Fire Ins. Co. v. United States, 50 F. Supp. 665 (E.D. Pa. 1943).

55. *See infra* notes 56-84 and accompanying text.

56. Treas. Reg. § 1.501(c)(3)-1(a) (1994); *see, e.g.*, Elisian Guild Inc. v. United States, 412 F.2d 121, 123 (1st Cir. 1969); Commissioner v. John Danz Charitable, 284 F.2d 726, 730 (11th Cir. 1960).

57. Treas. Reg. § 1.501(c)(3)-1(b) (1994).

58. *See* Treas. Reg. § 1.501(c)(3)-1(b)(1)(i)(b) (1994). The organization's purpose may be as broad or specific as the purposes allowed in section 501(c)(3). *Id.* § 1.501(c)(3)-1(b)(1)(ii). *See* Dumaine Farms v. Commissioner, 73 T.C. 650, 660 (1980). The regulations state that a mere statement in the articles that the organization has a charitable purpose is suitable. Treas. Reg. § 1.501(c)(3)-1(b)(1)(ii) (1994). The state law in which the organization is created controls in interpreting the articles of organization unless the organization shows a clear and convincing evidence of a contrary intent. *Id.* § 1.501(c)(3)-1(b)(5).

59. *See* Treas. Reg. § 1.501(c)(3)-1(b)(4) (1994); *see, e.g.*, Hall v. Commissioner, 729 F.2d 632, 634 (11th Cir. 1984); *Elisian Guild, Inc.*, 412 F.2d at 123; People's Translation Serv. v.

Published by eCommons, 1994

aspect of the test may be satisfied only by examining the manner in which the entity is organized.[60] This evaluation is accomplished by examining the entity's articles of organization and its actual activities.[61]

The second prong of the regulations requires that an organization operate exclusively for its exempt purpose. This operational restriction encompasses two main concepts. First, corporate earnings cannot inure to insiders—private shareholders or individuals.[62] Second, private interests must not benefit from the operation of the organization.[63] The two requirements are distinct and must be satisfied independently.[64]

The private inurement requirement means that a "private shareholder or individual can not appropriate the organization's funds except as reasonable payment for goods or services."[65] The reasonableness of

---

Commissioner, 72 T.C. 42, 44 (1979). The Service does not always require an express provision for the asset distribution of an organization upon dissolution. Rev. Proc. 82-2, 1982-1 C.B. 367. "Articles of organization" refer to a trust instrument, corporate charter, articles of incorporation, or any other written instrument from which an organization is created. Treas. Reg. § 1.501(c)(3)-1(b)(2) (1994).

60. *See* Treas. Reg. 1.501(c)(3)-1(b) (1994).

61. *See* Trinidad v. Sagrada Orden, 263 U.S. 578, 580 (1923); Harrison v. Barker Annuity Fund, 90 F.2d 286, 287 (7th Cir. 1937) (looking to manner in which corporation operates and its charter for determination of organizational purpose); Sun-Herald Corp. v. Duggan, 73 F.2d 298, 300 (2d Cir. 1934), *cert. denied*, 294 U.S. 719 (1935) (noting that clearly "organized" means incorporated and not "operated"); Sebastian-Lathe v. Johnson, 110 F. Supp. 245, 246 (S.D.N.Y. 1952) (finding lack of charitable
organizational purpose by examining certificate of incorporation); Home Oil Mill v. Willingham, 68 F. Supp. 525, 530 (N.D. Ala. 1945) (relying upon content of charter to find charitable organization's purpose). The courts are split over the degree of importance to attach to the articles of organization versus the actual activities of the organization when determining whether the organization has the requisite organizational purpose. *See, e.g.*, Stevens Bros. Found. Inc. v. Commissioner, 324 F.2d 633 (8th Cir. 1963), *cert. denied*, 376 U.S. 969 (1964); World Family Corp. v. Commissioner, 81 T.C. 958 (1983); Copyright Clearance Ctr. v. Commissioner, 79 T.C. 793 (1982); Greater United Navajo Dev. Enters. v. Commissioner, 74 T.C. 69 (1980); Christian Manner Int'l, Inc. v. Commissioner, 71 T.C. 661 (1978); Minnesota Kingsmen Chess Ass'n. v. Commissioner, 46 T.C.M. (CCH) 1133 (1983).

62. Treas. Reg. § 1.501(c)(3)-1(c)(2) (1994). The Code itself describes a tax-exempt organization to include an organization "no part of the net earnings of which inures to the benefit of any private shareholder or individual." I.R.C. § 501(c)(3) (1988 & Supp. IV 1992). The prohibition is a "nondistribution constraint." *See generally* Deborah A. DeMott, *Self Dealing Transactions in Nonprofit Corporations*, 59 Brook. L. Rev. 101, 102 (1990). For an analysis of impermissible forms of private inurement, see 1 Marilyn E. Phelan, Nonprofit Enterprises: Law & Taxation Section 11A:02 (1985 & Supp. 1992).

63. The organization must not be organized or operated for the benefit of private interests such as the organizer or his family, shareholders of the organization, or persons controlled directly or indirectly by the private interests. *See* Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii) (1994).

64. *See, e.g.*, American Campaign Academy v. Commissioner, 92 T.C. 1053, 1061-63 (1989); Canada v. Commissioner, 82 T.C. 973, 981 (1984); Aid to Artisans, Inc. v. Commissioner, 71 T.C. 202, 215 (1978).

65. Technical Instruction Manual, *supra* note 54.

the compensation may be shown in a variety of ways.[66] Within the meaning of 501(c)(3), a private shareholder or individual is a "person having a personal and private interest in the activities of the organization."[67] The term "person" includes an "individual, a trust, estate, partnership, association, company or corporation."[68] The applicable terms, taken as a whole, result in the designation of persons such as founders, directors, officers, or major contributors as insiders for inurement purposes.[69] It is not clear whether a physician who contracts with an IDS is an insider.[70] The Service has not squarely addressed the physician-insider issue because those IDSs that have been granted tax-exempt status have structured themselves to avoid charges of unreasonable compensation.[71] Since the existence of inurement violates the organizational requirement that the entity operate exclusively for its exempt purposes,[72] organizations must be certain that the physician-IDS relationship is not one that gives rise to inurement.[73]

The benefit proscription restricting private benefits from flowing from the organization must also be satisfied in order for the organiza-

---

66. The Service may find the compensation reasonable by comparing the amount paid to the individual with the services provided by the individual to the exempt organization. Smith, *supra* note 24, at 16 (citing Alive Fellowship of Harmonious Living v. Commissioner, 47 T.C.M. (CCH) 1134 (1984); World Family Corp. v. Commissioner, 81 T.C. 958, 968 (1983)). If comparable services could be obtained at an arm's-length bargain, it indicates that the compensation is reasonable. Smith, *supra* note 24, at 17 (citing B.H.W. Anesthesia Found. v. Commissioner, 72 T.C. 681, 686 (1979)). Accordingly, fair market value of services determines reasonableness. The Service defines fair market value as "the price at which a willing buyer and a willing seller agree, neither being under any compulsion to buy or sell, and both having reasonable knowledge of the relevant facts." *See IRS Guide on Tax Exemptions: Guidelines Detail Rules on Physician Involvement in Integrated Delivery: Internal Revenue Service*, AMERICAN MEDICAL NEWS, Oct. 4, 1990, at 3. A second way to demonstrate that the compensation is reasonable is to show that the expense deduction is a qualified Code section 162(a) deduction. Smith, *supra* note 24, at 17. This second method results in an examination of the overall relationship of the parties. *Id.* (citing Gen Couns. Mem. 38,905 (June 11, 1982)). Finally, the valuation of practices must also meet guidelines that require consideration of the economic outlook of the industry, book value of stock and hard assets, financial condition of the business, earning capacity of the company (supported by five years of profit and loss statements), and the estimated value of intangibles. Rev. Rul. 59-60, 1959-1 C.B. 237.

67. Smith, *supra* note 24, at 13 (citing Treas. Reg. § 1.501(a)-1(c) (1994)).

68. Smith, *supra* note 24, at 13 (citing 26 U.S.C. § 7701(a)(1) (1988 & Supp. IV 1992)).

69. Smith, *supra* note 24, at 13 (citing Bruce R. Hopkins, THE LAW OF TAX EXEMPT ORGANIZATIONS § 12.2 (6th ed. 1992)).

70. See *infra* notes 74-76, 83 and accompanying text for a discussion of the likelihood that an IDS physician is a risk to the tax-exempt status of the organization due to inurement.

71. *See infra* notes 155-206 and accompanying text.

72. Treas. Reg. § 1.501(c)(3)-1(c)(2) (1994). The purpose of the restriction on inurement exists to ensure that those persons who are involved with the organization do not obtain exempt-status monies by virtue of their position to the detriment of the public. *Id.*

73. For an example of the close scrutiny that is accorded to the relationships between tax-exempt health care organizations and physicians, *see, e.g.*, Harding Hosp. v. United States, 505 F.2d 1068 (6th Cir. 1974); Lowry Hosp. Ass'n v. Commissioner, 66 T.C. 850 (1976).

Published by eCommons, 1994

tion to show that it operates exclusively for its stated purpose.[74] A private benefit includes an advantage, profit, fruit, privilege, gain, or interest.[75] The private benefit prohibition applies to all kinds of persons and groups, not just to insiders who must not violate the inurement prohibition.[76]

An organization must satisfy a second requirement to meet the organizational test. This second requirement is interwoven with the first requirement that there not be private inurement.[77] The regulations provide that for the organization to be regarded as operating exclusively for its exempt purposes, the organization must engage primarily in activities that accomplish its exempt purposes.[78] The organization engages in the required activity if it engages "primarily in activities which accomplish one or more of such exempt purposes specified in

---

74. *See* Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii) (1994).

75. *See, e.g.*, American Campaign Academy v. Commissioner, 92 T.C. 1053, 1065-66 (1989); Retired Teachers Legal Defense Fund v. Commissioner, 78 T.C. 280, 286 (1982). An organization may provide benefits to private individuals or non-charitable recipients if the benefits are incidental in quality and quantity. Smith, *supra* note 24, at 19 (citing Gen. Couns. Mem. 37,780 (Dec. 18, 1978)). If the organization can accomplish its exempt purposes without providing the benefits to private persons or non-charitable recipients and does not, the organization violates the *qualitative* requirement and cannot become or remain tax exempt. *Id.* An organization violates the *quantitative* requirement if the benefit is substantial "in the context of the overall public benefit conferred by the activity." *Id.*

76. *See, e.g., American Campaign Academy*, 92 T.C. at 1068; People of God Community v. Commissioner, 75 T.C. 127, 133 (1980); Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii) (1994). For example, in *Sonora Community Hosp. v. Commissioner*, two doctors who had previously owned the hospital facilities and who founded the tax-exempt hospital shared a portion of the fees from a privately operated laboratory and x-ray department within the hospital even though they did not personally perform any services. 46 T.C. 519 (1966), *aff'd*, 397 F.2d 814 (11th Cir. 1968). The Tax Court held that the arrangement showed that the hospital significantly operated for the private benefit of the two doctors and not exclusively as a charitable organization. *Id.*

77. *See supra* notes 65-73 and accompanying text.

78. *See* Treas. Reg. § 1.501(c)(3)-1(c)(1) (1994). The word exclusively is not literally construed. A substantial nonexempt purpose, however, will result in a denial of tax-exempt status. Better Business Bureau v. United States, 326 U.S. 279, 283 (1945). For a discussion of the meaning of the term "substantial," see Peter Eliasberg, *Charity and Commerce: Section 501(c)(3)—How Much Unrelated Business Activity?* 24 TAX L. REV. 53 (1965). Nonprofit organizations using the exemption must pay income tax on that portion of income which is Unrelated Business Taxable Income (U.B.T.I.). *Nonprofit Corporations*, *supra* note 4, at 1616 (citing I.R.C. § 512(a)(1) (1988)). U.B.T.I. is "gross income derived by any organization from any unrelated trade or business . . . regularly carried on by it, less the deductions . . . directly connected with the carrying on of such trade or business." *Id.* at 1617. Thus, the nonprofit organization's exemption does not protect it from tax liability for activities due to an unrelated trade or business. *See* I.R.C. § 513(a) (1988). An unrelated trade or business is "any trade or business the conduct of which is not substantially related to the exercise or performance by such organization of its charitable . . . purpose or function constituting the basis for its exemption." *Id.* Even though "passive investment income, including dividends, interest, payments with respect to security loans, royalties, and rents from real property" is not always "substantially related" to organizations' exempt purposes, income from these sources is not included in U.B.T.I. *See* I.R.C. § 512(b)(1)-(3) (1988).

https://ecommons.udayton.edu/udlr/vol20/iss1/7

section 501(c)(3),"[79] and the organization states an exempt purpose which is in accord with one designated as proper under section 501(c)(3).[80] Moreover, the organization may not engage in substantial lobbying activities.[81]

All of the stated purposes in section 501(c)(3) require that the organization serve a public, rather than private, interest.[82] An IDS does not serve a public interest if it is organized for the benefit of private interests including individuals, shareholders, or persons directly or indirectly controlled by an insider's private interests.[83] Thus, an organization will fail both tests if it provides inurement to an insider. Finally, notwithstanding the exclusivity requirement, the Code allows an organization to participate in an "insubstantial part of . . . activities not . . . in furtherance of an exempt purpose."[84]

To obtain tax exemption as a charitable institution, a health care organization must conform to a definition of charity approved by courts and broadened upon by the Service through regulations. Although the term "charitable" is critical, the Code does not supply a definition.[85] According to the Treasury regulations, the term "charitable" includes "[r]elief of the poor and distressed or the underprivileged, advancement of religion; advancement of education or science . . . lessening of the burdens of Government; and promotion of social welfare . . . ."[86] The

---

79. Treas. Reg. § 1.501(c)(3)-1(c)(1) (1994).

80. Treas. Reg. § 1.501(c)(3)-1(b)(1)(i) (1994).

81. I.R.C. § 501(h) (1988); *see also* Treas. Reg. § 1.501(c)(3)-1(c) (1994). "The term lobbying expenditures means expenditures for the purpose of influencing legislation." I.R.C. § 501(h)(2)(A) (1988). The Internal Revenue Code provides a lobbying ceiling. *Id.* § 501(h)(2)(B). If an organization expends monies in excess of the ceiling it will be denied tax-exempt status. *Id.* § 501(h)(1)(A). A similar provision exists for grass roots expenditures, which are merely local lobbying activities. *Id.* § 4911(d).

82. I.R.C. § 501(c)(3) (1988). *See, e.g.*, Baltimore Health & Welfare Fund v. Commissioner, 69 T.C. 554 (1978); Callaway Family Ass'n v. Commissioner, 71 T.C. 340 (1978).

83. *See* Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii) (1994). *See also* Retired Teachers Legal Defense Fund v. Commissioner, 78 T.C. 280, 285 (1982); Kentucky Bar Foundation v. Commissioner, 78 T.C. 921 (1982); Christain Stewardship Assistance, Inc. v. Commissioner, 70 T.C. 1037 (1978). Even if a person or entity receiving a benefit is not an insider and the organization therefore does not violate the proscription against inurement, such person will violate the requirement of "exclusive" charitable purpose by serving a private purpose. For example, a hospital could not show that it had an exclusive charitable purpose when physicians who had been previous owners and founders of the hospital received a share of revenues from a privately owned portion of the hospital. Sonora Community Hosp. v. Commissioner, 46 T.C. 519 (1966), *aff'd*, 397 F.2d 814 (11th Cir. 1968). In *Sonora*, even though the physicians were not employed at the hospital, the fact that they collected significant revenues showed that the hospital did not operate exclusively for its exempt purposes. *Id.*

84. *Retired Teachers Legal Defense Fund, Inc.*, 78 T.C. at 287. *See* Treas. Reg. § 1.501(c)(3)-1(c) (1994).

85. Bob Jones Univ. v. United States, 461 U.S. 574, 585 (1983).

86. Treas. Reg. § 1.501(c)(3)-1(d)(2) (1994).

Published by eCommons, 1994

regulations further state that the term "charitable" is to be used in "its generally accepted legal sense" and is "not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of 'charity' as developed by judicial decisions."[87] The guidelines provided in the regulations are therefore not exhaustive, and interpretations of "charitable" must include common-law meanings.

In *Bob Jones University v. United States*,[88] the Supreme Court held that charities must be exempt in practice, regardless of their articulated purpose in the articles of incorporation.[89] The Court determined that underlying the Code was Congress' intention that the Code meet common-law standards of charity.[90] To be charitable, an educational institution seeking tax-exempt status needed to "serve a public purpose" and not be "contrary to established public policy."[91] In *Bob Jones University*, the educational institution had discriminated on the basis of race, and the Court observed that the discrimination was "contrary to public policy."[92] The Court accordingly denied the university tax-exempt status.[93]

Through the revenue rulings it issues, the Service provides guidance for health care organizations. The rulings assist the organizations with interpreting and complying with the relevant Code provisions. Various revenue rulings define requirements that nonprofit health care organizations specifically must meet in order to qualify as tax-exempt charitable organizations. In 1956, the Service issued Revenue Ruling 56-185 which mandated that a hospital must satisfy four conditions to have a charitable purpose.[94] First, the ruling required the hospital to be organized as a nonprofit hospital that operated for the purpose of caring for the sick.[95] Second, the hospital had to "be operated to the extent of its financial ability for those not able to pay for services rendered . . . ."[96] Third, the hospital could not restrict the use of its

---

87. *Id.*

88. 461 U.S. 574 (1983).

89. *Id.*; *see also* National Alliance v. United States, 710 F.2d 868 (D.C. Cir. 1983).

90. *Bob Jones Univ.*, 461 U.S. at 586.

91. *Id.*

92. *Id.* at 595. Illegal activities are another example of activity contrary to "public policy." *See* Synanon Church v. United States, 820 F.2d 421, 427 n.6 (D.C. Cir. 1987) (organization which willfully destroyed evidence relevant to its tax-exempt status was denied tax-exempt status).

93. *Bob Jones Univ.*, 461 U.S. at 595.

94. *Nonprofit Corporations*, *supra* note 4, at 1630.

95. *Joint Committee Report*, *supra* note 11.

96. *See* Rev. Rul. 56-185, 1956-1 C.B. 202, 203. This ruling is consistent with the early view that required hospitals to provide free care to the poor in order to be considered a charity. Rosenzweig, *supra* note 10, at 21 (citing O'Brien v. Physician's Hosp. Ass'n, 116 N.E. 975, 977 (1917)).

https://ecommons.udayton.edu/udlr/vol20/iss1/7

facilities to a particular group of physicians.[97] Finally, no earnings of the hospital could inure to a private shareholder or individual.[98]

In 1969, the Treasury Department revised its interpretation of the term "charitable."[99] The word charitable in section 501(c)(3) was henceforth to be used in its "generally accepted legal sense."[100] Consequently, the Service issued a new ruling, commonly referred to as the "Community Benefit Standard," that broadened the standard and serves as the foundation of present-day decisions that determine whether an organization has a charitable purpose.[101] Revenue Ruling 69-545 deemed the promotion of health to be a "benefi[t] to the community as a whole" under the term "charitable."[102] Revenue Ruling 69-545 eliminates the requirement that an entity care for persons below cost or without charge.[103]

In order for a health care organization to be a section 501(c)(3) tax-exempt entity, the organization needs to advance the health of a class of persons broad enough to benefit the community.[104] Specifically, the ruling states that a nonprofit hospital will meet the standard and therefore qualify for exemption when it meets several criteria. First, the hospital must have a board composed of prominent citizens drawn from the community.[105] Next, the nonprofit organization must have a medical staff open to all qualified physicians in the area, consistent with the size and nature of its facilities.[106]

Additionally, the organization must operate a full-time emergency room open to all persons regardless of their ability to pay.[107] The nonprofit organization must provide hospital care for everyone in the community able to pay the cost either personally, through private health

---

97. *Joint Committee Report*, *supra* note 11.

98. *Joint Committee Report*, *supra* note 11.

99. *Nonprofit Corporations*, *supra* note 4, at 1630.

100. *Nonprofit Corporations*, *supra* note 4, at 1630.

101. Smith, *supra* note 24, at 8; *see also* Rev. Rul. 69-545, 1969-2, C.B. 117. *See* Eastern Kentucky Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), *vacated on other grounds*, 426 U.S. 26 (1976) (challenge to Rev. Rul. 69-545 that it fails to identify a charitable class withstood). Revenue Ruling 69-545 reflects the hospital's changing role in the community and the community's changing expectations. Rosenzweig, *supra* note 10, at 13. No longer is the hospital an "almshouse" as it appeared to be under Revenue Ruling 56-185, rather a hospital is presently considered to be a major medical center. *Id.* Insurance and increased governmental support minimize the need for the historic "almshouse." *Id.* at 25.

102. *See* Rosenzweig, *supra* note 10, at 25.

103. *Joint Committee Report*, *supra* note 11.

104. *Joint Committee Report*, *supra* note 11.

105. TECHNICAL INSTRUCTION MANUAL, *supra* note 54. The term "community" does not include physicians, administrators, or others with a private interest in the organization. *Id.*

106. TECHNICAL INSTRUCTION MANUAL, supra note 54.

107. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

Published by eCommons, 1994

insurance, or with the aid of public programs such as Medicare.[108] Finally, the nonprofit organization must use excess funds in furtherance of exempt purposes.[109] Under the Community Benefit Standard, therefore, an organization can satisfy the definition of charitable if it operates an emergency room open to all persons regardless of their ability to pay and provides care on a nondiscriminatory basis to *paying* patients.[110]

A new revenue ruling enlarged the meaning of "charitable purpose" for health care organizations in 1983.[111] Revenue Ruling 83-184 allows more organizations to come under the "charitable" umbrella.[112] A nonprofit health care organization may now qualify for tax-exempt status, even without an emergency room, if a local health planning agency has determined that the operation of an emergency room is "unnecessary and duplicative" of services already provided in the area.[113] This provision allows certain specialty organizations to become tax exempt.[114] Under this current standard, an IDS may potentially qualify as tax exempt. The absence of an emergency room requirement makes it easier for an organization to become a qualified nonprofit health care organization.

B. Definition of an IDS and Explanation of Its Appeal to Health Care Professionals

The Service describes an IDS as "a health care provider (or one component entity of an affiliated network of providers) created to integrate the provision of hospital services with professional medical . . . services."[115] Hospitals have traditionally provided services and facilities such as room, board, emergency care, nursing, and diagnostic services for which they are paid by patients, insurers, or government programs.[116] Physicians in private medical practices provide medical and surgical services to patients, and admit and treat them as necessary in hospital facilities.[117] Patients, patients' insurers, or government programs traditionally pay the physicians separately.[118] In an IDS, one

108. TECHNICAL INSTRUCTION MANUAL, *supra* note 54. The Service has consistently interpreted "programs such as Medicare" to include Medicaid. *Id.*

109. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

110. *Nonprofit Corporations*, *supra* note 4, at 1630 nn.120 & 122 (citing Rev. Rul. 611-545, 19611-2 C.B. 117, 118; Rev. Rul. 56-185, 1956-1 C.B. 202, 203).

111. *See* Rev. Rul. 83-184, 1983-2 C.B. 114.

112. *See Nonprofit Corporations*, *supra* note 4, at 1630.

113. *See Nonprofit Corporations*, *supra* note 4, at 1630 n.124.

114. *See Nonprofit Corporations*, *supra* note 4, at 1630 n.124.

115. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

116. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

117. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

118. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

https://ecommons.udayton.edu/udlr/vol20/iss1/7

single entity provides and bills for both the hospital's and physicians' services.[119]

Although an IDS may take many forms, there are four general IDS models: (1) a Physician Hospital Organization;[120] (2) a Clinical Model;[121] (3) a Foundation Model;[122] and (4) a Hospital Controlled Model.[123] The models may all be referred to as "fully integrated."[124] Fully integrated aptly describes the IDS models because all aspects of health care are enveloped by the IDS organization in each model.[125] A "Physician Hospital Organization" (PHO) is an IDS consisting of a hospital or group of hospitals and physicians that contracts with a managed care organization.[126] A "Clinical Model" IDS is a hospital affiliate that administers and manages the business side of physician prac-

---

119. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

120. *See infra* note 126 and accompanying text.

121. *See infra* note 127 and accompanying text.

122. *See infra* note 128 and accompanying text.

123. *See infra* note 129 and accompanying text. This Comment does not classify a Medical Service Organization (MSO) as an IDS for discussion purposes because it is the least integrated delivery system. Terese Hudson, *Three Major Models; Before You Build Your Network, Consider These Legal Angles; Management Services Organizations (MSO), Medical Foundations, and Fully Integrated Entity*, HOSPITALS, June 20, 1993, at 31. An MSO is not fully integrated. TECHNICAL INSTRUCTION MANUAL, *supra* note 54. Full integration means all health care services are provided by one entity. The health care organization provides "one stop shopping." Interview with Chris E. Davis, District Sales Manager, Klais & Company, in Dayton, OH (Feb. 17, 1994). The MSO provides all property, support staff, management, and billing services that are required in an independent physician group private medical practice, in return for a share of the group's revenues. *See* Hudson, *supra*, at 31. The physician group and the MSO are each responsible for their own separate functions. *Id.* The MSO performs administrative functions, and the physician group provides health care. *Id.* The MSO form of organization is frequently used to coordinate managed care contracts and to bring diverse group practices together. *Id.* Anyone can own the MSO including a hospital, HMO, or the physicians. Physicians often prefer an MSO because they can help govern it or be actual partners in the MSO. *Id.* This aspect of management, however, is an attribute that would prevent a Foundation Model IDS from gaining tax-exempt status. The degree of physician control of the board and the questionable charitable purpose (management services) make the MSO an unlikely candidate for tax-exempt status. *See* Hudson, *supra*, at 40-41.

124. Hudson, *supra* note 123, at 31.

125. Hudson, *supra* note 123, at 31.

126. *Intermediate Sanctions*, *supra* note 1, at G-224. The IDS may contract with either employers or insurers. Jane E. Jordan & Tobin N. Watt, *PHOs Offer A Creative and Current Response to Changes*, HEALTH CARE COMPETITION WEEK, May 28, 1993. PHOs are horizontally integrated. TECHNICAL INSTRUCTION MANUAL, *supra* note 54, at 33. A PHO is characterized as horizontally integrated because physicians and hospitals establish the IDS under the joint ownership and control of both groups. *Id.* Because the physicians own and control the PHO Model, it is not exempt under I.R.C. § 501(c)(3). *Id.* The physician control violates inurement proscriptions. The advantage of the PHO type of model stems from the fact that it is a managed care arrangement in which physicians have the unique opportunity to substantially participate in the management, governance, and operation of the organization. Jordan & Watt, *supra*.

Published by eCommons, 1994

tices while the physicians operate the clinical side.[127] A "Foundation Model" IDS is operated by a foundation that provides hospital and medical services itself.[128] Finally, a "Hospital Controlled Model" IDS is a hospital that employs physicians.[129]

An IDS that can obtain tax-exempt status offers numerous advantages in today's competitive health care industry. The greatest advantage of being tax-exempt is that the IDS can receive income free of income tax.[130] A tax-exempt IDS also enjoys lower-cost, tax-exempt financing and exemption from local property taxes and federal payroll taxes.[131] Persons donating to an IDS may receive a charitable tax deduction write-off under sections 170(a) and 170(c) of the Code.[132] Aside from tax issues, the IDS possesses a bargaining advantage. Insurers like to "divide and conquer."[133] Because the IDS is one unit, it negotiates with the insurer on behalf of both the hospital and the physicians.[134] The ability to act as a unit places the IDS in a stronger bar-

---

127. Jordan & Watt, *supra* note 126. Generally, in the clinical model, an established medical group practice operates in conjunction with a hospital. TECHNICAL INSTRUCTION MANUAL, *supra* note 54. These group practices may be taxable, or, in certain circumstances, exempt. *Id.* A group of practicing physicians create a clinical model IDS to obtain more market share in the service area. *Id.* If the physicians' practice and hospital are nonprofit, the IDS is normally set up to take advantage of tax-exempt financing to provide funds for new projects or for improvements. *Id.*

128. TECHNICAL INSTRUCTION MANUAL, *supra* note 54. A Foundation Model IDS is typically a single corporation (the foundation), operating as a nonprofit organization under state law. *Id.* The IDS is created in order to obtain all of the assets needed to operate clinics, physician offices, and even hospitals. *Id.* Assets are acquired by various methods including by purchase, lease, license, stock transfer, gift, or any combination of these techniques. *Id.* The IDS foundation secures the services of physicians who will provide professional medical care, either through direct employment or independent contract. *Id.* The foundation then provides the health care, both medical and hospital, inpatient and outpatient. *Id.* The IDS foundation enters into all payor contracts, provides all nonprofessional personnel for the system, maintains all assets, and collects all revenues for services provided. *Id.*

129. *Intermediate Sanctions*, *supra* note 1, at G-224. This model usually entails a hospital creating a subsidiary corporation. The subsidiary will receive tax-exempt status if tax-exempt hospitals are involved. TECHNICAL INSTRUCTION MANUAL, *supra* note 54, at 32. The new corporation obtains physician services, either through direct employment or by independent contract. *Id.* Alternatively, the hospital, not the newly formed subsidiary, may employ the physicians. *Id.*

Some states, such as California and Texas, bar this model because they prohibit the "corporate practice of medicine," thus, making it illegal for health care organizations to employ physicians. *See* Boisture, *supra* note 5. States with such a ban often have an exception that allows medical foundations to accept payment for physician services. *Id.*; *see also* Hudson, *supra* note 123, at 31. In those states, the hospitals often form Foundation Model IDSs which then accept payment for physician services or contract with a physician group to provide services. Boisture, *supra* note 5; *see also supra* note 128 and accompanying text.

130. The IDS is required, however, to pay tax on unrelated business income. *See supra* note 78.

131. Hudson, *supra* note 123.

132. Hudson, *supra* note 123 (citing I.R.C. §§ 170(a), (c) (1988)).

133. Hudson, *supra* note 123.

134. Hudson, *supra* note 123.

https://ecommons.udayton.edu/udlr/vol20/iss1/7

gaining position.[135] The IDS can also eliminate administrative costs due to its cohesion.[136] Cohesion results in savings from the elimination of duplicative costs. Finally, the greatest nontax advantage may be efficiency. Because all participants share in the "bottom line," the physicians, hospital, and even the managed care entity strive to streamline costs.[137]

Insurers can set up an IDS to maximize control and ensure their ability to deliver cost-effective benefits.[138] Insurers have a critical interest in IDSs in today's health care environment. "If a Clinton reform plan is enacted [insurers] could be relegated to a minor claims processing role . . . or driven out of existence."[139] Therefore, insurers are on a "fast track to reinventing their companies."[140] The aggressive insurers are organizing IDSs with local physicians and hospitals.[141] Other insurers are building their own primary care networks[142] or are employing their own physicians whenever the insurer encounters resistance or a primary care shortage.[143] Understandably, insurers are trying to bond with the delivery system so that the insurer will play a meaningful role in the future of health care.[144]

III. Analysis

The Service has considered tax exemption for the Foundation Model IDS. To date, the Service has granted tax-exempt status to three Foundation Model IDS organizations.[145] Public determination rulings issued by the Service provide extensive guidance that practitioners may draw upon in forming an IDS. While the rulings directly address only the criteria relevant for forming a Foundation Model IDS, the rationale of the Service in granting the exemptions, along with revenue rulings and the predictions of industry experts, can assist practitioners in developing any of the four types of IDS models. Industry analysts predict that the delay an IDS will encounter in obtaining a determination letter, as well as the substantive limitations derived from the determination rulings,[146] will significantly slow tax-exempt organi-

135. Hudson, *supra* note 123.
136. *See* Smith, *supra* note 24, at 7.
137. *See* Smith, *supra* note 24, at 7.
138. Boisture, *supra* note 5.
139. Boisture, *supra* note 5.
140. Integrated Health Care Report, Oct. 1993, at 2.
141. *Id.*
142. A primary care network consists of a group of physicians that deliver basic or nonspecialized care.
143. Boisture, *supra* note 5.
144. Boisture, *supra* note 5.
145. *See infra* notes 149-206 and accompanying text.
146. *See infra* notes 207-84 and accompanying text.

Published by eCommons, 1994

zations' efforts to negotiate IDS agreements.[147] In some instances, analysts anticipate that providers and payors will turn to the for-profit organizational form to avoid the complex tax-exempt laws, the delay in waiting on determination rulings, and current regulatory trends.[148]

A. Illustrations of Various Dangers Involved in Structuring an IDS Resulting in Failure to Obtain Tax-Exempt Status

Recently, the Service determined that several IDSs qualified for exempt status under section 501(c)(3).[149] The determination rulings, however, only involved Foundation Models.[150] These three critical exemption determination rulings provide practitioners with guidance for qualifying an IDS for tax exemption.[151] The three rulings involved IDS organizations that held assets by purchasing a group medical practice and related assets or by entering into an agreement to lease the assets through an affiliate.[152] Each IDS then contracted with physicians to provide health care services at the IDS facilities.[153] Since the Service granted tax-exempt status to the IDSs in the three rulings, it logically follows that an IDS increases its likelihood of obtaining tax-exempt status by following the guidance provided in the determination rulings.[154]

The first determination ruling which granted tax-exempt status to an IDS involved Loma Linda University Medical Center, a nonprofit corporation.[155] The parent corporation, Loma Linda, created a nonprofit corporation called Friendly Hills Healthcare Network.[156] Friendly Hills proposed to the Service that it would have an emergency room operated for anyone, regardless of their ability to pay for emer-

147. Boisture, *supra* note 5.

148. *See infra* notes 285-96 and accompanying text.

149. *Full Text Exemption Ruling*, EXEMPT ORGANIZATION TAX REV. 490 (Mar. 1993) [hereinafter *Full Text Exemption Ruling*]; *Full-text Exemption Rulings: Facey Medical Foundation Qualifies for (c)(3) Exemption*, EXEMPT ORGANIZATION TAX REV. 828 (May 1993) [hereinafter *Facey Medical Foundation*]; *I.R.S. News Release*, 94 Tax Notes Today 26-8, Feb. 8, 1994, *available in* LEXIS, Taxana Library, TNT File [hereinafter *News Release*].

150. See *supra* note 128 and accompanying text for an explanation of a Foundation Model IDS. In an exemption application, an organization applies to the Service for tax-exempt status and receives a determination ruling.

151. These rulings are the only three rulings that have been issued concerning Foundation IDS organizations.

152. *Full Text Exemption Ruling*, *supra* note 149; *Facey Medical Foundation*, *supra* note 149; *News Release*, *supra* note 149.

153. *Full Text Exemption Ruling*, *supra* note 149; *Facey Medical Foundation*, *supra* note 149; *News Release*, *supra* note 149.

154. Della de Lafuente, *UniHealth Plan Gets IRS Nod*, MODERN HEALTHCARE, Feb. 14, 1994, at 4.

155. *Full Text Exemption Ruling*, *supra* note 149.

156. *Full Text Exemption Ruling*, *supra* note 149.

https://ecommons.udayton.edu/udlr/vol20/iss1/7

gency services.[157] The organization would operate clinics and a hospital, and would conduct medical research and education programs.[158] Friendly Hills represented that it would enhance the accessibility, quality, and cost-efficiency of services to communities that it served.[159] A board comprised of members of the community would control the daily operations.[160] No more than two members of the ten-person board could represent the physician group.[161] Furthermore, the physicians contracting with Friendly Hills would provide medical care to all persons regardless of ability to pay.[162] Medical care would also be provided without differentiation among persons using Medicare and state social programs as financial resources, and those insured through other methods.[163]

Friendly Hills purchased its assets via tax-exempt bonds and an installment note for less than fair market value from various physician-owned partnerships.[164] Under the contract, the physicians became providers of health care to patients of the Friendly Hills IDS on a "capitated" basis.[165] The amount of the physicians' compensation would be established through arm's-length bargaining and could not exceed competitive rates.[166] The tangible assets consisted generally of real property, a 274-bed hospital, clinic facilities throughout the area, intangible assets, improvements, fixtures, furnishings, equipment, and inventory.[167] The intangible assets included covenants not to compete, HMO contracts, an in-place work force, warranty rights, prepaid assets and deposits, utility rights, trademarks, and trade names.[168] The Service granted Friendly Hills tax-exempt status.[169] The Service issued the ruling contingent upon Friendly Hills' compliance with anti-kickback restrictions concerning referrals for Medicare or Medicaid patients.[170]

---

157. *Full Text Exemption Ruling*, *supra* note 149, at 491.
158. *Full Text Exemption Ruling*, *supra* note 149, at 490-91.
159. *Full Text Exemption Ruling*, *supra* note 149, at 490.
160. *Full Text Exemption Ruling*, *supra* note 149, at 491.
161. *Full Text Exemption Ruling*, *supra* note 149, at 491.
162. *Full Text Exemption Ruling*, *supra* note 149, at 491.
163. *Full Text Exemption Ruling*, *supra* note 149, at 491.
164. *Full Text Exemption Ruling*, *supra* note 149, at 490-91.
165. *Full Text Exemption Ruling*, *supra* note 149, at 491. Capitated compensation exists when providers are paid a set amount of money for services on a per-patient basis. Interview with Chris E. Davis, District Sales Manager, Klais & Company, in Dayton, OH (Feb. 17, 1994).
166. *Full Text Exemption Ruling*, *supra* note 149, at 491.
167. *Full Text Exemption Ruling*, *supra* note 149, at 490-91.
168. *Full Text Exemption Ruling*, *supra* note 149, at 490-91.
169. *Full Text Exemption Ruling*, *supra* note 149, at 490-91.
170. *Full Text Exemption Ruling*, *supra* note 149, at 491. See *infra* notes 261-84 and accompanying text for a discussion of the anti-kickback rules.

Published by eCommons, 1994

A similar determination ruling involved a subsidiary of UniHealth America, a nonprofit corporation.[171] The subsidiary was the Facey Foundation, an IDS.[172] Facey Foundation was set up to provide access to quality health care services at an affordable price, to conduct research programs, to provide public health education, and to offer extensive medical and record-keeping advantages.[173] Facey Foundation would have urgent care centers open to anyone regardless of their ability to pay.[174] Moreover, the Facey Foundation physicians contracted to provide health care without regard to the patients' abilities to pay and without discriminating against Medicare patients.[175] A board, representative of the community, was to be selected with the limitation that only two of ten board members could also be physician group members.[176] Finally, the foundation promised to provide up to $400,000 worth of annual charitable care, exclusive of bad debts.[177]

Another subsidiary of UniHealth owned health care assets that the Facey Foundation would lease.[178] The affiliate would charge the Facey Foundation no more than fair market value under the leases.[179] The Facey Foundation physician compensation arrangement was more financially beneficial to the physicians involved than was the physician compensation arrangement in Friendly Hills.[180] Initially, Facey Foundation would pay the doctors approximately eighty to eighty-five percent of gross revenue.[181] After two years, the doctors could negotiate for compensation from an arm's-length bargaining position reflecting reasonable market prices.[182] Again, the Service ruled that the IDS would be granted tax-exempt status if the foundation complied with anti-kickback laws.[183]

The Service released a third IDS determination ruling in February 1994.[184] The ruling approved tax-exempt status for the Harriman Jones Medical Foundation (HJMF), owned by UniHealth America,[185] a non-

171. *Facey Medical Foundation*, *supra* note 149.
172. *Facey Medical Foundation*, *supra* note 149.
173. *Facey Medical Foundation*, *supra* note 149, at 830.
174. *Facey Medical Foundation*, *supra* note 149, at 829.
175. *Facey Medical Foundation*, *supra* note 149, at 829-30.
176. *Facey Medical Foundation*, *supra* note 149, at 829.
177. *Facey Medical Foundation*, *supra* note 149, at 830.
178. *Facey Medical Foundation*, *supra* note 149, at 829.
179. *Facey Medical Foundation*, *supra* note 149, at 829.
180. *Facey Medical Foundation*, *supra* note 149, at 829.
181. *Facey Medical Foundation*, *supra* note 149, at 829.
182. *Facey Medical Foundation*, *supra* note 149, at 829.
183. *Facey Medical Foundation*, *supra* note 149, at 830.
184. *News Release*, *supra* note 149.
185. In addition to being the parent corporation of HJMF, UniHealth America is also the parent corporation of the Facey Foundation.

https://ecommons.udayton.edu/udlr/vol20/iss1/7

profit corporation.[186] The foundation was to operate for the community's benefit and would be representative of the community.[187] HJMF would provide inpatient and outpatient services.[188] HJMF would serve local area residents, expand clinical specialties, perform community medical education and research activities, recruit new physicians, increase access to health care, and generally improve the quality of the community's health care.[189] The foundation also promised to provide up to $750,000 of charitable care annually, exclusive of bad debts.[190] HJMF would conduct significant research programs and public health education programs.[191] Moreover, the contract with the providers stipulated that the foundation could not discriminate against patients requiring or seeking urgent care at clinics or hospitals with respect to a patient's ability to pay.[192] In addition, the physicians promised not to discriminate against Medicare and state social program patients.[193]

HJMF agreed to purchase the assets of an existing group medical practice from the current physician partners.[194] Under a contractual agreement, the physician practice group became providers of all of HJMF's medical services.[195] As part of the purchase price, HJMF would receive personal property and other assets, including equipment, leasehold improvements, contracts and leases, supplies, accounts receivable, and intangible assets.[196] The intangible assets would consist of the physician group's trade name, patient files and records, software, in-place work force, contracts to provide medical services, noncompetition agreements, and goodwill.[197] The purchase was to be at or below fair market value as determined by independent appraisals and arm's-length bargaining.[198] The IDS would maintain an independent board of directors, with a limitation in the bylaws that no more than twenty percent of the board could be financially related to any shareholder or employee of the physician group.[199]

186. *News Release*, *supra* note 149.
187. *News Release*, *supra* note 149.
188. *News Release*, *supra* note 149.
189. *News Release*, *supra* note 149.
190. *News Release*, *supra* note 149.
191. *News Release*, *supra* note 149.
192. *News Release*, *supra* note 149.
193. *News Release*, *supra* note 149.
194. *News Release*, *supra* note 149.
195. *News Release*, *supra* note 149.
196. *News Release*, *supra* note 149.
197. *News Release*, *supra* note 149.
198. *News Release*, *supra* note 149.
199. *News Release*, *supra* note 149.

Published by eCommons, 1994

Initially, the HJMF physicians were to be paid a percentage of adjusted gross revenue almost exclusively on a capitated basis.[200] The compensation would be paid according to a fee schedule.[201] The physicians would designate two members of a fee committee, and HJMF would choose three members.[202] The board would approve the selection of all practicing physicians.[203] After the initial compensation period, HJMF would establish a compensation committee to review the physicians' compensation.[204] The committee would be composed of three members, designated by the foundation, who could not be affiliated with the physicians.[205] The foundation would negotiate with the physicians at arm's length regarding their salaries, which could not exceed competitive rates.[206]

The Service will follow the guidelines of the Friendly Hills, Facey Foundation, and HJMF determination rulings in examining the potential for an IDS to obtain tax-exempt status.[207] The Service focused upon five key factors in the IDS determination rulings. The Service's analysis consists of determining whether: (1) the IDS provides a community benefit;[208] (2) the board of the IDS represents members of the community;[209] (3) the IDS practices nondiscrimination regarding patients;[210] (4) the direct and indirect compensation of physicians providing care is reasonable;[211] and (5) the IDS complies with anti-kickback laws.[212]

1. Community Benefit

In granting section 501(c)(3) status to Friendly Hills, the Facey Foundation, and HJMF, the Service found that all of the organizations provided a community benefit.[213] The Community Benefit Standard set forth in Revenue Ruling 69-545 was not established in response to an

200. *News Release*, *supra* note 149.
201. *News Release*, *supra* note 149.
202. *News Release*, *supra* note 149.
203. *News Release*, *supra* note 149.
204. *News Release*, *supra* note 149.
205. *News Release*, *supra* note 149.
206. *News Release*, *supra* note 149.
207. T.J. Sullivan, Technical Assistant for Health Care at the Service, stated that the factors mentioned in the determination rulings will guide future determinations. *IRS Focuses On Community Benefit In Integrated Delivery System Rulings*, Daily Tax Rep. (BNA) No. 156, at D-12 (Aug. 16, 1993).
208. *See infra* notes 213-29 and accompanying text.
209. *See infra* notes 230-34 and accompanying text.
210. *See infra* notes 235-45 and accompanying text.
211. *See infra* notes 246-60 and accompanying text.
212. *See infra* notes 261-84 and accompanying text.
213. *Full Text Exemption Ruling*, *supra* note 149; *Facey Medical Foundation*, *supra* note 149; *News Release*, *supra* note 149.

https://ecommons.udayton.edu/udlr/vol20/iss1/7

IDS.[214] The Service, in the determination rulings, however, discussed the benefit to the community and used language nearly identical to the Community Benefit Standard.[215] Presumably, an IDS must provide health care assistance in its locale to qualify for exempt status under section 501(c)(3).[216] The Service noted that the three IDSs provided charitable health care. The Service has stated, however, that if the IDS is a hospital, it will likely be required to have more than an open emergency room and a Medicare nondiscrimination policy to demonstrate sufficient community benefit.[217] This requisite showing would be especially true in outpatient or clinic settings.[218] The three favorable IDS determination rulings suggest that in addition to a strong commitment to accepting Medicare and Medicaid patients, the Service will require a significant amount of charity care beyond that entailed in the operation of an emergency room.[219]

Each IDS was able to demonstrate community benefit beyond open emergency rooms and nondiscriminatory practices. The foundation in Friendly Hills agreed that all financially needy emergency room patients who required hospitalization would be admitted to the hospital for care and would receive all required follow-up care free or at discounted rates.[220] This would include outpatient care through Friendly Hills' clinics. Similarly, Facey Foundation agreed to treat anyone in immediate need of care at one of its clinic locations without regard to the patient's financial resources.[221] Furthermore, Facey Foundation's contract with the physician group stipulated that a "substantial number" of the physicians would serve on hospital emergency room panels and render emergency room care without regard to the patients' ability to pay.[222]

Other examples of community benefit included Facey Foundation's provision of at least $400,000 in annual charitable care,[223] HJMF's

214. See *supra* notes 101-10 and accompanying text for a description of the Community Benefit Standard. When the Community Benefit Standard was set out in 1969, there were no IDSs in existence.

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

216. T.J. Sullivan, Special Assistant to the I.R.S Commissioner, stated in an interview that the Service derived the informal criteria for evaluating IDS applications for tax-exempt status from Revenue Ruling 69-545. Marlis L. Carson, *EO Officials Emphasize Health Care Compliance*, 94 Tax Notes Today 20-5, Jan. 31, 1994, *available in* LEXIS, Taxana Library, TNT File.

217. Boisture, *supra* note 5.

218. Boisture, *supra* note 5.

219. Boisture, *supra* note 5.

220. *Full Text Exemption Ruling*, *supra* note 149, at 491.

221. *Facey Medical Foundation*, *supra* note 149, at 830.

222. *Facey Medical Foundation*, *supra* note 149, at 829.

223. *Facey Medical Foundation*, *supra* note 149, at 830.

Published by eCommons, 1994

provision of at least $750,000 of charitable care,[224] and work in medical research and medical education.[225] Furthermore, the IDSs agreed to participate in Medicare and similar state programs.[226] Additionally, in the Facey Foundation ruling, the Service stressed that an IDS is a benefit to the community.[227] The existence of an IDS eliminates duplication of tests, procedures, and treatments, resulting in greater efficiency and reduced costs to the public.[228] Although the Service did not emphasize the issue in any of the rulings, the Service considers the likelihood of a community benefit to be greater when an IDS with a hospital has an open medical staff.[229]

2. Representative Board

An IDS has a greater likelihood of achieving tax-exempt status if the IDS structures the board of directors to be representative of the community. Because of the control the board retains over the operation of the IDS, the additional benefit to physicians or to the Medical Group through significant board participation presents a serious threat to recognition of an IDS's tax-exempt status.[230] Therefore, the less control service providers retain over the IDS organization, the more the venture looks "like a tax-exempt entity."[231] Only a minority of board members should represent physicians, the Medical Group, management, or other interested parties.[232] All three of the Foundation Models

224. *News Release*, *supra* note 149.

225. *News Release*, *supra* note 149.

226. *Full Text Exemption Ruling*, *supra* note 149, at 491; *Facey Medical Foundation*, *supra* note 149, at 830; *News Release*, *supra* note 149.

227. *Facey Medical Foundation*, *supra* note 149, at 828-30.

228. Boisture, *supra* note 5.

229. *IRS Focuses On Community Benefit in Integrated Delivery System Rulings*, *supra* note 207, at D-12. T.J. Sullivan of the Service emphasized that if a hospital entered into an IDS arrangement with a physician group, some physicians would not have a place to practice if they were not a part of the group. *Id.* The absence of an open staff, therefore, gives the IDS an unfair bargaining position.

230. TECHNICAL INSTRUCTION MANUAL, *supra* note 54. If physicians can control the organization's business aspects, such as physician compensation, the control could be indistinguishable from the private practice of medicine, which is not charitable and is taxable. *IRS Focuses On Community Benefit in Integrated Delivery System Rulings*, *supra* note 207, at D-12.

231. Julie Johnsson, *IRS Guide On Tax Exemptions: Guidelines Detail Rules on Physician Involvement in Integrated Delivery*, 36 AMERICAN MEDICAL ASSOCIATION, Oct. 4, 1993, at 3. Critics, however, believe that the winds of change will alter the stance of the Service. *See id.*; *see also* Hudson, *supra* note 123, at 31 (stating that many attorneys interviewed feel that the limitations placed upon physicians contracting with the IDS will not hold up under challenge). Because an IDS often alters the "entire functional relationship between the physician and an institutional provider with respect to managed care offerings," the IDS is an "entirely new entity that behaves differently in the marketplace." *See* Johnsson, *supra*. Thus, shared governance would be more appropriate. *Id.*; *see also Improper Activities*, *supra* note 15, at 1790.

232. Retired physicians formerly associated with the physician group will be treated by the Service as representatives of the physicians. Boisture, *supra* note 5.

https://ecommons.udayton.edu/udlr/vol20/iss1/7

to which the Service granted tax-exempt status proposed to maintain a board composed of no more than twenty percent physicians.[233] The twenty percent figure appears to be a "safe harbor" in establishing a representative board.[234]

3. Nondiscrimination

Revenue Ruling 69-545 has been interpreted to prohibit discrimination against Medicare and Medicaid patients.[235] While the ruling does not directly apply to an IDS, the Service placed emphasis on the foundations' nondiscrimination practices.[236] In the determination rulings, the Service considered participation in Medicare and Medicaid programs and nondiscrimination at the clinic or hospital to be important.[237]

Facey Foundation agreed that its hospitals and clinics would participate in Medicare and state social programs on a nondiscriminatory basis.[238] Additionally, the physicians agreed to treat patients requiring or seeking urgent care, regardless of the patients' ability to pay.[239] Furthermore, the physicians agreed not to discriminate against individual patients based on their financial resources at one of the foundation's clinics or hospitals.[240] Friendly Hills also agreed to participate in both Medicare and state social programs.[241]

HJMF provided similar evidence of its intent not to discriminate. Specifically, HJMF's contract with the physicians stipulated that the physician group could not discriminate against patients requiring or seeking urgent care at clinics or hospitals with regard to their ability to pay.[242] The physicians involved in the HJMF ruling agreed not to discriminate against patients whose care was supported by Medicare and state social programs.[243]

---

233. *See* Boisture, *supra* note 5.

234. The Service has stated that 20% is not an absolute requirement or limitation. *IRS Focuses On Community Benefit In Integrated Delivery Systems Rulings*, *supra* note 207, at D-12. If a board comprises less than 20% physicians, however, the Service's "comfort level will be great enough" that the Service will probably not question whether the organization's board is a community board. *Id.*

235. Smith, *supra* note 24, at 32.

236. *Full Text Exemption Ruling*, *supra* note 149, at 491; *Facey Medical Foundation*, *supra* note 149, at 830; *News Release*, *supra* note 149.

237. *Full Text Exemption Ruling*, *supra* note 149, at 491; *Facey Medical Foundation*, *supra* note 149, at 829-30; *News Release*, *supra* note 149.

238. *Facey Medical Foundation*, *supra* note 149, at 829.

239. *Facey Medical Foundation*, *supra* note 149, at 829.

240. *Facey Medical Foundation*, *supra* note 149, at 829.

241. *Full Text Exemption Ruling*, *supra* note 149, at 491.

242. *News Release*, *supra* note 149.

243. *News Release*, *supra* note 149.

Published by eCommons, 1994

In all of the Foundation Model determination rulings, the applicants clearly demonstrated that they would not discriminate based on the financial status of the patients. The Service has not established a minimum level of requisite nondiscrimination. The overriding principle remains that the Service is seeking evidence of a benefit to the community. Providing nondiscriminatory service satisfies that community benefit.[244]

4. Direct and Indirect Physician Compensation

The determination rulings scrutinize the direct and indirect physician compensation arrangement of the IDS.[245] Perhaps the greatest challenge that an IDS faces in obtaining a favorable determination ruling is in receiving approval for amounts paid to physicians for their practices and for the subsequent compensation arrangement between the IDS and the physicians.[246] Section 501(c)(3) expressly imposes restrictions upon inurement and private gain for tax-exempt status.[247] The rulings interpret section 501(c)(3) in a manner specific to an IDS. Inherent in section 501(c)(3) is the premise that the physicians' compensation is not unreasonable.

Friendly Hills, the Facey Foundation, and HJMF all expressly mandated that no more than fair market value would be paid to the physicians for their services.[248] It is crucial that indirect physician compensation not exist. In the past, the Service has focused upon non-salary payments to physicians that result in private gain.[249] These payments represent indirect compensation. One common area of abuse is in the purchase of intangible assets.[250] In each of the three determination rulings, the IDS purchase of intangibles was minimal, although this is not always the case. A failure to obtain charitable exempt status will occur when an IDS purports to purchase assets to use in the delivery of health care services of an organization, usually owned by physi-

---

244. Smith, *supra* note 24, at 32.

245. *See Full Text Exemption Ruling, supra* note 149, at 490-91; *Facey Medical Foundation, supra* note 149, at 828-29; *News Release, supra* note 149.

246. Smith, *supra* note 24, at 40.

247. *See supra* notes 67-76 and accompanying text.

248. *Full Text Exemption Ruling, supra* note 149, at 491; *Facey Medical Foundation, supra* note 149, at 829; *News Release, supra* note 149.

249. *1992 IRS Exempt Organizations CPE Technical Instruction Program Textbook: Chapter I: Reasonable Compensation*, 94 Tax Notes Today 70-23, Apr. 12, 1994, *available in* LEXIS, Taxana Library, TNT File.

250. Intangible assets represent an increase in the net worth of the business that results from the past operation of the business. Examples include agreements not to compete, goodwill, and patient lists.

https://ecommons.udayton.edu/udlr/vol20/iss1/7

cian groups, but does not do so in reality.[251] If the Service finds the arrangements to be "sophisticated disguises to share the profits [of the health care organization] with referring physicians, in order to induce physicians to steer referrals to the hospital," the Service will deny tax-exempt status.[252] While intangible assets do possess value, their value is more difficult to ascertain than the value of tangible assets.[253] As a result, the real intent of an IDS may be to conceal impermissible payments for future referrals when those payments can be easily disguised as a purchase of intangibles at their fair market value. This situation can be avoided if the physicians contracting with the IDS do not make referrals to the IDS.

Aside from the possibility of indirect compensation flowing to the physicians through the purchase price of their practices, the manner in which the physicians are directly compensated must meet certain criteria. The Service examines three key factors to determine whether a compensation plan results in inurement.[254] A compensation plan does not result in proscribed inurement if: (1) the compensation plan is consistent with exempt status, as would be the case with a plan that merely distributes profits to principals or transforms the organization's principal activity into a joint venture; (2) the compensation plan is the result of arm's-length bargaining; and (3) the compensation plan results in reasonable compensation.[255] Whether these criteria are met depends on the facts and circumstances of each determination ruling.[256]

The three IDS organizations that received favorable rulings compensated their physicians under either capitated contracts, a percentage of gross revenues, or a combination of both.[257] The Service stated that it will favorably view arrangements establishing compensation as a percentage of the IDS's capitation or adjusted gross revenues, but not as a percentage of net income.[258] The Service recommends that an IDS establish a compensation committee to determine each physician's appropriate compensation.[259] Each of the three IDS Foundation Models utilized a compensation committee. The compensation committee should not be subject to any influence by the physicians providing health care.

---

251. *HHS Casts Doubt on 501(c) Tax-Exemption Granted to Integrated Delivery Systems by IRS*, 5 MANAGED CARE OUTLOOK, May 18, 1993.

252. *Id.*

253. Boisture, *supra* note 5, at 33-34.

254. Rev. Rul. 611-383, 1969-2 C.B. 113.

255. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

256. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

257. *Full Text Exemption Ruling*, *supra* note 149, at 491; *Facey Medical Foundation*, *supra* note 149, at 829; *News Release*, *supra* note 149.

258. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

259. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

Published by eCommons, 1994

Therefore, it is important that none of the compensation committee members be physicians with past or present affiliation with the Medical Group or anyone related to these physicians.[260]

5. Anti-Fraud and Anti-Kickback Arrangements

A potential IDS faces a challenge in dealing with the tension between structuring a commercially reasonable business transaction and complying with anti-kickback rules.[261] The IDS determination rulings were all conditioned upon a requisite absence of violations by the IDS of the federal anti-kickback restrictions that prohibit the payment of remuneration in return for the referral of Medicare or Medicaid patients.[262] The Service mandates compliance with anti-kickback rules because failure to comply confers an impermissible private benefit on the seller in violation of the tax-exempt status.[263] Moreover, the Service does not view the purchase of a medical group's intangible assets by a tax-exempt organization as per se violative of tax-exempt status.[264]

A conflict exists, however, between the Service's treatment of and attitude toward IDS purchases of physicians' practices and that of the Department of Health and Human Services Office of Inspector General (OIG).[265] The OIG enforces Medicare or Medicaid fraud and abuse laws that include anti-kickback provisions.[266] Thus, the Service and the OIG both administer interrelated law.[267] A charitable organization may purchase intangible assets from a taxable entity, which in the formation of an IDS would likely be a physician group.[268] As long as the intangible assets contribute directly and substantially to the accomplishment of the purchaser's exempt purposes, the purchase of the intangible assets will not prevent the Service from granting tax-exempt

260. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

261. Smith, *supra* note 24, at 40.

262. 42 U.S.C. § 1320a-7 to a-7(b) (1988 & Supp. II 1990). The statute provides that the "secretary may exclude . . . from participation in any [Medicare/Medicaid] program . . . any individual or entity that the secretary determines has committed an act which is described in section 1320a-7a . . . or section 1320a-7b." *Id.* Sections 1320a-7(a) and 1320a-7(b) describe fraud, kickback, and other prohibited activities in detail. *Id.* § 1320a-7(b)(7).

263. *Non-Profit Hospitals' Acquisitions of Practices*, MASS. LAW. WEEKLY, Jan. 10, 1994, at 11 [hereinafter *Practice Acquisitions*]. The Service proposed revoking the tax-exempt status of several hospitals because it has discovered some cases of alleged over-payment for the purchase of practices. *Id.*

264. *Id.* at 11. After all, the Service did permit the IDS organizations to become tax exempt under § 501(c)(3). *See supra* notes 155, 183, 186 and accompanying text.

265. *See HHS Casts Doubt on 501(c)(3) Tax-Exemption Granted to Integrated Delivery Systems by IRS*, *supra* note 251.

266. *Practice Acquisitions*, *supra* note 263, at 11 (citing 42 U.S.C. § 1320a-7(b)).

267. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.

268. Rev. Rul. 76-91, 1976-1 C.B. 149.

https://ecommons.udayton.edu/udlr/vol20/iss1/7

status.[269] Even though the Service has ruled that the purchase of intangible assets is allowable, however, an IDS must also ensure that the OIG does not view the purchase as a violation of the anti-kickback laws.[270]

An IDS could violate the anti-kickback laws if a selling physician is "in a professional position to make referrals to, or otherwise generate business for, the purchasing practitioner."[271] Although safe harbor regulations[272] exist that can reduce the risk of violating the restrictions, the OIG has stated that the safe harbor rules "do not expressly protect the sale of a practice to . . . anyone other than another physician."[273] The OIG maintains that "it may be necessary to exclude from consideration [of the value of a physician(s) practice] any amounts which reflect, facilitate or otherwise relate to the continuing treatment of the former practice's patients, . . . [because these] amounts could be considered as payments for referrals."[274] "[A]ny amount paid in excess of the fair-market-value of the hard assets of a physician practice would be open to question."[275] Questionable items include goodwill, the value of the in-place workforce, covenants not to compete, exclusive dealing agreements, patient lists, and patient records.[276]

The purchase of intangible assets is suspect where there is both: (1) a continuing relationship between the health care provider that purchases the practice and the selling physician; and (2) the health care provider relies on referrals from that selling physician, as is the case with an IDS.[277] The concern of the OIG is that such a health care provider is, in effect, paying for a future stream of referrals.[278] Because of the physicians' past ownership of the IDS assets and the physician group's probable present contractual arrangement to provide medical

269. *Id.*

270. The tax code severely curtails the Service's ability to share information with the OIG. *IRS Focuses On Community Benefit In Integrated Delivery Systems Rulings*, *supra* note 207, at D-12. Such a prohibition makes it unlikely that the Service will examine whether anti-kickback provisions are violated. *Id.*

271. 42 C.F.R. § 1001.1152(e).

272. The OIG has issued regulations defining certain transactions which will not be subject to prosecution. *Practice Acquisitions*, *supra* note 263, at 11.

273. 56 Fed. Reg. 35,974 & 35,975 (1991).

274. *HHS Looks at Applicability of Anti-Kickback Statutes to Various Medical Practice Acquistions*, 93 Tax Notes Today 68-22, Mar. 26, 1993, *available in* LEXIS, Taxana Library, TNT File (letter from D. McCarthy Thornton, General Counsel of the OIG, to T.J. Sullivan, Technical Assistant for Health Care, IRS).

275. *Id.*

276. *Id.*

277. *See id.*

278. *Practice Acquisitions*, *supra* note 263, at 11.

Published by eCommons, 1994

services, a strong presumption of private benefit flowing to the Medical Group exists.[279]

For the IDS to obtain charitable tax-exempt status, the public benefit emanating from its activities must demonstrably outweigh any private benefit to the extent that the private benefit is merely incidental.[280] A potential IDS must take care to structure the purchase so that the price may not be questioned when a former physician-owner or partner contracts with the IDS. An IDS can accomplish this by utilizing arm's-length bargaining with independent appraisals of the fair market value of the assets.[281] One suggestion for completely alleviating risk in similar circumstances would be to arrange an outright purchase instead of a lease.[282] Another option would be to eliminate any purchase of intangibles.[283] Of course, it is critical that the physicians contracting with the IDS not be required to refer patients to the IDS to avoid direct violation of the anti-kickback rules.[284]

Various obstacles may cause health care providers and payors to forego organizing a Foundation Model IDS. First, there is a time delay encountered in obtaining a determination exemption ruling granting tax-exempt status for a Foundation Model IDS.[285] Additionally, organizers of such an undertaking should consider that they face the complexities of the tax law and a relatively scant amount of case law. Accordingly, organizers must possess a high degree of knowledge or have access to such knowledge.[286] In light of the recent arrival of the IDS upon the health care scene, useful information regarding IDSs is not common knowledge even among members of the industry. Finally, the substantive overall limitations reviewed in the three determination rulings weaken the ability of the IDS to bargain with physicians.[287] Accordingly, IDS organizers may instead elect to organize as a Medical Service Organization or some fully integrated Model other than a Foundation Model.

Alternatively, the organization could operate as a nonprofit hospital that simply employs physicians, without first seeking an advance determination ruling.[288] The nonprofit hospital may reasonably desire

---

279. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.
280. TECHNICAL INSTRUCTION MANUAL, *supra* note 54 (citing Rev. Rul. 69-266, 1969-1 C.B. 151).
281. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.
282. *See* TECHNICAL INSTRUCTION MANUAL, *supra* note 54.
283. TECHNICAL INSTRUCTION MANUAL, *supra* note 54.
284. *See* TECHNICAL INSTRUCTION MANUAL, *supra* note 54.
285. *See* Boisture, *supra* note 5.
286. *See* Boisture, *supra* note 5.
287. *See* Boisture, *supra* note 5.
288. *See* Boisture, *supra* note 5.

https://ecommons.udayton.edu/udlr/vol20/iss1/7

to proceed with its IDS formation, choosing to risk defending its IDS status in an audit by the Service over the cost and uncertainty of a determination ruling.[289] Such a course of action seems wise considering the small number of audits conducted,[290] the Service's desire to maintain its present number of personnel,[291] and the current "all or nothing" solution to tax-exempt status, despite the pressure for intermediate sanctions.[292] In a state with prohibitions against the "corporate practice of medicine," the formation of a Foundation Model IDS is unavoidable.[293] Finally, it must be noted that structurally, both physicians and hospitals benefit from the IDS form of organization. A hospital can increase its competitiveness in the managed care environment while being able to recruit and build loyalty with its physicians.[294] The physicians, on the other hand, share a similar desire with the hospitals to increase access to managed care contracts.[295] The IDS also lowers the physicians' administrative burdens and increases their access to capital.[296]

B. Potential Future Problems Resulting From a National Movement to Limit the Number of Tax-Exempt Entities in Health Care

Due to the enormous dollar value of obtaining a tax-exempt status to organizations and the potential for misappropriation of public dollars, the Service's granting and retention of exempt status to organizations has captured national attention.[297] The tremendous amount of dollars at stake does not alone command such attention. Evolution in the structure of health care in this Nation, combined with a seemingly upward spiral of abuse by nonprofit organizations, has generated skepticism regarding the federal government's current system of exemp-

---

289. *See* Boisture, *supra* note 5.

290. *Unofficial Transcript Of Oversight Hearing On Nonprofit Abuses*, 93 Tax Notes Today 131-19, June 21, 1993, *available in* LEXIS, Taxana Library, TNT File.

291. *Id.*; *see also* Linda Galler, *Emerging Standards for Judicial Review of IRS Revenue Rulings*, 72 B.U. L. REV. 841, 885 (1992); Oliver A. Houck, *With Charity For All*, 93 YALE L.J. 1415, 1425 n.18 (1994).

292. *Nonprofit Corporations*, *supra* note 4, at 1601.

293. *See* Boisture, *supra* note 5. See *supra* note 129 for a discussion of corporate practice of medicine.

294. Boisture, *supra* note 5.

295. *See* Boisture, *supra* note 5.

296. Boisture, *supra* note 5.

297. Some commentators assert that, because of the manner in which the Service has interpreted I.R.C. 501(c)(3), health care in this nation has been significantly and adversely affected. Daniel C. Schaffer & Daniel M. Fox, *Tax Administration as Health Policy: The Exemption of Nonprofit Hospitals*, 1969-90, 53 Tax Notes 217, 218 (1991), *available in* LEXIS, Fedtax Library, Txnmag File.

Published by eCommons, 1994

tion.[298] Critics of the present system believe that many nonprofit health care organizations no longer serve the public.[299] Furthermore, critics assail the nonprofit health care organizations as undeserving of the subsidy that they enjoy from the government, a subsidy to which their for-profit counterparts are not entitled.[300]

Health care organizations are among the worst offenders of section 501(c)(3) prohibitions. During audits of charitable organizations, the Service has uncovered "large salaries, complex compensation, and [the] flow of money from health care organizations into the hands of those who control the organizations."[301] Patient dumping[302] and marginal

---

298. Congress is re-examining the wisdom of the exemption. As a result, several proposals have been laid on the table which provide alternatives to the current system. Leading the fight is Congressman J.J. Pickle, Chairman of the Oversight Subcommittee of the House Ways and Means Committee. *See* Chisolm, *supra* note 41, at 310. Pickle began his crusade in 1987 when he became Chairman. *Id.* The House Ways and Means Committee conducted numerous hearings regarding hospital nonprofit organizations and generated a Report to the Senate of its findings in March of 1994. *Joint Committee Report, supra* note 11.

Activity at the state and local government level addresses a similar crisis relating to a nonprofit organization's tax-exempt status from payment of property taxes, which is beyond the scope of this Article. For an excellent discussion of the controversy at state and local levels, see Boisture, *supra* note 5.

299. *Nonprofit Corporations*, *supra* note 4, at 1620.

300. *Nonprofit Corporations*, *supra* note 4, at 1629 (citing Hall & Colombo, *supra* note 42, at 322-23). Critics against granting tax exemption to nonprofit organizations in the health care industry resent the "patient dumping" of indigents that occurs under Revenue Ruling 69-545 and the inhumane refusal to admit or treat those patients without insurance, Medicaid, or Medicare. *Id.* at 1629-30 (citing Lisa M. Enfield & David P. Sklar, *Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem*, 13 Am. J.L. & Med. 561 (1988)).

Thirty-seven million Americans do not have private or governmental health insurance. Congressional Research Service, Health Insurance and the Insured: Background Data and Analysis 3 (May 1988). Commentators argue that Congress should reconsider the exemptions because the current system is inequitable and inefficient. *See* Thomas R. Barker, *Tax Exempt Status of Hospitals of Charitable Organizations*, 90 Tax Notes Today 135-17, June 27, 1990, *available in* LEXIS, Taxana Library, TNT File. Critics question whether sufficient differences exist between the nonprofit health care organization and the for-profit health care organization, aside from considerations of universal coverage, to justify the tax advantages of the nonprofit organizations. Boisture, *supra* note 5. These same critics argue that a universal coverage plan would substantially reduce the demand for charity care and further erode the rationale behind the exemption. *Id.*

301. Marlis Carson, *Health Care Institutions May Lose Exempt Status, Warns Owens*, 93 Tax Notes Today 166-12, Aug. 10, 1993, *available in* LEXIS, Taxana Library, TNT file. The Commissioner of the Service provided examples to a House Subcommittee of actual past abuses by health care charitable tax-exempt organizations that the Service has uncovered. *House Ways and Means Oversight Subcommittee Letter and Report to Full Committee on Reforms to Improve the Tax Rules Governing Public Charities*, Daily Rep. for Execs. (BNA) No. 88-D102, at L-88 (May 10, 1994). In one example, a hospital was sold to a for-profit organization controlled by that hospital's board for less than fair-market value. *Id.* Other examples include: a hospital sold the expected net-revenue streams from outpatient surgery departments to joint ventures owned by physicians who referred patients to those departments; the CEO of a hospital received $600,000 in expense payments; a hospital made $1.5 million in loans to officers, directors, and employees; the director of surgery received a hospital loan for $845,000 secured by his home; a

https://ecommons.udayton.edu/udlr/vol20/iss1/7

community benefits persist.[303] Among tax-exempt organizations, the Service has stated that it plans to focus, in particular, upon IDSs.[304]

Remedies for noncompliance with tax-exempt status guidelines are ineffective and lack a deterrent effect. Any abuse in violation of section 501(c)(3) is sufficient for the Service to revoke the nonprofit status if inurement is proven.[305] The Service, however, does not possess sufficient resources to monitor violations.[306] Moreover, revoking the tax-exempt status is a harsh punishment, not always well-suited to the violation. Consequently, insiders' breaches of fiduciary duties and other instances of insider inurement, as well as the channeling of funds for private benefit, often go unpunished.[307] Furthermore, if the Service does choose to revoke the tax-exempt status, the insider who retains the funds, unless prosecuted in a civil suit, causes detriment to the entire organization.[308] "Penalizing the entire corporation for the improper activities of a director is not the most desirable, nor the most effective, means by which to encourage compliance . . . ."[309] The existing remedy, therefore, punishes the innocent while allowing the wrongdoer to escape retribution.

The severity of the all-or-nothing nature of the Service's decisions has prompted the Service to examine the possibility of implementing

---

hospital lent funds to doctors to set up private practices; and a hospital's doctors paid $9 million through a professional service contract so that the organization's annual information return did not show the doctors' names and salaries separately. *Id.* Additionally, field agents testified in a closed session before the Subcommittee regarding actual abuses encountered during on-going audits. *Id.* One abuse situation involved a small nonprofit clinic organization which was controlled by a CEO and a small board. *Id.* Every member of the board had significant business dealings with both the CEO and the clinic organization. *Id.* The board paid the CEO in excess of $1 million in salary. *Id.* The clinic made substantial use of credit card and cash disbursements to pay personal expenses. *Id.* The clinic then sold its charitable assets and began purchasing physicians' private practices at below fair-market values. *Id.* The physicians and their staffs then became employees of the organizations. *Id.* In another case, field agents described how a large health care organization paid its CEO extraordinary compensation including salary, substantial bonuses, and generous perks and fringe benefits. *Id.* All of the bonuses and benefits were shown as expenses on the Form 990 and were not reported as compensation to the officer involved. *Id.*

302. Carson, *supra* note 301. Patient dumping refers to a scenario where a hospital transfers or releases a patient because the patient cannot pay and/or is uninsured.

303. *Improper Activities*, *supra* note 15.

304. Carson, *supra* note 301.

305. *Nonprofit Corporations*, *supra* note 4, at 1598. Courts have construed the prohibition against inurement to prohibit self-dealing by directors of tax-exempt corporations. *Id.* The Service explains: "[t]he inurement prohibition of Code Sec. 501(c)(3) is generally directed at payments that are made to shareholders or individuals for purposes other than as reasonable compensation for goods or services." *Id.* at 1598 n.53 (citing 6 Stand. Fed. Tax. Rep. (CCH) § 3033.0227 (CCH explanation)).

306. *Nonprofit Corporations*, *supra* note 4, at 1600.

307. DeMott, *supra* note 62, at 131-37; *Nonprofit Corporations*, *supra* note 4, at 1630.

308. Boisture, *supra* note 5; *Nonprofit Corporations*, *supra* note 4, at 1630.

309. *Nonprofit Corporations*, *supra* note 4, at 1601.

Published by eCommons, 1994

"intermediate sanctions" for charities.[310] These sanctions would include penalty taxes that the Service could impose on physicians and other insiders who derive an improper benefit from dealings with health care providers.[311] Furthermore, the tax-exempt status of the IDS would not be revoked.[312] Therefore, the true wrongdoer would be penalized. Whether sanctions would be imposed on any involvement in a particular activity or merely on activity not meeting a fair market value standard remains to be determined.[313]

The Service has proposed other ideas for reform. For example, the Service suggests that it be allowed to disclose its enforcement actions, and similarly be allowed to publicly announce reasons for its revocation of an organization's tax-exempt status.[314] Other proposals include: (1) that the Service share investigatory information with states; (2) that the states provide resources for the purpose of helping the Service determine if an organization continues to perform public service; (3) that further limits be placed upon the deductibility of fundraising; and (4) that improvements be made to the federal reporting requirements for tax-exempt organizations.[315]

If Congress enacts a health reform package similar to President Clinton's proposed Health Security Act, the poor would have health insurance and nonprofit hospitals would have few, if any, "charity cases."[316] While the Code would be amended, nonprofit hospitals would generally remain exempt.[317] In order for the provision of health care services to remain a charitable activity under section 501(c)(3), a health care organization would be required to periodically assess the health care needs of its community and develop a plan to meet those needs.[318] This assessment would occur annually and include the partici-

---

310. Boisture, *supra* note 5.

311. Boisture, *supra* note 5. The IRS, key members of the House Ways and Means Committee, and major charity groups all endorse this concept. *Id.*

312. Boisture, *supra* note 5.

313. Boisture, *supra* note 5.

314. *Pickle Pushes For Reform of IRS EO Examinations*, 93 Tax Notes Today 244-38, Dec. 1, 1993, *available in* LEXIS, Taxana Library, TNT File.

315. *Id.*

316. *Plan Lets Many Hospitals Keep Tax Breaks; Clinton Proposal Would Cut Charity Load at Not-for-Profit Facilities*, WASH. POST, Dec. 28, 1993, at D1 [hereinafter *Clinton Proposal*]. Clinton's plan envisions large health plans integrating all aspects of care, from prevention to hospice, under the supervision of a primary care physician. Michael L. Millenson, *'One-Stop' Service Health-Reform Key; Firms Try to Integrate Aspects of Care*, CHI. TRIB., Jan. 23, 1994, at 19. The Clinton administration hopes that competition for consumers among plans will keep costs down. *Id.*

317. *Clinton Proposal*, *supra* note 316.

318. *Joint Committee Report*, *supra* note 11.

https://ecommons.udayton.edu/udlr/vol20/iss1/7

pation of community representatives.[319] The proposed assessment rule does not, however, establish any substantive requirements, not even regarding charity care.[320] Furthermore, the Service would not evaluate the content of the plan.[321]

The Clinton administration's proposal may be at odds with reform measures suggested by critics. While the Clinton proposal supports enhanced relationships between members of the industry, critics urge the opposite approach. The Service, members of Congress, and many critics of the current health care standards for tax exemption prefer that hospitals and physicians continue to interact at arm's length.[322] The Clinton proposal urges building alliances between hospitals and physicians.[323] It proposes community networks and collaboration among communities to build IDS organizations.[324] Implementation of a plan like the Clinton Health Security Act would add to the pressure to reexamine standards and the rationale of tax exemption, since the Clinton plan also envisions universal health care coverage.[325] Universal coverage would necessitate the federal government's expansion into the realm of financing the health care of citizens.[326] Consequently, the issue of whether the administering of health care is a charitable function would need to be re-examined.[327] An appropriate question one might ask is which activities will distinguish a nonprofit health care organization from its for-profit counterpart if all citizens have access to health care.[328]

---

319. *Joint Committee Report*, *supra* note 11. If the plan is enacted, the new standards would become effective on January 1, 1995.

320. Boisture, *supra* note 5.

321. Boisture, *supra* note 5.

322. Boisture, *supra* note 5.

323. Michael R. Callahan & Roger G. Bonds, *Clinton Reform Plan Could Bring Tax Troubles to Integration-Minded Health Care Providers*, MANAGED CARE LAW OUTLOOK, May 18, 1993.

324. *Id.*

325. The term "Universal Health Coverage" means that all taxpayers will have health insurance.

326. *Joint Committee Report*, *supra* note 11.

327. *Joint Committee Report*, *supra* note 11.

328. Boisture, *supra* note 5. Boisture argues that Clinton's plan may further narrow the operational differences between for-profit organizations and nonprofit organizations, thereby undermining the rationale for tax exemption of the typical nonprofit organization. *Id.*; *see also Clinton Proposal*, *supra* note 316. The prospect of hospitals retaining their ability to be tax-exempt has drawn substantial criticism. *Boisture, supra.* It has been suggested that Clinton's plan makes tax breaks superfluous. The critics argue that eliminating exemptions could help pay for the plan. *Id.* Conversely, industry members in support of continuing the tax-exempt status assert that nonprofit hospitals could provide other community services. *Id.*

The difficulty with justifying the continuation of tax-exempt status is especially clear when one considers a hospital in an affluent area. Paul Streckfus, *Is Health Reform Mandating Business As Usual for Tax-Exempt Hospitals*, 93 Tax Notes Today 260-23, Dec. 23, 1993, *available*

Published by eCommons, 1994

Consistent in all health-care plans proposed thus far, however, is the involvement of large groups of systems providing health care.[329] Moreover, under the Clinton plan, regional alliances would become tax-exempt organizations.[330] The government would directly subsidize these organizations.[331] The IDS can play a major role in such a scheme.[332] The IDS commands a significant possibility of controlling costs. Since the IDS is structured to pay physicians on a per-patient basis, as opposed to the traditional fee-for-service method where physicians are paid for procedures, a powerful incentive exists for doctors to keep patients healthy.[333] Furthermore, like a joint venture, physicians and hospitals share in the bottom line.[334]

IV. Conclusion

The world of health care is rapidly changing. Even the experts will likely find it difficult to predict the path health care will take. The IDS form of health care organization, however, has a solid future. In the future, as reform and change occur, the number of IDSs will undoubtedly increase. The IDS will be sought out by third-party payors, employers, and cooperatives,[335] as well as hospitals and physicians. Many industry analysts believe that health care reform will reward the IDS

---

in LEXIS, Taxana Library, TNT File. What, of significance, can a nonprofit "hospital in an affluent area do to benefit its wealthy community other than just be there[?]" *Id.* Suggestions include smoking reduction programs, educational programs, health screening, immunization, preventative care, and outreach programs. *Id.* The absurdity of such programs justifying a hospital's exemption is evident. First, there is no reason that a hospital in an affluent area should not charge for the programs. *Id.* Second, the hospital probably does not offer the programs unless there is some indirect financial benefit such as goodwill. *See id.* Finally, the government should not subsidize programs for the affluent through the tax system. *Id.* The critics argue that this nation has large, unmet medical needs rising to the level of a health care crisis. *Id.* An argument that "a few free educational programs entitles a hospital to substantial tax subsidies only makes the whole Clinton health care plan seem very suspect as a serious, well-intentioned effort to truly improve health care . . . ." *Id.*

329. Millenson, *supra* note 316.

330. Millenson, *supra* note 316.

331. Millenson, *supra* note 316.

332. A survey conducted by a health care executive search firm predicts that the IDS "will become the standard in health care delivery by the turn of the century." Millenson, *supra* note 316.

333. Millenson, *supra* note 316. Of the three IDS organizations in California, Medicare patients were hospitalized only half as often as the national average and below the rate for an HMO representing traditional fee-for-service care. *Id.* The number of high cost procedures was 40% lower than the national average for a Massachusetts IDS. *Id.* A typical IDS has 25% percent fewer specialist visits than the national average. *Id.* The IDS seems to be trying to ascertain how to improve the health of those it serves, while the traditional health care provider strives to "fill beds." *Id.*

334. *See* Millenson, *supra* note 316.

335. President Clinton proposes such cooperatives in his health care plan. He describes the cooperatives as "Regional Alliances." Richard Speizman, *Health Care Reform Bill Provides A*

https://ecommons.udayton.edu/udlr/vol20/iss1/7

for its organizational form.[336] If health care cooperatives become a reality, those providers who are part of a network that delivers fully integrated care will be in the best position to efficiently deal with the cooperatives.[337] The strategic position of the IDS is enhanced by significant scrutiny of the rationale for granting tax-exempt status to health care organizations.

It seems unavoidable that, at a minimum, health care reform will entail creating tighter standards for obtaining exemptions. A common theme among industry analysts is to ponder the justification for the tax-exempt status of HMOs and hospitals should a system of universal coverage be implemented. Providing a tax incentive for charity care would become illogical if a system of truly universal coverage is enacted to provide health care coverage for everyone. While a minimal need for charitable assistance will most likely remain, a significant portion of the charitable care provided under the present system will be absent.

In light of such a possibility, leaders of tax-exempt organizations in the health care field are well advised to prepare to lose a substantial amount of tax savings presently enjoyed. Furthermore, as is often the case with new social programs, the federal government lacks resources necessary to fund a national health care program. Many proposals for funding national health care seek to utilize government dollars that would flow from the elimination of a tax exemption for health care organizations. The powerful health care industry would no doubt lobby against such a drastic measure. In the long term, however, the probability of such a scenario seems inevitable.

The combination of these factors only serves to strengthen the already bright future of the IDS. The privilege of health care will likely become an entitlement for Americans in the form of a package of benefits. Obviously, the justification for tax-exempt status for the HMOs and hospitals under a national system of care would disappear. The justification for tax-exempt status for providers such as the hospitals and doctors who will administer the national program, however, is great. The IDS embodies the spirit of reform. The tax-exempt IDS is organized to nondiscriminatorily treat patients. The IDS model possesses built-in checks such as community involvement, arm's-length dealings with physicians, and a prohibition on the anti-kickback laws in order to prevent inurement and private benefit. The IDS system pro-

Role For Tax-Exempt Health Care Providers—At A Price, 61 Tax Notes 1399, Dec. 13, 1993, *available in* LEXIS, Fedtax Library, Txnmag.

336. Smith, *supra* note 24, at 6.

337. Smith, *supra* note 24, at 7.

Published by eCommons, 1994

vides an incentive for efficiency and the elimination of administrative costs.

The large number of IDS organizations being formed on a daily basis substantiates the belief in the future viability of the IDS. The greatest advantage of the IDS, however, is its critical role in administering health care. Politicians and the public firmly reject government administration of a system of national health care. A cost-effective private means of administration is critical. While many of the details remain unknown, it seems clear that the formation of an IDS is an option for a health care industry seeking to remain a key participant in the future of the national health care coverage. With so much uncertainty in health care today, however, perhaps the only certain advice to practitioners is to heed the words of wisdom originally spoken by Will Rogers: "Even if you're on the right track, you'll get run over if you just sit there."[338]

Valerie N. Hosfeld

338. *See* Beth Melville, *Sutter Health Executive: Hospitals Must Integrate—or Get Run Over*, Health Care Competition Week, Feb. 4, 1994.

https://ecommons.udayton.edu/udlr/vol20/iss1/7