MANDATING NONPROFIT BOARD COMPOSITION:

SHORT-CUT TO ACCOUNTABILITY OR DEAD-END STREET?

presentation to the Nonprofit Forum

by

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Yogi Berra is quoted as saying "If you come to a fork in the road, take it." The road to legal and public policy in America is a long and winding one, to borrow another phrase from popular culture, and it has many forks, detours, and dead ends. One less-frequently explored path in these environs takes us to the area of accountability of nonprofit organizations, and how it is best to be encouraged, monitored, and enforced.

Road Sign: " Caution - Accountability Ahead"

There is considerable popular sentiment today for finding ways to increase the accountability of these private organizations that are exempted from taxes, given other special perquisites and status, and then allowed simply to go their merry ways in pursuit of self-identified missions of public good. [1] Coming on the heels of several particularly public and egregious scandals resulting from an abuse of the discretion allowed within this loosely regulated area [2], it is becoming clear to many who have long wanted to tighten-up on governmental oversight and control of nonprofits that the time may now be right, politically, to do something. Just what that something (or some things) should be, however, is not all that clear nor the object of any consensus approach.

One fork in the road which is being taken more frequently is one that leads to governmental specification of nonprofit governing board composition. Examples of such instances can be found in the judicial, statutory, and administrative branches of the law, and at both the state and Federal levels. Some of these examples are reviewed below, followed by a brief analysis and comment on the trend.

Judicial Intervention: Buck and Bucks

The settlement of the Buck Trust case in California [3] provides one example of the path of judicial intervention in an effort to promote greater accountability, both through board composition and judicial oversight of governance and managerial functions. The case was quite complex and drawn-out, involving many facets, including interpretation of the **cy pres** doctrine under California law, the use of variance powers by community foundations, and offers of proof -- or the lack thereof -- in the judicial finding of fact [4]. Attention here, however, is limited to the governance and oversight aspects contained in the settlement's "Second Agreement," made among the Attorney General of California, the County of Marin, and the Marin Council of Agencies [5].

Under that Agreement, entered into within the context of the settlement of the case under the supervision of Superior Court Judge Homer B. Thompson, the composition of the governing board of the newly created Marin Community Foundation was specified. This was necessitated, of course, by the termination of the San Francisco Foundation's role as distribution trustee of the Trust, also effectuated within the same context. The new board is composed of seven trustees, appointed by the Marin Council of Agencies, the Interfaith Council of Marin, the President of the University of California, the Buck family, the Board of Supervisors of Marin

County (which appointed two seats), and the Board itself. With the exception of the trustee appointed by the Buck family, each had to be five-year residents of Marin County; one of the two trustees appointed by the Board of Supervisors of Marin County had to be representative of the County's poor and needy; and the University President's trustee appointment had to be a professional educator or a member of a governing board of a public or private school [6].

And as if that was not enough, the judge also appointed a full-time, paid special master to oversee the day-to-day operations of the new foundation [7]. This special master has exceptionally broad powers, including the right to review and approve line items in the foundation's budgets [8]. This places an additional and significant constraint on the governance powers of the board of trustees, since their only recourse if they disagree with any of his budgetary decisions is to appeal to the very court that appointed him and of which he is a representative [9].

To say that the role of the board of trustees in this unique arrangement is diminished would be somewhat of an understatement. In essence, what the court has really accomplished is simply substituted judgment, rather than the creation of inducements or incentives for the board to act in a more prudent and accountable manner. But reasonable minds can disagree, and the original special master in the case, Lawrence Sipes, is quoted as saying ..."It seems to me that accountability in the foundation

world, generally, is minimal to non-existent. There is an experiment involved in the current state of affairs, and a large part of that is centered around accountability" [10].

It should be noted that Judge Thompson, in the Buck Trust case, clearly intended at least some of his interventions to be time-limited. It is also worthy of note that the judge's order was dated in August of 1986, some nine years ago. And Mr. Sipes is also quoted as asserting about his job that ..."This should not be a permanent position, but that doesn't preclude it from being a very long-term position [11]."

Another significant case upon the highway of governance intervention is, of course, the Boston University affair. Not actually a case of judicial intervention, for the jurisdiction of a court was not obtained, the matter was a settlement between the University and the Commonwealth's Attorney General in which he agreed not to sue the University or its Trustees, officers, or employees over certain governance, executive compensation, conflict of interest, and related-party transaction policies, as well as their procedures for proving accurate information to both the Trustees and the Massachusetts Division of Public Charities [12].

The Attorney General, Scott Harshbarger, had conducted an intensive investigation of the University and its practices and concluded the trustees had not lived up to their responsibilities

to oversee and monitor the activities of the University, although in the agreement, no wrongdoing was admitted on the part of the University or its trustees [13]. But from the nature of the changes required by the agreement, along with statements from the Attorney General's office, it is clear that Harshbarger and his staff believed that the University's trustees were asleep at the wheel -- that they were too "inbred" and stayed on the Board too long; that they did not receive adequate information from management to accomplish appropriate oversight functions; that there was excessive executive compensation; that there was at least the potential for or the appearance of conflicts of interest and related-party transactions among the trustees and/or officers and staff; and that there were incomplete or misleading reports filed with the Attorney General's Public Charities Division [14]. This review and discussion is intentionally limited to those changes relating to board composition and selection.

Like the Buck Trust case, the form of settlement for Boston University was an agreement, "freely" entered into by the affected parties. On November 16, 1993, the Chairman of the Board of Trustees of Boston University, Arthur G.B. Metcalf, signed the letter of agreement of the same date sent to him by Richard C. Allen, Assistant Attorney General and Director of Public Charities, Public Protection Bureau of the Attorney General's Office [15]. In exchange for not being sued, the trustees "agreed" to steer a course amending the University's By-Laws by January 15, 1994, to

alter the method by which trustees are selected, and their terms of office. The following are excerpts from the press release accompanying the publication of the agreement by the Attorney General's Office:

"* Selection of Trustees: new trustees are to be nominated by a Nominating Committee at least one-third of whose members are selected by the University's Alumni Association and may not be University trustees or employees or former trustees or employees. If approved by at least 20 percent of the committee's members, a Nominating Committee report or minority report may be made public. University management may provide staff support to the Nominating Committee process, but final deliberations and selections will be solely the responsibility of the Nominating Committee.

* Trustee Term Limits: a term limit of eight years will apply to the office of Chairman of the Board of Trustees. If 40 percent or more of the trustees at any one time have served more than 12 years on the Board, a term limit of 13 years will apply until the number of trustees serving more than 12 years has been reduced to below 40 percent.

* Term of the Agreement: the term of the agreement extends to January 1, 1999 [16]."

Also like the Buck Trust settlement, the Boston University case involved attempts to rectify perceived past wrongdoing or inappropriate behavior and interpretation of law, and the interventions were intended to be of limited duration. In each instance, the Judge in Buck and the Attorney General in Boston, undertook remedial actions of a time-limited nature, to drive home the point that accountability should be enforced, and that governance is the right road to take.

The Boston University case was neither new nor unique in Massachusetts. It had been preceded almost two years earlier by a very similar such investigation and agreement modifying the board selection processes and composition requirements of Berkshire Health Systems, Inc., a nonprofit, exempt organization operating health care facilities in Massachusetts [17]. It is interesting to note, however, that the Berkshire Health settlement did not contain a time-limiting clause, as did the later university case, and one would assume, therefore, that the terms of the settlement are to be permanent. Also, it is curious that the Attorney General chose to use the time-limiting clause in the later of the two iterations of agreement.

"Yield": Statutory Specification

Following the road farther, there can be found precedent

for statutory authority for private, nonprofit board composition specification. There are examples at both the state and Federal levels. For illustrative purposes only, several examples are cited below.

In New York "...no less than one third of the members of the governing authority of an HMO (health maintenance organization) shall be composed of residents of New York State. Within one year of the HMO receiving a certificate of authority, no less than 20 percent of the members of the governing authority shall be enrollees of the HMO. Employees of the HMO or providers of health services may not serve as enrollee representatives [18]."

Tracing a similar route, Pennsylvania insurance and health laws require at least one third of the directors of an HMO to be subscribers to the plan [19]. And West Virginia statutes, similar to those in many states, grant tax-exempt status to Blue Cross and Blue Shield Plans [20], but restrict and specify Plan board composition in the following manner: "The board of directors of any corporation organized under this article shall consist of at least seven members, all of whom shall be residents of the State of West Virginia, a majority of whom shall be subscribers to its services, one of whom shall be a person licensed to practice medicine under the laws of the State of West Virginia, one of whom shall be a person connected with the healing arts, and one of whom shall be a member of the general public not connected with any

contracting party. The members of the board shall serve without compensation but may be reimbursed for expenses incurred in carrying out their duties as members of the board [21]." And a few years back, there was a strong but unsuccessful movement to extend similar board specifications to cover hospitals, as well.

Also at the state level there is an emerging trend in Pennsylvania to tie governmental board specification to the receipt of state funding. Two recent examples involve Hahnemann University in Philadelphia [22], and The Medical College of Pennsylvania, East Falls, Philadelphia [23]. In each case, legislation introduced to provide state appropriations for educational programs was amended before passage to include the following provisions:

> "The Secretary shall not release more than the first quarterly payment until such time as the Trustees of Hahnemann University {and, in parallel legislation, for The Medical College of Pennsylvania} include five members appointed by the Governor and the General Assembly. The Governor, the President Pro Tempore of the Senate, the Minority Leader of the Senate, the Speaker of the House of Representatives and the Minority Leader of the House of Representatives shall each, upon invitation by the Trustees, appoint a nonelected official to serve as a member of the Board and the terms of office shall be coterminous with that of their appointing authority [24]."

Both institutions are very large, with assets and operating budgets in the hundreds of millions of dollars, and the responsibilities of the trustees -- and implications of governance interventions -- are significant. Given that, it is interesting to note the amount of the appropriations involved: $4.8 and $3.3 million respectively [25]. With the amount of funds and number of board seats involved, it would appear that there is rapid inflation in the price of state money in Pennsylvania, and that the currency is governance.

At the Federal level, a since-expired statute and implementing regulations also traversed the by-ways of board specification, and may shed some light on the practical wisdom of taking such trips. The "National Health Planning and Resource Development Act of 1974" set forth an elaborate and ambitious framework for attempting to contain spiralling health care costs, and achieve other socially desirable objectives, through a complex system of mandated and better-coordinated community health planning initiatives [26]. One level of this system consisted of local health planning agencies, under the Act called Health Systems Agencies ("HSAs"), which could be either public or private nonprofit organizations, and which were delegated numerous powers and responsibilities, including Certificate of Need determination authority [27]. However, the composition of the boards of the HSAs were very specifically dictated by law [28].

The legislative history of the Planning Act, however, reflected some skepticism about the wisdom of granting such powers to private organizations whose governing boards were self-selected, or worse, that were controlled by physicians or others perceived by the drafters as having motives other than public service at heart, if not outright conflicts of interest. It stated:

> "Because of the important and constructive role consumers of health care services must play in the development of short and long-term health plans, and because of the relatively disproportionate influence experience has shown that provider groups, particularly physicians, have on health planning boards, the proposed legislation requires that a majority of the members of the governing bodies of health planning agencies be consumers of health care services [29]."

> "The intent of the definition of "providers of health care services" contained in the proposed legislation is to include any individual with an existing **or potential** conflict of interest with respect to the recommendations of the health planning agency. Although the committee recognizes the valuable contributions providers of health care services can and must make to the health planning process, it also believes that if the plan which emerges is to be viable, **their influence on the health planning process must be appropriately limited** [30]."

Furthermore, the signposts of the legislative history went on to indicate that:

"The proposed legislation directs that the governing body of the health planning agency shall be between 10 and 30 members in size, but may exceed 30 if there is an executive committee of not more than 25 empowered to act for the governing body in all ways other than the establishment and revision of the long-range goal plan and short-term priorities plan [31]."

"The Committee intends that, in selecting the consumer members of a health planning agency governing body, representatives of consumer groups, such as labor unions, consumer advocacy groups, and other organizations representing the interests of consumers, as well as individual consumer members, be considered [32]."

"In recognition of the important role units of local government play in the American health care industry, both as providers and consumers of services, the proposed legislation directs that public elected officials comprise a portion of the remaining members of the governing body [33]."

"Providers representing health institutions in the area, health care insurance programs in the area, and health

professionals in the area should all be participants in the local Health Planning Agency's policy process. In addition, the Committee wishes to assure that a designee of the Administrator of Veterans' Affairs shall be an ex-officio member of the health planning agency's governing body, if a Veteran's Administration hospital is located and functioning in the health area served by the agency and the committee bill so provides [34]."

Given the specificity of the HSA board composition mandates, it is not at all surprising that implementation of them met difficulty, and indeed some commentators viewed them as particularly disastrous [35].

Tollgates of Administrative Law

Not to be left on the shoulder of the road to exempt organization accountability, the Internal Revenue Service, in an increasing series of determination letters and private letter rulings, has begun driving towards a new policy of specifying private board composition. These well-intentioned bureaucrats, striving to prevent possible future abuses of governance oversight and potential conflicts of interest, are mechanics toiling under the hood of nonprofit organizations in the health care sector, and seeking to fix something very important -- governance -- even

before it is broken. And it would appear that they are doing so with scant, if any, statutory authority.

On January 29, 1993, the Service issued a determination letter to the Friendly Hills HealthCare Network, d/b/a Friendly Hills HealthCare Foundation, in California, granting exempt status in response to its application for exemption from Federal income tax under Section 501(c)(3) of the Internal Revenue Code [36].

Friendly Hills was proposing creation and operation of "...a vertically-integrated, primary care-driven, regional health care delivery system in a managed care environment [37]." In the letter, Marvin Friedlander, Chief of the Exempt Organizations Rulings Branch 1, went through the usual litany of things the Service looks for in granting exempt status to hospitals and other related institutional health care providers, such as the elements of the "community benefit" test [38]. But the sixth paragraph added a new and additional requirement. It read ..."You will have a 10-member board. No more than two of the ten members will represent the Medical Group [39]. You have stated that you intend to ensure the independence of your board as a body controlled by members of the community [40]."

There was no further explanation of this new requirement within the letter. But here was born the Service's 20% rule whereby the boards of these emerging new health care systems must not have

more than 20% of "insider" or physician members, if they are to qualify for exempt status. However, the last sentence of the paragraph oddly seems to imply a different notion altogether -- control; and a certain class of individuals who can comprise the remaining board members -- members of the community [41]. The issue of control as the operative standard has since arisen in subsequent IRS statements, as indicated later in this review.

Two months later, on March 31, 1993, Jeanne S. Gessay, Chief of the Exempt Organizations Rulings Branch 2, sent a determination letter to the Facey Medical Foundation, also in California, similarly granting exempt status to a public benefit corporation seeking "...to further its goal of shaping an integrated multi-institutional health care system designed to provide access to quality health care services at an affordable price [42]."

This time, however, the Service was more detailed in its board composition specifications. The operative paragraph stated:

> "You will have a ten member board of directors. Eight members will be elected by UHA [43] and two will be designated by Facey Medical Group ("Medical Group," a new professional corporation formed by the former physicians of Facey). Your by-laws state that no more than 20% of your board members may be financially related, directly or indirectly, to any

shareholder or employee of Medical Group. You have stated that, in order to ensure that you operate for the benefit of the community, your board will be independent and broadly representative of the community. The board will have responsibility for all business decisions and charitable aspects of your health care delivery system. Any committees or subcommittees created to consider the business or charitable operations of your system must also be independent and broadly representative of the community. However, you may create committees to consider the clinical or professional service aspects of the health care to be provided in your system, and we recognize that these latter committees may contain unlimited physician representation [44]."

These strictures have spawned much commentary and speculation among practitioners in the exempt organization area, some of it rather chilling. For example, one commentator has suggested that ..."It would be a mistake to calculate the 20 percent rule only in the context of physicians and their interested parties. The IRS has long been of the view that 'persons having a personal and private interest in the tax-exempt organization' should be considered as insiders... Examples of such 'persons' include the organization's creator or the creator's family, shareholders, trustees, officers, members, founders, or shareholders (sic) [45]." They could also be interpreted to include nuns from religious orders operating hospitals and other medical

facilities.

Continuing its march down this boulevard, but perhaps taking a slight detour along the way, the Service issued a Private Letter Ruling on September 29, 1994, to the Williamsburg, Virginia, Community Hospital [46]. The hospital wanted to establish a proprietary physician-hospital organization (PHO) with 75 members of its 100 member medical staff, and retain a fifty percent ownership interest, with the other half owned by the doctors. The purpose was to better position the hospital to respond to large employers in the area with competitive managed care proposals for group health insurance business [47]. The issue before the IRS, requested in the Private Letter Ruling, was whether such arrangement would adversely affect the hospital's exempt status under 501(c)(3).

In ruling that the arrangement would not jeopardize the hospital's tax exemption, two reasons were cited by the Service: (i) the physicians would not exert "control" over the PHO and its operations, and the ruling noted that under the facts presented, no more than 20 percent of the PHO board members would be medical staff members; and (ii) the hospital's interest in the proposed PHO would be proportionate to its share of contributed capital [48]. Although this example represents an instance where an exempt organization is, in essence investing in a for-profit and taxable health care entity, rather than itself emerging as part of a new

health care system or network seeking exempt status, it is relevant, and perhaps revealing of the Service's evolving position on these matters, that such prominence was given to the notion of "control," even while at the same time referring to the 20 percent "safe harbor" idea. Similar positions have been taken where exempt hospitals enter into joint ventures with taxable management service organizations (MSOs) [49].

The result of these actions is that when an exempt hospital is co-venturing with a taxable entity, the issue is more one of "control" of the taxable entity's board; but when an exempt hospital engages in the creation of a proposed new exempt entity for the purposes of establishing a health care network or integrated system, the higher standard -- the 20% "safe harbor" notion -- will be used in exemption determinations.

Congress Takes the Same Fork?

When the Congress considered in 1994 the health care reform legislation presented by President Clinton in late 1993 [50], hearings were held and reform packages reported out of both the House Ways and Means and the Senate Finance Committees [51]. The "Chairman's mark" in the Ways and Means Committee version contained provisions that would essentially codify the Service's 20% "safe harbor" rule regarding the independence of governing

boards of nonprofit, exempt providers of health care services and related organizations [52]. However, this would apply much more broadly -- to all exempt hospitals and other related organizations -- than has the Service's use of the rule regarding integrated systems. The Senate version did not contain such a provision.

The Ways and Means package would have amended Internal Revenue Code Sections 501(c)(3) and (4), and related sections, to provide that such providers and related organizations, in order to qualify for exemption, must:

> "...be governed by an independent board of directors, at least 80 percent of the members of which receive no compensation (directly or indirectly) (a) for medical services performed in connection with the organization or (b) as an officer (including individuals having powers or responsibilities similar to those of officers) of the organization. However, independent board members could be compensated for services performed as a members of the board; [53]."

This provision has sparked some response. For example, Robert A. Boisture, Esq., has commented:

> "This proposal would codify, and apply to health care organizations generally, the 20-percent limitation on

insider/physician board representation applied by the Service in recent exemption determinations involving integrated delivery systems. The 20-percent limitation would require major changes in board composition for many tax-exempt health care organizations. It also could significantly impede exempt hospitals' efforts to form integrated delivery systems by acquiring existing medical practice groups, since the medical groups will often insist on significantly greater board representation. The proposal clearly reflects concerns among some members of the Ways and Means Committee staff that hospitals and other tax-exempt health care organizations have been unduly responsive to the financial interests of physicians and other insiders. These concerns appear to be fairly widespread on Capitol Hill, though it is significantly less clear how strong the support is for the proposed restriction on board composition, at least in its present form [54]."

Road Map to Reason

Some legal and policy questions raised by all these travels are that, given the desire for more accountability of nonprofits, are these the right paths to take? Which fork in the road should be chosen? How much, if any, governmental intervention into the structure and composition of nonprofit boards should be

encouraged -- or tolerated -- as a means of assuring, or attempting to assure, independence of judgment and appropriate governance behavior? And how far can this trend go before the voluntary nature -- the very core essence and value -- of these organizations is rendered but a hollow historical artifact? Some commentary is offered.

The basic mission of nonprofit, charitable organizations is to promote the **public** as opposed to a **private** good. And there clearly should be accountability and safeguards designed to decrease the chance that abuses will occur, as well as mechanisms of intervention and remediation should misbehavior appear. Present law offers all of these, although there may be differences of opinion as to how effectively they have been used. They should at least be examined before new approaches are pursued and unusual forks in the road taken.

The foregoing examples of governmental intervention in nonprofit board composition can be analyzed in two categories. The first can be seen as remedial in nature and include the judicial and attorneys general interventions. These are designed in response to specific cases of perceived bad behavior, and are crafted to correct abuses and fix breakdowns, be they on roads leading from San Francisco or Boston. A strong case can be made for the efficacy and appropriateness of such mechanical interventions. Afterall, the remediation affects only the organizations and individuals engaging

in alleged misbehavior, not all members of the class or classes of nonprofits, and at least some of the specific examples cited had the additional safeguard of time-limited applicability. All of these attributes, it can be argued, are intended to make repairs with precision tools, not pipe wrenches.

Notwithstanding, there has been commentary that some of these remedial attempts have resulted in rather nasty messes [55]. Others have examined methods of corrective intervention and recommended caution and care in addressing abuses by fiduciaries and trustees [56]. And still others have called for augmenting the powers of the attorneys general in these areas by creating public membership rights in certain nonprofit institutions [57], and, more generally, for the need to restructure nonprofit boards to achieve more accountability [58].

The second category of examples cited above are more wide-sweeping, and are described here as prophylactic in nature. It identifies an entire class of entities and individuals and assumes that their behavior will be, or is for the purposes of prior restraint, **per se** abusive. This category declares that the possibility or appearance of a conflict of interest, in an attempt to ward-off bad behavior before it starts, is to be considered an actual conflict, regardless of the facts and circumstances of any particular case. Specific behavior is not relevant, for it assumes that the behavior of physicians, officers, and other insiders will

always be self-serving. It assumes that they will not disclose conflicts and abstain from voting on matters pertaining to them, and that they will never obey existing state laws with regard to the duties of trustees and other fiduciaries, nor Federal laws prohibiting private inurement [59] and, in the case of health care providers, extensive new laws prohibiting fraud and abuse of the Medicare and Medicaid programs [60], as well as outlawing kick-backs and self-referrals to entities with which the referring party has a financial interest [61]. And it assumes that physicians, officers, representatives of religious orders operating medical facilities, and other insiders either will not or cannot act as members or representatives of -- and in the best interests of -- the communities within which they work, and often live.

Air Bags or Crash-Avoidance?

This latter category attempts mechanical repair with a pipe wrench and a sledge hammer. And it transports the well-intentioned precepts of accountability down a dead-end street, for the damage caused to the independence and voluntary nature of nonprofit organizations may very well be greater than the potential abuses which they are intended to prevent. This would be arguable in the absence of existing law and oversight authority, but such a vacuum does not presently exist.

It is also a prophylactic remedy that precludes the possibility of encouraging accountable behavior among people who are quite naturally affiliated with the organization. The result of the governmental intervention is to effectively prohibit these classes of individuals from acting at all, substituting instead the judgment of others, who are presumed, also by their classification, to be free from self-interested conflicts and more appropriate community representatives. To argue against the 20% rule, or other numerical and formulaic approaches, is not to argue in favor of control -- or even influence by -- individuals with conflicts of interest and the potential for private inurement. It is to suggest, however, that more precise tools with which to repair breakdowns as they may occur are already in the tool box and should be used as designed. The formulaic approaches merely add additional, and un-needed, tools of less exacting precision.

Additionally, even if such blanket categorization were desirable, the operative standard ought to be control, and not a much lower percentage resulting in such an unnecessarily high standard. If the fear is that insiders will subvert the mission and operation of the exempt organization to line their own pockets, it is not reasonable to conclude that this will occur unless substantial powers of persuasion or intimidation are attributed to this class of citizens. Control usually means fifty percent or more.

Furthermore, the desire to require community-representative and independent boards, as admirable as it may be for hospitals and other community-serving organizations, surely should be limited in application to those types of charities deriving their exempt status from the "community benefit" criterion. The trustees of special-purpose private trusts, for example, need not be dictated by criteria irrelevant to their stated purposes.

Nonetheless, the 20% rule and other examples of governmental intervention into the specification of nonprofit board composition are very much alive and well in the land. Legal and public policy is speeding down this avenue, where no "Dead-End" signpost has yet been erected. Better minds and reason suggest that the brake be applied and the course re-examined, before a horrible crash occurs.

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NOTES

1. See articles critical of and/or reporting governance and oversight problems within the charitable nonprofit sector in, for example, **Crain's New York Business**, "Nonprofits: NY's New Tammany Hall" series, Vol. X, No. 44, and Vol. X, No. 45 (Oct. 31 - Nov. 6, 1994, and Nov. 7 - 13, 1994); **The Philadelphia Inquirer**, "Warehouses of Wealth: The Tax-Free Economy," series (April 18-25, 1993); **The Boston Globe**, "Medical Billions," series (May 8-10,1993); and, variously, reports in **The Chronicle of Philanthropy** and other public and trade press regarding the United Way, Covenant House, PTL Ministries, and other reports.

2. Much press and public attention has surrounded the scandals involving Father Ritter and Covenant House, Bill Aramony and the United Way of America, the trustees of the New York Historical Society, John Silber and Boston University, Jim Bakker and PTL Ministries, and others. These alleged abuses have lead to calls for tighter rules and greater accountability from such organizations.

3. In the Matter of the Estate of Beryl H. Buck, Deceased, No. 23259 (August 15, 1986), Homer B. Thompson, J.

4. Dale, Harvey P., "The Buck Trust," working draft, with permission (1987).

5. Ibid. 3; see also Maloney, Douglas J., "The Aftermath," 21 U. of San Francisco L. Rev. 681 - 762.

6. Ibid.

7. Maloney, (note 30).

8. Ibid.

9. Ibid.

10. The Chronicle of Philanthropy, 1:15, 4-7 (May 16, 1989).

11. Ibid.

12. Letter of Agreement between The Commonwealth of Massachusetts, Office of the Attorney General and Dr. Arthur G.B. Metcalf, Chairman and on behalf of Trustees of Boston University, November 16, 1993, (hereinafter "letter"); and The Commonwealth of Massachusetts, Office of the Attorney General, NEWS RELEASE, December 14, 1993, "A.G. Obtains Agreement with B.U. on Governance Procedures," (hereinafter "release").

13. Ibid., letter.

14. Ibid., letter and release.

15. Ibid., letter.

16. Ibid., release.

17. Letter of Agreement between The Commonwealth of Massachusetts, Office of the Attorney General, and Richard E. Sitzer, Chairman of the Board, and Keith T. Pryor, President, and on behalf of, Berkshire Health Systems, Inc., March 23, 1992; and The Commonwealth of Massachusetts, Office of the Attorney General, NEWS RELEASE, March 24, 1992, "A.G. Obtains Agreement from Berkshire Health Systems to Reform Corporate Governance."

18. 10 N.Y.C.R.R. ss 98.11(f), definition supplied. This statute applies equally to for-profit and nonprofit health maintenance organizations.

19. 28 Pa.Code ss 9.96(a); and see generally, 40 P.S. ss 1551 et seq.

20. W.Va.Code ss 33-25-1.

21. Ibid., ss 33-25-4.

22. House Bill 2796, The General Assembly of Pennsylvania, Session of 1994, printer's no. 3972 (June 20, 1994); parallel Senate version passed and signed into law by the Governor.

23. House Bill 2797, The General Assembly of Pennsylvania, Session of 1994, printer's no. 3960 (June 20, 1994); parallel Senate version passed and signed into law by the Governor.

24. Ibid., ss 2 and ss 3, respectively.

25. Ibid., ss 1.

26. P.L. 93-641; 88 Stat. 2225; 42 U.S.C. 300 k, et seq.

27. The Certificate of Need concept, community health planning, and private nonprofit agencies to accomplish it were originated in New York State by work done by the United Hospital Fund, following its 1937 study The Hospital Survey of New York, and others on a private, voluntary basis; and through state statute eventually authorized under the Metcalf-McClosky Act of 1964. There were several more limited Federal health planning initiatives prior to the passage of 93-641.

28. P.L. 93-641, ss 1412(b)(4).

29. Legislative History, P.L. 93-641, at 7885.

30. Ibid., emphasis supplied.

31. Ibid.

32. Ibid.

33. Ibid.

34. Ibid.

35. Sieverts, Steven, "Governance of Health Systems Agencies," in Health Planning Issues and Public Law 93-641, pp. 21-27, American Hospital Association, Chicago (1977).

36. IRS Exemption Ruling, Friendly Hills Health Care Network, 93 TNT 40-113 (January 29, 1993); also at Vol. 2, BNA Health Reporter, p. 206 (hereinafter cited as 2 H.L.R. 206).

37. Ibid., 3rd paragraph.

38. These include having an open medical staff; having, in most cases, an emergency room open too the public; providing free emergency care to those unable to pay; providing, to the extent feasible, other medical services on a free or discounted basis to those in need; accepting Medicare and Medicaid patients on a nondiscriminatory basis; among other criteria.

39. The Friendly Hills Medical Group ("Medical Group") was the entity representing the consolidated group practices of four California partnerships and one corporation commonly owned by the

involved physicians and which was purchased by Friendly Hills through an Asset Purchase and Donation Agreement.

40. Ibid. note 36, sixth paragraph.

41. Ibid.

42. IRS Exemption Ruling, Facey Medical Foundation, third paragraph, 2 H.L.R. 454 (March 31, 1993).

43. UniHealth America, a 501(c)(3) organization, and the sole corporate member of the Facey Medical Foundation.

44. Ibid., note 42, eighth paragraph.

45. Peregrine, Michael, 3 H.L.R. 1729.

46. P.L.R. (No. pending); 3 H.L.R. 1550 (Sept. 29, 1994).

47. Ibid., and Peregrine, at 3 H.L.R. 1729.

48. Ibid., and 3 H.L.R. 1730.

49. For an insightful review of this issue, see Griffith, Gerald M., "Tax-Exempt Status of Hospitals and Physician "Control"," Journal of Health and Hospital Law, Vol. 27, No. 9 (Sept., 1994),

257-288.

50. Health Security Act of 1994, proposed.

51. Chairman's Mark, House Ways and Means Committee, June 29, 1994, ss 5, "Tax Treatment of Organizations Providing Health Care Services and Related Organizations," at 293, et seq.; and Chairman's Mark, Senate Finance Committee, July 2, 1994, ss k, "Tax Treatment of Organizations Providing Health Care Services and Related Organizations," at 58, et seq.

52. Ibid., Chairman's Mark, Ways and Means, at 297.

53. Ibid., at 298. It is ironic that the Committee would insist on such a rule relating to 20% of a nonprofit board of directors, yet fully sanction compensation of all directors; as the latter would, by most definitions, obviate the "voluntary" nature of the organization.

54. Boisture, Robert A., "Proposals Affecting Tax-Exempt Health Care Organizations in the Ways and Means and Finance Committees' Health Care Bills," The Exempt Organization Tax Review, Vol. 10, No. 1, at 109-113 (July 1994).

55. See Maloney, note 5.

56. Fremont-Smith, Marion R., "Duties and Powers of Charitable Fiduciaries: The Law of Trusts and the Correction of Abuses," 13 U.C.L.A. Law Review, 1041 (1966).

57. Dumiere, Robin, and Stephen Weiner, "The Public Interest and Governing Boards of Nonprofit Health Care Institutions," 34 Vanderbilt Law Review, 1029 (1981).

58. Fishman, James J., "The Development of Nonprofit Corporation Law and An Agenda for Reform," 34 Emory Law Journal 617 (1985).

59. See American Campaign Academy v. Comm., 92 T.C. 1053 (1989); G.C.M. 39,770 (Dec. 15, 1988).

60. 42 U.S.C. ss 1320a-7B, et seq.

61. Ethics in patient Referrals Act of 1989, 42 U.S.C. ss 1395nn; and as amended, 42 U.S.C. ss 1395n(a)(1).