Nonprofit Forum

THE DONATIVE THEORY OF CHARITY, OR HOW THE LATE BERT PARKS MIGHT HAVE GRANTED TAX EXEMPTION HAD HE BEEN COMMISSIONER OF THE INTERNAL REVENUE SERVICE

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February 12, 1992

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WHAT'S CHARITABLE?

The debate about the tax-exempt status of some charitable organizations has intensified of late, spreading from the relative calm of academia into the somewhat more combative political and judicial arenas.[1] Called into question are YMCA's, university book stores, museum shops and, perhaps most pointedly, voluntary hospitals, or at least some yet-to-be-defined subset of them. The debate querries not only whether they should pay taxes or not, for some or all of their activities, but it also questions the even more fundamental issue of whether they are really charitable organizations at all, given changed cirmcumstances and perceptions.

Some ask that if a for-profit entity, essentially commercial in nature, has to pay taxes, then why shouldn't a not-for-profit which is also eseentially commercial in appearance? Do we not now really have two classes of not-for-profit entities, one of which may continue to deserve relief from the burdens of supporting the government through taxation, and the other type not? It is an idea made appealing by its simplicity and straightforwardness. But like most simple solutions to complex social and legal problems, maybe closer scrutiny is adviseable.

Recently, two of the more clever and thoughtful scholars in the area of the theories underlying the charitable exemption from taxation have been Professors John D. Colombo and Mark A. Hall.[2] From a continuing series of articles[3], they have argued for the notion that only those not-for-profit charitable organizations actually perceived as such by their respective publics, as reflected quite directly by the extent of charitable contributions

given to them, ought to be treated as charitable by public policy as ennunciated through the Internal Revenue Code. This school of thought, which owes a good deal of its origin to Professor Henry Hansmann[4], is often referred to as the "donative theory" or "market in altruism" rationale for the charitable tax exemption.

The purpose of this paper is to posit some general goals or precepts which, from clearly ennunciated public policy and legal guidance, our society expects the charitable exemption criteria to achieve, and then to attempt to see whether the "donative" theory is up to the task. Hint: it is not. Also, the "charity care" or "relief of poverty" criterion will also be examined to see whether such outcome-dictate measures are similarly up to the task. Hint: they aren't, either. Furthermore, this paper proposes that both categories of approaches fail simply because they are attempting to measure the wrong thing, at least according to the posited precepts. Hint: there is hope for a better definition of community benefit and charity.

And finally, not to be entirely negative--in fact, I believe, quite to the contrary--this paper offers suggestions; drawn from the literature, the law, and from reality; as to what the proper criteria for charity really are, or at least what this author believes they were intended and ought to be, at least with regard to private, voluntary hospitals.

COMMON SENSE AND HISTORY

Both the Internal Revenue Service and the Supreme Court of the United States have considered these issues a number of times over the years, and have concluded that, although the notion of "charity" is not specifically defined

within the Internal Revenue Code, the definitions of charity contained in the long and rich history of the English and American law of private trusts should prevail and be used in this important context.[5] The Supreme Court, in the Bob Jones University vs. United States case, made itself quite clear on the issues of tax exemption and charity:

> Tax exemptions for certain institutions thought to be beneficial to the social order of the country as a whole, or to a particular community, are deeply rooted in our history, as in that of England. The origins of such exemptions lie in the special privileges that have long been extended to charitable trusts.[6]

And the court even makes reference to common sense and history, as well as the common law, in explaining their interpretation of the Congressional intent behind the relevant sections of the Internal Revenue Code:

> The form of Section 170 simply makes plain what common sense and history tell us: in enacting both Section 170 and Section 501 (c)(3), Congress sought to provide tax benefits to charitable organizations to encourage the development of private institutions that serve a useful public purpose....[7]

Furthermore, it was in this same case that the Justices quoted the now famous formulation of the notion of charity provided by Lord MacNaughten in 1891 in the English case of Commissioner v. Pemsel:

> "Charity" in its legal sense comprises four principal divisions: trusts for the relief of poverty; trusts for the advancement of education, trusts for the advancement of religion; and trusts for other purposes beneficial to the community, not falling under any of the preceeding heads.[8]

Thus the court has delineated the framework within which the very notion of charity itself is to be defined.

This is an important point of departure, because inherent in the adoption of the law of trusts is the notion of private, voluntary governance. Also included is the idea of fiduciary responsibility and management of the trust or charity, in concert with carrying out the purpose or intent of the entity.[9] This may be either specifically dictated, or interpreted over time, by the trustees, according to the nature of the charity. It is also important to note the "community benefit" category of charity, and that it is separate and distinct from the relief of poverty definition.

VOLUNTARY DISCRETION

Fundamental to this area of the law is the principle that the mission of a charity, like the purposes of a trust, is to be maintained and pursued by the trustees or governors of the charitable organization.[10] They are charged with, and indeed government entrusts them with, the responsibility for, in some cases, continually determining the mission of the organization, and in all cases, the ways and means by which such goals are pursued. These voluntary trustees are thus given the latitude and discretion of judgement for these basic stewardship functions. In a very real sense, the public, through its agent government, cedes to these voluntary, private stewards, a quasi-public function of defining and pursuing a public goal.

Under trust law, where the purposes of the trust are clearly defined by the testator or donor, the trustees are duty bound to enforce the express dictates of the trust purposes, unless they are contrary to public policy. In the case of a modern-day voluntary hospital, however, these duties and responsibilities are more difficult, for they involve not only the responsibilities to carry out and effectuate the trust's mission, but also, and more complex, the duty to continually ascertain the mission itself.[11]

Many of these hospital institutions were formed years ago by individual founders or donors; religious, ethnic, or otherwise; who clearly ennunciated the communities to be served and/or the purposes for which the trust property--the hospital corpus--was established. In those instances and for those years, the trustees had merely to manage the trust assets to effectuate the clearly stated goals of the donation. In more recent times, and after many intervening years, and frequently, many additional donors and changing community demographics--and even geographics--the trustees are charged not only with stewardship for the originally and interveningly contributed assets, but also for attempting to ascertain, over time and through changing circumstances, the very mission and purpose of the organization as well as the strategies and methods by which such ends are best pursued. For trustees, these are perhaps the most onerous and difficult set of fiduciary duties and responsibilities.[12] But, at least according to trust law, they are voluntary duties, subject only to judicial review of identified cases of clear abuse and dereliction of the fiduciary and stewardship duties of the voluntary trustee.

In the case of most voluntary, community hospitals, therefore, the question of mission and governance comes down to what is in the best interests of the community to be served by the hospital. From a practical point of view, this is both an institutional and a community process and determination. For example, a hospital that chooses to be only a "body repair shop", dedicated only to providing the best quality medical care to the patients who happen to seek it out, clearly deserves no special societal treatment. The services offered by them differ in no appreciable way from those provided by a purely for-profit hospital pursuing the same or similar objectives.[13]

On the other hand, however, a hospital whose trustees interpret their stewardship to entail provision of services beneficial to the community represents a different situation altogether; for in this type of situation, there is a balancing done on the part of the trustees to effectuate an attempt to not only preserve the corpus of the "trust" over time, but also to pursue a service mission to the community. Very often this is a difficult and complex task.[14]

In these situations, which probably represent a very large percentage of the voluntary hospitals in America, the governors or trustees undertake to define a specific geographic community for which they assume service responsibilities above and beyond those of a mere "body repair shop." They seek to identify the unmet health care needs of that identified population; either by themselves or in concert with other providers, social service, and government entities within the community; and to put together a plan designed to serve the needs of that community while at the same time striving to attain the goals of quality and excellence of medical care within their four walls.[15] To be sure, the receipt of donated, charitable funds can help further that mission, but their relatively low levels--or even their absence altogether--do not alter the fundamental character or nature of the entity's mission of community service.

COMMUNITY SERVING OR SELF-SERVING

Furthermore, a community-serving, as opposed to a purely self-serving institution, will actively seek to involve the community and its non-hospital representatives in that process, and will report to the community and the hospital's various constituencies both its activities undertaken in service to the community, and its resources dedicated to that purpose. Community

identification, needs assessment, service plan development, community involvement, and disclosure and reporting of resources used and results obtained are all crucial parts of what a hospital's community benefit governance ought to be.[16]

All of these activities; in addition to the extant legal requirements for charitable organizations, such as the "non-distribution constraint," the prohibitions against political activity, substantial lobbying efforts, private enurement and benefit, and operation for a purpose contrary to public policy; and the requirement that they be formed under a state's not-for-profit corporation law; are quite enough to assure society that the public's benefit is being pursued. Calls for other standards must be evaluated against this rich backdrop of process criteria which have evolved to reward or encourage organizations that are structured and operated in a manner designed to pursue benefit for the community. One hopes that they will be successful in pursuit of their missions, but it is both illogical and self-defeating to establish criteria that would, in effect, require ultimate success at the mission as a pre-requisite to their encouragement.

Given this history of community benefit, it is no surprise that legal precedent has obtained that the receipt of fees-for-services, in this context, is not in and of itself determinative of whether an organization, otherwise clearly non-profit in nature, is to be considered a charity. Under this analysis, the source of payment for the services rendered within such a hospital; whether from donations, self-pay, government programs, or private insurance; are not dispositive of mission orientation, or in other words, its charitable nature. As important as specific outcomes are, such as actual relief of poverty; under this trust theory analysis, it is just as acceptable

to suggest that intent, as embodied in an institution's mission statement; and action, as expressed through its community benefit plan and implementation; are activities sufficient to warrant compliance with notions of charity under existing policy and law.

THE BEAUTY PAGEANT

So it is against this background and analysis of the law of trusts and charity that Colombo and Hall's theory, and the relief of poverty criteria suggested by others, are to be scrutinized. And the result of this exercise might point public policy in the right direction in determining which hospitals, otherwise organized on a not-for-profit basis, should and which should not, be exempt from taxation at the Federal, state, or local levels.

Colombo and Hall argue not just for a charity care standard for hospital tax-exempt status, although they include it, but rather for their "market in altruism" approach. This notion is really their interpretation of Hansmann's "donative theory" of nonprofit organizations.[17]

This idea is illuminating only in that it recognizes that the American public can "vote with their feet" or checkbooks with respect to charities, and simply choose not to give contributions to those organizations that they deem not to be behaving charitably. In this manner entities are, or can be, charitable only the extent that the public, or some subset thereof, perceives them as being charitable. This curious notion is neither an outcomes measure--that is, one that looks to see how much of a particular good, such as free care to the poor, a hospital actually provides--nor a process-oriented criterion--that is, one that seeks to set the parameters of the types of organizational structure, governance, and management which society desires to

encourage.

Rather, Colombo and Hall borrow upon Hansmann's notion of a dichotomy between those nonprofit organizations which are seemingly commercial in nature, and hence not deserving of tax-exempt favoritism; and those that are "donative" in nature, in that they receive a substantial proportion of their revenues from charitable contributions.[18] Only these latter types of organizations are "true" charities, according to this simple and restrictive analysis, and deserve the special treatment of tax-exempt status. So in a sense, the Colombo and Hall idea is nothing new. They simply take Hansmann's formulation to its logical conclusion, adding along the way an arbitrary minimum amount--30%--of a hospital's revenues which must be derived from donations in order to deemed charitable.[19]

As Congressman Brian J. Donnelly has suggested, tax-exemption is a threshold standard like most government standards.[20] The criteria used in determining which hospitals meet this threshold should be, by their very nature, minimal tests. For those desiring higher standards and seeking to identify not the poor-performing hospitals but the very best, one should look to the private sector with its long history of very high yet flexible certification and accreditation standards. In fact, as described by Kovner and Hattis[21], there is an important national demonstration project being undertaken at this time to establish and test voluntary accreditation standards for the very purpose of determining community benefit among hospitals. But that is not what the tax-exemption standards are all about, nor should they be.

What is unique about voluntary organizations consists in their governance and management, and in their very "voluntariness."[22] They are unique because they are structured in a way that is neither wholly public nor

wholly private. They are private in the sense that they are governed by private individuals serving as trustees in establishing a mission for the organization and in attempting to effectuate it over time, and because they are not creatures of government.[23]

On the other hand, these voluntary institutions are public in the sense that the community benefit standard overlays a requirement, which admittedly should be made more explicit, that these institutions affirmatively strive to assess community need, and to undertake some objectively verifiable efforts to both meet those needs and to involve the community in those processees.[24] Implicit also in such a requirement is a concomitant reporting requirement by which such institutions should disclose to the public all of their community benefit processees and activities, and the resources available and allocated towards such ends.[25]

When added to the extant procedural requirements for tax-exemption already mentioned, these requirements go beyond just a more rigorous application of the IRS "organizational test"[26], and cross over into the "operational test"[27] by setting observerable operational criteria. But unlike the donative theory or the outcome-mandate criteria, these standards would not dictate results and tie the hands of hospital trustees and managers, and thus devoluntarize the institution. To the contrary, they would at the same time be more rigorous than current law, be consistent with the procedural nature of present criteria, and would interpret the trust law precedent and the community benefit idea, as it should be, in a manner that both promotes community service and preserves the fundamentally voluntary nature of the voluntary hospitals and other similar institutions.

Both the "market in altruism" or "donative theory," which results

really in nothing more than a beauty pageant or public popularity contest; and the "relief of poverty" criterion, which dictates outcomes for governance and management; amount to <u>substituted judgement</u> by lawmakers in place of the voluntary governors or trustees. On the one hand, they are not really allowed to ennunciate a mission unless the donations are always there; and on the other hand, the mission--relief of poverty--is decided for them by the government. In either case, there is nothing left for the voluntary trustee stewards to do. Once this occurs, the institution ceases to be voluntary in nature and loses its most essential and defining attribute. Such definitions do not fit within the framework of the law of private trusts.

Although there may be weaknesses in the analogy, neither corporate law nor the S.E.C. seek to guarantee that a for-profit business make a profit, nor do they penalize them if they fail to do so. What those bodies of law do, however, is set some basic ground rules along the way, about how we expect the game to be played and what sorts of structures and behaviors are and are not acceptable. Likewise, the rules for voluntary hospitals should not seek to prescribe their outcomes or their successes, nor to guarantee that they produce a certain result; such as a pre-determined or set amount of quantifiable free care given to the poor; nor penalize them through the tax code if they do not. Tax exemption criteria simply ought to provide the ground rules within which they may operate--and further, encourage the types of private structures, organizational forms, and behaviors which we perceive to be beneficial to our communities.

WHAT IS NEEDED?

However, in commenting on the status of existing law, Colombo and Hall assert that "...yet everyone who now considers the issue, even the hospital industry, conceives that something more is required. The debate really turns on what that 'something else' is that hospitals should provide."[28] With this I wholeheartedly concur. However, in picking the donative theory, the authors have just chosen the wrong measure. The evaluative criteria I suggest are the qualitative or "process" standards referred to above.

One state has already seen the wisdom in this and has adopted legislation regarding the accountability of voluntary hospitals as to their community service performance. The New York State Community Service Plan requirement, effective on January 1, 1991, represents precisely the sort of process criteria I suggest.[29] The similarity of these criteria to those being developed by the Hospital Community Benefit Standards Program, and to those under consideration by the Catholic Health Association, may be reflection of a trend toward a fairly broad concensus on this issue. But Hall and Colombo dismiss such standards because they do not lead necessarily to the actual free-care outcomes that they desire. They also argue that the approach would enmesh the Congress in a "metaphysical values debate" over the performance of the tax-exempt hospitals in relation with others.[30]

By way of response I suggest that the motivations of donors to charity are far from clear, and that their perceptions of what has become a very complex area--the operation of a modern-day hospital--may not always square with actual performance. Also, there is very little methaphysical about process criteria. The sorts of questions these criteria would ask are very

concrete and measurable:

> Does the hospital formally commit itself to service for a designated community, by means of a mission statement or other formal instrument? Has the hospital undertaken, either by itself or in collaboration with others, a health care needs assessment for the population within the designated community? Has the hospital, either by itself or in collaboration ith others, set specific community health improvement goals for this designated population? Has the hospital developed--and annually reviewed and revised--a specific community benefit plan to effectuate these activities, including any number of objectively demonstrable programs, such as special initiatives for the poor and other underserved individuals? Is there evidence in all of these processees of community input and involvement? Does the hospital take a leadership role in pursuing community input and involvement? Does the hospital regularly report on its community benefit activities and divulge the financial resources, on a combined basis, made available to do so?

COMMUNITY BENEFIT: PROCESS CRITERIA

I would suggest that none of these questions are metaphysical, and that all of them are more easily answered than the questions, assumptions and calculus required by the "donative theory" or "market in altruism" approach proffered by Professors Colombo and Hall. I believe that the trust law "process" criteria of charitable status will produce a result more rationally consistent with extant law than will one which would leave the metaphysical questions to a beauty contest waged by hospitals with the assistance of Madison Avenue. This would surely result if hospitals were put on notice that it is their public image and popularity which will determine their charitable status.

In conclusion, two observations are pertinent. First, neither the "donative theory," which measures only a public's perception of performance; nor the relief of poverty criterion, which seeks to prescribe and require the

success of an organization's mission; are consistent with and supportive of the trust law interpretation of a voluntary, trustee-governed, community benefit institution, particularly as it applies to a non-profit, voluntary hospital. Second, the basic tenets of trust and tax law should clearly require that a community benefit institution be one that serves the community instead of itself, and that it manifest its commitment to do so through its ennunciated mission and its processes for service, quality, community involvement, and disclosure. To be sure, deciding which hospitals are "charitable" must be done on a case-by-case basis, or what the Internal Revenue Service calls a "facts and circumstances" test. But given the intense public scrutiny now being placed on our nation's hospitals, they should be evaluated both individually and against a clearer standard, reasonably derived from the Supreme Court's understanding of common sense and history. Otherwise, "...we will return after these messages for the swimsuit competition--so please stay tuned."

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New York, New York
February 12, 1992

NOTES

1. Utah County v. Intermountain Health Care, Inc., 709 p. 2d 265 (Utah 1985); Medical Center Hospital of Vermont, Inc. v. Burlington. 566 A. 2d 1352 (Vt. 1989); Downtown Hospital Association v. Tennessee State Board of Equalization, 760 S.W. 2d 954 (Tenn. App. 1988); and St. Luke's Hospital v. Board of Assessment Appeals, No. 88-C-2691 (Pa. Ct. Cm. Pl., Lehigh Co. April 19, 1990). See also State v. Methodist Hospital System, No. 494, 212 (126th Judicial District, Travis County, TX, filed November 26, 1990; and In Re Health East, Inc., No. 1988-1297 (Pa. Ct. Cm. Pl., Orph. Ct. Div., Lehigh Co., July 12, 1990); and H.R. 790, 102d Cong., 1st Sess., 137 Cong. Rec. E395-97 (1991); H.R. 1374, 102d Cong., 1st Sess., 137 Cong. Rec. E896 (1991); and United States General Accounting Office, "Nonprofit Hospitals: Better Standards Needed for Exemption," 12 (1990).

2. Mark A. Hall, Professor, Arizona State University School of Law, Tempe, Arizona; and John Colombo, University of Illinois Law School, Champaign, Illinois.

3. Hall and Colombo, "The Charitable Status of Nonprofit Hospitals: Towards a Donative Theory of Tax Exemption," 66 Wash. L. Rev. 307-411 (1991); "The Donative Theory of the Charitable Exemption," 53 Ohio St. L.J. 1, 14-25 (forthcoming 1992); Hall, "Modern Theories of Hospital Tax Exemption," presented at conference: "Rationales for Federal Income Tax Exemption," The Program on Philanthropy and the Law, New York University, School of Law (October 10-11, 1991); and Colombo and Hall, "The Future of Tax Exemption for Nonprofit Hospitals and other Health Care Providers," in Health Matrix, Case Western Reserve University School of Law (forthcoming 1992).

4. Hansmann, "The Role of Nonprofit Enterprise," 89 Yale L.J.: 835 (1980).

5. Rev. Rul. 69-545, 1969-2 C.B. 117; and Bob Jones University v. United States, 461 U.S. 574 (1983).

6. Ibid, Bob Jones University v. U.S., at 588.

7. Ibid at 587-588.

8. Ibid, and Commissioners v. Pemsel A.C. 531, 583 (emphasis added) (1891).

9. 4 A. Scott, Law of Trusts, Section 368, pp. 2853-2854 (3d. ed. 1967).

10. Ibid.

11. Seay and Vladeck, "Mission Matters," in In Sickness and in Health: The Mission of Voluntary Health Care Institutions, McGraw-Hill (1988).

12. Ibid.

13. Sigmond, "Old and New Roles for the Community Hospital," William B. Woods Mem. Lec., Park Ridge Hospital, Rochester Area Hosp. Council (October 22, 1981); and "Re-examining the Role of the Community Hospital In A Competitive Environment," Michael M. Davis Mem. Lec., Center for Health Care Administrative Studies, Grad. School of Business, Univ. of Chicago (May 10, 1985); and Seay and Sigmond, "Community Benefit Standards for Hospitals: Perceptions and Performance," 5 Frontiers of Health Services Management 3, 3-39 (Spring 1989).

14. Ibid, and McCormack, "Hospital Strategy and Public Policy: Seeking the 'Just Right' Balance," in In Sickness and In Health, Seay and Vladeck, eds.

15. Ibid, Jones and Du Val, "What Distinguishes the Voluntary Hospital in an Increasingly Commercial Health Care Environment?" in In Sickness and in Health, Seay and Vladeck eds., and Kovner and Hattis, "Benefitting Communities," Health Management Quarterly (Winter 1990).

16. Ibid.

17. Ibid, note 4, supra.

18. Ibid, and note 3, supra.

19. Colombo and Hall, "The Future of Tax Exemption for Nonprofit Hospitals and Other Health Care Providers," in note 3, supra.

20. "The Tax-Exempt Status of Hospitals," Hearings Before the Committee on Ways and Means, United States House of Representatives, 102d Congress, 1st Session, July 10, 1991.

21. Kovner and Hattis, ibid.

22. Ibid, note 9, supra.

23. Garrow v. Elizabeth General Hospital and Dispensary, 79 N.J. 549, 557, 401 A. 2d. 533, 537 (1979); and Guggenheimer, "Making the Case for Voluntary Health Care Institutions: Policy Theories and Legal Approaches," in In Sickness and In Health, ibid.

24. Seay and Sigmond, note 13, supra.

25. Ibid.

26. Treas. Regs. SS 1.501 (c) (3)-1 (b) et seq.: IRS pub. 557.

27. Treas. Reg. SS 1.501 (c) (3)-1 (c) (1), et seq.

28. Ibid, note 19, supra.

29. N.Y. Public Health Law, Sec. 2803-1 (McKinney 1991).

30. Ibid, note 28, supra.