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Boards Of Directors Under Fire: An Examination of Nonprofit Board Duties in the Health Care Environment

*Naomi Ono**

INTRODUCTION

The era of deference toward boards of directors is over. In recent years, the actions of boards of directors have come under increased scrutiny and the fiduciary duty doctrines have been reinforced. The proliferation of lawsuits brought by attorneys general against directors of various organizations demonstrates the states' willingness to examine director conduct. Nowhere is this more evident than in the health care field, where a rapidly changing environment is compelling directors to face increasingly demanding and challenging responsibilities. The recent expansion of federal and state regulation, combined with the growing complexity of business transactions, has increased liability exposure for nonprofit organizations and their directors. Several investigations of nonprofit health care organizations' boards of directors have been brought in the past few years by attorneys general alleging that directors breached their fiduciary duties.[1]

Traditionally, the hospital industry has largely comprised nonprofit, tax-exempt hospitals that have played a tremendous role in the furnishing and delivery of health care services. However, this sector has undergone astounding transformations as health care entities evolve from stand-alone facilities to consolidated delivery systems. At the same time, alterations are being made to the nonprofit status of some of these entities. These evolutionary changes in the way health care delivery systems are being structured and regulated require board members to confront

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1. *See infra* notes 165-179 and accompanying text.

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a myriad of issues that inevitably arise under distinct factual scenarios.

Board members of nonprofit health care organizations are bound not only by the general laws governing corporate directors, but they must also adhere to the state and federal laws that regulate the health care industry in particular. Under both the general and health care specific rules, the directors' primary responsibilities are to adhere to their fiduciary duties of care and loyalty. Recent case law and federal regulations expand and clarify directors' fiduciary duties. The decision in *In re Caremark International Inc. Derivative Litigation*[2] requires boards of directors, in fulfilling their fiduciary duties, to be responsible for ensuring that adequate information and reporting systems exist which facilitate in uncovering and responding to employee misconduct.[3] *Caremark* illustrates the Delaware Chancery Court's willingness to impose stringent requirements on boards of directors in areas in which courts previously deferred to boards' discretion.[4] The duty of boards to monitor the affairs of the corporation on whose board they serve has been amplified by the United States Sentencing Commission's promulgation of Federal Sentencing Guidelines for Organizations.[5] The guidelines permit the imposition of significantly reduced sanctions for organizations convicted of criminal wrongdoing if those organizations have adopted "an effective program to prevent and detect violations of law."[6] The availability of reduced penalties in cases where an organization is convicted of a crime serves as a strong incentive for boards to implement effective compliance programs.

In addition, the threat of individual liability may induce board members to perform their fiduciary duties in an appropriate manner. The Taxpayer Bill of Rights 2,[7] signed into law by President Clinton on July 30, 1996, may be applied specifically to boards of directors of health care organizations. This legislation allows the Internal Revenue Service ("IRS") to hold individual directors and managers of tax-exempt corporations accountable for fraud and abuse in health care systems through the imple-

2. 698 A.2d 959 (Del. Ch. 1996).
3. *See id.* at 969-70.
4. *See* Graham v. Allis-Chalmers Mfg. Co., 188 A.2d 125, 130 (Del. 1963).
5. *See* U.S. SENTENCING GUIDELINES MANUAL § 8 (1995).
6. *Id.* § 8C2.5(f).
7. *See* Taxpayer Bill of Rights 2, Pub. L. No. 104-168, §§ 1311-14, 110 Stat. 1452, 1475-81 (codified as amended in scattered sections of 26 U.S.C. (1996)).

mentation and imposition of excise taxes on "excess benefit transactions."[8] Therefore, the Taxpayer Bill of Rights 2 provides directors who may be held personally liable for the payment of exise taxes an additional incentive to fulfill their fiduciary duties.

Affiliations between nonprofit health care entities and for-profit organizations is another topic engendering much discussion. Such transactions have generated concerns among attorneys general and the communities the nonprofit entities serve regarding the proper distribution of charitable health care services and resources. Upon the dissolution or conversion of nonprofit entities, boards of directors must be cognizant of charitable trust laws which require nonprofit corporations to dedicate their assets to specified charitable purposes.[9] Further, boards of directors must be aware that several states, concerned with the conversion of nonprofit health care entities to for-profit entities, have enacted legislation mandating government approval prior to consummation of particular transactions.[10]

The purpose of this Article is to illustrate the application of fiduciary duty principles to directors of nonprofit health care corporations in a health care environment that is changing at unprecedented rates. Part I reviews general corporate law, discusses the basic duties imposed upon board members in the health care context, and demonstrates the application of the board's fiduciary duties to factual scenarios using case examples.[11] Part I also discusses the Taxpayer Bill of Rights 2 in detail and offers suggestions to assist in protecting directors against the imposition of excess benefit penalties.[12] Part II analyzes the recent *Caremark* case and its effect on director liability with respect to corporate compliance systems.[13] An examination of the United States Sentencing Guidelines complements the conclusion reached in *Caremark*.[14] Part III expands on basic nonprofit corporate law doctrines and addresses some of the issues boards must confront in nonprofit conversions.[15] The Article concludes

8. *See id.*

9. *See* IVA AUSTIN WAKEMAN SCOTT & WILLIAM FRANKLIN FRATCHER, SCOTT ON TRUSTS § 348.1 (4th ed. 1989).

10. *See infra* note 180 and accompanying text.

11. *See infra* notes 17-81 and accompanying text.

12. *See infra* notes 82-103 and accompanying text.

13. *See infra* notes 107-112 and accompanying text.

14. *See infra* notes 113-144 and accompanying text.

15. *See infra* notes 145-179 and accompanying text.

by discussing California legislation as an illustration of the states' attempts to regulate nonprofit conversions.[16]

I. LEGAL FRAMEWORK

Board members of nonprofit, tax-exempt health care organizations are governed by a variety of state and federal laws. The most prevalent of those laws are those that require directors to fulfill their fiduciary duties of care and loyalty.

A. Directors' Fiduciary Duties

The concept of fiduciary duties is embedded in corporate law. Until relatively recently, the actions of nonprofit boards of directors were rarely challenged by attorneys general on fiduciary duty grounds. Some authors suggest that directors of nonprofit corporations have been protected from liability because of the deference accorded them in light of the corporations' nonprofit status.[17] This perception is due in part to the fact that nonprofit corporations typically have boards of directors that comprise members who serve on a voluntary basis.[18] Several states have enacted assorted statutes providing volunteers of nonprofit organizations with a limited form of statutory immunity which insulates the volunteers from individual liability.[19] In addition, the parties that have standing to challenge the actions of directors of nonprofit corporations are generally limited to the members of the board, the corporate members, and the state's attorneys general.[20] Attorneys general have, until recently, lacked the ability

16. *See infra* notes 181-189 and accompanying text.

17. *See* Eric S. Tower, *Directors' Duty to Obtain a Fair Price in the Conversion of Nonprofit Hospitals*, 6 ANNALS HEALTH L. 157, 167 (1997) (citing HOWARD L. OLECK & MARTHA E. STEWART, NONPROFIT CORPORATIONS, ORGANIZATIONS AND ASSOCIATIONS 889, 889 (1994) and Michael Peregrine, *Doing "Big Deals" and the Board's Duty of Care*, 28 J. HEALTH & HOSP. L. 327, 327 (1995)); *see also* DANIEL L. KURTZ, BOARD LIABILITY: GUIDE FOR NONPROFIT DIRECTORS 23, 99 (1988) (noting that a number of states have enacted legislation shielding uncompensated directors of charitable corporations from liability to third persons).

18. The voluntary basis on which directors of nonprofit corporations serve is distinguished from their counterparts in for-profit organizations in which the directors are often highly compensated business leaders.

19. *See* David James Bush, Comment, *The Constitutionality of the Charitable Immunity and Liability Act of 1987*, 40 BAYLOR L. REV. 657, 662 n.41 (1988).

20. *See* SUBCOMMITTEE ON THE MODEL NONPROFIT LAW, AMERICAN BAR ASSOCIATION, REVISED MODEL NONPROFIT CORPORATION ACT §§ 1.70, 3.04, 6.30 (1987) [hereinafter "RMNCA"]. Although the RMNCA has not been expressly adopted by all states, several of its provisions are similar to those implemented by many states and provide valuable guidance to the nonprofit corporate law analysis.

to adequately supervise nonprofit corporations because of the scarcity of financial resources.[21] Further, although boards of nonprofit organizations are accountable to the public, often there is little public oversight.[22]

Although the law historically grants deference to directors of nonprofit corporations based on their volunteer status and the perception that they will act in the public interest, their conduct is governed by the same corporate standards as directors of for-profit corporations.[23] Nonprofit directors serve as fiduciaries and are responsible for fulfilling unyielding fiduciary obligations to both the corporation and the public at large.[24] The two bedrock fiduciary duties are the duty of care and the duty of loyalty.

1. The Duty of Care

The duty of care mandates that a director act in good faith, in a manner that he or she reasonably believes to be in the best interests of the corporation, and with the care that an ordinarily prudent person in a like position would reasonably be expected to exercise under similar circumstances.[25] The duty of care requires members of boards to inform themselves of all material facts necessary to reach reasoned decisions.[26]

The propriety of director actions is governed by the business judgment rule.[27] The business judgment rule creates a legal pre-

21. *See* James J. Fishman, *The Development of Nonprofit Corporation Law and an Agenda for Reform*, 34 EMORY L.J. 617, 669 (1985).

22. *See id.* at 677-78. However, this contention is being diminished by state officials and lawmakers who are responding to the changing nature of health care delivery through the proposal and enactment of laws which specifically regulate nonprofit health care organizations. *See id.* at 680-83.

23. *See* RMNCA, *supra* note 20, § 8.30. The primary difference between nonprofit corporations and for-profit corporations lies in the nondistribution constraint which prohibits a nonprofit corporation from paying dividends or otherwise distributing any part of its net income or earnings to persons involved in the organization. *See id.* § 13.01. This contrasts with a for-profit corporation which is owned by its shareholders who share in the profits and losses of the corporation and maintain control over the corporation through their reserved powers and the board of directors they elect. The control of a nonprofit corporation is vested in its members through their reserved powers and the board of directors they choose or through the sole governance of a self-perpetuating board of directors. In either type of corporation, the boards of directors have analogous duties, whether the beneficiaries are the shareholders or the public-at-large.

24. *See* HOWARD L. OLECK, NONPROFIT CORPORATIONS, ORGANIZATIONS AND ASSOCIATIONS § 265 (5th ed. 1988).

25. *See* RMNCA, *supra* note 20, § 8.30(a).

26. *See id.* § 8.30(b).

27. *See* Oberly v. Kirby, 592 A.2d 445, 462 (Del. 1991) (asserting that a court cannot second guess the wisdom of a facially valid decision made by charitable fiduci-

sumption that in making a business decision, board members fulfilled their fiduciary duties of care by making good faith, informed decisions with an honest belief that the action taken was in the best interests of the company rather than in their own self-interest.[28] When the business judgment rule applies, the burden falls on the party challenging the directors' actions to rebut the presumption that the directors acted in good faith by proving the board members acted improperly.[29] A party challenging whether a board has properly discharged its duty of care must prove that the directors' actions or omissions have risen to a level akin to gross negligence.[30] If the plaintiff is successful, the burden shifts to the directors to prove they acted with the requisite degree of care.[31] Therefore, although directors may be held liable for gross negligence in carrying out their duties, they will not be held liable for mere mistakes or errors in judgment as long as they acted in good faith.[32] It should be noted that the business judgment rule protects director action and not director inaction.[33] The rule does not protect directors who inattentively fail to act, but does protect directors who make a conscious deci-

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aries); John v. John, 450 N.W.2d 795, 799-800 (Wis. Ct. App. 1989) (stating that bad faith, willful abuse of discretion, or fraud is a prerequisite to courts interfering in corporate affairs); Morris v. Scribner, 508 N.E.2d 136, 139 (N.Y. 1987) (declaring that the courts should not interfere with the decisions of members of religious corporations absent dishonest or unfair conduct); Queen of Angels Hosp. v. Younger, 136 Cal. Rptr. 36, 43 (Cal. Ct. App. 1977) (recognizing that where there is no reasonable basis for the settlement of a claim, the settlement of such a claim is not the proper exercise of sound business judgment). The business judgment rule has been described as both a presumption and a rule of substantive law. *See* Aronson v. Lewis, 473 A.2d 805, 812 (Del. 1984) (presumption: "presumption that in making a business decision the directors of a corporation acted on an informed basis, in good faith and in the honest belief that the action was taken in the best interests of the company"); Sinclair Oil Corp. v. Levien, 280 A.2d 717, 720 (Del. 1971) (rule: "court will not substitute its judgment for that of the board if the latter's decisions can be attributed to any relevant business purpose").

28. *See* Smith v. Van Gorkom, 488 A.2d 858, 872 (Del. 1985) (citing *Aronson*, 473 A.2d at 812).

29. *See id.*

30. *See id.* at 873 (citing *Aronson*, 473 A.2d at 812). Actual formulations of the rule may differ across jurisdictions. For a complete discussion on the business judgment rule, see Michael J. Kennedy, *The Business Judgment Syllogism - Premises Governing Board Activity*, 985 P.L.I. CORP. 723, 733 (1997).

31. *See Van Gorkom*, 488 A.2d at 873.

32. *See id.*

33. *See Aronson*, 473 A.2d at 813 ("Technically, [the business judgment rule] has no role where directors have either abdicated their functions, or absent a conscious decision, failed to act."); James E. Spiotto, *Director and Officer Liability: Who Watches the Watchmen?*, 931 P.L.I. CORP. 361, 373 (1996).

sion to refrain from acting in the exercise of valid business judgment.[34]

The Delaware Supreme Court case of *Smith v. Van Gorkom*,[35] while involving the sale of a railroad shipping company, contains lessons concerning corporate decision-making which are particularly prescient for health care providers. In *Van Gorkom*, the shareholders of Trans Union Corporation brought a class action lawsuit against the board of directors alleging that the directors had breached their duties of care by approving a $690 million merger between Trans Union and a wholly owned subsidiary of Marmon Group, Inc.[36] The plaintiffs attacked the approach used by the board to reach this fundamental business decision and argued dereliction of duty by the board.[37] Jerome Van Gorkom, Trans Union's chairman of the board and chief executive officer, proposed that Marmon Group acquire Trans Union for fifty-five dollars per share.[38] The basis for the price was a preliminary study performed by Trans Union's chief financial officer which indicated that a leveraged buyout would be feasible at fifty dollars per share but difficult at sixty dollars per share.[39] Marmon Group agreed to offer fifty-five dollars per share and the merger was subsequently approved by the Trans Union board in a two-hour meeting held on one day's notice.[40] At the meeting, Van Gorkom made a twenty-minute presentation and an attorney stated that the board might be subject to litigation if the offer was not approved and that a fairness opinion was not required by law.[41] The chief financial officer explained that his efforts to discover the feasibility of a leveraged buyout did not constitute an evaluation of the fair price or an estimation of the value of the company, and that the fifty-five dollars per share offer was at the low end of the possible price range.[42] The directors did not inquire as to the basis for determining the merger price and no explanation was offered.[43] Further, although copies of the proposed merger agreement were distributed at the meeting, none of the directors had the opportunity to review the

34. *See Aronson*, 473 A.2d at 813.
35. 488 A.2d 858 (Del. 1985).
36. *See id.* at 863.
37. *See id.* at 864.
38. *See id.* at 868.
39. *See id.* at 869.
40. *See id.*
41. *See id.* at 867.
42. *See id.* at 868-69.
43. *See id.*

documents.[44] The *Van Gorkom* court held that the directors were grossly negligent and breached their fiduciary duties of care to the stockholders.[45] The directors' decisions were not protected by the business judgment rule because the directors did not take the appropriate steps to become informed about the proposed merger prior to approving it.[46]

The seminal case addressing directors' fiduciary duties of care in a nonprofit health care context is *Queen of Angels Hospital v. Younger*.[47] In *Queen of Angels*, the hospital's Catholic sponsor claimed it was owed sixteen million dollars for past services rendered by its Sisters.[48] The Queen of Angels board subsequently executed a settlement agreement with the Catholic sponsor which provided that the Hospital would pay the sponsor $200 per month for each Sister over the age of seventy, whether or not she had worked at the Hospital.[49] The California Court of Appeals held that the board of directors of the hospital breached its fiduciary duty of care when it approved a settlement for claims for which there was no reasonable basis.[50] The court reasoned that although the sponsor claimed in good faith the right to compensation, the board did not properly exercise its business judgment.[51] The court explained that the services rendered by the Sisters were considered by both parties to be donations and therefore, there was no legal obligation to pay for the claim.[52] Accordingly, the board had no reasonable basis for believing in the validity of the claim and breached its fiduciary duty of care by entering into an inappropriate settlement.[53]

Van Gorkom and *Queen of Angels* illustrate that perhaps the single most important component of board conduct is not the actual decision that is rendered, but rather, the decision-making process utilized by the board to reach its decision. The business judgment rule provides judicial protection where an informed, appropriate decision-making process is utilized and where the board's deliberative process is supported by documentation containing the reasons for their decision. The decision-making and

44. *See id.* at 868.
45. *See id.* at 864.
46. *See id.*
47. 136 Cal. Rptr. 36 (Cal. Ct. App. 1977).
48. *See id.* at 39.
49. *See id.*
50. *See id.* at 42.
51. *See id.*
52. *See id.*
53. *See id.*

documentation process must demonstrate that the board exercised due care in following a particular course of action. Boards should create and retain background memoranda, meeting notes, minutes, and well-crafted board resolutions for all corporate actions likely to attract scrutiny. A director may properly rely on the records of the corporation and other information, opinions, or reports presented to the corporation by individuals considered to have professional or expert competence in a particular area as long as those individuals have been selected with reasonable care.[54]

Boards must always encourage active board member participation in all corporate decisions. The board should hold meetings with prior notice and distribute relevant documents in time for all board members to acquire available information regarding the proposed action and review the documentation that is provided. Board leaders must disclose all prior communications regarding the proposed action, including the deal background. In order to be fully informed, boards should utilize outside consultants and experts as appropriate, review the proposed transaction and agreement terms in detail, engage in thoughtful and honest discussions, and monitor activities that have been delegated to committees or individual board members. Board members must recognize that in satisfying their duties of care, they must make careful, educated, and honest decisions.

2. The Duty of Loyalty

Integration and consolidation activities are creating additional pressures on directors to be fastidious in avoiding conflicts of interest and even the remote appearance of a conflict.[55] The duty of loyalty requires directors to be disinterested and independent and act in the best interests of the corporation.[56] The increasing number of mergers, acquisitions, and conversions to for-profit status has the potential of creating additional conflicts as directors may have interests in one or more of the entities

54. *See* RMNCA, *supra* note 20, § 8.30(b).

55. For a complete discussion concerning situations involving nonprofit directors' duties of loyalty, see Michael W. Peregrine, *The Nonprofit Board's Duty of Loyalty in an 'Integrated' World*, 29 J. HEALTH & HOSP. L. 211, 211-19 (1996).

56. *See* RMNCA, *supra* note 20, § 8.30 n.4; *see, e.g.*, Guth v. Loft, Inc., 5 A.2d 503, 510 (Del. 1939) ("Corporate officers and directors are not permitted to use their position of trust and confidence to further their private interests . . . . [A]n undivided and unselfish loyalty to the corporation demands that there shall be no conflict between duty and self-interest.").

involved. The duty of loyalty may be compromised whenever a director has a conflict of interest, derives an improper financial benefit from a transaction through competing with the corporation, or usurps a corporate opportunity.[57]

In today's consolidating health care industry, potential conflict of interest situations abound. Sometimes the conflict is evident, such as when a director simultaneously serves on the boards of two separate nonprofit health care corporations or when a director procures real property or intellectual property which the corporation may want to acquire or develop in the future.[58] Other conflicts, however, are much more subtle. For example, a conflict may exist when a board member invests in for-profit corporations which compete with the nonprofit corporation on whose board he or she serves. Situations in which a director, who is also a physician, is asked to confront issues such as physician compensation,[59] the acquisition of other medical practices, or clinical issues affecting his or her personal practice may also create a conflict that may violate the director's duty of loyalty.

The existence of a conflict of interest involving one or more board members does not necessarily preclude a board from entering into a proposed transaction. In some circumstances, a conflict may not taint the entire transaction. In determining whether a particular transaction may be enforced even if a conflict exists, courts will examine whether the director disclosed the conflicting interest and the manner in which other board members approved the transaction.[60] Again, process is crucial. A conflict of interest or interested-director transaction is revo-

57. *See generally* DENNIS J. BLOCK ET AL., THE BUSINESS JUDGMENT RULE: FIDUCIARY DUTIES OF CORPORATE DIRECTORS 124-51 (4th ed. 1993 & Supp. 1995); CHARLES HANSEN, A GUIDE TO THE AMERICAN LAW INSTITUTE CORPORATE GOVERNANCE PROJECT 56-72 (1995).

58. *See* Peregrine, *supra* note 55, at 215-16.

59. To prevent "interested physicians" from dominating tax-exempt integrated delivery systems' boards of directors, the IRS announced a safe harbor which limited physician representation on such boards to no more than twenty percent. *See* William S. Painter, *Recent Legislation, Cases, and Other Developments Affecting Healthcare Providers and Integrated Delivery Systems*, SB51 A.L.I-A.B.A. 100, 127 (1997). However, in 1996, the IRS shifted away from its emphasis on the twenty percent limitation of physician representation to a more flexible approach. *See id.* The new position states that tax-exempt hospitals will not jeopardize their exemption even if physician representation on the board is more than twenty percent as long as a majority of the voting members of the board comprise independent community members and the organization adopts a substantial conflicts of interest policy. *See id.*

60. *See* RMNCA, *supra* note 20, § 8.31; Peregrine, *supra* note 55, at 213.

cable unless the transaction is (1) approved or ratified by disinterested members of the board, a committee of the board, or disinterested members of the corporation who, after full disclosure, reasonably believe that the transaction is fair to the corporation, (2) approved by the state attorney general, or (3) validated by a court in an action in which the attorney general is joined as a party.[61]

In addition to avoiding conflicts of interest, the duty of loyalty prohibits board members from usurping corporate opportunities. The usurpation of a corporate opportunity occurs when a director takes advantage of his or her position as a director by capitalizing on a business opportunity that properly belongs to the corporation.[62] An opportunity is a "corporate opportunity" if the corporation is financially able to undertake it, if the opportunity relates to the corporation's line of business, if the corporation has a reasonable business expectancy in the opportunity, and if by appropriating the opportunity, the director's interest will conflict with the interests of the corporation.[63] If an opportunity is considered a "corporate opportunity," the director must follow specific procedures before pursuing it. In order to take any action on his or her own behalf, the director must make full disclosure of the business opportunity to the board and request that the board make a diligent inquiry as to whether the corporation is able and willing to pursue it.[64] In other words, if the opportunity is considered a corporate opportunity, the director must disclose the business opportunity and wait for the corporation to reject it before appropriating it for himself.

The seminal case discussing nonprofit boards' fiduciary duties of loyalty is *Stern v. Lucy Webb Hayes National Training School for Deaconesses & Missionaries*.[65] In *Stern*, the plaintiffs brought a class action lawsuit alleging that individual members of the board of directors of a hospital breached their fiduciary

61. *See* RMNCA, *supra* note 20, § 8.31(b).

62. *See* Guth v. Loft, 5 A.2d 503, 510 (Del. 1939).

63. *See id.* at 511. *See generally* Victor Brudney & Robert Charles Clark, *A New Look at Corporate Opportunities*, 94 HARV. L. REV. 997, 1031-33 (1981) (discussing the issue of whether a business opportunity properly belongs to a corporation).

64. *See* AMERICAN LAW INSTITUTE, PRINCIPLES OF CORPORATE GOVERNANCE: ANALYSIS AND RECOMMENDATIONS, § 5 (1994).

65. 381 F. Supp. 1003 (D.D.C. 1974).

duties of loyalty by mismanaging hospital funds.[66] The allegations were supported by evidence which demonstrated the directors failed to disclose their individual interests in transactions in which board members deposited hospital funds in non-interest bearing accounts at financial institutions in which the directors had interests.[67] Further, the evidence indicated the directors failed to pursue investments with institutions which maintained superior terms in favor of those institutions in which they had interests.[68] The directors also failed to follow the hospital board's conflicts of interest policy.[69] Consequently, the District Court for the District of Columbia held that the directors breached their duties of loyalty because they were grossly negligent in failing to properly supervise the company's investments and engaging in self-dealing transactions.[70] The court reasoned that although the noninterested directors may be assumed to have been aware of the various bank affiliations of the defendants, the defendants did not alert the noninterested directors to the conflicting interests prior to securing approval of particular transactions.[71] Therefore, the court held the interested directors liable for breaches of their fiduciary duties of loyalty to the corporation.

In light of the tremendous potential for conflicts of interest arising in a health care environment that is reorganizing and consolidating, it is vital that directors adhere to their fiduciary duties of loyalty. A step that all boards must take to ensure

66. *See id.* at 1007. Plaintiffs also alleged that board members breached their fiduciary duties of care. *See id.* However, for the purposes of this discussion, only the fiduciary duty of loyalty allegations will be addressed.

67. *See id.* at 1016.

68. *See id.*

69. *See id.* at 1015. The hospital's conflicts of interest policy was based on guidelines issued by the American Hospital Association and included provisions requiring the disclosure of any possible conflicts of interest on an annual basis or when the interest becomes a matter of board action, documentation of such disclosure, and prohibiting that member from voting or using his influence regarding the matter. *See id.*

70. *See id.* at 1015-16. The court also held that the defendant board members breached their duties of care stating that they "failed to exercise even the most cursory supervision over the handling of Hospital funds and failed to establish and carry out a defined policy." *Id.* at 1016. The court reasoned that the defendant board members breached their duties of care when they allowed the hospital's finances to be managed almost exclusively by two of the hospital's officers, the finance and investment committees did not meet until ten years after their creation, and none of the directors appointed to the committees ever objected to the absence of meetings. *See id.* at 1008, 1015.

71. *See id.* at 1016.

compliance with the duty of loyalty is to develop and institute a substantial conflicts of interest policy. The IRS has issued a sample conflicts policy for tax-exempt health care organizations, and boards would be wise to use the sample policy as a guide for instituting their own.[72] The sample policy recommends the implementation of particular procedures to address conflicts of interest. First, a director must disclose any potential conflicts of interest to those members or committees who are considering a proposed transaction.[73] The next step is to determine whether a conflict exists.[74] If a conflict does exist, the policy should enunciate standards and procedures to be utilized in addressing actual or potential conflict situations.[75] The policy should include provisions requiring appropriate disciplinary or corrective action if a member fails to properly disclose an actual or potential conflict,[76] mandating that certain information regarding the disclosure of conflicts of interest be reflected in the board meeting minutes,[77] prohibiting physicians who receive compensation from the entity from membership on compensation committees,[78] and insisting that board members sign annual statements indicating that they understand and will comply with the corporation's conflicts of interest policy.[79]

The policy should also address situations in which a conflict is detected. In the event a conflict exists, the board has several options. First, the chairperson of the board or committee may appoint an independent member or committee to investigate alternate courses of action and determine whether a more advantageous arrangement may be obtained from a source which does not give rise to a conflict of interest.[80] If there are no feasible alternative arrangements, the disinterested directors may vote to determine whether the transaction is in the corporation's best interests and whether the transaction is fair and reasonable to the corporation.[81]

72. *See* Painter, *supra* note 59, at 163-69.
73. *See id.* at 165.
74. *See id.*
75. *See id.*
76. *See id.* at 166.
77. *See id.*
78. *See id.* at 166-67.
79. *See id.* at 167.
80. *See id.* at 165.
81. *See id.*

B. The Taxpayer Bill of Rights 2

In addition to directors' fiduciary duties of care and loyalty, directors of tax-exempt organizations may be held personally liable for violations of the tax-exemption requirements.[82] The IRS has the power to impose different levels of sanctions. First, the IRS may revoke the entity's tax-exempt status.[83] The IRS has seldom imposed this severe sanction, described by some as "draconian," because to do so would deprive the community of much-needed health care services and fail to punish those involved in the improper decision.[84] In 1996, the Taxpayer Bill of Rights 2 created an alternative to revocation of tax-exempt status.[85] The law authorizes the IRS to impose excise taxes, also known as intermediate sanctions, on "disqualified persons" and

82. Section 501 of the Internal Revenue Code grants particular organizations exemption from federal income tax if they are "organized and operated . . . for religious, charitable, scientific . . . or educational purposes." I.R.C. § 501(c)(3) (West Supp. 1997). There are basically two tests that are employed in determining whether a corporation meets the requirements of § 501(c)(3), the organizational test and the operational test. In order to satisfy the organizational test, the tax-exempt purposes of the corporation must be designated in its articles of incorporation or bylaws. Treas. Reg. § 1.501(c)(3)-1(d)(3) (as amended in 1990). Health care entities have been permitted to take advantage of the exemption from federal taxes since the promotion of health has long been considered a charitable purpose. Rev. Rul. 69-545, 1969-2 C.B. 117. The operational test examines the manner in which the corporation actually functions and requires that the organization be operated primarily for charitable purposes. There are two elements which must be scrutinized in determining whether the operational test is satisfied, private benefit and private inurement. The first, private benefit, requires that the corporation serve a public rather than a private interest. Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii) (as amended in 1990). In other words, any benefit to an individual or entity must be incidental to the greater public benefit. *See id.* In making such a determination, the Service will weigh the relevant facts and circumstances of each case. *See id.* Two tests have been formulated to ascertain whether the private interests in a transaction are served no more than incidentally, the qualitative test and the quantitative test. *See id.* The qualitative test asks whether the private benefit is a necessary concomitant to achieve a public benefit. *See id.* The quantitative test inquires whether the private benefit is quantitatively incidental to the public benefit. *See id.* The second part of the operational test, private inurement, requires that no person having the ability to influence the decisions of an exempt organization receive any portion of the net earnings of the corporation. Treas. Reg. § 1.501(c)(3)-1(c)(2) (as amended in 1990).

83. *See* Treas. Reg. § 1.501(c)(3)-1 (as amended in 1990).

84. *See* Barbara J. Calderone, *Taxpayers' Bill of Rights 2: Making Sense of the Sanctions*, 30 J. HEALTH & HOSP. L. 61, 71 (1997); Lawrence E. Singer, *The Conversion Conundrum: The State and Federal Response to Hospitals' Change in Charitable Status*, 23 AM. J.L. & MED. 221, 247 (1997); Douglas M. Mancino, *New 'Intermediate Sanctions' May Cause Public Charities to Change the Way They Do Business*, 85 J. TAX'N 368, 373 (1996).

85. *See* Taxpayer Bill of Rights 2, Pub. L. No. 104-168, §§ 1311-14, 110 Stat. 1452, 1475-81 (codified as amended at 26 U.S.C. § 4958 (1996)).

organization managers who engage in "excess benefit transactions."[86] "Excess benefit transactions" are transactions in which a tax-exempt organization provides an economic benefit to a disqualified person and the value of the benefit provided exceeds the consideration received by the organization.[87] A "disqualified person" is one who has a substantial interest in the corporation or who is able to substantially influence the affairs of the corporation.[88] Disqualified persons may include persons such as key doctors,[89] officers and directors who are in a position to exercise substantial influence over the corporation,[90] and individuals who have authority or responsibility similar to that of an officer, director, or trustee.[91]

A disqualified person who has benefited from an excess benefit transaction will be assessed a tax in an amount equal to twenty-five percent of the excess benefit.[92] If the disqualified person does not correct the excess benefit transaction within the taxable period, an additional tax equal to two hundred percent of the excess benefit will be assessed.[93] Further, organization managers who participate in excess benefit transactions are subject to a tax equal to ten percent of the excess benefit, unless the managers' involvement is not willful and is due to reasonable cause.[94]

Excess benefit transactions may arise in a variety of situations. Virtually any situation in which an individual who substantially influences the affairs of the corporation makes or receives a payment that cannot be supported by an independent appraisal or which is unreasonable because it exceeds fair mar-

86. *Id.*

87. *See id.* at 1476 (codified as amended at 26 U.S.C. § 4958(c)(1)(A)).

88. *See id.* at 1477 (codified as amended at 26 U.S.C. § 4958(f)(1)).

89. *See* H.R. 506, 104th Cong., 58 n.1 (1996). Under the Taxpayer Bill of Rights 2, physicians will not automatically be deemed disqualified persons based on their status as medical staff members. *See id.* This view is a departure from the one previously expressed by the IRS. In 1986, the IRS had indicated that it believed employed physicians or physicians who had a close professional relationship with an organization had a personal and private interest in the activities of the organization and thus, were subject to the private inurement proscription. Gen. Couns. Mem. 39,498 (Apr. 24, 1986).

90. *See* H.R. 506, 104th Cong., 58 n.10 (1996). Directors may not be in a position to exercise substantial control over the organization in cases where they are part of a large board. *See id.*

91. *See* Taxpayer Bill of Rights 2, Pub. L. No. 104-168, § 1311, 110 Stat. 1452, 1475 (codified as amended at 26 U.S.C. § 4958(f)(2)).

92. *See id.* at 1475 (codified as amended at 26 U.S.C. § 4958(a)(1)).

93. *See id.* at 1476 (codified as amended at 26 U.S.C. § 4958(b)).

94. *See id.* at 1475-76 (codified as amended at 26 U.S.C. § 4958(a)(2)).

ket value is suspect. For example, if a nonprofit hospital acquires a medical practice and the purchase price exceeds the fair market value for that type of practice, the physicians and managers who are involved in the transaction may be subject to excess benefit taxes. Further, if a physician renders medical care services or consulting services and the total compensation paid for those services surpasses the reasonable prevailing market rate, a tax may be levied against both the physician and managers who knowingly approved an improper transaction.[95]

An interesting caveat to the penalties imposed pursuant to the Taxpayer Bill of Rights 2 is the effect of directors' and officers' ("D & O") liability insurance on the payment of intermediate sanctions. Although corporations may purchase D & O insurance policies to cover liability in cases in which a tax is levied, the payment of a tax or the insurance premium must be considered in determining the reasonableness of a director's or officer's compensation package.[96] Therefore, the logic behind D & O insurance becomes circuitous when insurance is paid on behalf of a director or officer whose compensation is already considered excessive, thereby triggering the payment of another excess benefit payment which is paid by insurance, triggering the payment of another excess benefit payment, and so on.[97]

The legislative history of the Taxpayer Bill of Rights 2 establishes a rebuttable presumption that a compensation arrangement is reasonable if three criteria are satisfied.[98] First, the compensation agreement must be approved by an uninterested board or committee composed of individuals unrelated to the disqualified person.[99] Second, the board or committee must rely on appropriate comparable data in setting the level of compensation.[100] This requires the board or committee to consider data such as compensation levels paid for functionally equivalent po-

95. An intriguing situation which has generated considerable discussion in the health care arena is currently taking place in Birmingham, Alabama. The IRS has threatened to revoke Baptist Health System's tax-exempt status based on allegations that it paid more than fair market value when acquiring physician practices. *See* Mary Chris Jaklevic, *IRS Threatens to Pull Ala. System's Exemption*, MOD. HEALTHCARE, Dec. 22, 1997, at 3. This instance appears to be the first time that an IRS audit has focused exclusively on an organization's acquisition of physician practices. *See id.*

96. *See* Gerald M. Griffith, *Analysis and Perspective*, 5 Health L. Rep. (BNA) 1759 (Dec. 5, 1996).

97. *See id.*

98. *See* H.R. 506, 104th Cong., 56-57 (1996).

99. *See id.*

100. *See id.*

sitions by similarly situated organizations, the location of the organization, and other reliable information.[101] Third, the basis for the board's determination must be adequately documented.[102] For instance, the minutes of the board or committee meeting should reflect the board or committee's review of the individual's qualifications and verify the basis upon which they relied in determining that the compensation was reasonable.

Because the statute has not yet been applied to the health care industry, the implications of the intermediate sanctions are far from clear. The IRS plans to issue proposed regulations related to health care institutions under the intermediate sanctions provisions.[103] Nevertheless, it is obvious that the sanctions provide a direct avenue by which individual directors may be held liable for violations of the tax-exemption laws. In order to protect themselves, directors must place themselves in a position to take advantage of the rebuttable presumption of reasonableness. Accordingly, they must fulfill their fiduciary duties by acquiring information about proposed transactions, examining the available information, and obtaining independent appraisals concerning the reasonableness of compensation packages. Further, detailed board minutes reflecting the disclosure of facts and circumstances of conflict of interest arrangements and the board's rationale for entering into particular transactions are crucial to avoid the imposition of excess benefit penalties.

II. Effective Compliance Programs

The development and implementation of compliance programs is a topic which merits specific mention. Compliance programs are plans instituted by or imposed on organizations for the purpose of preventing and detecting violations of state and federal anti-fraud laws.[104] United States Attorney General Janet Reno has asserted that the eradication of health care fraud is one of the top enforcement priorities of the Clinton Administration.[105] In keeping with this theme, the government has in-

101. *See* Calderone, *supra* note 84, at 61.

102. *See* H.R. 506, 104th Cong., 56-57 (1996).

103. *See Taxation: Precedential Guidance, Federal Court Actions Among 'Coming Attractions,' IRS Official Says*, 7 Health L. Rep. (BNA) 392, 393 (Mar. 5, 1998).

104. Numerous consultants have developed and are marketing compliance programs.

105. *See* U.S. Dep't of Justice, Dep't of Justice Health Care Fraud Report, Fiscal Year 1994, Introduction, § III (A)(1) (Mar. 2, 1995).

creased its investigations of health care fraud and rigorous enforcement efforts are sure to continue.[106]

A. *Caremark International, Inc. Derivative Litigation*

In examining boards of directors' fiduciary duties in the compliance context, board members should be especially mindful of acting in good faith to assure that adequate corporate information and reporting systems exist. An effective compliance program involves all layers of the organization and adheres to the organization's purpose, mission, and values. The lessons learned from *In re Caremark International Inc. Derivative Litigation*[107] are particularly instructive in this regard.

In *Caremark*, several stockholders filed derivative lawsuits against Caremark directors alleging the directors breached their fiduciary duties of care to the corporation.[108] These allegations arose during the time period coinciding with federal indictments charging Caremark and its directors with various criminal violations based on the alleged payment of remuneration to induce the referral of Medicare or Medicaid patients in violation of Medicare's anti-kickback law.[109] The Delaware Court of Chancery applied the business judgment rule and found that the directors did not violate their fiduciary duties of care because the directors acted in good faith, expended reasonable efforts in the exercise of their monitoring responsibilities, and there was no knowing violation of the law.[110] Although no directors were found individually liable for breach of their fiduciary duties, the court concluded that boards, in order to satisfy their duties of care, must ensure that adequate information and reporting systems exist to assure that accurate and timely information is brought to their attention to allow them to reach informed judgments.[111] Under *Caremark*, directors may be held personally liable for losses caused by a breach of the duty of care either by

106. *See* Thomas E. Bartrum & L. Edward Bryant, Jr., *The Brave New World of Health Care Compliance Programs*, 6 ANNALS HEALTH L. 51-52 (1997) (offering statistics related to the government's success in prosecuting health care fraud).

107. 698 A.2d 959 (Del. Ch. 1996)

108. *See id.* at 964.

109. *See id.* at 963-64.

110. *See id.* at 967-72.

111. *See id.* at 969-70. The *Caremark* court clarified the holding in *Graham v. Allis-Chalmers Mfg. Co.*, 188 A.2d 125, 130 (Del. 1963) in which the Delaware Supreme Court stated "absent cause for suspicion there is no duty upon the directors to install and operate a corporate system of espionage to ferret out wrongdoing which they have no reason to suspect exists."

failing to maintain reasonable information and reporting systems, or by failing to monitor and improve suspect practices which have been brought to their attention.[112]

B. The United States Sentencing Guidelines and Requirements for Effective Compliance Programs

The holding in *Caremark* is enhanced by provisions contained in the United States Sentencing Guidelines. Those provisions offer significant penalty mitigation to corporations convicted of crime, that have effective compliance programs in place.[113] The hallmark of an acceptable compliance program is that it "generally will be effective in preventing and detecting criminal conduct."[114]

The ability of health care organizations to develop and implement effective compliance programs will be critical in insulating those organizations from harsh criminal sanctions. Despite the identification of the importance of compliance programs in all health care organizations, the Officer of Inspector General of the Department of Health and Human Services ("OIG") has only developed a Model Compliance Program for Clinical Laboratories.[115] Therefore, no definitive governmental guidelines have been promulgated which specify the factors necessary for effective health care compliance programs.[116] However, in structuring a compliance program, boards of directors may look

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112. *See* Richard S. Gruner, *Director and Officer Liability for Defective Compliance Systems:* Caremark *and Beyond*, 995 P.L.I. CORP. 57, 68 (1997).

113. *See* U.S. SENTENCING GUIDELINES MANUAL *supra* note 5, § 8C2.5(f). The organizational sentencing portion of the Guidelines provides:

> If the offense occurred despite an effective program to prevent and detect violations of law, [a reduced fine will be levied]. . . .
>
> Provided, that this subsection does not apply to an individual within high-level personnel of the organization within which the offense was committed where the unit had 200 or more employees, or an individual responsible for the administration or enforcement of a program to prevent and detect violations of law participated in, condoned, or was willfully ignorant of the offense. Participation of an individual within substantial authority personnel in an offense results in a rebuttable presumption that the organization did not have an effective program to prevent and detect violations of law.

Id.

114. *Id.* § 8A1.2(k).

115. *See* OIG Model Compliance Plan for Clinical Laboratories, 62 Fed. Reg. 9435 (1997).

116. The Department of Health and Human Services Office of Inspector General is currently attempting to develop a model compliance plan for hospitals. *See HHS Reworking Model Compliance Plan for Hospitals After Industry Feedback*, Health Care Daily (BNA) D4 (Oct. 6, 1997), *available in* Westlaw, BNA-HCD File.

to the minimum requirements of an effective program as listed in the United States Sentencing Commission Guidelines for the Sentencing of Organizations,[117] the Model Compliance Plan for Clinical Laboratories which was released in 1997,[118] and corporate integrity agreements entered into by the OIG with entities that were alleged to have violated fraud and abuse laws.[119]

Although a detailed discussion regarding the requirements of an effective compliance program is outside the scope of this article, the minimum requirements should be mentioned.[120] The Sentencing Guidelines delineate seven minimum elements which are essential to a finding that a corporation has instituted an "effective" compliance program. First, the organization must have compliance standards and procedures that are "reasonably capable of reducing the prospect of criminal conduct."[121] This requirement prescribes the establishment of a committee comprising individuals from various disciplines within the organization which is assigned the responsibility of developing the compliance program.[122] The committee should include legal counsel to maximize the attorney-client privilege of the committee's work.[123] Further, the committee should assess the legal issues affecting the organization's business and evaluate current polices to determine whether they satisfy the corporation's goals.[124]

Second, the program must delegate to high-level personnel the duty to oversee the compliance standards.[125] High-level personnel refers to "a director; an executive officer; an individual in charge of a major business or functional unit of the organiza-

117. *See id.* For a thorough discussion regarding the Federal Sentencing Guidelines Requirements, see Greg Radinsky, *Making Sense of the Federal Sentencing Guidelines: How Health Care Corporations Can Manage Risk by Adopting Corporate Compliance Programs*, 30 J. HEALTH & HOSP. L. 113 (1997).

118. *See* OIG Model Compliance Plan for Clinical Laboratories, 62 Fed. Reg. 9435.

119. *See* Radinsky, *supra* note 117, at 113 n.8. A corporate integrity agreement is an agreement that a corporation enters into with the OIG in any settlement arising out of allegations of health care fraud. *See* HELEN R. TRILLING & JOAN H. KRAUSE, CORPORATE INTEGRITY AGREEMENTS: AN ONGOING RELATIONSHIP WITH OIG (Oct. 16-18, 1996).

120. For an excellent discussion regarding the development and requirements of an effective compliance program, see Bartrum & Bryant, *supra* note 106, at 51.

121. U.S. SENTENCING GUIDELINES MANUAL, *supra* note 5, § 8A1.2(k)(1).

122. *See* Radinsky, *supra* note 117, at 115.

123. *See id.*

124. *See id.*

125. *See* U.S. SENTENCING GUIDELINES MANUAL, *supra* note 5, § 8A1.2(k)(2).

tion," or "an individual with a substantial ownership interest."[126] That individual should periodically report to the board of directors or its executive committee and be responsible for enforcing the program consistently.[127] Another important responsibility of the compliance officer is to continuously monitor the program's effectiveness by evaluating the program and making necessary adjustments as the business and regulatory environment changes.[128]

Third, the organization must avoid assigning substantial discretionary authority to individuals who the organization knows, or should know, have the propensity to engage in illegal activities.[129] This requires the organization to monitor employee performance and develop policies to be followed in the case where an employee is charged with criminal activity that relates to his or her job responsibilities.[130] Fourth, the compliance standards and procedures must be communicated to all employees and agents through an effective means, such as the distribution of training manuals or training programs.[131]

Fifth, the organization must administer auditing and monitoring activities and implement mechanisms through which employees can report instances of noncompliance with state and federal laws.[132] This requirement addresses the inspection and improvement of performance as well as the determination of whether the compliance program is being followed.[133] These functions should be performed regularly by independent auditors who have access to all necessary organization resources.[134] Further, the reporting system must be available to all employees and may be anonymous, such as through a hotline, a mail drop, or an ombudsperson.[135]

Sixth, the organization must enforce its compliance standards consistently and implement "appropriate disciplinary mechanisms" for violations of the compliance program.[136] This means that when a violation of the program occurs, the violation must

126. *See* Radinsky, *supra* note 117, at 115.
127. *See id.* at 115-16.
128. *See id.*
129. *See* U.S. SENTENCING GUIDELINES MANUAL, *supra* note 5, § 8A1.2(k)(3).
130. *See* Radinsky, *supra* note 117, at 116.
131. *See* U.S. SENTENCING GUIDELINES MANUAL, *supra* note 5, § 8A1.2(k)(4).
132. *See id.* § 8A1.2(k)(5).
133. *See* Radinsky, *supra* note 117, at 116.
134. *See id.*
135. *See id.* at 116-17.
136. *See* U.S. SENTENCING GUIDELINES MANUAL, *supra* note 5, § 8A1.2(k)(6).

be treated promptly, effectively, and consistently, with all levels of employees being treated in a comparable manner for similar violations.[137] Finally, if a violation of state or federal law occurs, the organization must take "all reasonable steps to respond appropriately to the offense and to prevent further similar offenses."[138] This requirement demonstrates the need for the implementation of reporting and disciplinary procedures which must be followed when violations occur. Further, it suggests that the organization should be especially conscious of areas in which misconduct has occurred in the past.[139]

The OIG's Model Compliance Plan for Clinical Laboratories expands upon the seven elements enumerated above and tailors them to use in a clinical laboratory setting.[140] Notable features of the plan include the following: (1) the requirement that specific policies concerning designated areas of potential fraud, such as billing, marketing, and claims processing, be written and distributed to organization employees; (2) the use of adherence to the compliance program as a factor in evaluating supervisors or managers; and (3) the adoption of requirements applicable to record creation and retention.[141]

The corporate integrity agreements between the OIG and organizations that have been investigated for fraud and abuse display the onerous requirements that the government will impose on entities alleged to have violated federal laws and demonstrate the specificity required in developing an acceptable compliance program.[142] In addition to the payment of large civil or criminal fines, the Department of Health and Human Services has required health care organizations to prepare an annual report to be submitted to the Department, perform an annual audit for all services provided for which claims for government payments are made, establish new ordering and billing procedures, develop educational programs for employees, voluntarily disclose misconduct, allow the Department to examine the or-

137. *See* Radinsky, *supra* note 117, at 117.

138. U.S. SENTENCING GUIDELINES MANUAL, *supra* note 5, § 8A1.2(k)(7).

139. *See* Radinsky, *supra* note 117, at 117.

140. *See* OIG Model Compliance Plan for Clinical Laboratories, 62 Fed. Reg. 9435.

141. *See id.*

142. The Attorney General has directed that every settlement entered into by the Department of Justice and the OIG for health care fraud must contain provisions addressing government-supervised corporate integrity agreements. *See* Bartrum & Bryant, *supra* note 106, at 55.

ganization's records at any time without prior notice, and provide payment for subsequent government investigations.[143]

The court in *Caremark* did not make any sweeping changes to corporate law.[144] However, the court explicitly addressed the issue of corporate directors' potential liability for failing to adequately monitor a corporation's activities and illustrates the demanding standards that may be imposed on boards of directors of health care organizations. The necessity for the development and implementation of effective compliance systems was reinforced by the United States Sentencing Guidelines and various corporate integrity agreements derived from settlements between health care organizations and the government. The essence of these authorities is that in monitoring a health care corporation's activities, the board of directors must keep informed of the organization's affairs and institute an effective, dynamic monitoring system designed expressly for the particular organization that takes into consideration the organization's unique purpose, the applicable laws, and involves the entire organization.

III. NONPROFIT CONVERSIONS

In recent years, the hospital industry has undergone a metamorphosis from domination by a nonprofit delivery model to an industry in which certain markets are controlled by for-profit providers.[145] The integration of health care services has generated an increase in transactions involving for-profit organiza-

143. *See, e.g.*, Radinsky, *supra* note 117, at 113 n.8 (mentioning the SmithKline Beecham Clinical Laboratory's corporate integrity agreement with the OIG); TRILLING & KRAUSE, *supra* note 119; *California Lab to Pay $5.2 Million to Settle Medicare Fraud Charges*, Health Care Daily (BNA) D8 (Feb. 18, 1997), *available in* Westlaw, BNA-HCD File (reporting particular provisions contained in the corporate integrity agreement included in Meris Laboratory, Inc.'s settlement with the Department of Justice); *Spectra Labs to Pay $10 Million, Enters Corporate Integrity Program*, Health Care Daily (BNA) D2 (Dec. 24, 1996), *available in* Westlaw, BNA-HCD File (listing the requirements of Spectra's corporate integrity agreement).

144. *See* Stephen F. Funk, Comment, *Recent Development in Delaware Corporate Law:* In re Caremark International Inc. Derivative Litigation*: Director Behavior, Shareholder Protection, and Corporate Legal Compliance*, 22 DEL. J. CORP. L. 311, 321-22 (1997).

145. *See* Ron Winslow & George Anders, *Not-for-Profit Hospitals Tempt Public Concerns: Many Are Takeover Targets as Nation's Big Chains Seek Ways to Expand*, WALL ST. J., Oct. 11, 1994, at A2. *See generally* Linda B. Miller, *The Conversion Game: High Stakes, Few Rules; A Close Observer of Scores of Hospital Conversions Asks, "Who Really Benefits From These Deals?*, HEALTH AFF., Mar.-Apr. 1997, at 112 (discussing the need for studies focused on nonprofit conversions and the impact of the transactions on affected communities).

tions acquiring or affiliating with nonprofit organizations.[146] Although transactions involving both nonprofit and for-profit entities are often controversial, sometimes there are strong incentives for nonprofit entities to enter into such transactions. Two of the most prevalent incentives are that entering into a transaction with a for-profit entity provides immediate access to capital[147] and affiliation enhances the nonprofit organization's ability to secure essential managed care contracts.[148] Nonprofit to for-profit transactions raise a myriad of issues which must be carefully addressed by the boards of directors of the organizations involved.[149] When faced with a nonprofit to for-profit conversion, directors must consider their fiduciary obligations, laws regulating charitable trusts, and state and federal laws regulating charitable organizations.

A. Fiduciary Duties

The starting point for any significant business transaction is that directors must always fulfill their fiduciary duties of care and loyalty. In satisfying their duties of care, each director must determine in good faith whether a particular transaction allows the entity's assets to be used for the charitable purposes stated in the organization's articles of incorporation and serves the best interests of the corporation and the community.[150] Further, directors must ensure that they discharge their duties of care by maximizing the value of the nonprofit's assets to assure that a particular transaction continues to satisfy the charitable purposes of the organization and protect the interests of the community.[151] In making these determinations, the board must scrutinize all available information, conduct independent studies

146. *See* Singer, *supra* note 84, at 221-22; Tower, *supra* note 17, at 157.

147. *See* Gary Claxton et al., *Public Policy Issues in Nonprofit Conversions: An Overview: Does Ownership Status of Hospitals and Health Plans Make a Difference? A Review of Conversion Activity Raises Questions for Public Debate*, HEALTH AFF., Mar.-Apr. 1997, at 9, 13.

148. *See* Julie Marquis, *Report on Hospital Sale Gives Both Sides Fodder; Health: If For-Profit Firm Buys Queen of Angels, It Will Likely Halt Money-Losing Services, Study Says, But Could Land Coveted HMO Contracts*, L.A. TIMES, Mar. 18, 1998, at B3.

149. For an in depth discussion concerning the diverse state laws that apply to nonprofit conversions, see Donald Shriber, *State Experience in Regulating a Changing Health Care System: The Differing Politics, Experience, and Legislative Backdrops in States Around the Country Lead to Substantial Variation When It Comes to Regulating Nonprofit Conversions*, HEALTH AFF., Mar.-Apr. 1997, at 48.

150. *See supra* notes 25-54 and accompanying text.

151. *See* Claxton et al., *supra* note 147, at 21-23; Tower, *supra* note 17, at 157.

to ensure that the full value of the corporation is realized, utilize the knowledge of independent experts, engage in honest discussions concerning the effect of the proposed transaction, and document the basis for their decisions.

The directors must also ensure that they comply with their duties of loyalty by acting in the best interests of the corporation and refraining from acting in their own best interests.[152] A few duty of loyalty problems that may arise in the conversion context include an offer of employment or financial incentives to officers or directors upon consummation of the transaction[153] or a sale of all a charitable nonprofit's assets to a for-profit corporation controlled by the nonprofit's board of directors.[154] In order to fulfill their fiduciary duties of loyalty to the corporation, board members must give particular care to clarifying the roles of the chief executive officer, the executive staff, and board members after a transaction is completed. Directors should avoid the appearance of impropriety and assure that any potential or actual conflicts of interest are disclosed and addressed through the corporation's conflicts of interest procedures.[155]

B. Charitable Trust

Another area that must be examined in a sale by a nonprofit entity to a for-profit entity is the law of charitable trust. The assets of nonprofit health care organizations are governed by state charitable trust laws which generally require that a nonprofit corporation be under the same duty as a charitable trust to devote its assets to specified charitable purposes.[156] Usually, the charitable purposes are designated in the corporation's char-

152. *See supra* notes 55-81 and accompanying text.

153. *See Ethics and the CEO*, HOSP. & HEALTH NETWORKS, Jan. 20, 1998, at 28-32, 34. On October 13, 1997, the governor of California signed legislation prohibiting directors and officers of nonprofit health facilities negotiating a sale or transfer with a for-profit facility from receiving compensation after the sale or transfer, unless the board members are physicians or health care providers who have provided direct patient care services. *See* CAL. HEALTH & SAFETY CODE § 1260 (West Supp. 1998).

154. *See* James F. Peltz, *Lawmakers' Plans Could Make HMO Buyout Costly*, L.A. TIMES, Oct. 8, 1991, at 9A.

155. *See* Judith Bell et al., *The Preservation of Charitable Health Care Assets: Key Points that Can Make or Break the Conversion Process from the Community's Perspective*, HEALTH AFF., Mar.-Apr. 1997, at 125.

156. *See* Queen of Angels Hosp. v. Younger, 136 Cal. Rptr. 36, 39 (Cal. Ct. App. 1977) (citing Pacific Home v. County of Los Angeles, 41 Cal. 2d 844, 852 (1953)); SCOTT & FRATCHER, *supra* note 9, § 348.1; Fishman, *supra* note 21, at 649-50.

ter or are specified at the time the assets are donated.[157] The charitable trust doctrine requires that when a charitable organization seeks to convert to for-profit status, the organization must ensure that the assets it accrued while serving as a charity will be used to carry on the charitable purposes of the organization.[158]

A leading case involving the application of charitable trust law in the health care arena is *Queen of Angels Hospital v. Younger*.[159] In *Queen of Angels*, the Queen of Angels Hospital, a nonprofit corporation, sought to lease its hospital facilities to a for-profit hospital corporation and apply the proceeds not to the operation of the hospital, but to the establishment and maintenance of outpatient medical clinics to serve the indigent community.[160] The attorney general challenged the board's decision and contended that the use of the assets in the operation of the clinics "would constitute an abandonment of Queen's primary charitable purpose and a diversion of charitable trust assets."[161]

The California Court of Appeals, in examining the claim, looked to the hospital's articles of incorporation and noted that the articles contained several corporate purposes, including the establishment, ownership, maintenance, and operation of a hospital in the city of Los Angeles.[162] The court evaluated California charitable trust law and determined that "although Queen is entitled to do many things besides operation of hospital, essential to all those other activities is the continued operation of a

157. *See Queen of Angels Hosp.*, 136 Cal. Rptr. at 39 (citing *Pacific Home*, 41 Cal. 2d at 852); *see also* Robert A. Boisture & Douglas A. Varley, *State Attorneys Generals' Legal Authority to Police the Sale of Nonprofit Hospitals and HMOs*, 13 EXEMPT. ORG. TAX. REV. 227 (1996). Where it has become impossible or impracticable to fulfill the settlor's specific intent, courts may utilize a doctrine known as cy pres to prevent a charitable trust from failing. *See* RESTATEMENT (SECOND) OF TRUSTS § 399 (1959). The cy pres doctrine allows a court to circumvent the settlor's exact intention by permitting the application of trust assets in a manner that is consistent with the general purposes of the testator, carrying out the settlor's intent "as nearly as" possible. *See id.*

158. *See Queen of Angels Hosp.*, 136 Cal. Rptr. at 39 (citing *Pacific Home,* 41 Cal. 2d at 852). The Restatement (Second) of Trusts defines a charitable trust as "a fiduciary relationship with respect to property arising as a result of a manifestation of an intention to create it, and subjecting the person by whom the property is held to equitable duties to deal with the property for a charitable purpose." RESTATEMENT (SECOND) OF TRUSTS § 372 (1959).

159. 136 Cal. Rptr. 36 (Cal. Ct. App. 1977).

160. *See id.* at 39.

161. *See id.*

162. *See id.* at 40.

hospital."[163] The court concluded that the corporation's primary purpose was the operation of a hospital, and therefore, the corporation could not, consistent with the trust imposed upon it, abandon those operations in favor of the operation of outpatient clinics.[164]

A recent case that addresses both the fiduciary duties of directors as well as the charitable trust doctrine is *Kelley v. Michigan Affiliated Healthcare Systems, Inc.*[165] The underlying transaction in *Kelley* involved a joint venture between a nonprofit hospital, Michigan Affiliated Healthcare System, Inc. ("MAHSI"), and a for-profit organization, Columbia/HCA Healthcare Corporation.[166] The partnership required MAHSI to provide a majority of its assets to the venture in exchange for cash and a limited partnership interest.[167] The attorney general sought to block the venture based in part on allegations that the transaction violated charitable trust law and that the directors breached their fiduciary duties of care.[168]

The Michigan Court of Claims granted summary judgment motions in favor of the attorney general on the charitable trust allegations, reasoning that the venture constituted an abandonment of MAHSI's charitable purpose.[169] The court explained that the process of taking assets from the nonprofit organization and allowing those assets to be used to generate benefits for the for-profit entity was not permissible under the applicable state law.[170] The court ruled against the attorney general on the breach of fiduciary duty allegations, explaining that the board fulfilled its responsibilities by performing due diligence and by acting with the requisite degree of care.[171]

Similar challenges to board decision-making have been mounted in several other states. In California, for example, the attorney general contested a joint venture between Sharp Health Care and Columbia/HCA based on violations of charita-

163. *See id.*
164. *See id.* at 41.
165. Kelley v. Michigan Affiliated Healthcare Sys., Inc., No. 96-838-CZ (Mich. Ct. Cl., Sept. 5, 1996); *See* Michael W. Peregrine, *State Attorneys General Increase Enforcement of Charitable Trust and Fiduciary Duty Laws*, 24 HEALTH L. DIG. 3, 4 n.12 (1996).
166. *See* Peregrine, *supra* note 165, at 4.
167. *See id.*
168. *See id.*
169. *See id.* at 5.
170. *See id.*
171. *See id.*

ble trust laws and breaches of the fiduciary duty of care by directors.[172] Sharp Health Care eventually terminated its joint venture discussions.[173] In Ohio, the attorney general asserted similar allegations in contesting the sale of assets of Blue Cross & Blue Shield Medical Mutual of Ohio to an affiliate of Columbia/HCA.[174] Medical Mutual ultimately canceled the sale and entered into an agreement with the Ohio attorney general's office which requires Medical Mutual to transfer its charitable assets to a private foundation dedicated to preventative health care for indigent children and adults if the company converts to for-profit status, is sold, or goes out of business.[175] The Texas attorney general also attempted to challenge a merger between Blue Cross and Blue Shield of Texas and Healthcare Services Corporation based on charitable trust and fiduciary duty laws.[176] In that case, a judge ruled that Blue Cross and Blue Shield of Texas was not a charity and that the board of directors of the Texas Blues did not breach its fiduciary duties by entering into the merger agreement.[177] Interestingly, the attorney general in Florida has recently challenged the validity of the sale of Boca Raton Community Hospital to a consortium of three nonprofit hospitals, which demonstrates the application of charitable trust principles to transactions among nonprofit corporations.[178] The decision to sell the hospital was ultimately rescinded by the hospital's board of trustees.[179]

These examples are indicative of the types of challenges that may be brought against nonprofit corporations and their boards.

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172. *See* Jeannine Mjoseth, *California AG Action Underscores New Aggressiveness by State Officials*, 5 Health L. Rep. (BNA) 1683 (Nov. 21, 1996).

173. *See Sharp Terminates Planned Joint Venture with Columbia*, 6 Health L. Rep. (BNA) 325 (Feb. 27, 1997).

174. *See Ohio AG Files Suit Against Blues, Seeking to Retain Charitable Assets*, 5 Health L. Rep. (BNA) 1086 (July 18, 1996).

175. *See Medical Mutual of Ohio: Reaches Settlement Over Assets*, HEALTH LINE (Dec. 22, 1997).

176. *See Judge Clears Way for Proposed Merger of Texas-Illinois Blues*, 7 Health L. Rep. (BNA) 278 (Feb. 19, 1998).

177. *See id.* The state is currently considering an appeal of the decision. *See Appeal Decision Hinges on Final Judgment in Texas-Illinois Blues Merger Litigation*, 7 Health L. Rep. (BNA) 585 (Apr. 9, 1998).

178. Butterworth v. Boca Raton Community Hosp., Case No. CL9610191AF (Cir. Ct. Palm Beach Co., Dec. 2 1996). The attorney general's complaint alleges that the initial corporate purpose of the community hospital was to operate a community-based facility and therefore, it would be inconsistent with that intent to sell the hospital to out-of-town hospital systems. *See* Peregrine, *supra* note 165, at 8.

179. *See* Bruce Jaspen, *Board Shelves Plan to Sell Fla. Hospital*, MOD. HEALTHCARE, Dec. 23, 1996, at 6.

In order to avoid attorney general challenges to nonprofit to for-profit transactions, boards must not only adhere to their fiduciary duties, but understand and comply with the charitable trust doctrine.

C. *Statutory Responses*

Attorneys general in all states are intensifying their efforts to enforce charitable trust laws and fiduciary duty principles in nonprofit to for-profit conversions. Some states have enacted legislation that requires attorney general review as a necessary prerequisite to the sale of a nonprofit health care organization to a for-profit organization.[180]

California, a state that has been particularly aggressive in policing nonprofit conversions, is one of the many states that has enacted specific statutes governing conversions. California requires that written notice be given to the attorney general prior to selling, leasing, conveying, exchanging, or otherwise disposing of all or substantially all of the nonprofit, tax-exempt corporation's assets.[181] California law also allows the commissioner of corporations to block nonprofit health care service plan conversions through the denial of their applications.[182] The statute is grounded in charitable trust principles and requires that converting entities donate assets equal to the entity's fair market value to a foundation, overseen by the attorney general, which will use the assets to serve the health care needs of the people in California.[183] Further, laws in California require public hearings and allow regulators who are reviewing proposed conversions to hire independent experts to assist them in making their determinations.[184]

A debate that is currently receiving considerable media attention in California involves Tenet Health Care Corporation, the nation's second largest for-profit hospital company, which is attempting to acquire Queen of Angels' Hollywood Presbyterian

180. *See, e.g.*, CAL. CORP. CODE § 5913 (West 1990 & Supp. 1998); GA. CODE ANN. § 14-3-1202(g) (1994); MO. REV. STAT.§ 355.656(7) (Supp. 1998); MONT. CODE ANN. § 35-2-617(7) (1997); N.C. GEN. STAT. § 55A-12-02(g) (1997); OR. REV. STAT. § 65.534(7) (1996); *see also* Boisture & Varley, *supra* note 157, at 227. For an excellent discussion on nonprofit conversions and the regulatory responses thereto, see Singer, *supra* note 84, at 221.

181. *See* CAL. CORP. CODE § 5913.

182. *See* CAL. HEALTH & SAFETY CODE § 1399.70 (West Supp. 1998).

183. *See id.*

184. *See* CAL. CORP. CODE §§ 5916, 5919 (West Supp. 1998); CAL. HEALTH & SAFETY CODE § 1399.74 (West Supp. 1998).

Medical Center, a nonprofit hospital. Queen of Angels currently provides the majority of its health care services to a community composed of people who maintain full-time jobs, but who are unable to obtain health insurance.[185] Queen of Angels has historically provided three times as much charity medical care as other nonprofit hospitals in the nation.[186]

A public meeting concerning the sale was held pursuant to California law at which numerous concerns were voiced, including the inadequacy of provisions addressing the continuation of the current levels of charity care, the maintenance of particular health care services such as emergency room and obstetrical services, and the ability of Tenet to discontinue essential but unprofitable services.[187] Further complicating the situation is a lawsuit that has been brought by the medical staff of the hospital which seeks to remove the directors and replace the current members with court-appointed receivers.[188] The issue of whether the Tenet-Queen of Angels agreement adequately protects the charitable nature of the nonprofit entity is yet to be resolved.[189] Regardless of the ultimate resolution of the Tenet-Queen of Angels situation, it is clear that nonprofit conversions will be scrutinized by state attorneys general to ensure that char-

185. *See* Jackie Goldberg et al., *Protect the Sick at the Economic Bottom; Health Care: The State Should Stop the Sale of Queen of Angels Hospital*, L.A. TIMES, Mar. 1, 1998, at M5.

186. *See id.*

187. *See* Julie Marquis, *Hospital Sale Deal Lambasted; Health: At Public Meeting, Foes Voice Fear That Queen of Angels' Services Will Be Cut By For-Profit Firm, Which Says Its Does Not Foresee Doing So*, L.A. TIMES, Mar. 1, 1998, at B1. For a description of the impact of public disclosure in nonprofit to for-profit conversions, see Judith Bell et al., *supra* note 155, at 125. (advocating the use of public hearings prior to the approval or disapproval of health care organization conversions to allow the community affected by the change to voice their concerns regarding issues such as the continued provision of health care services in the community and the adequacy of valuation methods employed).

188. *See* Julie Marquis, *Debate on Hospital Takeover Escalates; Courts: Suit by Staff of Catholic-Run Queen of Angels-Hollywood Presbyterian Seeks to Have Board of Directors Removed After Panel Voices Plans to Sell Nonprofit Facility to Chain*, L.A. TIMES, Nov. 21, 1997, at B1.

189. Cardinal Roger M. Mahoney, Archbishop of Los Angeles, has formally opposed the sale, insisting that his consent is required prior to any sale and stating his preference for allying Queen of Angels with another Catholic hospital. *Los Angeles Archbishop Formally Opposes Sale of Hospital to Tenet*, 7 Health L. Rep. (BNA) 322 (Feb. 26, 1998). In an attempt to circumvent the requirement of obtaining consent from the archdiocesan bishop, the board of directors of Queen of Angels amended its bylaws to eliminate the need for such approval. *Queen of Angels Board Amends Bylaws to Eliminate Need for Bishop's Approval*, 7 Health L. Rep. (BNA) 493 (Mar. 26, 1998).

itable assets are protected and that nonprofit boards are fulfilling their fiduciary obligations.

IV. Conclusion

While board service may never have been more vital to nonprofit health care organizations, the liability exposure has never been greater. The appropriateness of nonprofit director conduct is being challenged by attorneys general across the nation. Further, the risk of liability to directors of health care organizations has dramatically increased because of the expansion of nonprofit and for-profit affiliations in recent years and due to the rigorous enforcement of the federal and state health care laws by government agencies. The dynamic nature of the health care environment, combined with the increasing numbers of complex business transactions, has created new demands on nonprofit boards. The *Caremark* case illustrates the necessity of instituting compliance systems which detect and address violations of state and federal laws. Moreover, the recent availability of intermediate sanctions which may be levied against directors for violations of tax-exemption laws illustrates the expanding liability of individual directors. Boards of directors of nonprofit health care organizations must respond to these changes and fulfill their fiduciary duties of care and loyalty by protecting the corporations and the communities they serve.

There is no single principle that can be pronounced and followed which will ensure immunity from fiduciary duty challenges for members of nonprofit boards of directors. However, organizations may implement procedures that will limit those instances in which the propriety of directors' actions will be viewed as suspect and that will assist in protecting boards of directors from the imposition of liability.

Boards of directors must be vigilant in exercising their fiduciary duties. The application of general corporate law, federal tax-exemption law, charitable trust law, and state conversion law to boards of directors' fiduciary duties illustrates the pervasive nature of the fiduciary duty doctrines. In recognizing the importance of their fiduciary duties, the first precept that board members must follow is that they must consistently fulfill their obligations to the corporation and the public by acting in good faith. A showing of good faith should be evidenced by the routine use of independent directors whose purpose is to ensure that any action taken by the board is in the corporation's best

interests. Further, boards should devise and execute an extensive conflicts of interest policy that governs the disclosure and process used to address directors' conflicts of interest which implicate their duties of loyalty. Another significant element that boards must recognize is that the decision-making process is critical. Boards must adhere to particular procedures in approving any transaction. Prior to making a significant business decision, boards should insist upon full disclosure of the facts and circumstances relevant to a complete understanding of the situation, have time to consider all available information, engage in complete and candid discussion, solicit the opinions and assessments of unbiased experts, procure the advice of legal and financial advisors, and provide adequate documentation to support the deliberative process. Moreover, it is imperative that boards diligently maintain an understanding of the operations of the corporation through being involved in the administration and enforcement of compliance programs.

Developments in the health care industry require sophisticated directors who are able to understand complex legal issues. Boards must not only comprehend basic corporate law, but also be cognizant of general laws that govern health care delivery. Only in meticulously fulfilling their corporate duties will the interests of the board, the organization, and the community be well served.