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Tackling the "Evils" of Interlocking Directorates in Healthcare Nonprofits

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"The practice of interlocking directorates is the root of many evils."[2]

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* *See* LOUIS D. BRANDEIS, OTHER PEOPLE'S MONEY AND HOW THE BANKERS USE IT 70 (1914).

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Introduction

The nonprofit[3] sector and matters of nonprofit governance have been in the national spotlight much of late.[4] One area of heightened interest is directors of healthcare entities regularly serving on the board of more than one healthcare organization. Even when board membership of related entities is relatively independent, one corporation's business plan frequently is affected by (or even controlled by) the business needs of a separately incorporated parent, affiliate, or other related organization. Very little caselaw addresses "interlocking" directorates for nonprofit board members, and the caselaw that does exist tends to

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[2] BRANDEIS, *supra* note *, at 51. The context for this comment relates to the cronyism in bank boards of trustees that was endemic to the banking industry in the early 1900s. Brandeis wrote a series of articles that appeared in Harper's Weekly opposing the state of interlocking boards in banking because they facilitated a "money monopoly" that concentrated power in the hands of a few wealthy and powerful men. *See id.* at 1, quoting Governor Woodrow Wilson (before he became President Wilson). Brandeis later states that the "nexus between all the large potentially competing corporations must be severed if the Money Trust is to be broken." *Id.* at 78. The power in healthcare is not nearly as concentrated in boards of directors as it once was in the banking industry, but the warning reminds us to question the status quo.

[3] A nonprofit corporation can be better described as not profit-sharing. The corporation can earn a profit, but any profit must be used to carry out the mission of the corporation and cannot inure to the benefit of individuals who work for the organization or to other private parties. The rules are dictated by the state in which the corporation is incorporated. Being a nonprofit corporation must be distinguished from having tax-exempt status, which is a federal status granted by the Internal Revenue Service that allows the corporation to avoid certain federal taxes so long as it meets certain requirements. While the two are related, they are fundamentally different legal issues that are often combined and/or confused. *See* Joseph A. Schumpeter, *Developments in the Law: Nonprofit Corporations*, 105 HARV. L. REV. 1578, 1581-83 (1992) (describing the nature of the nonprofit corporate form).

[4] *See*, *e.g.*, PANEL ON THE NONPROFIT SECTOR, STRENGTHENING TRANSPARENCY GOVERNANCE ACCOUNTABILITY OF CHARITABLE ORGANIZATIONS: A FINAL REPORT TO CONGRESS AND THE NONPROFIT SECTOR (2005) (hereinafter "FINAL REPORT"), *available at* http://www.nonprofitpanel.org/final/Panel_Final_Report.pdf. This project, sponsored by Independent Sector (a private coalition of nonprofit organizations that studies the nonprofit sector) and presented to the Senate Finance Committee at its request, provides an example of the focus on the charitable sector. The Panel submitted a report of more than one hundred pages to the Senate Finance Committee enumerating the ways in which the nonprofit sector (an incredibly large number of corporations and corporate missions are included in this thought) is invaluable to the United States, how the sector can improve itself, and what government can do (or should refrain from doing) to improve transparency, governance, and accountability (as the title suggests). *See id*. As an example of the focus on governance, the Panel recommends:

> As a matter of recommended practice, charitable organizations should adopt and enforce a conflict of interest policy consistent with its state laws and organizational needs. The IRS should require every charitable organization to disclose on its Form 990 series return whether it has such a policy. Charitable organizations should also adopt policies and procedures that encourage and protect individuals who come forward with credible information on illegal practices or violations of adopted policies of the organization. There should be a vigorous sectorwide effort to educate and encourage all charitable organizations, regardless of size, to adopt and enforce policies and procedures to address possible conflicts of interest and to facilitate reporting of suspected malfeasance and misconduct by organization managers.

Id. at 8.

address narrow, fact-based, state law interpretive issues rather than elucidating the nature and scope of fiduciary duties – leaving the doctrine in this area severely underdeveloped.[5] Guidance from state statutes and supplementary guidance documents such as the Revised Model Nonprofit Corporation Act is minimal as well. Within this vacuum, considerable tension exists between the modern reality of overlapping boards, which often occur due to integration of healthcare entities into "delivery systems," and the traditional doctrine of fiduciary duties, which contemplates that directors will serve only one corporation.[6]

It is a long-standing principle of corporate law that directors owe fiduciary duties to the corporation(s) on whose boards they sit.[7] Nonprofit directors' fiduciary duties are threefold: the duty of care, the duty of loyalty, and the duty of obedience.[8] The duty of care requires directors to act in an informed, careful manner in their decision-making.[9] The duty of loyalty commands directors to act without self-interest, in good faith, and in the best interests of the corporation at all times.[10] The

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[5] *See, e.*g., Health Maintenance Network of Southern California v. Blue Cross of Southern California, 202 Cal. App. 3d 1043 (1988) (discussing certain bylaw amendments that were contrary to California law and inconsistent with principles of corporate independence for a subsidiary); Health America Pennsylvania, Inc. v. Susquehanna Health System, 278 F. Supp. 2d 423 (2003) (reviewing the mergers that created an integrated delivery system and determining that they did not violate the anti-trust principles of the Clayton Act); Manhattan Eye, Ear & Throat [MEETH] v. Eliot Spitzer, 186 Misc.2d 126 (1999) (denying a petition to sell a historic nonprofit hospital for failure to prove that the transaction was fair and reasonable); Richmond County Hospital Authority v. Richmond County, 336 S.E.2d 562 (1985) (examining the actions of a public authority in running a hospital and selling some of its assets); *see also* John K. Wells, *Multiple Directorships: The Fiduciary Duties and Conflicts of Interest That Arise When One Individual Serves More Than One Corporation*, 33 J. MARSHALL L. REV. 561, 563 (2000) (lamenting that courts have given very little guidance on the duties of directors of for-profit, general corporations that serve multiple boards).

[6] *See* Melissa Middleton, *Nonprofit Boards of Directors: Beyond the Governance Function*, *in* THE NONPROFIT SECTOR 141, 141 (Walter W. Powell ed., 1987), noting, "Only a meager amount of literature is available to help frustrated board members and managers." *Id*. at 141.

[7] *See* Koehler v. Black River Falls Iron Co., 67 U.S. 715, 720-21 (1862). Justice Davis stated the fiduciary principle thus:

> Instead of honestly endeavoring to effect a loan of money, advantageously, for the benefit of the corporation, these directors, in violation of their duty, and in betrayal of their trust, secured their own debts, to the injury of the stockholders .... Directors cannot thus deal with the important interests entrusted to their management. They hold a place of trust, and by accepting the trust are obliged to execute it with fidelity, nor for their own benefit, but for the common benefit of the stockholders of the corporation.

Id.

[8] *See* James J. Fishman, *Improving Charitable Accountability,* 62 MD. L. REV. 218, 229-30 (2003). For-profit directors must only adhere to the duty of care and the duty of loyalty; the duty of obedience is applied only to nonprofit corporations. Query whether the duty of obedience should apply to for-profit healthcare entities, which still must abide by rules of licensure and statutory mission; perhaps that is a question for another paper.

[9] *See* ALICE G. GOSFIELD, MICHAEL F. ANTHONY, JOEL L. MICHAELS & RONALD N. SUTTER, HEALTH LAW PRACTICE GUIDE Vol. 1 at 6-63 – 6-64 (2003) (citing N.Y. Not-for-Profit Corp. Law § 720-a).

[10] *See* Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-For-Profit Hospitals*, 50 UCLA L. REV. 1345 (2003) (describing fiduciary duties from a state law perspective).

duty of obedience obliges directors to ensure that the charitable mission of the corporation is carried out and to obey laws relevant to the organization.[11] While the duty of care and the duty of loyalty are well-established, the duty of obedience is a more recent development and not fully incorporated into the canon of nonprofit fiduciary duties.[12]

Three examples will help to illustrate the strains and conflicts that are endemic in modern nonprofit governance. The first relates to integration of the finance and service aspects of healthcare and the conflicts that may be predestined to arise in healthcare systems that have integrated these functions (known as vertically integrated delivery systems). The break-up of Allina Health System by the Minnesota Attorney General serves as a parable, as it illuminates the critical issue of whether the duty of loyalty and the duty of obedience can be honored while serving more than one board of directors when the corporations are related but have conflicting licensure mandates. The second example hypothesizes an urban-suburban hospital system and the typical conflicts of interest that arise when multiple healthcare entities that provide essentially the same services join forces by contract and by agreeing to be governed by one umbrella board of directors or by boards of directors with overlapping members (called 'horizontal' integration). The third example is a smaller, community-based hospital and home health agency that share board members; this model exists in many communities across the country and highlights the idea that even when integration has not occurred, business plans can affect close entities. Each of the three examples raises questions about overlapping directors' duties, particularly the duties of loyalty and obedience.

The current reality of the healthcare industry and corporations in general is that directors sit on multiple boards.[13] Some would argue (as did, in another context, Justice Brandeis) that this practice should be halted entirely because it is nothing but a grab at power and control by individuals attempting to avoid certain constraints of the corporate form. While the argument has merit, this article will focus on the extant

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[11] *See* MICHAEL W. PEREGRINE & JAMES R. SCHWARTZ, THE APPLICATION OF NONPROFIT CORPORATION LAW TO HEALTHCARE ORGANIZATIONS 40-41 (2002) (citing DANIEL KURTZ, BOARD LIABILITY: GUIDE FOR NONPROFIT DIRECTORS (Moyer Bell Ltd. 1988)).

[12] To wit, the American Law Institute has been in the process of creating Principles of the Law of Nonprofit Organizations, and the draft document does not separately delineate the duty of obedience; instead, it discusses the director's duty to adhere to laws applicable to the organization as a part of the duty of care. *See* A.L.I. PRELIMINARY DRAFT #3 PRINCIPLES OF THE LAW OF NONPROFIT ORGANIZATIONS, § 305 Comments on Subsection (b), 67 (2005) (on file with author). The draft document recognizes that the organic documents of the nonprofit may help guide directors, but the drafters deliberately did not separate the duty of obedience doctrinally. *See id.* at 70. The ALI drafters appear concerned with the influence of trust law and the restrictions of cy pres-type doctrine. See id. at 32. Given the restrictions that are imposed on healthcare entities due to the licensure aspect of their organizational mission, the flexibility envisioned by the A.L.I. drafters could not exist for healthcare entities. Further, adherence to the duty of obedience might aid directors in their quest to serve multiple organizations well and fairly.

[13] The authors of the Revised Model Nonprofit Corporation Act acknowledge this in the commentary. *See* Rev Model Nonprofit Corp. Act § 8.31 commentary (1987) (recognizing that board members are often chosen for their ability to make connections for an entity) [hereinafter RMNCA].

problem, as the complete cessation of such interlocking boards does not appear to be immediately attainable. Board members are entitled to more certain guidance, and the communities they serve are entitled to socially responsible nonprofit institutions.[14] Therefore, the time is ripe to modify the doctrine of fiduciary duties so that it encompasses this reality of overlapping boards; recognizes the trend toward more global, comprehensive, and proactive governance in the healthcare sector; and enables directors to decipher, document, and resolve conflicts at a more meaningful point in their decision-making processes. If we want high-level stewardship to steer board members faced with conflicts, then we must provide a substantive doctrine that guides and that can be employed easily by the largest and smallest, most and least sophisticated institutions.[15]

This article will first discuss the three examples of overlap in nonprofit boards of directors to create a frame of reference for analyzing this feature of nonprofit boards. Next, the article will describe and analyze the deficiencies in the doctrine of fiduciary duties as they are traditionally defined, why fiduciary duties must better guide directors in serving multiple boards, and how the duty of obedience can become doctrinally more potent by bifurcating the defined and guiding mission of the organization into what I have dubbed "charter mission" (meaning the nonprofit corporate mission as suggested by the state's nonprofit act) and "licensure mission" (meaning the healthcare mission as dictated by state licensure statutes and regulations). The article will then briefly address the reasons why the usual approach to conflicts by for-profit corporations – inform and recuse – is insufficient for healthcare nonprofits. Finally, the article will set forth a proposal that includes the procedural and substantive modifications necessary to catalyze a shift in understanding and to achieve the level of guidance that directors and their organizations so clearly need.

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[14] *See* FINAL REPORT, *supra* note 4, at 21, stating, "Public trust is essential to a viable nonprofit sector."

[15] Also, boards must be able to decipher and solve conflicts of interest before getting so embroiled in resulting problems that attorneys general intervene, as they have been doing with more regularity lately. *See* Thomas L. Greaney & Kathleen M. Boozang, *Mission, Margin, and Trust in the Nonprofit Healthcare Enterprise*, 5 Yale J. Health Law & Policy 1, 2-3 (2004) (discussing the overreaching of state attorneys general in recent efforts at controlling the activities of nonprofits and the reasons that such "activism" is inappropriate); *see also* Dana Brakman Reiser, *Enron.org: Why Sarbanes-Oxley Will Not Ensure Comprehensive Nonprofit Accountability*, 38 U.C. DAVIS L. REV. 205, 206-07 (2004) (noting that "activist state AGs" have become more active in overseeing the activities of nonprofits, going so far as to propose financial accountability legislation that mirrors Sarbanes-Oxley); Evelyn Brody, *Whose Public? Parochialism and Paternalism in State Charity Law Enforcement*, 79 INDIANA L.J. 937, 940-41 (2004) (describing the rise in state attorney general activity in the nonprofit sector as a rise in "parochialism and paternalism"); Michael W. Peregrine & James R. Schwartz, *Key Nonprofit Corporate Law Developments in 2002*, 12 HEALTH L. REP. 324, 328 (2003) (suggesting that, in order to diffuse attorney general attention to parent/subsidiary fiduciary conflicts, counsel to healthcare organizations with such structures should draft affiliation agreements that anticipate potential conflicts of interest and where loyalties lie in the event that conflicts arise).

I. Understanding Board Overlap

Historically the overlap in nonprofits' boards of directors has not been accidental, nor has it been a necessarily bad thing. In fact, the creation of connections for business purposes and for development of resources has been important for all nonprofits, not just those within the healthcare industry.[16] This was particularly true when nonprofits were generally small businesses that relied on volunteer community leaders to complete their boards of directors, who in turn created opportunities and obtained benefits for their nonprofits.[17] Healthcare has become an industry of large, sophisticated, and interconnected businesses, and boards of directors continue to overlap between healthcare entities. This occurs for a variety of reasons, ranging from the economic sensibilities of alignment (as with vertically integrated delivery systems) to the business strategy of connecting entities to capture markets (as with horizontally integrated healthcare systems).[18] In smaller communities, the reasons for board overlap appear not to have changed over time; small communities still rely on limited pools of volunteers.

Each of the three examples discussed below involves affiliation and/or integration of healthcare entities, which has become customary in the industry during the past twenty or so years.[19] Horizontal integration indicates the merger or alignment of several entities within the same market that provide essentially the same types of services in order to capture the market and to encourage efficiencies.[20] More specifically, in a horizontally integrated system, a number of hospitals in varied locations with different specialties might affiliate in order to consolidate resources and thus create greater efficiencies through economies of scale and through creation of centers of excellence.[21] The trend of health system integration was first experienced as horizontal integration of healthcare entities and then moved toward vertical integration.[22] In the

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[16] *See* Peter Dobkin Hall, *A Historical Overview of the Private Nonprofit Sector*, *in* THE NONPROFIT SECTOR 3, 14 (Walter W. Powell ed., 1987) (describing nonprofit development in the United States and providing historic examples of board overlap in nonprofit organizations, such as Walter S. Gifford serving on the boards of the Rockefeller Foundation and the National Research Fund).

[17] *See* Middleton, *supra* note 6, at 143 (commenting that nonprofit board members tend to create inter-organizational 'linkages' by having board members who are affiliated with a number of community groups).

[18] *See* Thomas L. Greaney, *Managed Care Competition, Integrated Delivery Systems and Antitrust*, 79 Cornell L. Rev. 1507, 1516 (1994) (describing the ways in which integrated delivery systems promote efficiency in the context of managed care contracting).

[19] *See* Dana Brakman Reiser, *Decision-Makers Without Duties: Defining the Duties of Parent Corporations Acting as Sole Corporate Members in Nonprofit Health Care Systems*, 53 RUTGERS L. REV. 979, 985-86 (2001) (describing the trend of consolidation and affiliation in the healthcare industry).

[20] *See id*. at 4-5, 7; *see also* Michelle M. Mello, Carly N. Kelly & Troyen A. Brennan, *Fostering Rational Regulation of Patient Safety*, 30 J. Health Pol. Pol'y & L. 375, 415 (2005) (noting that insurers have successfully worked with integrated delivery systems to create monetary incentives to improve quality of care).

[21] *See id.* at 8.

[22] *See* Douglas A. Conrad & Stephen M. Shortell, *Integrated Health Systems: Promise and Performance*, *in* INTEGRATED DELIVERY SYSTEMS: CREATION,

healthcare context, vertical integration refers generally to the combination of finance and service that theoretically increases economic efficiencies by reducing risk for the payor and by increasing revenue through aligning the interests of healthcare finance and healthcare provider.[23] Thus, a home health agency, long term care facility, hospital, ambulatory care facility, and managed care organization might affiliate to create a unified organism of care in a vertically integrated system.[24] The key feature, though, is the alignment of finance and service.

Other industries generally effectuate vertical and horizontal alignment by merger; in the healthcare industry, however, the possibilities of integration often are limited to creating alignment of interests and mechanisms of control by two methods -- contract and governance. The parties to the integration will enforce the alignment by drafting contracts requiring certain behaviors and by oversight of one another's enterprises via overlapping board membership and/or creation of parent-subsidiary corporate family trees.[25] Healthcare entities that would choose to merge, believing it to be a benefit to both parties, are frequently precluded from doing so directly and are required to maintain separate incorporation for any number of the following reasons: licensure; accreditation; Medicare provider status; asset protection (which is key in a business that frequently experiences tort liability); Medicare and Medicaid rules regarding fraud and abuse; and preservation of tax-exemption if some business activities are considered taxable. So, for example, a hospital is licensed to be a hospital in each state in which the hospital provides services, and an HMO is licensed to be an HMO in each state in which the HMO assumes the risk of healthcare finance. [26] The two cannot generally merge without running afoul of state department of health licensure proscriptions, resulting in inefficient business practices as each branch of the business seeks to comply with the regulatory requirements of the other; putting at risk the statutorily required insurance reserves of the managed care entity in the

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MANAGEMENT, AND GOVERNANCE 4 (1998) (explaining the trend during the 1970s and 80s toward horizontal integration and the subsequent movement toward vertically (or "virtually") integrated healthcare systems).

[23] *See id*. at 5. Vertical integration in healthcare has also been referred to as "diversification" indicating the intent to control the "delivery of a continuum of health services to defined populations." *Id*.

[24] *See id.* at 9.

[25] *See* Greaney & Boozang, *supra* note 15, at 23 (noting the general structure of integrated delivery systems in the context of describing Allina and its fight with the Minnesota attorney general); *see also* Greaney, *supra* note 18, at 1517-18 (describing degrees of integration in the context of the constantly shifting healthcare markets of the early 1990s).

[26] Staff-model HMOs are an exception; however, but for Kaiser Permanente, they appear to have failed as an experiment. For a new take on Kaiser Permanente, see Steve Lohr, *Is Kaiser the Future of American Health Care?*, N.Y. TIMES, October 31, 2004, Business, *available at* http://www.nytimes.com/2004/10/31/business/yourmoney/. The article asserts that the Kaiser Permanente version of staff-model HMOs is the wave of the future in healthcare because Kaiser manages care, not just costs, as other staff-model HMOs do. A policy expert at the World Health Organization, Neelam Sekhri, was quoted thus: "What works at Kaiser is the integration of the financing and delivery of care, and the aligned incentives that allow you to make more rational decisions about health care for members." *Id.* Other staff-model HMOs appear to have failed because they manage only cost, not care.

event of a successful malpractice recovery; and risking the tax-exempt status of the hospital because of the (usually) taxable status of the managed care entity.

Healthcare entities have responded by creating integrated systems wherein the component parts are separately incorporated, intending that each component operates to the benefit of the whole, and with a single corporate parent orchestrating the unified operation.[27] One of the critical tools used by these systems to accomplish the goal of a "unified whole" is overlapping directorates, and integration generally results in an "interorganizational alliance."[28] The existence of multiple separate entities working together but separately incorporated creates conflicts that are highly likely to recur, as tension is never relieved by a true organizational merger.[29] And so, three examples follow to demonstrate different aspects of the difficulty with the current standards for fiduciary duties as applied to overlapping boards of nonprofit healthcare organizations. The first example is Allina; the second is a horizontally integrated hospital system; and the third is a local and informally integrated healthcare system.

A. The Story of Allina Health System

The tale of Allina Health System (Allina) is instructive because its story illustrates the difficulties of vertical integration from corporate, financial, and licensure perspectives. Allina also demonstrates trends in integration, as Allina was initially a horizontally integrated system consisting of separately incorporated hospitals, clinics, outpatient facilities, and other such direct patient care facilities named HealthSpan Health System (HealthSpan). HealthSpan integrated with Medica Health Plans (Medica), a nonprofit, separately incorporated health maintenance organization (HMO).[30] HealthSpan and Medica combined as separately incorporated "divisions" of an unincorporated vertically integrated

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[27] In the past this model has been described by some as a 'foundation model' integrated delivery system, but the reality is the old adage if you've seen one, you've seen one. For a brief description of foundation model systems, see Greaney, *supra* note 18, at 1519-20.

[28] *See* Conrad & Shortell, *supra* note 22, at 7.

[29] *See Statements of Antitrust Enforcement Policy in Health Care*, issued jointly by the Federal Trade Commission and the Department of Justice (August 1996), *available at* http://www.ftc.gov/reports/hlth3s.htm. Since the Policy Statements, very little guidance has been issued by the FTC or the DOJ on integration for healthcare entities. *See* Robert F. Leibenluft & Tracy E. Weir, *Clinical Integration: Assessing the Antitrust Issues*, *in* HEALTH LAW HANDBOOK 1, 3-5 (Alice G. Gosfield, ed. 2004).

[30] Allina Health System was a complex organism consisting of "19 hospitals, 48 medical clinics, one HMO, two insurance companies, a preferred provider organization, a third party administrator, a home health care service, a transportation service, an equipment company, nursing homes, three foundations, printing companies, and a web service entity." OFFICE OF MINNESOTA ATTORNEY GENERAL MIKE HATCH, COMPLIANCE REVIEW: CONFLICTS OF INTEREST, § 2.1 at 1 (2001) (on file with author) (hereinafter "COMPLIANCE REVIEW"). Medica was a fully functioning and profitable solo HMO before the merger that formed the Allina health system in 1994, and it was the second largest HMO in Minnesota, covering approximately 580,000 enrollees. *Id.* at §§ 1.1, 3-4, 8.

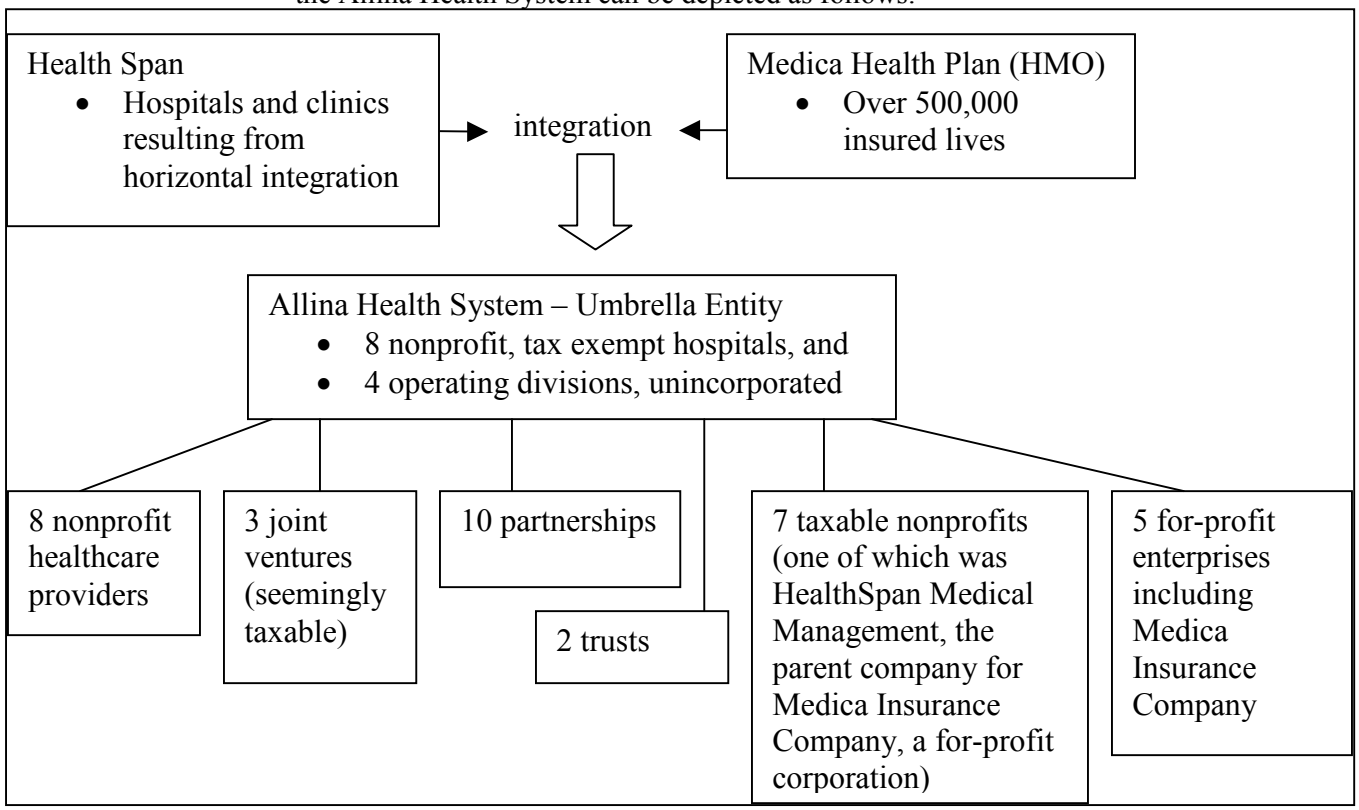
healthcare delivery system that became Allina.[31] Paradoxically, the Allina union resulted from Minnesota legislation that called for the formation of "integrated service networks" ("ISNs"), which were essentially vertically integrated delivery systems.[32]

Once concatenated, Medica generated approximately fifty percent of all revenue for the Allina Health System, despite its

[31] *See* COMPLIANCE REVIEW, § 1.11 (noting that the fundamental goal of a merger between Allina and Medica that occurred in 1994 was to create an IDS). Allina Health System was a tax-exempt charitable organization under Section 501(c)(3), but Medica was a tax-exempt social-welfare organization under Section 501(c)(4) of the Internal Revenue Code. *See id*. § 2.1 at 2. The chief difference is that a social-welfare organization may lobby.

[32] *See id*. at 5, citing the MinnesotaCare Act, MINN. STAT. 62N.02 (1997, expired). Though the MinnesotaCare Act was ultimately abandoned, the mergers that it encouraged remained intact. MinnesotaCare Act was an interesting example of the effort to encourage integration that occurred across the country to encourage greater efficiencies in healthcare delivery and finance. The Minnesota Health Care Commission was charged with presenting a cost containment plan that would slow the health care spending growth rate in Minnesota by January 1993. MINNESOTA HEALTH CARE COMMISSION, CONTAINING COSTS IN MINNESOTA'S HEALTH CARE SYSTEM (Aug. 13, 1999), http://www.health.state.mn.us/mhcc/costcont.htm. *See also* MINN. STAT. 62J.015 (1992). The Commission's cost containment plan featured, among other things, Integrated Service Networks (ISNs), which encouraged the development of competing ISNs that were to be accountable for the cost and quality of their services and responsible for providing a full array of health care services. *See id.* ISN services were to be provided at fixed prices, which was intended to create incentives for participating providers and health plans to operate efficiently. *See id.* The Commission called for payment systems, purchasing reform, and health care data systems to facilitate consumers' ability to compare data on ISN prices and quality and to encourage competition. *See id.* The bill was signed by Governor Carlson in April of 1992, and it made Minnesota one of the first states to address the 'epidemic' of rising health care costs. *See* Eric H. Chadwick, *MinnesotaCare: Workable Financing or Just Wishful Thinking?*, 19 WM. MITCHELL L. REV. 961, 963 (1993); s*ee also* MINN. STAT. 62J.015-.29 (1992). The MinnesotaCare Act was enacted in pieces dating from 1992 to 1997. *See* TERESA A. COUGHLIN, SHRUTI RAJAN, STEPHEN ZUCKERMAN & JILL A. MARSTELLER, URBAN INSTITUTE, HEALTH POLICY FOR LOW-INCOME PEOPLE IN MINNESOTA (Nov.1, 1997), *available at* http://www.urban.org/UploadedPDF/Hp_minn.pdf. Following multiple mergers, Minnesota was left with "four mega systems;" Allina, Blue Cross/Blue Shield of Minnesota, Fairview, and Health Partners insured 90% of the state's residents by 2001. *See* Kaiser Daily Health Policy Report, *Minnesota Health System 'Under Siege' as Costs, Premiums Rise Faster Than National Average* (July 24, 2001), http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=5976. The consolidation of the state's healthcare systems caused concern among Minnesota policymakers, who worried that the savings from the ISN consolidations would not be passed through as reduced consumer premiums and health care service costs. *See* HEALTH POLICY FOR LOW-INCOME PEOPLE IN MINNESOTA, 3. As a result, Minnesota made efforts to prevent further consolidations, but it did not undo extant ISNs; the 1997 version of the MinnesotaCare Act sought to "eliminat[e] integrated service networks" in favor of alternative service delivery mechanisms, such as Community Integrated Service Networks (CISNs), purchasing cooperatives, and provider-sponsored organizations. MN Legis. 225 (1997). Finally, the ISN law was repealed and draft ISN rules were discarded. *See* MINNESOTA DEPARTMENT OF HEALTH, 1997 MINNESOTACARE GROWTH LIMIT IMPLEMENTATION REPORT EXECUTIVE SUMMARY (Aug. 20, 1999) (on file with author). MinnesotaCare proved to be a failed experiment; between 2000 and 2001, Minnesota's health care costs rose nearly twice as fast as the national average. Duane Benson, a former supporter of MinnesotaCare, commented that the final result was "not what we thought it would be." *See* Kaiser Daily Health Policy Report, *Minnesota Health System 'Under Siege' as Costs, Premiums Rise Faster Than National Average*, (July 24, 2001), http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=5976.

proportionally small size within the conglomerate, and it was controlled tightly by Allina.[33] Allina had an umbrella board of directors comprised of twenty voting members and up to eight ex-officio members (including the president and chief executive officer of Allina).[34] Of the twenty Allina board members, seven served on the Medica board of directors (separately), which contained seven board members total.[35] Of the seven board members, Allina had the ability to elect and remove four directors, and the other three board members served at the pleasure of Allina (had to be ratified by Allina).[36] In simplified form, indulging the need to overlook some of the many subsidiary and sub-subsidiary relationships, the Allina Health System can be depicted as follows:[37]



As part of a compliance review of Allina, Minnesota Attorney General Mike Hatch issued a six-volume finding that concluded Allina and Medica could not coexist as an integrated delivery system.[38] Attorney General Hatch found that the boards of Medica and Allina were guilty of a host of errors that violated their fiduciary duties. To name a

[33] *See* COMPLIANCE REVIEW, *supra* note 30, § 2.3 at 5.
[34] *See id.* § 2.2 at 3.
[35] *See id.*
[36] *See* COMPLIANCE REVIEW, *supra* note 30, vol. 2, exhibit 6, Fifth Restated Bylaws of Medica Health Plans.
[37] *See id.*, vol. 1, exhibit 5. The Organizational Chart is highly complex and the key is difficult to decipher due to the variety of corporate entities involved; any errors are due to the author's inability to read the AG's Organizational Chart as it was intended.
[38] *See id.* § 1.11 at 27. Hatch wrote that there were "numerous and irreconcilable conflicts of interest among the non-profit corporations and the communities they serve." *Id*.

few: First, the boards of each entity overlapped to a great degree and were elected solely by, or had to be approved by, Allina's directors.[39] Moreover, the board of Allina and the board of Medica met at the same time; and, at concurrent meetings, the Allina board members appeared to make all decisions for both Allina and Medica, referring to Medica as a "division" even though it was a separate corporation.[40]

Second, one checking account was used for all Allina Health System corporations (not just Allina and Medica).[41] The Attorney General acknowledged that this would not be unusual for one large corporation. Because Allina consisted of numerous for-profit and nonprofit corporations, however, Hatch stated that an accounting impossibility was created and deemed it a deliberate scheme to confuse the government and other interested parties.[42] Hatch also concluded that the "crisscross transactions" that occurred between the corporations in the one checking account were breaches of the directors' three fiduciary duties.[43]

Third, Medica paid referral fees to certain influential physician groups to increase patient referrals from those groups to Allina.[44] This served as evidence that the directors and officers of Allina who also served as directors and officers of Medica were serving the corporate interests and purposes of Allina at all times, not of Medica. This in turn created a conflict of interest.[45]

Fourth, Medica pre-funded the medical services of Allina to finance capital improvements needed by Allina; more specifically, Medica paid Allina thirty million dollars before medical records existed for the patients who had received services.[46] Attorney General Hatch found the pre-funding arrangement to be contrary to the sound fiscal practices of a conventional HMO and a violation of the directors' fiduciary duties.[47] The attorney general also was troubled by Allina's

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[39] *See id.* § 1.10 & exhibit 62 at 18 (Bylaws of Allina Health System, Article VII, stating that the Board of Directors of Allina was responsible for electing all Operating Unit Boards). Consumer members of the Medica board were elected by extant consumer members of the board, but they had virtually no voting rights except to elect the next set of consumer directors; though not elected by the Allina directors, they could not be elected without approval of the Allina board. *See id*. § 2.3 at 6.

[40] *See id*. § 2.16 at 32 (so referred in the board minutes).

[41] *See id.* The Compliance Review notes that, in using one central business office, the system used one checking account to process "in aggregate over $3 billion." *Id*. § 2.8 at 14.

[42] *See id*. § 2.8 at 14-15.

[43] *See id*. § 2.8 at 15.

[44] *See id.* § 2.7 at 12. For instance, in 1998 Medica paid Aspen Clinic approximately 13 million dollars to build patient referrals to Allina and 1.5 million dollars in subsequent years to continue the influence. *See id.* This is potentially a violation of certain federal statutes such as the anti-kickback statute, the "Stark" law, and any state prohibitions on fee-splitting, but such fraud and abuse statutes were not the focus of Attorney General Hatch's investigation (or this paper).

[45] *See id*. at 13. Attorney General Hatch asserts a breach of all three fiduciary duties in the context of the referral fees. *See id.* The fees were not in the financial interest of Medica, thus the accusation of only acting in Allina's interest.

[46] *See id*. § 2.9 at 16. Typically insurers review medical records to ensure reasonableness and medical necessity before paying healthcare providers for the services or items claimed. Prepaying is almost unheard-of.

[47] *See id*. § 2.9 at 17.

control over Medica's ability to set fee schedules and by the increased payments that Medica conferred on Allina.[48]

Fifth, Medica's decision to remain in the Medicare + Choice market -- when it was losing money in that market -- was deemed the result of a conflict of interest. The decision clearly benefited Allina by virtue of the increased hospital admissions of well-insured patients. Allina earned a large amount of its revenue from the senior market, but this decision deprived Medica of needed funds.[49]

Sixth, the Minnesota Attorney General's office found that conflicts of interest arose between the mission of Medica as an HMO and the mission of Allina Health System, conflicts that appeared to deprive the Medica directors of the ability to consider the best interests of the HMO's enrollees.[50] Attorney General Hatch stated, "because it directly owns [hospitals], the primary corporate responsibility of Allina Health System is to assure the prudent and safe operation of these hospitals…."[51] This assessment was grounded in the Minnesota statute that describes the mission for hospitals (and other patient care entities) as, essentially, the institutional care of human beings.[52] On the other hand, Attorney General Hatch stated that Medica had a "clear statutory mission" to "manage health care costs and try to keep premiums down."[53] This conclusion derived from the Minnesota enabling statute for HMOs, which was created in 1973, presumably pursuant to the mandate of the federal HMO Act of 1973.[54] The Minnesota HMO statutory language reflects findings made by the federal government that HMOs were more efficient and therefore economically more sound than traditional indemnity insurance.[55] In light of the HMO statutory mission,

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[48] *See id*. § 2.11 at 20.

[49] *See id*. § 2.14 at 25. By example, even though only 6.5% of enrollment in Medica was attributable to Medicare, Medicare policies were responsible for 20% of net operating losses for Medica in 1999. *See id.* As Attorney General Hatch wrote, "… there was a clear conflict of interest between Allina Health Systems and Medica as it related to the Medicare patient. *Medica steadily lost money on Medicare policies while Allina Hospitals clearly made money on the treatment of Medicare patients*." *Id*. at 29 (emphasis added).

[50] *See id*. § 2.21 at 33-34.

[51] *See id*. § 2.2 at 2.

[52] See MN Stat. § 144.50. subd. 2 (1996). The statute states:

> Hospital … shall mean any institution, place, building, or agency , in which any accommodation is maintained, furnished, or offered for five or more persons for: the hospitalization of the sick or injured; the provision of care in a swing bed …; elective outpatient surgery for preexamined, prediagnosed low risk patients; emergency medical services offered 24 hours a day, seven days a week, in an ambulatory or outpatient setting in a facility not a part of a licensed hospital; or the institutional care of human beings.

Id.

[53] COMPLIANCE REVIEW, *supra* note 30, § 2.4 at 7-8.

[54] *See* 42 U.S.C. § 300e-10 (2000) (originally enacted as the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, § 2, 87 Stat. 931).

[55] The Minnesota statute states:

> Faced with a continuation of mounting costs of health care coupled with its inaccessibility to large segments of the population, the Legislature has determined that there is a need to explore alternative methods for the delivery of health care services, with a view toward achieving greater efficiency and economy in providing these services.

Attorney General Hatch concluded that Medica's mission conflicted with Allina's mission to ensure that the patient care side of its organizations were "adequately capitalized and financed to serve the needs of patients."[56] In other words, Medica had to create economic efficiencies (pay less) while Allina had to increase its income to serve its patients (charge more).[57] Any action taken by the board of either entity contrary to the mission of the entity would therefore, as Attorney General Hatch stated, be a conflict of interest and impermissible as a breach of the duty of loyalty and the duty of obedience.[58]

While the conclusions that Attorney General Hatch reached are sound, disappointment arises from the lack of analysis or guiding principles. The future IDS is left with an example of predecessors' violations of fiduciary duties without any guiding analysis. While they may be difficult to separate, no line was drawn between licensure/mission conflicts and corporate/fiduciary duty conflicts.[59] For example, the Compliance Review crunches the numbers involved in the pre-funding arrangement, and then concludes: "The officers and directors of Medica, by permitting Medica to engage in a pre-funding transaction with Allina, have compromised their duty of loyalty, of due care and of obedience to the mission of Medica."[60] Ratifying the prepayment plan undoubtedly was a breach of fiduciary duties by the Medica directors, but an opportunity existed to describe that a breach of the duty of loyalty occurred because the directors were diverting funds; and that a breach of the duty of care occurred because the directors did not obtain the necessary information to determine whether the funds should be allocated as they were; and a breach of the duty of obedience occurred because the licensure mission of Medica required it to ensure that it paid money only for legitimate services while its corporate mission as a nonprofit prevents private inurement and private benefit. Likewise, after painstakingly tracing the complex history of Allina hospital mergers, Medica's history, corporate governance, and other details of Allina, the

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Minn. Stat. 62D.01 subd. 2.

[56] *See* COMPLIANCE REVIEW, *supra* note 30, § 2.5 at 9.

[57] *See id*. § 2.6 at 9. Hatch made the following introductory statement,

> [T]he object of a non-profit organization which owns hospital ought to be to ensure safety and financial stability in its hospitals. The interest of a nonprofit HMO, however, is presumably to make certain that premiums are efficiently utilized on behalf of its members for quality health care. The goals of Medica and Allina have clashed in a variety of ways over the past several years.

Id. § 1.10 at 22.

[58] *See id.* The conclusion by Attorney General Hatch that the missions of an HMO and a hospital system are irreconcilable leads to speculation regarding whether a vertically integrated IDS with interlocking board members could ever exist. If the statutory mission of a licensed HMO and a licensed hospital, ambulatory care facility, nursing home – essentially any patient service – inherently conflict, then vertical integration that includes the feature of interlocking directorates would never be appropriate so long as healthcare entities cannot fully merge due to licensure constraints. In the continuum of the history of integrated delivery systems, such a conclusion would have been a major milestone.

[59] Also unfortunately, the Compliance Review has statements like, "A more serious concern is that Medica … [redacting begins]." COMPLIANCE REVIEW § 1.10 at 23. One can only imagine what the more serious concerns might be.

[60] COMPLIANCE REVIEW, *supra* note 30, § 2.9 at 17.

finding avows, "Putting it simply, the mission of the Allina Health System and Medica HMO are different and at times conflicting."[61]

Perhaps the conclusory statements were due to the fact that the duty of obedience is tied to the mission of a healthcare nonprofit, which is in part dictated by statutory mission, but Attorney General Hatch did not clarify whether this was the issue or the analysis. An opportunity was missed to delineate such a distinction, which could have been significant in the development of the doctrine of fiduciary duties for healthcare entities. The distinction between *corporate* mission and *licensure* mission is vital for parsing fiduciary duties for directors on multiple boards; the contours of this idea will be discussed below.

B. The Hospital Chain

Where horizontal integration of healthcare providers occurs, it is not unusual for systems to be governed either by one umbrella board of directors or by placing members of each board of directors on the boards of the other member entities within the system. While vertical mergers slowed due to failures of the predicted economies of scale and healthcare delivery, horizontal mergers appear to remain popular, particularly among hospitals and physician groups.[62]

To imagine the complexities of horizontal integration, suppose that a hospital chain is formed between two successful suburban hospitals (Hospital A and Hospital B) and an occasionally-struggling urban hospital (Urban Hospital). Each of the hospitals remains a separately incorporated, nonprofit, tax-exempt hospital, and the affiliation does not necessitate a modification of the nonprofit mission set forth in each hospital's articles of incorporation. To ensure a unity of purpose, the members of the boards of directors begin to serve on the board of at least one other board in the system, though no umbrella board is formed. So, the system would appear as follows:

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[61] *Id*. § 2.5 at 9.

[62] *See* Evelyn Brody, *Whose Public? Parochialism and Paternalism in State*, 79 IND. L.J. 937, 939 (2004) (discussing the ongoing process of hospital integration in the context of state interference in mergers and conversions). Allina furnishes us another example for purposes of exploring overlapping boards. Before Allina and Medica amalgamated, Allina grew as a horizontally integrated healthcare system through merging a number of hospitals and then a number of nursing homes. Allina Health System, as a horizontally integrated system, was created by a series of mergers that occurred over the course of eleven years. The system consisted of no fewer than eleven separate legal entities. Each of the hospitals within the system was treated as an unincorporated operating unit of Allina. In deconstructing the structural and ethical problems of Allina, Attorney General Hatch noted that the horizontal integration was incomplete at the time of the merger with Medica. The hospitals were described as competing with each other for patients (or "business"), having decentralized administration, failing to centralize physicians' services, and being inefficiently lead by "co-leaders." *See* COMPLIANCE REVIEW, *supra* note 30, § 2.2 at 2-4; *see also* Robert S. Huckman, *Hospital Integration and Vertical Consolidation: An Analysis of Acquisitions in New York State*, NBER Working Paper Series, Working Paper 11379, *available for purchase at* http://www.nber.org/papers/w11379 (2005) (noting the significant number of hospital consolidations and integrations over the past two decades).

Urban Hospital	**Suburban Hospital A**	**Suburban Hospital B**
Board Members:	Board Members:	Board Members:
A, B, I, J, K, L, M	A, B, C, D, E, F	E, F, G, H, I, J

As a result of the merger, the controlling board members are able to move the entire neurosurgery department to Hospital A, and the neurosurgeons have relocated their offices to Hospital A to centralize this set of highly specialized and highly lucrative services. A cardio-thoracic center of excellence is created at Hospital B, which will require the sub-specialized cardiac physicians from Urban Hospital and Hospital A to relocate to Hospital B. Though some patients will have to travel a greater distance to obtain these specialized services, the consolidation enables the hospitals to create true depth and expertise in neurology and cardiology, facilitating optimal levels of office and operating room experience, creating the foundation for research, and serving the system's larger community with services that are improved from a quality and a cost perspective. Other specialized services are moved around as well, but each hospital maintains the basic services required to be deemed a general hospital, including an emergency room.

Seemingly as a result of the affiliation and the attendant shifting of services, Urban Hospital starts to lose money on an annual basis. The other hospitals in the system are financially stable, and Hospital A is turning a comfortable profit due to the increase in neurosurgery. The board of directors of Urban Hospital holds a meeting specifically to discuss the deficit that Urban Hospital is carrying. The members of the board decide that it is in the best interest of the integrated delivery system to contribute fifty percent of the profits of each hospital to Urban Hospital until a new business plan can be found and instituted for Urban Hospital. In this way, Urban Hospital can continue to treat the two populations that rely on it the most, charity care patients who use the emergency room in a clinic capacity, and trauma patients who are seen first in the emergency room of Urban Hospital but who may, upon stabilization, be referred to Hospital A or Hospital B for advanced or continuing care.

The suburban hospital board members are potentially breaching their fiduciary duties (namely duty of loyalty) to the Hospital A and Hospital B simply by supporting Urban Hospital. The board members from Urban Hospital, sitting on the boards of Hospital A and Hospital B, are breaching fiduciary duties (namely duty of care) that they owe to their hospital if too much time is taken attending to the needs of the suburban hospitals. While it is doubtful that the board members of Hospitals A and B would be found to violate the duty of care (the procedure by which they reach the decision to support Urban Hospital seems reasoned and informed), it is highly probable that they are violating their duty of loyalty to Hospital A and Hospital B by shifting funds to Urban Hospital. It is also possible that the duty of obedience is being breached if the statutory mandate of each separately incorporated hospital requires that profits be used to further the charitable purpose of that particular nonprofit organization.

On the other hand, the missions of the hospitals, from a licensure perspective, would be nearly if not totally identical. In this case, the generic overarching mission of a hospital, to ensure that care is provided to everyone in the community and that it is adequately funded, is met. It is then possible that the duty of obedience is not breached while the duty of loyalty is called into question. As a policy matter, the public is served by supporting and maintaining Urban Hospital, both in terms of public health and in terms of the public fisc (the more Urban Hospital is supported by the system hospitals, the less it must be supported by charity care reimbursement and other funds that derive from taxpayer dollars). We can see that traditional definitions of fiduciary duties do not serve the board members, or the communities their organizations support, very well.

C. The Small Town Joint Venture

The third example is a smaller, community-based hospital (Hometown Hospital) and a home health agency (HHA) that share board members. Hometown Hospital treats a large number of elderly patients, and it is a major source of referrals for HHA. The nurses at Hometown Hospital are specifically trained in the criteria for receiving reimbursement for home health services, and some of them are independent contractors who also work for the home health agency. As is common in rural and smaller communities, Hometown Hospital and HHA work together to ensure that qualifying patients are funneled to HHA. The boards contain overlapping members because the community lacks volunteers, and because it keeps business flowing well; everyone is satisfied with the arrangement.

HHA reevaluates its business plan and decides that it should serve the competing hospital in the neighboring town (Neighbor Hospital) in order to stay financially healthy; reimbursement rates are not what they used to be. HHA commences discussions with Neighbor Hospital to place nurses at the hospital a few days per week. HHA does not want to alert Hometown Hospital of its new enterprise for fear of losing patient referrals from Hometown Hospital. HHA believes Hometown Hospital will be concerned that HHA may not be serving its patients as thoroughly as it could be and may be concerned that HHA is diverting patients to Neighbor Hospital when opportunities arise.

Board members who sit on both boards, upon learning of the relationship with Neighbor Hospital, will suffer from divided loyalties at the least. Though no usurpation of corporate opportunity is occurring by a member of the board – the traditional definition of a conflict of interest – any board member who sits on both boards now has information that is detrimental to Hometown Hospital if it is *not* revealed and detrimental to HHA if it *is* revealed. The small town operation has a dissimilar feel from the large healthcare systems; we may have different expectations for rural and small-time entities, but courts expect the directors to execute their fiduciary duties with the same level of care, loyalty, and obedience. The conundrum is clear; and, whatever the directors do, the mere possession of information is outside the usual bounds of courts' analysis of the duty of loyalty.

II. Fiduciary Duties – Traditional Doctrine, Modern Shortcomings

The notion of fiduciary duties stems from both charitable trust and corporate law principles and extends to the nonprofit corporate sector in distinctive ways. Although the actions of nonprofit boards of directors have been granted more than the usual amount of deference by courts because members generally serve unpaid, the conduct of nonprofit boards of directors is governed by standards substantially similar to those that govern for-profit organizations.[63] In no small part, this parallel is due to the principles set forth in the Revised Model Nonprofit Corporation Act.[64] Unlike for-profit corporate directors, however, nonprofit directors owe fiduciary duties to both the corporation and the public.[65] Thus, we see that nonprofit directors must adhere to the two most familiar fiduciary duties, the duty of care and the duty of loyalty, but directors of nonprofit corporations have been held recently to a third duty, the duty of obedience. The duty of obedience is tied to the public benefit aspect of nonprofit status that is particularly important for healthcare entities.[66]

A. The Duties Reviewed

Blacks Law Dictionary defines the doctrine of fiduciary duties thus: "A duty to act for someone else's benefit, while subordinating one's personal interest to that of the other person. *It is the highest standard of duty implied by law* (e.g. trustee, guardian)."[67] Healthcare nonprofits experience a greater imbalance of power than other nonprofits due to the nature of the provision of healthcare and lack of medical knowledge of the typical beneficiary of a healthcare nonprofit, the patient.[68] That directors have so much responsibility, and so little oversight, is of concern to many and helps to explain the need for greater recognition of the duty of obedience, which will be discussed below and addressed by suggestions in this article.[69]

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[63] *See* RMNCA § 8.30 (1987).

[64] *See id.*

[65] *See* HOWARD L. OLECK, NONPROFIT CORPORATIONS, ORGANIZATIONS AND ASSOCIATIONS 265 (5th ed. 1988).

[66] *See* Naomi Ono, *Boards of Directors Under Fire: An Examination of Nonprofit Board Duties in the Health Care Environment,* 7 ANN. HEALTH L. 107, 108 (1998); DANIEL L. KURTZ, BOARD LIABILITY: GUIDE FOR NONPROFIT DIRECTORS 84 (1988).

[67] BLACK'S LAW DICTIONARY, 625 (6th ed. 1990) (emphasis added).

[68] *See* Henry B. Hansmann, *The Role of the Nonprofit Enterprise*, 89 YALE L.J. 835, 862 (1980) (discussing the problem of the contract analogy for nonprofits that provide complex personal services).

[69] *See* Harvey J. Goldschmid, *The Fiduciary Duties of Nonprofit Directors and Officers: Paradoxes, Problems, and Proposed Reforms*, 23 J. CORP. L. 631, 632-33 (1998) (observing that many nonprofits have directors who are no more than "window dressing" and that ineffective governance hinders the ability of nonprofits to carry out their missions).

1. The Duty of Care

The duty of care requires directors to act in an informed, careful manner and to affirmatively protect the interests of their organization.[70] This is traditionally framed by asking whether directors have: (1) acted in good faith, (2) with the degree of diligence, care and skill that ordinary, prudent persons would exercise in like circumstances, and (3) in the best interests of the corporation.[71] Thus, the duty of care refers to the way in which directors arrive at decisions made on behalf of the corporation, not the validity or soundness of the decisions themselves.[72] A court reviewing an alleged breach of the duty will consider process, not substance.

Directors who have met the elements of the duty of care are generally protected from personal liability by courts under the business judgment rule,[73] which shields directors from judicial scrutiny when they act reasonably and in an informed manner on behalf of the corporation.[74] Though anecdotal evidence indicates that the business judgment rule is applied less frequently to the directors of nonprofit corporations, it can still protect them from liability for bad outcomes.[75] An outstanding question is whether state attorneys general will apply the business judgment rule when exercising their oversight of nonprofits.[76]

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[70] *See* KURTZ, *supra* note 66, at 22-30 (exploring the meaning and contours of the duty of care).

[71] *See* GUIDEBOOK FOR DIRECTORS OF NONPROFIT CORPORATIONS, 19 (George W. Overton, Jeannie Carmedelle Frey eds., 2002) [hereinafter GUIDEBOOK]. The third element overlaps with the duty of loyalty and is not always described as a required element of the duty of care.

[72] *See* Fishman, *supra* note 8, at 232 (discussing the meaning of the duty of care).

[73] *See* KURTZ, *supra* note 66, at 49 (discussing the nature of the business judgment rule). Fishman calls this the "best judgment rule" in the nonprofit setting. *See* Fishman, *supra* note 8, at 233.

[74] *See* KURTZ, *supra* note 66, at 49-51 (discussing the doctrine of the business judgment rule).

[75] Some believe directors of nonprofits need the protection of the business judgment rule less than the directors of for-profit corporations because courts are traditionally lenient with nonprofit directors due to the voluntary nature of their service. *See id*. at 50. Kurtz notes, "Is there a suitable alternative need or justification for the rule for nonprofits and, if so, when should it be applied? To some extent, that justification may be found in the uncompensated nature of the service of the typical nonprofit director, whom courts are reluctant to hold to too exacting a standard of conduct." *Id.* Note that the business judgment rule never applies to breaches of the duty of loyalty. *See id.* at 49-50; *see also* Lawrence E. Singer, *The Conversion Conundrum: The State and Federal Response to Hospitals' Changes in Charitable Status*, 23 AM. J.L. & MED. 221, 235 (1997). Singer notes that generally the decisions of the directors of nonprofits are protected by the business judgment rule, but the rule offers no shield where self-dealing is alleged; as a corollary, plaintiffs who breach claims for breaches of fiduciary duties are most successful when the duty of loyalty is implicated. *See id.*

[76] *See* MARYLAND INSURANCE ADMINISTRATION, LEGISLATIVE REPORT ON MIA ORDER NO. 2003-02-032, 111 (July 3, 2003), *available at* http://www.mdinsurance.state.md.us/documents/LegislativeCareFirstReport07-03.pdf (reporting that the Maryland Commissioner of Insurance deliberately ignored the business judgment rule in order to investigate and prevent the proposed conversion of CareFirst, the sole member of Blue Cross Blue Shield in Maryland, Delaware, and Washington, D.C.). The Commissioner unequivocally stated that the business judgment rule had "no place" in the regulatory proceeding. *Id*. at 71-72.

2. The Duty of Loyalty

The duty of loyalty commonly is described as requiring directors to act without self-interest, in good faith, and in the best interests of the corporation that they serve, at all times.[77] This entails both an affirmative duty to protect the interests of the corporation and an obligation to refrain from conduct that would injure the corporation.[78] The duty of loyalty derives from state statutory law, the Revised Model Nonprofit Corporation Act, caselaw, and occasionally from Internal Revenue Service rulings and interpretations.[79]

Breaches of the duty of loyalty arise when a director has a conflict of interest, which traditionally has been deemed to occur in three situations. In the first, a director has interests on both sides of a transaction and could experience personal monetary gain if the transaction were approved.[80] In the second, the director appropriates a corporate opportunity without notifying the board or management of the existence of the opportunity, thus usurping potential financial reward for the corporation.[81] A third breach of the duty of loyalty occurs when a director provides an economic benefit for a third party, even if the third party is another nonprofit organization.[82]

The key to each of the three traditional breaches is that the director is using the corporation for monetary benefit, which would be a particular problem for nonprofit corporations due to their corporate nonprofit purpose.[83] Using the nonprofit for personal gain is contrary not only to the general nonprofit corporate standards but also violates the public trust placed in nonprofits. In modern healthcare, however, breaches of the duty of loyalty can also occur when a director makes a decision that is detrimental to the welfare of one corporation to benefit another – a control (as opposed to monetary) situation that is not contemplated by traditional duty of loyalty doctrine.

When nonprofit directors encounter situations in which a conflict of interest could arise, the duty of loyalty has been interpreted to command that the conflicted director "act with candor and care."[84] The

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[77] *See* GUIDEBOOK, *supra* note 71, at 29. Under the duty of loyalty, nonprofit directors are required "to exercise their powers in good faith and in the best interests of the corporation." *Id*.

[78] *See id*. (stating that the duty of loyalty contains the negative principle that "the director shall not use a corporate position for individual personal advantage"); *see also* J. FISHMAN & STEPHEN SCHWARZ, NONPROFIT ORGANIZATIONS: CASES AND MATERIALS 200 (1995).

[79] *See* Schumpeter, supra note 3, at 1583 (describing the different areas of the law that affect nonprofit corporations and noting that nonprofits are subject to and benefit from the tax-exempt regulatory regime).

[80] *See* KURTZ, *supra* note 66, at 59.

[81] *See id.* A corporate opportunity has been appropriated when a director uses his position to capitalize on a business opportunity that more properly belongs to the organization. *See* Ono, *supra* note 66, at 115 (citing Guth v. Loft, 5 A.2d 503, 510 (Del. 1939)).

[82] *See* KURTZ, *supra* note 67, at 59.

[83] This constraint is honored in the duty of obedience, discussed in the next sub-section.

[84] *See* GUIDEBOOK, *supra* note 71, at 30.

permissibility of a nonprofit corporation undertaking a conflicted transaction, then, is dependent on the manner in which the director handles the conflict.[85] Although conflict of interest transactions indicate a breach of the director's duty of loyalty, conflicted transactions are not automatically void, despite that breach of fiduciary duty.[86] To prevent the nullification of a conflicted deal, the corporation must be able to demonstrate that (1) the challenged transaction "was approved by a disinterested majority of the board . . . after full disclosure by the affected director of the material facts regarding the transaction and the director's interest therein," or (2) the challenged transaction "was fair to the corporation at the time it was entered into."[87] Prior to becoming involved in a transaction that may provide a corporate opportunity to an organization, directors have usually been instructed that they should disclose the facts surrounding the transaction to the board of directors "in sufficient detail and in adequate time to enable the board to act or decline to act" with regard to the questionable transaction.[88] Thus, nonprofit directors are obligated to make objective decisions for the corporations that they serve and must either refrain from or obtain approval for entering into transactions where objectivity may be compromised.[89]

The expectation that directors will intuitively know when "in adequate time" occurs and what constitutes "sufficient detail" is unreasonable (for both for-profits and nonprofits), as is the notion that fiduciaries should simply know how to interpret conflicts with little to no guidance. The focus on a particular transaction and its monetary implications is perplexing, as the per-transaction standard leaves directors with no principled direction, particularly when they serve multiple boards or when they serve mirror boards (*i.e.* boards that contain the same directors). Strictly speaking, a director is automatically violating the duty of loyalty by serving more than one board because the duty requires the director to act in the best interest of the corporation at all times. Tension immediately arises from the service of multiple boards; and directors sitting on mirror boards, under the traditional rule, could never consummate a conflicted transaction, which would result in complete inertia.

3. The Duty of Obedience

The doctrine of fiduciary duties has been expanded in the nonprofit context, at least by a handful of courts, to include a new duty

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[85] *Id*. Trustees of charitable trusts may not engage in self-dealing or conflicted transactions, ever. *See* John G. Simon, *The Tax Treatment of Nonprofit Organizations: A Review of Federal and State Policies*, *in* THE NONPROFIT SECTOR: A RESEARCH HANDBOOK 67, 89 (Walter W. Powell, ed., 1987).

[86] *See* RMNCA § 8.31; the commentary notes that the drafters of the RMNCA rejected the trustee standard. *See* RMNCA §8.31 cmt. pt. 1. In the case of a trust, if a fiduciary enters into a transaction and fails "to disclose all pertinent circumstances, or if the transaction is unfair to the other" courts can nullify the transaction. *See* Fishman, *supra* note 8, at 228.

[87] *See* GUIDEBOOK, *supra* note 71, at 31.

[88] *See id.* at 34.

[89] *See* FISHMAN & SCHWARZ, *supra* note 78, at 200.

that is key to this discussion: the duty of obedience.[90] This duty directs board members to ensure allegiance to the entity's charitable mission and to obey all laws relevant to the organization.[91] While the duty of obedience was once subsumed within the duty of care for nonprofit corporations (a holdover from borrowing general corporate law principles), some courts have recognized it as a distinct fiduciary duty for nonprofit board members.[92] In order to understand this duty, it is helpful to describe how healthcare nonprofits' missions are formulated. To facilitate the discussion herein, I have separated the discussion into what I call charter mission and licensure mission.

a. Charter Mission

The corporate purpose of a nonprofit corporation is stated in its articles of incorporation (also called the corporate charter) and in its bylaws. The corporate purpose stated in the charter is dictated in part by state statute, meaning the reasons that a state's nonprofit act allows an entity to be organized as a nonprofit corporation and to receive state non-taxable status.[93] In addition, the application for the corporation's federal tax-exempt status may contain a more specific description of the organization's nonprofit goals.[94] Corporate purpose is particularly important for nonprofit organizations, as they can only incorporate for the permitted reasons delineated in the incorporating state's nonprofit corporation statute. Failure to so organize, or failure to so operate, can remove the state's imprimatur to operate as a nonprofit corporation. The corporation would lose tax-free status at the state level and perhaps be forced to return profits to the state that would have been collected from a for-profit organization, and it could result in loss of federal tax-exempt

[90] The following summarizes the states that have adopted the duty of obedience for nonprofit directors either by common law or statute (though not always in the healthcare context): California has interpreted the duty of obedience strictly (see Queen of Angles Hosp. v. Younger, 136 Cal. Rptr. 36 (Ct. App. 1977); New York too has taken a strict view of the duty of obedience (see MEETH v. Spitzer, 186 Misc. 2d 126 (N.Y. Sup. Ct. 1999); see also Consumers Union of U.S., Inc. v. State of New York, 840 N.E.2d 68 (N.Y. 2005)). Other states have afforded nonprofit directors more flexibility in fulfilling their missions: Missouri is one example (see Taylor v. Baldwin, 247 S.W.2d 741 (Mo. 1952)); New Jersey is another (see City of Paterson v. Paterson Gen. Hosp., 235 A.2d 487 (N.J. Super. Ct. Ch. Div. 1967)). Other states are on the cusp; for instance, in Georgia the duty has been recognized in a dissenting opinion (see Shorter College v. Baptist Convention of Georgia, 614 SE.2d 37 (Ga. 2005)).

[91] *See MEETH*, 186 Misc. 2d at 152.

[92] *See* Goldschmid, *supra* note 69, at 641 (acknowledging the analytical reasons for separating duty of care and duty of obedience but choosing to subsume duty of obedience within the duty of care for purposes of for-profit analog analysis). Some courts have described the duty of obedience as part of the duty of loyalty. By example, the court in *Summers v. Cherokee Children & Family Service*, 112 S.W.3d 486 (Tenn. Ct. App. 2002), stated that a "director's duty of loyalty lies in pursuing or ensuring pursuit of the charitable purpose or public benefit which is the mission of the corporation." *Id.* at 504. Some consider the duty of obedience to be a partnership principle that derives from the agency relationship of partners; when partners decide on a course of action for the partnership, each partner had a 'duty of obedience' to carry out that decision. *See*, *e.g.*, 7 Ill. Prac., Business Organizations, § 3.17A (2004) (describing the fiduciary duty of each partner to facilitate the chosen action).

[93] *See* GUIDEBOOK, *supra* note 71, at 6.

[94] *See* Kurtz, *supra* note 66, at 85.

status (most likely under Internal Revenue Code section 501(c)(3) for a healthcare provider).

State nonprofit statutes tend to list cursorily the possible purposes for which a nonprofit may be incorporated, and the list usually includes such purposes as educational, religious, charitable, eleemosynary, and fraternal; healthcare is generally considered to be a "charitable" activity and tends not to be listed separately.[95] The absence of healthcare in most nonprofit statutes forces incorporators of healthcare nonprofits to rely on historical statements of nonprofit corporate purpose for other healthcare entities' charter missions.

From the state's perspective, it is important for healthcare nonprofits to adhere to their corporate purpose so that the state can easily determine that ongoing tax-exempt status is warranted. From the entity's perspective, being true to corporate purpose can facilitate constancy and continuity for the typical revolving door of board members, officers, and employees. Notably, different healthcare nonprofits may have very similar charter missions; for example, two general hospitals incorporated in the same state are likely to have the same charter mission.

b. Licensure Mission

The mission of a healthcare entity also derives from its license to provide healthcare; I call this licensure mission. Consistent with the highly regulated nature of healthcare, every healthcare provider must be licensed to provide the services of that type of institution in each state in which the services are offered. For instance, a hospital must be licensed under department of health rules in the state(s) in which the hospital provides services. Licensure mission, therefore, is the intended *healthcare* purpose of the organization as dictated by the statutory and regulatory schemes that create the licensure of the entity.

Licensure mission is unlike charter mission in a few respects. First, jurisdictionally, the statutory schemes are distinct in creation and in enforcement. Corporate charters are overseen by state departments of treasury, while licensure of healthcare entities is performed by state departments of health. Second, each serves a separate purpose and defines the corporation differently. Charter mission explains the type of special corporation, but licensure mission defines the services provided to the community. Third, the enforcement of the two missions is accomplished by different means and with different goals in mind. Though both ultimately serve the community, adherence to charter mission could be described as a furtherance of fiscal trust, while

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[95] *See*, *e.g.*, KY. REV. STAT. ANN. § 273.167 (West 2005), which states in typical fashion:

> Corporations may be organized under KRS 273.161 to 273.390 for any lawful purpose or purposes, including, without being limited to, any one or more of the following purposes: charitable; benevolent; eleemosynary; educational; civic; patriotic; political; governmental; religious; social; recreational; fraternal; literary; cultural; athletic; scientific; agricultural; horticultural; animal husbandry; and professional, commercial, industrial or trade association; but labor unions, cooperative organizations, and organizations subject to any of the provisions of the insurance laws or banking laws of this state may not be organized under KRS 273.161 to 273.390.

adherence to licensure mission could be described as adherence to medical standards and purposes. The two missions overlap, but they are established by dissimilar means. Perhaps more than nonprofit charter mission, the licensure mission could help to guide directors in their service to the organization and its community.

c. Mission Interpretation

Traditionally directors have been granted considerable latitude in interpreting broadly-stated objectives for their nonprofit corporations; however, a few courts have interpreted the duty of obedience as charging directors with adhering to the charter's stated objectives, even if alternatives exist that directors believe may be better for the corporation and/or necessary for the served community.[96] This doctrine and its consequences illuminate a major difference between nonprofits and general corporations, and it is worth restating -- nonprofits can exist only for a purpose specified by the relevant state nonprofit corporation act, which must be mentioned in the entity's articles of incorporation.[97] If the nonprofit neglects its declared purpose(s), then theoretically the nonprofit must cease operations or become a for-profit corporation and divest a portion of its past profits.[98]

The duty of obedience is strikingly similar to a trustee's duty to administer a trust in a manner that is consistent with the wishes of the trust's creator, as it requires that directors maintain and promote the corporation's charitable or public interest purpose.[99] The obvious difference is that the creator of the trust in this case is the state, which has decided the permissible objectives for nonprofit corporations and their state tax-exempt status. States then allow the trust that is the nonprofit corporation to self-administer its charitable goals, often with little more guidance than to obey the corporate mission.

The rationale of the duty of obedience stems from the notion that nonprofit corporations are characterized by their specific, state-sanctioned objectives, but they may not be driven by desire to generate a profit.[100] Additional justification for the duty grows from the idea that donations to nonprofit corporations "are made in reliance upon the fulfillment of those charitable purposes."[101] The duty of obedience also

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[96] *See* FURROW ET AL., *supra* note 99, at 509. *See also MEETH* 186 Misc. 2d at 149, 152, 155. Note, however, that a nonprofit board may modify the fundamental objectives of an organization if it amends its articles of formation and its bylaws, and if it notifies the appropriate state officials. *See* RMNCA §§ 10.01-10.02, 10.05.

[97] *See* Fishman, *supra* note 8, at 237 (stating that directors have in the duty of obedience a responsibility that resembles trustees' duty to administer the trust in the manner proscribed by the trust's creator because the directors of a nonprofit must adhere to the purposes for which the nonprofit was created).

[98] *See generally* Greaney & Boozang, *supra* note 15, discussing the lengths to which state attorneys general have gone in pursuit of recompense when nonprofit healthcare organizations convert.

[99] *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 508-09 (3d ed. 1997).

[100] *See* PEREGRINE & SCHWARTZ, *supra* note 11, at 3-4 (discussing the fundamental differences between for-profit and nonprofit organizations).

[101] *See* KURTZ, *supra* note 66, at 85 (quoting Trustees of Rutgers College in New Jersey v. Richman, 125 A.2d 10, 26 (1956)).

reflects an underlying reality that the ability to utilize private funds is contingent on the confidence that donors have in the honesty of those ultimately accountable for managing them.[102] With this background, some courts have rejected any shift of corporate resources to other objectives, despite the seeming merit of those other objectives.[103]

Though it is difficult to discuss the duty of obedience without visiting *Manhattan Eye, Ear & Throat Hosp. v. Spitzer* ("MEETH"), the proverbial jury is still out on whether this case will become paradigmatic or atypical.[104] In MEETH, a financially-strapped hospital sought authorization from the New York State Attorney General, Eliot Spitzer, to sell a substantial portion of its assets to a cancer center and a real estate developer.[105] The authorization arguably was obligatory under the terms of New York Not-for-Profit Corporation Law section 511, which requires that a New York court determine whether transactions are fair and reasonable to the not-for-profit corporation and promote the objectives of the organization.[106] Attorney General Spitzer determined that the sale would have altered the mission of MEETH by incorporating "unstudied and unevaluated charitable purposes" into the original mission.[107] As a result, Spitzer objected to MEETH's petition, asserting that MEETH accepted the offers without considering other possibilities that potentially would have advanced the original objectives of MEETH.[108] The court held that MEETH failed to meet both prongs of the section 511 test not only because the terms of the transaction failed to account for MEETH's value as a going concern and for the value of the good will in MEETH's name, but also because the directors failed to demonstrate that the sale would promote the founding, declared purposes of the organization.[109]

In discussing the duty of obedience, the MEETH court declared that nonprofit directors must remain faithful to the purposes and

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[102] *See* Kurtz, *supra* note 66, at 85.

[103] *See*, *e.g.*, MEETH v. Spitzer, 186 Misc. 2d 126 (N.Y. Sup. Ct. 1999). MEETH could be atypical because very little caselaw exists yet regarding the duty of obedience, and because another New York court interpreted the attorney general's power under §§ 510 & 511 quite differently. *See* Nathan Littauer Hosp. Assn v. Spitzer, 734 N.Y.S.2d 671 (N.Y. App. Div. 2001). *Littauer* is different in important ways, including that the court found the proposed transaction did not fall within the statutory requirement for court review and notice to the attorney general because affiliation via a newly formed parent corporation merely involved restating the certificate of incorporation. *See id*. at 674-75.

[104] *See MEETH* , 186 Misc. 2d at 127. Few cases exist to serve as examples for interpreting and understanding the duty of obedience to date, though New York is emerging as a bit of a hotbed of the duty's doctrine given the state's statutory framework and the activity of Attorney General Spitzer. See, e.g., Consumers Union of U.S., Inc. v. State of New York, 840 N.E.2d 68 (N.Y. 2005), in which the conversion of Empire Blue Cross and Blue Shield was challenged by a consumer group on a variety of grounds, including violation of the duty of obedience; like MEETH, the state attorney general had jurisdiction because of statutory section 511.

[105] *See MEETH*, 186 Misc. 2d at 127.

[106] *See* McKinney's N-PCL § 511.

[107] *See MEETH*, 186 Misc. 2d at 141.

[108] *Id*. at 144. The failure to evaluate the deal properly was a breakdown of the duty of care; non-adherence to mission was a failure of the duty of obedience.

[109] *Id*. at 158.

objectives of the organization they serve.[110] The court observed that in limited cases financial difficulties may necessitate the sale of an organization's assets and the assumption of a new mission, but the duty of obedience requires the directors to first and foremost preserve the organization's original mission.[111] Ultimately the court held that a sale will not be approved for a nonprofit corporation if it fails to promote the purposes of the corporation (and indicates the advancement of a new mission) when no reasoned determination proves that the original mission could not be continued.[112]

MEETH exhibits the heightened interest in the concept of the duty of obedience. If enforced, this duty can act as a rein on board activities, but the more important issue is whether board members appreciate what it means to adhere to their own statutory mission, and how license-based mission can expound on the statutory mission of a healthcare nonprofit. More than the duty of loyalty, the duty of obedience may help to refine doctrine surrounding conflicts of interest.

B. The Void of Guidance

"What is unclear, however, is what nonprofit boards are actually supposed to do."[113] Directors in modern healthcare nonprofits frequently serve more than one board, yet no authority addresses this common occurrence, making it difficult for directors to fulfill fiduciary obligations.[114] The caselaw that does exist rarely if ever addresses broader principles of loyalty or obedience.[115] Other sources of authority, such as the Revised Model Nonprofit Corporations Act, fail to provide adequate information, even in explanatory comments.[116]

1. Caselaw, By Example

Nonprofit corporations have generated caselaw that is discombobulated at best.[117] The lack of consistent standards by which to understand the fiduciary duties of boards of directors is confused by courts' inability to determine whether the corporate standard or the charitable trust standard is persuasive; *Stern v. Lucy Webb Hayes National Training School for Deaconesses and Missionaries* ("Stern") serves as a cogent example. Also, extant guidance is retroactive and

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[110] *Id*. at 152.
[111] *Id*. at 156.
[112] *Id*. at 158.
[113] Goldschmid, *supra* note 69, at 639.
[114] *See id*. at 243-44. The author notes that the laws regarding the responsibilities of fiduciaries are "abstract and offer little concrete guidance."
[115] *See* Wells, *supra* note 5, at 563.
[116] RMNCA (1987).
[117] *See* Thomas H. Boyd, *A Call to Reform the Duties of Directors Under State Not-for-Profit Corporation Statutes*, 72 IOWA L. REV. 725, 732-33 (1987). Boyd notes that "Application of various standards to directors of not-for-profit corporations has resulted in a confusing body of case law. … a court applied different standards to the same institution [in one case]." *Id*.

generally too circumstance-specific to guide directors in future actions in a meaningful way; MEETH is an example of this problem.[118]

Stern involved breaches of the duty of care and duty of loyalty by the board of a hospital.[119] Before determining whether fiduciary duties were breached, the court had to determine which standard to use, charitable trust or general corporate; this was particularly an issue because the first version of the Model Nonprofit Corporation Act did not adopt fiduciary duties for nonprofit board members.[120] Because the trouble in *Stern* was failure to manage (rather than mismanagement), the directors would have breached their duty of care regardless of the standard applied.[121] Nevertheless, *Stern* helped to establish that nonprofit directors can be held liable for "gross negligence" when their mismanagement leads to corporate losses.[122]

In the context of this discussion, *Stern* set forth the standard that the duty of loyalty is breached when a director knowingly permits the nonprofit organization to enter a business transaction either with himself or with an entity in which he has a substantial interest without informing the board of his interest and then withdrawing from a vote on the transaction.[123] Dicta of the *Stern* court is remarkable for not having been followed despite its prescience; the court stated that a director is responsible for ensuring that the directors who are charged with approving the interested transaction are informed not only of the conflicted director's interest, but also of any "significant reasons, unknown or not fully appreciated by such persons, why the transaction might not be in the best interests" of the healthcare organization.[124] The *Stern* court began to grapple with the importance of information and the need for uninterested (or un-conflicted) directors to appreciate what might not be in the best interests of the corporation, even if no usurpation or actual financial conflict exists.[125]

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[118] *See* MEETH v. Spitzer, 186 Misc. 2d 126 (N.Y. Sup. Ct. 1999).

[119] *See* Stern v. Lucy Webb Hayes Nat'l Sch. for Deaconesses & Missionaries, 381 F. Supp. 1003 (D.D.C. 1974).

[120] *See id*. at 1013 (noting that charitable corporations are a relatively new creature but that most courts had been utilizing general corporate standards).

[121] As the court noted, "Total abdication of the supervisory role … is improper even under traditional corporate principles." *Id*. at 1014.

[122] *Id*. at 1013 (citing 1 HORNSTEIN, CORPORATION LAW AND PRACTICE § 446 (1959)).

[123] *Id*. at 1015-16.

[124] *Id*. at 1015.

[125] The full language of the court's standard is as follows:

> (2) he knowingly permitted the hospital to enter into a business transaction with himself or with any corporation, partnership or association in which he then had a substantial interest or held a position as trustee, director, general manager or principal officer without having previously informed the persons charged with approving that transaction of his interest or position *and of any significant reasons, unknown to or not fully appreciated by such persons, why the transaction might not be in the best interests of the hospital*; or
>
> (3) except as required by the preceding paragraph, he actively participated in or voted in favor of a decision by the Board or any committee or subcommittee thereof to transact business with himself or with any corporation, partnership or association in which he then had a substantial interest or held a position as trustee, director, general manager or principal officer.

Id. (emphasis added).

More specifically, the *Stern* court had an opportunity to explore the idea of a duality of interest, as the hospital had adopted guidelines promulgated by the American Hospital Association (AHA) that formed a model conflict of interest policy. In this policy, the AHA explained that modern hospitals were likely to have board members that experienced a "duality" of interest or conflict of interest because board members were likely to be chosen for their "expertise, their leadership … in other fields, or their specialized representation of significant community interests."[126] The AHA's ethics advisory document strongly recommended that such dualities be disclosed and made a "matter of record through an annual procedure and also when the interest becomes a matter of board action."[127] The AHA recognized that such dualities could be beneficial for the hospital; however, the *Stern* court did not explore the possibilities for expanded discourse of conflicts presented by the case.

MEETH also is cited as a modern case that hashes out the intricacies of board duties.[128] As was discussed above, the members of the board of directors of MEETH were deemed to violate their fiduciary duties (specifically, the duty of care) by accepting an offer for the sale of the historic Manhattan hospital before investigating options that would have adhered to the original mission of the hospital.[129] The trouble with *MEETH* as a discussion of fiduciary duties is at least threefold. First, the case is founded on a unique state law that requires court approval to sell all or substantially all of the assets of a not-for-profit corporation.[130] New York appears to be virtually alone in mandating court oversight; most states simply require some form of notice, often to the state attorney general.[131] Second, the case merely instructs boards of directors on how *not* to act; the two-pronged test set forth by the court is an interpretation of a state law that does not inform boards regarding their future conduct. Third, the New York statute is a quasi-cy pres scheme that does not contain many direct analogs. Thus, even the 'model' caselaw for nonprofits does not significantly advance understanding of the doctrine of fiduciary duties.

2. The Revised Model Nonprofit Corporation Act

The Revised Model Nonprofit Corporation Act ("RMNCA") also fails to provide directors with a meaningful method of parsing fiduciary duties. In fact, the drafters of the RMNCA appear to have deliberately narrowed the sections of the act that address conflicts of interest.[132] The RMNCA was a complete amendment of the original Model Nonprofit

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[126] American Hospital Association, *Resolution of Conflicts of Interest*, Ethics Management Advisory, at 1.

[127] *Id*. at 1015, citing the hospital's bylaws as adopted from the AHA guidelines.

[128] *See* MEETH v. Spitzer, 186 Misc. 2d 126, 127 (N.Y. Sup. Ct. 1999).

[129] *See id*. at 156-59.

[130] *See* N.Y. Not-For-Profit Corporation Law § 511 (McKinney 2005).

[131] *See* BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, HEALTH LAW 894 (5th ed. 2004) (commenting on the duty of obedience and the difference between New York and other states' standards).

[132] *See* RMNCA §§ 8.30-8.31.

Corporation Act, and the revision was supposed to improve on the original model act's obvious deficiencies, such as a complete lack of defining principles for the duty of care and the duty of loyalty.[133]

While the intent of the drafters of the RMNCA was to include guidance on conflicts of interest, they defined conflicts too narrowly for the model to be of much use. The drafters decided that fiduciary duties protect the interests of those who make donations to public benefit corporations so that donors know that their monies will only be used for the intended public purpose, not for directors' personal benefit.[134] The narrow focus on monetary issues facilitated the narrow scope of the doctrine as it became codified in state law. The authors of the RMNCA acknowledged the debate about the appropriate model for nonprofit corporations (trust versus general corporation), and they chose the model of a general corporation with "little difficulty."[135]

Thus, the RMNCA describes the duty of care as the same duty that directors of for-profit corporations owe – the duty of an ordinarily prudent person under like circumstances.[136] This provides much in the way of leeway and little in the way of guidance. Likewise, regarding the duty of loyalty, the RMNCA states that directors must act in good faith and in a manner "they reasonably believe to be in the best interests of the corporation."[137] The comment explicitly states that the development of standards in the area of the duty of loyalty is left to the court system.[138] As discussed above, this has not occurred, and the courts have not provided meaningful instruction to directors.

The RMNCA also does not provide advice or standards on the duty of obedience.[139] The drafters deliberately left the matter of corporate purpose to state courts and to the Internal Revenue Service, as they perceived the matter of corporate purpose as tied to satisfying 501(c)(3) requirements.[140] At the time it was drafted, the authors of the RMNCA

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[133] *See id*., Introduction at xix. More specifically, the first model nonprofit corporation act "did not set forth standards of care or loyalty for directors or officers. It did not deal with statutory immunity or protection for directors who acted with due care and did not breach their duty of loyalty. Nor did it provide conflict of interest rules." *Id.*

[134] *See id*., Introduction at xxvi; §§ 8.30-8.31.

[135] *See id*., Introduction at xxxv, stating,

> There has been no consensus on the standards that should be applicable to director of nonprofit corporations. Some commentators have suggested trust standards, while others have suggested business standards. The Subcommittee had little difficulty in rejecting trust standards and adopting the same general language the [Model Business Corporation Act] uses for directors of business corporations.

[136] *See id*. § 8.30(a).

[137] *See id*. § 8.30(a), § 4 cmt.. The duty of loyalty standard becomes more confusing with regard to disposition of property by a nonprofit because the drafters of the RMNCA left open the possibility that a trust standard would apply. *See*, *e.g.*, RMNCA § 12.02 and commentary.

[138] *See id*. § 8.30, §4 cmt..

[139] Daniel L. Kurtz, one of the drafters of the RMNCA, wrote an indispensable book, *Board Liability: Guide for Nonprofit Directors*, that was published a year after the RMNCA. *Board Liability* has become an important resource for understanding the contours of the duty of obedience. One must wonder why Kurtz did not push to introduce the duty of obedience into the RMNCA while working on the drafts, as the BOARD LIABILITY project began sometime in 1984; the two projects surely overlapped.

[140] *See* RMCNA Introduction at xxiii.

found it sufficient to delineate what constitutes a conflict of interest transaction and to provide for attorney general oversight to prevent abuses by directors of public benefit nonprofit corporations.[141] Times have changed, though, and the RMNCA has become outdated.

III. The For-Profit Corporate Approach Is Unsatisfactory for the Nonprofit Healthcare Organization

For-profit general corporations have been utilizing the 'inform and recuse' method codified by Delaware statutory section 144 for many years.[142] Essentially this method requires the conflicted director to reveal the existence of the conflict and then to remove herself from voting on the issue. This approach is deemed to remove the "taint" from the transaction, and thereby courts apply the business judgment rule to the decision-making of the non-conflicted directors and ignore any conflicts that would otherwise void a transaction. The subtext to this approach is that the directors will not be faced with the scenario that healthcare nonprofits face -- the inevitability of repetition, which may be unique to healthcare nonprofits due to the need to adhere to charter mission and licensure mission. Further, directors in the for-profit sector, especially in publicly held corporations, are subject to a variety of controls that simply do not exist for nonprofit organizations.[143]

General business corporations are "an instrument through which capital is assembled for the activities of producing and distributing goods and services and making investments … with a view to enhancing corporate profit and shareholder gain."[144] While the mission of a nonprofit is its foundation and *raison d'etre*, the mission of a for-profit is

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[141] *See id*. at xxviii.

[142] *See* Del. St. Title 8 § 144 (2005). Section 144 provides:
(a) No contract or transaction between a corporation and 1 or more of its directors or officers, or between a corporation and any other corporation, partnership, association, or other organization in which 1 or more of its directors or officers, are directors or officers, or have a financial interest, shall be void or voidable solely for this reason, or solely because the director or officer is present at or participates in the meeting of the board or committee which authorizes the contract or transaction, or solely because any such director's or officer's votes are counted for such purpose, if: (1) The material facts as to the director's or officer's relationship or interest and as to the contract or transaction are disclosed or are known to the board of directors or the committee, and the board or committee in good faith authorizes the contract or transaction by the affirmative votes of a majority of the disinterested directors, even though the disinterested directors be less than a quorum; or (2) The material facts as to the director's or officer's relationship or interest and as to the contract or transaction are disclosed or are known to the shareholders entitled to vote thereon, and the contract or transaction is specifically approved in good faith by vote of the shareholders; or (3) The contract or transaction is fair as to the corporation as of the time it is authorized, approved or ratified, by the board of directors, a committee or the shareholders. (b) Common or interested directors may be counted in determining the presence of a quorum at a meeting of the board of directors or of a committee which authorizes the contract or transaction.

[143] *See* Goldschmid, *supra* note 69, at 636 (discussing a series of occurrences in the 1990's that made the boards of for-profit entities more responsible and responsive).

[144] ALI §2.01 (T.D. No. 2, 1984), *cited in* KURTZ, *supra* note 66, at 3.

simply to earn money for the continuing success of the corporation and the happiness of its shareholders.[145] Setting aside healthcare purpose momentarily, for-profits and nonprofits can be differentiated easily by the financial imperative and the markets in which general corporations operate.[146] For-profit entities are subject to different restrictions than nonprofits, particularly if they are publicly traded; also, they have markets in which they must compete, and they have shareholders, each of which exert some degree of control over the purpose of the for-profit.[147] For-profits' charters state typically they are formed for 'any lawful purpose,' or (bluntly) any lawful method to prosper for shareholders; they are not restricted by notions of mission.[148] In the general corporate sector, entities tend to merge and/or otherwise transact in such a way that the matter for which the conflict exists is unlikely to arise again, even if directorates overlap.[149]

Delaware recognizes that serving in multiple directorates is possible and that serving more then one board is not per se invalid.[150] Delaware courts have acknowledged that it is common for directors to serve more than one board and that such directors owe the same fiduciary duties to each corporation; neither may dilute the duties owed to the other.[151] The Delaware common law on interested transactions that once resembled the per se voidability of trusts has been invalidated by the 1967 enactment of section 144. [152] Now, to be disqualified under

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[145] *See* 1 HEALTH LAW PRACTICE GUIDE § 6:47.1 (American Health Lawyers Ass'n 2003). The *Health Law Practice Guide* notes, "it must be remembered that the duty to members of a charitable organization is not to maximize profits (as in the case of a for-profit corporation) but instead to advance the organization's charitable purpose)." *Id*.

[146] In hospital markets, for profit and nonprofit organizations may directly compete; also, in a horizontal integration, it is sometimes possible for hospitals to merge rather than affiliate by contract and overlap.

[147] *See* Goldschmid, *supra* note 69, at 637 (noting that nonprofits are not bound by or protected by shareholder voting in the context of acquisitions).

[148] *See* Peggy Sasso, *Searching for Trust in the Not-for-Profit Boardroom: Looking Beyond The Duty of Obedience To Ensure Accountability*, 50 U.C.L.A. L. REV. 1485 (2003). Lamenting the omission of the duty of obedience from the RMNCA, the author states,

> [T]he RMNCA carries its theme of creating symmetry between nonprofit and for-profit corporate law to an illogical extreme. The two entities measure accountability by very different standards, with the for-profit corporation relying on market indicators to assess performance, while the not-for-profit corporation derives its standard of accountability from legal and social norms. Presumably the RMNCA assumed the duty of obedience was adequately addressed through duties of care and loyalty.

Id. at 1522.

[149] The exception is a transaction that results in or deals with a wholly-owned or non-wholly-owned subsidiary, in which case general corporations may face similar issues to healthcare nonprofits. *See*, *e.g.*, Anadarko Petroleum Corp. v. Panhandle E. Corp., 545 A.2d 1171 (Del. 1988).

[150] *See* ERNEST L. FOLK, FOLK ON DELAWARE CORPORATE LAW §144.10 (Aspen 1992), noting, "Interlocked boards are 'not in themselves unlawful,' and charter or by-law provisions that 'merely facilitate[] the functioning of the [interlocked] board, cannot be said to constitute a contract contrary to public policy.'" *Id*. (citing Sterling v. Mayflower Hotel Corp., 93 A.2d 107, 118-19 (Del. 1952)).

[151] *See* Warshaw v. Calhoun, 221 A.2d 487 (Del. Ch. 1966).

[152] *See* Potter v. Sanitary Co. of America, 194 A. 87 (Del. Ch. 1937) (strongly condemning interested director behavior). Historically, transactions between

Delaware law, a director must have a "substantial" interest such that the director could not make a decision based solely on the corporate merits of the transaction because she is too influenced by "personal or extraneous considerations."[153] Thus, not only are interested transactions not per se invalid, but the standard by which directors are determined to be "interested" gives directors great flexibility.

The permissive approach embraced by Delaware for general corporations is illuminated by *Warshaw v. Calhoun*, in which the Delaware Chancery Court determined that "individuals who act in a dual capacity as directors of two corporations, one of whom is parent and the other subsidiary, owe the same duty of good management to both corporations. This duty is to be exercised in light of what is best for both corporations."[154] The *Warshaw* court further decided that multiple directorships, while permissible, are no excuse for not serving each corporation equally in performing the duty of "good management."[155] In absolving the defendants of personal liability, the court relied on the business judgment rule and the presumption that directors act in the best interests of the corporations that they serve, even if financial harm comes to a subsidiary corporation or its shareholders.[156] The court relied in part on the assumption that the circumstances giving rise to the minority shareholder's action were singular and unlikely to be repeated.[157]

Healthcare entities, specifically vertically and horizontally integrated entities, are likely to experience the same conflicts recurrently. As was discussed by example above, an HMO will have the statutorily mandated mission to manage healthcare costs and to keep premiums as low as possible, and a hospital will be charged with the statutory mission of institutional care of humans. Neither mission will be altered absent statutory modification by state legislature. Thus, the directors who sit on overlapping boards of two such healthcare entities will be constantly faced with conflicting licensure missions. Also, for-profit subsidiaries of nonprofit organizations will face similar problems to the nonprofit;

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corporations having overlapping directors and officers were characterized automatically as "constructively fraudulent" if no shareholder ratification occurred. *See* Marciano v. Nakash, 535 A.2d 400, 403 (Del. 1987).

[153] *See* Cede & Co. v. Technicolor, Inc., 634 A.2d 345, 362 (Del. 1993).

[154] Warshaw v. Calhoun, 221 A. 2d 487, 492 (Del. Ch. 1966) (citing Abelow v. Midstates Oil Corp., 189 A.2d 675 (Del. 1963); *see also* Levien v. Sinclair Oil Corp., 261 A.2d 911, 915 (Del. Ch. 1969), rev'd on other grounds, 280 A.2d 717 (Del. 1971), on remand to 300 A.2d 28 (Del. Ch. 1972), and on remand to 314 A.2d 216 (Del. Ch. 1973), jmt. aff'd by 332 A.2d 139 (Del. 1975) (stating that multiple directorships are not an excuse for diluting fiduciary duties owed to each corporation; such would be a "turnabout under [Delaware] law." *Id*. at 915.).

[155] *See Warshaw*, 221 A.2d at 487.

[156] *Id*. at 492-93.

[157] *Id*. The suing minority shareholder was dissatisfied that her investment had not generated a significant return, and she pointed to the corporate parent-subsidiary relationship as evidence of wrongdoing. As the court stated, "plaintiff's [sic] case … rests entirely upon the proposition that there is something inherently wrong in permitting Securities to retain its personal holding company status to the financial loss of its stockholders." *Id*. at 494. The particular decision at issue was the decision of the parent holding company not to acquire additional shares of the stock of its subsidiary upon issuance of new shares. The issuance of new shares was, in the history of the companies, a singular action. *Id.* at 490-93.

affiliation of nonprofit healthcare entities creates complications whether the affiliation is nonprofit to nonprofit or nonprofit to for-profit.

Healthcare nonprofits have no shareholders to oversee their activities; instead they serve a given community through fulfilling their licensure and charter mission, the *sine qua non* of their existence. Constant recusal ultimately would mean a failure of overlapping directors to serve the community; also, recusal would become a farce. Certain directors (or all directors, in the instance of mirror boards) would never be able to vote and would ultimately violate the duty of care in the process of attempting to honor the duty of loyalty. A fresh approach is needed for healthcare nonprofits with overlapping boards.

IV. Proposals for Proactive Boards

It is important for directors to be able to proactively resolve conflicts, but the need for clear guidance for overlapping boards goes beyond the avoidance of government interference. Intervention by an attorney general does nothing to advance norms in board behavior, the same problem that has been experienced in caselaw.[158] A preference for models of proactive self-regulation and for more global (rather than situational) approaches to governance and management has emerged in the healthcare industry.[159] As a procedural and economic matter, self-

[158] *See* Fishman, *supra* note 8, at 250 (observing that boards tend to settle when an attorney general brings an action against a charity, which contributes to the dearth of guidance for board behavior).

[159] An example of this trend for the healthcare industry is the model corporate compliance guidances issued by the Department of Health and Human Services Office of the Inspector General (the "OIG"). *See* Department of Health and Human Services Office of the Inspector General Compliance Program Guidances for the healthcare industry, available at http://oig.hhs.gov/fraud/complianceguidance.html. Sarbanes-Oxley appears to contribute to this trend as well. *See* Board Source & Independent Sector, *The Sarbanes-Oxley Act and Implications for Nonprofit Organizations* (Jan. 2006), http://www.boardsource.org/clientfiles/Sarbanes-Oxley.pdf (noting that nonprofits are not directly governed by Sarbanes-Oxley but that the legislation does set benchmarks that are useful for the nonprofit sector). Boards of directors are instructed to lead the march toward program integrity, which requires high levels of ethical behavior set by example at the top of every healthcare organization. *See* OFFICE OF INSPECTOR GEN. OF THE U.S. DEP'T OF HEALTH AND HUMAN SERVS., CORPORATE RESPONSIBILITY AND CORPORATE COMPLIANCE: A RESOURCE FOR HEALTH CARE BOARDS OF DIRECTORS 1, *available at* http://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRsceGuide.pdf. The OIG now interprets the duty of care to include an understanding of a healthcare entity's systems and the compliance program that is employed by the entity. *See id.* at 1. The OIG, in conjunction with the American Health Lawyers Association, created this document, in which they wrote: "Embedded within the duty of care is the concept of reasonable inquiry. In other words, directors should make inquiries to management to obtain information necessary to satisfy their duty of care." *Id.* Citing In re Caremark International, Inc. Derivative Litigation, 698 A.2d 959 (Del Ch. 1996) (which involved a shareholder derivative suit for breach of the duty of care when directors approved kickbacks for prescription practices), the guidance states that failure to "reasonably oversee the organization's compliance program" or acting as "mere passive recipients of information" can lead to violation of fiduciary duties. OFFICE OF INSPECTOR GEN. OF THE U.S. DEP'T OF HEALTH AND HUMAN SERVS., CORPORATE RESPONSIBILITY AND CORPORATE COMPLIANCE: A RESOURCE FOR HEALTH CARE BOARDS OF DIRECTORS 1-2, *available at* http://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRsceGuide.pdf. Though the OIG acknowledges that directors are not charged with day-to-day oversight of the organization (that is the role of management in any organization), it still instructs

regulation has been shown to be more cost-effective and better business for the corporation not only because efficiencies are created from discovered internal problems, but also because litigation and government intervention are extraordinarily costly, thereby harming the entity and the community it serves.[160] The expectation for high-level stewardship indicates that the decision-making of board members faced with conflicts must be better informed and carefully considered with an eye toward primacy of the duty of obedience. Though volunteer board members have been let off the hook for lack of training and for general ignorance in the ways of the healthcare business world, governmental and community expectations have been changing.[161]

Healthcare entities are different than other corporations and even other nonprofits; Professor Hansmann has discussed the higher standard of healthcare nonprofits in terms of inequality of information that leads to an imbalance between the patient and the healthcare provider.[162] Many regulators and consumers have been disturbed by the rise of for-profit entities in healthcare precisely because healthcare is expected to be exceptional (and should not be motivated by profit).[163] But the confusion surrounding duties goes beyond these concerns, as conflicts can arise from information and from efforts at control. Because directors are often chosen for their ties in the community, and sometimes because they sit on the boards of other key businesses, "interested" transactions are not at all unusual and, perhaps in certain instances, can be beneficial.[164]

A. Procedural Shifts

This article suggests that several procedural changes are necessary to facilitate responsible overlapping boards. First, duality or multiplicity of interests must be recognized and revealed at the outset of board service; directors should perform a kind of due diligence upon

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directors that their obligations extend to the oversight of compliance programs. *See id*. at 2-3.

[160] *See* OIG Draft Supplemental Compliance Program Guidance for Hospitals, 69 Fed. Reg. 32012 (2004). The OIG observes:

> Compliance programs help hospitals fulfill their legal duty to refrain from submitting false or inaccurate claims or cost information to the Federal health care programs or engaging in other illegal practices. A hospital may gain important additional benefits by voluntarily implementing a compliance program, including: Demonstrating the hospital's commitment to honest and responsible corporate conduct; increasing the likelihood of preventing, identifying, and correcting unlawful and unethical behavior at an early stage; encouraging employees to report potential problems to allow for appropriate internal inquiry and corrective action; and through early detection and reporting, minimizing any financial loss to government and taxpayers, as well as any corresponding financial loss to the hospital.

Id. at 32013.

[161] *See id.* at 2 (noting that courts often apply the business judgment rule).

[162] *See* Hansmann, *supra* note 68, at 844-45 (stating that nonprofit 'enterprises' meet the need created by a market failure that arises from beneficiaries' inability to police certain producers of items or services, dubbed "contract failure").

[163] *See* BRADFORD H. GRAY, THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS 7 (1991).

[164] *See* Fishman, *supra* note 8, at 236 (writing that interested transactions are "often a necessity" for nonprofit corporations).

being asked to serve and document any actual or potential conflicts of interest. Second, nonprofit corporations should have more intelligible articles of incorporation and bylaws so that directors (and their communities) better understand the mission of the organization.[165] Third, though due diligence and proper documentation could lead to mitigation upon occurrence of a deviant event, the appropriate state agency should at least share oversight with the state attorney general to help inform the prosecution, which generally is not versed in the intricacies of healthcare. Fourth, the RMNCA should be modernized to catalyze a progression in nonprofit statutory law that would aid this doctrinal evolution.

1. Multiplicity of Interest – Documentation and Disclosure

The first procedural step requires recognition of the import of interests that are divided before they are conflicted, meaning a diversion of interest that arises from sitting on two boards, whether or not a traditional financial conflict of interest arises. This is a procedural issue because it requires directors to revise and refine the level, depth, and most importantly the timing of disclosures of divisions of interest. It requires substantive metamorphosis as well, but the end result is an important change in procedure.

The idea of a duality, division, or multiplicity of interest serves as a starting point. The AHA recognized the existence of a duality of interest among board members in a series of management advisories that have not been updated in over a decade (but that have been in circulation since the 1970's); but rarely has duality been recognized as an important precursor to a conflict of interest.[166] Duality, or division, of interest indicates that a director of a healthcare organization may have concomitant obligations that can benefit or burden the institution. This duality is quite common for members of nonprofit boards of directors who, as was discussed above, frequently sit on multiple boards.[167] Historically, this multiplicity was seen as beneficial to corporations for the potential connections, both in the community and economically, that

[165] Better sense of mission does not necessarily mean that the mission is constricted, only that it is clearer.

[166] *See* American Hospital Association, *AHA Management Advisory: Ethical Conduct for Health Care Institutions* (1992), *available at* http://www.aha.org/aha/resource_center/resrouce/resource_ethics.html [hereinafter *Ethical Conduct*]; American Hospital Association, *AHA Management Advisory: Resolution of Conflicts of Interest* (1990) (on file with author) [hereinafter *Resolution*]; American Hospital Association, Guidelines: Resolution of Conflicts of Interest in Health Care Institutions (1975) (on file with author) [hereinafter *Guidelines*]. For a brief discussion of the problems healthcare institutions face due to dualities of interest (and one of the only discussions), see L. Edward Bryant, Jr., *Responsibilities of Directors of Not-For-Profit Corporations Faced with Sharing Control with other Nonprofit Organizations in Health Industry Affiliations: A Commentary on Legal and Practical Realities*, 7 ANNALS HEALTH L. 139 (1998).

[167] *See Resolution*, *supra* note 166, at 1 (introducing the idea that healthcare entities' administrators often have outside interests that affect and can be affected by the decisions of a particular institution).

could be made.[168] Today, with increased integration of healthcare entities and continued perceived benefit from multiple board memberships, accepting the dual nature of multiple memberships allows the context in which conflicts later arise to be more informed.

Division allows for "divided loyalties" and does not implicate monetary issues per se; it expands the scope of self-examination and self-disclosure that must occur in order to properly serve multiple boards. If such dualities are recognized, then a director would consider competing interests and divulge information regarding her division of interests earlier. The division or duality of interest that exists should be immediately apparent upon appointment to a new board, and the director should document the circumstances that give rise to the division as well as the reasons by which the director concludes that service of multiple boards is acceptable. Directors are already charged with a certain level of sophistication if they serve healthcare entities in these times of heavy fraud enforcement.[169]

Directors should not be held to more than a 'reasonableness' standard in performing this evaluation, much like the business judgment rule.[170] Unlike the business judgment rule, immunity is not being proposed here, but the reasonableness standard is doctrinally familiar and useful here. Best practices would call for the corporation to keep a record of the director's due diligence; each director could be required to list all boards on which they serve as a condition of board membership to facilitate the information sharing and keeping.

Even with disclosure occurring earlier, directors need a compass for making decisions. That compass could be, at least in part, effectively drafted articles of incorporation and bylaws.

2. Charter Documentation

Insufficient charter documents contradict the stricter requirements non-profit corporations face regarding their creation and dissolution compared to other organizations.[171] To enable directors to perform initial due diligence, healthcare nonprofit organizations should have well-crafted articles of incorporation and bylaws.[172] If the articles

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[168] *See* Goldschmid, *supra* note 69, at 647-48 (noting that Professor Hansmann's suggestion that all conflicted transactions be banned for nonprofit corporations is impractical because interested transactions can be "useful" and directors with connections in other organizations can be the most useful for nonprofits) (citing James J. Fishman & Stephen Schwarz, CASES AND MATERIALS ON NONPROFIT ORGANIZATIONS, 58-69 (1995)).

[169] *See supra* note 161 and accompanying text.

[170] *See* GUIDEBOOK, *supra* note 71, at 28-29. As the Guidebook states, "A director exercising good-faith judgment will usually be protected from liability to the corporation or to its membership under the Business Judgment Rule." *Id*. at 28. As Daniel Kurtz puts it, nonprofit directors must act in a manner that is "plausibly rational." Kurtz, *supra* note 66, at 49. 'Plausible rationality' seems a fair standard here as well.

[171] *See* Fishman, *supra* note 8, at 226 (noting that nonprofit corporations are the favored form for charities to take because, compared to unincorporated associations and charitable trusts, nonprofit corporations have greater flexibility in governance, though they must deal with greater formalities in their creation and dissolution).

[172] The articles of incorporation are the original documentation from the state that create the corporation and set forth the purposes for which it is formed. The bylaws

of incorporation and bylaws clearly set forth the mission of the organization, board members will be positively affected in at least two ways. First, directors would be able to make a preliminary determination as to whether they can serve multiple healthcare entities. Second, it would assist in the issue of nonprofits' accountability, which has long been seen as a shortcoming of the nonprofit sector because of the nebulousness of fiduciary duties and because of the lack of oversight (a diminished issue if the directors follow through on the suggestions herein).[173]

The preliminary determination as to whether multiple entities can be served with fealty to charter mission and licensure mission can be achieved if a nonprofit's charter documents facilitate the decision-making process of directors. Without clear statements about the purposes for which the organization was formed, the community that it serves, and the manner in which directors are to make potentially conflicted decisions, directors cannot be expected to understand the potential danger (or utility) of sitting on multiple boards. States should require more than just a recitation of the pertinent statutory nonprofit formation purposes. If the statutory requirement were to require, for instance, a reflection of the licensure requirements for the entity, then the articles of incorporation might aid the directors in understanding and carrying out their organization's mission (and the state in enforcing the mission).[174]

3. No Safe Harbor

It might appear that this article, in proposing a procedure of due diligence and documentation, is suggesting that directors who perform such acts would be protected absolutely from investigation, prosecution, or other governmental oversight; however, no safe harbor is recommended. The division documentation could be a mitigating factor should the government investigate an organization, but it would not be an absolute shield. Due diligence serves other purposes, though; it enables investigating agencies to infer that a nonprofit's directors intended to

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are functionally a code of conduct for the corporation that set forth the management and rules for the organization.

[173] *See* Reiser, *supra* note 15, at 210-18 (dividing nonprofits' accountability into three categories, financial accountability, mission accountability, and organizational accountability in order to identify ways to address the long-standing concerns about the nonprofit sector and its apparent lack of oversight and accountability to the public).

[174] The mission language in the charter could be affected by amendments to the enabling licensure statute; however, licensure statutes tend not to change the purpose or nature of the healthcare provider being regulated. Instead, licensure statutes generally are amended to add conditions of licensure such as reporting requirements or patient information requirements. If the statutory licensure mission of the provider is not altered, then charter documents would not be affected. Of course, hospital licensure statutes (and other healthcare licensure statutes) can vary vastly from state to state. *See* John D. Blum, *Beyond the Bylaws: Hospital-Physician Relationships, Economics, and Conflicting Agendas*, 53 Buff. L. Rev. 459, 461 & fn. 4 (2005) (using the examples of Delaware, Hawaii, and Illinois hospital licensure statutes to display the variance within this category of state statutory law).

take their governance role seriously, and it enables government investigators to better understand the mission of the organization.[175]

The question becomes which governmental agencies would best oversee the activities of healthcare nonprofits. Attorneys general traditionally have the power to investigate the activities of nonprofits as protectors of the communities served by nonprofits, but they are not necessarily expert in the legal issues faced by nonprofits or the healthcare industry.[176] Also, some scholars have questioned exactly whom the state attorney general is representing in actions taken against nonprofits; oftentimes the AG's focus on financial issues excludes the notion of fidelity to mission.[177] Recent attorney general actions do not necessarily protect the community intended to be served by healthcare nonprofits; also, some unnecessary meddling in governance affairs post-action has become controversial.[178] For instance, Attorney General Hatch named eight members to Medica's board of directors once the split between Allina and Medica occurred; the board members subsequently petitioned the court to terminate their settlement with Hatch, charging too much interference in corporate affairs.[179] Attorney General Hatch undoubtedly had a difficult task in unwinding the underdeveloped and abandoned law in Minnesota regarding integrated service networks so that the development of Allina could be understood separately from the shortcomings of the state's failed legislative effort.[180] Undoubtedly conflicts of interest existed at Allina, but perhaps the attorney general's findings could have been clarified, and thus more informative for directors of other integrated healthcare entities, if the expertise of the relevant regulating agencies had been utilized. Drawing on the ongoing example of Allina and its continued fallout, it appears that other state agencies would help to round out the oversight of healthcare entities and their boards.[181]

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[175] *See* Evelyn Brody, *Whose Public? Parochialism and Paternalism in State Charity Law Enforcement*, 79 INDIANA L.J. 937, 975 (2004) (taking issue with the recent actions of attorney generals in the nonprofit sector, particularly with regard to their lack of understanding concerning the nature of nonprofits).

[176] *See id.* at 976-77, stating that "state attorneys general have no necessary expertise, much less the resources, to address the myriad concerns of the hundreds of thousands of charities that function in the United States today."

[177] *See* Reiser, *supra* note 15, at 234-35 (asserting that attorneys general are overly concerned with financial issues to the detriment of mission fidelity and corporate accountability).

[178] *See* Brody, *supra* note 175, at 1007.

[179] *See id*. An editorial in the Star Tribune "noted the unease of some observers when the attorney general proposed to install his own board: 'Some said it would give on elected official too much power over the health care of 1 million Minnesota consumers; other said it would be a conflict of interest for the state's top consumer watchdog to supervise a company run by his own appointees. … If Hatch appointed competent and honorable people, then a judge should ask why the attorney general continues to second-guess their judgment. If Hatch appointed directors who are bungling the job, then a judge should ask why the attorney general should be allowed to repeat the experiment.'" *Id.* at 1007-08 (citing Editorial, Hatch vs. Medica*; Attorney General Should Let It Be*, STAR TRIB. (Minneapolis, Minn.), May 10, 2003, at A22). Additional anecdotes are well described by Brody. *See id*. at 984-1018.

[180] *See supra* note 33 and accompanying text.

[181] *See* Neal Gendler, *Judge Ends Medica Suit by Hatch*, STAR TRIBUNE, Aug. 19, 2005, *available at* http://www.startribune.com/stories/462/5568118.html.

To the extent it is apposite in a given state, the department of treasury, the department of health, and the department of insurance should be included as expert investigators and enforcers for healthcare nonprofits.[182] The department of treasury is the entity that generally registers corporations; the department of health generally is the entity that licenses healthcare organizations to provide services to the community; and the department of insurance is the entity that licenses managed care entities and other health insurers. The mechanism of oversight is simple: licensure. The licensure process creates proficiency in healthcare that would help to address one of the most frequent complaints about non-profits, that they are unaccountable to any shareholder or other overseeing interested party.[183] In healthcare, the regulating agencies could be considered interested parties. Though they may lack expertise specific to the corporate sphere, regulating agencies have knowledge that could help eliminate the awkward assumptions of attorneys general and help reduce the interference of the cy pres-like machinations that have been witnessed recently.[184] Some have suggested that special commissions could be formed to help with oversight of nonprofits, but improvements in the functioning of healthcare nonprofits, whether or not they have overlapping boards, would not necessarily be enhanced by an extra layer of non-expert oversight.[185]

4. Revise the RMNCA

The original Model Nonprofit Corporation Act ("Model Act") was created in 1954 and was the result of a joint effort between the ABA and the American Law Institute. Upon completion, the majority of states adopted it.[186] The RMNCA remains the primary model for states' nonprofit corporation statutes.[187]

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[182] Attendance to state-oriented issues becomes particularly sticky if the healthcare entity spans multiple states. As became apparent in *Health Midwest v. Kline*, No. 02-CV-08043, 2003 WL 328845, at * 16-17 (D. Kan. Feb. 6, 2003), attempting to adhere to state regulations across borders can be a significant challenge. *See* Greaney & Boozang, *supra* note 15, at 27-30, describing the "border war" that arose between Missouri and Kansas; *see also* Brody, *supra* note 15, at 1008-17 (describing the *Health Midwest* pleadings).

[183] *See* Robert A. Katz, *Let Charitable Directors Direct: Why Trust Law Should Not Curb Board Discretion Over a Charitable Corporation's Mission and Unrestricted Assets*, 80 CHI.-KENT L. REV. 689, 689-93 (2005) (describing failure of accountability to introduce the idea that agency theory may be better suited to nonprofit corporations than trust theory or corporate theory).

[184] *See* Brody, *supra* note 175, at 957 (describing the ability of courts to modify charitable trusts when their purposes have become impossible to carry out under the cy pres doctrine).

[185] *See* Fishman, *supra* note 8, at 222 (recommending the creation of public-private charity commissions to improve the problem of accountability for charitable organizations in general and with no particular focus on the unique issues faced by healthcare entities).

[186] *See* Henry Hansmann, *The Evolving Law of Nonprofit Organizations: Do Current Trends Make Good Policy?*, 39 CASE W. RES. 807, 810-11 (1989) (discussing the 'organizational' history of nonprofit corporations in the context of then-current legal trends).

[187] *See id.* at 810.

One of the major deficiencies of the Model Act, and thus the RMNCA too, is that the drafters of the Model Act adopted the Model Business Corporation Act virtually wholesale (with the exclusion of provisions that clearly could not apply to nonprofit corporations, such as stockholders rights).[188] As has been stated here already and observed by others in the past, the drafters did not include guidance on fiduciary duties in the Model Act.[189] While this deficiency was partially rectified by the inclusion of a description of conflicts of interest for nonprofit directors in the RMNCA,[190] the extant model policy on conflicts of interest is not sufficient for modern healthcare organizations.

The RMNCA is ripe for another reconfiguration, one that encourages coherence in understanding the fiduciary duties of nonprofit directors. While many scholars have espoused the notion of the duty of obedience, courts have yet to adopt the doctrine with any consistency or vigor.[191] Because so many states follow the RMNCA, a new revision could influence states' recognition of the importance of the duty of obedience, particularly in parsing the duties of directors who serve multiple boards. Also, the RMNCA must be modified to recognize that directors do often serve multiple boards and attempt to assist in the multiplicity of interest conundrum. Revising the RMNCA to substantively address the doctrine of fiduciary duties could help to move past the disparate attempts to reconcile traditional duties with modern board structures.

B. Substantive Shifts

If the fact of overlapping board membership is accepted as a starting point, then the question that must be asked (and that has never been answered) is not just *whether* a director can be fair to both (or many) entities, but also *how*. Directors need efficient and ethical means to serve more than one board of directors, which also indicates that potential conflicts should be addressed before they arise. This may signify that directors determine that some conflicts are acceptable because licensure missions align; or, this may indicate that directors cannot serve multiple healthcare organizations' boards, particularly in situations involving a form of vertical integration.

Substantively, the law should be modified to recognize the possible range of conflicts, not just the traditional and limited idea of financial conflicts of interest, and that sometimes the traditional conflicts

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[188] *See id*. at 814 (describing the Model Act as unstable for lack of any clear theory or vision of the nonprofit as a separate creature from the for-profit corporation).

[189] *See* Hansmann, *supra* note 186, at 814, stating that the Model Act was "muddled concerning permissible purposes for incorporation, vague and excessively permissive about distributions of net assets to members on dissolution, and completely silent about the critical issue of directors' and officers' fiduciary obligations."

[190] The RMNCA is based in part on the California nonprofit corporation statute, which divides nonprofits into three categories and was the source of some bemusement by nonprofit scholars. *See* Hansmann, *supra* note 186, at 816-819 (deriding the three category approach to nonprofit statutes as "poorly conceived to meet the needs of the nonprofit sector and its patrons.") (citing Cal. Corp. Code §§ 5000-10841 (West. Supp. 1988)).

[191] *See supra* section II.B.

should not be a cause for concern in modern healthcare.[192] First, the duty of obedience should be recognized as the third leg in a tripod of fiduciary duties for healthcare nonprofits. An additional needed development in the doctrine of the duty of obedience is to bifurcate it into charter mission and licensure mission. This would inspire discussion of conflict or congruence of mission rather than limiting dualities of interest to being interpreted as conflicts of financial interest. Second, the duty of obedience facilitates the interpretation and understanding of the duty of loyalty such that a director should know whether she could act in the best interests of more than one corporation. Third, the duty of care can be informed by the duty of obedience and the duty of loyalty, so that directors recognize that having information that is necessary for fulfilling the duty of care may mean violating the duty of loyalty or the duty of mission and could make service of multiple boards untenable in certain situations.

1. Elevating and Parsing the Duty of Obedience: Charter Mission and Licensure Mission

The duty of obedience, or more appropriately, the duty of mission, may be the best conduit to revising norms.[193] The "duty to ensure that the charitable mission of the corporation is carried out"[194] should no longer be a subsidiary piece of the duty of care analysis. The duty of obedience is a crucial aspect of the doctrine of fiduciary duties for healthcare nonprofits (and perhaps healthcare for-profits). The extant definition of the duty of obedience, which requires adherence to the mission of the organization and faithfulness to the laws applicable to the organization, is too nebulous to be doctrinally sound. At least with regard to healthcare nonprofits, the notion of fidelity to mission should be comprised of two elements: adherence to charter mission and adherence to licensure mission.

Charter mission would be established in the stated objectives of the corporation that render it eligible for nonprofit status. Thus, the charter mission is dictated in part by the requirements of the nonprofit statute of the home charter state and in part by the language in documents like the articles of incorporation and bylaws of an organization (which should be drafted according to the new procedures set forth above). It was the charter mission, set forth in the certificate of incorporation, that the court in MEETH relied on in determining that the sale of MEETH's property and establishment of community clinics was not true to the mission of being a "hospital in the City, County, and State of New York."[195] Charter mission is limited by the purposes for which a nonprofit corporation can be formed in the state of incorporation; thus, the charter mission of a subsidiary could not be written (manipulated) to

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[192] *See* Reiser, *supra* note 15, at 234 (discussing "activist AGs" tendency to focus on financial issues).

[193] As has been stated by Professor Hansmann, the "principal function of the nonprofit form" is to "serve effectively as fiduciaries for their patrons." Hansmann, *supra* note 186, at 819.

[194] MEETH v. Spitzer, 186 Misc.2d 126, 152 (1999).

[195] *Id.* at 128.

serve a system or a parent corporation, because those are not accepted reasons for forming nonprofit corporations.

Licensure mission would invoke the state's statutory vision of the healthcare entity's social role to determine if the entity is behaving in a way that is true to its delineated healthcare function. The activities of healthcare nonprofits are therefore governed, constrained, and defined by both their charter mission and the licensure mission as set forth by the states in which the entity provides healthcare services. To require nonprofit healthcare organizations to only adhere to their charter mission is to look at the picture with one eye. Licensure is pivotal in determining the nature and purpose of a healthcare entity. Depending on state requirements, it can even make a for-profit behave like a nonprofit.[196] Thus, whether or not a healthcare nonprofit drafts its documents to reflect both corporate and licensure requirements for the type of services provided, directors must understand that their duty of obedience is comprised specifically of the two elements of charter mission and licensure mission. The last aspect of the duty of obedience, adherence to applicable laws, is not essential to the analysis; it evokes the duty of care, which would be violated if directors were to ignore all laws that apply to a given entity. Perhaps this vague and overly broad element of the duty of obedience has stood in the way of the principle being fully accepted. Regardless, the duty of obedience can now be described as adherence to charter mission and licensure mission, which can then help with interpretation of the duty of loyalty.

2. Duty of Loyalty Viewed through Duty of Obedience

The baseline for the duty of loyalty informed by duty of obedience is that multiple directorships are common, though they can be vexatious.[197] Thus, the predicate goal is not to eliminate overlap, but to

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[196] For an example of such legislation, see N.J. Stat. 26:2H-18.51 (2005), which requires all general hospitals to provide charity care services and provides subsidies to the hospitals that bear the charity care burden the most through a state fund. The legislative history notes the policy goals of the state:

> Access to quality health care shall not be denied to residents of this State because of their inability to pay for the care; there are many residents of this State who cannot afford to pay for needed hospital care and in order to ensure that these persons have equal access to hospital care, it is necessary to provide disproportionate share hospitals with a charity care subsidy supported by a broad-based funding mechanism.

Id.

[197] Louis Brandeis disagreed with this premise, though his comments about overlapping directorates were famously (or infamously) made in the context of the dominance of the banking industry in the early 1900s, which Brandeis dubbed the "Money Trust." *See generally* LOUIS D. BRANDEIS, OTHER PEOPLE'S MONEY (1914). The passing and context of time help to dispel the unease that comes from his statement: "The practice of interlocking directorates is the root of many evils. It offends laws both human and divine. Applied to rival corporations, it tends to the suppression of competition and to violation of the Sherman law. Applied to corporations that deal with each other, it tends to disloyalty and to violation of the fundamental law that no man can serve two masters." *Id*. at 51. Brandeis continued:

> But the compelling reason for prohibiting interlocking directorates is neither the protection of stockholders, nor the protection of the public from the incidents of inefficiency and graft. Conclusive evidence (if obtainable) that the

decide when it is appropriate and how directors can work through multiplicities of interest based upon their understanding of the mission of each organization and the healthcare system with which the organization may be affiliated. The duty of loyalty analysis for nonprofits still bears the marks of its origins in for-profit corporate law. But, considering only financial interests when evaluating conflicts is limiting and insufficient for healthcare nonprofits. The overarching concept of the duty of loyalty – acting in the best interests of the corporation at all times – is informative, but impracticable when serving multiple healthcare organizations.[198] If the assessment of conflicts is expanded to include an evaluation of conflicting missions, however, then the duty of loyalty can be a more meaningful, proactive, and global doctrine.

Directors should determine whether they could properly act in the best interests of an organization by drawing upon the charter and licensure mission of each organization. As Attorney General Hatch correctly noted in the Allina investigation, the missions of HMOs and hospitals may always conflict.[199] A director being asked by an HMO to keep the costs of care down, and being asked by hospitals to increase reimbursement to provide more and better in-patient care services, may find that she is constantly at odds with herself and unable to wear both directorial hats for a vertically integrated healthcare system. Only by understanding the dual nature of the healthcare entity's mission can a director make a meaningful decision about her duty of loyalty to each organization. Alternatives to limiting board memberships may need to be found, for instance, by allowing for non-voting board members, or by including ex-officio members without voting rights, or by balancing board membership so that the original entity cannot be out-voted by allied entities.

3. Duty of Care Informed by the Other Two Fiduciary Duties

The duty of care is not necessarily violated by serving multiple boards so long as attention is paid to each board. This is more a practical, temporal matter than a legal matter; and, the duty of care is the least problematic duty in board overlap, unless a director is too busy with other boards to properly monitor organizational activities. Recall that the duty of care is a measure of a director's attention to a particular entity for which she sits on a board; in order to fulfill the duty of care, the director must act in a reasonably informed manner. The idea that directors should adhere to the laws applicable to the organization belongs here, not

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> practice of interlocking directorates benefited all stockholders and was the most efficient form of organization, would not remove the objections. For even more important than efficiency are industrial and political liberty; and these are imperiled by the Money Trust.

Id. at 62.

Efficiency is indeed one of the dominant reasons that overlapping boards occur in healthcare, making it more difficult to dismiss the need for efficiency for the benefit of "liberty" as Brandeis advocated.

[198] Though Brandeis may have been onto something, see *supra* note 197 and accompanying text, this article accepts the current condition of healthcare organizations in which overlapping boards are prevalent and unlikely to diminish in the near future.

[199] *See* COMPLIANCE REVIEW, *supra* note 30, § 2.5 at 9.

under the duty of obedience. If a director has performed the appropriate due diligence and has determined that the duty of obedience and the duty of loyalty can be served, then the duty of care will likely fall in line. It is thus the last priority in resolving multiplicities of interest.

C. Reevaluating Multiple Board Memberships

To fulfill its ethical duties, a board must not only keep corporate and charitable purposes in sight, it must also consider the public's viewpoint and assure the healthcare consumer that decisions have been made in an ethically sound and effective manner. With an ethical lens placed over the new perception of fiduciary duties described above, it becomes clear that directors may need to limit the number of boards on which they serve, particularly if the entities have conflicting charter or licensure missions; but, the community and/or healthcare consumer may be better served by directors sitting on multiple boards. Revisiting the three examples helps to focus the implications of revising fiduciary duties for healthcare nonprofits.

1. Vertically Integrated Systems

The break-up of Allina Health System has served as a warning to many in the healthcare industry about sloppy alliances and the import of attention to mission, but the industry might have learned more if the Compliance Review had included an analysis of Allina's corporate structure, which separated the hospital and health insurance divisions into independent nonprofit corporations with overlapping boards of directors for control purposes. "Obvious" conflicts of interest arose between the mission of Medica as a health maintenance organization and the mission of the Allina Health System, conflicts that appeared to deprive the Medica directors of the ability to consider the best interests of the HMO's enrollees.[200] Any action taken by the board of either entity contrary to the mission of the entity would therefore be a conflict of interest and potentially impermissible as a breach of the duty of loyalty and the duty of obedience.[201]

Hatch hit a fountainhead of potential exposition: when finance and service are combined, can directors ever be faithful to their fiduciary duties for each organization? It could be difficult. Applying the bifurcated duty of obedience informing duty of loyalty analysis in combination with procedural improvements advocated above, it seems that directors would have to recognize from the inception of their services that the financial entity and the service entity in a vertically integrated delivery system will have conflicting missions. Unless the entity were truly integrated into a staff-model HMO, the licensure mission of each entity will have inherent tensions that will not be

[200] *See* COMPLIANCE REVIEW, *supra* note 30, § 2.21 at 33.

[201] The Compliance Review does not delineate the duties violated this specifically, but it does conclude that the series of conflicted transactions led to higher premiums for Medica policyholders, which contravened Medica's mission as an HMO and would not have occurred but for the dominance of Allina. *See* COMPLIANCE REVIEW, § 2.21 at 35.

resolved by 'inform and recuse.' The directors of the HMO would always be attempting to serve their charter and licensure mission of creating economic efficiencies. The directors of the hospital (or hospital system) would serve their charter and licensure missions by seeking to increase and improve the institutional care of human beings.

The directors who serve both entities could reasonably conclude, before sitting through even one board meeting, that they would encounter conflicts of mission at every turn. Had the Allina directors performed this analysis, they could have avoided a good amount of the scrutiny they faced. If they had decided that board overlap was appropriate after performing the due diligence on their charter and licensure missions, then each fund-shift between entities would have been analyzed too with an eye toward the licensure mission conflict they were facing in addition to the duty of loyalty issues that were created. It would have been clear that keeping Medica in the Medicare + Choice market in order to serve the needs of Allina's hospitals was not only a breach of the duty of obedience, but also a breach of the duty of loyalty. The analysis would be similar in any vertically integrated system, though not all are created and run like Allina.

2. Horizontally Integrated Systems

The clarifications that result from including the charter mission/licensure mission bifurcation can be seen as well in the second example, wherein a typical hospital system of multiple hospitals is governed by one umbrella board of directors or by boards of directors with overlapping members. The board members of the suburban hospitals are potentially breaching their fiduciary duties to the individual suburban hospitals simply by supporting Urban Hospital, but the public fisc and the public health are served by maintaining Urban Hospital.

If the public benefits from the directors of a horizontally integrated system supporting the member hospitals of the system, then the directors should not be held accountable for breaching fiduciary duties. If we apply the 'obedience informing loyalty' analysis, the missions of the hospitals align from a licensure perspective. Each of the institutional entities in a horizontally integrated system will have the goal of (by example) the institutional care of human beings. Further, states tend to impose similar requirements on institutional healthcare entities to maintain their nonprofit status, such as the provision of charity care. Thus, even though they are separately incorporated, the organizations have virtually identical licensure missions. The ultimate simplifying approach would be for the hospitals to merge, but mergers and acquisitions can be tricky for regulatory reasons, such as the difficulty involved in combining and obtaining Medicare provider numbers (the major source of income for many hospitals) and in re-forming hospitals' contractual relationships with other healthcare entities and providers.[202]

[202] *See* Carl H. Hitchner, Clare Richardson, Judith E. Solomon & Charles B. Oppenheim, *Integrated Delivery Systems: A Survey of Organizational Models*, 29 WAKE FOREST L. REV. 273, 284 (1994). The authors note the difficulties facing healthcare entities seeking to fully integrate, stating that IDSs face "daunting legal obstacles. A basic issue, for example, is the ability of an integrated delivery system itself to obtain its

Also, licensure may restrain a hospital from composing itself as one corporate entity with many facilities.[203]

Recognition of similar licensure missions creates a new understanding of overlapping directors in horizontally integrated systems. Instead of breaching their duty of obedience, they may instead be enhancing it if they serve multiple entities in one system. In the example of the urban/suburban system, the directors are not necessarily violating the duty of obedience by creating centers of excellence or by financially supporting the less stable Urban Hospital.[204] The traditional financially-focused analysis of the duty of loyalty would require the directors to keep the money and to reinvest it in Hospital A and Hospital B. But, if the duty of loyalty is informed by the duty of obedience, the directors would not be breaching their duty of loyalty to shift money to Urban Hospital to keep it afloat, as they share the same market and the same patients, and all of them will potentially be stronger from a *mission* perspective if Urban Hospital does not go bankrupt.

In instances where the duty of loyalty might once have been violated, we see that the duty of obedience influences the understanding of "conflict" to draw the focus to serving the community rather than focusing on the current transaction's financial impact. The global approach is more satisfying for a healthcare nonprofit and helps directors to perform their duties in a more proactive, comprehensive way. Also, this interpretation of the fiduciary duties of nonprofit directors is consistent with the desire to infuse nonprofit law with trust principles that have often been peripherally informative but not comfortably doctrinally infused into nonprofit directors' fiduciary duties.

3. *Smaller Alliances*

Hometown Hospital and HHA share board members in the last example; the overlapping board does not exist to create an integrated delivery system, and no formal contracts exist between the entities. Nevertheless, the alliance is beneficial to both entities in terms of relationship building and maintenance. In the small community, the boards contain overlapping members because the community lacks options and because overlap helps to keep business flowing. When HHA

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own Medicare provider number and bill for all system services. Because integrated delivery systems often are comprised of a number of separate legal entities, particularly with respect to the physician component, single point billing would require assignment of claims to the system's billing entity." *Id.* at 284. The authors proceed to list serious complications arising from Medicare reimbursement rules, and conclude by noting, "Under these statutory and regulatory constraints, many integrated delivery systems find it difficult to function effectively as integrated billing units for Medicare purposes." *Id.* at 285.

[203] *See* Thomas H. Brock, *Minimizing antitrust exposure in a virtual merger – tips for hospitals entering virtual mergers*, HEALTHCARE FIN. MGMT., Sept. 1999, *available at* http://www.findarticles.com/p/articles/mi_m3257/is_9_53/ai_55834426 (noting that hospitals "face difficulties in attempting to fully combine disparate systems of governance, administration, and day-to-day operations" and other problems unique to the highly regulated nature of hospitals and other healthcare entities).

[204] On the other hand, if the urban patients cannot realistically reach the centers of excellence when their services are required, then the directors on the board of Urban Hospital have violated their duty of obedience with regard to Urban Hospital.

decides to serve Neighbor Hospital, board members who sit on both boards may suffer from divided loyalties. One of the most difficult issues that arises is whether the directors have a duty to inform Hometown Hospital of the new branch of potentially competing business. If the directors who sit on HHA's board reveal the information to Hometown Hospital's board, then they will breach their duty of loyalty to HHA; and if they do not reveal the information, they breach their fiduciary duties to Hometown Hospital.

The bifurcated duty of obedience analysis will be influenced by the community that the charter mission identifies as the one to be served by each entity. If one entity serves a larger catchment area than the other, then the charter mission may help the directors to determine whether they need to reveal the potential line of new business. For instance, if Hometown Hospital serves a smaller geographic area than HHA, then HHA's directors may decide that no conflict of mission exists when the HHA starts to serve another local hospital that by virtue of the HHA's charter mission is properly served. The licensure missions of the entities are likely complementary (patient service in an institution versus patient service in the patient's home).

Where the duty of obedience analysis only moderately assists in analyzing the new business for HHA, the duty of loyalty helps to determine whether the directors have a duty to reveal the information they have to the Hometown Hospital board. In the example, we see the limitations of the traditional interpretation of the duty of loyalty, as no financial usurpation or opportunity actually exists; the hospital does not have its own home health agency and would not be able to perform the services that HHA is proposing to expand to Neighbor Hospital. Fears of service loss, and perhaps a fear of competition, legitimately exist, but that does not fit squarely within the traditional definition of conflict of interest.[205] Nevertheless, if information can be deemed a potential source of conflict, viewing the informational tension of the directors through the lens of serving the community, then the directors should inform the board of Hometown Hospital of HHA's plan to extend services and, in subsequent vote regarding HHA, recuse themselves depending on the context of the vote. Avoidance of breaching the duty of loyalty to HHA is aided by considering the needs of the community as it is served by both entities as viewed through their charter missions and licensure missions.

IV. Conclusion

Overlapping boards of directors are a fixture in nonprofit healthcare organizations, yet little guidance is available to their directors or the agencies that regulate them. While overlapping boards can be

[205] Fear of competition is not a legally acceptable reason to withhold information, as it could potentially result in a Sherman Act violation. *See* 15 U.S.C. §§ 1-7 (2005). On the other hand, Sherman Act violations rely on restraint of trade among the states (its source of authority is the Commerce Clause), so with a local hospital and healthcare providers, the chances of the Department of Justice becoming involved are slim. *See* U.S. DEP'T OF JUSTICE, ANTI-TRUST DIVISION MANUAL ch. II, *available at* http://www.usdoj.gov/atr/foia/divisionmanual/ch2.htm#a1.

beneficial, they can also lead organizations astray. The key for directors is to determine whether they can and/or should serve multiple boards, and what effect their multiplicity of interest will have on their role in the governance of various organizations. A part of the solution is resolution of the temporal problem – what "conflict" means and when it must be considered – and must take into account many factors, including the social function of nonprofit healthcare organizations, the suitability of traditional corporate norms to the governance of those enterprises, and the importance of mission to healthcare entities in serving a community. It is unreasonable to expect directors to adhere to high ideals of fiduciary responsibility when they have no guidance for such responsibility or the means by which they can explore its contours.

To achieve this from a procedural perspective, multiplicity of interests must be recognized and revealed at the outset of board service by having directors perform due diligence upon being asked to serve on any board and to document all actual or potential conflicts. Better drafted articles of incorporation and bylaws would help directors to understand and maintain the charter and licensure mission of the organization. To facilitate the state's dealings with healthcare nonprofits, the healthcare-specialized agencies should at least share oversight with the state attorney general. Also, the RMNCA should be revised to catalyze an evolution in nonprofit statutory law.

Additionally, from a substantive perspective, the possible range of conflicts for nonprofit healthcare directors, not just the traditional and limited idea of financial conflicts of interest, must be defined and applied. The duty of obedience should be recognized as doctrinally essential for defining fiduciary duties for healthcare nonprofits. The duty of obedience should be bifurcated into charter mission and licensure mission, which would allow a discussion of conflict of mission rather than just conflicts of financial interest. The duty of obedience can then enlighten the interpretation and understanding of the duty of loyalty such that a director may know at the outset whether she could act in the best interests of more than one corporation. Also, the duty of care can be informed by the duty of obedience and the duty of loyalty, so that directors recognize that information that is necessary to fulfill the duty of care may lead to violating the duty of loyalty or the duty of obedience. Each of these steps should aid directors serving overlapping boards to avoid the "evils" that have been much discussed but little defined.